"The Analyst is Present":

Viewing the Psychoanalytic Process as Performance Art

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Abstract

Since its establishment as a profession, psychoanalytic practitioners have struggled with understanding the true nature of their work. Many remain devoted to Freud's medical model and aspire to establish a logical-positivistic basis for psychoanalysis. Others view the field more broadly, and consider psychoanalysis a distinctively humanistic discipline. This paper suggests that the bifurcation may be resolved by focusing on clinical as opposed to theoretical psychoanalysis – an emphasis that illuminates its artistic elements. Psychoanalysts' work may be likened to performance artists, primarily because they work to create an *experience* in their patients. Additionally, they give with their psyche-somas, reminiscent of how actors use their bodies as instruments; they face each session in a fashion akin to how painters face the white canvas or writers the blank page, and; they choose from an infinite number of possible models for co-constructing ways of understanding their patients' experiences. Regardless of past or future theoretical differences, psychoanalysts provide creative, transformative experiences most accurately described as *transformational encounters.* Psychoanalysis is a verb, a process. While it alleviates pain caused by various mental disorders, it also assists persons in discovering their individuality, authenticity, and singularity. In support of the artistic foundation of the psychoanalytic process, the paper includes three scenes that demonstrate how patients experience precipitous, essential breaks in their repetitive, internal dramas, resulting in them experiencing themselves as *beings*, capable of change. It thereby demonstrates how psychoanalytic

practitioners bring something new to life, further validating how psychoanalysis qualifies as an artistic endeavor.

Keywords: psychoanalysis, transformational encounters, performance art, intersubjectivity, humanism, hermeneutics.

Paper

In 1896, when Freud coined the term "psychoanalysis" (Gay, 1988, p. 103), he created a technique specifically applicable to patients with mental disorders. Consonant with this initial view of the process, the first psychoanalysts treated individuals suffering from such Victorian-era termed disorders as obsessional neurosis, hysteria, and melancholia. Yet, even in those early years, Freud and other practitioners struggled with the actual nature of their work. Some patients presented with distinct symptoms like anxiety or depression; others sought help for concerns about their work, their relationships, or other, wide-ranging elements of their life experiences. Were these pioneer psychoanalysts actually treating distinct mental illnesses, or were they helping individuals explore the meanings of their lives? By the mid-20th century, the burgeoning controversy regarding the precise aims of psychoanalysis flowed into two distinct streams.

Many psychoanalytic practitioners remained devoted to the exclusively medical vision. They applied techniques like confronting ego defenses – exposing the emotionally painful, unconscious conflicts patients were masking – thereby reducing psychological symptoms. Using the sine qua non of the psychoanalytic process, these analysts focused on transference as the vehicle for their treatment. Such psychoanalysts typically sought scientifically based sources of information. They pursued observational studies of infants, researched cognition and emotion, conducted outcome studies, and otherwise leaned towards the

scientific in an effort to establish an empirical basis for psychoanalysis. They believed the field would persist as one intervention among many, alongside psychopharmacology and cognitive-behavioral therapy, in the cadre of treatments for mental illness.

Other psychoanalysts, particularly during the last fifty years, applied their techniques with broader strokes. They utilized their training to help those with difficulties that defied traditional medical categorization, such as persons who felt socially alienated, failed to achieve romantic intimacies, felt personally inadequate, or found their lives meaningless. While not hostile to science, these psychoanalysts worked, wrote, and researched in more humanistic realms. They sought information outside of their field – in literature, philosophy, and history – to find support for their work. They believed these disciplines offered greater insights into human subjectivity than could the sciences alone. They viewed their work as hermeneutical and exploratory rather than as a process solely intended to cure illnesses. Orange (2011) notes that, because of Freud's "stronger insistence on the status of psychoanalysis as a natural science, our awareness of psychoanalysis as hermeneutics has arrived only recently" (p. 2).

Despite its having been tossed and turned by the streams of scientism and humanism, psychoanalysts, regardless of their particular theoretical orientation (Freudian, Jungian, Kleinian, etc.), have consistently relied upon, and written about, four foundational tenets: the idea that an unconscious mind exists, that some kind of force or drive motivates human beings, that individuals tend to form repetitive psycho-behavioral patterns (the repetition compulsion), and that these unconscious features tend to be projected onto the psychoanalytic relationship in the form of the transference. The four foundational themes were originally delineated by Freud (1914), and later elaborated upon by others including Lacan (1978), Rangell (2006), and Harari

(2004). Of course psychoanalysts also attend to other signs of the unconscious, such as dreams or parapraxes, but these four elements provided steady points of reference.

Unlike physicians, armed with stethoscopes, syringes, medications, EKG machines, thermometers, and other forms of technology for evaluating and treating patients, psychoanalysts greet their patients solely with their *beings.* They bring no interventional technologies to the process. They offer reverie, containment, interpretation, confrontation, empathy, and similar rhetorical or interpersonal influences to promote transformation in their patients. Whereas artistry certainly comprises a component of what other professionals provide, psychoanalysts work *entirely* within the interpersonal relationship, rendering the artful element of their services more central.

The Shorter Oxford English Dictionary (2002) defines art as "the application of skill according to aesthetic principles, esp. in the production of visible works of imagination, imitation, or design" and as "skillful execution of workmanship" (p. 122). Inarguably distinct from each other, art and psychoanalysis nonetheless share critical features, by definition and by practice. Psychoanalysts apply skills according to aesthetic principles (taking the form of technique arising from theory), produce visible works (evident in the transformational experiences for their patients), and execute their workmanship (through the interpersonal effects just noted). Although they may not formally identify it as such, their artistry may be likened to a form of performance art.

The Nature of the Psychoanalytic Process in Real Time

This paper delves into the psychoanalytic process *from the inside,* meaning the subjective experience of the session, as it actually unfolds, in real time. Psychoanalysts create and manage intensive interpersonal relationships intended to be transformative for patients. They concern

themselves with the *beings* of patients. Therefore, their clinical work, given its artistic nature, resides in the realm of humanism. For the purposes of this paper, the word *humanism* – fraught with different and conflicting meanings – refers to constellations of philosophical and ethical perspectives that emphasize human subjectivity and privilege the value and agency of human beings. And that returns this discussion of the psychoanalytic process – one that could never be reduced to an equation – back to the arts, especially performance art. The psychoanalytic process requires spontaneity and improvisation by psychoanalysts, rendering it an artistic production. Psychoanalysts have a unique opportunity for responsively and actively treating persons whose relief from suffering requires a certain kind of change: A transformative *experience* of enduring significance.

Therefore, in place of the word psychotherapy, or psychoanalysis, I propose the phrase *transformational encounters* because this more accurately describes what actually occurs in psychoanalysts' offices. The *psycho* component of the word psychotherapy or psychoanalysis implies a fixed physiological entity, like a liver or kidney, while in truth the *psyche* is more verb than noun. An extremely dynamic entity, *psyche* arises out of many complex determinants – biological, cultural, historical, social and more. The *therapy* component suggests treatment of an illness that represents but one feature of how psychoanalysis can be utilized. In a similar vein, *analysis* implies a sequential, linear process that fails to account for the dynamism and creativity of actual psychoanalysis.

Individuals, patients, analysands – variously named – seek the assistance of professionals called psychoanalysts for a variety of reasons. Orange (2011) calls them "fellow sufferers" (p. 4), and explains how the word "patient" derives from the Latin, *patior,* which means to suffer, to undergo. Once these persons consult psychoanalysts, they engage in sets of meetings that –

precisely because the transference forms the cornerstone of the process – consist of interpersonal *encounters* intended to achieve a form of *transformation*. As previously noted, these transformational encounters correspond uniquely and fundamentally with performance art; conversely, these have little in common with clinical procedure as it is currently accepted and defined in medicine.

But one example of the central role that artistry plays in the psychoanalytic process, psychoanalysts make choices about design elements of the space in which they apply their interventions well before meeting their first patient. The more conservative psychoanalyst's consulting room may tend towards the spare, and appear more traditionally office-like. Such strategic choices may ensure that projections are focused more onto the analyst. They reduce possible distractions caused by ornate furnishings. In contrast, psychoanalysts who privilege the relational elements of the process may make decorative choices intended specifically to buttress, even comfort, patients when they experience uncomfortable emotional states. These analysts emphasize patients' emotional safety over the potential for distraction. Their walls may be softened by paint, and three-dimensional décor, such as books, lamps, and paintings, may purposefully create the feeling of a living room in a comfortable home. Psychoanalysts plan, deliberately and creatively, setting the stage for their transformational encounters. Winnicott, who apparently worked in a rather classical fashion, nonetheless demonstrated a warm personal style in his actual interactions with his patients (Little, 1990). Orange (2011) writes of Winnicott, "his style, including his office, seems to have been informal, unpretentious, and welcoming" (p. 163).

When the patient enters the consulting room, the curtain lifts. The psychoanalytic performance begins. The patient meets the psychoanalyst, trained in a variety of psychoanalytic

theories, having undergone years of psychoanalysis, and ready to receive whatever patients care to report, describe, or enact. The psychoanalytic process subsequently unfolds in accordance with the theoretical leanings of the psychoanalyst but, more importantly, in a manner influenced by the unique features of each "therapeutic dyad" (Freedman 1980, p. 259). Whether the initial session or the fiftieth one, the psychoanalytic process differs sharply from standard procedures in physicians' offices. Patients presenting with a sore throat to a specialist in internal medicine will be subjected to a fairly consistent set of procedures including examining the mouth, throat, and neck and ordering laboratory tests to assess for an elevation in white cells. Patients presenting for psychoanalysis can expect no such standardized procedures. On the contrary, the process will vary, usually quite markedly, depending on the personalities of the participants, their aesthetic styles, and the theoretical orientation of the psychoanalyst.

Patients in psychoanalysis may have similar experiences with psychoanalysts of the same theoretical school. If consulting conservative psychoanalysts, for example, they may well find a commonality in the use of silence, in the frequency of questions asked, and in the generally more passive approach. But even such commonality in technique would vary greatly depending on the specific qualities of each unique psychoanalyst-patient dyad. Psychoanalysts cannot help but use their personal styles to establish an intimacy that is "mutual but asymmetrical" (Aron, 1996, p. 43). Their tools consist of their personalities and styles, a variety of interpersonal influences as noted above, and a focus on the four tenets and other signs of unconscious processes. Their work progresses in a fashion analogous to the way a director of modern dance uses choreography, a painter uses brushes, or a writer uses the keyboard.

A feature of the first one hundred years of its existence, psychoanalysis tended to spawn competing schools that suggested if not required practitioners to adopt certain attitudes and apply

certain techniques in conducting their work. Generations of psychoanalysts learned to put their "singularities" (Ruti, 2012) aside in order to attend to certain proscribed elements of the psychoanalytic process. They might, for example, explore stages of psychosexual development (if Freudian), archetypes and imagery (if Jungian), envy and aggression (if Kleinian), environmental impingements (if influenced by Fairbairn, Winnicott, or other British Object Relations theorists), or the subtle dance of inter-action during sessions (if Self-Psychological, Intersubjective or Relational).

Their patients, in turn, have as many stylistic variants as their psychoanalysts: Some present with triangular love situations that fit the Freudian model, and others with aggressive fantasies that comport with the Kleinian model. Jungian theory may work well with persons actively reporting dreams, particularly if they have mythological or anthropological themes. Some patients are highly emotional; others more cognitive. Some wait passively in silence for their psychoanalysts to speak; others express highly personal, emotionally vulnerable information when first greeted in the waiting room.

As I argue when presenting the performative aspect of psychoanalysts' actual work, these personal, stylistic features – in psychoanalysts and in their patients – typically prove more significant than the theory guiding the process. Theory results from a collective enterprise featuring argumentation, criticism, and revision. Burke (1954) writes, "*Theory* (literally, a *looking-at,* or *viewing*) plays a large part, not only in the technique of the physician, but in the patient's response" (p. 125). Psychoanalysts will continue to elaborate upon old, or to develop new, ways of viewing the mind as well as the psychoanalytic process. I submit, however, that personal styles – influences that have been marginalized in psychoanalytic theory development – are, in truth, crucial elements of the transformational process. (Such styles even influence choice

of or comfort with a particular theory). For example, the personality of an extremely gregarious, outgoing psychoanalyst trained in traditional Freudian analysis will arguably have a greater effect on the process than his or her devotion to that theory. A rather cold, emotionally distant psychoanalyst trained in the Relational school may similarly – although immersed in an entirely opposite theoretical perspective emphasizing a more engaging, interpersonal approach – demonstrate more of the neutrality characteristic of the earlier, more conservative schools. These ideas resonate with Stolorow and Atwood's (2002) suggestion that the "impact of the analyst, of his interpretive activity, and his theoretical preconceptions, whatever they may be…" (p. 102) must be considered primarily from the viewpoint of the subjectivities of psychoanalysts and their patients.

Psychoanalysts working within certain theoretical viewpoints make spontaneous and highly creative decisions, on a moment-to-moment basis, during each psychoanalytic session – much like artists standing before their canvases and authors sitting before their keyboards. Theory, which risks objectification of psychoanalysts and patients if adhered to excessively, influences the process like the genre of an artist or a writer influences their craftsmanship. Psychoanalysts devoted to more traditional themes of neutrality and abstinence demonstrate creativity in the way they time their interpretations, suppress certain emotions, such as sympathy, avoid asking questions, and eschew offering reassurance. Alternatively, Lacanian analysts, steadfastly focusing on linguistic features of the work, make spontaneous decisions about selecting which words to pursue. Self-Psychologists, Intersubjectivists, or Relationalists similarly make certain strategic decisions regarding empathic attunement.

Just as artists encounter limitations related to the medium with which they work, i.e. the size of the canvas on which they paint or the piece of marble that they sculpt, psychoanalysts

face numerous limits including their personhood, the varieties of interpersonal influences already noted, and session length and frequency. Countless creative choices nonetheless exist. In fact, limitations are notorious catalysts for innovation.

Previous Views of Psychoanalysis as Art

When he moved from the suggestive technique to the analytic one, Freud (1905) compared suggestion to painting and analysis to sculpture. He writes that sculpture "proceeds per *via di levare*, since it takes away from the block of stone all that hides the surface of the statue contained in it" (p. 260). Loewald (1980), one of the first psychoanalysts to consider his work as primarily artistic in nature, explicitly compared psychoanalysis to drama. He believed that psychoanalysts and their patients together create, produce, and perform a play. 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" (Loewald, 1980, p. 369). Winnicott (1955) refers to "psychoanalysis as an art" (p. 24). Of him, Orange (2011) writes, "Both process and spirit embodied a two-person creative aliveness" (p. 162).

Bion (1965) described psychoanalytic work as a "transformation, analogous to the artist's painting that is a product of the particular artist's approach" (p. 8-9). According to Jacobus (2005), Bion viewed the psychoanalytic encounter as "a site of turbulence, a mental space for further ideas which may yet be developed'" (p. 258). Years before Hoffman (1998) presented his dialectical-constructivist model, Bion (1991) had already documented the dual role of the analyst observing and participating, acting as subject and object at the same time. Lacan (1979) viewed psychoanalysis as fundamentally an artistic endeavor, writing, "psychoanalysis is perhaps the only discipline comparable to those liberal arts, inasmuch as it preserves something of this proportional relation of man to himself—an internal relation, closed on itself, inexhaustible,

cyclical …" (p. 406). Psychoanalytic methods, he adds, are "derived from that fundamental art of psychoanalysis […] constituted by that inter-subjective relationship which, as I said, is inexhaustible since it is what makes us human" (p. 406). Szasz (1988) believed that psychoanalysts' "activities would constitute, and be classified as, art rather than science" (p. 208).

Bollas (1987) describes the psychoanalytic process as a performance in the sense that, in order to find their patients, psychoanalysts "must look for him within ourselves" (p. 202), adding "we are being taken into the patient's environmental idiom, and for considerable stretches of time we do not know who we are, what function we are meant to fulfill, or our fate as his object" (p. 202-3). Symington (2002), describing how patients engaged in psychoanalysis mourn, writes, "if the death is photographed, it does not become emotionally real; if it is painted, it does" (p. 68). More recently, Ringstrom (2001, 2007, 2008, 2012) has explored the role of improvisation in the psychoanalytic process. He contends, as do I, that psychoanalysts must be emotionally present, responsive, prepared to engage with a variety of personalities, and that psychoanalysis may be likened to drama. Ringstrom (2012) believes "the improvisational metaphors of scripts, assigned roles, dramatic arches, and sequences" allow psychoanalysts to "expect (and direct) the other to be in each present moment" (p. 470).

Scholars outside of psychoanalysis have similarly commented on the artistic elements of the field. Burke (1966) argues that not only literary, but all fields of human study, such as psychoanalysis, cannot understand human motivation without considering its necessarily theatrical, dramatic elements. By applying the "dramatistic" (p. 63) lens to any human production or experience, Burke intends that literary critics, audiences, and professional observers of human behavior, including psychoanalysts, generate heuristic or exploratory

responses (as opposed to closed, deterministic conclusions). Toward this end, he proposes a "dramatistic terminology (built around a definition of man as the symbol-using, symbol-misusing, symbol-making, and symbol-made animal)" (p. 63). Human motivation is performed, he suggests, through the "dramatistic pentad: act, scene, agent, agency, and purpose" (Burke, 1945, p. 538). He writes that, "the difference between a thing and a person is that the one merely *moves* whereas the other *acts*" (Burke, 1966, p. 53).

Writing from a multi-disciplinary perspective, Burke (1954) opposed the growing reliance on purely deductive studies in all fields. He thinks poetry reveals the "concentration point" (p. 66) of human desire. Considering scientific approaches to understanding human motivation a form of rationalization, he recommends a "corrective" (p. 66) in the form of "a *rationale of art* – not however, a performer's art, not a specialist's art for some to produce and many to observe, but an art in its widest aspects, an *art of living*" (p. 66). Encountering the many varieties of the human experience, psychoanalysts immerse themselves, in their daily work, in their patients' theatrical constructions of their lives. Their manner of engaging them similarly resides in the realm of the dramatic, as Loewald (1980) also noted.

Butler (1997, 2005) suggests that humans, on some level, perform their actions, their feelings, and their speech. She writes, "Language is the name for our doing: both "what" we do (the name for the action that we characteristically perform) and that which we effect, the act and its consequences" (1997, p. 8). Although referring to identity formation, rather than to the artistry of psychoanalysis, Butler (2005) writes that when we speak of our selves, "we become speculative philosophers or fiction writers" (p. 78). In a similar vein, Orange (2011) observes how psychotherapies, generally, focus on language. She adds, "language, resonant and heavy with history, is its medium, and the participants inhabit it, as other artists inhabit their media" (p.

22). Psychoanalysts' utilize elements of literary criticism and applied philosophy, respectively, as they illuminate the ideologies and narratives of their patients. From within psychoanalysis, and from outside the discipline, many scholars compare the psychoanalytic process, and even the experience of being human, to drama or theater.

The Artistic Nature of the Psychoanalytic Process

Hoffman's (1998) dialectical-constructivist model offers a clinically useful, descriptive view of the psychoanalytic process without adhering to a specific psychoanalytic theory. It thereby more clearly acknowledges the artistry inherent in the psychoanalytic process. Unlike specifically Freudian or Jungian recommendations for technique, for example, Hoffman's model invites flexibility in theoretical modeling and in clinical method. The phrase "dialectical-constructivist" concisely if broadly defines the nature of the inter-personal, contractual service called psychoanalysis. The dialectical component of the phrase refers to the manner in which psychoanalysts become engaged in *relationship* with their patients in dichotomous and paradoxical ways; the word constructivist allows psychoanalysts and their patients to either choose from myriad extant theory or create their own, unique models for explaining recurrent unconscious themes.

Beginning with the dialectical component of psychoanalytic work, Hoffman describes a paradoxical process. On the one hand, psychoanalysts receive invitations into any number of enactments propelled by their patients' unconscious schemata, their own, and the combination of the two – a concept captured by Ogden's (1994) idea of "the analytic third" (p. 4). Essentially all psychoanalytic theorists agree that the *unconscious inner world* or *the internal object world* – which I prefer to call *the internal drama* – influences if not possesses the psychoanalytic relationship itself. On the other hand, by virtue of the service they sell, psychoanalysts pull away

from their relationships with their patients – immersed as it is with unconscious, dramatic themes – and reflect, plan, intervene. The dialectical component of Hoffman's model consists of this back-and-forth, this dance of engagement and dis-engagement, of subjectivity and objectivity, of being invited into enactments and then withdrawing in order to interpret them or intervene in some way.

Regarding the constructivist element, psychoanalysts, in partnership with their patients, create models of what motivates a particular patient, of their internal unconscious drama, of the meaning of the repetition compulsion, or of how those themes map onto the psychoanalytic relationship. They offer interpretations, confrontations, empathic attunement, or other ways of engaging patients. The creativity inherent in the psychoanalytic process resides primarily within the constructivist component of Hoffman's (1998) model. Psychoanalysis emerged – not from magic or in isolation – from Freud's early writings. Its roots lie in millennia of writings in philosophy, history, political science, literature and more. Psychoanalysts use the hand of human history – its humanism – in offering ideas about what motivates patients, how their unconscious internal dramas were forged, the nature of the repetition compulsion, and the "third" element (Ogden, 1994, p. 4) that dynamically possesses psychoanalytic relationships.

Regardless of their theoretical stance, psychoanalysts ideally strive for presence in real time, shoring back natural feelings when they consider what would be most effective in fomenting transformation. Psychoanalysts embody separate professional and personal personas, but their subjective selves persist, of course, across their varied social roles. In some ways, psychoanalysts behave much like actors who similarly manage their emotional experiences while performing. Actors' skills may often be judged in terms of their effectiveness in either hiding their feelings or demonstrating emotional states alien to their authentic selves. Further, they

behave differently when on stage. They adjust their theatrical work in reaction to the varied states or styles of different audiences. In much the same fashion, psychoanalysts occupy a distinct professional role and, regardless of their particular doctrine or style of practice, modify their professional behavior to comport with their patients' unique styles. Not only psychoanalysts, but also their patients play roles in a way that Butler (2005) calls "performative," affected by what Burke (1966) calls their "terministic screens" (p. 44). Exemplifying his concept, and referring to dream interpretation, Burke describes a man who

> reports his dream to a Freudian analyst, or a Jungian, or an Adlerian, or to a practitioner of some other school. In each case, we might say, the 'same' dream will be subjected to a different color filter, with corresponding differences in the nature of the dream as perceived, recorded, and interpreted. (It is commonplace that patients soon learn to have the kind of dreams best suited to the terms favored by their analysts) (p. 46).

Performances and terministic screens are affected by myriad influences, including of course the multiple elements affecting patients' internal dramas, and the personal styles and theoretical schools to which their psychoanalysts adhere, as Burke suggests in this excerpt regarding dream interpretation. Context exerts influence as well. The same patient who openly rages against her parent in the consulting room may remain silent in his or her living room at home. By inference, then, psychoanalysts and their patients, in the course of their conjointly created psychoanalytic process, cause the fourth wall to vanish – consistent with Loewald's (1980) observations. They engage in a fashion comparable to a theatrical performance.

Psychoanalysis as Performance Art

The term “performance art,” related to postmodernist traditions in Western culture, emerged during the 1960s and 1970s out of concepts of visual art. Its precursors include work by Antonin Artaud, Dada, the Situationists, Fluxus, Installation Art, and Conceptual Art (Parr, 2010; Goldberg, 2001; Goldberg & Anderson, 2004, McEvilley, 2012; Pena & Sifuentes, 2011). Considered the antithesis of theater, performance art nonetheless features a relationship between performer and audience. Ideally, it contains, by definition, an ephemeral and authentic experience for both parties, “an event that cannot be repeated, captured, or purchased” (Parr, 2010, p. 25). Those who consult psychoanalysts have *purchased* the experience, but not in the sense meant by scholars of performance art who mean an audience paying for a musical, operatic, or theatrical performance. Performance art, in contrast, consists of an *actual experience*. Similarly, psychoanalytic encounters create an ephemeral encounter each session, one that cannot be repeated or captured. Pena and Sifuentes (2011) would likely consider a psychoanalytic session a form of performance “exercise” (p. 35).

According to a *New York Times* review (Cotter, 2010), performance artist Marina Abramovic created an emotional reaction in her viewers by asking attendees of her exhibit at the Museum of Modern Art (MOMA) in New York to walk between two nude people. Her performance art piece entitled, *The Artist Is Present*, asked visitors to choose between walking around or between two naked persons – a decision intended to provoke an emotional experience. Psychoanalysts function much like Ms. Abramovic, albeit in a more structured and bounded manner. Like performance artists, psychoanalysts offer *experiences.* Even more classically oriented psychoanalysts provoke and disrupt. If they do not at least interpret, or interfere with, the repetition compulsion in some way, then they fail to provide the service for which they receive payment. Psychoanalysts may be passive to the extent that they stay attuned

to their patients and immersed in their (mutual) projections, but change typically requires an active, often unsettling intervention. Referring to Lacan, Ragland (1995) asserts "the inertia of *jouissance.*.. makes a person's love of his or her symptoms greater than any desire to change them" (p. 85). In other words then, transformation in patients requires action by psychoanalysts so as to overshadow their attachment to their problematic unconscious dramas. Psychoanalysts' professional behaviors resemble performance art in at least three distinct ways.

First, as Lacan (1960, 1979, 2002) observed, psychoanalysts give with their actual *beings*. In addition to offering patients their words (through interpretations) and their desire (to pursue unconscious themes), psychoanalysts lend their bodies or, to use Winnicott's (1992) phrase, their "psyche-somas" (p. 185), to the psychoanalytic process. Lacan (2002) wrote, "the patient is not alone in finding it difficult to pay his share," adding "the analyst too must pay" (p. 216). Psychoanalysts allow their patients to project onto them, using them as receptors, screens, or containers (Bion, 1965). In this sense, psychoanalysts' art form parallels that of actors whose cliché about their work – "my body is my instrument" – equally applies. Psychoanalysts use *their* psyche-somas as their instruments. Unsurprisingly, psychoanalysts often refer to, and write about, en-*act*-ments, when describing their clinical experiences.

Their interventions, or better, their provocations, as well as their lending their *beings* to the psychoanalytic process, creates disorientation, loss, and the possibility for re-creation of identity in patients. Of the impact of psychoanalysts' allowing transference phenomena to possess them, Butler (2005) writes that such an engagement

> *recreates and constitutes anew* the tacit presumptions about communication and relationality that structure the mode of address. Transference is thus the recreation of a primary relationality within the analytic space, one that *potentially*

> *yields a new or altered relationship* (and capacity for relationality) on the basis of analytic work (italics mine) (Butler, 2005, p. 50-51).

Here, Butler describes how psychoanalysts' beings, as vehicles of transformation, can create different ways of relating to others, ones that transcend the well-worn unconscious pattern manifest in the transference. Phillips (2012) similarly describes how psychoanalysts affect the transference by interfering with "our culturally inherited roles or parts or options," adding that, "we may not choose them in a way an actor might choose a role, but we may choose them in the way an animal tries to find an environment that works for it…" (p. 183). Bollas (2013) writes, "Whereas Freud privileged self-representation, especially through his emphasis on free association, Winnicott and Khan's praxis was based on self-presentation – on *being*, or form, as communication" (italics mine) (p. 10-11). Bollas similarly privileges the psychoanalysts' actual existence as a transformational vehicle. These authors unite in their vision of psychoanalysts as giving of their *being* in doing psychoanalytic work.

Second, much like the way painters describe their apprehension of the blank canvas, psychoanalysts encounter sessions with their patients with at least some trepidation regarding the unknowable meeting that awaits them. Since it's a common cliché that painters fear the blank canvas and writers the blank page, would not the psychoanalysts' fear of the pending psychoanalytic encounter represent the same phenomenon? Of course, excessive anxiety early in an analytic process could reveal possible projective identification, but any sense of certitude about how a particular session will unfold – particularly if based on theoretical conceptions – objectifies patients. (I suggest that my students model their psychoanalytic behavior on the main character in the television show *Columbo* – the detective who approaches each crime scene as if

he knows nothing, as if he is, to use Bion's [1970] phrase, "refraining from memory and desire" [p. 31]).

As noted earlier, some patients present experiencing intensive competition with their fathers, others fill entire sessions with dream material, others feel the envy and rage described so poignantly by Klein and her followers, and still others experience hungry deficits of the type described by such theorists as Winnicott (1965, 1992), Balint (1979), Kohut (1977), and Brandchaft (2002). If excessively invested in one particular psychoanalytic model, psychoanalysts may well at least miss the subtleties of their patients' presentations or, at worst, and as just noted, objectify or even violate them. I recently began psychoanalysis with a patient who terminated treatment with his prior analyst, a well-known adherent to the Kleinian school, after she insisted that the patient's dream represented his feeling envious of her. After repeated protests, and even mature efforts to respectfully disagree with the psychoanalyst, the patient terminated treatment, concluding that the analyst in question was not "seeing" him. Openness to what emerges in real time is the artistic foundation of the psychoanalytic attitude. Psychoanalysts may be the *most* artistic in the way they use their *presence* in this fashion. This *personal process* emerges in real time as the performance art of psychoanalysis plays out.

Finally, psychoanalysts and their patients choose from an infinite number of possible ways of understanding the phenomena they explore together. Psychoanalyst-patient dyads discover widely divergent ways of viewing unconscious internal dramas, of what drives patients, of the meaning of compulsively repeated themes and of the transference. Grotstein (1990) recommends psychoanalysts "become immersed in the language of the patient," resulting in the:

> formation of a virtually imperceptibly different 'third language,' that of reciprocity or of a reconciliation between the two languages to comprise a most

> optimal and benevolent form of 'folie à deux,' the third language of the therapeutic alliance (p. 182).

What could be more spontaneous and artistic than developing a shared language with patients, one unique to each psychoanalytic relationship?

Psychoanalysts' freedom to select from such a broad palette – consistent with Hoffman's (1998) model – further supports the fundamentally artistic nature of their endeavors. They are tasked with helping patients animate models of self that are varied, mobile, and capable of continuous revision, especially beyond the consulting room. These new narratives ideally show sufficient resilience to resist the controlling forces patients face in their daily lives. Typically, patients' spouses, relatives, or coworkers will be invested – consciously and unconsciously – in patients' identities remaining static. They will be prone to continue to view them through their previously held, likely rigid "terministic screens" (p. 44) to use Burke's (1966) phrase. Ideally, patients will successfully resist these influences. As a result of their repetitive and transformational *experiences* in the consulting room, patients become persons, enacting an authentic self that exercises its right to be, and to be anew, across various social contexts.

Three Performance Pieces

Lacan (1960, 1979, 2002) ended psychoanalytic sessions whenever he felt his patients felt the most moved, the most emotionally provoked – whether this was after five minutes or five hours. Bouchard, Normandin, and Séguin (1995) use the phrase "urgency point" (p. 729), as did Paniagua (2008), when describing key, here-and-now moments in the psychoanalytic encounter. Baranger and Baranger (2009) utilize precisely the same phrase to describe points in analysis when themes come alive in actual here-and-now experience (p. 50). Godbout (2005) writes of

"the importance of detecting an urgency point and … of letting oneself be impregnated by it" (p. 89) when at crucial transformational moments.

I eschew categorizing my approach to transformational encounters into any psychoanalytic school, viewing such identifications as a form of reductionism that in turn objectifies. Some readers may interpret the following excerpts as suggesting that I work in an Intersubjective or Relational fashion. However – and consistent with the thesis of this article – that style, if present, reflects mostly the specific psychoanalyst-patient dyads I am presenting rather than my adherence to any particular psychoanalytic theory.

I offer these three psychoanalytic scenes to exemplify how psychoanalysts work to achieve transformation through the performance art called psychoanalysis. They enter their sessions free of memory and desire, utilize various means of interpersonal influence, utilize the four basic tenets or other signs of unconscious processes, and ready themselves for spontaneity and improvisation while simultaneously monitoring their professional boundaries. Depending on an essentially infinite number of variables, psychoanalysts may interrupt their patients' discourse or they might not; they may attune intensely to patients emotional states at some points and distract them at others; they may ask questions at times and avoid doing so at others; they may comment on a transference theme at some points but at other times they will wait; they may explore drive or motivational forces at some times but not at others. Of course this listing of psychoanalyst behaviors must necessarily be incomplete because the multiple variables in motion, all dynamically and temporally in interaction with one another, preclude developing any definitive and predictive algorithm.

Burke's (1945, 1954, 1966) scholarship on the dramatistic nature of human motivation, and Butler's (1997, 2005) work on the performative elements of identity, provide support for the

artistic, theatrical nature of psychoanalysts' work from outside of the field. The dialectical-constructivist model and similar ones from within psychoanalysis also support the idea that psychoanalysts *perform* in a certain unique fashion. These case examples, fictionalized to protect their identities, nonetheless represent what actually occurred with these patients.

First Scene*:* A particularly startling point of urgency occurred after treating Mr. A, a young man age 17, towards the end of the first year of psychoanalytic psychotherapy. He consulted me, at his parents' request, on a twice-weekly basis for two years. I felt I made no progress in helping him during the first year. In school he was acting out in a highly destructive but predictable way. He refused to do homework assignments. He challenged the authority of teachers whom he disrespected. The most obvious feature of his personal history surrounded his having two likely sources of rage, both of which he consciously denied: He had an autistic younger brother, his only sibling, and; he felt that this brother had taken much of his parents' attention away from him. He adamantly opposed any suggestion that these situations had a negative impact on him, saying, "my parents love us both equally." He yearned to serve in a law enforcement role, specifically for the Department of Homeland Security. His parents were physicians. Mr. A believed that his career choice would either demean him, his family, or both. When I interviewed his parents right after the treatment started, I found no evidence of their judging him for what appeared to be his sincerely authentic interest. On the contrary, they both seemed to be supportive of him.

Towards the end of that first year of the psychotherapy, I began to feel anxious that his parents would feel angered at his lack of progress. That image entered my psyche-soma at that point, creating tension, conflict, and irritation. The acting out that had brought him to my attention continued unabated. Mr. A and I had discussed, repeatedly, the potential meanings of

his anger, the way his behavior at school impacted others, the underlying need to for him to be in control (and therefore not vulnerable), and his general lack of empathy. He entertained these theories intellectually, but quickly rejected them. He regularly distracted me from the analytic process by asking about my work. He particularly enjoyed asking me pointedly about other patients he saw in my waiting room.

One day, and without warning, Mr. A was speaking about his future when he made this simple parapraxis, "I'm not sure that I'll ever have money because I'll *just* be working as a cop." Likely because of my own anxiety at his intransigent symptoms, and my guilt regarding his parents' expectations of my work with their son being dashed, I heard that slip of the tongue like a clap of thunder. Here is our exchange:

ANALYST: Did you hear what you just said?

MR. A: I don't think so. I only said that I wouldn't make that much money.

ANALYST: You qualified your statement with a '*just*.' That was the first time I've ever heard you devalue your plans for your life.

MR. A: What do you mean? (He seemed defensive).

ANALYST: Mr. A, you know what I mean. You said it. (I felt irritated). You put yourself down. It's not your parents you need to worry about. It is *you*.

MR. A: Holy shit. (A long silence ensued).

ANALYST: Yes… you see that now.

MR. A: (Another long silence occurred). Oh my god, oh shit… I've never felt it like that, like I'm bad in some way. I could never get your point because I expected that it came from my parents, but it doesn't. It comes from me. It's the way I feel about *me*.

ANALYST: Yes, exactly that, you feel as if you are bad in some way. And, sadly, that has become *your* creation.

This unique moment represented a turning point in this young man's life. The ensuing year was markedly different from the first. Mr. A's defenses became more pliable. He was more emotionally vulnerable. He was intrigued about the type of relationship he had with himself. He felt the pain of his own self-attack. These developments led to another year of sessions characterized by his working through his self-judgment and his pain at that internal assault. Gradually, he retracted his projections onto his teachers back into himself, causing him to experience less anger and a greater sense of peace as these conflicting parts of himself integrated. In the same vein, he became much more engaged in his work with me, i.e. the distracting commentary regarding patients he met in the waiting room abruptly stopped. The process ended with his experiencing a greater appreciation for his parents' positive qualities, and a new found, viscerally experienced realization of how he had unconsciously felt inadequate in reaction to his living with two highly achieving parents. Ultimately, he terminated the treatment with greater self-respect and cessation of the acting-out behaviors that led to his referral for psychoanalytic-psychotherapy in the first place.

Second Scene: This example also features an urgency point that similarly altered the course of the analytic process and the patient's life. In stark contrast to Mr. A, Dr. B – an African-American professor of anthropology – had an extremely negative experience with her parents, particularly her mother, during her childhood years. A highly intelligent, attractive 40 year-old-woman, Dr. B sought formal psychoanalysis for treatment of chronic depressive symptoms. She consulted me four or more times each week. She was the second of three children, the only daughter. Her father, a constitutional attorney often away at work, was critical

and narcissistic. Her mother, a thoracic surgeon, seemed to compete with her from infancy. Dr. B has many early memories of her mother calling her "stupid," "ugly," and "foolish."

Dr. B's mother practiced with another prominent surgeon, a male who molested Dr. B first at ages four and five, and then again at age 14 when he attempted an actual sexual assault. The mother, who was having an affair with this same medical colleague, defended him. When Dr. B told her mother these stories, she insisted that Dr. B had fabricated them. The causation of the chronic mental pain in Dr. B – namely extreme feelings of emptiness, emotional insecurity, and a phobia of intimacy – was unusually clear. Equally so was her terribly negative image of herself, a self-valuation that contributed to her compulsion to repetitively choose abusive romantic partners.

This particular interchange occurred about two years into the psychoanalysis, after many layers of defense had been penetrated, and while we together intensely scrutinized the transference.

DR. B: If you continue to move that close to me, to follow me so well, to know me, I will hurt you.

ANALYST: How?

DR. B: Remember that dream I had, of the glass window with the wooden frame around it? And I am on a grass field, lying down, covered by it?

ANALYST: Yes.

DR. B: I'm now imagining nothing but the glass. The frame is gone. As I try to stand, the glass shatters. You are there, trying to help me up, but the shards of glass are pointing towards you. (She began sobbing intensely).

ANALYST: And you fear I will be hurt.

DR. B: More than just hurt, bloodied and killed.

ANALYST: You feel fury to the point of violence towards me. You believe you could kill me.

DR. B: (She entered a semi-psychotic state and appearing agitated). It is real. I'm stabbing you right now. (She sobbed again). The glass is cutting you up.

ANALYST: (I kept silent for a minute or two). You feel like your *being* itself is dangerous.

DR. B: Because it is. I will poison you for sure, and you won't see me anymore. You will vanish. You will not have me as a patient.

ANALYST: (I remained quiet for another minute or two). Dr. B, we are here, together, at the core of your open wound. I'm sitting right here, listening to you, listening to your fury.

This exemplifies a transformational encounter, to use my phrase, or a "transformation," to use Bion's (1965, p. 2). According to Jacobus (2005), Bion would have viewed the scene just described as occurring at the "site of turbulence" (p. 258). The relationship between Dr. B and I had fallen into an extremely regressed state, one in which Dr. B experienced herself, in the anguished present, as the enraged infant experiencing homicidal affect towards caregivers projected onto me. I contained her painful emotion and aggressive thoughts.

In the ensuing weeks, I interpreted how her childhood trauma had understandably elicited rage. I further suggested that the multiple psychological injuries she sustained led to the conviction that she was an unworthy child deserving of criticism and neglect. In time, I successfully competed with Dr. B's attachment to her internal objects (referring here to Fairbairn's [1952] idea that all psychoanalysts compete with their patients' relationships with

their internal objects). Inter-subjectivists or Relationalists may well have not stayed with the patient's aggression for as long as I did. Perhaps they would have reassured her, or stayed empathically attuned until the anger dissipated. These respectable differences in personal style, and theoretical approach, lend further support for my contention that psychoanalysis has a foundationally artistic nature. Other psychoanalysts may well have helped her as much as I did. Perhaps they would have been more effective. In any case, I did stay closely present with Dr. B during this session, but she left in a state of rage. She remained infuriated with me, and full of terror, over the course of several subsequent sessions.

Dr. B's depression lifted for several weeks after this period of rage at me subsided. In the subsequent months, we were able to re-enact these encounters at such depth and intensity – "shattering" describes them best – that the chronic depression ended for longer periods of time, revealing that, to use Fairbairn's (1952) own words, the "bad" (p. 66) self was being "exorcised" (p. 70) by the then-deepened process.

Third Scene: After three uninterrupted years of psychoanalysis for four or fives sessions per week Dr. C, a tall, thin, 35-year-old Native-American psychiatrist/psycho-pharmacologist was making slow progress altering a problematic unconscious internal drama. She was handsome, in an unusual, angular way. She behaved in an intensely loving manner towards her two daughters and her friends. She had a strong sense of intuition, bordering on the prescient. She would, at times, lapse into a "dream world" that she described as having a "magical quality." And yet Dr. C took little ownership of her loving nature, her appearance, or her intuition. She considered herself a "messy person." She viewed herself as excessively "needy," particularly in regards to men.

The formation of Dr. C's identity brings to mind Butler's (2005) ideas regarding the performative elements of self-concept. Butler describes how individuals "make a sequence and link one event to another, offering motivations to illuminate the bridge, making patterns clear, identifying certain events or moments of recognition as pivotal, even making certain recurring patterns as fundamental... " (p. 66). It also brings to mind Burke's (1945, 1954, 1966) famous concept of how humans use symbols, but symbols also use humans. He writes,

> An 'ideology' is like a god coming down to earth, where it will inhabit a place pervaded by its presence. An 'ideology' is like a spirit taking up its abode in a body: it makes that body hop around in certain ways; and that same body would have hopped around in different ways had a different ideology happened to inhabit it (Burke, 1966, p. 6).

The way I just described Dr. C as presenting herself dovetails with Burke's ideas well, i.e. Dr. C's failure to acknowledge her own capacities for love or her intuitive abilities represent a certain negative, self-hating ideology that ruled her. Referring to the way in which identity is constructed through a form of performance, Butler (2005) writes,

> I also enact the self I am trying to describe; the narrative "I" is reconstituted at every moment it is invoked in the narrative itself. That invocation is, paradoxically, a performative and non-narrative act, even as if functions as the fulcrum for narrative itself. I am, in other words, doing something with that "I" – elaborating and positioning it in relation to a real or imagined audience – which is something other than telling a story about it, even though "telling" remains part of what I do." (p. 66)

Butler's (1997, 2005) conception, as applied to identity, differs substantially from my conception of the performative aspects of the clinical psychoanalyst. Burke's (1945) "dramatistic pentad" (p. 538) comes closer to illuminating the psychoanalytic process in which "act, scene, agent, agency, and purpose," (p. 538) dynamically unfold throughout each psychoanalytic encounter. In the course of the psychoanalytic process, both psychoanalysts and patients perform, but how they act, their purposes, their responsibilities, their roles, and their objectives diverge. In the psychoanalytic encounter, and to borrow Abramovic's phrase, "the analyst is present" (Cotter, 2010), the unfolding, dynamic relationship between psychoanalysts and patients serves as the bedrock that facilitates patients' transformation. Each encounter is unique. Psychoanalysts' performances, in conjunction with their patients, can be neither duplicated nor mechanized.

Although psychoanalysts may ascribe to formal theories, no theory will be performed the same way because the participants' singularities (Ruti, 2012) vary. An analyst's subscribed theory combined with that same analyst's personality, and that of the patient, plus whatever dynamic contextual features exist, renders every performance unique. (Even carefully written theatrical scripts are never performed never the same way twice). Using their various forms of interpersonal influences like brushes, or like choreography, and utilizing their creative interpretation of the work of analysts past, psychoanalysts perform their transformational work.

I relied mostly on Lacan's (1960, 1978, 1979, 2002) distinction between ego and subject in my work with Dr. C. As occurred in the two prior scenes, the urgency point involved a live, emotional element of our interpersonal relationship, one centered on her perception of her criticizing me. Dr. C's ego, particularly early in our work together, consisted of the self-perception just noted – an unattractive, "messy person" with excessive interpersonal needs and little appreciation of her unusual capacity for intuition and insight. For perhaps one full year

before this scene occurred, I helped Dr. C in her discovery of the origins of these unconscious themes, with rejection by a narcissistic mother being significant, but sexual objectification by her father being the most impactful. Just as Dr. C entered adolescence, her father made a sexual remark about her breasts. She could "never forget" her father's statement. She came to understand that it fomented her retreat into negativity regarding her appearance. Further, she had understandably equated attractiveness with vulnerability and danger.

This encounter represents a milestone in her taking ownership of several positive elements of her authentic self, and her beginning the process of relinquishing her unfounded, excessive self-criticism.

DR. C: Joel (a colleague with whom she had been intimately involved for six months) told me that I have 'coercive needs.'

ANALYST: I wonder what you think he meant by that.

DR. C: (With irritation). It's obvious, don't you think? He's just caught on to how demanding I am, the same needy way that pushed away men before him, the same demands that annoy you.

ANALYST: How do you see me as annoyed by you?

DR. C: When I am critical of you, like when I tell you how that pile of papers on your desk is always so fucking neat, I feel you tense up.

ANALYST: Yes, I think you're right.

DR. C: (Pauses for a long while).

ANALYST: I'm thinking now of all we've discussed about your intuition, that intuition you reluctantly call 'magical,' and how you deny its power. You quickly sense a reaction in me when you comment on my desk, or my bookshelf, but here's how I experience it. I

feel nervous about *me*, not about your criticizing me. I feel self-conscious about my neatness. Can you see you how you immediately translate that into a negative judgment of you?

DR. C: I guess. (Another long pause passed). Or at least I'll take your word for it. (She sounded irritated).

ANALYST: You seem to be shrugging my perception off. You seem convinced that I seem annoyed because of *you.*

DR. C: Yes, I sense your discomfort. I hate doing it to you.

ANALYST: I know you can sense it. This makes me think of the 'magic' you tell me about. You are highly sensitive to me, but you then project a reaction that seems to be more about you than about me. How ironic! You worry about being not neat enough; I worry about being too neat!

DR. C: I always think you will think me strange, like I sound like a sorceress or something.

ANALYST: And so what if you are? Call it what you want, it is such an unusual quality. I'm reminded now of those images of the orbs that you have in your dreams and your imagination.

DR. C: And what about my 'coercive needs?'

ANALYST: (Being ironic). As you know, I've just felt so overwhelmed by your infantile demands these long three years together. You've always asked for so much, crisis calls, extra sessions, discounted fees. Need I go on?

DR. C: (Laughing). So you have no sense of me as having 'coercive needs.'

ANALYST: No, I never have, ever, but clearly you see yourself that way, or at least you fear that you're that way, and Joel's using that phrase lit you up.

This excerpt dramatizes Dr. C's initial effort to invite me, with words and affect, into an enactment that emphasizes the various ways she negatively values herself. I declined the invitation, shared my subjective experience of shame at my own compulsivity, and proposed an interpretation that her sense of me as angry constituted a projection. We shared an opportunity for her to experience, in real time, the power of her intuition – as evidenced in her sensitivity to my emotional reaction to her critiques. She appeared to experience relief that she could reveal herself as an unusually sensitive and intuitive *subject*. Towards the end of that short piece of dialogue, I used humor to facilitate the expulsion of the self-criticism fomented by her partner's criticism of her.

Readers will likely interpret my interactions with Dr. C display as reflecting my working in an Intersubjective or Relational style with her. As I witnessed our relationship evolving over time, and also observed her personal style, I concluded that the broadly defined interventions suggested by these schools of thought would be most beneficial for Ms. C. But then again, as I just noted, I relied on many Lacanian ideas when discussing her unconscious themes. Were the interpersonal dynamics different, or if I had adopted a more conservative Freudian or Kleinian stance, I would not have offered up such vulnerable self-disclosures. For reasons relating to our respective subjectivities, I intervened in a fashion quite different than how I had with Dr. B, with whom I encouraged her aggression to linger.

Conclusion

Psychoanalysts are neither research scientists objectively observing inter-personal processes, nor are they medical practitioners applying procedures. They are, instead, vulnerable

human beings engaged in a profession – one most unusual and rare in an era when all that cannot be measured, weighed, or quantified in some fashion tends to be viewed as lacking legitimacy. They offer help that primarily takes the form of exploring unconscious schemata, personal motivation, and repetitive psycho-behavioral themes. They focus on how these map onto the psychoanalytic relationship. Their work or, more accurately, their performances with their patients, are nonlinear, dynamic, and unpredictable.

From its earliest formation, psychoanalysis rebelled against the profession to which it was bound. It would not be strictly medicine. It would become a field of its own. It would continue to evolve away from other traditional, more linear definitions characteristic of most professions in the world, certainly far from the typical services provided by industrialized health care. Psychoanalytic practice resides firmly in the realm of humanities, specifically art, and more specifically performance art. It is no accident that Freud pulled Oedipus from a staging of Sophocles's *Oedipus the King*. First performed in Greece, c. 429 BCE, and highly popular with Western European audiences in Paris and Vienna in the early 20th century, these theatrical productions led numbers of philosophers and psychoanalysts – not just Freud – to develop ideas concerning the transformative power of art and performance.

This more artistic vision of psychoanalysis will likely require further cultural accommodation. By definition, art brings something new into being. The English word, "create," derives from the Indo-European root, "ker," kere," which means to grow, to make, to create (Weiner, 2000, p. 41). Typically, new and different things in the field of psychoanalysis encounter, at least initially, skepticism and resistance to change. Perhaps Toynbee (1962) put it best when he wrote, "A fatuous passivity towards the present springs from an infatuation with

the past" (p. 261). It may be difficult for psychoanalysts to embrace the primarily artistic nature of their clinical work.

Psychoanalysts manage an intimate, asymmetrical, bounded relationship that comprises the medium of the service they sell. They strive to help individuals who consult them to grow, to create, and to come into being. The psychoanalytic project would be best served by relinquishing its *infatuation with the past* and breaking with reductionist comparisons to science or, more specifically, to medicine. In truth, psychoanalysts, in conjunction with their patients, practice performance art, bringing relief to suffering that defies description through language alone.

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