Method, technique, and theory in psychoanalysis[*]

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Abstract. The author summarizes parts of two papers that appeared in Italian and were presented at International meetings (Galli, 2006, 2009). The following topics, among others, are discussed: the history of psychoanalytic theory of technique with a critique to some aspects of contemporary psychoanalysis; intersubjectivity; the concept of analytic neutrality; the relationship between psychoanalysis and psychotherapy; technical spontaneity; the identity of psychoanalysis and therapeutic identity; interdisciplinarity and the relationship between psychoanalysis and other disciplines; psychoanalytic training; the concept of "continuous interpretative activity"; self-disclosure in analysis; the relationship between theory and technique in psychoanalysis; psychiatric diagnosis and psychoanalytic diagnosis; the relationship between the person of the analyst and therapeutic technique.

Keywords: psychoanalytic theory of technique, history of psychoanalytic ideas, sociology of psychoanalysis, politics of psychoanalysis, contemporary psychoanalysis, psychoanalytic training, psychoanalytic theory.

I intend to summarize some of the viewpoints that I have expressed at different stages over the fifty-five years of my experience in the trenches, since the time of my move from Milan to Basle where I took my training in psychoanalysis and worked in psychiatry in the psychotherapeutic treatment of psychotic patients (see Galli, 2013). The basic theory that I can now formulate, *a posteriori*, is that what is presented today on the market as innovation and contemporary psychoanalysis is in large part what was once considered wild psychoanalysis.

I will re-examine some excerpts from an article in which I expressed my thinking: it was entitled "Technique and theory of technique in psychoanalysis from archaic to the postmodern" (Galli, 2006); other passages can be found in an essay titled "The therapeutic identity in the realm of uncertainty" (Galli, 2009). Both papers appeared in *Psicoterapia e Scienze Umane* (www.psicoterapiaescienzeumane.it), an Italian quarterly journal I founded in 1967. These encapsulate the evolution of some of my earlier ideas, especially those regarding some current vicissitudes within the psychoanalytic movement, and the professional and existential frameworks of the therapist as a person within the analytic relationship.

My present-day thesis arises out of my discomfiture with a widespread cultural phenomenon in our field. This phenomenon is based on the belief that we have gone beyond technique and theory of the interpersonal approach, disparaging them and the epistemological questions that they once embraced, and replacing them in the market of ideas with the concept of "intersubjectivity".

This concept has played the role of providing technical dignity to the process of liberation from the

[*] Parts of this article are excerpts of two papers previously published in Italian in the journal *Psicoterapia e Scienze Umane* (Galli, 2006, 2009), which were previously presented at various meetings: as opening remarks of the *VII Joint Meeting* of the *American Academy of Psychoanalysis and Dynamic Psychiatry* (AAPDP) and the *Organizzazione di Psicoanalisti Italiani - Federazione e Registro* (OPIFER) "In the Footsteps of Silvano Arieti: The Relational Paradigm in Psychoanalysis" (Bologna, June 24-26, 2005); at the Second National Meeting of the Italian Chapter of the *Society for the Exploration of Psychotherapy Integration* (SEPI) "La pratica dell'integrazione in psicoterapia" (Florence, March 24-26, 2006); and at the XIV Forum of the *International Federation of Psychoanalytic Societies* (IFPS) "Psychoanalysis in Transition: The Interplay of Internal and External Worlds" (Rome, May 23-27, 2006). This material, in a different version and with a first part that here has been omitted, appeared as the first chapter, titled "Racconti di guerra. Psicoanalisi, salute mentale e pratiche istituzionali, ieri e oggi, in Italia" ("Tales of war. Psychoanalysis, mental health and institutional practices, yesterday and today"), of the book edited by Paola Cuniberti & Luigi Caparrotta, *Psicoanalisi in trincea. Esperienze, pratica clinica e nuove frontiere in Italia e nel Regno Unito*. Milan: FrancoAngeli, 2012, pp. 35-57. Translated by Joyce Myerson and Paolo Migone.

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prison of “standard technique”. It is to theory that has been attributed the misunderstanding of considering in technical terms the “truth” of psychoanalysis (the truth in terms of interpretation, the truth in terms of the ground rules or frame of therapy, and the fact that concrete therapeutic behaviors are activated through a type of “as if” relationship with theory). This idea has been expressed in dogmatic terms, establishing the fantasy of an ontology of psychoanalytic technique. What happened is that the system of consensus of a particular social group has been transmitted as if it was derived from technique (in fact, technique is more “visible”, more concrete, so to speak – think of the couch that has often been considered a sort of status symbol).

A serious misunderstanding came into being when, in terms of the diffusion of the profession, rules concerning technique and methodology were equated with the essence of psychoanalysis itself, causing a particular distortion of training within the discipline, a phenomenon that I have called the formation of the *Mummia Ridens* (the “laughing mummy”). At the beginning of the 1980s, some articles of respectable authors, dealing with the permission to laugh in analysis, began to appear in the literature: thus the mummy-analyst was given permission to laugh, and since then a “new way” of understanding the concept of neutrality was born.

Above and beyond the complexity of the issue, a major theoretical misunderstanding has been created: it is believed that theory has impeded clinical flexibility, thus inaugurating a phase of mere a-theoretical clinical description – a sort of “descriptive clinicism” – that characterizes much of current psychoanalytic literature. Concepts such as countertransference, empathy, subject, and so on, have become fashionable, and in pages and pages of this new literature one finds descriptions of the analyst’s personal laments, of interactions that read as if they were taken from soap operas, of what happened when “Mary Jane brought flowers”, of the analyst who tells the patient of his own childhood experience when he had measles, as well as outbursts of all kinds of self-disclosures. In other words, whereas once upon a time we had an analyst enshrouded in mystery, now we have an analyst exposed in his underwear. In this passage from non-revelation to self-revelation, all that has happened is merely an inversion of the meaning of the analyst’s power. Someone has to explain to me why, if every morning for a half hour I talk to the doorman or, over coffee, to the bartender, and at one point either of them tells me about how he cried on the first day of school, my existential condition (and my neurosis) does not suddenly change, but when my analyst tells me this kind of story, then it does.

A large part of current literature verges on the pathetic, such as, for example, the attempt in 1979 by Kernberg – who had realized that the therapists reared in the enclosures of classical institutes were not able to treat real patients, and that the professional reputation of psychoanalysis was in decline – to organize a panel on the possibility of teaching psychotherapy in psychoanalytic institutes. To this rather timid proposal, Leo Stone (1979) responded that it was also possible to learn from African witch doctors, integrating scientifically their observations; the Brazilian Zimmermann (1979) strongly disagreed; Widlocher (1979), who got the message, said that, to all intents and purposes, teaching psychotherapy could be done. The point is that the icon of “classical technique” had been applied to trainee-patients (i.e., candidates), while with real patients everyone was forced to do other things (and this was common knowledge); and that when the trainee-patients were faced with their first clinical cases they felt unprepared, panicked, and experienced a sort of “patient-shock”, although there were attempts at containment of this reaction through supervision.

At first the shock was concealed because of high market demand and it was possible to say, “You, ugly patient, are not suitable for psychoanalysis”. But today, with the crisis in the demand for analysis, rules and theory change. It is more common to say “Good morning, Mr. Patient. How many sessions a week do you prefer, Mr. Patient? What do you want to be treated for, Mr. Patient? Yesterday I had diarrhea, Mr. Patient. Oh, what a fright this morning, Mr. Patient!”. What prevails is a clinical technique of the “anything-goes” variety, sometimes even bordering on the vulgar because the phenomenon that I once called “the psychoanalysis of the freed slaves (*liberti*)” (Galli, 2006, p. 155) is now *de rigueur*. In other words, with the fall of institutional hierarchies, the once shy and fearful candidates, brought up as slaves, now enjoy the prestige of emancipated slaves. Often their attempts at self-disclosure exhibit the transparency of pub talk, when they present their personal tales as if they were clinical cases.

In essence, the long march to free psychoanalysis from the encumbrance of the unconscious seems to be successful, inaugurating the "culture of the obvious". Since it has now become an honor to engage in discussion with academic psychologists, previously neglected by psychoanalysts, they have thus achieved their revenge: the only problem is that the psychoanalyst is treated as a member of the ancillary class by these *nouveaux riches*, like the kindly maid, paid by the hour, and who, on occasion, speaks pearls of wisdom; neuroscientists at times even smile at us with benevolence.

I have been trying to expose problems I had already regarded as obvious 50 years ago. This does not mean that I was particularly smart, but only that a researcher, even as young as I was, was capable of recognizing them. To voice these thoughts at that time meant not to be considered a real analyst, and for many years I was perceived as a wild beast, in good company with other very good wild psychoanalysts; to this day I still continue not to be deemed a psychoanalyst, as I persist in the practice of uncertainty.

I would like to mention sections of two papers I gave in 1960 and 1962. In the first, I discussed the concept of "technical spontaneity". In the second, I made an attempt to give centrality to the issues of interpretation and insight without falling into the dichotomy between interpretation and emotional experience (Alexander *et al*., 1946), a focal point in the debate at that time (Eissler, 1950), particularly for those who, like me, used to treat psychotic patients not considered suitable for psychoanalytic treatment. My purpose in all this is to illustrate the difference between those who, at the time, believed the interpersonal perspective to be an intrinsic and internal heritage of psychoanalysis, and those who, moving within the rigid confines of submission to the "mainstream", were not able to navigate in troubled waters.

I have to say that, in more than 50 years of activity in this field, I have met many people who have always been very capable of defining psychoanalysis. I have also had the pleasure of seeing many beliefs progressively falsified. And yet, I can still be surprised: too often the falsification of a thesis has not led to an explanation for the falsification, but simply to a change in the thesis, now propounded with the same, often aggressive self-confidence. The discussions on technique often implied a conflict with those who "knew" what psychoanalysis was. We should not think that in this field there is a coherent and structured body of knowledge common to all practitioners within the discipline, and that the debate takes place within the framework of this common body of knowledge and of its possible configurations. In this field, the parochial nature of the transmission of knowledge has been decisive. The problem related to geographical areas is extremely important for what in a given moment was judged to be the technique of psychoanalysis. In other fields, the common body of knowledge is more independent of strictly personal transmission. In our field, the relevance of affective components in the training process strongly influences the kind of culture and knowledge to which a professional is connected. It is evident that affective components are associated with therapeutic investigation. It is this issue of emotional involvement, of the affective dimension of the relationship, that indubitably continues to cause much debate. We must not make the mistake of seeing this problem as linked only to cultural isolation or as a problem of one sector with a high degree of provincialism, so that references to authority end up prevailing over critical thought. Seen as a global phenomenon, it represents the accumulation of all the emotions that have regulated research in this field. We can all see the dual nature of this phenomenon: on the one hand, as I am suggesting, we have a reading through the lens of sociology of knowledge; on the other, we have a reading through the lens of the literature – i.e., of those organized moments in which the attempt at defining the axes of the problem of psychoanalytic technique has taken the written form (that may include the affective history as an element which is intrinsic to this field of investigation) – as the element around which, from its foundation, psychoanalysis rotates.

From this perspective, it is important today not to fall into the trap of ecumenical "good will". In my opinion, interdisciplinarity does not mean pursuing the myth of merging the various disciplines in order to find the so-called common language (see the "common ground" idea of Wallerstein [1989, 1990], and Gabbard [1995]). It means, on the contrary, aiming for as much fragmentation, mutual contrast and deconstruction as possible.

The function of knowledge today leads to disaggregation, not to unity, i.e., a function that, by branching off, leads to the fruitful examination of new problems. This, in my opinion, is one of the most substantive messages of psychoanalysis – the learning to see new problems, to ask ourselves what allows us to deconstruct a given conceptual system in order not to enter into redundancy. A global view of these phenomena does not mean to line them up in rows so that a new rationality can emerge. The task is to interrupt the mechanism of pseudo-scientific exclusion without replacing it with that of a pluralism that tolerates contradictions (what we could call the "parallel tolerances"[1] of pluralism).

Now we know very well the stereotyped aspects that are present in classical technique, and we have lost the illusion that this classical technique is really something definitive to which one must adhere in order to be viewed as a "real" analyst. We see that, at most, what has always been advocated as classical technique could be defined, if we had to provide a working definition, as classical *attitude*, not classical technique. It has been, in essence, simply the prescription for a series of behaviors and attitudes.

Regarding the concept of analytic neutrality, the definition of behaviors which are "neutral" simply means to define *a priori* – i.e., outside the interaction with the patient – the characteristics of the analyst as a neutral object (e.g., think of Meltzer's [1967] indications to wear the same dress, the same tie, to keep the same furniture in the office, etc). The concept of interpretation – as if we could actually know what it is, as if each time that we face this issue we could dissect it into both its theoretical and clinical components – still functions as a slogan, a kind of communication that has the effect of inhibiting any further questioning or reflection. The treatment of psychoses – and, later, of the so-called borderlines – broke the schema of the so-called classic position, and many clinical experiences in this area are recognizable in the attempts at theoretical systematization over the last 10-20 years.

The trend towards quiet reciprocal acceptance (living together, tolerating each other), towards an ecumenical superficiality to which some recent papers seem to point, would only represent, however, an attempt to stabilize the social "status" of the therapists. From this point of view, I hope that the years to come will be characterized by a return to intolerance, for the sake of intellectual rigor in the process of concept formation and clarification. Obviously this is meant to take place differently than before, when we wanted to identify the doctrinal body of psychoanalysis as something rigid, prefixed, and based on untenable assertions.

This attitude has often become a widespread clinical culture and belongs to the worst aspects of our discipline. These elements need to be eliminated or reduced without losing sight of the knowledge value that even the most dogmatic positions have had. When positions have been accepted in a non-critical manner, we have witnessed moments of rigidity in the global body of knowledge. Regarding the characteristics of the educational systems in psychoanalysis, even trainees have been treated as "externals" towards whom the "trainers" dispense axioms.

Thus, within the psychoanalytic community, a contrast has been created between those who are involved with theoretical research, with all its intrinsic complexity, and those towards whom the results of theoretical research, rather than the process through which the results have been reached, have been directed. Any change in doctrine has been perceived as a threat to the scaffolding of the professional safety system, leading to dogmatic orthodoxy. Hypotheses, viewpoints, and conflicts had often to be stated with much emotionality due to personal conflicts within the group to which one belonged. So in many cases this fed the myth of the "discoverers" one had to emulate, rather than focus on the process of discovery.

This set of phenomena has made integration of these two positions more difficult. I believe that transmission of the concepts of our discipline, and of their history, should not be made easy, and that the diffusion of the respective models should be problematicized rather than de-problematicized.

[1] This concept refers, in part, both to Herbert Marcuse's (1965) idea of "repressive tolerance", and to an expression of an important Italian politician, Aldo Moro (1916-1978), who was using the oxymoron "*convergenze parallele*" ("parallel convergences", i.e., the idea that two political parties could converge on specific issues while being totally different in their overall ideas and values); see Galli (1986 p. 372, 1990).

Thus we can communicate the problems and the ways in which they were gradually solved and continually re-examined, rather than hand down a story of single conceptual definitions which one must embrace. The initial path may be more difficult and lead to confusion, but it is a confusion from which one can emerge with an elasticity that allows one to infer the technical intervention from the clinical data at hand, in any given situation, and to deduce the clinical guidelines from theoretical formulation.

A series of behavioral rules are part of classic technique. We cannot isolate the pure formulation of interpretations from the definition of the characteristics of the field and of the attitude of the person who formulates the interpretations. If we accustom ourselves to passively receiving the indications of behavior from an expert therapist, we will have learned a series of behaviors that are not linked to each other, behaviors that may well be clinically useful, but we will always remain passively dependent on the person from whom we learned these behaviors. The organization of the theoretical field and the understanding of the links that regulate the how and the why of each behavior become more difficult. (In terms of the analysis of training processes and of the interaction between the "person" and technique, and to have an idea of the concept of technical spontaneity, I refer to another paper: Galli, 1960).

I intend to briefly discuss my position on the issue of interpretation as presented in 1962, at the first training course organized by our group, then called "Milan Group for the Advancement of Psychotherapy" (later it took the name of *Psicoterapia e Scienze Umane*). It was the first time Silvano Arieti spoke to our group. He read two papers, and there was a lively exchange following the delivery of my paper, entitled "Scientific foundations of psychotherapy" (Galli, 1962). Here I will present only the part of my paper dealing with interpretation, a subject I only touched upon at the time, and subsequently more fully systematized.

The problems that had to be confronted were the following: (a) the debate with Franz Alexander (1946) on "corrective emotional experience"; (b) the possibility of maintaining the central role of insight as a specifically psychoanalytic therapeutic factor; (e) the issue of non-verbal communication, a central aspect of Tauber & Green's (1954) book *Prelogical Experience.* Since I was working mostly with psychotic patients and with what today is known as borderline psychopathology, the limits of verbal interpretation were very clear to me. But I did not want to give up the epistemological relevance of the concept of insight. So I suggested that we consider the problem in terms of communication theory, starting from Wiener's (1948) cybernetics.

Every act, word, gesture, and aspects of mimicry are communicative signals: the continuous conscious and unconscious organization and re-organization of the above semantics constitutes the interpretative sequence, in other words, the (signifier) response to the other's communication. In this way, the concept of interpretation can be disconnected from the verbally oriented act and the concept of "continuous interpretative activity" is introduced, as a semantic complex regulated by the analyst's ego functions and by the spontaneous relational component, both subject to *a posteriori* verification, and either as self-reflection or as confrontation with other colleagues.

My thinking took its starting point not only from the clinical situation, but also from the research of Harold Searles (1965) and Frieda Fromm-Reichmann on the *a posteriori* control of those non-visible factors which became recognizable when re-examining sessions with psychotic patients. In this way, insight maintained its centrality as an outcome, possible only because of the asymmetry of the psychoanalytic situation and the maintenance of this asymmetry on the part of the analyst by means of various devices, among them the therapeutic setting's ground rules (or frame) viewed in a non rigid and definitive way, i.e. as a continuous actualization of the analyst's activity.

The specific person the analyst is, with his/her personal characteristics as well as his/her sense of persistence as a guarantee of neutrality, thus becomes important. In other words, his/her neutrality is guaranteed by his/her qualities of stability and persistence, characteristics which are not hidden but visible. The analyst thus becomes an independent variable in the relationship, in the sense that the patient's variables may change while those of the analyst remain relatively stable, making him/her predictable and therefore a "neutral" reference point (to this regard, see also Codignola, 1977).

The basic thesis I have suggested for many years and that I present here is briefly the following. The methodological tools for this critique of psychoanalysis have always been around. And for this reason the only issue is when "critical consciousness" appears in the psychoanalytic field and how it appears. The delay in its appearance demonstrates the strength of the organization and the excess of credibility attributed to it. The historical interpretation of the phenomenon has often assumed the character of historicist "continuism" and displayed a tendency to justify itself at all costs, in order to conceal the recognition of phenomena that have facilitated the transmission of dogmas and given rise to stereotypes in our field, while maintaining an "as if" relationship with theory.

Here is a summary of my perspective:

1. The transmission of psychoanalytic culture has been a sequence of *doctrinal truths* presented as *truths of faith* by the institutional establishment.
2. This phenomenon originates in the epistemological mistake of confusing the concept of "standard technique" with the method and the very essence of psychoanalysis. The criterion of truth has been established by the control over analytic behaviors, instigating a culture of submission.
3. This has produced psychoanalytic organizations with a basic philosophy akin to religious transmission (what is transmitted is the "truth" and not the way to find it). The critical analysis of problematic issues becomes replaced by a positional declaration on the part of "godfather" figures: quotations from so-called authorities take the place of the analysis of concepts.
4. Thus a virus has spread like an epidemic, a disfiguring form of psychic rheumatoid arthritis transmitted throughout the ranks of analysts by means of the training systems. This arthritic illness has produced a paralysis (hence the "mummy"). Education of this kind has produced "miseducation".
5. The crisis in authority and the progressive disappearance of the most powerful and influential godfathers, from the second to the third generation of analysts, has caused chaos in the top ranks, in the passage from the emperor culture to the king culture, then to that of generals and currently to that of colonels. Where content is concerned, we have gone from dogmatic certainties to "relativistic uncertainties".
6. The new system of self-confidence is represented by a series of "liberators". The new godfathers, usually local colonels, discover the obvious fact of the analyst being a person like anyone else and play the role of cortisone, loosening rigidity in the joints. Mummies begin to walk around and are so astonished by this discovery that they begin to go around preaching this "new" experience, presenting it as the new technique. It is like suddenly setting free the bound feet of Japanese geishas.
7. What ensues is a description of the first steps, of the short walk during the analytic session. The first "liberators" have great success. The simple act of drinking a glass of water during the session (icon of the "new" clinical theory) is reported as if it were news of a Lourdes miracle. The extraordinary news is that the analyst is a normal person, who goes to the toilet like everybody else, and who, improved by the end of his paralysis, at times does not even need the crutch of the handicapped.
8. To the miraculously cured, this experience seems so important that they feel the need to tell it to the world. One of the necessary ingredients for being able to think like this is the loss of the sense of the ridiculous. It is interesting to observe the seriousness with which they narrate the intense emotion felt during the encounter with the patient. The existential dramaturgy and the *petit bourgeois* mass sentimentalism fill the iconography of this new psychoanalysis. And such excellent work thus comes out of the descriptions of the attachment styles of developmental psychologies: the poor baby in the patient and the poor baby in the analyst join in empathy, and together, in mutual effort, create a mommy story. And in this way they both get cured (but why, during these self-disclosures, do we never hear of indecent exposure or loss of control, but only of grief or anguish? Is there a technical reason?). In concrete terms, we cannot reward today the result of a past misinterpretation, given that we are often dealing with ex-believers who continue to produce parallel cultures of followers by way of the existent "schools", a phenomenon especially evident in those countries where there is a legislation on psychotherapy that implies the definition of different "schools". In my opinion, there has never existed two psychoanalytic techniques, but two types of psychoanalysts: one who, if s/he accepts a gift or "laughs in analysis", immediately feels the need to communicate the happy event to all and sundry by writing an article, and one for whom the obvious incidents occurring during the analytical relationship have always been applied towards the goal of analysis, using clinical reality

as their reference point rather than the "rules" that, by the way, are continuously being contradicted, to the extent that, already by 1964, I had written that Sasha Nacht's (1963) essay *La Présence du Psychanalyste* ("The Presence of the Analyst") was needed to give permission to many colleagues to feel human when they were treating patients.

To conclude: in recent years the number of analysts who no longer believe in Snow White has increased. The problem is that in many cases they have begun to believe in Santa Claus.

The therapeutic identity

I will now discuss the issue of therapeutic identity. Convinced as I am of the importance in our work of personal identity as a specific tool with high "use value" – compared with other professions in which role identity and technical procedures are much more relevant – instead of talking about sociology and the social psychology of the professions, I intend to concentrate my thoughts within the framework of the person, i.e., by working with a radical "subjectivation". In this context, I portray my personal "realm": what everybody has inside of himself or herself, who I am, where I come from, and through this process I will be guided by three benchmarks: the autobiographical method, presently much appreciated by historians as longitudinal reconstruction (the "ego-history", as some call it); the defining of the processes leading to professional identity; and the foundational criteria of psychoanalysis.

These foundational criteria represent my main interest and have guided my approach to this day, beginning with my 1960 lecture on "Psychosomatic medicine and the doctor-patient relationship", in which I proposed the concept of technical spontaneity as an outcome of the training process, as well as my 1962 lecture on "The scientific foundation of psychotherapy". As I mentioned above, in the latter I establish the basis, anchoring my argument in cybernetics and communication theory, of the semantic continuity of communication without separating verbal and nonverbal codes, criticizing a concept of interpretation limited only to verbal language. The "bracketing" of the truth of interpretation is rooted in this point of view. In later papers (e.g., Galli, 2006), I conceptualized the "interpretive activity" as a continuous restitution of meanings, organized by the therapist's total person with signs and words at the conscious and non conscious level, in the epistemic asymmetry of the relationship.

From the methodological point of view, the therapist-person becomes the hinge in a field with high inner mobility between the two polarities of redundancy and entropy. The therapist develops and establishes himself or herself as a catalyst for making quick decisions in a probabilistic system with a high rate of uncertainty. What follows, at the level of training, is the priority of learning to tolerate uncertainty rather than the priority of procedures (*Training* or *Bildung*?). In a way, in the 1960s we stated that the "personal is political", I could now say that the "personal is scientific", thus anchoring a pole of knowledge in the reality principle as a way to free our imagination.

My contribution is to the theme of a common home-base of psychotherapy to which we are all connected, regardless of our different schools or approaches. Permit me to speak of the soil in which the tree of psychotherapy has grown and continues to grow, without entering into the details of the specific contribution and expertise of each one of us. It is a tree that dips its roots into the therapist's identity and gives us the capacity to handle uncertainty. This is the "realm" of uncertainty – a methodological specificity of the clinical decision process, in contraposition to the false certainties made present in our profession due to the social pressure from the standard of mere usefulness, in conjunction with the return of the dominating "medicalism" in psychiatry.

My thesis is based on the idea of the centrality of the therapist's person on all levels – that of the therapy, the research, and the implicit theories that regulate the way we work on a concrete level, *vis-à-vis* the explicit theories however useful and indispensable they may be. Explicit theories are often like the metaphor of the handle we grab when we are on the bus, but in reality not attached to anything: you think it supports you but eventually, at the end of your trip, you realize that you are the one holding it up.

Now I will put forward and articulate two problems strictly in methodological terms.

The first one deals with the subject of the reasons behind clinical practice (Galli, 1988). The "clinical operation" is the conversion – intrinsic to all types of psychotherapy – of the procedure prescribed by the theory into the procedure that is actually applied to a given patient. The change factor is the indicator of the interaction between the therapist's person and the patient's person, the constraints of inner consistency and/or the fallacies of the theoretical model. In this way we can verify, for research purposes, the consistency between clinical practice and the theoretical frame of reference, so that the technical modifications, *vis-à-vis* the stated procedures and parameters introduced into the concrete clinical situation, can further clarify theoretical aspects that need to be worked through, and an additional systematization of theory and theory of technique may occur. From this perspective, the different psychotherapeutic approaches can be positioned, along a *continuum* from a greater to a lesser degree of proximity, between theory and technical procedure: a greater proximity in terms of behavioral techniques, a lesser proximity in terms of cognitive-behavioral techniques; and a much lesser proximity in terms of psychodynamic techniques. Empirical observation shows that the stated procedure and the therapist's actual behavior never fully coincide, even if the therapist claims to have rigorously applied the procedure. Prescribed behavior and actual behavior are always somehow different, and observable variations are the basis for hypothetical-inferential investigation with an *a posteriori* verification as the basis for prevision and confirmation. In this light, the "therapist-filter", conscious and unconscious – or, rather, from the descriptive standpoint, conscious and non-conscious – plays a key role.

The second issue deals with the measurement tool. On the strictly empirical level, the link between training and the measurement tool in research and clinical practice is apparent:

a) Current knowledge of psychological and psychoanalytic research allows for the understanding of a wide range of normal and pathological behaviors;
b) This knowledge allows for a series of clinical interventions that have an effect that we can foresee: a reasoned sequence of these interventions is the essence of psychotherapy;
c) Some clinicians are better than others in performing these interventions;
d) This ability comes from a knowledge of theory, clinical experience, and personality factors;
e) Specific training techniques may improve this personal skill;
f) Psychotherapists may be defined as persons who are able to perform therapeutic actions with a higher likelihood of success than others.

This is a definition of the psychotherapist in probabilistic terms, hence, an observable measurement tool from the point of view of research. These methodological statements are necessary in order to avoid the risks of "spontaneistic" subjectivism and idealization of the concept of therapeutic personality.

Let us move on to the construction of the psychotherapist's identity. Identity is historically constructed. There are two main factors in a professional's individual historical process and they are the following: a) what s/he actually does in daily practice, which we call professional competence; b) the social representation that becomes part of the self-image as inner representation.

As we have seen before, there are professions in which these two elements are close to each others, while in others they are very separate. In professions such as surgery – with a high degree of procedure – role, competence, and representation are closer to each other and their activity can be better defined in terms of outcome. In professions such as psychotherapy, with a high degree of relational aspects, the stagnation and oscillation of the therapeutic processes impact simultaneously the prevalence of the representational area and the high level of pressure on self-esteem. A large part of the pursuit of a sense of validation takes place outside of clinical work, which is intrinsically ungenerous in terms of providing narcissistic gratifications. The result is a tension that increases dependence on the environment and on training. Labels such as memberships or professional degrees remain, of course, within the area of propaganda and not necessarily in the area of competence.

The pieces of the human journey that we carry within, when making our life choices, and hence the part of our person that we sell as our professional identity, and that constitutes an irreducible motivational drive, allows us to overcome moments of therapeutic impotence, which in our job occur much more frequently than moments of joy due to success. For this reason, I want to emphasize the importance of everyone's personal realm as a professional ingredient. I could say that it is the point at which our identity's construction converges with the irreducibility of the self. This is the nuclear self in Winnicott (1960), or the maturational self in Kohut (1971, 1977), and at any rate it represents the ultimate barrier to fragmentation – just as Freud (1937, p. 225; p. 508 Italian edition) said that in moments of clinical difficulty we resort to our "witch", i.e., metapsychology, the private witch in our personal realm protects us from desperation.

My personal history from my birth and early life in a town in Campania (an Italian region around Naples), up to my medical degree, lies somewhere amidst the "possibilism" of the totally secular Neapolitans, the protestant ethics of the Teutonic north of Basle and Zurich, the busy life of Milan, the Sicilian-Swiss emotional rigor of my first teacher in psychotherapy, Gaetano Benedetti, who in fact was born in Sicily but lived in Basle. All this contains some measure of family pride. I have to say that I am proud of this mixture of traditions. Even if it is a private world, I would like to share something that I have learned. During my adolescence in Nocera (Campania), I took to heart a truism which penetrates the Neapolitan spirit: you should always do serious and important things but you should never take yourself seriously, otherwise you are finished. I think that everybody should follow this suggestion, in order to avoid identifying too much with our own role.

Psychiatric diagnosis and psychoanalytic diagnosis

In this last part of my paper, I wish to explore the dialectical comparison between the psychiatric and the psychoanalytic diagnostic conceptions. As is well-known, since the early 1980s we saw the triumphant success of psychiatric "diagnosticism", with the series of *Diagnostic and Statistical Manuals* (DSM) *of Mental Disorders*, from DSM-III up to DSM-5. In 1984, I wrote a paper entitled "Orphans of the neurosis" (Galli, 1984)[2]: with this title I was alluding to those psychoanalysts who were beginning to move toward a "diagnosticism", subordinate to psychiatry. I must say, especially now that we saw the polemics that surrounded the DSM-5 process, that attempts to transform existence into illness – and consequently attempts to shift from a cure of the soul to pills and neurons, even if the former is riding a wave of triumph – are miserably failing, just like the house of cards upon which economic globalization has been built.

Although research on the nervous system (such as, for example, work on mirror neurons), can be very interesting, the social phenomenon of propaganda swarming around this work, its *vulgata* so to speak, is laughable. Empathy becomes "true" and Martin Buber[3] was right because the neuron said so!

I believe that today it is important to refer again to the strength and dignity of the psychoanalytic approach, without seeking social legitimization and the right to exist in an ancillary position in relation to the neurosciences. Let us take back the human condition. Let us not leave it to the illusion of the behavioral control of brain mechanics. Quoting Paul Parin (1998), the great psychoanalyst from Zurich, do we actually wish to «leave research on the unconscious sources of human tragedy to an electronically guided cybernetics that fascinates so many scientists and promises definitive salvation from the uncertainty of our existence?» (p. 369). This cautionary

[2] The disappearance of the term "neurosis" from classification had decapitated that "central complex of the neurosis" (Jung, 1911-12) which in Freud (1912-13, p. 29) would become the "Oedipus complex". Not even the Kleinian perspective, with its radical concept of the pre-genital, had ever gone so far!

[3] On the contribution of Martin Buber, see the round table on "Martin Buber's influence on modern psychiatric thought" organized by our group in Milan in 1962, reprinted in the section "Traces" of issue no. 2/2015 of *Psicoterapia e Scienze Umane*, pp. 275-304. The round table was chaired by Franco Fornari, and the panelists were Pier Francesco Galli, Virgilio Melchiorre, Mara Selvini Palazzoli, and Enzo Spaltro; interventions were made also by Leonardo Ancona, Enzo Codignola, Gianfranco Garavaglia, and Silvia Montefoschi.

statement has become even truer since the series of DSMs has produced several orphanages lately, some of them quite crowded, such as for example the orphanage of the many disorders that have been included in the wider spectrum of borderline disorders, a once triumphant category, with its several treatment procedures that the clinical reality of treatment-resistant patients is already sadly dissolving. In my opinion, a grotesque scenario is being staged. It resembles a great "DSM of history and existence", perched on the pedestal of this "phenomenon's dictatorship". What is more, the pill of happiness will prove to be bogus along with all these other false idols. Lets' take back our "civilization and its discontents", with all of its suffering and *mal de vivre*.

Conclusions

I will conclude with a reference to the "relationship" criterion, i.e., the psychoanalytic technique based on transference, which cuts across any kind of classification and presents, in its basic definition, the differentiation between transference neurosis and narcissistic neurosis. The focus on transference characterizes a fundamental aspect of psychoanalytic diagnosis, in which all three aspects of psychoanalysis come together – theory, research as a continuous process, and technique – so that the statement "psychoanalysis is analysis of transference" becomes axiomatic. At the same time, the handling of transference (i.e., positive transference), hence of the relationship in itself, is conceptualized within the theory of therapeutic factors.

In May 1954, in Arden House (Harrison, New York), a symposium on "The widening scope of indications for psychoanalysis" compared the various positions on this topic at the time. Papers were presented by Leo Stone (1954), Edith Jacobson (1954), and Anna Freud (1954). The symposium was sponsored by the *New York Psychoanalytic Society* (and the various addresses were published in issue no. 4, 1954, of the *Journal of the American Psychoanalytic Association*; for an historical reconstruction, see Friedman, 1978).

The concept of "standard technique" was progressively becoming an object of criticism, while the variables related to the "therapist's personality" (with its consequent focus on countertransference), together with the therapeutic efficacy of the psychoanalytic situation *itself*, was acquiring more and more attention. For this reason, the concept of the "analytic frame" or "setting" began to take on greater significance.

If we examine this trend, we see the diagnostic criteria suggested by authors, like Kohut and Kernberg, who studied narcissism. The main characteristic of narcissistic disorders is represented by the fact that their symptoms may also appear in any other type of disorder. In terms of differential diagnosis, narcissistic disorders can be distinguished from the diagnosis of other disorders by drawing upon the personal experience or the "feelings" of the therapist. The affects that narcissistic personalities induce in the therapist become an important part of the semeiotics of these psychopathologies.

Thus countertransference acquires a specific diagnostic value, and the objectivization of the therapist's feelings becomes one of the criteria of psychoanalytic diagnosis, maybe the characteristic that, more than any other, typifies psychoanalytic diagnosis. It is noticeable that a position based on the developmental lines of structure formation leads – both in Kohut and, even more so, in Kernberg – to a form of "psychoanalytic diagnosticism" that reformulates exclusion categories, with an approach resembling the psychiatric one.

If we observe the overall state of research in the psychoanalytic field, we cannot speak of a "psychoanalytic decision" in general on the more or less appropriate opportunity of beginning psychoanalytic treatment with any given patient, but rather of a "decision of the psychoanalyst", i.e., of "that" specific psychoanalyst in "that" specific work situation in "that" specific moment in his/her life with "that" specific patient. Paradoxically, within psychoanalytic diagnosis seen as a dimensional *continuum* extending the range from severe to milder forms of psychopathology, we can state that the only fixed point is the decision of that therapist to begin that treatment. From this perspective, it is evident how artificial the separation between diagnosis and treatment is, and even

more evident is the relevance of the idiosyncratic aspects of the therapist. At home everyone is king, whether you like it or not.

Sociology of knowledge was a method aimed at purifying the individual datum from the interfering variables related to the researcher's subjectivity, with particular attention to value systems. In my opinion, particularly in the humanities and in the social sciences, value systems are part of the construction of the datum, of its place within the historical context, and of the understanding of its implications. The unitary body of knowledge obtained via the psychoanalytic method allows us to maintain the hope for change, one that sustained generations of colleagues through their technical tribulations, through their disappointments due to therapeutic failures, and through their experience of the systematic doubt that seems to accompany therapeutic successes.

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