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Facts or Fantasies:

On the Nature of Psychoanalytic Data[1]

IN THE FOURTH CENTURY B.C. a Taoist monk, Chuang Tsu, wrote a now famous parable:

> Once upon a time, I, Chuang Tsu, dreamed I was a butterfly, flying happily here and there. Suddenly I woke up and I was indeed Chuang Tsu. Did Chuang Tsu dream he was the butterfly, or did the butterfly dream he was Chuang Tsu? (Feng & English 1974).

This may seem a rather esoteric way to start a presentation on the data of psychoanalysis, but the question is germane. Who dreams the dream? Does the dream perhaps dream the dreamer? My thesis is that it is precisely this issue which lies at the core of a major psychoanalytic schism, one with profound and perhaps irreconcilable consequences for our understanding of the process of therapy and the very nature of change, itself.

We would all agree that symbolization, in its divers manifestations (dreams, fantasies, the patient's representation of events, even language, itself), mirrors actual events. But when there is distortion, when an evident gap exists between real events and their symbolic representation, does the distortion reflect an attempt to grapple with a poorly comprehended reality; or, is the reality only a jumping-off point for an autonomous fantasy process, internally driven and motivated? It is on this point that the intra-psychic and interpersonal analysts differ most sharply.

As Lester Havens put it:

> . . . according to interpersonal theory, the presence of the people in the room and the anxious responses to them have been learned. Introjects have

[1]This paper, in slightly different form, was presented originally to the Detroit Psychoanalytic Society Nov. 21, 1980.

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> rubbed off, as it were, from reality; the patient's projections are assumed to reflect the patient's experience. People, in short, drive each other mad. Psychoanalysis, in contrast, assumes the presence of instincts in conflict with each other or with psychic structures. The result of these conflicts is projected. These projections are fantasies that may reflect more of wishes and their counterforces than they do of the patient's actual experience. (Havens 1976).

For Freud then, symbolism built on ordinary events. It was the symbolic process itself, its ability to "dream" the patient, which fascinated Freud, as it still does contemporary Freudian analysts. "Fantasy stands out against the background of a primordial contact with an undeceptive reality," as Ricoeur writes (Ricoeur 1978). H. S. Sullivan, on the other hand, developed a psychology which was apple-pie American empiricism, rooted in real experience. Mead, Cooley, Peirce, Adolph Meyer were his forebears and the linguists Sapir and Korzybski, his working colleagues. His case material shows his unstinting search for the detailed event, his attention to nuances of cultural experience, his emphasis on what Laing—out of Marx—called "mystified" experience (Laing 1967). "People come to me to get their lives untangled," he said. Not, you will note, to have their fantasies deciphered (Kvarnes 1976).

Sullivan was not much interested in dreams or fantasies, except as distorted reflections of real events. He would have, I suspect, stayed with a more communicational model of psychoanalysis, but rather complex political considerations led him to compete with the European Freudians flooding America after the Nazi-inspired diaspora. He consequently elaborated a modified drive theory, one based on anxiety instead of libido; thus introducing a certain amount of obfuscation into what started out as primarily a straightforward clinical inquiry.

A reverse attempt at bridge-building has come from the object-relationship theorists who differ widely in their emphasis on the relevance of real experience.[2] As Gedo states, like the interpersonalists, "they conceptualize past transactions with people as a general source of human motivation rather than intrinsic drives" (Gedo 1979). Thus, to varying degrees, they establish a psychoanalytic position which takes into account interpersonal transfers; what people call out in each other and how they distort each other's real performance. Indeed, reading Kohut's somewhat jesuitical attempts

[2]See Antonovsky for an exegesis of this issue (Antonovsky 1980).

to elaborate a new theory and still stay in the good graces of his establishment, one wonders whether he has built a bridge to interpersonal theory or simply crossed it.

To give a quick example: if the patient thinks that you are poisoning his soup, the Freudian sees some small and trivial event as having set off a paranoid mechanism of projection. The Interpersonalist wonders, what did he *really* do with the patient which cannot be identified or responded to and is therefore amplified in this way? Did he, in the previous session, in some real way, rebuff the patient? For him, the therapy lies in the patient's being able to establish the interrupted threads of connection between the event (unattended) and the symbolism. I consider this to be an absolutely vital distinction, certainly deserving more elaborate documentation. But if, for the purposes of this presentation, one accepts this distinction as a premise, I shall go on to explore how this schism came about, and some of its clinical consequences.

It is commonly held that the great epiphany of psychoanalysis came about in 1897 when Freud's seduction/betrayal theory was discarded. Freud decided, to his great dismay, that his previously held idea that neurosis was caused by actual seduction by the caretaker or parent was untenable. He had previously written to Fleiss that "in every case, the father, not excluding my own, had to be blamed as a pervert." (Rothstein 1980) Via a quantum intellectual leap, he now reversed his original position. The seduction, he decided, was "fantasy." It was symbolic and, since external stimulation did not supply the necessary energy, the entire theory of an internal machinery "driven" or energized by an intrinsic libido emerged. Why did he not go in the other obvious direction, the one now held by interpersonalists and family therapists: namely, that the seductions were real, but not *literal*? Obviously, there are many more ways of seducing a child than by frank genital abuse. Freud had already, in his case examples, touched on just such betrayals, such failures of what Erik Erikson was later to call *fidelity* (Erikson 1964). Erikson's exegesis of the Dora case delineating the blatant disloyalties of Dora's father, and indeed of Freud, followed easily from Freud's own observations. The discrepancies were clearly waiting to be seen. Why did he not see them? Or, perhaps more to the point, why did he not *see* that he saw them?

Marianne Krüll has suggested an interesting answer to that ques-

tion in her book *Freud und Sein Vater*[3] (Krüll 1979). Krüll examines the critical years from 1885 to 1897 when Freud repudiated his seduction theory. Krüll, as I do, considers this point in Freud's theorizing not as the beginning of psychoanalysis but as a "major derailment." In October 1896, the year prior to his theoretical shift, Freud's father had taken ill and died. Freud, then forty, described the death of his 81-year-old father as "the most upsetting loss in the life of a man." In May of 1897, when Freud was on the verge of expanding his seduction/betrayal theory, he was suddenly overcome with malaise and intellectual paralysis. Several months later, he repudiated five years of work on the seduction theory. Krüll sees the key to Freud's decision in a dream he reported to Fleiss, a dream that occurred the night after his father's funeral. It was later reported in *The Interpretation of Dreams* in a slightly modified form. In the dream, he read on a board the following message: "It is requested to close the eyes." Krüll believes that Freud explicitly accepted his father's injunction "not to look." Freud, she claims, had been on the brink of delineating dynamic family processes—mystification, betrayal and exploitation—which would have compromised his relationship to his father.

There was indeed much mysterious to Freud in his father's history, including an unmentioned second wife (Freud's mother was Jacob's third wife), and the reasons for the family leaving Freiburg for Vienna when he was four. Some mystery or possibly "scandal," causing the hasty departure was implied (Schur 1972). The claim that Freud stood his theoretical position on its head because of an injunction not to "see" his own father's behavior, i.e., out of a wish not to confront his relationship with the now-dead father, may seem far-fetched. But one may turn for further verification to the "specimen dream" of psychoanalysis, the Irma Dream of 1895 (Freud 1953). This is the dream of Irma's injection, about which in 1900 Freud wrote to Fleiss, "Do you actually suppose that some day this house will have a marble plaque with the inscription: 'Here on July 24th, 1895, the mystery of dreams was revealed to Dr. Sigm. Freud.'"

In the dream Irma attends a reception given by the Freuds and

[3]It has not been translated from the German as yet. I am working from a review by Sophie Freud Loewenstein, Freud's granddaughter (Loewenstein 1980).

complains to Freud of pains in her throat and stomach. Freud reproaches her for not accepting his "solution." He looks in her mouth and discovers a white leukoplakic patch and some curly structures modelled on the turbinal bones of the nose. There is then an elaborate exchange in which his friend "Otto" is held responsible for having given her an injection with a dirty syringe. The dream mechanism is described as Freud's annoyance with Otto's criticism of the cure and his wish for revenge. The dream, then, is a symbolic revenge: it is Otto's fault, not his. Charles Rycroft attempts in his book *The Innocence of Dreams* to anchor the dream in reality by pointing out the sexual connotation of the imagery and Freud's possible jealousy of Irma's attraction to the young and handsome "Otto" (Rycroft 1979). This interpretation would correspond more to the actual circumstances surrounding the dream.

There is, however, a simply incredible story underlying all this. Max Schur, Freud's physician and colleague, in *Freud—Living and Dying*, has examined the unpublished Fleiss correspondence and presents the following events: Freud, as is known, has an intense attachment to Fleiss, a Berlin ear-nose and throat specialist, who had a theory that related sexual pathology to nasal anomolies (Schur 1972). Freud was initially very taken with this view, which as Sulloway points out, was not, in its context, considered a crank idea (Sulloway 1979). There was, among physicians of the time, considerable interest in the correlation of nasal pathology and sexual disorders. It was known that in lower animals the hippocampal cortex is connected with smell and in humans with emotion. It was also noted that periodicity of nasal mucosal swelling occurred with menstruation and sexual arousal. No less an authority than Kraft-Ebbing publicly lauded Fleiss' theories. At any rate, Fleiss performed some fairly draconian nose surgery to relieve emotional difficulties and had, in fact, done such surgery on Freud's nose.

Consider this: Freud had asked Fleiss to operate on Emma (Irma), since the therapy was going slowly. Fleiss did a major excision of her turbinate bone, left inadvertently a half-meter strip of iodoform gauze in the wound, and went home to Berlin. Upon later discovery and removal of the gauze by another surgeon, Emma hemorrhaged severely and went into shock. She was extremely ill afterward and required several other surgical interventions. Freud blamed, not Fleiss, but the second ENT man for the

hemorrhage! Schur agrees that Freud was unable to blame his father-substitute, Fleiss, although Schur did not have available some of Krüll's other data.

Why, then, when Freud interpreted the dream, did he not consider its obvious reality implications? Quite simply, the dream *says what happened*, and the intensity of the dream, and Freud's guilt, is quite appropriate to the stimulus. The symbolism leads to a real event: one need not postulate an energic source from within.

In other words, Freud deliberately decided to minimize the reality, the actual events, that stimulated the dream and to treat it as though it were a symbolic construct around a minor event—Freud's wish not to be criticized. Freud says, "Look, what a brouhaha symbolism makes of a simple, very trivial event!" Much the same observation of dissimulation could be made about, say, the Schreber case. As Schatzman has pointed out, every one of Schreber's delusions could be related to an actual apparatus of his father, a well-known and widely-read educator (Schatzman 1973). Schreber's father had developed devices, really straitjackets and braces, to prevent masturbation in children. Freud knew and mentioned the father's work. Why would not Freud have seen what seems to us obvious symbolic representations of the real? Krüll would say that Freud could not "see" the real failure of the father figure and so, made it a fantasy, something "all in his head."

I must re-emphasize this point: the consequence of believing that the dream dreams the person, that the fantasy is the patient's reality, is that real events are devalued, designified and seen only as the grain of sand that starts the pearl-making process. All of Freud's cases support this point: what the parents really do is *not* important, only the fantasy elaborations count. It would seem, then, that psychoanalysis, historically at least, is based on a deception, really a lie; what Sartre called *Bad Faith* (Sartre 1953). One can see the present consequences of this position. Intrapsychic analysis has affirmed this stance, and the literature is full of clinical examples wherein the most blatant reality is ignored in pursuit of symbolization.

I'll go later to an example, but to validate for the moment that I am not kicking a dead horse, note this quote from Giovacchini who said in 1975, "the psychoanalytic setting is so constructed that the reality of the surrounding culture does not operate as such: references to reality can be regarded as reflections of various mental opera-

tions of the analysand" (Giovacchini 1975), or, Louise Kaplan saying that, "the passions of childhood, our appetites, dreads, longings, envies, jealousies, came into existence in connection with our infantile interpretations of an actual world populated by ordinary persons" (Kaplan 1979).

I think this position is dead wrong. Freud, like his model Moses, made a wrong turn in the desert. The consequence is a therapy that emphasizes distortion and misunderstanding and which has as its cure the giving up of one's own idiosyncratic reality. It may appear at this point that I've set up a straw man; no one, you say, is *that* opaque or unaware of the importance of real events and misconstrued experience in the patient's life. It is true that most analysts give some lip service to the importance of actual experience, but the real differences emerge in their treatment of the so-called "transference."

If one believes in the relevance of concrete events in the patient's present life and history, then one must also believe in their relevance to the patient/therapist interaction. The interpersonal therapist must grapple with the *real* matrix of events and personalities in which every therapy is embedded. It is not a question of what the patient has projected "onto" or "into" the therapist, but of really *who* the therapist is and *what* he brings to the therapy encounter. There are profound assumptions about the therapy process which are the therapist's contributions to the mystification process.

For example: Why treat a particular patient? To what end? Since patients come to treatment to have their neurosis perfected, do we agree to their goals? When do we get discouraged? Give up? Are we allowed to dislike them? Be hurt? What response is appropriate? The entire pragmatics of the therapy are relevant. Who referred the patient? Fees, office settings, age, beauty, ugliness, fatness, aesthetics, ethnicity, all establish a matrix of interaction long before the actual process of therapy begins. You will note I am carrying this position to its extreme—much further than the object-relationship therapists who see their reaction to the patient as relevant, useful, but as projected *into* them by the patient and revealing something about the patient, but not about themselves. Thus we see the spate of articles by "empathetic" therapists learning all sorts of things about the patient by contemplating their own resonating navels.

Like the eponymous Narcissus of their favorite syndrome, they may have fallen into their own pond.

The clinical material I wish to use is from an article by a British Kleinian, Donald Meltzer. The article, titled "Routine and Inspired Interpretations," was first published in the April 1978 issue of *Contemporary Psychoanalysis* and was reprinted in a volume entitled *Countertransference*, edited by L. Epstein and A. Feiner (Meltzer 1978, Epstein and Feiner 1979). The article is of particular interest because of two distinct levels of transaction. The first is the absolute incapacity of the therapist, at first bound to his theory, to see the simple facts of his relationship to the patient as reflected in a dream. And the second level is the therapist's inspired efforts to transcend his theoretical position and engage the patient in an authentic process. The dream is:

> He and the analyst seem to be sharing a hotel room which is overlooked by rooftops filled with people. At one point the analyst seems to be squatting over the patient, saying something like "in fact, you have never actually seen my anus." The patient felt a mixture of intense emotions. On the one hand, he felt embarrassed that the people across the way would surely see this as a homosexual relationship. But even more acute was a feeling of triumph over the analyst, who was apparently quite unaware that behind him was a mirror which enabled the patient to look directly between his buttocks. These appeared huge and muscular, like a Japanese wrestler's. (p. 214).

This dream was analyzed totally without reference to current reality. The usual childhood associations and transferential associations follow. The therapist fails to connect the dream with the obvious fact that he is reading a paper based on this case to the British Psychoanalytic Society (where it was received in a "friendly but uneasy way"), that this is the audience watching in the dream, that the therapist's "ass is hanging out," that he doesn't know it, but the patient does, that the patient and therapist are collaborating in some collusive way that the British Psychoanalytic Society might be uneasy about, and that the patient has mixed feelings about his case material being used in a battle the therapist may be having with his colleagues. Does this sound extreme? Later in the article we are told that "the patient himself heard about it (the case presentation) through a friend [sic!], realized it was about his material and asked to read it. I agreed; he was pleased with it and found that its content corresponded to his recollection—and all Hell broke

loose! He gave up his career, left his wife, gave over to a 'latent perversion,' failed to attend sessions, did not pay his bills and lost most of his friends" (p. 225). Later material (yes, the therapy did continue for several more years) revealed the patient's childhood devotion to secretly sucking his thumb; i.e., that this man was a master at keeping sly secrets.

The dream not only told what was happening, but foretold what *would* happen. Attending to what the patient said in the dream would have alerted the therapist to the patient's awareness of the forthcoming presentation and would have opened up the exploration of the patient's collusive secret setting-up of the therapist. But it would be only an exploration of the patient's participation. To include the therapist evoked an authentic risk, since the therapist did not really know what he was doing. But it would appear to be his wish to expose himself in some combative way to the conservative psychoanalytic society. Was he using the patient to work through his own rebelliousness?

At this point, the therapy sounds like an opéra bouffe. All is in disarray. But the therapist does an interesting and courageous thing. He gives up knowing without giving up the therapy. He and the patient spend several more years sorting it all out, and a second recovery occurs which he suspects, but *is not sure*, may be more authentic. He stops guiding the patient and becomes a co-voyager.[4] I think he comes out as changed as the patient. The final form of the paper says, "I am *letting* my ass hang out." I don't know, he says, and I quote, "whether this has been a successful analysis or a catastrophe . . . but it has had a profound influence on my own development." So, in the end, we can say that the dream says as much about the therapist and his goals and development as it does about the patient. Remember that this was the *patient's* dream. Certainly one must agree that his unconscious grasp of events, real events, was remarkable. I do not believe that this example is extreme or unusual. The literature is chock-full of examples of obvious interpersonal realities sacrificed to procrustean theoretical positions.

If the data of psychoanalysis is disguised reality, and not auto-

[4]In his own somewhat floridly literary concept, he stops playing Virgil, the guide to the patient's Dante, and becomes instead Daedelus to his Leopold Bloom, a fellow-wanderer in the *double-entendre* maze (p. 219).

nomous fantasy, what is left of the process? Well, in the middle ages, it was known that night air caused the ague. Consequently, windows were sealed, plants removed from the rooms, and beds heavily muffled in hangings. It was also known that the night vapors were worse in low lands, so people built their houses, whenever possible, on high land. They did not, of course, know about the anopheles mosquito carrying the parasite of malaria. They used the paradigm of Aristotle's humors and devised what is called an algorithm for preventing the ague; that is, a systematic series of steps that led to an ordered outcome. The paradigm may be wrong or, to our eyes, naive; and yet, the algorithm may work. Freud's paradigm was Newtonian and energic. But his algorithm is pragmatic and not paradigm-bound. To put it more simply, the theory can be separated from the therapy and may not even have very much connection.

What is the algorithm, i.e., what systematic process is undertaken in analysis? First, a highly-constrained situation is established. Time, financial arrangements are defined; contact with the patient is limited. An atmosphere of safety is established. Both patient and therapist must feel protected by the rules. After all, the crucial difference between the psychoanalysis milieu and "real life" is that we don't have to live with our patients. If we don't need them to sustain us, we are free to engage them.

Second, the patient talks to us, and we listen. The process is, to this extent, verbal. The patient free-associates or tells more organized stories of his life. We can inquire, extend the data or be sufficiently depriving of feedback to stimulate fantasy. So far, this is simply a disciplined investigation. Psychoanalysis begins when what is talked about between the two participants is also *experienced* between them. This was, of course, Freud's great discovery, the transference. Freud said that "nothing so affects the analysand as what he experiences in the transference." The transference becomes, as he defined it in "Remembering, Repeating and Working Through," "the playground" of the therapy (Freud 1914).

So, the algorithm requires three steps: the establishment of constraints, an extended verbal inquiry and the experiencing in relative safety of what is talked about. We may differ with Freud's paradigmatic assumptions about *what* is talked about and *what* is experienced. He thought, as do many contemporary therapists, that the patient gets better because he experiences his *inappropriate-*

ness, his distorted fantasies. Some interpersonalists may believe that the patient gets better because he learns in the transference how to delineate and respond effectively to different levels of interaction. Still, for all of us, the method is essentially the same. When the patient talks about his life, we do not say, "What is he saying about himself?" We say, "What is he saying *to me* about himself? Who am I for him? Who is he for me? What is he doing with me by telling me, and what am I doing with him when I choose to ask this, rather than that, or to answer or to hold my tongue?" *Analysis is what is done about what is said.*

Let us suppose a patient finds himself having a fantasy of infantile dependency on the analyst and experiences a yearning to be cared for. We may differ on our perception of the central issue: Is it a regressive fantasy? Is he coming in touch with a hidden childishness? Will he receive in the therapy a symbolic gratification that will permit him to grow up, or will he locate some real need in his experience with the therapist that he cannot yet identify or formulate, and which the fantasy represents? Where we can agree is in the perception that psychoanalysis is not really the talking cure; it is the experiencing cure. But what has perhaps been confusing is that it is language as behavior. We *behave* with the patient through language. "Words are also deeds," as Wittgenstein said succinctly.

What happens to psychoanalysis if we see fantasy and symbolism as an effort to grapple with real experience, but still apply the same algorithm? Then, psychoanalysis becomes a circumscribed *semiotic event*. Semiotics, first defined and named by C. S. Peirce, the American philosopher, (Peirce 1955) refers to "the transmission of signals, signs, signifiers and symbols in any communication system whatever" (Wilden 1972). In the hierarchical ordering there is speech, then the intricate machinery for processing speech (language) and finally a more extensive system of coded communication which involves speech, non-verbal cueings, and most important, the cultural and social context of communication, what Morris called the "pragmatics" of communication. It becomes a communication between two real people engaging in a real way out of their own experience and personality. This engagement occurs through language and involves a series of communications and metacommunications, i.e., communications about communications. Thus, as the patient talks about his life, he is talking to the therapist, presenting it in a certain way to the therapist,who selec-

tively hears, decides what to respond to. There can be no response without selection. Thus, the therapist, in responding, behaves with the patient around what they discuss. What is talked about is simultaneously played out (in language) between them (Levenson 1979). There is no issue of "distortion" or of discovering what is the truth or of arriving at some distinction between real and unreal. This is strikingly different from the classical format.

This example is from Greenson: The patient points out that when he expresses political opinions that match the therapist's, he gets marginal cues of approval; when he doesn't he is subjected to masked hostile analysis. He documents this position with examples. The therapist, decently and honestly, is amazed at his blindspot. He validates the patient's perception, admits his fault and then asks, why do you feel obliged to satisfy my political views? This is just at the time when the patient has struck back (Greenson 1976)! He plays out exactly that kind of authoritarian inquiry of which the patient complains. The discourse doubles back on itself and stops. What does it say but, "Very well, you caught me and you were right; now, let's get back to working on you." Why not wonder how they got into that subtle coercion? How does it match with other aspects of the patient's life? What was called out in the therapist? Let us suppose the patient was always very submissive to his father's opinions. That does not explain why the therapist coerced him. Or, if the therapist has that tendency, it does not explain why he did it with this patient, or why he is so astonished to be caught out. Would it be unscientific to suggest that they talk about their mutual experience, rather than "analyze" the patient's distortions?

The therapy need not double back on the patient to discover his distortion but may explore a widening circle of interpersonal reamifications. Paradoxically, nothing gets resolved or clearer; it simply gets more elaborated. From this view cure is enrichment of the self, not clarity about motives.

This is, I realize, a very confusing issue, since it depends on understanding that we are talking about the same algorithmic process but from markedly different underlying assumptions. Let me briefly review. I am saying that Freud was in the process of developing a unique and novel therapeutic procedure which cured psychological difficulties by some process implicit in talking with the patient. He fell afoul of his own dynamics and made a crucial in-

version of the theory which has haunted us ever since. If we discard the inversion (the belief in the primacy of fantasy, symbolism) and, instead, adopt a semiotic language model, we can still use the psychoanalytic model, but to entirely different ends, with an entirely different concept of therapy and its outcomes. The therapist, instead of being an archaeologist sorting through shards to reconstruct the vessel, becomes a participant in a journey, a fellow-traveller. He is not interested in what is wrong with the patient; he is interested only in expanding what goes on between them. Since he is aware that, when he listens, he also participates (a basic axiom of operational theory), the way he hears is necessarily a selection and is therefore behavior with the patient. *There is no right way to hear the material.* Like a stern canoist in the rapids, the therapist simply maintains headway.

This can be disorienting. Before, we had a simple task: it was to set the patient's thinking right. As I pointed out in the Greenson example, that kind of purity breaks down very quickly if one becomes at all self-reflective. Therefore, one cannot respond out of knowledge of the truth but out of "in-touch"-ness with one's own experience of the situation. If I feel angry at the patient, the question is not what is my counter-transference, or what has he projectively inserted into me, or what have I picked up about him, as though my reaction had some supernal validity. All I can do is utilize my reaction, not necessarily by informing the patient, although that can be a useful technique, as long as my reaction is presented as my own, not as a wonderful insight about him. One could define this as the issue of authentic response.[5]

Freud came upon a momentous discovery, the transformational nature of discourse. It is no doubt audacious to say, but he put this discovery to the service of his own neurosis. Isn't it extraordinary how his later life played out the prophesy of the Irma dream with its leukoplakic spots? No one reading Schur's account of Freud's long tortured course with his mouth cancer can accept the simple explanation that "sometimes a cigar is just a cigar" or that he had a severe case of nicotine addiction. The suicidal tenacity with which he stuck to the cigars deserves a better explanation. He started by adulating Fleiss as a good father and copying him and

[5]See Levenson for an expanded examination of authenticity in psychoanalysis (Levenson 1974).

ended by dying of Fleiss's symbolic ministrations, as almost did Irma in reality.

Freud paid a high price for "closing his eyes," for the point in Sophocles's *Oedipus Rex* is that his father *did* try to kill him. It is curious that Freud took a story that had to do with the inevitability of concrete events and turned it into a parable of symbolic motivations with no basis in reality. Nothing could be more concrete than Oedipus' cry in *Oedipus at Colonus,* the last of the Sophoclean trilogy, written when Sophocles was in his eighties.

> How could you justly blame it upon me? . . . How could you find guilt in that unmeditated act? . . . If someone tried to kill you here and now, you righteous gentlemen, what would you do, inquire first if the stranger was your father? (Fitzgerald 1941).

If one holds to the discovery of discourse as transformation, but shifts the model from the search for distortion to the search for real experience, one comes out with a different kind of psychoanalysis, closer to the contemporary search for interaction with the use of countertransference as a legitimate tool of therapy and as a goal, a therapy that is not politicized and allows the patient to arrive at his own solutions or even *no* solution at all. We want the patient not to be more loving, more related, more able to "share," or more sincere, but more able to be both loving and hating, and knowing when and in what settings each reaction occurs. Nature has equipped us with an extraordinary semiotic sensibility, a virtual Stradivarius of linguistic instruments. All we want is that the patient do a little better with it than to play "Three Blind Mice."

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