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Insight and Responsibility
Lectures on the Ethical Implications of Psychoanalytic Insight

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Childhood and Society
Young Man Luther
Insight and Responsibility

W. W. Norton & Company, Inc. New York
The first lecture focused on the origin (and the originator) of psychoanalysis at the turn of the century. The second is an exposition of the meaning of clinical experience for a psychoanalyst half a century later. This lecture was given as a contribution to an interdisciplinary symposium on "Evidence and Inference" at the Massachusetts Institute of Technology, in 1957.

1

The letter which invited me to this symposium puts into the center of my assignment the question, "How does a... clinician really work?" It gives me generous latitude by inquiring about the psychotherapist's reliance on intuition ("or some other version of personal judgment") or on objectified tests ("relatively uniform among clinicians of different theoretical persuasions"). And it concludes: "To the extent that intuition plays a role, in what way does the clinician seek to discipline its operation: by his conceptual framework? by long personal experience?" This emphasizes, within the inquiry of how a clinician works, the question of how he thinks.

Such an invitation is a hospitable one, encouraging the guest, as it were, to come as he is. It spares the clinician whatever temptation he might otherwise feel to claim inclusion in the social register of long established sciences by demonstrating that he, too, can behave the way they do. He can state from the outset that all four: intuition and objective data, conceptual framework and experience are acceptable as the
corners of the area to be staked out; but also, that in one lecture he can offer no more than phenomenological groundwork of a markedly personal nature.

The invitation in my case is addressed to a psychotherapist of a particular “persuasion”: my training is that of Freudian psychoanalyst, and I help in the training of others—in the vast majority physicians—in this method. I shall place vocation over persuasion and try to formulate how the nature of clinical evidence is determined by a clinician’s daily task. If I, nevertheless, seem to feel beholden to Freud's conceptual system—that is, a system originated around the turn of this century by a physician schooled in physicalist physiology—the reason is not narrowly partisan: few will deny that from such transfer of physicalistic concepts to psychology new modes of clinical thinking have developed in our time.

“Clinical,” of course, is an old word. It can refer to the priest’s administrations at the deathbed as well as to medical ministrations to the sick. In our time and in the Western world, the scope of the clinical is expanding rapidly to include not only medical but also social considerations, not only physical well-being but also mental health, not only matters of cure but also of prevention, not only therapy but also research. This means that clinical work is now allied with many brands of evidence and overlaps with many methodologies. In the Far East, the word “clinical” is again assuming an entirely different historical connotation, insofar as it concerns mind at all: in Communist China the “thought analyst” faces individuals considered to be in need of reform. He encourages sincere confessions and self-analyses in order to realign thoughts with “the people’s will.” There is much, infinitely much to learn about the ideological implications of concepts of mental sickness, of social deviancy, and of psychological cure. Yet, I feel called upon to speak of the nature of evidence gathered in the psychotherapeutic encounter.

Let me briefly review the elements making up the clinical core of medical work as the encounter of two people, one in need of help, the other in the possession of professional methods. Their contract is a therapeutic one; in exchange for a fee, and for information revealed in confidence, the therapist promises to act for the benefit of the individual patient, within the ethos of the profession. There usually is a complaint, consisting of the description of more or less circumscribed pain or dysfunction, and there are symptoms, visible or otherwise localizable. There follows an attempt at an anamnesis, an etiological reconstruction of the disturbance, and an examination, carried out by means of the physician’s naked senses or supported by instruments, which may include laboratory methods. In evaluating the evidence and in arriving at diagnostic and prognostic inferences (which are really the clinical form of a prediction), the physician thinks clinically—that is, he scans in his mind different models in which different modes of knowledge have found condensation: the anatomical structure of the body, the physiological functioning of body parts, or the pathological processes underlying classified disease entities. A clinical prediction takes its clues from the complaint, the symptoms, and the anamnesis, and makes inferences based on a rapid and mostly preconscious cross-checking against each other of anatomical, physiological and pathological models. On this basis, a preferred method of treatment is selected. This is the simplest clinical encounter. In it the patient lends parts of himself to an examination and as far as he possibly can, ceases to be a person, i.e., a creature who is more than the sum of its organs.

Any good doctor knows, however, that the patient’s complaint is more extensive than his symptom, and the state of sickness more comprehensive than localized pain or dysfunction. As an old Jew put it (and old Jews have a way of speaking for the victims of all nations): “Doctor, my bowels are sluggish, my feet hurt, my heart jumps—and you know, Doctor, I myself don’t feel so well either.” The treatment is thus
not limited to local adjustments; it must, and in the case of a
"good" doctor automatically does, include a wider view of
the complaint, and entail corresponding interpretations of the
symptom to the patient, often making the "patient himself" an
associate observer and assistant doctor. This is especially im-
portant, as subsequent appointments serve a developing treat-
ment-history, which step by step verifies or contradicts whatever
predictions had been made and put to test earlier.

This, then, for better or for worse, is the traditional core
of the clinical encounter, whether it deals with physical or
with mental complaints. But in the special case of the psycho-
therapeutic encounter, a specimen of which I intend to present
and to analyze presently, three items crowd out all the others,
namely, complaint, anamnesis, and interpretation. What goes
on in the therapist's mind between the verbal complaint ad-
dressed to him and the verbal interpretation given in return—
this, I take it, is the question to be examined here. But this
means: in what way can the psychological clinician make his
own perception and thought reliable in the face of the patient's
purely verbal and social expression, and in the absence of non-
verbal supportive instruments? At this point I am no longer
quite so sure that the invitation to "tell us how a ... clinician
really works" was so entirely friendly, after all. For you must
suspect that the psychotherapist, in many ways, uses the setting
and the terminology of a medical and even a laboratory ap-
proach, claiming recourse to an anatomy, a physiology, and a
pathology of the mind, without matching the traditional text-
book clarity of medical science in any way. To put it briefly,
the element of subjectivity, both in the patient's complaints
and in the therapist's interpretations, may be vastly greater
than in a strictly medical encounter, although this element is
in principle not absent from any clinical approach.

Indeed, there is no choice but to put subjectivity in the
center of an inquiry into evidence and inference in such clin-
ical work as I am competent to discuss. The psychotherapist

shares with any clinician the Hippocratic fact that hour by
hour he must fulfill a contract with individuals who offer them-
seles to cure and study. They surrender much of their most
personal inviolacy in the expectation that they will emerge
from the encounter more whole and less fragmented than
when they entered it. The psychotherapist shares with all
clinicians the further requirement that even while facing most
intimate and emotional matters, he must maintain intellectual
inner contact with his conceptual models, however crude they
may be. But more than any other clinician the psychotherapist
must include in his field of observation a specific self-awareness
in the very act of perceiving his patient's actions and reactions.
I shall claim that there is a core of disciplined subjectivity in
clinical work—and this both on the side of the therapist and
of the patient—which it is neither desirable nor possible to re-
place altogether with seemingly more objective methods—
methods which originate, as it were, in the machine-tooling
of other kinds of work. How the two subjectivities join in the
kind of disciplined understanding and shared insight which
we think are operative in a cure—that is the question.

2

First, a word about "history taking," as the anamnesis is called
today. In clinics, this is often done by "intake" workers, as if
a patient, at the moment of entering treatment, could give an
objective history of his sickness, and could reserve until later
a certain fervent surrender to "the doctor." In the treatment
proper, of course, much of this history will be reported again
in significant moments. Whether or not the psychotherapist
will then choose to dwell on the patient's past, however, he
will enter his life history and join the grouping of individuals
already significant in it. Therefore, without any wish to crowd
him, I think I would feel methodologically closest to the his-
torian in this symposium.

R. G. Collingwood defines as an historical process one "in
which the past, so far as it is historically known, survives in the present.” Thus being “itself a process of thought . . . it exists only in so far as the minds which are parts of it know themselves for parts of it.” And again: “History is the life of mind itself which is not mind except so far as it both lives in historical process and knows itself as so living.”

However, it is not my task to argue the philosophy of history. The analogy between the clinician and the historian as defined by Collingwood to me centers in the case-historian’s function in the art of history-taking, of becoming part of a life history. Here the analogy breaks down; it could remain relevant only if the historian were also a kind of clinical statesman, correcting events as he records them, and recording changes as he directs them. Such a conscious clinician-historian-statesman may well emerge in the future.

Let me restate the psychotherapeutic encounter, then, as an historical one. A person has declared an emergency and has surrendered his self-regulation to a treatment procedure. Besides having become a subjective patient, he has accepted the role of a formal client. To some degree, he has had to interrupt his autonomous life-history as lived in the unself-conscious balances of his private and his public life in order, for a while, to “favor” a part-aspect of himself and to observe it with the diagnostic help of a curative method. “Under observation,” he becomes self-observant. As a patient he is inclined, and as a client often encouraged, to historicize his own position by thinking back to the onset of the disturbance, and to ponder what world order (magic, scientific, ethical) was violated and must be restored before his self-regulation can be reassumed. He participates in becoming a case, a fact which he may live down socially, but which, nevertheless, may forever change his view of himself.

The clinician, in turn, appointed to judge the bit of interrupted life put before him, and to introduce himself and his method into it, finds himself part of another man’s most inti-
views concerning his person-to-person encounter in the therapeutic setting. At any rate, he recognizes his activities as a function of life-historical processes, and concludes that in his sphere one makes history as one records it.

3

It is in such apparent quicksand that we must follow the tracks of clinical evidence. No wonder that often the only clinical material which impresses some as being at all "scientific" is the more concrete evidence of the auxiliary methods of psychotherapy—neurological examination, chemical analysis, sociological study, psychological experiment, etc.—all of which, strictly speaking, put the patient into non-therapeutic conditions of observation. Each of these methods may "objectify" some matters immensely, provide inestimable supportive evidence for some theories, and lead to independent methods of cure in some classes of patients. But it is not of the nature of the evidence provided in the psychotherapeutic encounter itself.

To introduce such evidence, I need a specimen. This will consist of my reporting to you what a patient said to me, how he behaved in doing so and what I, in turn, thought and did—a highly suspect method. And, indeed, we may well stand at the beginning of a period when consultation rooms (already airier and lighter than Freud's) will have, as it were, many more doors open in the direction of an enlightened community's resources, even as they now have research windows in the form of one-way screens, cameras, and recording equipment. For the kind of evidence to be highlighted here, however, it is still essential that, for longer periods or for shorter ones, these doors be closed, soundproof, and impenetrable.

By emphasizing this I am not trying to ward off legitimate study of the setting from which our examples come. I know only too well that many of our interpretations seem to be of the variety that given by one Jew to another in a Polish railroad station. "Where are you going?" asked the first. "To Minsk," said the other. "To Minsk!" exclaimed the first, "you say you go to Minsk so that I should believe you go to Pinsk! You are going to Minsk anyway—so why do you lie?" There is a widespread prejudice that the psychotherapist, point for point, uncovers what he claims the patient "really," and often unconsciously, had in mind, and that he has sufficient Pinsk-Minsk reversals in his technical arsenal to come out with the flat assertion that the evidence is on the side of his claim. It is for this very reason that I will try to demonstrate what method there may be in clinical judgment. I will select as my specimen the most subjective of all data, a dream-report.

A young man in his early twenties comes to his therapeutic hour about midway during his first year of treatment in a psychiatric hospital and reports that he has had the most disturbing dream of his life. The dream, he says, vividly recalls his state of panic at the time of the "mental breakdown" which had caused him to interrupt his studies for missionary work abroad and enter treatment. He cannot let go of the dream; it seemed painfully real on awakening; and even in the hour of reporting, the dream-state seems still vivid enough to threaten the patient's sense of reality. He is afraid that this is the end of his sanity.

THE DREAM: "There was a big face sitting in a buggy of the horse-and-buggy days. The face was completely empty, and there was horrible, slimy, snaky hair all around it. I am not sure it wasn't my mother." The dream report itself, given with wordy plaintiveness, is as usual followed by a variety of seemingly incidental reports of the events of the previous day which, however, eventually give way to a rather coherent account of the patient's relationship with his deceased grandfather, a country parson. In fact, he sees himself as a small boy with his grandfather crossing a bridge over a brook, his tiny hand in the old man's reassuring fist. Here the patient's mood changes to a deeply moved and moving admission of
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and in his life, and had expressed trust in and even something akin to affection for me.

As to the rest of the hour of the dream-report I listened to the patient, who faced me in an easy chair, with only occasional interruptions for the clarification of facts or feelings. Only at the conclusion of the appointment did I give him a résumé of what sense his dream had made to me. It so happened that this interpretation proved convincing to us both and, in the long run, strategic for the whole treatment. (These are the hours we like to report.)

As I turn to the task of indicating what inferences helped me to formulate one of the most probable of the many possible meanings of this dream-report, I must ask you to join me in what Freud has called “free-floating attention,” which—as I must now add—turns inward to the observer’s ruminations even as it attends the patient’s “free associations” and which, far from focusing on any one item too intentionally, rather waits to be impressed by recurring themes. These themes will, first faintly but ever more insistently, signal the nature of the patient’s message and its meaning. It is, in fact, the gradual establishment of strategic intersections on a number of tangents that eventually makes it possible to locate in the observed phenomena that central core which comprises the “evidence.”

I will now try to report what kinds of considerations will pass through a psychotherapist’s mind, some fleetingly, others with persistent urgency, some hardly conscious in so many words, others nearly ready for verbalization and communication.

Our patient’s behavior and report confront me with a therapeutic crisis, and it is my first task to perceive where the patient stands as a client, and what I must do next. What a clinician must do first and last depends, of course, on the setting of his work. Mine is an open residential institution,
working with severe neuroses, some on the borderline of psychosis or psychopathy. In such a setting, the patients may display, in their most regressed moments, the milder forms of a disturbance in the sense of reality; in their daily behavior, they usually try to entertain, educate, and employ themselves in rational and useful ways; and in their best moments, they can be expected to be insightful and to do proficient and at times creative work. The hospital thus can be said to take a number of calculated risks, and to provide, on the other hand, special opportunities for the patient’s abilities to work, to be active, and to share in social responsibilities. That a patient will fit into this setting has been established in advance during the “evaluation period.” The patient’s history has been taken in psychiatric interviews with him and perhaps with members of his family; he has been given a physical examination by a physician and has been confronted with standardized tests by psychologists who perform their work “blindly,” that is, without knowledge of the patient’s history; and finally, the results have been presented to the whole staff at a meeting, at the conclusion of which the patient himself was presented by the medical director, questioned by him and by other staff members, and assigned to “his therapist.” Such preliminary screening has provided the therapist with an over-all diagnosis which defines a certain range of expectable mental states, indicating the patient’s special danger points and his special prospects for improvement. Needless to say, not even the best preparation can quite predict what depths and heights may be reached once the therapeutic process gets under way.

The original test report had put the liability of our patient’s state into these words: “The tests indicate border-line psychotic features in an inhibited, obsessive-compulsive character. However, the patient seems to be able to take spontaneously adequate distance from these border-line tendencies. He seems, at present, to be struggling to strengthen a rather precarious control over aggressive impulses, and probably feels a good deal of anxiety.” The course of the treatment confirmed this and other test results. Thus, a dream-report of the kind just mentioned, in a setting of this kind, will first of all impress the clinical observer as a diagnostic sign. This is an “anxiety dream.” Such a dream may happen to anybody, and a mild perseveration of the dream state into the day is not pathological as such. But this patient’s dream appears to be only the visual center of a severe affective disturbance: no doubt if such a state were to persist, it could precipitate him into a generalized panic such as brought him to our clinic in the first place. The report of this horrible dream which intrudes itself on the patient’s waking life now takes its place beside the data of the tests and the range and spectrum of the patient’s moods and states as observed in the treatment, and shows him on the lowest level attained since admission, i.e., relatively closest to an inability “to take adequate distance from his border-line tendencies.”

The first “prediction” to be made is whether this dream is the sign of an impending collapse, or, on the contrary, a potentially beneficial clinical crisis. The first would mean that the patient is slipping away from me and that I must think, as it were, of the emergency net; the second, that he is reaching out for me with an important message which I must try to understand and answer. I decided on the latter alternative. Although the patient acted as if he were close to a breakdown, I had the impression that, in fact, there was a challenge in all this, and a rather angry one. This impression was, to some extent, based on a comparison of the present hour and the previous one when the patient had seemed so markedly improved. Could it be that his unconscious had not been able to tolerate this very improvement? The paradox resolves itself if we consider that cure means the loss of the right to rely on therapy; for the cured patient, to speak with Saint Francis, would not so much seek to be loved as to love, and not so much to be consoled as to console, to the limit of his capacity. Does the
dream-report communicate, protesting somewhat too loudly, that the patient is still sick? Is his dream sicker than the patient is? I can explain this tentative diagnostic conclusion only by presenting a number of inferences of a kind made very rapidly in a clinician's mind, and demonstrable only through an analysis of the patient's verbal and behavioral communications and of my own intellectual and affective reactions.

5

The experienced dream interpreter often finds himself "reading" a dream-report as a practitioner of medicine scans an X-ray. Especially in the cases of wordy or reticent patients or of lengthy case reports, a dream often lays bare the stark inner facts.

Let us first pay attention to the dream images. The main item is a large face without identifying features. There are no spoken words, and there is no motion. There are no people in the dream. Very apparent, then, are omissions. An experienced interpreter can state this on the basis of an implicit inventory of dream configurations against which he checks the individual dream production for present and absent dream configurations. This implicit inventory can be made explicit as I have myself tried to do in a publication reviewing Freud's classic first analysis of a "dream specimen." The dream being discussed, then, is characterized by a significant omission of important items present in most dreams: motion, action, people, spoken words. All we have instead is a motionless image of a faceless face, which may or may not represent the patient's mother.

But in trying to understand what this image "stands for," the interpreter must abandon the classic scientific urge (leading to parsimonious explanation in some contexts but to "wild" interpretation in this one) to look for the one most plausible explanation. He must let his "free-floating" clinical attention and judgment lead him to all the possible faces which may be condensed in this one dream face and then decide what probable meaning may explain their combined presence. I will, then, proceed to relate the face in the dream to all the faces in my patient's hierarchy of significant persons, to my face as well as those of his mother and grandfather, to God's countenance as well as to the Medusa's grimace. Thus, the probable meaning of an empty and horrible face may gradually emerge.

First myself, then the patient's facial and tonal expression reminded me of a series of critical moments during his treatment when he was obviously not quite sure that I was "all there" and apprehensive that I might disapprove of him and disappear in anger. This focused my attention on a question which the clinician must consider when faced with any of his patient's productions, namely, his own place in them.

While the psychotherapist should not force his way into the meanings of his patient's dream images, he does well to raise discreetly the masks of the various dream persons to see whether he can find his own face or person or role represented. Here the mask is an empty face, with plenty of horrible hair. My often unruly white hair surrounding a reddish face easily enters my patients' imaginative productions, either in the form of a benevolent Santa Claus or that of a threatening ogre. At that particular time, I had to consider another autobiographic item. In the third month of therapy, I had "abandoned" the patient to have an emergency operation which he, to use clinical shorthand, had ascribed to his evil eye. At the time of this dream-report I still was on occasion mildly uncomfortable—a matter which can never be hidden from such patients. A sensitive patient will, of course, be in conflict between his sympathy, which makes him want to take care of me, and his rightful claim that I should take care of him—for he feels that only the therapist's total presence can provide him with sufficient identity to weather his crises. I concluded that the empty face had something to do with a certain tenuousness in our relationship, and that one message of the dream might
be something like this: "If I never know whether and when you think of yourself rather than attending to me, or when you will absent yourself, maybe die, how can I have or gain what I need most—a coherent personality, an identity, a face?"

Such an indirect message, however, even if understood as referring to the immediate present and to the therapeutic situation itself, always proves to be "overdetermined," that is, to consist of a condensed code transmitting a number of other messages, from other life situations, seemingly removed from the therapy. This we call "transference." Because the inference of a "mother transference" is by now an almost stereotyped requirement, and thus is apt to lead to faulty views concerning the relationship of past and present, I have postponed, but not discarded, a discussion of the connection between the patient's implied fear of "losing a face" with his remark that he was not sure the face was not his mother's. Instead, I put first his fear that he may yet lose himself by losing me too suddenly or too early.

6

Clinical work is always research in progress, and I would not be giving a full account of the clinician's pitfalls if I did not discuss in passing the fact that this patient's dream happened to fit especially well into my research at the time. This can be a mixed blessing for the therapeutic contract. A research-minded clinician—and one with literary ambitions, at that—must always take care lest his patients become footnotes to his favorite thesis or topic. I was studying in Pittsburgh and in Stockbridge the "identity crises" of a number of young people, college as well as seminary students, workmen and artists. My purpose was to delineate further a syndrome called "identity-confusion," a term which describes the inability of young people in the late 'teens and early twenties to establish their station and vocation in life, and the tendency of some to develop apparently malignant symptoms and regressions.⁸

The nature of clinical evidence must re-open rather than close questions of finalistic diagnosis. Perhaps there are certain stages in the life cycle when even seemingly malignant disturbances are more profitably treated as aggravated life crises rather than as diseases subject to routine psychiatric diagnosis. Here the clinician must be guided by the proposition that if he can hope to save only a small subgroup, or, indeed, only one patient, he must disregard existing statistical verdicts. For one new case, understood in new ways, will soon prove to be "typical" for a whole class of patients.

But any new diagnostic impression immediately calls for epidemiological considerations. What we have described as a therapeutic need in one patient, namely, to gain identity by claiming the total presence of his therapist, is identical with the need of young people anywhere for ideological affirmation. This need is aggravated in certain critical periods of history, when young people may try to find various forms of "confirmation" in groups that range from idealistic youth movements to criminal gangs.⁴

The young man in question was one among a small group of our patients who came from theological seminaries. He had developed his symptoms when attending a Protestant seminary in the Middle West where he was training for missionary work in Asia. He had not found the expected transformation in prayer, a matter which both for reasons of honesty and of inner need, he had taken more seriously than many successful believers. To him the wish to gaze through the glass darkly and to come "face to face" was a desperate need not easily satisfied in some modern seminaries. I need not remind you of the many references in the Bible to God's "making his face to shine upon" man, or God's face being turned away or being distant. The therapeutic theme inferred from the patient's report of an anxiety dream in which a face was horribly unrecognizable thus also seemed to echo relevantly this patient's religious scruples at the time of the appearance of psychiatric symptoms.
— the common denominator being a wish to break through to a provider of identity.

This trend of thought, then, leads us from the immediate clinical situation (and a recognition of my face in the dream face) to the developmental crisis typical for the patient's age (and the possible meaning of facelessness as "identity-confusion"), to the vocational and spiritual crisis immediately preceding the patient's breakdown (and the need for a divine face, an existential recognition). The "buggy" in the dream will lead us a step further back into an earlier identity crisis — and yet another significant face.

The horse and buggy is, of course, an historical symbol of culture change. Depending on one's ideology, it is a derisive term connoting hopelessly old-fashioned ways, or it is a symbol of nostalgia for the good old days. Here we come to a trend in the family's history most decisive for the patient's identity crisis. The family came from Minnesota, where the mother's father had been a rural clergyman of character, strength, and communal esteem. Such grandfathers represent to many today a world of homogeneity in feudal values, "masterly and cruel with a good conscience, self-restrained and pious without loss of self-esteem." When the patient's parents had moved from the north country to then still smog-covered Pittsburgh, his mother especially had found it impossible to overcome an intense nostalgia for the rural ways of her youth. She had, in fact, imbued the boy with this nostalgia for a rural existence and had demonstrated marked disappointment when the patient, at the beginning of his identity crisis (maybe in order to cut through the family's cultural conflict), had temporarily threatened to become somewhat delinquent. The horse and buggy obviously is in greatest ideological as well as technological contrast to the modern means of locomotor acceleration, and, thus, all at once a symbol of changing times, of identity-confusion, and of cultural regression. Here the horrible motionlessness of the dream may reveal itself as an im-

important configurational item, meaning something like being stuck in the middle of a world of competitive change and motion. And even as I inferred in my thoughts that the face sitting in the buggy must also represent the deceased grandfather's, also framed by white hair, the patient spontaneously embarked (as reported above) on a series of memories concerning the past when his grandfather had taken him by the hand to acquaint him with the technology of an old farm in Minnesota. Here the patient's vocabulary had become poetic, his description vivid, and he had seemed to be breaking through to a genuinely positive emotional experience. Yet as a reckless youngster he had defied this grandfather shortly before his death. Knowing this, I sympathized with his tearfulness which, nevertheless, remained strangely perverse, and sounded strangled by anger, as though he might be saying: "One must not promise a child such certainty, and then leave him."

Here it must be remembered that all "graduations" in human development mean the abandonment of a familiar position, and that all growth — that is, the kind of growth endangered in our patients — must come to terms with this fact.

We add to our previous inferences the assumption that the face in the dream (in a condensation typical for dream images) also "meant" the face of the grandfather who is now dead and whom as a rebellious youth the patient had defied. The immediate clinical situation, then, the history of the patient's breakdown and a certain period in his adolescence are all found to have a common denominator in the idea that the patient wishes to base his future sanity on a countenance of wisdom and firm identity while, in all instances, he seems to fear that his anger may have destroyed, or may yet destroy, such resources. The patient's desperate insistence on finding security in prayer and, in fact, in missionary work, and yet his failure to find peace in these endeavors belongs in this context.

It may be necessary to assure you at this point that it is the failure of religious endeavor, not religiosity or the need for
reverence and service, which is thereby explained. In fact, there is every reason to assume that the development of a sense of fidelity and the capacity to give and to receive it in a significant setting is a condition for a young adult’s health, and of a young patient’s recovery.

The theme of the horse and buggy as a rural symbol served to establish a possible connection between the nostalgic mother and her dead father; and we now finally turn our attention to the fact that the patient, half-denying what he was half-suggesting, said, “I am not sure it wasn’t my mother.” Here the most repetitious complaint of the whole course of therapy must be reviewed. While the grandfather’s had been, all in all, the most consistently reassuring countenance in the patient’s life, the mother’s pretty, soft, and loving face had since earliest childhood been marred in the patient’s memory and imagination by moments when she seemed absorbed and distorted by strong and painful emotions. The tests, given before any history-taking, had picked out the following theme: “The mother-figure appears in the Thematic Apperception Tests as one who seeks to control her son by her protectiveness of him, and by ‘self-pity’ and demonstrations of her frailty at any aggressive act on his part. She is, in the stories, ‘frightened’ at any show of rebelliousness, and content only when the son is passive and compliant. There appears to be considerable aggression, probably partly conscious, toward this figure.” And indeed, it was with anger as well as with horror that the patient would repeatedly describe the mother of his memory as utterly exasperated, and this at those times when he had been too rough, too careless, too stubborn, or too persistent.

We are not concerned here with accusing this actual mother of having behaved this way; we can only be sure that she appeared this way in certain retrospective moods of the patient. Such memories are typical for a certain class of patients, and the question whether this is so because they have in common a certain type of mother or share a typical reaction to their mothers, or both, occupies the thinking of clinicians. At any rate many of these patients are deeply, if often unconsciously, convinced that they have caused a basic disturbance in their mothers. Often, in our time, when corporal punishment and severe scolding have become less fashionable, parents resort to the seemingly less cruel means of presenting themselves as deeply hurt by the child’s wilfulness. The “violated” mother thus tends to appear more prominently in images of guilt. In some cases this becomes an obstacle in the resolution of adolescence—as if a fundamental and yet quite impossible restitution were a condition for adulthood. It is in keeping with this trend that the patients under discussion here, young people who in late adolescence face a breakdown on the borderline of psychosis, all prove to be partially regressed to the earliest task in life, namely, the acquisition of a sense of basic trust strong enough to balance that sense of basic mistrust to which newborn man (most dependent of all young animals and yet endowed with fewer inborn instinctive regulations) is subject in his infancy. We all relive earlier and earliest stages of our existence in dreams, in artistic experience, and in religious devotion, only to emerge refreshed and invigorated. These patients, however, experience such partial regression in a lonely, sudden, and intense fashion, and most of all with a sense of irreversible doom. This, too, is in this dream.

The mother’s veiled presence in the dream points to a complete omission in all this material: there is no father either in the dream or in the associated themes. The patient’s father images became dominant in a later period of the treatment and proved most important for the patient’s eventual solution of his spiritual and vocational problems. From this we can dimly surmise that in the present hour the grandfather “stands for” the father.

On the other hand, the recognition of the mother’s coun-
tenance in the empty dream face and its surrounding slimy hair suggests the discussion of a significant symbol. Did not Freud explain the Medusa, the angry face with snake-hair and an open mouth, as a symbol of the feminine void, and an expression of the masculine horror of femininity? It is true that some of the patient’s memories and associations (reported in other sessions in connection with the mother’s emotions) could be easily traced to infantile observations and ruminations concerning “female trouble,” pregnancy, and post-partum upsets. Facelessness, in this sense, can also mean inner void, and (from a male point of view) “castration.” Does it, then, or does it not contradict Freudian symbolism if I emphasize in this equally horrifying but entirely empty face a representation of facelessness, of loss of face, of lack of identity? In the context of the “classical” interpretation, the dream image would be primarily symbolic of a sexual idea which is to be warded off, in ours a representation of a danger to the continuous existence of individual identity. Theoretical considerations would show that these interpretations do not exclude each other. In this case a possible controversy is superseded by the clinical consideration that a symbol to be interpreted must first be shown to be immediately relevant. It would be futile to use sexual symbolism dogmatically when acute interpersonal needs can be discerned as dominant in strongly concordant material. The sexual symbolism of this dream was taken up in due time, when it reappeared in another context, namely that of manhood and sexuality, and revealed the bisexual confusion inherent in all identity conflict.

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Tracing one main theme of the dream retrospectively, we have recognized it in four periods of the patient’s life—all four premature graduations which left him with anger and fear over what he was to abandon rather than with the anticipation of greater freedom and more genuine identity: the present treatment—and the patient’s fear that by some act of horrible anger (on his part or on mine or both) he might lose me and thus his chance to regain his identity through trust in me; his immediately preceding religious education—and his abortive attempt at finding through prayer that “presence” which would cure his inner void; his earlier youth—and his hope to gain strength, peace, and identity by identifying himself with his grandfather; and, finally, early childhood—and his desperate wish to keep alive in himself the charitable face of his mother in order to overcome fear, guilt, and anger over her emotions. Such redundancy points to a central theme which, once found, gives added meaning to all the associated material. The theme is: “Whenever I begin to have faith in somebody’s strength and love, some angry and sickly emotions pervade the relationship, and I end up mistrusting, empty, and a victim of anger and despair.”

You may be getting a bit tired of the clinician’s habit of speaking for the patient, of putting into his mouth inferences which, so it would seem, he could get out of him for the asking. The clinician, however, has no right to test his reconstructions until his trial formulations have combined into a comprehensive interpretation which feels right to him, and which promises, when appropriately verbalized, to feel right to the patient. When this point is reached, the clinician usually finds himself compelled to speak, in order to help the patient in verbalizing his affects and images in a more communicative manner, and to communicate his own impressions.

If according to Freud a successful dream is an attempt at representing a wish as fulfilled, the attempted and miscarried fulfillment in this dream is that of finding a face with a lasting identity. If an anxiety dream startling the dreamer out of his sleep is a symptom of a derailed wish-fulfillment, the central theme just formulated indicates at least one inner disturbance which caused the miscarriage of basic trust in infancy.

It seemed important to me that my communication should
include an explicit statement of my emotional response to the dream-report. Patients of the type of our young man, still smarting in his twenties under what he considered his mother's strange emotions in his infancy, can learn to delineate social reality and to tolerate emotional tension only if the therapist can juxtapose his own emotional reactions to the patient's emotions. Therefore, as I reviewed with the patient some of what I have put before you, I also told him without anger, but not without some honest indignation, that my response to his account had included a feeling of being attacked. I explained that he had worried me, had made me feel pity, had touched me with his memories, and had challenged me to prove, all at once, the goodness of mothers, the immortality of grandfathers, my own perfection, and God's grace.

The words used in an interpretation, however, are hard to remember and when reproduced or recorded often sound as arbitrary as any private language developed by two people in the course of an intimate association. But whatever is said, a therapeutic interpretation, while brief and simple in form, should encompass a unitary theme such as I have put before you, a theme common at the same time to a dominant trend in the patient's relation to the therapist, to a significant portion of his symptomatology, to an important conflict of his childhood, and to corresponding facets of his work and love life. This sounds more complicated than it is. Often, a very short and casual remark proves to have encompassed all this; and the trends are (as I must repeat in conclusion) very closely related to each other in the patient's own struggling mind, for which the traumatic past is of course a present frontier, perceived as acute conflict. Such an interpretation, therefore, joins the patient's and the therapist's modes of problem-solving.

Therapists of different temperament and of various persuasions differ as to what constitutes an interpretation: an impersonal and authoritative explanation, a warm and fatherly suggestion, an expansive sermon or a sparse encouragement to go on and see what comes up next. The intervention in this case, however, highlights one methodological point truly unique to clinical work, namely, the disposition of the clinician's "mixed" feelings, his emotions and opinions. The evidence is not "all in" if he does not succeed in using his own emotional responses during a clinical encounter as an evidential source and as a guide in intervention, instead of putting them aside with a spurious claim to unassailable objectivity. It is here that the prerequisite of the therapist's own psychoanalytic treatment as a didactic experience proves itself essential, for the personal equation in the observer's emotional response is as important in psychotherapy as that of the senses in the laboratory. Repressed emotions easily hide themselves in the therapist's most stubborn blind spots.

I do not wish to make too much of this, but I would suggest in passing that some of us have, to our detriment, embraced an objectivity which can only be maintained with self-deception. If "psychoanalyzed" man learns to recognize the fact that even his previously repudiated or denied impulses may be "right" in their refusal to be submerged without a trace (the traces being his symptoms), so he may also learn that his strongest ethical judgments are right in being persistent even if modern life may not consider it intelligent or advantageous to feel strongly about such matters. Any psychotherapist, then, who throws out his ethical sentiments with his irrational moral anger, deprives himself of a principal tool of his clinical perception. For even as our sensuality sharpens our awareness of the orders of nature, so our indignation, admitted and scrutinized for flaws of sulkiness and self-indulgence, is, in fact, as important tool both of therapy and of theory. It adds to the investigation of what, indeed, has happened to sick individuals a suggestion of where to look for those epidemiological factors that should and need not happen to anybody. But this means that we somehow harbor a model of man which could serve as a scientific basis for the postulation of an ethical rela-
tion of the generations to each other; and that we are committed to this whether or not we abrogate our partisanship in particular systems of morality.

A certain combination of available emotion and responsive thought, then, marks a therapist's style and is expressed in minute variations of facial expression, posture, and tone of voice. The core of a therapeutic intervention at its most decisive thus defies any attempt at a definitive account. This difficulty is not overcome by the now widespread habit of advocating a "human," rather than a "technical" encounter. Even humanness can be a glib "posture," and the time may come when we need an injunction against the use in vain of this word "human," too.

**What do we expect** the patient to contribute to the closure of our evidence? What tells us that our interpretation was "right," and, therefore, proves the evidence to be as conclusive as it can be in our kind of work? The simplest answer is that this particular patient was amused, delighted, and encouraged when I told him of my thoughts and of my anger over his unnecessary attempts to burden me with a future which he could well learn to manage—a statement which was not meant to be a therapeutic "suggestion" or a clinical slap on the back, but was based on what I knew of his inner resources as well as of the use he made of the opportunities offered in our clinical community. The patient left the hour—to which he had come with a sense of dire disaster—with a broad smile and obvious encouragement. Otherwise, only the future would show whether the process of recovery had been advanced by this hour.

But then, one must grant that the dream experience itself was a step in the right direction. I would not want to leave you with the impression that I accused the patient of pretending illness, or that I belittled his dream as representing sham despair. On the contrary, I acknowledged that he had taken a real chance with himself and with me. Under my protection and the hospital's he had hit bottom by chancing a repetition of his original breakdown. He had gone to the very border of unreality and had gleaned from it a highly condensed and seemingly anarchic image. Yet that image, while experienced as a symptom, was in fact a kind of creation, or at any rate a condensed and highly meaningful communication and challenge, to which my particular clinical theory had made me receptive. A sense of mutuality and reality was thus restored, reinforced by the fact that while accepting his transferences as meaningful, I had refused to become drawn into them. I had played neither mother, grandfather, nor God (this is the hardest), but had offered him my help as defined by my professional status in attempting to understand what was behind his helplessness. By relating the fact that his underlying anger aroused mine, and that I could say so without endangering either myself or him, I could show him that in his dream he had also confronted anger in the image of a Medusa—a Gorgon which, neither of us being a hero, we could yet slay together.

The proof of the correctness of our inference does, of course, not always lie in the patient's immediate assent. I have, in fact, indicated how this very dream experience followed an hour in which the patient had assented too much. Rather, the proof lies in the way in which the communication between therapist and patient "keeps moving," leading to new and surprising insights and to the patient's greater assumption of responsibility for himself. In this he is helped, if hospitalized, by the social influences of the "therapeutic community," and by well-guided work activities—all of which would have to be taken into account, if I were concerned here with the nature of the therapeutic process rather than with that of clinical evidence. But it is important to remember that only in a favorable social setting, be it the private patient's private life or the hospitalized patient's planned community, can the two
main therapeutic agents described here function fully; the insight gained into the pathogenic past, and the convincing presence of a therapeutic relationship which bridges past and future.

I may now confess that the initial invitation really requested me to tell you "how a good clinician works." I have replaced this embarrassing little word with dots until now when I can make it operational. It is a mark of the good clinician that much can go on in him without clogging his communication at the moment of therapeutic intervention, when only the central theme may come to his awareness. Since a clinician's identity as a worker is based (as is anybody else's) on decisive learning experiences during the formative years of his first acquaintance with the field of his choice, he cannot avoid carrying with him some traditional formulations which may range in their effect from ever helpful clarifications to burdening dogmatisms. In a good clinician, such formulations have become a matter of implicit insight and of a style of action. On the other hand, he must also be able to call his ruminations to explicit awareness when professional conferences permit their being spelled out—for how else could such thinking be disciplined, shared and taught? Such sharing and teaching, in turn, if it is to transcend clinical impressionism, presupposes a communality of conceptual approaches. I cannot give you today more than a suggestion that there is a systematic relationship between clinical observation on the one hand and, on the other, such conceptual points of view as Freud has introduced into psychiatry: a structural point of view denoting a kind of anatomy of the mind, a dynamic point of view denoting a kind of physiology of mental forces, a genetic point of view reconstructing the growth of the mind and the stages marking its strengths and its dangers, and finally, an adaptive point of view. But even as such propositions are tested on a wide front of inquiry (from the direct observation of children and perception experiments to "metapsychological" discussion), it stands to reason that clinical evidence is characterized by an immediacy which transcends formulations ultimately derived from mechanistic patterns of thought.

The "points of view" introduced into psychiatry and psychology by Freud are, at this time, subject to a strange fate. No doubt, they were the bridges by which generations of medical clinicians could apply their anatomical, physiological, and pathological modes of thinking to the workings of the mind. Probably also, the neurological basis of behavior was thus fruitfully related to other determinants; I myself cannot judge the fate of Freud's neurological assumptions as such. A transfer of concepts from one field to another has in other fields led to revolutionary clarifications and yet eventually also to a necessary transcendence of the borrowed concepts by newer and more adequate ones. In psychoanalysis, the fate of the "points of view" was pre-ordained: since on their medical home ground they were based on visible facts such as organs and functions, in the study of the mind they sooner or later served improper reifications, as though libido or the death-instinct or the ego really existed. Freud was sovereignly aware of this danger, but always willing to learn by giving a mode of thought free reign to see to what useful model it might lead. He also had the courage, the authority, and the inner consistency to reverse such a direction when it became useless or absurd. Generations of clinical practitioners cannot be expected to be equally detached or authoritative. Thus it cannot be denied that in much clinical literature the clinical evidence secured with the help of inferences based on Freud's theories has been increasingly used and slanted to verify the original theories. This, in turn, could only lead to a gradual estrangement between theory and clinical observation.

I should, therefore, say explicitly which of the traditional psychoanalytic concepts have remained intrinsic to my clinical
way of thinking. I would say that I have to assume that the patient is (to varying degrees) unconscious of the meaning which I discern in his communications, and that I am helping him by making fully conscious what may be totally repressed, barely conscious, or simply cut off from communication. By doing so, however, I take for granted an effective wish on his part (with my help) to see, feel and speak more clearly. I would also assume a regressive trend, a going back to earlier failures in order to solve the past along with the present. In doing so, however, I would not give the past a kind of fatalistic dominance over the present: for the temporal rear can be brought up only where the present finds consolidation. I would also acknowledge the power of transference, i.e., the patient's transfer to me of significant problems in his past dealings with the central people in his life; but I would know that only by playing my role as a new person in his present stage of life can I clarify the appropriateness of his transferences from the past. In this past, I would consider libidinal attachments and relationships of dependence and of abandonment of paramount importance: but I would assume, in line with everything that we have learned about human development, that these relationships were not disturbed only by a libidinal disbalance. Such disbalance, in fact, is part of a missed mutuality which kept the child from realizing his potential strength even as the parent was hindered in living up to his potentialities by the very failure of mutuality in relation to this child. You will note, then, that in naming the rock-bottom concepts of repression and regression, transference and libido, I have tried to keep each linked with the observation and experience of the clinical encounter as a new event in the patient's life history. You would find other clinical workers similarly groping for a position which permits them to honor the therapeutic contract as they use and advance the theory of the field. At the end, the therapist's chosen intervention and the patient's reactions to it are an integral part of the evidence provided in the thera-

The Nature of Clinical Evidence

I have given you an example which ends on a convincing note, leaving both the patient and the practitioner with the feeling that they are a pretty clever pair. If it were always required to clinch a piece of clinical evidence in this manner, we should have few convincing examples. To tell the truth, I think that we often learn more from our failures—if indeed we can manage to review them in the manner here indicated. But I hope to have demonstrated that there is enough method in our work to force favorite assumptions to become probable inferences by cross-checking the patient's diagnosis and what we know of his type of illness and state of physical health; his stage of development and what we know of the "normative" crisis of his age-group; the co-ordinates of his social position and what we know of the chances of a man of his type, intelligence, and education in the social actuality of our time. This may be hard to believe unless one has heard an account of a series of such encounters as I have outlined here, the series being characterized by a progressive or regressive shift in all the areas mentioned: such is the evidence used in our clinical conferences and seminars.

Much of clinical training, in fact, consists of the charting of such series. In each step, our auxiliary methods must help us work with reasonable precision and with the courage to revise our assumptions and our techniques systematically, if and when the clinical evidence should show that we overestimated or underestimated the patient; or ourselves, the chances waiting for him in his environment, or the usefulness of our particular theory.

In order to counteract any subjectivity and selectivity, whole
treatments are now being sound-filmed so that qualified secondary observers can follow the procedure and have certain items repeated many times over, sometimes in slow motion. This will be important in some lines of research, and advantageous in training. Yet, it confronts a second observer or a series of observers with the task of deciding on the basis of their reactions, whether or not they agree with the judgments of the original observer made on the basis of his unrecordable reactions. Nor does the nature of clinical evidence change in such new developments as group-psychotherapy, where a therapist faces a group of patients and they face one another as well, permitting a number of combinations and variations of the basic elements of a clinical encounter. Clinical evidence, finally, will be decisively clarified, but not changed in nature, by a sharpened awareness (such as now emanates from sociological studies) of the psychotherapist’s as well as the patient’s position in society and history.

The relativity implicit in clinical work may, to some, militate against its scientific value. Yet, I suspect, that this very relativity, truly acknowledged, will make the clinicians better companions of today’s and tomorrow’s scientists than did the attempts to reduce the study of the human mind to a science identical with traditional natural science. I, therefore, have restricted myself to giving an operational introduction to the clinician’s basic view which asserts that scientists may learn about the nature of things by finding out what they can do to them, but that the clinician can learn of the true nature of man only in the attempt to do something for and with him. I have focused, therefore, on the way in which clinical evidence is grounded in the study of what is unique to the individual case—including the psychotherapist’s involvement. Such uniqueness, however, would not stand out without the background of that other concern, which I have neglected here, namely the study of what is common to verifiable classes of cases.
References

I  The First Psychoanalyst


II  The Nature of Clinical Evidence


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