

EDGAR A. LEVENSON, M. D.

---

## THE ENIGMA OF THE TRANSFERENCE\*

---

*Abstract:* Metapsychologies are essentially ontologies; that is, they are world-views and as such are ineluctably immersed in their time and place. They are neither right nor wrong, but, rather, relevant or irrelevant. An epistemological approach to the praxis of psychoanalytic therapy indicates that there are two striking clinical phenomena—the associative flow of data and the transference enactment, or replay, of what is being talked about. All psychoanalysts must struggle with how to integrate these two clinical parameters into their metapsychological premises. It is suggested that the recent discovery of “mirror neurons” might provide a frame of reference. Elucidation and enactment may be two sides of the same cognitive process that leads to change.

---

*Keywords:* psychotherapy, psychoanalysis, metapsychology, transference, enactment, mirror neurons, flow of consciousness.

---

PSYCHOANALYSIS HAS FROM ITS INCEPTION been biased toward theory, metapsychology, presumably the font of the mutative therapeutic action. Far less emphasis has been put on the phenomenology of therapeutic action; that is, *how* people change. This valorization of metapsychology is coming increasingly under scrutiny as the erstwhile sharp-edged doctrinaire distinctions between positions blur and attention shifts to an emergent neuropsychological paradigm—to be sure, at this stage of knowledge, more a metaphor than a genuine model (Pulver 2003). In other words, now that it is less clear that we are right and you are wrong, we are all beginning to wonder what it is we are doing when we do what we all know how to do.

---

\*This paper was presented as the 11<sup>th</sup> annual Sydney E. Pulver M.D. lecture at the Psychoanalytic Center of Philadelphia on October 17, 2008. An earlier version was presented at the conference of the American Psychological Association, Division 39, “Knowing, Not Knowing and Sort-of Knowing: Psychoanalysis and the Experience of Uncertainty,” New York City, April 9, 2008.

Metapsychology, for all its claim to ontological truth, always reflects the current culture, the social context in which we are all immersed, but of which we are largely unaware. As Gregory Bateson (1979) said, the point of the probe is always in the heart of the explorer (p. 87). The current emphasis on the vicissitudes of early mothering, especially as described in attachment theory, reflects a cultural change, from the patriarchal, oedipal-oriented (conflict and envy) world in which I both grew up and became an analyst, to a matriarchal, nurturing one in which early mothering and empathy are privileged. One also notes, not inconsequentially, that the demographics of psychoanalysis have shifted from largely male and medical to female and psychological along with a radical shift in the economics. Believe it or not, when I entered the field in the early 50s, psychoanalysis was the second highest paid medical specialty and we had waiting lists! Clearly this circumstance made for a therapeutic milieu that tolerated more frustration and tempted therapists less to overaggressive interventions.

But does anyone entirely believe that if secure attachment takes place, all subsequent troubles are weathered: oedipal, family, sibling, peer group, societal, midlife, and old age? Whatever happened to the father? It appears that, although we are ostensibly ecumenically intended, agreeing to disagree amicably, psychoanalysis is still split into what Cooper (2008) calls a "growing plurality of orthodoxies", adamant, entrenched, and highly politicized (p. 235). Yet surely everyone from Freudian to relational therapist is on to something, has grasped some aspect of our proverbial elephant, the nature of mind.

Once thought of as the "Ghost in the Machine," mind and its correlate, consciousness, have become of cardinal interest (Levenson, 2001). We are now in the Age of the Mind, and the nature of consciousness is hotly debated in an obscure, virtually medievalist sectarianism amongst the "mentalists," the "functionalists," the "materialists," and the "mysterians" (Damasio, 1994). Suffice it to say that the debate centers on whether consciousness is merely an epiphenomenon of the brain—an inevitable outcome of organic complexity—or whether it is of another essence altogether.<sup>1</sup> Consciousness, as Damasio says, is "the last great mystery and may lead us to change our view of the universe we inhabit" (p. 21). What

---

<sup>1</sup> See Chalmers (1996) and Searle (1997) for a discussion of a belief in a fundamentally irreducible consciousness

“mind” is remains something of a mystery. As Jonathan Miller (1995) put it, “[W]e are the unwitting beneficiaries of a mind that is, in a sense, only partially our own” (p. 64).

Consequently, I suggest that our current focus be not on competing metapsychologies and their interpretive sets, but on how mind works, how experience is processed and integrated. We must understand the phenomenology of change, how people comprehend their being in the world, and how the analyst’s presence and interactions foster flexibility and growth.

Regardless of theoretical positions, most analysts are struck by two oddly autonomous parameters of observation: first, the flow of consciousness as it is evidenced in the patient’s narrative—the unconscious associations, the “red line” of coherence that runs through the ramblings of a session—and, second, the transference enactment, the way analyst and patient behave with each other in the course of the inquiry. Clearly, both the interpersonal and the intrapsychic coexist: the relationship between the intersubjective world and the still mysterious internal processes of change must be synthesized. Integrating these two striking aspects of the analytic process has been, for me, consistently the most puzzling and yet rewarding aspect of the therapeutic endeavor.

The patient’s flow of consciousness, the intrapsychic, is the classic *sine qua non* of the analytic process—not necessarily limited to free-association, since the same order is equally evident in a detailed inquiry. As Bolas (1999) put it,

[There is an] understandable and inevitable tension between the goal of free association and the wishes of the analyst to understand the material: as free association unbinds meaning—in what Laplanche terms and celebrates as the “anti-hermeneutics” of psychoanalysis—while interpretation creates and binds meaning. No sooner are such understandings established than the workings of the unconscious, evident through free association, break the interpretation into particles of meaning, which constitute a “use of the Object,” hopefully celebrated by the analyst’s unconscious working along similar lines even as such use disperses his interpretive creations [p. 70].

The second striking manifestation is, of course, the relationship between the patient and therapist, the uncanny way the two play or enact, or reenact, the very patterns that are under inquiry. This is, of course, the storied

transference, these days considerably loosened from Freud's original constraints, but still clearly central to the process.

Two clinical excerpts are, I think, illuminating. The first illustrates the coherence of the patient's unconscious flow of associations, which seem, at least at first view, to be independent of the therapist's participation. It very much reflects Masud Khan's aphorism that we are the servants of the patient's process (quoted in Milner, 1969, p. xxxi). The second example, also a dream, illustrates less the flow of unconscious associations than the intricate interweaving of content and transference enactments.

The first patient, a 30-year-old man, has a dream about three weeks into therapy. He is "with another guy." Perhaps they are reviewing his portfolio. That's all. That's the dream. Who is the guy? He doesn't know. He is thinking of working for a friend of his mother's brother—his famous Uncle Max, the family patriarch, who is wealthy and powerful and helps them all with their problems, financial or personal. Oh yes, there are snakes floating around overhead. Also something like hieroglyphics, bits of information. Any other associations? Other ideas? None. Suddenly he remembers that the dream takes place in his parents' garage, at their country house. What about the house? His parents own an isolated country house. He often visits there without them. He must enter the house through the garage, which is always left unlocked. He must first reach over a shelf in the dark to find the light switch. Then he must reach deeper into the dusty, cobwebbed space to find the house key. Then he must take the key around to the front of the house and open the main door. Otherwise, he could enter through the garage, go down the stairs from the garage to the cellar—a very spooky place that he has always avoided—and then he can go up the back stairs into the house. He never *ever* goes into the cellar. The garage is scary enough since it is never locked. Every time he opens the door, he expects to be attacked by "a bum or bear or something."

Why doesn't he just leave another key hidden near the front door? It's not clear; he never thought about it. Does his father go through all this when he uses his house? Where were the bits of hieroglyphics? The associations begin to proliferate: to the movie *Indiana Jones and the Temple of Doom*. It seems that entering the garage is like the movie—always hidden rooms, monsters, having to reach through icky bugs and snakes—Indiana Jones's Achilles heel, his phobia. What about snakes? Constrictors . . . not vipers . . . constriction . . . squeezed. He doesn't have a snake phobia, but he hates spiders!

Hieroglyphics come back into play. He has always been interested in archeology, thought it would be a wonderful thing to do. It is his grandfather's and his father's interest. Grandfather would spend weeks meticulously repairing antique vases from his homeland. His father also loved antiquities. When my patient was a child, his grandfather would play with him, breaking a vase, burying the pieces and having him find them, dig them up, and reconstitute the item.

This profuse flow of associations to a very brief dream! Some of the associations were totally spontaneous, others a consequence of my detailed inquiry; all seem to come from some entirely autonomous source. They are, to put it technically, metonymic not metaphoric; that is, they are private associations,<sup>2</sup> whose relevance only the patient knows, as compared with metaphor, which is in the common domain, a story. Certainly I have no idea where it is headed, although I do ask detailed questions that focus on the odd omissions.

One certainly could infer a transferential subtext. The patriarchal Uncle Max who helps everyone, the fascinating game of inquiry and reconstitution (Freud, after all, considered psychoanalysis an archaeological process), the coded messages—all point to a view of transference and of the therapy. Is it a game to make the patriarch happy? Does it really engage him? The questions proliferate, but here I want simply to show how this dream has a blatant associative aspect and a much more implied and less self-evident transferential dimension.

The second dream is far more elaborate, richly metaphoric, and chock full of blatantly obvious transferential implications. Indications of an associative flow are sparse. For this 50-year-old woman, it is her first dream in vivid color and occurs one year into therapy. In the dream she is at a conference where she meets Osama Bin Laden. He is her height, has hazel eyes, but something seems to be wrong with his shoulder. He asks if she hates him. She explains that she is Jewish and pro-Israel. She's telling him "straight." He is listening, looking her straight in the eye. Then Bin Laden wants to kiss her. He chews food and then passes it to her lips, as a mother bird or a wild dog would (note the polarities of nurturance—a bird or a carnivore). This, he explains, is "an old Indian custom." He has a virus, and she is thinking of getting him medicine (she doesn't seem concerned about catching some disease from being fed by him).

---

<sup>2</sup> See Levenson (1991, p. 38) for elaboration of this theme

In contrast to the first dreamer's, her associations are minimal: namely that her mother had visited India twice (without her father). I point out to her the stunningly obvious—that I am her height, have hazel eyes, and, when she started in therapy with me a year earlier, I had just had shoulder surgery and my arm was in a sling for many weeks. (In both Bin Laden's and my case, it was specifically the right shoulder.) This dream is a veritable palimpsest of unconscious process: first, the content, her apparent unawareness of perfectly obvious themes; her presenting me with the themes so that I can prechew them and force feed them back to her—which, of course, I proceed to do by explaining the dream to her. Does she need to be told that her feelings about Osama are ambivalent? That he represents me, the therapist? All he lacks is a name tag!

She has wonderful dreams—at least at that stage of the therapy—that make me feel very insightful and clever, and I usually fall for “interpreting” them to her. If they are so obvious, why doesn't she see them? How can someone so smart be so dumb? It is a prime example of R. D. Laing's (1967) dictum about mystification: the patient learns not to know what the patient knows she knows but is not supposed to know. In this dream, although there are many rich threads of inquiry into her history, the interactive replay of those themes with me is most instantly obvious.

The two dreams illustrate the polarities in the dialectic between the intrapsychic process of unconscious flow and the interpersonal process of transference enactment. Why don't analysts simply use both parameters of therapy flexibly, moving freely between them? One would think that a therapist could easily be aware of these two clinical parameters. However, they exert a strangely compelling gestalt figure-ground effect; while one is being observed, the other tends to disappear. In each of the clinical cases that phenomenon is so striking that one is tempted to think, “Ah. So that's how it works. That's where the clinical leverage lies!” A surprising amount of deliberate effort is required to move back and forth between inquiry and the awareness of interaction.

Psychoanalytic groups do seem to privilege one or the other as a means of institutional definition; drive, interpersonal, theory, relational theories, all prioritize either flow of consciousness or interaction. It all used to be much simpler. In the Good Old Days of only one psychoanalysis, you either were or were not an analyst: this, of course, was decided by the powers that be—and the White Institute, and its epigones, were not analysts. Simple as that. It was a pragmatic application of Popper's (1963) principle of falsifiability—you can't say what a thing is if you can't say what it isn't.

Psychoanalysts defined themselves by declaring who wasn't. The struggle for status, prestige, patients, and candidates invokes a polarization: them—us. The minute you are convinced you are right and that your system is the only Truth—you've established a religion. Current ecumenism allows for multiple versions of psychoanalysis, some of which admittedly may strain the definition of the process. But at least we now talk to each other.

In 1983, Greenberg and Mitchell published their seminal *Object Relations in Psychoanalytic Theory*. By subsuming virtually every psychoanalytic position—other than Freudians—under the rubric of “relational” (including Kleinian, Kohutian, interpersonal, Winnicottian, etc.), they essentially politically outflanked and isolated them and pressured them to participate in an ecumenical movement that may have had as much to do with pragmatics as any genuine substantive synthesis would have.

At about the same time, Merton Gill (1983) presciently identified the problem. Gill, who was perhaps the most unyielding of the Freudian analysts on the committee—that in 1942 expelled the early group of interpersonalists from the American Psychoanalytic Association (for, among other shortcomings, not conforming to the five-day/couch rule)—had been drifting toward an interpersonalism of his own. He and I corresponded about my book *The Fallacy of Understanding* (1972), and he came to White and attended some of our Clinic meetings. In 1982, at White, he gave a remarkable talk defying the then current draconian bans, an act of no small moral courage. He had reviewed the entire corpus of interpersonal writings and, with his fresh and original intelligence, saw that there were, as he said, two dichotomies in psychoanalysis.

He was referring to the distinction between two major cleavages in psychoanalytic thought. One cleavage is between the interpersonal paradigm and the drive-discharge paradigm. The other cleavage is between those who believe the analyst inevitably participates in a major way in the analytic situation and those who do not. I came to realize that I had assumed that these two cleavages ran parallel to each other, or at least that those who adhered to the interpersonal paradigm would also ascribe to the analyst a major participation in the analytic situation (Gill, 1983, p. 201).

Note that Gill accepted the relational–drive dichotomy as valid. He went on to say that variations in the use of the second parameter cut across institutional and metapsychological loyalties and affiliations. He was, in essence, saying that within any psychoanalytic group there will be in this second cleavage marked variations, which one might consider as a

continuum of activity, running from analysts who see themselves as the curative event in a patient's life (charismatic or restitutive), to those who see the cure as the analyst curing herself (analysis of countertransference), to those who believe in the analysis of resistance and transference as getting out of the way of the patient's self-curative potential to allow some self-regulating (intrapsychic) activity on the patient's part. The spectrum runs from the mutative effects of the analyst's engagement to emphasis on the unimpeded flow of consciousness.

These are, obviously, different stations on the currently loosely defined and delineated continuum of "transference." The distinctions Gill made may define analysts' doctrinaire and institutional loyalties; but I suspect that when they work most analysts intuitively employ, sometimes even outside their awareness, both sides of the interaction, language and behavior. In that way they can monitor the interpersonal field closely, either to influence it or to get it out of the way of the mutative insight. This attention to the transference may, sometimes inadvertently, be far more relevant to the cure than the canonical metapsychological considerations.

Transference is, of course, a highly overloaded rubric. Freud's (1905) case study of Dora is considered the emblematic origin of his thinking on transference. That three-month treatment ended with an abrupt and unanticipated termination. Dora had told Freud at the beginning of the session that she would not continue. Freud continued his inquiry, ignoring her statement. At the end of the session, she said goodbye pleasantly and came no more! Freud's first reaction was hurt—why did she treat me so shabbily? But Freud being Freud, he morphed his disappointment into the concept of resistance and transference.

Erik Erikson (1968) subsequently made much of Freud's complicity in the female repression of the day—that is to say, Dora had good reason to be angry. I would like to take it one step further and suggest that *her response was inevitable no matter what Freud did!* Psychoanalysis begins when even the best intentioned efforts fail. It is the analysis—not the avoidance—of the failure that defines transference and countertransference and constitutes the major leverage of the process.

Freud (1914a) defined the centrality of transference: "Any line of investigation no matter what its direction, which recognizes these two facts [transference and resistance] and takes them as the starting point of its work may call itself psychoanalysis, though it arrives at results other than my own" (p. 10). And about the same time, Freud (1914b) wrote that the whole structure of psychoanalysis stands apart from metapsychological

considerations, which, he said, can be replaced and discarded without damaging the structure.

People resist change, for whatever reason, and that resistance takes the form of an interaction with the therapist *that recapitulates, in action, the very issue under discussion*. Freudians saw this enactment as a resistance to a confrontation with unconscious fantasy, and consequently they interpreted *away* from the transference to get back to the fantasies. Currently, most of us interpret *into* the transference since we view it as a fruitful area of inquiry. We all agree that what happens between the patient and therapist is integral to the cure. We differ on what it is: the elucidation of fantasies projected onto the therapist, or the field of interaction itself.

It is my contention that transference is far more enigmatic, indeed uncanny, than one might suspect. It is not simply a form of resistance to change, as the Freudians would have it, but rather some *mysterious, inherent, correlate of the inquiry*—inherent, insofar as it may be a natural aspect of cognitive process, not an artifact of anxiety or defense.

The two striking phenomenological aspects of the analytic praxis are patients' flow of consciousness and the uncanny tendency of their simultaneous relationship to play out or *mirror* what is being said. Say a patient tells you how hurt he was by his father's criticism when he was a child and then is hurt because you are ending the session five minutes early. It may matter less whether you interpret his hurt feeling as a distortion carried over from his childhood or as a real enactment between the two of you that he is overvaluing, even if you wonder why you ended the session too early. The real value may lie in the recognition that *something is being replayed*. Why this should be so requires the elaboration of a number of axioms.

First, all experience (perception) is an interpretation. This is not an issue of philosophic realism. How you experience a bear or, for that matter, a potential lover, depends not just on the immediate circumstances (the bear is blocking your passage on the trail or sunning itself in a zoo enclosure), but on sociocultural experience: that is to say, memory. Perception is 90% memory—the "mind's best guess" (Gregory, 1966, p. 2).

Second, all interpretation is selectively biased. Perception is always distorted or constricted; however caused, distortion is the sine qua non of neurosis. But how? There is a range of possibilities: simply the necessity to select from multiple perspectives; the force of unconscious drive; interpersonal anxiety (out of awareness); or being misled by other people, deliberately or unconsciously. Our therapeutic endeavors with our patients

are, then, all about omissions—what is left out of awareness—be it by repression, inattention, dissociation, or mystification.

From my point of view, all experience is interpersonally determined. Cognition itself is interpersonal. The interpersonal modus is contagious anxiety. Sullivan (1953) posited that it is the anxiety of the significant other, the necessary caretaker, that frightens the child, causing a wave of “contagious” anxiety that then becomes responsible for the subsequent mechanisms of neurotic denial. This disruptive anxiety creates a cognitive dissonance that is then obscured, by the other, largely through the medium of language. The child is *mystified*; that is, she learns through the pressure of anxiety not to see what is there to be seen. She must learn to “close the eyes.” This was the theme of Freud’s (1900) dream about this father’s death and, not incidentally the Greek meaning of *mystes*—to close the eyes, to not see.

This is not to deny that there is distortion at play in patients’ current lives. Nor am I implying that all a patient need do is to see what is there to be seen. Mystification and its concurrent anxiety operate most strongly in early life events, but current events reiterate the earlier patterning. It is not that the patient is wrong about the present, but the affect and, more important, the sense of semiotic confusion and impotence resonate powerfully with earlier experience. The patient is not wrong in perceptions, but the affect and sense of helplessness surely are.

As Peter Fonagy and his colleagues (2002) put it:

We move away from the model where an early relationship is principally seen as the generator of a template for later relationships. Instead, we argue that early experience no doubt via its impact upon development at both psychological and neuropsychological levels determines the “depth” to which the social environment may be processed,. *Suboptimal early experiences of care affect later development by undermining the individual’s capacity to process or interpret information concerning mental states that is essential for effective functioning in a stressful social world* [p. 7; italics added]

Axiomatic to my view of therapy is that one cannot *not* interact: one cannot *not* influence. The major instrument of mystification is language; language being not merely speech, but the sum of all its semiotic cues: nonverbal (tonal, prosodic); nuances of irony, sarcasm, humor. The child learns to not know what it knows it knows; that is, she is essentially talked

out of her perceptions. But language, unfortunately, is less about communication of information than about deception and control—power. This “anxiety of influence,” as every therapist is aware, may keep the patient from accepting insights from the therapist who may well be right but experienced as intrusive. (Bloom 1973). So, again from the interpersonal view, resolving neurotic conflict means getting a better grasp of what’s going on around you and to you; that is, mastering the semiotic world of experience.

Mystification, then, is the gap between what is said and what is shown: in semiotics, between *langue* and *parole*, speech and language (Levenson, 1983). Mystifications severely limit the possible range of responses, so that neurosis becomes a variety of cliché. According to the old psychoanalytic aphorism, the patient knows only one way of doing something and that doesn’t work; or, alternatively, it works too well to allow change! It follows that the major instrument of demystification is the matching of what is said against what is done. The therapist and the patient talk; the talking is an interaction because it is not possible to talk without taking a selective position about the content; and that selective position is a bit of behavior with the patient. Speech *is* behavior: to repeat, one cannot *not* interact. The interpersonal field between patient and therapist is an enactment of what is simultaneously talked about. This correspondence may well be, not some consequence of psychoanalytic inquiry, or stress of the field, *but an intrinsic part of semiotic communication*.

The experience of transference enactment is often eerie. For example, analysts may find themselves imitating, or mirroring, the behavior of patients. Years ago, I worked with a depressed and self-devaluing young woman. I caught myself, on leaving the office in the evening, imitating her strange gait. In another, more extensive example, I had a vivid experience of this mimetic response. A 60 year-old man is telling me about his childhood, how he felt tortured by his father’s teasing, which was always ostensibly playful. He is the younger of two brothers, with an eight-year age gap between them, and he was always being ragged about things he really could not be expected to have grasped at his age. As he tells me about the teasing, he begins to laugh and laugh and—when I say to him that he sounds on the edge of tears—he breaks into sobs, saying how much he loved his father. Two weeks later, in his first session after his return from a ski trip, he turns on me in a rage as he is leaving at the end of the session, and says, “Why were you laughing at me when I first came in?”—staggering me.

After he left, I realized I had started laughing when I came out into the waiting room to greet him. I thought I was glad to see him—but why laughter? And, in truth, as I tried to review it, I had been feeling, very faintly, something akin to ridicule. He was on to something, and I told him so the next session. I still do not entirely understand my reaction.

We tend to think of empathy as affective, as containing the patient's fear of emotional flooding; that is, empathy is the ability of the therapist to grasp the patient's affective experience and to contain it. But what of imitation? I suspect that it is a powerful therapeutic response, an attempt to capture the patient's experience by essentially embodying it. It is quite possible that a patient may, in addition to experiencing the therapist's empathic holding (presumably a requisite for restitution of a developmental deficit), also experience an opportunity to learn, by imitating the therapist, a theory of mind, or empathy for others: change may be less a matter of containment and restitution than really of new learning.

Here we get into fascinating aspects of current neuropsychological research. The dichotomies between left and right brain are now long familiar and hardly require repetition (Schore, 1994). I would like, however, to spell out some remarkable new findings on what have been called "mirror neurons." There are fascinating developments in the phenomenology of learning and, fueled by new techniques of brain monitoring, in the study of consciousness and mind that collate with current studies in child development and mother-child interaction. Children, we are told, learn first mimetically, imitatively. Tilting one's head, sticking out one's tongue calls out an imitative response from very young infants. As they mature, they imitate, experience the imitation, and then categorize the experience in language.

I have elaborated on the body-mind link and on this very possibility—that learning may be first bodily, first imitative, mimetic, and *then* cerebral (Levenson, 1998). This idea suggests the interesting possibility that psychoanalytic insight may be first experienced and *then* formulated; that the direction of learning may be, not from the head to the body, but quite the opposite—a matter of what is said about what is experienced. According to Rizzolatti and Simigaglia (2008), "The rigid divide between perceptive, motor, and cognitive processes is to a great extent artificial: not only does perception appear to be embedded in the dynamics of action, becoming much more composite than used to be thought in the past, but the acting brain is also and above all a brain that understands" (p. xi).

It is a common clinical experience that interpretations of both meaning

and awareness (Gill, 1983) work better *after* enactment. If interpretations precede enactment it doesn't work. At best, one gets intellectual agreement, compliance, from the patient.

Mirror neurons were first reported in 1995 by Iacomo Rizzolatti at the University of Parma (Iacoboni and Mazziotta, 2007; Rizzolatti and Sinigaglia, 2008). Mirror neurons are neurons that fire both when an animal performs and acts and when it observes another animal performing the same act. This mirroring or imitation is felt by some researchers to be the next big thing in neurological discovery, the "great leap forward" in human evolution, the next cognitive revolution, after the Copernican, Darwinian, Freudian, the discovery of DNA and the genetic code. Now the claim, admittedly florid, is made that empathy, language, theory of mind may all depend on this mirroring capacity. Also claimed, but open to a good deal of question, is the finding that autistic children may lack mirror neurons and that this link may account for their inability to empathize—however hyperbolic this may be, it is clear that mirror neurons may open the door to a new understanding of how people learn through interaction, through behavior as well as language (Ramachandran, 2000).

All this certainly advances a conception of psychoanalytic learning qua change as the matching of interpretation to transference. How does this speech–action parallel process translate into therapeutic praxis? I have written elsewhere of the algorithm of therapy (Levenson, 1983). It consists of three components: frame, inquiry, and enactment. The frame is a set of constraints defined outside and before the psychoanalytic interaction. It provides the patient, and, more important (and less frequently noted), the therapist with a sense of safety and containment. It protects both participants from becoming overanxious and limits the risk of mutual out of awareness interactions.

The therapist and the patient engage in a verbal inquiry that may be free associative or a more detailed inquiry. Inevitably this leads, not to greater clarity, but to a deconstructed inquiry: coherence is lost, tangential associative threads emerge. Dreams, leaps of association occur. In pursuit of the inquiry, the enactment I have been explicating takes place.

Menninger and Holzman (1973) called this direction of flow the "therapeutic cycle"; that is, when the process was proceeding correctly, the material cycled from the present; *through the transference*; and then to the history and back to the present. Note that the useful recall of the past only occurs after the resolution (enactment with therapist) of the transference. A therapy that links present difficulties to past experiences is educational

but not quite psychoanalytic in scope if it lacks the transition through the patient/therapist enactments.

### Summary

I am proposing that the therapeutic power of psychoanalysis does not depend on the primacy of metapsychology or on the presumably mutative interpretations thereof. Metapsychology is ontology; and the claim to knowing—to having a coherent theory of causality and treatment—undermines our appreciation of how little we understand about how people experience change and the underlying neuropsychological processes of change. Sullivan is purported to have said, “God keep me from a clever psychoanalyst!” Truly, humility is the beginning of wisdom.<sup>3</sup>

Observation of the praxis of therapy—what it is that we actually do, the *act* of therapy—illuminates two cardinal aspects of the process: the patient’s flow of consciousness and the analyst’s vocal and behavioral participation. Very early, Freud saw in that process that patient–therapist interactions obstructed insight and change. What he saw as resistance to insight, with all its ramifications, I now see as enactment, which differs from “acting-out,” that anathema of psychoanalysis. Acting-out is a breaking of the frame, when some out-of-awareness material emerges as a disruptive piece of behavior in or outside the therapy room. How we assess enactment varies. I see it as an inherent part of the interaction, necessary to the process and the cure, not as a by-product of pathological defense.

One might well see this dialectic between speech and action in terms of the long-established neuropsychological paradigm of a right brain–left brain dichotomy. Recently, however, the discovery of “mirror neurons” has suggested that mirroring may be a vital part of relating to another, as vital an *embodied* aspect of empathy and theory of mind as affective empathy—I know you because I feel your feelings. The original distinction between sympathy and empathy is considerably obfuscated in current psychoanalytic discourse. Much of what therapists call empathic response is simply sympathy and solicitude, since the therapist often cannot have a real grasp of the patient’s experience. For true empathy, we must have experienced to some significant degree what the patient experiences; mirroring or imitation may serve that purpose, albeit in an adumbrated form.

---

<sup>3</sup> See Richards (2003) for an eloquent plea for a measure of humility.

Bodily learning, “embodied cognition,” may be an essential part of the therapeutic process. To quote Saporta (2008):

Cognitive scientists and linguists are coming to a new appreciation of Freud’s body ego in their recent emphasis on embodied cognition. This is an appreciation that the experience of the body in motion and the body’s encounter with the world structure the way we think and the metaphors and language through which we conceive of ourselves and the world. *There is evidence that the influence of the body and physical context is not limited to early development but has an ongoing influence on the structure of thinking* [p. 8; italics added].

The distinctions Gill (1983) made still define our doctrinaire and institutional loyalties, But I believe that our “talking cure” may invoke, indeed require, a corresponding behavioral component, not as an issue of psychoanalytic technique (the use of transference), but because it is an inherent aspect of the still mysterious processes of cognition and consciousness. The inquiry (flow of consciousness, detailed inquiry, drift of topics) and the transference enactment—what is said and what is shown—may not be different points on a therapeutic and theoretical continuum, but, rather, two sides of the same coin.

#### REFERENCES

- Bateson, G. (1979), *Mind and Nature; A Necessary Unity*. New York: Dutton.
- Bloom, H. (1973), *The Anxiety of Influence*. New York: Oxford University Press.
- Bollas, C. (1999), *The Mystery of Things*. New York, Routledge.
- Chalmers, D. J. (1996), *The Conscious Mind*. New York: Oxford University Press.
- Cooper, A. M. (2008), American psychoanalysis today: A plurality of orthodoxies. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 36: 235–253.
- Damasio, A. R. (1994), *Descartes’ Error*. New York: Grosset/Putnam.
- Erikson, E. (1968), *Identity, Youth and Crisis*. New York: Norton.
- Fonagy, P., Gergely, G., Jurist, E. & Target, M. (2002), *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.
- Freud, S. (1900), *The Interpretation of Dreams. Standard Edition*, 4. London: Hogarth Press, 1953.
- Freud, S. (1905), Fragment of an analysis of a case of hysteria. *Standard Edition*, 7:7–123. London:Hogarth Press, 1963.
- Freud, S. (1914a), On the history of the psychoanalytic movement. *Standard Edition*, 14:7–66. London: Hogarth Press, 1957.
- Freud, S. (1914b), On narcissism: An introduction. *Standard Edition*, 14:69–102. London: Hogarth Press, 1957.
- Gill, M. (1983), The interpersonal paradigm and the degree of the analyst’s involvement. *Contemporary Psychoanalysis*, 18:200–237.

- Greenberg, J. & Mitchell, S. (1983), *Object Relations in Psychoanalytic Theory*. Cambridge, MA: Harvard University Press.
- Gregory, R. L. (1966), *Eye and the Brain*. Princeton, NJ: Princeton University Press.
- Iacoboni, M. & Mazziotta, J. C. (2007), Mirror neuron system: Basic findings and clinical applications. *Annual of Neurology*, 62:213.
- Laing, R. D. (1967), *The Politics of Experience*. New York: Pantheon Books.
- Levenson, E. (1972), *The Fallacy of Understanding*. Hillsdale, NJ: Analytic Press, 2005.
- Levenson, E. (1983), *The Ambiguity of Change: An Inquiry into the Nature of Psychoanalytic Reality*. Hillsdale, NJ: Analytic Press, 2005.
- Levenson, E. (1991), *The Purloined Self*. New York: Contemporary Psychoanalysis Books.
- Levenson, E. (1998), Awareness, insight and learning. *Contemporary Psychoanalysis*, 34:223–249.
- Levenson, E. (2001). The enigma of the unconscious. *Contemporary Psychoanalysis*, 37:239–252.
- Menninger, K. & Holzman, P. (1973), *Theory of Psychoanalytic Technique*. New York: Basic Books.
- Miller, J. (1995), Going unconscious. *New York Review of Books*. 42:59–65.
- Milner, M. (1969), *The Hands of the Living God*. New York: International Universities Press.
- Popper, K. (1963), *Conjectures and Refutations*. London: Routledge.
- Pulver, S. (2003), On the astonishing clinical irrelevance of neuroscience. *Journal of the American Psychoanalytic Association*, 51:755–772.
- Ramachandran, V. S. (2000), Mirror neurons and imitation learning as the driving force behind “the great leap forward” in human evolution. [www.edge.org/3rd-culture/ramachandran/ramachandran].
- Richards, A. (2003), Psychoanalytic discourse at the turn of our century: A plea for a measure of humility. *Journal of the American Psychoanalytic Association*, 51(suppl):72–125.
- Rizzolatti, G. & Sinigaglia, C. (2008), *Mirrors in the Brain: How Our Minds Share Actions and Emotions*. London: Oxford University Press.
- Saporta, J. (2008), Digitalizing psychoanalysis and psychotherapy. *American Psychoanalyst*, 42(2):1–9.
- Schore, A. (1994), *Affect Regulation and the Origin of the Self*. Hillsdale, NJ: Erlbaum.
- Searle, J. (1997), Consciousness and the philosophers. *New York Review of Books*, XLIV (4):43–50.
- Sullivan, H. S. (1953), *The Interpersonal Theory of Psychiatry*. New York: Norton.

---

Edgar A. Levenson, M. D. is Emeritus Fellow and Faculty, William Alanson White Institute, and Clinical Professor of Psychology, New York University Graduate Studies Division.

330 West 58 Street, Ste. 204  
 New York, NY 10019  
 ealevensonmd@aol.com