

Which Way in Psychoanalysis?

The Problem of Suggestion in the Postmodern world¹

Ronald C. Naso, Ph.D.

Abstract

The postmodern critique of psychoanalysis resurrects the problem of suggestion in full force. Contemporary psychoanalysts rely on one or more of six related strategies to avoid this unfortunate consequence. However, as Freud recognized early on, such strategies alone cannot remediate this problem. Without a viable solution, practitioners must confront the possibility that their interpretations enjoy no hegemony over nonpsychoanalytic ones and that their therapeutic results may be indistinguishable from the effects of suggestion and influence that they ambivalently embrace.

“...[T]he therapist is engaged in the effort to change his patient’s mind by an exemplary deepening of it” (Reiff, p.21)

THE RELATIONSHIP between interpretation and suggestion has been problematic from the beginning. No one saw this more clearly than Freud who consistently distinguished psychoanalytic treatment from hypnosis. When his close friend and confidant, Wilhelm Fliess, suggested that Freud was simply reading his own thoughts into the patient’s material, Freud rejected the idea and the friendship. In a different context, Adler in 1907 also questioned the principles underlying psychoanalytic interpretation, making the prescient observation that “there is more than one way in psychoanalysis” (Nunberg & Federn, 1962, p. 234). Eventually, Freud proposed a number of safeguards, both epistemological and behavioral, that he believed would adequately control, if not eliminate, the threat posed by suggestion.

¹ (2005). Which way in psychoanalysis? The problem of suggestion in the postmodern world. *Psychoanalytic Psychology*, 22: 382-394.

The following paper argues that suggestion and influence, broadly conceived, are unavoidable in the treatment situation. A reconstruction of the postmodern argument for psychoanalytic knowledge supports this assertion. In an attempt to circumvent the epistemological problems engendered by this argument, most contemporary practitioners rely on one or more of six related strategies. Unfortunately, none remediate the problem created by linking suggestion inextricably to the therapeutic relationship. This leaves practitioners in the unenviable position of having to defend their method against the charge of direct influence and suggestion on a purely subjective basis, unable to utilize evidence from other sources. While perhaps not inherently untenable for postmodern nonanalysts, it is a position that seriously weakens the plausibility of psychoanalytic method and, in a circular fashion, fuels unsuccessful efforts at remediation. This failure also undermines any argument that claims therapeutic benefit resulting from the unique elements of psychoanalytic treatment. In this way, the postmodern turn brings us full circle to the very problems that have haunted psychoanalysis from the beginning: Namely, what distinguishes the psychoanalytic method from treatments that achieve their results on the basis of suggestion. The postmodern stance has yet to be fully examined from this perspective.

Psychoanalytic truth and therapeutic action

Freud's vision was rather specific with respect to the therapeutic action of psychoanalysis. The patient's task was to remember, via interpretation and reconstruction, what had been repressed and rendered unconscious. Freud believed interpretation to be the analyst's most important tool in the effort to uncover repressions and unconscious meaning. Interpretation uncovered memories of events, real or imagined. "...[E]xplaining the pathological influences in the present of infantile fantasy, experience, and conflict was what defined the therapeutic process and accounted for the resulting relief from neurotic problems" (Schafer, 1999, p. 503). Therapeutically, psychoanalysis offered the hope that one could live a life less encumbered by the legacy of the past through a better understanding of the ways in which one's early relationships taint the perception of current relationships transferentially.

But problems emerged early on with the application of this clinical approach. Freud (1920) recognized that uncovering unconscious material and communicating it to the patient alone did not produce reliable results. Something more than interpretation was necessary. He asserted that the analyst must "...induc[e] by human influence..." (p. 18) the patient to overcome his resistances to recollection. Only through the transference does the patient gain conviction as to the truth of interpretations. Fueled powerfully by the transference, suggestion was the analyst's "most powerful dynamic weapon" (Freud, 1926, p.224). Yet, it also was conceptualized as something separable from the clinical material. Freud believed the energy of personal influence catalyzed change and created conviction about the unconscious material uncovered but, ultimately, could be disentangled from the insights achieved. The stage was thus set for what has become a fundamental tension between the clinical and scientific aims of psychoanalysis.

Freud and suggestion

Only a century ago hypnosis, along with other nonspecific treatments such as electrotherapy, hydrotherapy, massage and rest cures, was the norm for helping patients with mental disorders. Freud used all of these treatments. Near the end of 1887, he came to rely almost exclusively on

hypnosis. Despite his initial disagreement with Bernheim's purely psychological account of hypnosis, Freud was impressed with one of his findings. Despite posthypnotic amnesia, Bernheim found that he was able to prompt patients to recall information when he applied pressure to their forehead and urged them to remember. The pressure technique was, for Freud, an important transition away from reliance on hypnosis toward free association.

This transition proved only marginally helpful in disposing of the problem of suggestion. Abandoning hypnosis eradicated the use of direct suggestions or imperatives to perform certain actions and relinquish specific symptoms. Freud (1893) believed that any attempt to influence the patient ultimately would be "betrayed in the end by some contradiction..." (p. 295). This position applied not only to suggestion in the form of imperatives, but to all forms of influence. The therapist thus was free to offer interpretations to patients without fear of doing harm.

Why has the problem of suggestion not attracted more attention? In part because analysts, like Freud himself, believe they enjoy two types of protection against suggestion. The first is a clinical or behavioral one that derives from the concept of analytic neutrality. In the classical view, the relationship between analyst and analysand is not mutual or affective, but rather formal and unidirectional. The analyst is "opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (1912, p. 118.). To engage in self disclosure or to introduce the analyst's emotionality into the relationship departs from "psycho-analytic principles and verges upon treatment by suggestion" (p. 118). The analyst's restraint in this regard is essential to preserve the purity of the clinical data, uncontaminated by the analyst's expectations. In large part, training analysis further insures this purity.

The second protection pertained to the distinctive nature of proof in Freud's writings. Freud was not naïve about the patient's wish to please the analyst. He recognized that expectancies find their way into the clinical material despite neutrality. But Freud asserted repeatedly that, even under the sway of transference reactions, there were limits to such influence. "The danger of leading our patient astray by suggestion, by persuading him to accept things...has certainly been enormously exaggerated" (1937, p. 262). He believed that any such influence, anything that did not accord with what historically was true, would be discovered in the course of analysis. An insight that was purely the result of suggestion could neither lift repressions nor produce enduring improvement.

Suggestion and expectancy in the analytic setting

There is an accumulating body of research directly challenging Freud's Victorian view of suggestion. In general terms, Frank (1961) argues that the treatment context sets the stage for influence in four distinct ways: (a) It offers an emotionally-charged, intimate relationship with patients who are both demoralized and expect help; (b) The community sanctions the therapist as an authority who exercises his expertise through a set of specialized procedures that distinguishes the treatment relationship from other relationships; (c) The therapeutic rationale plausibly explains the patient's difficulties and offers a believable ritual for restoring health; (d) The treatment process encourages clinical material to develop in a particular direction via operant conditioning. All four elements highlight the intrinsic imbalance of power that characterize all therapeutic relationships and maximize the potential for influence.

The psychoanalytic setting in particular embodies these features. Its structure with respect to the duration and frequency of sessions, the use of the couch, the exclusive focus on the patient and his or her dreams, fantasies and imagery, all set the stage for influence. In addition, the fundamental rule, much like a hypnotic induction procedure, engenders a mode of cognition in which patients are open to influence. The analyst's relative silence increases the likelihood that his or her comments will be weighted disproportionately. Brenneis (2000) concludes that "...the same factors...facilitat[ing] the therapeutic benefits of psychoanalysis also maximize social influence" (p. 76). He further states that "...certain tacit or overt beliefs held by a clinician could find their way into the patient's material" (p. 76). Similarly, Hoffman (1996) maintains that "...to pick up on one or another of the patient's more or less ambiguous communications...is also to *lead the patient* in a particular direction" (p. 106).

However, so long as Freud could maintain that his method uncovered hidden motives which, when correct, mediated the removal of symptoms, his conclusions were logical and valid. Given the absence of support for what Grunbaum (1984) calls Freud's Necessary Condition Thesis and the postmodern rejection of analytic neutrality, on what basis do contemporary analysts claim authority for their readings?

The postmodern response

By arguing that they deal exclusively with reasons rather than causes, individual meanings rather than universal laws, some psychoanalysts have tried to answer the charge that data generated by the clinical encounter possess no validity. This argument also has led them to a greater appreciation of the analyst's impact on the clinical data. Initially, this recognition remained implicit because the major emphasis of these efforts was to expose the problem of historical truth and, clinically, to debunk the complementary myth of the anonymous, neutral analyst. The more active the therapist's role in shaping the clinical data, the more difficult it was to view him or her as the objective purveyor of truths that lay fully formed beneath the surface of consciousness. This perspective also has led theorists like Schafer (1983 and 1992) and Spence (1982) to assert that the clinical data may be conceptualized in multiple ways and that analysts of different theoretical persuasions uncover meanings consistent with their orientations and supported equally by the data.

The postmodern turn, however, engenders a much more radical program that challenges efforts at easy definition. Its key ideas coalesce around the consistent rejection of metatheories or grand narratives (Lyotard, 1984) and of the efforts within any discipline, tradition, or cultural institution to establish knowledge about reality apart from the language used to construct it. Postmodernism embraces novelty, fragmentation, and the pursuit of uniqueness as ends in themselves, playfully celebrating the signifier which always is constituted subjectively, without any external or real world referent. It juxtaposes scientific knowledge and narrative understanding in which distinctions, such as subject and object, are dissolved. Fundamentally, it regards human subjectivity as impenetrable to scientific understanding.

Of particular relevance to psychoanalysis is the fact that this perspective denies direct knowledge of other minds. One knows and has immediate access only to one's own subjectivity. Knowledge of others is problematic and conjectural. While not new philosophically, the conjectural nature of knowledge is uniquely forceful when combined with the denial of a reality against which

the truth of one's conjectures can be ascertained. As Eagle (2003) astutely has noted, this view not only creates "...untenable philosophical positions... [in which]...there are no truths about the mind to be learned or discovered" (p. 415), but also precludes the possibility of asserting genuine understanding of others. Most importantly, this philosophical stance deprives analysts of their greatest asset—clinical experience. The notion of clinical experience implies an accumulation of knowledge that is enduring and, potentially, verifiable. It holds the promise that one may generalize from individual instances and generate clinical hypotheses that can be tested and put to good use.

Postmodern theories purport that psychoanalysis, unlike science, deals exclusively with meanings which are subjective, highly individual, and do not lend themselves to verification or falsifiability. Like its modernist predecessor, postmodernism construes analytic experience aesthetically which, like a work of art, invites attention by virtue of its distinctive status as a signifier. Presentational form and narrative construction suppress representational meaning. Unlike modernism, however, postmodernism denies the validity of truth claims making reference to a reality beyond that which is subjectively constituted. It resists efforts to impose or restore unity and coherence, arguing that there is no meaning beyond the play of signifiers. Methodologically, the psychoanalytic enterprise is viewed as disciplined, but nonempirical, subjective rather than objective and, above all, operating via empathy and self-reflection. From these assumptions, the following argument may be constructed.

1. *Meanings within the psychoanalytic situation are co-created by therapist and patient.*
2. *The meanings thus created are completely context-dependent and unique to this relationship.*
3. *The analyst greatly influences these meanings by virtue of his (real) relationship with the patient.*

Given the truth of these premises, psychoanalysts conclude that their understanding is pluralistic, perspectivistic, and irreducible to any authoritative version. To paraphrase Hoffman (1996), if one agrees that the analyst's basic activity is that of construction, then one must conclude that he or she shapes unconscious experience rather than discovers it. But, psychoanalysts have not universally adopted this point of view. Indeed, like postmodernism itself, their writings reflect a diversity of viewpoints unified by the expression of a deconstructionist sensibility.

Both Hoffman (1996) and Mitchell (1998), among others, propose a radical version of this doctrine. Both maintain that psychoanalysts possess no absolute knowledge of other minds and that the pursuit of neutrality is motivated by the wish for an objectivity that is completely unattainable. Hoffman makes the point quite forcefully: We cannot "neutralize our personal and theoretical prejudices so that their effects will be negligible" (p. 109-110). The analyst's interpretations never are simply or exclusively reflections of the patient's experience, uninfluenced by his relationship and interaction with the analyst. The same is true of the analyst's emotional attunement. Mitchell also emphasizes the completely personal nature of the analyst's understanding: "It is *one's own* understanding, based on one's own assumptions about human life, one's own dynamics, and so on" (p. 20).

Analytic neutrality is thus inconsistent with a perspective in which two subjectivities, essentially unknowable to each other in any absolute sense, struggle to understand each other. Knowledge about the patient is largely a function of the analyst's rather than the patient's subjectivity. Understanding others is conjectural and mediated by self reflection. Limiting the

therapeutic relationship to what historically has been called the working alliance does not do justice to the possibilities within this encounter. Insofar as it involves the analyst's real, nontransferential participation, it is unique, nonreplicable, and completely context-dependent. It is an experience shared only by the participants. There is no way to distinguish between the patient's and the analyst's perspectives.

This position in its purest form posits influence as intrinsic to human relationships and subjectivity as antithetical to the possibility of objective, authoritative knowledge in any form. Unique and personal, the analytic experience lies beyond the reach of scientific understanding. It is not surprising that some writers take this position to its logical conclusion: "Patients who come for treatment are...seeking to be influenced" (Slavin, 1998). Or, more to the point, practitioners should "relinquish all hope of an influence-free analytic position" (McLaughlin, 1996, P. 202). In this view, change occurs in the context of a power relationship in which influence is exercised benevolently. Influence is the driving force of change and the clinical data represent an inseparable mixture of the patient's and analyst's understanding.

Safeguarding Analytic Authority

Not all psychoanalysts are comfortable with the conclusions drawn by Mitchell and Hoffman. Rejecting the antiquated notion of neutrality is one thing; it is quite another to accept that this rejection logically entails relinquishing claims for the unique value of psychoanalytic treatment when suggestion and the therapeutic relationships are linked inextricably. Uniqueness hinges on the ability to separate results wrought psychoanalytically from those achieved nonspecifically on the basis of suggestion. In their defense, contemporary theorists offer six proposals to rescue the validity of their interpretations.

1. *Therapeutic Frame.* Psychoanalysis is defined by its technique, rules, and structure. Jointly, they create unique "analytic possibilities" (Mitchell, 1998) and prevent the emergence of a purely personal relationship (Hoffman, 1994). Postmodern writers emphasize that the unique structure of the psychoanalytic setting profoundly shapes the clinical material. Yet, paradoxically, they assert that this same structure protects the data from undue influence or manipulation.

In this way Schafer's theorizing, for example, retains a somewhat classical view of the analyst's behavior and of the therapeutic frame. Rather than emphasizing the analyst's unconscious processes or nontransferential relationship with the patient, he focuses on how the analyst's theory shapes the clinical data. Importantly, for Schafer, analytic neutrality is maintained. The analyst does not uncover *the meaning*, but identifies, constructs, and organizes patterns of meaning consistent with particular psychoanalytic storylines which are embedded in a matrix of potential narratives that may be examined with respect to their assumptions, values, and utility (Schafer, 1992).

Unfortunately Schafer's view, like other arguments relying on support from the therapeutic frame, is flawed. It assumes that the therapeutic frame alone provides adequate protection against the deleterious effects of suggestion. To be sure, it certainly offers some degree of protection. For example, it prevents the more overt forms of suggestion originally identified by Freud. However to conclude that the therapeutic frame alone eradicates all untoward influences is unwarranted. These forces are subtle and constituted by the very nature of the therapeutic encounter. To assume that

they also are adequately controlled by the structure of this encounter simply begs the question. This is true as well for weaker claims that acknowledge influence, but assert that it fails to taint the clinical data irremediably. Without some mechanism for independent verification, all versions of this argument reduce to a belief in the omniscience of the analyst.

2. *Observational Distance.* Conceptually distinct from the notion of therapeutic frame, observational distance refers to the therapist's attitude or positioning with respect to the therapeutic process. Analytic opinion is quite varied in its assessment of how much participation is appropriate, but there is a reasonable degree of consensus about the importance of maintaining a stance in which the analyst can identify unconscious meaning. Schafer's participation, for example, is a more abstract or cognitive one that reflects the ways in which he understands and organizes the clinical data. It is of course rooted in his perspective and subjectivity, but these factors remain in the background of his theorizing. He views the proper role of the analyst to be one in which he is "...positioned to listen and think in terms of unconscious transference constructions of experience..." (1999, p. 523) made possible by a "stable sense of reality" (p. 524) rather than the reactive emotionality he attributes to some analysts. This distance provides the analyst with an ideal vantage point from which to identify and interpret unconscious meaning. Heightened awareness of influence makes it possible to analyze its effects and/or to put them to good use (Grossman, 1996). These are quite different possibilities. The latter is transparently suggestive.

Brenner (1996) holds that influence alone neither invalidates nor prejudices all observations. It is possible to evaluate its significance by specifying the conditions under which particular observations are believed to be accurate. Alternatively, hypotheses may be made in a probabilistic fashion (Rubinstein, 1976). The fact that participation taints observations therefore places limits on their accuracy and challenges the analyst to be more precise in stating the conditions under which they are true. However, without subjecting these observations to testing outside the individual treatment session and by leaving the specification of these observational conditions solely at the discretion of the individual analyst, such arguments assume rather than establish the observational accuracy necessary for validation.

3. *Narrative Fit.* This position holds that analytic constructions need not be true literally or historically, but must be apt and fit the data. Spence (1982) offers the term "narrative truth" in an effort to describe the standards of proof in a field where the data are not archival and where there is virtually no opportunity to examine the raw material free from the treating analyst's inferential processes. Postmodern theorists underestimate the importance of archival data for addressing problems of analytic understanding, relying completely on material that already has undergone significant transformation by the analyst. For this reason, discussions of how a patient's statement disconfirms the analyst's hypothesis or interpretation are rare.

Several related ideas are offered under this heading as alternatives to independent confirmation. All embrace a standard of proof that is textual or thematic. They are concerned with how the information is organized rather than with how it might be falsified. Schafer's notion of psychoanalytic storylines and Summers (2000) description of the continual refinement of understanding on the basis of newly emerging clinical material are recent examples of this position. Both suggest that the data somehow are woven into existing narrative templates in a disciplined fashion. They also imply that there are procedures or decision-making rules for reliably

organizing the data, identifying what is interpretable and, most important, recognizing which data fit a particular formulation. In 1907, Freud voiced this same hope when he claimed that it would be possible to learn the psychoanalytic method “once the arbitrariness of individual psychoanalysts is curbed by tested rules” (Nunberg & Federn, 1962, p. 237). Almost one hundred years thence, no reliable way of identifying and certifying unconscious meaning has been established.

4. *Authenticating Experience.* Analysts purport to be able to discern authentic affect or genuine expressions of emotion in the clinical situation. These experiences frequently are construed as certifying the interpretations that have preceded them. Though postmodern theorists shy away from using the term “cause”, the inference from authentic experience to “truth”, however one qualifies the term, nevertheless is an instance of *post hoc ergo propter hoc*. Similarly, while few analysts naively claim that memories elicited in treatment are veridical, they frequently offer them as evidence of an interpretation’s aptness. This strategy is problematic without independent corroboration (Brenneis, 2000; Birch, 1998). The work of Loftus (1993) strongly supports this conclusion. Laboratory studies provide additional evidence that various types of feedback can transform memory in an expectancy-congruent direction (Ross and Conway, 1986; Hirt, Lynn, Payne, Krackow and McCrea, 1999; and Hirt, Erickson and McDonald, 1993). Specifically, this research suggests that subjects tend to distort expectancy-inconsistent information in a direction that is expectancy-congruent.
5. *Utility.* Almost all postmodern theorists rely on some version of this concept to replace validity achieved by independent corroboration. Thus, the analyst and patient together create an understanding that is helpful as opposed to true or falsifiable. The basis for their conviction in the truth of this understanding is grounded in its “intuitive, pragmatic credibility” (Schafer, 1992), “enrichment of common sense” (Mitchell, 1998, p. 8), and ability to overcome some unspecified threshold of “skepticism” (Hoffman, 1996). In other words, they are valid because “they have proved helpful in generating a sense of personal meaning and value” (Mitchell, p. 26).

The utility argument suffers two distinct liabilities: First, it accords exclusively to the individual analyst the ability to distinguish understanding that is credible and useful from that which is false and impractical. Second, it claims that he or she can identify correctly the precise variables mediating therapeutic change. Decades of psychotherapy research suggest that identifying these variables is, at best, a daunting task (Blatt and Ford, 1994). In classic Associationist fashion, the argument from utility often rests on little more than the belief that an antecedent event (such as a powerful insight, experience, or memory) causes or is the reason for another by virtue of the fact that the first occurs earlier than the second. This clearly is not necessarily true.

6. *Narrative Limits.* Actual experience provides constraints against which interpretations are measured (Mitchell, 1998). Alternatively, there are indisputable elements or “givens” of experience that constrain possible interpretations (Hoffman, 1996). Less frequently cited is Strenger’s (1991) notion of external coherence. This concept provides some protection against relativism by imposing the minimal requirement that interpretations be consistent with findings established by other disciplines. While narrative limits prevent the postmodern perspective from lapsing into frank relativism, they do little to establish the truth or validity of an interpretation. At best, they render some interpretations less probable by demonstrating their inconsistency with existing knowledge

Mitchell (2000) offers a similar view that validity is established by the analyst's "rigorous thinking...continually cross-checked with clinical experience" (p. 159). Presumably such cross-checking involves information beyond the individual treatment session and thus represents a modest improvement upon the notion of narrative fit. However, unless one can separate the analyst's inferences from the data engendering them, this method will fail to meet the conditions of independence necessary to establish clinical findings in the strict sense.

Influence: Claimed and Disclaimed

No analyst claims to use the therapeutic relationship intentionally to direct or control the patient's behavior. Yet writers like Renik and Hoffman assert that the treatment context is so personalized and unique that the analyst's emotions exert a major impact on the therapeutic process, making real influence and persuasion unavoidable. Hoffman deals explicitly with this issue:

I believe it is an overreaction both to the idea of brainwashing and to the dangers of unwitting and unexamined suggestion to deny that psychoanalysis entails a complex kind of concentrated social influence which partakes of some of the ingredients that Berger and Luckman (1967) attribute to 'resocialization'. Not the least of these ingredients is a culturally sanctioned power that is invested in the analyst and that is sustained and cultivated in an ongoing way by the ritual features of the psychoanalytic process itself (1996, p. 117-118).

Hoffman not only acknowledges the important role of expectancy within analytic treatment, but also conceptualizes it as operating through the interpretive constructions and overall structure provided by the analyst. The analyst's specialized role imbues him with the kind of power more typically seen in methods whose aim is direct influence and control. "...[T]he analyst's personal involvement in the analytic situation has, potentially, a particular kind of concentrated power because it is embedded in a ritual in which the analyst is set up to be a special kind of authority" (Hoffman, p. 120). In taking this position, does Hoffman cross the boundary between psychoanalytic and nonpsychoanalytic perspectives? Do the qualifying terms "unwitting" and "unexamined" in any way lessen the dangers so powerfully posed by suggestion? These questions are important not because the answers can be used to dismiss his views, but because they have far reaching implications for understanding how change occurs in treatment. By viewing the analyst's influence as instrumental rather than incidental to this process, the role of understanding and self-knowledge necessarily is diminished.

For Freud, transference propelled the patient forward in treatment, but ultimately was a means for achieving a deeper appreciation of the legacy of the past. The patient's conviction in the correctness of this understanding removed symptoms. Hoffman and others, by contrast, see the analyst's real relationship acting as a catalyst for change in much the same way as a parent's relationship does with a child. The child's wish for parental recognition and affirmation is not transference, but real. Relative success or failure on the child's part carries great weight emotionally and developmentally. Hoffman suggests that it is the patient's capacity to relate to the analyst at critical moments in an intimate, loving, nontransference way that makes treatment possible. Put another way, the patient's success at engaging the therapist in reality possesses enormous power because it is recognized as an exception to this highly structured and ritualized relationship. It is

affirming in the sense that it makes the patient feel special, unique, and connected to the therapist in something more than his or her professional capacity.

This point is critical in understanding Hoffman's position. Transference alone is insufficient to the task of psychoanalytic treatment. In what can only be described as an inversion of the concept of transference neurosis, the patient is not liberated by the knowledge that his relationship with the analyst is repetitive unconsciously and, therefore, largely the patient's creation. Rather, it is the patient's capacity to successfully engage the analyst outside the transference, to win his interest, love, and concern that establishes the conditions for self understanding.

Other writers attempt to rescue Hoffman's argument from this conclusion by emphasizing, like Freud, that any deleterious effects of suggestion come under analytic scrutiny. Whatever untoward influence occurs in the analytic encounter will be subjected to analytic sensibility. Hoffman, however, rejects this strategy as "continual doing and undoing" (p. 109). Debriefing cannot eradicate influence.

But why, one may ask, does Hoffman need to be rescued from this position when he recognizes and accepts that the rejection of analytic neutrality and falsifiable understanding entail the inseparability of interpretation and influence. For psychoanalysts, the response must be that Hoffman's position, taken to its logical conclusion, renders the therapeutic relationship indistinguishable from a personal, nonanalytic one. It permits, if not promotes, direct gratification of the patient's wishes and diminishes the mutative role of specifically psychoanalytic interventions.

This stance also interestingly suppresses important disparities between Hoffman's radical view of the therapeutic process and his actual practice, at least as conveyed in his writings. Hoffman alludes to these tensions, but does not make their impact explicit with regard to his technique which does not depart from accepted practice. This point is critical to an overall assessment of his views. For example, Hoffman (1996) accepts his patient's invitation to view a videotape only after carefully evaluating the request as a symbolic communication within a specific developmental, historical, and theoretical context. Consistent with Lipton (1977), he reflects on the meaning of the offer, not simply as a behavior with a fixed meaning which, therefore, evokes a pre-programmed response, but with respect to its purpose. This stance allows him to evaluate the patient's request in terms of its relationship to the treatment as a whole, as well as to avoid artificiality and promote the working alliance. His decision to emphasize the subjective and personal aspects of the interaction conceals the existence of crucial background structures and knowledge that make his approach psychoanalytically plausible. Were it not for these assumptions, beliefs, and commitments, what would prevent Hoffman from visiting his patient to watch the videotape together?

Conclusion

While many epistemological problems went unrecognized by Freud, suggestion was *not* one of them. He differentiated his method from that of hypnosis throughout his career and, in fact, grounded the validity of his interpretations in terms of their freedom from suggestion. Despite

evidence that now calls Freud's judgment in these matters seriously into question, contemporary practitioners lack his clear perception of the dangers suggestion poses.

The postmodern argument for suggestion and influence is a cogent one. The psychoanalytic setting shares many features with the hypnotic setting and, hence, creates the optimal conditions for persuasion. However, psychoanalysis as a field has been slow to assimilate the rather compelling evidence from research conducted in the areas of expectancy and suggestion. These data suggest that interpretations do not simply offer universal, objective, or veridical explanations, but (clinically and theoretically-informed) conjectures about the patient in a context that maximize his or her expectancies and the analyst's influence.

The real problem confronting contemporary psychoanalysis is how to best handle the implications of the postmodern argument. Analysts cannot reject neutrality and objectivity yet claim authoritatively to discern authenticity and evaluate evidence impartially. "...[D]econstruction accepts no self-exclusionary limits on its application..."(Schafer, p. 158). Without the possibility of independent verification or interpretive constraints, psychoanalysts are left with two troubling conclusions: First, psychoanalytic readings enjoy no hegemony over nonpsychoanalytic ones. Second, psychoanalysis as a therapy may operate on the basis of the same factors as other suggestive treatments. While the first conclusion presents little difficulty for a perspective which is not aimed specifically at establishing authoritative readings, it creates an insuperable dilemma for psychoanalytic practitioners who must provide treatment without belief in the possibility either of knowing anything about what is in the patient's mind (Eagle, 2003, p. 418) or of possessing knowledge that *makes a difference* clinically. Not only does this perspective preclude discovery of the deeper patterns and dynamics in the patient's life, but diminishes their importance insofar as their truth may correspond only inadvertently to something independent of the analyst's constructions. The issue of hegemony, therefore, emerges not so much in the context of the postmodern perspective itself, but in a misconstrual of the usefulness of its ideas for psychoanalysis. It is particularly devastating to the efforts of practitioners who seek in the postmodern turn a means of vindicating their interpretations in the absence of extraclinical evidence. Interestingly, even a cursory review of postmodern clinical case descriptions reveals contradictions between this philosophical position and actual practice. These disparities result from unacknowledged, but necessary modernist assumptions that vouchsafe the psychoanalytic and clinical plausibility of what analysts do. Despite its growing tolerance of relativism, psychoanalysis cannot fully assimilate postmodern ideas without abandoning its unique perspective on the human condition and its clinical method. Yet, in the end, this is precisely what the postmodern turn requires. These are the implications of a view that is entirely personal, subjective, and based on each analyst's construction of the clinical data.

The issue of influence is uniquely forceful in postmodern thinking because it is viewed as intrinsic rather than peripheral, constitutive rather than situational. However, the impact of mutual influence on the analyst's ability to establish the truth or falsity of inferences is unclear and, likely, exaggerated. Are we simply to assume that suggestion, like subjectivity, is irreducible and irretrievably contaminates all inferences such that we can only know what is in our own minds? Is it possible to establish the conditions under which patients and our inferences about them are more or less vulnerable to the deleterious effects of suggestion? Unfortunately, the postmodern perspective brooks no such distinctions by denying any means of testing such hypotheses nontextually. For this

reason, it is contradictory for psychoanalysts persuaded by postmodern ideas to claim protection from influence by virtue of clinical countermeasures. It is equally improbable that they validly or reliably can discern the distinctive agents of change. Importantly, this is not necessarily because these changes do not exist, but rather because, even if the unique contribution of each participant could be separated, analysts still would remain in the unenviable position of having to detect very small effect sizes. Contrary to Mitchell's call for validity of the "nonstatistical sort", such effect sizes will most likely be discernable *only* through statistical analysis. If what made a difference in treatment was apparent to the naked eye, to paraphrase Freud "where pluralism was, there certitude would be".

Psychoanalysis has yet to gather the evidence necessary to reject the null hypothesis that treatment results are achieved solely on the basis of suggestion and expectancy. To be distinctive, it must be able to reject the rival claim that it is simply a form of social influence animated by a commitment to the nonmanipulative promotion of self knowledge utilizing a method that discourages direct control or persuasion. More than anything, the postmodern turn focuses attention on the fact that influence operates ubiquitously within the treatment setting. It exposes the myth of the neutral analyst operating with a kind of surgical detachment on clinical data which he or she plays no role in shaping.

The question of how human beings change, develop, and are transformed through relationships with others must remain an open one. For this reason, the choice of "which way" in the title of this paper is not meant to suggest a rigid dichotomy between alternatives for psychoanalysis. It is offered instead in the spirit of Adler's insight that more than one way is possible. In the end, I do not think that postmodernism advances our efforts to resolve the most pressing problems in contemporary psychoanalysis. Its greatest contribution resides in the challenge it presents to establishing clinical findings on a more solid footing. However, its potential for offering a productive way of meeting this challenge pales by comparison with that of scientific method. The superiority of scientific method rests not in its ability to provide a pure, nonperspectivistic account of reality, but rather in the opportunity it offers, to paraphrase D'Andrade (1995), to test ideas in a relatively unbiased way despite what we might want to be true.

References

- Birch, M. (1998). Through a glass darkly: Questions about truth and memory. *Psychoanalytic Psychology*, 15, 34-48.
- Blatt, S. J. & Ford, R. Q. (1994). *Therapeutic change*. New York: Plenum.
- Brenneis, C. B. (2000). Evaluating the evidence: Can we find authenticated recovered memory? *Psychoanalytic Psychology*, 17, 61-77.
- Brenner, C. (1996). The nature of knowledge and the limits of authority in psychoanalysis. *Psychoanalytic Quarterly*, 65, 21-31.
- D'Andrade, R. (1995). Moral models in anthropology. *Current Anthropology*, 36, 399-407.
- Eagle, M.N. (2003). The postmodern turn in psychoanalysis: a critique. *Psychoanalytic Psychology*, 20, 411-424.
- Frank, J.D. (1961). *Persuasion and Healing*. Baltimore: Johns Hopkins University Press.
- Freud, S. (1893). Studies on Hysteria. *Standard Edition*, 2. London: Hogarth Press, 1955.

- _____. (1912). Recommendations to physicians practicing psycho-analysis. *Standard Edition*, 12, 109-120. London: Hogarth Press, 1958.
- _____. (1920). Beyond the pleasure principle. *Standard Edition*, 18, 3-64. London: Hogarth Press, 1955.
- _____. (1926). The question of lay analysis. *Standard Edition*, 20, 179-258. London: Hogarth Press, 1959.
- _____. (1937). Constructions in analysis. *Standard Edition*, 23, 255-270. London: Hogarth, 1964.
- Grossman, L. (1996). The analyst's influence. *Psychoanalytic Quarterly*, 65, 681-692.
- Grunbaum, A. (1984). *The Foundations of Psychoanalysis: A Philosophical Critique*. Berkeley & Los Angeles: University of California Press. *Psychological Issues*, 61. International Universities Press: Madison, CT.
- Hirt, E. R., Erickson, G.A., & McDonald, H.E. (1993). The role of expectancy timing and outcome consistency in expectancy-guided retrieval. *Journal of Personality and Social Psychology*, 65, 640-656.
- Hirt, E. R., Lynn, S. J., Payne, D.G., Krackow, E., & McCrea, S. M. (1999). Expectancies and memory: inferring the past from what must have been. In: Kirsch, I. (Ed.). *How expectancies shape experience*. American Psychological Association: Washington, D.C.
- Hoffman, I.Z. (1994). Dialectical thinking and therapeutic action in the psychoanalytic process. *Psychoanalytic Quarterly*, 63, 187-218.
- _____. (1996). The intimate and ironic authority of the psychoanalyst's presence. *Psychoanalytic Quarterly*, 65, 102-136.
- Lipton, S. (1977). The advantages of Freud's technique as shown by his analysis of the Rat Man. *International Journal of Psychoanalysis*, 58, 255-274.
- Loftus, E.F. (1993). The reality of repressed memories. *American Psychologist*, 48, 518-537.
- Lyotard, J. (1984). *The Postmodern Condition: A Report on Knowledge*. Translated by G. Bennington & B. Massumi. Minneapolis: University of Minnesota Press.
- McLaughlin, J. T. (1996). Power, authority, and influence in the analytic dyad. *Psychoanalytic Quarterly*, 65, 201-235.
- Mitchell, S. (1998). The analyst's knowledge and authority. *Psychoanalytic Quarterly*, 67, 1-31.
- Mitchell, S. (2000). Response to Silverman. *Psychoanalytic Psychology*, 17, 153-159.
- Nunberg, H. & Federn, E., ed. (1962). *Minutes of the Vienna Psychoanalytic Society*. Vol. 1. (trans. M. Nunberg in collaboration with H. Collins). New York: International Universities Press.
- Rieff, P. (1966). *The Triumph of the Therapeutic: Uses of Faith after Freud*. University of Chicago Press.
- Ross, M. & Conway, M. (1986). Remembering one's own past: The construction of personal histories. In R. M. Sorrentino & E.T. Higgins (Eds.), *Handbook of motivation and cognition* (Vol. 1, pp. 122-144).
- Rubenstein, B. B. (1976). On the possibility of a strictly clinical psychoanalytic theory: An essay in the philosophy of psychoanalysis. In: Gill, M. M. & Holzman, P. S. (Eds.). *Psychology versus Metapsychology: Psychoanalytic essays in memory of George S. Klein*. International Universities Press: New York.
- Schafer, R. (1983). *The analytic attitude*. Basic Books: New York.
- _____. (1992). *Retelling a life. Narration and dialogue in psychoanalysis*. New York: Basic Books.
- _____. (1999). Interpreting sex. *Psychoanalytic Psychology*, 16, 502-513.
- Slavin, J. H. (1998). Influence and vulnerability in psychoanalytic supervision. *Psychoanalytic Psychology*, 15, 230-244.
- Spence, D. P. (1982). *Narrative Truth and Historical Truth*. New York: Norton.

- Strenger, C. (1991). Between hermeneutics and science: An essay on the epistemology of psychoanalysis. *Psychological Issues*, (whole no. 59).
- Summers, F. (2000). The analyst's vision of the patient and therapeutic action. *Psychoanalytic Psychology*, 17, 547-564.