The Second Psychoanalytic Paradigm

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Identifying the Second Psychoanalytic Paradigm: Foundations and Clinical Frontiers for the 21st Century

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The relational psychoanalytic movement represents the second paradigm in the more than one-hundred-year history of psychoanalysis. The *first paradigm*, organized around the drive-based theories of Freud, views mind or psyche as residing in the individual, and as emerging from underlying, biological forces; the *second paradigm* envisions mind as relational and embedded, therefore resulting from many more complex determinants, and ultimately even transcending the concept of an independent psyche through such ideas as "the myth of the isolated mind" (Stolorow & Atwood, 1994, p. 234) and "contextualism" (Orange, Atwood, & Stolorow, 1997). Its genesis is traceable to British object relations theory, particularly the work of Fairbairn (1952), but it twisted and turned its way through American object relations, self-psychology, inter-subjectivity and now relational psychoanalytic theory.

These developments clearly meet the criteria for Thomas Kuhn's concept of a paradigm shift (Kuhn, 2012, p. 179). Kuhn writes, "a paradigm governs, in the first instance, not a subject matter but rather a group of practitioners [and therefore a study of] paradigm-shattering research must begin by locating the responsible group or groups" (p. 179). Just such a cluster of clinicians started with Fairbairn's work during the 1940s and 1950s, and then gradually transitioned through such theorists as Jacobson (1954), Winnicott (1960), Guntrip (1967), Kohut (1975), Bollas (1979), Ogden (1988), Hoffmann (1991), Renik (1993), Stolorow and Atwood (1994), Mitchell (1998), Bass (2001), Miller (2008), Tublin (2011), Ringstrom (2012), and many others.

Such a fundamental paradigm shift adheres to Hegel's (Kaufmann, 1966) view of history as developing through a process that moves from thesis to antithesis to produce a synthesis. Historically, psychoanalysis has cycled through this same process, beginning with the thesis consisting of the initial set of psychoanalytic discoveries made by Freud, Jung, Klein, and many others who recommended the application of certain techniques to promote change in patients. Approximately fifty years later, an antithesis emerged in the form of analytic theorists describing how the transformational process actually resulted primarily from analysts' *relationships* with their patients. Now a synthesis has been created, in the form of the second psychoanalytic paradigm, which encompasses and expands on the initial psychoanalytic model. In brief, the structure of the first paradigm's doctor-patient relationship vanished. Now a new, interpersonal transformational process—driven by co-participants – lies at the forefront of psychoanalytic thinking.

This paper focuses on that new synthesis, one that offers patients help by applying well-established methods of uncovering unconscious processes as they unfold within the context of an intensely dynamic, interpersonal, intimate relationship. I shall address some of the ways that the actual psychoanalytic process has changed as a result, what it now seeks to achieve, how psychoanalytic theory fits into the

newer paradigm, and how the sociocultural role of psychoanalysts and the nomenclature they use are affected.

The second psychoanalytic paradigm highlights one, crucial new element: *intimacy* in the psychoanalytic relationship. Modern psychoanalysts perform their work, struggling with an asymmetrical closeness necessary for transformation, without behaving like a "surgeon," as Freud (1912, p. 115) once mandated it, or like a lover, as Renik (1993) implies when he describes "effective clinical psychoanalysis as not unlike good sex" (p. 565). Therefore, substantial new challenges animate the consulting rooms of contemporary psychoanalysts.

As psychoanalysis enters the 21st century, cult-like adherence to psychoanalytic schools, named after individual theorists such as Freud, Jung, and Klein, increasingly fades. Instead, clinicians describe transformations occurring in patients as a result of intimate psychoanalytic processes. They refer to unique angles on the work, or elements of specific case dynamics, without archaic devotion to heroic-like psychoanalytic pioneers. Yet these contemporary psychoanalysts continue, as they always have, to utilize well-established 20th century ideas, such as the pursuing unconscious themes in dreams, in the transference and counter-transference, and in repetitive, psycho-behavioral life trends, in their efforts to help those who seek their help.

Possibly for the first time in the entire history of psychoanalysis, an over-arching systematization may be possible – taking the form of this concept of the second psychoanalytic paradigm – utilizing a dialectic method traceable to ancient Greek reasoning. Certain well-worn mental phenomena, emerging primarily from ideas described during the first fifty years of psychoanalysis, remain useful vehicles for bringing dark unconscious themes in persons' lives into the open. At the same time, and paradoxically, newer psychoanalytic ideas – such as vastly unique nature of any particular psychoanalysis, the contributory elements specific to each psychoanalyst and patient, and the centrality of artistry, improvisation, openness and spontaneity as reflected in Renik's edgy comment – beg for integration.

The Transition from the First to the Second Psychoanalytic Paradigm

Greenberg and Mitchell (1983) believe that only two major paradigms comprise the history of psychoanalysis, the initial one being the "drive-structural" and the more recent one the "relational-structural" (p. 24, 38). The second paradigm already goes by many names, with Stolorow, Brandshaft, and Atwood (1987) calling it *inter-subjectivity theory*, Mitchell (1988) calling it *relational-model theorizing*, infancy researchers Beebe, Jaffe, and Lachmann (1992) calling it *a dyadic systems perspective*, and Hoffman (1991) using the phrase *social constructivism*. Aron (1996) views the ideological shift as movement from an objectivist (or positivist) to a constructivist epistemology (Aron, 1996, p. 256). He interchangeably uses the words "relational-perspectivism" or "relational-constructivism" to describe the newer paradigm (p. 27). Even Wallerstein (1998), known for his devotion to more classical psychoanalytic approaches, acknowledges a "paradigm shift" emerging from a combination of the British object relations school and Harry Stack Sullivan's interpersonal perspective (p. 201). I offer that the relational-structural model has in fact transcended, and now encompasses, the earlier model, and thus the idea of a second psychoanalytic paradigm.

Interestingly, physics has similarly had two main paradigm shifts in the last century. Early in the 20th century, locality and causality were linked by Einstein's theory of special relativity. With the later emergence of quantum field theory, these same two concepts became radically altered. When considering two entangled particles, for example, measurement of one instantaneously affects the state of the other, rendering the meaning of causality ambiguous. Further, during the early 20th century, Einstein's application of general relativity to describe the universe rendered it static. More recently, astrophysicists observe that the universe is expanding, implied by the redshift of distant galaxies. Current theorists now question whether the universe ever had a clear beginning, e.g.,recurrent big bangs versus eternal inflation (JR Garrison, personal communication, December 16, 2012).

While not falling into the same bifurcation, world history similarly seems to be moving towards a more global, integrative status in the aftermath of World War II – this despite the rise of fundamentalism which will ultimately fail because it represents history moving backwards. And in the broader area of the history of ideas, this paradigm shift in psychoanalysis also parallels the transition from the modern to the post-modern period.

Many psychoanalytic theorists have contributed to the paradigm shift that is the focus of this article, but Fairbairn's (1952) contributions mark the clearest turning point. For that reason, this paper will emphasize his work. Whereas others had remained closely tied to the cult of personality surrounding Freud, with its attendant devotion to drive theory, Fairbairn, delivered from the foundations of psychoanalytic thought, offers the cornerstone of a new paradigm.

The ideological revolution occurred in 1943 when WRD Fairbairn wrote:

> ...It is high time that psychopathological inquiry, which in the pasthas been successively focused, first upon impulse, and later upon the ego, should now be focused upon the object towards which the impulse is directed. To put the matter more accurately, if less pointedly, the time is now ripe for a psychology of object relationships ... psychology may be said to resolve itself into a study of the relationships of the individual to his objects, whilst, in similar terms, psychopathology may be said to resolve itself more specifically into a study of the relationships of the ego to its internalized objects (pg. 60).

In this paragraph, Fairbairn offers up his version of the complexities of the "internal world," one that differs significantly from the one presented by Melanie Klein (1959) and, before her, Sigmund Freud (1923). The *crucial* ideological shift here – and one *not* made by Klein or Freud – concerns Fairbairn's emphasis on the *social* nature of human persons, and by implication, how their "inner worlds" are primarily of a communal, social nature rather than of an individualistic, instinct-driven one.

While Freud, Klein, and most of their followers were busy elaborating on their visions of individualized, hydraulic-like models of the mind, Fairbairn – and in no small way a result of his working in relative isolation in Edinburgh – proposesan entirely different, and in many ways radical, departure.He notes, for example,that the Freudian concepts of the oral phase, the anal phase, and the phallic phase were not developmental phases as such. They represent, instead, the means through which infants connect to their mothers or other care-taking persons.

Fairbairn (1952) adds:

> The ultimate goal of libido is the object; and in its search for the object libido is determined by similar laws to those which determine the flow of electrical energy, i.e., it seeks the past of least resistance. (Fairbairn, 1952, p. 31)

The profound difference between the foundations of psychoanalytic thought and its second paradigm is represented by Fairbairn's assertion thatpersons are not motivated by biological drives, but by their need to attach to others.

Psychoanalysis in the Second Paradigm I: The Dialectic of Schemas and Intimacy

Much of Fairbairn's ideology may be condensed into the simple idea that, when efforts to attach to primary caretakers are thwarted, i.e., through childhood trauma, persons retreat into their unconscious minds as a way of finding safety and sanctuary, therefore forming an internal world. A fine example of modern-period thinking, Fairbairn called this "the endopsychic structure" (Fairbairn, 1943, p. 328). Further, in order to keep the outside world a safe place in which to live, infants and toddlers more specifically internalize images of self and other linked together into a schema that he termed "dynamic structures" (p. 377). Such unconscious configurations comprise the internal object world. Through that reasoning, Fairbairn essentially solved the riddle as to how persons often suffer so persistently from negative self-images. They carry, within their unconscious, internal, dramatic themes that include multi-determined, caretaker-like figures criticizing internalized components of themselves, and thus the resultant low self-valuation.

In consonance with post-modern ideas, and recognizing that persons' "internal worlds" are much like dynamic unconscious dramas, the phrase "internal drama" seems a more accurate description of this phenomenon. I therefore shall hereafter use the phrase *internal drama* instead of *internal object world* because the latter represents archaic modern period thinking.

Fairbairn next explains why such negative, unconscious dynamic structures prove so resistant to change, and that is because they represent an internal family in which individuals are understandably enmeshed. No one wants to be an orphan. He stresses that psychoanalysts should, in effect, assault patients' attachment to their internal drama, even at the price of temporary orphan-hood. In order to do so, psychoanalysts must develop an intimate, "I-Thou" (Buber, 1958) relationship with their patients.

> Fairbairn stresses that the most formidable of the psychoanalysts' tasks is: overcoming of the patient's devotion to his repressed objects – a devotion which is all the more difficult to overcome because these objects are bad and he is afraid of their release from the unconscious. (Fairbairn, 1943, p. 335)

With this, Fairbairn offers the best explanation of resistance in the entire history of psychoanalysis. Further elaborating on the crucial import of *intimacy* in the therapeutic encounter, Fairbairn (1943) writes "bad objects can only be safely released, however, if the analyst has become established as a sufficiently good object for the patient" (p. 333).

Using his earlier theological training as a source of metaphors for these unconscious, internal dynamics, Fairbairn (1943) famously adds: *"it may be said of all psychoneurotic and psychotic patients that, if a True Mass is being celebrated in the chancel, a Black Mass is being celebrated in the crypt"* (p. 70, my italics). The evolution of psychoanalytic theory, beginning with Klein's object relations model, all involved, to one extent or another, attempts to answer this crucial question: What precisely is occurring in that intense ceremony being held in the dark basement of the unconscious? Or, in other words, what is the composition of this internal drama?

Winnicott (1956), for example, emphasizes the formation of an unconscious "false self" in babies forced to adapt to their caretakers' failures. The false self emerges – a sort of adaptive façade – to accommodate to what the caretakers need, but at the expense of the emergence of the authentic or "real" self (p. 387). Balint (1968), yet another theorist bridging the first and second psychoanalytic paradigms, also stresses the crucial importance of caretakers' attending to babies' needs. Without such attunement, persons are at greater risk of developing a "basic fault" (p. 21) in their personality structures. The theories are as varied as the individual theorists.

Greater understanding of how the internal drama is formed, and to what extent biological, early social learning, cultural, or other elements may contribute to it, has and will continue to require decades of exploration. Suffice it to say, however, that likely all of the above-noted factors contribute to the development of the unconscious internal dramas of persons. Influences from within the family of origin may be usefully characterized as a form of *indoctrination*. People learn about who they are, who others are, and how relationships work, primarily from their earliest interpersonal childhood experiences which again obviously occurs in biological, cultural, and perhaps even broader contexts. All persons in fact have an ongoing, and concurrent, relationship with themselves, namely with their resistant-to-change internal drama, at the same time that they are in relationship with the external interpersonal world. A detailed exploration of the development of the unconscious internal drama represents an immense task, and strays beyond the bounds of this particular contribution. Therefore, I now proceed without further exploration of causation, and persist with this clinical focus on how such unconscious, internal dramas can be transformed.

So, then, just how does psychoanalysis affect change in the internal dramatic world, namely in those persistent, theatrical themes that affect so much of conscious life? Quite simply, psychoanalysts must first and foremost develop intimate bonds with their patients. Their relationships must be intimate enough to allow for these "bad objects," as Fairbairn (1943) writes early into the second paradigm, or "organizing principles," as Stolorow & Atwood (1980, p. 285) write well into the second paradigm, to be released and, for lack of a better word, "processed" in the course of the interpersonal psychoanalytic process.In other words, clinical psychoanalysts apply any number of well-worn methods, i.e., interpretation of the transference, but only within a new understanding of the analyst-patient relationship, namely one of co-equals or co-participants in a highly complex process intended to facilitate personal transformation.

From Abraham's (1923) early work on anal character to Zimmer's (2010) recent paper on invasive internal objects, three central psychoanalytic ideas dominate the psychoanalytic literature: The existence of an unconscious mind (wherein a certain internal drama exists and emerges in a variety of forms such

as dreams), the transference/counter-transference process (resulting from the projection of themes from this unconscious internal drama), and the repetitive nature of psycho-behavioral themes (caused if not influenced by the same). Few if any past or current psychoanalytic theorists deny that an internal, unconscious world exists, that projection of themes from the unconscious create transference/counter-transference phenomena, and that these same trends are seen to repeat over a lifespan – interpersonally and behaviorally – in a fashion that Freud called the "repetition compulsion" (Freud, 1923). In fact these same three central ideas – remnants of the initial psychoanalytic paradigm – remain active in the second paradigm, although they are now viewed from quite a different, much more dynamic, and complex angle.

Jumping decades forward now into more recent writings from the relational school, Renik (1993) was among the first theorists to emphasize that the subjectivity of the psychoanalyst must be increasingly considered in terms of how psychoanalysts help people transform themselves. Although Fairbairn clearly built the bridge to the second psychoanalytic paradigm, he still operated essentially from the standpoint of an invulnerable doctor to his passive patients (Guntrip, 1975). Renik (1993) was but one of a series of authors who overtly emphasized more detailed elements of the I-Thou psychoanalytic relationship and, with it, the increased personal vulnerability of the psychoanalyst. For example, he writes that relational psychoanalysis "accepts the analyst's constant subjectivity" and that "the unconscious personal motivations expressed in action by the analyst are not only avoidable, but necessary to the analytic process" (p. 562).

Aron (1996) describes the psychoanalytic relationship as one of mutual intimacy, but asymmetrical attention. He notes that just because "the influence between patient and analyst is not equal does not mean that it is not mutual; the analytic relationship may be mutual without being symmetrical" (p. 77). Such ideas would be nothing less than heretical to psychoanalysts, like Freud, writing during the modern period. At that point, psychoanalysts were viewed as knowledgeable doctors treating ignorant patients.

Even more provocatively, and foreshadowing many of the clinical problems that second paradigm psychoanalysis creates and this papers addresses, Renik (1993), repeating in more detail what appeared earlier in this paper, writes again that: "perhaps we should think of effective clinical psychoanalysis as not unlike good sex, in that it is impossible to arrive at the desired outcome without, in some measure, relinquishing self-control as a goal" (p. 565). Relinquishing self-control? It is difficult to imagine an attitude that could possibly be so opposite to, so at odds with, Freud's early belief that effective psychoanalysts should behave like surgeons.

Among the most current controversies in the second paradigm concern how to integrate "technical" interventions into the more free-floating, relational nature of the newer model, and so here again is the dialectic theme characteristic of second paradigm psychoanalysis. Tublin (2011) proposes a reconceptualization of technique, but from the point of view of "therapeutic intent" rather than "objective correctness" (p. 519). Schimmenti and Caretti (2010) precisely demonstrate this dialectical process in their article on how technological addiction allows individuals surcease from painful states of mind. The authors write, "technological addiction is grounded in more chronic and pathological dissociative defense mechanisms" (p. 115). Simply remove the word "technological" and this entire sentence could have been pulled randomly from psychoanalytic literature in the first half of the last century.

Miller (2008a, 2008b) demonstrates this same dialectical process in his two articles regarding the effect of psychoanalysts' emotional reactivity on the transformational process. He proposes that the emotionality of the analyst be integrated into the psychoanalytic process, describing it as a "complex emotional system that is both stable and constantly in flux" (2008a, p. 20). He writes, "these therapeutic processes, configured in a dynamic, interactive, and continuous manner, form the analytic context" (2008a, p. 20). In his companion article, Miller (2008b) elaborates on the specific relevance of dynamic systems theory, a mathematical model used to predict future states of systems based on their current state. He applies that model to emotion in general, and then to emotion in therapeutic interaction. Here,Miller also demonstrates the aforementioned dialectic when he writes: "Conceptualizing the patient-analyst relationship as a dynamic interaction of patterns of emotional cooperation and competition that stabilize into recurrent states of emotional relatedness enables us to understand how the emotional relations between the patient and the analyst reflect the adaptive strategies of both participants, and the way these strategies mirror the recurrent organizing principles that characterize transferential relationships" (p. 275). Can't you just hear the echoes of past-century Hartmann's (1948) "adaptive strategies" and Freud's (1893) "transference" reverberating through the complex, dynamic theories of the second psychoanalytic paradigm?

Even more recently, Grossmark (2012) describes how inter-subjective engagements allow for the re-integration of dissociated and unformulated states, proposing a concept of "benign regressive mutual regulation" as a phrase to describe such a process (p. 629). Here the reader may remember Balint (1968), who himself used the phrase "benign regression" in his writings but only in reference to the patient (p. 126). Although he did not develop the ideas completely, Balint was one of the many transitional thinkers who viewed the psychoanalyst-patient relationship as a crucial component of transformation.

Psychoanalysis in the Second Paradigm II: The Liberation from Technique

Having now reviewed some of the most recent writings in second paradigm psychoanalysis, it appears clear that working clinically in this newer psychoanalytic paradigm requires surrender to the lack of any true, objective techniques – a path that veers far from psychoanalysis' original medical genesis. Freud's work was influenced, of course, by his scientific and medical training. The subsequent evolution of his work in the United States in particular was strongly influenced by the medical model. The second psychoanalytic paradigm – through the vehicle of an intensive, if asymmetrical, intimacy between two parties – seeks transformations in attitude, emotion, cognition, psycho-social-behavioral patterns and more – while retaining the use of first paradigm ideas such as transference and counter-transference.

Although the transformational vehicle is a two-person intimate relationship, its tools – such as empathy, interpretations, clarification of feelings, and confrontation – differ little from methods used by first paradigm psychoanalysts or any type of depth psychotherapists, including Jungians. Second psychoanalytic paradigm work remains a type of "talking" therapy. It is, unequivocally, an intimate, interpersonal process. As such, it cannot help but privilege speech, but the material available for joint exploration by analyst and patient are essentially infinite. Therapeutic dyads may attend to language, behavior, voice tone, affects, postural changes, current and past real-life interpersonal themes, historical

events, culture, mythology, dreams, transference, counter-transference, or any number of possibly imaginable media for furthering understanding of the conscious and unconscious dynamics of the patient's internal drama. Given this, it is difficult to understand why relational psychoanalysis has been criticized for ignoring the unconscious (Rudden, 2010). Second psychoanalytic paradigm therapists seek unconscious themes just as ardently as their original paradigm predecessors but, again, they do so using a co-participant model, or two-psychology one, and their sources of information are therefore vastly expanded.

Consistent with Tolstoy's observation that "all happy families are alike; each unhappy family is unhappy in its own way" (Tolstoy, 2000, p. 1), individuals are similarly unhappy in their own unique ways. An essentially unimaginable range of painful feelings or problematic life paths exists, and second paradigm psychoanalysts flow with the unique experience of individuals. Psychoanalytic sessions unfold as dynamic, dyadic experiences, in no way comparable to, say, a physician injecting an intramuscular medication into a patient.

Mitchell (1988) writes:

> Unless the analyst affectively enters the patient's relational matrix or, rather, discovers himself within it – unless the analyst is in some sense charmed by the patient's entreaties, shaped by the patient's projections, antagonized and frustrated by the patient's defenses – the treatment is never fully engaged, and a certain depth within the analytic experience is lost. (p. 293)

Ironically, as medicine descends into the jaws of the international, industrial complex (Goldsmith, 1990), second paradigm psychoanalysis moves in the opposite direction. Medical patients internationally are increasingly treated in an assembly line fashion; in second-paradigm psychoanalysis, the exclusive individual subjectivity of each person is highlighted. And each "therapeutic dyad" (Freedman, 1980, p. 259) has its own uniqueness, rendering, again, the work of psychoanalysis much more artistic than medical or scientific.

Psychoanalysis in the Second Paradigm III: The Clinician as Artist

One of the earliest psychoanalysts to emphasize the primarily artistic nature of psychoanalysis was Loewald (1980) who in fact compared psychoanalysis to a form of dramatic art. He writes that analyst and patient together to create a play, if you will, and they are co-creators of this production (p. 355). He writes, "in the mutual interaction of the good analytic hour, patient and analyst – each in his own way, and on his own mental level – become both artist and medium for each other" (p. 369). Szasz (1978) writes psychoanalysts' "activities would constitute, and be classified as, art rather than science" (p. 208).

The work of second-paradigm psychoanalysts requires great improvisation, as has been extensively explored by Ringstrom (2001, 2007, 2008, 2012).They must be open to whoever walks in the door. None of those individuals should be reduced to how they describe themselves or others have described them, i.e., low self-esteem, a diagnosis, or a theme in their relationship history. Psychoanalysts must be acutely emotionally present, and be able to attune to any of a variety of personalities who present in their offices, from those that are highly internalized and cognitive on one end to those that are extremely

externalized and emotional on the other. Each psychoanalytic encounter stands alone, although sets of them may be organized around the attainment of some type of a transformational goal. Each therapeutic dyad becomes immersed in the internal dramas of both parties, creating infinite complexity, but the analyst strives to keep the focus asymmetrically on the patient. In a sense then, and again, psychoanalysts are much like performance artists. Ringstrom (2012) writes that it is only through

> the improvisational metaphors of scripts, assigned roles, dramatic arches, and sequences that otherwise lifeless theories such as those of chaos, complexity, and dynamic systems come alive and become meaningful.
>
> The very idea of scripts, for example, embodies the semifixed and illusory ways we imbue our own character – in other words, our own sense of self as well as how we expect (and direct) the other to be in each present moment…(p. 470)

Regarding the question of what has been unfortunately called technique in psychoanalysis, *not*technique exists under the second psychoanalytic paradigm. Moreover, to adhere to technique violates the entire psychoanalytic project because it treats the vibrant, subjective human person as a*thing*. Many years before anyone had coined the phrase relational psychoanalysis, Szasz (1988) had already begun to view the psychotherapeutic relationship as a form of creative, dynamic, relational contract, and one free from technical methods.

He writes that the psychoanalytic relationship should be as natural, spontaneous, and unrehearsed as is the relationship between other persons who respect (and perhaps are fond of) each other.

> Accordingly, from such a perspective there is – there can be – no such thing as a*psychoanalytic technique* or *psychotherapeutic method…*a therapist's…relationship with his client cannot be, and cannot be reduced to, a technique – just as a person's relationship with members of his family or friends cannot be reduced to a technique. (p. xiii)

And now that some introduction to the process of how intimacy and lack of technical processes represent the key features of the second psychoanalytic paradigm, and further how free-flowing that process must be, attention can turn now to a consideration of the goals of the psychoanalytic experience.

The Goals of Clinical Psychoanalysis: An Introduction

In the first psychoanalytic paradigm, psychoanalysis was purely a medical treatment for mental disorders. Physicians utilized technical interventions to cure patients. Under the second psychoanalytic paradigm, the goals of the process are much broader. Various mental health disorders as described in the DSM-IV (American Psychiatric Association, 2000), such as Bi-Polar Disorder or Major Depression, may well be helped by psychoanalysis. But such healing occurs almost as a byproduct of the psychoanalytic work.

Through the vehicle of the intimate psychoanalytic relationship, the inner dramas of patients' may be transformed, leaving them with clearer visions of self and other. Over time, internal dramas begin to comport themselves more to the external, interpersonal ones, resulting in sharper visions of self and other. As Grotstein (1979) contends, psychoanalysis is the process of learning to differentiate between

persecutory objects and real persecutors. He writes,"The purpose of the use of an omnipotent and omniscient power was to be able to disappear as true selves confronting difficult experiences and to allow omnipotent deputies to dispel the persecutors instead" (p. 429). In just a few words, Grotsteinelucidates how successful analysis helps individuals understand the process of projection, while equally learning that real people in the interpersonal world can be problematic if not downright persecutory.

Many thinkers in and outside of psychoanalysis have viewed autonomy as a general goal for maturity and individuation. Freud (1926) himself believes that psychoanalysts help individuals find personal autonomy, writing, "we seek rather to enrich him [the patient] from his own internal resources, by putting at the disposal of his ego those energies which, owing to repression, are inaccessibly confined in the unconscious" (p. 256). Chodorow (1986) similarly views psychoanalysis as creating increased agency and autonomy. Referring to the famous Freudian phrase "where id was, there ego shall be" (Freud, 1933, p. 80), Chodorow writes, "where false, reactive self was, there shall true, agentic self be, with its relationally based capacity both to be alone and to participate in the transitional space between self and other that creates play, intimacy, and culture" (p. 203). More recently, Zizek (2012) writes, "For Kant as for Rousseau, the greatest moral good is to lead a fully autonomous life as a free, rational agent, and the worse evil is subjection to the will of another" (p. 337).

The Greeklyric poet Pindar(518-438 B.C.E.) appeals to athletic competitors in his Second Pythian Ode, line 72, to "be what you know you are." Psychoanalysis offers the same appeal to persons to learn and become who they are, by introducing individuals to themselves,in the context of but one highly intimate, transformational relationship.

Taking this a step further, Nietszche writes,

> My formula for greatness in a human being is *amor fati*: that one wants nothing to be different, not forward, not backward, not in all eternity. Not merely bear what is necessary, still less conceal it—all idealism is mendaciousness in the face of what is necessary— but *love* it. (Nietszche, 1908, p. 258)

Surpassing Pindar's appeal to the athlete to "become who you are," the psychoanalytically astute Nietzsche creates a universal imperative. He calls for individuals to accept their lives as they are, with their faults, their losses, and even their eventual deaths.

Steiner (1997) argues that "Nietszche's 'become what you are' [referring to Nietszche's translation of Pindar] is the antithesis to the Sinai-imperative, "'Cease being what you are, what biology and circumstances have made you. Become, at a fearful price of abnegation, what you could be.' So ordains the God of Moses, of Amos, of Jeremiah" (p. 65). Invoking Nietszche,Steiner advocates an "overcoming"of one's nature, the precise argument advanced by thinkers along the entire continuum from the political, i.e., the framers of the US Constitution, through Eastern and Western philosophy, to the various religious and spiritual traditions, and to any number of ideologies that call for humans to strive for a higher ideal.

Finally, before deferring further exploration of the goals of psychoanalysis to others, the motto of the French revolution, namely "liberté, égalité, fraternité" (Leroux, 1840; Chisholm, 1911) may be viewed as an ultimate goal of psychoanalysis, the final self-actualization or integration. Under this model, attributed

to French philosopher Pierre Leroux, individuals seek to maximize their individual liberty. In other words, they are free to be all that they are, and live a highly engaging and fulfilling life. At the same time, however, they must learn to treat others equally, and this goes directly to the ideals of inter-subjectivity, namely to avoid sado-masochistic engagements, and to be capable of intense, open communication in a manner which results in needs and wants being negotiated in an open, clear, and fair fashion. This would enhance if not define any true intimacy. Finally, the ideal of "fraternité" speaks to the broader moral appeal, namely that, for lack of a better phrase, people are all in this life together, and by implication even in relationship with the earth and the cosmos.

In the final analysis, most psychoanalysts would agree that, as Freud put it, successfully integrated and mature patients still face the inevitable pain of everyday life. Freud (1893-1895) famously writes that, "...much will be gained if we succeed in transforming your hysterical misery into common unhappiness" (p. 305). Perhaps more romantically, Lucaks' (1974) phrase briefly captures a way to describe the goal of psychoanalysis: "The voyage is completed: the way begins" (p. 73). Or, finally, in homage to Kierkegaard's (1968) remark that "an existing individual is constantly in the process of coming to be" (p. 68), effective psychoanalysis enlivens individuals' capacity for being.

Here we encounter an extremely difficult problem, and that is how to define goals for transformation without interfering with individuals' personal moral development. Using Lacan's work as a vehicle, Kirschner (2012) recently addresses precisely this ethical problem. Lacan (1959-60) advises psychoanalysts to help their patients find their desire. He famously writes, "Ne jamais ceder sur son desir," meaning "Never to cede or give ground to one's desire," an admonishment that isthe ethical principle specific to psychoanalysis. Kirschner adds that, for Lacan, "the whole analytic experience is no more than an invitation to the revelation of his [the patient's] desire" (p. 221). But what if the patient's desire is to commit an act of terrorism?

As Kirschner notes, psychoanalysts' desire to do good, to help, can also go astray. So the problem of achieving authenticity, of being who you are, of being the best you can be, of finding one's true desire, or of finding maturity, integration, individuation, and intimacy still evades the problem of morality. And so here the question of the higher, perhaps moral goals of the psychoanalytic process must be deferred to Kirschner and other writers.

The Management of Boundaries

The problem of boundary maintenance in clinical work may well prove to be the most crucial and imperative problem facing second paradigm psychoanalysis. Boundaries have ancient roots traceable to consideration of the social roles inherent in all of the professions. In his Nichomedian Ethics, 350 B.C.E., Aristotle writes of the crucial importance of the polis, by which he meant "political community." Viewing human beings as "political animals," he stresses that great consideration must be given to how persons relate to each other. It follows then that, even before considering paradigms or theories of psychoanalytic practice, psychoanalysts must begin by considering the social context in which they sell their services, including the boundaries within which they provide them.

Boundaries must be understood and maintained from the onset of the psychoanalytic process. They are far more important than theory. Because what psychoanalysts sell is a type of relationship – a transformative one – boundaries must be in place well before the work can even begin. They form the crucible of the psychoanalytic process. Psychoanalysts need not look into their own historical or current texts for guidance on boundaries. They should, instead, look to related fields, specifically sociology, cultural anthropology or, perhaps even political science, for answers. Certain well-established cultural and social dyads such as teacher-student, parent-child, priest-penitent serve as models that, in the final analysis, trump anything that can be offered, at least in terms of theory, in the entire history of the studies of boundaries in psychoanalysis.

Defining the extreme limits of the psychoanalytic encounter proves relatively straightforward. For example, sexuality on the one end, and aggression on the other, may be viewed as absolute end points of the container of the psychoanalytic process. Patients are emotionally vulnerable, particularly when considered in comparison with their analysts. The professionals providing the sought-after transformation are, in contrast, relatively invulnerable. Therefore, any type of sexual or aggressive behavior is a violation of their fiduciary responsibility. (The word, *fiduciary*, frequently viewed as related to finances, is derived from the Latin *fiduciarius,* meaning holding in trust, and relating also to trusting, ethical relationships such as between psychoanalysts and their patients).

Instead of falling prey to internal or external invitations for various boundary violations – many of which feel like a natural component of intimacy, that key feature of second paradigm psychoanalysis – psychoanalysts, by virtue of their professional role, instead must ride the wave of their patients' various experiences, intense affective states, projections and more. To use Gabbard's (1994) words, they "respond rather than react" (p. 76).

The real work lies in finding ways of navigating between the extreme boundary-limits noted above, namely sexuality and aggression, but in a fashion that neither alienates nor seduces the patient. This was far less challenging early in psychoanalysis, where the social roles between doctor and patient were so well established, but of course sexual misconduct was rampant then nonetheless (Gabbard & Lester, 1995). With the advent of the new paradigm, and its emphasis on intimacy, finding a middle ground not only proves elusive in general, but it must artfully be adjusted for each therapeutic dyad. For example, certain psychoanalysts may invite their patients to call them by their first name, but some patients may prefer to remain formal. Consistent with all that has thus far been written about second paradigm psychoanalysis, with its emphasis on building autonomy and strengthening subjectivity, the desires of that particular patient should certainly be honored.

As another example, consider just a small sampling of the literature available on self-disclosure under the second paradigm. Some degree of agreement exists, for example, that if self-disclosure exists at all, it should be limited to whatever is clearly in the best interests of the patient. Bass (2001, 2007) has explored how the relational (second paradigm) allows for more flexibility in this area, specifically noting that self-disclosure can at times be helpful to a patient, and at other times problematic. In discussing the differences between self-disclosure that results in a re-enactment of the patient's problematic internal drama from one which may open up fresh possibilities for relating, Bass (2007) writes, "The art of

psychoanalysis resides in how well we go about trying to tell the difference and how resourcefully we are able to manage to move forward with the work when we are unsure" (p. 11). Earlier, and from the realm of self-psychology, emerged the concept of "optimal provision" (Lindon, 1994, p. 549), a parallel idea that considers how much giving, i.e. hugging, offering of gifts, provision of advice, can be helpful but only if provided within certain bounds.

As a small component of my own psychoanalytic practice, I provide forensic mental health assessments, mostly in the area of administrative law which is concerned with the legal and regulatory guidelines governing the practice of various professions, including medicine, law, and the variety of occupations contained within the mental health field. During the last five years, many of the case materials I reviewed, or the mental health professionals I evaluated, used second paradigm or relational models as explanations for unprofessional behaviors. These include a female analyst who told her male patient that sexual encounters with her would help him with his sexual functioning; a male patient whose analyst told him that, apart from his lesbian-wife, she felt closer to him than to anyone else in his life; an analyst who incorporates monthly dinners out with one particular patient believing that it will enhance his progress in treatment; a male analyst who took a three-week international trip with a female patient on the grounds that he was treating her agoraphobia; and a male analyst who, working with a male patient struggling with communicating with his wife, invited the wife to an individual session (without the husband present) in order to help her understand the mind of the patient's wife. These fictionalized examples parallel real recent cases; they all represent violations of proper psychoanalytic boundaries, and again in each case the psychotherapists involved used the intimacy that characterizes second paradigm of psychoanalysis to justify their improper and ultimately counter-therapeutic behavior.

The aspirational psychoanalytic goals of presence and intimacy, of spontaneity and artful responses to the mutual dynamics that unfold in a session, or in sets of sessions, reaches vastly unexplored regions where boundary maintenance is concerned. The problem of boundaries, of defining the frame of the psychoanalytic encounter, will require extensive exploration as the second psychoanalytic paradigm unfolds. Again, because of the extremely harmful nature of boundary violations, such intensive study should be the highest priority for future exploration of the clinical aspect of second paradigm psychoanalysis.

The Role of Psychoanalytic Theory

Ideally, the proper affect of psychoanalysts, when first encountering their transformational partner, should be something akin to sheer terror. They should be fully aware of the distortions and limitations of the lenses which they view others. Knowing these obscurities in their vision, their limited knowledge of their own internal drama or their "organizational principles" (Stolorow, 1993), their unconscious personal cultural influences, etc., psychoanalysts encounter the unknown other. Further, it is only after patients have felt so carefully listened to, and that an in-depth effort has been made to understand them, that any hope exists at all that some theoretical model could then, and only then, be applied, by both parties, as a means of understanding. If applied at all, theory needs to comport to the internal drama or other organizational schemas of one or both parties, and perhaps should be chosen from an array of already extant theories in addition to whatever new ones the psychoanalytic dyad might develop.

The history of psychoanalytic ideas is rife with theorists discovering similar if not identical phenomena, and then writing their vision of the same basic concepts, often using their own unique nomenclature. Perhaps the best-known recent example of such is Kohut's (1977) development of self-psychology, a set of ideas that greatly overlaps with those explicated by Fairbairn (1952) several decades earlier.

Summers (1996) acknowledges this when he writes that the pointis not that Fairbairn had already developed Kohut's self psychology, but

> that the differences between them are not *paradigmatic* in the sense that self psychologists tend to believe they are. Rather, they are variations of the shared paradigm that the infant is initially object seeking and that development is a matter of the changing nature of the way objects are used. (p. 161)

But, in truth, Kohut's ideas nonetheless sound much like Fairbairn's, and even by Summers' admission greatly overlap with them, even if Kohut may well have discovered them independently.

The history of the development of theory seems more related to individual theorists, and to their spectrum of patients, then to some abstract, scientific, logical-positivistic model of theory. Atwood and Tomkins (1976) were among the first authors to suggest that every psychoanalytic theory has its roots in the personality of the theorist. They suggest that a general theory of personality will reach a greater degree of consensus "only if it begins to turn back on itself and question its own psychological foundations" (p. 166). As Atwood and Stolorow (1993) suggest in their book, *Faces in a Cloud,* psychoanalytic theory emerges, again, mostly from the personality of the theorist.

It indeed appears that psychoanalytic theory resulted from the unique, creative observations by particular psychoanalysts working with particular sets of patients and then collecting and codifying the resultant themes into a theoretical model. In a true Hegelian and Nietzschian sense, these psychoanalysts, many of who were charismatic, attracted many followers or "slaves," who adhered to the models of their teachers or "masters" (Nietzsche, 1908; Hegel, 1952).

Therefore, individuals seeking the help of psychoanalysts would be best served by finding professionals who are as open as possible, and free from pre-conceived, rigid theoretical viewpoints. Patients should beware of any "true believers" (Hoffer, 1951) in any theory, whether they are Jungian, Freudian, Kleinian, or Lacanian. Such psychoanalysts, by definition, have already restricted the freedom of their patients before the first session has even begun. Devotion to theory in the place of an intimate encounter with patients constitutes what Lacan (1973) calls "meconnaissance" (p. 83), literally a misrecognition or misunderstanding of the human subject, or what Sartre (1993) wrote in 1943 "mauvaise foi," meaning bad faith, a similar violation of the unique sanctity of the person.

In moving the second psychoanalytic paradigm forward, psychoanalytic theories must take an increasingly secondary, tertiary or even an absent role – this latter action could take the form of suspending theory. It is crucial that second paradigm psychoanalysts form intimate relationships, and then facilitate a transformational process that is open and in complete adherence to fiduciary responsibilities andprofessional boundaries. The transformational process of psychoanalysis usually proceeds through the use of the transference and the counter-transference as a vehicle, now seen as more of a matrix between the two parties, and often taking the form of types of enactments. In the

frontiers of the second paradigm, psychoanalysts become engaged in this complex interactional matrix. They enable transformation, offering non-technical observations that facilitate patient's reworking of their internal relational models. The transformational process precedes the formation of a theory. A theory is the result of the process, just as an event sets a precedent for the law.

The Social and Political Role of Psychoanalysts

Clearly the socio-economic role of the psychoanalytic profession needs further exploration and study, including how or even if psychoanalysis itself might or might not fit into the medical-industrial complex. Looking at psychoanalysis from the viewpoint of liberal democratic capitalism, consumers pay certain professionals, called psychoanalysts or psychoanalytic psychotherapists thus far, to achieve some sort of change in their behaviors, attitudes, thoughts and/or feelings. By instituting the formal re-naming of this type of service as provision of transformational encounters – a topic to be addressed soon – the field of psychotherapy and psychoanalysis butts up against a terribly complex barrier resulting from the extant medical-industrial complex.

In accordance with Fairbairn's model of development that considers "mature dependency" (Fairbairn, 1941, p. 260) the developmental goal (instead of independency), consenting adults understand that times arise when they need the help of professionals such as lawyers, physicians, accountants, financial advisors, and the like. Like it or not, this kind of categorization of services now occurs internationally. The question as to how the profession of psychoanalysis fits into this mix lingers. Are they charged with the treatment of mental health conditions still? Or are the services they provide broader in nature, say personal growth, for lack of a better phrase, or proffering a relationship that helps individuals with mental pain and troubled lives?

Unfortunately, because of the limitations imposed by the modern period, the field of psychoanalysis remained imprisoned in the medical model, particularly in America. But in truth, and as noted previously, psychoanalysts are quite the opposite of medical doctors. They have no technology whatsoever to offer, save a form of interpersonal influence that takes a few simple forms as previously noted: interpretations, clarification of feelings, confrontations, attunement, explanations and other rhetorical devices. Physicians have extensive knowledge of human physiology, and have access to a vast array of technology ranging from anti-biotic medication to nuclear radiation to treat many varied medical conditions. (Actually, medicine could be greatly enhanced through the use of an I-Thou relationship as a vehicle for medical healing, and this would be worthy of at least a book, particularly given the now-international trend towards a heightened industrialization medicine, resulting in human patients being treated ever more like objects).

In terms of the history of economics, psychoanalysts sell their relational wares in a fashion much more consonant with medieval times than with the industrial or post-industrial periods. Some situations exist in which psychoanalysts work in large medical settings, such as teaching hospitals or community clinics, but even in those settings there exists one person, the psychoanalyst, selling one service, transformational encounters, to one other person, the patient who is in turn the agent of change. The work of the psychoanalyst has almost a craft-like quality to it, and each analyst sells a unique craft in consonance

with his or her personality and that of their patient. For psychoanalysts, their media is the bounded relationship, structured for the creation of some kind of alteration in mood, attitude, behavior, relational theme, or more.

Further, those interested in seeking the help of relational psychoanalysts, or whatever they might call themselves under the second paradigm, need to be well-informed as to the goals of that particular type of work. Individuals seeking relief from well-identified "symptoms," such as a social phobia, for example, or a problematic habit, such as cigarette smoking, may well be better served by consulting professionals using a one-person, expert-novice model, such as a cognitive-behavioral therapist. Those therapists tend to work in the role of a specialist offering specific techniques, i.e. muscular relaxation exercises, desensitization procedures and the like, to relieve symptoms. Similarly, individuals suffering from what will almost certainly soon prove to be neurological conditions, such as Major Depression, Bi-Polar Disorder, or Schizophrenia, will require the help of physicians, specifically neurologists or psychiatrists, trained in the provision of psychotropic medications. Ideally, the patients of these physicians would have maximal agency and be able to apply *caveat emptor* to their interactions with these medical providers. But, again, psychoanalysts work in a different fashion, one that honors the subjectivity, authenticity, and autonomy of those consulting them, whether or not a physician has diagnosed them with a form of mental illness.

Therefore, psychoanalysts should more properly be viewed, in terms of their social role, much more like teachers or clergy people than like physicians. In a certain sense – and this likely elicits discomfort from readers – psychoanalysts are similar to prostitutes in that they, like those working in the "oldest profession," are in fact selling a form of relationship. Perhaps, as Fairbairn suggested, and since they delve into dangerous areas of the unconscious, psychoanalysts are more like shamans, spiritual healers, or even exorcists. Fairbairn (1943) writes, *"the psychotherapist is the true successor to the exorcist, in that he is concerned, not only with 'the forgiveness of sins', but also with 'the casting out of devils'"*(p. 70, my italics).

By entering into an intense, intimate relationship with their patients, psychoanalysts give with their beings. Like the exorcists that anticipated them, they literally take their patients' feelings, attitudes, ideas, and more right into their psyche-somas. Lacan (2002) believes that "the patient is not alone in finding it difficult to pay his share," adding "the analyst too must pay" (p. 216). He proceeds to describe how psychoanalysts give with their words, namely offering ideas and interpretations; they give with their personhood by allowing themselves to be a screen onto which patients project their internal dramas, and; they give with their actual beings by becoming immersed in a relationship that affects their entire psyche-soma.

Similar to those in the acting profession, who are advised to use their body as "an instrument" to communicate with their audiences, psychoanalysts use their entire beings as a vehicle for change. In their efforts to help individuals who present with chronic low self-esteem, crying spells, unending mourning, a history of being in the victim role in abusive relationships, or any number of painful problems of living, psychoanalysts enter into an intense but structured intimate relationship with them intended to facilitate transformation.

To approach a limit of being provocative, perhaps psychoanalysts should also be viewed as revolutionaries. With their patients as co-conspirators, they throw Molotov cocktails against defensive structures, blocking the problematic internal dramas and, after the walls have fallen and both parties have been possessed by their mutual dramas, together they create a new, more integrated dramatic theme, a new government based on fairness, authenticity, and reciprocity.

Ideas for a New Nomenclature

Linguistically, the term *psychoanalyst* denotes a single person acting in the role of doctor **(**a noun-like entity**)**, allegedly analyzing **(**a verb-like activity**),** psyche (also a noun-like entity). Second paradigm psychoanalysts do no such thing. Instead, they apply their expertise to createintimate encounters intended to facilitate transformation in those who choose to consult them. These meetings are much more accurately represented by the phrase *transformational encounters.* As I noted earlier, psychoanalysts are experts in establishing and then analyzing intimacy within a directive, bounded context.

Early in his career, Freud (1926) struggled with language for the profession. He also failed to view psychoanalysis as a technical intervention. In a letter to his friend William Fliess, in 1888, Freud indicated that his “technique” consists of “talking people into and out of things” (p. 18). He also sought different descriptions of his occupation in the post-script to his 1926 paper, “The Question of Lay Analysis.” In place of the word *psychoanalyst*, he considers the phrase “secular pastoral worker,” adding that he reaches that conclusion because psychoanalysts explore the meaning in patients’ lives.

A half-century later, Szasz (1965) also sought a more accurate description of the psychoanalyst. He recommends that psychoanalysts use “iatroi logoi,” a phrase meaning “healing words” in Greek, to describe the way they offer personal change. He suggests that the word for “the modern, secular cure of souls” be “iatrologic” and for psychoanalysts themselves to usethe word “iatrologicians” (Szasz, 1978, p. 208)**.**

Sullivan (1954) suggested replacing *psychoanalyst* with the phrase “participant observer” (p. 18). Fairbairn (1958) liked the word “interventionist” (p. 375). These phrases and words are well-intended and highly accurate in some ways, but they fail to address emotion, interpersonal dynamics, and many of the other extensive and complex elements of the psychoanalytic encounter.Linguistically, the term *psychoanalyst* denotes a single person acting in the role of doctor **(**a noun-like entity**)**, allegedly analyzing **(**a verb-like activity**)**, psyche (also a noun-like entity). Second paradigm psychoanalysts do no such thing.

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In place of archaic words like *analysand* or *patient*, the word *agent* would seem more accurate. This captures the element of autonomy and self-control, despite how contextualized is that concept. It also implies human freedom.

Regarding the word *psychoanalysis*, to compile the complexity of contextualism and embeddedness of our field into a single term is impossible. While the word has nostalgic appeal, it has proven elastic enough to tie together and name a field that includes scholarship as well as treatment. Considering, again, that Freud spoke of his work as a "technique" that consists of "talking people into and out of things" (1926, p. 18), the word *psychoanalysis* has always been a *working term*.

Given the immensely complex and dynamic nature of their work, these unusual professionals, and the unique services that they provide, lack sufficiently accurate and descriptive terms for what they do andhow they describe their work to each other. Establishing a precise description for the sociocultural roles and even names for psychoanalysts and what they do, particularly those working within the second paradigm, has clearly defied description, at least thus far. Much further work in this area remains to be done.

Conclusion

In moving forward with the clinical element of the second paradigm of psychoanalysis, the field must embrace how the psychoanalytic process has left the traditional roles of doctor and patient behind. In brief, the process centers on how both parties to the psychoanalytic dyad engage in an intimate but asymmetrical transformational process. Together they become immersed in unconscious dramas, calling out or even becoming possessed by bad objects or organizing principles, and then enacting them, commenting on them, and ultimately altering them. And yet much work remains to be done on how psychoanalysts, or interventionists, facilitate transformation in their patients.

Of course also much greater exploration of goals lies ahead, but the second psychoanalytic paradigm has definitively transcended the original medical origins of psychoanalysis. Whereas psychoanalysis remains useful and effective in treating certain mental health problems, its ken has expanded to a quest for clarity of subjectivity and, with it, greater authenticity, increased capacity for interpersonal intimacy, and perhaps even a broader compassion for all human subjects.

Because of the centrality of clinical intimacy in the second psychoanalytic paradigm, psychoanalytic boundaries require much greater definition. Sexual misconduct and other less dramatic forms of boundary violations appear to be occurring more commonly, sometimes with relational theory serving as an excuse for such behavior. Extensive, additional questions regarding therapeutic boundaries require answers, for example how much should psychoanalysts self-disclose, should sessions always be in consulting rooms, and what are the limits of psychoanalysts' intervention? Second paradigm psychoanalysts struggle with the bounds of their openness, artistic freedom, spontaneity, and intimacy inherent in their work. Answers to these problems will allow clinical psychoanalysts to take their place, with integrity, among the other helping professions.

Some application of psychoanalytic theory will likely be a required part of the psychoanalytic process, but this must be applied carefully, gently, and in such a fashion that subjectivity is not violated. The problem of theory centers on the realization that, if a map is roughly analogous to the terrain it describes, psychoanalytic theory is a terrible map. It may not be analogous to the person or to the therapeutic dyad at all or, worse, it may be violate and objectify the parties. Mathematical models such as dynamic systems theory are amazingly interesting, from a purely intellectual perspective, but offer little relevance to the work of the clinical psychoanalyst. The actual unfolding of a psychoanalytic session or even sets of sessions behaves much more like music or dance, and can therefore never be reduced to a model or a formula.

Psychoanalysts might most appropriately greet the beginning of a *transformational encounter* with a sense of fear at the unknown worlds that lie before them. The process should then proceed with a phenomenological exploration of the mysterious personhood of the patient, and perhaps finally involve the use of psychoanalytic theory to facilitate the transformational process. Because of the risk of objectification, extreme caution is in order. As Taleb (2007) puts it, “A theory is like medicine (or government): often useless, sometimes necessary, always self-serving, an on occasion lethal. So it needs to be used with care, moderation, and close adult supervision”(p. 285).” But there might yet be a place for it. Klein (1957) was so brilliant, for example, in opening up the entire area of envy and its many problematic manifestations.

By surrendering to the idea that psychoanalysts offer no techniques and that they sell intimate transformational encounters, psychoanalysis and, by extension, psychoanalytic psychotherapy, will begin to encounter difficulties with the medical-industrial complex. That internationally dominant model of health-care delivery seeks specific procedures administered by providers to patients. So as the field descends into the rabbit hole of seeking understanding of depth psychotherapy as sets of transformational encounters, clinical psychoanalysis will need to seek pathways for working within or outside of this medical paradigm. One option is of course to continue to lie, i.e., to treat the “psyche” as if it is some sort of a “thing” subject to “treatment.” The other option would be to educate the public about the subtleties of the process, and how it eludes traditional professional categorization.

The ideas regarding new nomenclature offers the possibility for growth in terms of being more accurate in our collegial communications, whether psychoanalysts are contacting each other regarding their transformational encounters or are writing about their work in scholarly papers or books. Clearly this area needs much greater elucidation. The words suggested in this paper may not sufficiently capture the complex nature of psychoanalytic work. The phrase *transformational encounter* seems entirely accurate and useful, albeit somewhat awkward. Whether the use of words like *interventionist* and *agent* prove useful remains to be seen.

So now this paper draws to an end with a fairly clearer view of the second paradigm in psychoanalysis, and with an equally clear vision of its clinical frontiers. Readers have now been introduced to the nature and goals of transformational encounters, the need for clearer boundaries in the work, the difficulty involved in applying psychoanalytic theory in the clinical process, the socio-economic context of second paradigm psychoanalysis, and the challenge of finding new nomenclature for use in the psychoanalytic

profession. Extensive, further exploration remains to be done, including but not limited to what lies beyond inter-subjectivity, e.g., biological, ecological, and even cosmological substrates, what are the philosophical and historical foundations of this profession, where science fits into the second psychoanalytic paradigm, and how psychoanalytic training needs to change significantly. I now defer to my colleagues around the world to boldly break through the frames of this one scholarly contribution and courageously move forward with the continually evolving world of psychoanalysis, now entering the frontiers of its second century.

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