R ritual and Spontaneity in the
Psychoanalytic Process

PSYCHOANALYTIC RITUALS

There is a fixed routine in the psychoanalytic process, a routine with
the kind of symbolic, evocative, and transforming potential that
gives it the aura of a ritual.1 There are fixed times, a fixed place, and
a fixed fee. Each appointment is usually 45 or 50 minutes long.
Commonly the seating arrangement is the same every time, whether
or not it entails the use of the couch. The couch itself, when it is
used, adds to the peculiarity of the situation, to its foreignness, and
perhaps to the mystique of the now seemingly disembodied analyst's
voice.

In addition to these “extrinsic” factors (Gill, 1954, 1984a), within
the process itself there is a fundamental asymmetry. The patient is
invited to “free associate,” and thereby, presumably, to expose the
structure of his or her emotional life. The analyst remains strangely
hidden or anonymous, strangely, that is, relative to the norms of
ordinary social conduct. Although analysts vary considerably in the
ways that they conceptualize the role of their own subjective, personal

1. Catherine Bell (1992) writes that “ritualization is a way of acting that
specifically establishes a privileged contrast, differentiating itself as more
important or powerful. Such privileged distinctions may be drawn in a vari-
ety of culturally specific ways that render the ritualized acts dominant in
status” (p. 90).
reactions in the process, few if any—notwithstanding Ferenczi’s experiments late in his life—would advocate the complete breakdown of this asymmetry. If there is room in our culture for that kind of process, it is certainly difficult to imagine what it could mean in the context of a professional service in which one party pays the other for confidential psychological help. Indeed, we are in Ferenczi’s debt for exposing the untenability of anything approaching a fully mutual analysis. One of the problems Ferenczi (1932) ran into very quickly was that he couldn’t possibly speak freely to RN about what came to his mind and still honor the confidentiality of his experiences with other patients, because those experiences were often precisely what came to his mind (p. 34).

The analytic frame, of course, provides the general boundaries for the relationship, a multifaceted scaffolding of protection for both the patient and the analyst. It sets up the special “potential space” in which the “play” of psychoanalysis can go on (Winnicott, 1971; Modell, 1990). As Modell says, “Despite the spontaneity and unpredictability of the affective relationship between the analyst and the analysand, there are also certain affective constants that are institutionalized as part of technique and contribute to the frame or the rules of the game” (p. 30). We usually think of these institutionalized constants, combined with the fixed aspects of the setting, as contributing to a safe environment, one that provides the context for the real analytic work (as in the working alliance) or is in itself the vehicle for a good deal of therapeutic action (as in the holding environment). From this point of view, deviations from psychoanalytic rituals might be thought to endanger the atmosphere of safety that they are designed to foster and their nurturant, development-facilitating potential.

DOES THE FRAME CREATE A SANCTUARY?

There are, however, important counterpoints to the view that the analytic frame establishes a standard, safe environment. First of all, the extent to which the setting can be standardized is limited. Psychoanalytic rituals leave a great deal of room for variations in the manner in which they are carried out. Thus, if the rituals were adhered to by an analyst in a very rigid way, that in itself would be experienced by the patient as a choice by the analyst, one that would be highly suspect in terms of its motivation. This goes without saying, of course, for the interactions that go on within the context of
the frame but are not themselves conspicuously defining of it. What the analyst will say, for example, between 9:00 A.M., when he or she opens the door and says “come in,” and 9:50, when he or she says “it’s time to stop,” is (or should be) clearly less predictable than those starting points and end points themselves. But it is also the case that even the start of the hour and its conclusion leave much latitude for the analyst to convey a range of personal attitudes and moods. Is the analyst smiling, or frowning, or neither? Does he or she say “Hi, Bob. C’mon in,” or just “hello,” or nothing—maybe just a slight nod of the head? At the end, does the analyst say, “Our time is up” or “we have to stop now” or “I know this is a difficult moment to stop, but we are out of time for today”?

The conclusion of a session is of special interest. Because it is the last moment, it has special weight. Whatever taste it leaves is apt to linger at least until the next session, which is not to say the taste has to be pleasant. Sometimes it might seem “best” for a session to end on a sour note: depressed or angry or whatever. But it’s important to recognize that there is an element of choice, uncertainty, and responsibility associated with the analyst’s contribution to the ending. As much as we might like to feel that what we do at the end of a session merely conforms to a standard routine for which we are not personally responsible—a little like merely “following orders”—the conclusion of every session is a joint construction, one that is chosen, in part, by us, however much it is organized around a given, objective boundary.

Suppose a patient says, with about a minute to go, “I feel like I’m going in circles today and not getting anywhere. Frankly, I don’t think I’ve changed much since I started seeing you,” and suppose he or she then falls silent. Now there is a half minute or less left. As the analyst, I could wait 20 seconds or so in what might feel like a heavy silence and then simply say, “it’s time to stop.” We would be ending then on a certain kind of note. I could tell myself that, after all, it’s the note the patient chose to end on. The patient’s action and the clock created that ending, not I. Because it’s the ending created by the patient and the standard time limit, it’s the “right” one for the patient and me to live with and, perhaps, to explore the next time we meet. Certainly the patient is a major architect of the session’s conclusion. To leave it at that, however, would be to deny that in being silent for those last seconds I was choosing a course of action and thereby cocreating that ending. First of all, in all likelihood I would not, in fact, know what the time was to the second, but even if I did, I could have said it was time to stop just a few seconds after the
patient spoke, or I could have waited about 20 seconds more than I did. These are options that are likely to create three very different endings with very different affective colorations. And then, there is the alternative of actually responding directly to the patient’s comment. There are innumerable possibilities of course. On the side of combatting the mood set by the patient, if it seemed to fit, I could say, “I think it means something that you say that right at the end. In fact, I think that it’s your way of expressing your anger about having to leave”; or maybe, “Really? I thought that was a good session and that we accomplished a lot. Aren’t you doing that number on yourself and on me that we’ve talked about many times?” Whatever I said, I would then have the option of saying “it’s time to stop” right after I made my comment, or waiting a few seconds to give the patient a chance to respond. The latter might be a risk, because I’d be running over and I’d be concerned about inviting a response and then having to cut the patient off. So maybe I’d say, “Unfortunately, it looks like I’m going to have the last word today, because we do have to stop.” The point is that each of these options, the various lengths of silence and the various comments that I might make, constructs a different ending and a different reality. Moreover, in that moment, in that split second which is the moment of choice and of action, there is no way to know what is the “right thing” to do. Indeed, there can be no single “right thing” for the patient or for the relationship. The moment is shot through with uncertainty. First, I don’t know just what it means that the patient has said what he or she has said. Second, I don’t know the full meaning of whatever inclinations I may have to be silent or to speak. And third, whatever I choose to do, I don’t know what opportunities are being lost and what would have happened if I had chosen a different course. The safety afforded by the analytic frame is a qualified one in that it cannot spare the patient or the analyst these uncertainties and the anxieties that attend them.

Ultimately, constructing a “good-enough ending” is the challenge of termination, a separation process that can be decisive in terms of the outcome of the entire analysis. And yet the boundary situations

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2. Of course this is a hypothetical example, so the possibilities of what I might say are relatively unconstrained. But even with a real case, there would be infinite possibilities, although they would be encompassed within a narrower range. “Infinite” does not mean “unlimited.” As noted in chapter 3 (p. 77), “there are infinite numerical values between the numbers 5 and 6, but that range excludes all other numerical values.”
associated with the endings of sessions and with the ending of the analysis as a whole are also like any moment within every session, which is always both structured by analytic ritual and left to the participants to create. Thus in every moment there is a kind of ricocheting going on, a dialectical interplay between ritual and spontaneity, between what is given and what is created, between what is role-determined and what is personal, between constraint and freedom.

In fact, in a general way, it could be said that in our neuroses we suffer from the dichotomous organization of these polarities, a feeling that the choice is between a suffocating submission to internal and external constraints, on the one hand, and a loss of control in which “all hell breaks loose,” on the other. We hope that through analysis it will be possible for us to replace such dichotomous thinking with dialectical thinking, with an integrative sense of the interdependence of apparent opposites. In that light, perhaps, we can reaffirm Freud’s aphorism, in somewhat revised form: “where id [and superego were, split off from each other,] there ego shall be, [mediating their dialectical relationship]” (cf. Freud, 1933, p. 80).

Before moving to a fuller clinical illustration, I’d like to discuss another counterpoint to the view of the frame as a kind of sanctuary. Not only is it not possible for the analyst’s behavior to be fully standardized, but also the intrinsic features of the frame are not simply benign. Racker (1968) says that no encounter with the actual person of the analyst is necessary in order for the patient to begin speculating about the complementary countertransference. He says:

[T]he analyst communicates certain associations of a personal nature even when he does not seem to do so. These communications begin, one might say, with the plate on the front door that says ‘Psychoanalyst’ or ‘Doctor’. What motive (in terms of the unconscious) would the analyst have for wanting to cure if it were not he who made the patient ill? In this way the patient is already, simply by being a patient, the creditor, the accuser, the ‘superego’ of the analyst, and the analyst is his debtor (pp. 145–146).

But is a reparative motive, which is, after all, relatively benign, the only kind that the patient can plausibly attribute to the analyst for assuming this rather peculiar role? It seems to me there are others that are much more threatening to the patient’s sense of safety. Is the analyst not the person who has detected a certain need in the society for understanding, for love, for an idealized object; the one who has scanned the culture (usually with special attention to the white,
urban middle class and upper class) and thought, "why shouldn't I take advantage of this hunger, this craving that a lot of people have for this kind of attachment"? Is the analyst not also the one who has found a way to feed his or her narcissism without being subjected to very much personal risk, or, perhaps, one who fears and craves intimacy and has found a way to have it while still maintaining a good deal of control and distance, or who enjoys his or her sense of power over the people (if business is good, the many people) who want to be his or her special or favorite one? Finally, what could be better than to have all of this hidden under the guise of being the "good-enough parent" who provides, "objectively," a secure holding environment, armed against whatever protests might arise with knowing interpretations of the "neurotic transference"?

These motives, and others like them, comprise the dark, malignant underside of the analytic frame. It is a side that I think we commonly deny. It's rather astonishing, I think, how ready we are to compare ourselves to rather ideal parents, not perfect perhaps, but surely "good enough," and how prepared we are to see the influence of the pathogenic aspects of the patient's past upon the entry into the analytic space of the so-called "bad object" (cf. Slavin and Kliegman, 1992).

The rituals that constitute the frame are undoubtedly essential to the process, and deviations from them are certainly as open, if not more open, to suspicion regarding their self-serving nature as is their religious observance. What I'm questioning is the neatness of the dichotomy: adherence to the frame creates safety, deviation from the frame creates danger. Even if the frame is mostly beneficial, it does not create a perfect sanctuary because, as I have said, it cannot eliminate the analyst's personal participation as a coconstructor of reality in the process and because its defining features are, in themselves, suspect.

Psychoanalytic rituals provide usefully ambiguous grounds, not only for new experience and development, but also for neurotic repetition. Acknowledging this reality has at least two important clinical implications. First, the patient's conscious and unconscious objections to analytic routines, even his or her rage about them, must be taken seriously. By that I mean more than that we have to get into the patient's world and see it from his or her point of view. That attitude can be subtly patronizing, to the extent that we consider the patient's perspective to stem from deficits or even from unresolved conflicts originating in childhood, and to the extent that

we hope that the patient will eventually come to see things from a more developmentally advanced perspective. Instead, I mean that we recognize what may be objectionable about the frame, even from the point of view of a mature, “healthy” adult, so much so that we may wonder what kind of pathology would result in a person being willing to go along with it at all! The one in need is the one who may be driven to accept an invitation to be exploited, and the analytic arrangement can be construed, quite plausibly, as extending such an invitation. A second clinical implication of acknowledging the malignant aspects of the frame, in addition to recognizing a place for an unobjectionable negative transference (cf. Guidi, 1993) and for reasonable resistance, is that such acknowledgment provides theoretical grounds for considering the benign potentials of momentary deviations from the standard routine. A readiness to deviate in certain limited ways may offset the exploitative meanings that can get attached to maintaining the frame in an inflexible manner. There is no way for the analyst to know, with certainty, what course to pursue with respect to the balance between spontaneous, personal responsiveness and adherence to psychoanalytic rituals at any given moment, nor can the balance that is struck be one that the analyst can completely control. The basis for the patient’s trust is often best established through evidence of the analyst’s struggle with the issue and through his or her openness to reflect critically on whatever paths he or she has taken, prompted more or less by the patient’s reactions and direct and indirect communications.

With these ideas as background, let’s take a closer look at a piece of clinical experience.

CONFRONTING A PHOBIA WITHIN
THE ANALYTIC SETTING: 
A SERENDIPITOUS OPPORTUNITY

A patient, Ken, is in my private, downtown office on the 21st floor for the first time. For about three years we had met four times per week at my office at the university, which was on the seventh floor. In that office there was one small window at the foot of the couch. Here, there are two enormous windows on the wall across from the couch to the patient’s right, about 6 or 7 feet away. The patient is terrified of heights. The theme of high places is at the center of a complex knot of symptoms, an amalgam of depression, anxiety,
obsessional tendencies, and phobia. Ken has had full-blown panic attacks just contemplating certain situations that involve heights, not to mention being in them. On one occasion, he traveled to another city for a meeting where he was to make a presentation on a subject of great interest to him. At the last moment, to his dismay and embarrassment, he had to back out, because to get to the room where the meeting took place he would have had to walk across a corridor with a railing overlooking an atrium. But his reactions are variable, and sometimes he has managed very well in situations that could have been disabling. In general, he is a very competent, resourceful person, a mental-health professional himself and a psychotherapist. Ken is also a devoted husband and father of three young children.

At the university office, Ken had generally felt comfortable. He had rarely felt anxious during a session. Sometimes he would get anxious after a session while waiting for the elevator, which was next to a window. Often he would take the stairs rather than wait. He had told me of a fantasy of coming back to the office to ask for some ill-defined help. He had thought of my comforting him or perhaps waiting with him at the elevator, but he never acted on that impulse. In general, he had always been respectful of the conventional limits of the analytic situation and had made good use of it as a context for expressing and exploring the things that troubled him. In many ways he was an ideal analysand, reporting many dreams and experiencing and reflecting upon transference issues in the here and now and in terms of genetics.

Changes in my schedule and Ken’s made it more convenient to have first one, then two of our four sessions in my downtown office. The idea of meeting there was broached for the first time by me, anticipating a day when the university would be closed because of a holiday but when I would be working in my practice. Ken actually declined that invitation, but he subsequently brought up the possibility himself because he wanted to take advantage of the opportunity to tackle his fear of heights within the context of the analysis. We did, however, discuss the fact that once the option was made available, Ken felt some internal pressure to try it, along with a sense that I might want him to. And it is true that I thought this might be a serendipitous development. The combination of the two locations

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4. In an earlier draft of this chapter, this information was disguised. After reading it, the patient said he felt that the disguise took too much away from the atmosphere of the process and that it was not necessary.
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I could provide the opportunity to confront the phobia directly, as Freud (1919) suggested was necessary with such symptoms, but with the advantage of having that confrontation woven into the analytic routine itself. The latter would include alternation between the “safer” and the more “dangerous” settings.

So, here we are at the end of this first session on the 21st floor. Ken has managed to get through this hour without a major attack of anxiety or vertigo. He was quite anxious at the beginning, although it was not as bad as he had anticipated, especially with the window shades pulled down, something I had done in advance at Ken’s request. He said, “I was afraid I would be drawn to the windows and I would become like a robot or an automaton, unable to control myself. And then what would you do? Would you stop me? Of course, I feel that you would.” I say that he may have a wish for an experience in which I stop him physically from doing something self-destructive. He says he feels that would be a demonstration of will and strength for his benefit. He reports a dream. “There is a truck with long boards of wood. Somehow I go underneath all the wood boards. They started to slide out of the truck on top of me and I realized I could be crushed. But I got out and I didn’t panic. I don’t remember whether there was anyone else helping. I think I just got out myself.” He spontaneously thinks of the unloading of a truck as a metaphor for the analysis. Then he associates to his father. He thought of him as husky and strong physically, but he always felt threatened by him rather than comforted. He says his father “always wanted to win,” whereas he, as a father himself, enjoys roughhousing in a playful way with his own children. I say, “Meeting with me here has a lot of meaning for you I think. It’s probably not just the height as such that is affecting you.” The patient says, “I could get into resenting it, having to put myself through this. But I do have a sense that we are in this room together and that in general we are in the process together, and that helps.” Now this much-anticipated and dreaded first time is over. I say it’s time to stop. Ken sits up. He seems a bit shaky. Then he looks at me and, rather to my surprise, he says, “I don’t feel too bad, but I wonder if you’d mind walking to the elevator with me?”

MOMENT OF TRUTH: THOUGHT IN ACTION

I think it’s good to stop at points like this to consider the analyst’s position, because, as an exercise, it’s useful to consider the kinds of
attitudes the analyst may have toward the patient's request without the benefit of hindsight.

The instant the patient's question is posed I am called upon to act. There is no way that I can "call time" to think it over. If I hesitate or if I say, "Well, wait, let's think about this for a moment," or "maybe you could say a little more about what you're feeling," I am of course acting in a particular way. There is no way to just think about it without acting, and however I act will have some sort of complex meaning to myself and to the patient. The commonsense idea, one that is highly valued psychoanalytically, that I should think before I act is of little or no help in this respect. It certainly will not do to say "let's think about it and talk about it more tomorrow and then we'll see." The moment of truth is now. What I do will express something about me, about our relationship, and about the patient. While it cannot be action following thought in a linear way, it might, nevertheless, be action that is saturated with thought or thought-full.

Does it make any sense to ask what is the right thing or the best thing for the analyst to do? Many would say, "it depends." More needs to be known about the patient, his history, his dynamics, the status of the transference, and the nature of the process in this very session. I have told you so little, after all, of what I know or knew, so little, one might say, of what was "going through my mind." But even if I could explicate all of the issues pertaining to that list of considerations about the patient, to what extent would that put us in a better position to decide what I should have done and with what attitude? Is an accurate assessment of the patient's state of mind possible? And if it were possible, would it be enough?

The alternative to the view that the analyst should act simply in accord with an assessment of the patient takes it for granted that the analyst acts in relation to a complex, only partially conscious, organization of his or her own thoughts and feelings. In the moment of action there is no sharp split between what is personally expressive and what is in keeping with one's technical principles or diagnostic assessment. Expressive participation and psychoanalytic discipline are intertwined (chapter 7). If there is a "right" or best thing for the analyst to do, it might be something that is integrative of as many considerations about the relationship as possible. From the point of view of a supervisor or consultant, for example, the information that is relevant would have to include the nature of the analyst's experience. And the suggestions that a supervisor would make would take account of the analyst's involvement in the process. The supervisor might say, "Given that the patient was apparently experiencing such
and such and that you [the analyst-supervisee] were experiencing such and such, might it have been useful to do or say this or that?” Let me emphasize that I’m not saying that this “given” in the analyst’s experience should be immune from criticism. After all, there are certain attitudes and perspectives that we try to cultivate so that the probability will be higher that our experience will at least include certain properties: empathic listening, for example, theoretically informed understanding, critical reflection on our own participation, and so on. In fact, part of my purpose in this paper is to convey my own sense of the optimal analytic attitude, one that allows for a range of countertransference experiences that can be used constructively to promote the process.

SOME BACKGROUND: A CHILDHOOD OF SCARCE LOVE AND DREADED IMPULSE

Certainly, as I said, I have conveyed only a small fraction of the information about the patient that was relevant to my action at that moment. In fact, what I could formulate to myself at that time, not to mention what I can recapture from memory, is probably only a fraction of the information I was processing. Considerations of confidentiality limit even further what I can convey to you accurately. Finally, whatever information is selected and however it is organized constructs a story line of some kind, a particular narrative account among the many that might be pertinent and even compelling (Schafer, 1992). With those qualifications, here are a few more highlights from the patient’s history.

Ken was an only child. His mother was alcoholic, estranged from her unsympathetic, self-centered husband, painfully lonely, and often depressed. When the patient was 15 years old she killed herself, using a combination of drugs, a plastic bag over her head, and gas sucked in from a Bunsen burner from the patient’s chemistry set. The patient came home from school one day and found the house locked. A note on the door suggested he go to a neighbor’s house until his father came home. Later, the father and the patient descended the winding stairs to the basement where they found the mother’s body. There was a note addressed to the patient that read: “I had to do this. I couldn’t take it anymore. You go on and have a happy life. You’re great.” In this act, the mother constructed, not a “good enough” ending, surely, but a catastrophic one, for her son to carry with him for the rest of his life.
The patient’s father was a salesman. He was very narcissistic, full of a kind of bravado, a macho style that was decidedly unempathic in terms of its responsiveness to the patient’s needs and sense of vulnerability. The father’s “competitiveness” was so extreme it often deteriorated into virtual abuse. Here’s one telling story. In playing one-on-one basketball when the patient was in his early teens, the father, who was much taller, was happy to block all the patient’s shots and win the game ten to nothing. Indeed, Ken, who was a quiet, sensitive type and something of a bookworm, often felt his father didn’t particularly like him. In fact, Ken thought his father preferred two of his nephews, both of whom liked hunting and fishing, activities that were quite abhorrent to the patient.

Ken had only scant and fragmentary memories of his mother. What was particularly striking was that he had vivid memories of parts of her body, distinct images of them in the bathtub, for example, especially her breasts, which he admired. He had more difficulty remembering her face, not to mention difficulty recapturing a sense of her as a whole person. Toward the end of the first year of the analysis the patient recalled a moment in his early teenage years when, looking at his mother passed-out drunk in her bed, while his father was out of town on one of his many business trips, he thought to himself, “Why don’t I just have sex with her and get her pregnant. Maybe that will enliven her and make her happy.” Ken also had conscious wishes that his mother would die, which were countered, in part, by his realizing that her death would leave him alone with his father. Many times he fantasized wishfully and anxiously about his father being killed in a plane crash and not returning from one of his trips. At times, he was also very afraid of his father. On one occasion he refused to go on an amusement park ride with him for fear that his father would push him out of the elevated car to his death.

Thus, perhaps an important aspect of the atmosphere of the patient’s childhood could be characterized as one that was full of the dangers of eruption of incestuous, patricidal, matricidal, and infanticidal impulses. We developed a picture of his environment as one in which he felt that he was left alone with dangerous temptations. He had a sense that it was all too easy for him and others to act on impulses that were destructive to him, to them, or to both. It felt like he had only his own will to prevent an action that could be disastrous, and his own will often did not seem up to the challenge. He had his parents as models, after all. In the end, through an act signifying the ultimate abdication of responsibility, his mother left him with a terrible choice. He could try to demonstrate that one could be
moved by forces beyond one’s control to do oneself in. If he threw himself out the window, or more precisely, if he succumbed to what he experienced as a force drawing him out the window, he could say, “This must be how it was for her; she loved me but could not stop herself.” But if he stopped himself with thoughts like, “what will become of those I care about, including my children?” he was left with the agonizing question as to why she couldn’t or wouldn’t have done the same for him.

A WALK TO THE ELEVATOR:
AN EXPERIENCE IN “LIMINAL” SPACE

Let us return now to Ken’s request. Notice that it occurs after the “official time” is up. Now we are in that interval that occurs in every analytic hour between the ending of the formally allotted time and the moment the patient leaves the office. I think it’s a particularly interesting time because it is both inside and outside the frame. It occupies a place akin to what the anthropologist Victor Turner (1969) identifies as “liminal.” Turner (1969) writes, “Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial” (p. 95). Although Turner is interested in liminality as it is reflected specifically in the rites of passage of certain tribal cultures, what he has to say about it can be generalized to other aspects of social life (cf. Foorcher, 1975). Indeed, the basic dialectic that underlies social life is exposed under the conditions of liminality. This is the dialectic of spontaneous, egalitarian relatedness, what Turner calls “communitas,” and structured, hierarchical role-relatedness:

It is as though there are two major “models” for human interrelatedness, juxtaposed and alternating. The first is of society as a structured, differentiated, and often hierarchical system of politico-legal-economic positions with many types of evaluation, separating men in terms of “more” or “less.” The second, which emerges recognizably in the liminal period, is of society as an unstructured or rudimentarily structured and relatively undifferentiated comitatus, community, or even communion of equal individuals who submit together to the general authority of the ritual elders. . . . [F]or individuals and groups, social life is a type of dialectical process that involves successive experience of high and low, communitas and structure, homogeneity and differentiation, equality and inequality [pp. 96–97].
And further, very much in keeping with my view of the analytic process, Turner writes that “wisdom is always to find the appropriate relationship between structure and communitas under the given circumstances of time and place, to accept each modality when it is paramount without rejecting the other, and not to cling to one when its present impetus is spent” (p. 139).

So when the time is up we enter that peculiar, liminal zone that is “neither here nor there.” I think it’s useful to consider it not only for its own sake, but also because it exposes more clearly the dialectic between ritual and spontaneity within the process as a whole. The strategy is analogous to learning about so-called normal mental processes by studying psychopathology. In this instance we have not only the period in the office after the time is up, which, after all, is ironically a part of normal analytic routine, but the prospect of time spent with the patient outside the office. In these two liminal zones, the one more outside the ritual than the other, the personal-egalitarian aspect of my relationship with Ken is highlighted and partially extricated from the role-defined hierarchical aspect, so that the tension between the two is felt more acutely than usual.

I responded to Ken’s request immediately, simply by saying “sure,” and we walked to the elevators. My immediate feeling was that it would have been extremely stingy of me to decline or even to hesitate, since it had been such an ordeal for Ken to tolerate the session in this office. I knew, after all, that the idea of meeting at this location was initiated originally by me. Also, the patient’s request, an aggressive initiative on his part, was out of character. It was a risk for him to make it, and I thought he might well feel not only disappointed, but also humiliated if I said no. I certainly didn’t want to be like his father blocking his own in basketball. That danger seemed greater to me than the dangers of complying. Also, because the request was so unusual, I felt inclined to give the patient the benefit of the doubt and respect whatever creative wisdom might have prompted it. Another consideration might have been that I felt that, over time, I had conveyed enough of an impression of personal availability to contribute to the patient’s readiness to make the request. In any case, as Ken and I waited in the hallway we made a little small talk about the elevators, the express type versus the local type, which stopped at which floors, which he came up on, and so on. After a couple of minutes, one opened up and Ken stepped in. We shook hands just as the doors began to shut. It was not our customary way of parting. I’m not sure which of us reached out first.

Before getting to the patient’s retrospective view of the experience
the next day I want to stop to talk a bit more about the episode at
the elevator, an example of an “extra-analytic” interaction. How do
we conceptualize the nature of the interaction in the hallway? On the
surface it could hardly be more mundane. Just a little, rather uninter-
esting small talk. But as we are waiting there is a little tension in
the air, a touch of awkwardness, and a feeling that what’s happening
has a little extra “charge.” Would we say that the analyst, ideally,
would feel entirely comfortable in that situation? Would we say that
the patient, too, would be comfortable the closer he was to com-
pleting his analysis? My own view is that regardless of the specif-
ic personalities of the participants, and regardless of the amount and
quality of analytic work each has under his or her belt, there is a
reside of tension that is likely because here, in the hallway, outside
the psychoanalytic routines of time, place, and role-defined interac-
tions, the analyst emerges out of the shadows of his or her analytic
role and is exposed, more fully than usual, as a person like the
patient, as a vulnerable social and physical being. At this moment,
in Turner’s terms, “communitas,” a sense of equality and of mutual-
ity, moves into the foreground while role-determined, hierarchi-
cal structure shifts to the background. This reversal of figure and
ground is likely to feel conflictual because both parties have much
invested in the analyst’s relative invisibility. The analyst’s capacity for
an encompassing perspective and for constructive use of his or her
special expertise is enhanced by the protections against narcissistic
injury that a position of relative anonymity affords. This aspect of
the ritual provides some rational ground for the analyst’s authority
in relation to the analyst. Beyond those rational grounds, how-
ever, there is an irrational component to that authority, a certain
element of mystique that gives the analyst a special kind of power.
Only with that magical increment of power does the analyst stand a
chance of doing battle with pathogenic object relations that were
absorbed before the patient was old enough to think, or most impor-
tantly, to think critically. And only the analyst’s relative anonymity
can allow the patient to invest him or her with that magical power,

5. This heightened sense of visibility can occur within the customary
hour too, at times, as might happen if the analyst moves to open a window
or changes the furniture arrangement or the place where he or she sits.
6. The authority and the mystique are ironie because the grounds for
them have been largely eroded in our culture and because within the process
itself they are subjected to critical scrutiny in the analysis of the transference.
(See chapters 1 and 3.)
one that represents, in more or less attenuated form, the power of the longed for omniscient, omnipotent, and loving parent.

So, it’s not surprising that there is a little tension and a little awkwardness accompanying the small talk as we wait for the elevator. But it would be misleading to say that the special authority of the analyst, both its rational and its irrational components, are dissolved in these circumstances. Let’s not forget that a reversal of figure and ground does not mean that one side of a dialectic is sacrificed in favor of the other. Rather, the two poles, that of spontaneous, egalitarian, informal participation and that of authority-enhancing, role-related, formal participation, continue to work in tandem, synergistically, the one potentiating the impact of the other. On a personal level, many relational themes are being played out, more than I can mention here, and more, indeed, than either participant could be aware of back then, or even now in retrospect. For one thing, this is a kind of transgression that I am joining the patient in, a bit of mischief in relation to the psychoanalytic “authorities,” the tribal “elders,” but also in relation to those authorities as they are internalized as part of my own (and maybe the patient’s) psychoanalytic conscience. There is also a sense, however, that the transgression is a minor one, a forgivable one, even, perhaps, a constructive one. We both know that we will be back inside the analytic frame the next day and we both fully expect that this very interlude of escape from it, this relatively “frameless” experience, as Grotstein (1993) calls it, will probably be subjected to routine analytic scrutiny. We will then be able to explore the latent meanings of our interaction in the hallway as though it were part of the manifest content of a dream (cf. Kern, 1987).

Aided partly by this expectation, at the very moment that I transgress I am aware, implicitly, that the patient and I are also trying to construct a noncatastrophic transgression, a nonincestuous, nonsuicidal, nonhomicidal violation of the rules. We are trying to differentiate this illicit act, stepping out the door together, from stepping out of the 21st-floor window, from being drawn into an incestuous abyss with the mother, from killing the mother, from killing the father, from being killed by the father, from the mother killing herself. In these scenarios, the patient may be either in the parent’s or in the child’s role, casting the analyst into the complementary position. All these potential differentiations—in which, hopefully, something new will emerge out of the shadows of something old—all these possibilities have special power, not only because they have been or will be understood analytically, but also because in the background it is the
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The analyst who is participating in them and authorizing them. By making more vivid the patient’s sense, as Ken puts it, “that we are in this together,” by being, for the moment, a person conspicuously like the patient himself, by trusting the patient’s conscious judgment, by extending myself beyond what is most comfortable for me (which reciprocates the patient’s extension of himself in coming to my private office), by spending some time with the patient that is not paid for, by all of these simultaneous actions and others, I have at least a fighting chance, as the analyst, operating with the mantle of authority that is uniquely mine by virtue of my ritually based position, of overcoming the soul-murdering impact of the parents’ conduct. I have a chance of reaching the patient with messages such as, “You are a person of worth; you have a right to be fully alive; you don’t have to be buried alive under those wood boards; your feelings matter; you deserve respect as a unique individual; you can have concrete impact on me without destroying me or yourself; your desire, even when it runs counter to what is conventionally sanctioned, is not necessarily deadly; indeed, that desire has the potential to do more good than harm.” In sum, I am in a position to offer the patient a profound kind of recognition and affirmation. What is transformative, however, is not this action alone, but a continual struggle with the tension between spontaneous responsiveness and adherence to psychoanalytic ritual and a continual effort, in Turner’s (1969) words, “to accept each modality when it is paramount without rejecting the other” (p. 139).

Now let’s return to the particulars of the process and consider the patient’s experience of the episode as he reported it the next day, now in the relative comfort of the university office.

**THE PATIENT’S REFLECTIONS: COCONSTRUCTING NEEDS AND WISHES**

“When I asked you to walk me to the elevator I wondered if you were irritated. But I felt you were being friendly and supportive in the hallway. I had very mixed emotions about asking you to do that, because I was actually feeling good enough. It wasn’t a necessity. I didn’t feel like I had become liquid and needed you to pour me into

7. The point bears a rough similarity to that of Strachey (1934) on the therapeutic action of mutative interpretations via the analyst’s acceptance of the patient’s “id-impulses.”
the elevator. Yet I was afraid if I didn't ask I might just be overwhelmed at the last minute. Then I was also conscious that maybe I was testing you a little to see how flexible you would be. That doesn't feel real terrific. A little dishonest maybe.” I asked. “Did you plan on it beforehand?” Ken replied, “Yes, as a kind of contingency plan. But then it got to be sort of a superstition.” I said, “So it was important in itself, just the wish that I go with you.” Ken replied, “Yes, and without the excuse of my being terrified.”

The patient then expressed interest in how my career was going. He wondered whether my colleagues, if they knew about it, would approve of my walking with him to the elevator. He also expressed concern about the sincerity of my action. Maybe its self-aggrandizing purpose was to impress others with, and congratulate myself for, my independence of mind. He thought maybe his doubts were carried over from his mistrust of his parents. He grew up feeling there was something uncertain about the extent and quality of their interest in his well-being. His mother seemed very pleased by his excellent grades, but did not want him to tell others about them lest they become envious. So the grades became a kind of guilty secret between them and a special gift just for her. His next associations were the following: “You know, something was going on with me then sexually too. I was looking up little girl’s dresses and there was the sex play with the little girl next door. We were taking turns in the closet, dropping our pants and exhibiting ourselves. It was such a small house. How could my mother not know what was going on in the back bedroom?”

There are many issues raised by this vignette. What I want to emphasize is the fact that the patient spontaneously brings up the possibility that his own behavior was manipulative after I complied with his request. In effect he says that he might have been disguising a forbidden, oedipal wish, one that had the potential to jeopardize my “marriage” to the analytic community, as a developmental need. He also comments, however, that if he didn’t ask, “he might have been overwhelmed at the last minute.” It is easy to imagine that he might have panicked if he had asked and I had said no. I think it’s probable that the sense that there was something dubious about the request might not have developed or jelled enough for the patient to verbalize it to himself, much less to me. So the act of acceding to the patient’s request facilitates the emergence of his sense that the request might not have been necessary, whereas a refusal to accede to it, or even signs of reluctance, might have fostered a feeling in him that I was withholding help when he desperately needed it. One
might say that the way the analyst responds influences the kind of experience that is created or "constructed" within the patient at that moment. One of the central implications of "constructivism" in psychoanalysis is just this: namely, that the patient's experience does not emerge in a vacuum but is, rather, partly a result of what the analyst is doing or conveying (chapters 5 and 6; Mitchell, 1991). The interaction of the experiences of the participants is constructed in that sense, not just in the sense of interpretation that attaches meaning to those experiences "after the fact," so to speak. Before that, there is the active construction of the "fact" itself.8

That the patient reflects on the illicitly wishful aspects of his request and then associates to "forbidden" sexual acts in his childhood is of special interest, because the entire episode is occurring against a backdrop of struggle between myself and the patient in which I was usually the one to suggest that his symptoms had partly to do with unresolved conflicts about sexuality and aggression, whereas he took the position that his problems stemmed more simply from not feeling sufficiently appreciated and loved. Once he summed up two years of analytic work by saying that he thought the heart of what he was learning in analysis was that he wanted people to like him, a formulation that I thought fell a bit short of the complexity and profundity of my own interpretive contributions. Sometimes Ken would report extraordinarily evocative dreams, full of images of sex and violence in a somewhat disinterested manner, almost as though he was bored by them. Meanwhile, I'd be bursting with ideas about what they might mean. We came to understand this scene as an enactment in which the patient was like his sexually enticing but inert, semiconscious, inebriated mother while I was in a position like the one he was in as a child: left alone with my psychoanalytic "drives." So, to put it a bit schematically, I was caught in a dilemma: I could interpret actively and be experienced as a kind of rapist, or I could be more passive and compliant and be experienced as one who, through a kind of benign neglect, allowed the patient to drift along, identified with his mother, in his own semiconscious, anesthetized state.

I might add that Ken had a great deal of interest in psychoanalysis and had read a lot of Freud and of Kohut. He never could quite locate me because, although it was clear to him that I was not

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8. No "backward causation" is implied here. The issue is the construction of experience as it is developing through the interaction, what I have called the "prospective" aspect of constructivism (see chapter 6).
Kohutian, I did not seem to fit his preconceptions of what a Freudian would be like either. It pleases me that in the course of the analysis he seemed to come to an understanding of himself that involved some kind of integration of the two perspectives, an integration reflecting, not surprisingly, something more like my own viewpoint. He still thought, however, somewhat to my disappointment, that self psychology could encompass the integration we had developed. So in the end we had negotiated a compromise, although, thankfully no doubt, we still had our share of healthy differences.

EXISTENTIAL AND SYMPTOMATIC PANIC

It is not hard to understand the patient's panic as a symptom, one that can be interpreted in a variety of ways. One that I referred to earlier is that it reflects Ken's sense, fostered by a variety of traumatic events and themes in his life, that he and others might not be able to inhibit acting upon enormously destructive impulses. One might say that the patient felt that he was always in danger of losing his sense of his own humanity, that he could at any moment become a robot, a monster, or a very destructive, instinctually driven animal. Interestingly, one of the first things he said to me was that he was pleased to see that I had a book by Kohut in my bookcase because he didn't want to be perceived as "a bundle of drives." The patient was obsessed with certain horrifying images, one of which was of a woman whose normal outward appearance concealed a completely mechanical apparatus under the skin. Another image that preoccupied him was that of a certain type of reptile, or a type of toad, the slimiest and ugliest he had ever encountered. He was disgusted by these images but sometimes couldn't get them out of his mind. The force of gravity came to represent the force of his own instinctual life pulling him down, pulling him into an incestuous snare with his mother who, figuratively, was continually calling to him from her grave.

In the transference, the patient's panic got organized around a conflict between a longing to be taken over by me and fiercely competitive ambitions. A central task was to differentiate the possibility of my benign influence (through consideration of interpretations, through absorption of my regard for him, and through selective identifications) from what the patient seemed to experience uncon-
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...sciously as an emasculating homosexual submission. The complementary task was to differentiate expressions of his own healthy ambition and competitiveness in our relationship from murderous inclinations. Full-scale panic attacks, accompanied by a kind of vertigo, would often occur in the office when I was saying something that the patient felt was important for him to consider. Sometimes the governing unconscious paradigm seemed to be "kill or be killed" or "rape or be raped" reflected symbolically as a conflict within the patient between speaking in a controlling way and passively listening. At times, the patient's urgent need to block my speaking, to block my "shots," as it were, took the form of a full-blown panic attack. As I spoke, he'd raise his hand and say "stop, please." Then, shuddering, he'd turn on his side and face the back of the couch.

These were just a few of the dynamics underlying the symptom that we explored. But to think of Ken's panic only as a symptom obscures its existential, universal implications. Symptoms are often thought of as involving partial misappraisals of what is possible in the present associated with experiences that were not optimal and not necessary in the course of development. Many would say that these difficulties can be alleviated in analysis by a combination of new understanding and a corrective interpersonal experience, an experience that facilitates development and that obviates the need for the symptom as a way of dealing with psychological predicaments. Even if we no longer think of the therapeutic action of analysis as a matter of simply making the unconscious conscious, but rather of "negotiating," opening up, and promoting new ways of being in the world, we are also not likely to consider the route to health to be one that entails, ironically, a certain increment in self-deception: If it's not simply a matter of making what is unconscious conscious, we'd nevertheless be averse to thinking that it's a matter of making what is conscious unconscious! Yet I think there is a kernel of truth in that seemingly paradoxical idea.

Human consciousness brings with it the awareness that to invest in and care about ourselves and others entails, not only the risk of devastating loss, but absolute knowledge of its inevitability. Our

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9. The issues appear to be related to what Freud (1937) referred to as "biological bedrock," the repudiation of femininity, which in men takes the form, according to Freud, of an inability to allow themselves to be influenced by their analysts (presumably male) because such influence is equated with castration.
challenge is to be fully engaged in living, even though we know we are heading right toward the edge of the cliff and that there is no way to avoid going over it. Ken is right; we are going out that window. There is a sense in which catastrophic anxiety, utter debilitating terror, is always rational and the absence of it is always irrational. That is, to invest in and enjoy life means, in some measure, avoiding thinking about death; it means drawing the blinds, it means huddling up against a protective wall, against the back of an analyst's couch. Of course, there is an irony here because the irrational becomes rational when we recognize that that avoidance is our most sensible course. We might as well build our "sandcastles" (Mitchell, 1986) because the alternative leaves us alone with the vertigo of meaninglessness. With full acknowledgement of their looming presence, we nevertheless have to turn our attention away from our mortality and from a haunting sense of our ultimate insignificance in order to make living possible at all. The universal bad object is out there for all of us as nothing but the human condition. To combat it we band together in groups, in families, in communities, in cultures, to make and sustain our sense of worth. As part of that spectacular effort that is as natural to human beings as building nests is to birds, we imbue the mind-bodies of our children with love before they are able to think critically. We lock in their sense of worth in such a way that they can withstand the assault of reflective consciousness and yet join us in the business of socially constructing some kind of sustaining reality (Berger and Luckmann, 1967; also see Nagel, 1986).

This locking-in of self-worth is precisely what my patient, Ken, did not get enough of from the critical authorities, namely his parents, in the critical period when he needed it most and was most open to it. Not only did he not get enough love and affirmation in that phase to buffer his awareness of the void that surrounds us all, but in the end, his mother, as a consequence surely of her own unspeakable suffering, removed whatever porous shield her presence may have offered against the harsh reality of an indifferent universe. She, in her anguish, presented him instead with a devastating mes-

10. Jessie Taft (1933), the Rankian, writes, "To put it very simply, perhaps the human problem is no more than this: If one cannot live forever is it worth while to live at all?" (p. 13).

11. Freud, unfortunately, never took death anxiety seriously in his theory building, an omission that has all the signs of defensive denial (chapter 2; Becker, 1973).
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We know that winter is always some mean-er blinds, it back of an the irra-avoidance is th the ver-heim away from insinifiversal bad condition. As part of s building with love in personal universe, ting mes-

Fragments of a Termination

I shall close by reporting a few of Ken's very rich dreams in the termination phase of his analysis. About five months before the end he reported a dream in which he was on a field where "they had let loose a whole bunch of animals from the zoo: armadillos and one

12. See Mitchell (1986) following Winnicott on "going out to meet and match the moment of hope" in analysis (p. 115).
animal I made up, this big scaly thing like an anteater. It had big folds of skin all over it. The skin was so scaly that I couldn't see the face. And I just found it disgusting." In the same session Ken reported a dream in which he was walking around in a downtown street, feeling aroused and wanting to masturbate. He felt he was close to an orgasm but that he first had to find a woman with whom he could make eye contact, someone who would look at him with a warm and lively expression. In these dreams we can see the tension between the patient's horror of a mindless life of the flesh and his groping for a way to integrate his own sexuality with interpersonal engagement and personal wholeness.

With regard to the patient's difficulty allowing me to be the one who could help him to achieve that integration, not long before, the patient dreamt that he was eating some kind of fish with maggots in it that turned into something like fruit-fly larvae. He took some into his mouth but then spit them out, feeling disgusted and like he wanted to throw up. We talked about the patient's aversion to incorporating something from me, perhaps very specifically a particular line of interpretation having to do with sexual conflict, but more broadly, whatever I, as a man, had to offer him. Then about a month before the end, the patient reported the following dream:

I was down in the basement. Someone was trying to get in with a drill. The basement in the dream is like a fortress. There is a big door with a deadbolt and a key lock. Somebody is drilling a hole in it. And I am standing there by the door thinking I can almost see the point of the drill coming through. And I think it was you out there. And I have the idea that if I can put my finger on the point of the drill you'll know I'm in there and that I'm alive. And I'm thinking that it's dangerous. [Laughs] This gets so phallic as I speak. I don't know how big the drill is. If you stand too close to it it could run right into your body. So the fears are there, and yet somehow it also feels like it's going to be OK.

So here is the patient identified with his mother and yet struggling to differentiate himself from her. He's in the basement where she killed herself, and there I am outside, perhaps like he was outside when he came home from school that awful day when he found the door locked. But now there is some kind of rescue operation going on. In order to be saved, to make contact, he has to touch that phallic object, he has to let himself be reached and touched by my own attempts to break through to him. To do this he has either to overcome the sense that the contact is necessarily sexual, or better, to be less threatened by whatever sexual and aggressive dimensions there
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On the second day, after being 'found' by the street cougher, he could be the one before, the maggots in a more particular at a month's old. And I am not of the "I'll know" dangerous drill. So the be OK.

Struggling where she as outside found the phallic ion going that phallic my own at over-tet, to be ions there may be in our encounter. Finally, he has to let me reach him, despite his having felt impotent to reach his mother. Here he has to overcome a need he feels to absolve himself by proving that such "awakenings" are simply impossible.

And apropos of my theme in this chapter, the moment of contact in the dream occurs in a moment of trespass. Someone is breaking into the basement of Ken's home. An intruder is entering where, presumably, he has no place, where he does not belong. The law is being broken, the patient's private space is being violated. Surely this cannot be a precedent, a prescription for a way of living. Locks on doors are there for safety, there to create environments in which we can live with some semblance of security, even environments in which we can create illusions of security, in which we can hide from the terror of annihilation. But there are times when our "security systems" reach a point of diminishing returns and they need to be deactivated, if only temporarily. So it is with the analytic frame. It's there to protect us, to create an environment that is especially conducive to both exploration of meaning and affirmation of worth. But it has its dark, suffocating side, especially when it is taken too seriously and adhered to too zealously. Thus, the ideal holding environment becomes one in which the frame itself is fully understood to be a construction, a set of ritual activities that are enriched by their integration with the analyst's personal, spontaneous participation. Such participation sometimes takes the form of limited departures from the frame, excursions into liminal space, although more commonly it involves qualities of naturalness and spontaneity that are mingled with the ritualized, role-determined aspects of the process. Analysis then becomes a model for living, a rich dialectic between plunged into experience and reflecting on its meaning (Becker, 1973, p. 199). It entails for the analyst an integration of being with the patient as a fellow human being, sharing the same kind of personal vulnerability, and being, ironically, the very one who is idealized and authorized by the culture and by the patient himself or herself to bestow upon the patient a sense of personal significance and worth, the kind that stands a chance of overcoming the most profound kinds of childhood injuries, even as they are joined by the inexorable insults of the human condition.

ADDENDUM

In the last hour, Ken brought me a gift, a fossil sculpture reminiscent of a time when he and his father went hunting for fossils, a memory
that was recovered now for the first time and that was one of the very few fond memories he had of his father. The gift, also interpreted by the patient as symbolic of the excavations of the analysis, was accompanied by a note, one that was a far cry, needless to say, from the one the mother left upon her “termination.” Ken’s note read, in part, “I can’t describe all that you’ve meant to me. You know anyway. I’m going to continue to try to let you into my life.”

After I said it was time to stop, we stood tentatively in that liminal space, a moment in time that was both “inside” and “outside” the analysis. As I reached out to shake Ken’s hand, he said, “If you don’t mind, I’d rather have a hug.” We embraced and said goodbye, thereby, coconstructing, hopefully, a good-enough ending for that last hour and for the analysis.