

"Subjectivity behind the couch"

Aim: To arouse interest, not convert

My history and orientation

"How such a person can see anything in Freud"

How Freud hit upon technique

Hypnosis; Bernheim tactic; Fundamental Rule

Scandal: Century after Anna O., 85 years after Interpretation of Dreams

"Theme-tracing" The red thread.

Indirect allusions. DRAW

In dreams, latent vs manifest content A Flies (349)

|| Read theme-examples ||

B High School Student; VA Patient

C U NU (400)

D Parapraxes (385)

Why is there a philosophy-of-science problem?

NOT "conceptual"

Rats have expectancies. Computers search for proofs.

NOT "ontologically improbable"

Ball-player; cat reflex; math solutions; post-hypnotic suggestions

Problem epistemological. Too loose a fit, too many options,

"too many unknowns in relation to equations"

This problem exists even if had (a) Naive patients

(b) No indoctrination

(c) No (or randomly chosen) interventions

outline + materials
probably used for
5/25/89 lecture,
video cassette # 11

Not due solely to lack of algorithm for probabilifying (hypothesis/evidence)-relation. Many disciplines lack that. History, inference in law courts, much of biology. E.g., nobody can compute a probability-number, on the evidence, that Hauptmann kidnapped Lindbergh baby, that Goering arranged Reichstag fire, or that man evolved from an apelike ancestor. Not clear to me why worse here.

***Biggest problem here is selection of "good" sessions (like U NU) out of big batch that are mediocre, some uninterpretable.

Suggestions in chapter. Three here:

1. Sudden effects E Doll (355)
 F Janet (357)
2. Prediction (U NU is one)
Abortion (Reik)
Fire-ambition
 G Waterpipe
 H Green hat
3. Block-theme method

Told you not to convince or convert. My view "Something here, but how much?"

A (124)

*Subjectivity in Psychoanalytic Inference:
The Nagging Persistence of Wilhelm
Fliess's Achensee Question*

An alternative subtitle to this essay, which my non-Freudian Minnesota colleagues urged upon me, would have been, "Whose mind does the mind-reader read?" To motivate discussion of a topic not deemed important by some today, consider the story of the last "Congress" between Freud and Fliess, the rupture of their relationship at Achensee in the summer of 1900—the last time the two men ever met, although an attenuated correspondence continued for a couple of years more. Setting aside the doubtless complex psychodynamics, and the prior indications (from both content and density of correspondence) that the relationship was deteriorating, I focus on the intellectual content of the final collision. Fliess had attacked Freud by saying that Freud was a "thought reader" who read his own thoughts into the minds of his patients. Freud correctly perceived that this choice of content for the attack was deadly, that it went for the jugular. Freud's letter to Fliess after the meeting (Freud 1954) indicates that Fliess had written, apparently to soften the blow of the criticism, something about "magic," which Freud again refused to accept and referred to as "superfluous plaster to lay to your doubts about thought reading." (p. 330) A year later Freud is still focusing on the thought-reading accusation, and writes, "In this you came to the limit of your penetration, you take sides against me and tell me that 'the thought-reader merely reads his own thoughts into other people,' *which deprives my work of all its value* [italics added]. If I am such a one, throw my everyday-life [the parapraxis book] unread into the wastepaper basket." (p. 334) In a subsequent letter Freud quotes himself as having exclaimed at Achensee, "But you're undermining the whole value of my work." (p. 336) He says that an interpretation of Fliess's behavior made the latter uncomfortable, so that he was "ready to conclude that the 'thought-reader' perceives nothing in others but merely projects his own thoughts into them. . . and you must regard the whole technique as just as worthless as the others do." (p. 337) (Italics added)

Not to belabor the point, it seems that when Fliess wanted to hurt, he knew precisely what was the tender spot, and so did Freud. So that in addressing myself to this vexed topic of the subjectivity of psychoanalytic inference, I am at least in good company in thinking it important. Surely it is strange that four-fifths of a century after the publication of the *Interpretation of Dreams* it is possible for intelligent and clinically experienced psychologists to reiterate Fliess's Achensee question, and it is not easy to answer it.

B

Example: A high school student is talking to a counselor about whether to go to the University or a smaller local college. He seems overly anxious. The counselor asks him a general lead question to get the overall picture as the student sees it, i.e., "Suppose you tell me a little about yourself and your background." In the first counseling session, the following 5 spontaneous remarks occur: "My father never had any education -- I don't mean he was dumb, he just never went far in school." "So I took some IQ test, I forget the name of it; they never told me the score and I never asked." "Naturally a person wants to succeed at whatever he tries." "Sometimes I think the simple life on the farm is best for people." "One thing I will say for myself, I've always been a fast reader." You don't have to be a psychotherapist to trace the theme here -- alluded to, hinted at, but never explicitly mentioned: "Am I bright enough for college?" He is scared, but the anxiety is presented in connection with which college. Note that not very much "displacement" has taken place -- the presented problem is very close to the real one. ("Real one" at the first level of analysis, of course. Why he feels intellectually inferior is a second question, which you may or may not be able to get to. But you may not need to, to help him.)

Put next to each other, read in quick succession, these 5 allusions are easy to interpret. However, they don't usually come thus neatly packaged for us. Imagine the 5 spread out over your hour session, i.e., separated in time by an average of 12 minutes. Besides, each is imbedded in its own content (cf. hidden figures puzzles). Thus,

Remark about father's lack of schooling is in context of giving you his ethnic, cultural, family background.

Remark about IQ is in context of what his high school counselor advised him regarding choice of schools.

Remark about "succeeding" is in context of his older brother failing in the hardware business, which has cut down the family finances.

Remark about the "simple farm life" is in context of his approaching summer vacation and how he looks forward to it.

Remark about his reading rate is in context of telling you his extra-curricular interests and hobbies, of which reading is one.



Example: A veteran comes to the St. Paul V.A. Mental Hygiene Clinic with presenting complaints of tension, irritability, and attacks of what he himself described as "anxiety." The anxiety attacks typically occur at home; on rare occasions they have occurred at work, but in every instance toward the end of the working day. The patient is married, with three small children. It develops in the initial interview that he is unusually religious and is an adult convert to Roman Catholicism, which he spent some time studying intensively. He is a docile, conventional, and somewhat obsessional character. To the psychology trainee he reports the following dream:

"We were out in a field killing sheep. I would lift up the sheep to cut its throat; the sheep didn't seem to object or even to be frightened. But each time, as I lifted the sheep up, it seemed there was an angel hidden underneath, which flitted away."

The trainee asks him what comes to mind in thinking about this dream, and the patient's only association is to the sacrificial lamb idea in the Bible, which he links to the story of Abraham's trial of faith with respect to the intended sacrifice of his son Isaac. After these two brief associations, there is a pause, and then the veteran drops the dream and goes on to discuss his symptoms, his reactions to them, and their effect upon his life, with a good deal of repetition and expression of discouragement. He goes on along these lines for 15 minutes or so.

The last symptom in this recounting was his increased irritability at home, especially when the children make too much noise. He then goes on to rebuke himself excessively, with extreme condemning words such as "It's a terrible thing to be so impatient," or "I feel so ashamed of myself I can hardly stand it." He then develops the idea that actually his children are rather well-behaved, which is all the more reason he should be more patient, and in the course of making this point he says "Not that they're little angels, I don't mean that, of course."

The hypothesis which occurs to the listener, provided he takes note of the phrase "little angels" and associates it to the dream content (which the trainee, seeing her first therapy case, failed to notice during the hour but heard when listening to her own tape) is that the dream expresses the death wish against the noisy children, but is careful to make clear that sheep don't object to being killed; and anyway the killing doesn't quite come off because attention is shifted to the angel which flits away. The linkage is between the angels in the dream and the reference 15 minutes after mentioning the dream to the children as "little angels," together with lambs as objects of killing and which are helpless, dependent little creatures. The choice of manifest content to express this via the religious domain of ideas is probably at least in part determined by the fact that the patient has conflict between his religious objections to contraception and his great fear of adding any more children to the family. Concentration of probing along these lines in the immediately following sessions was very fruitful and largely confirmatory of this construction. I would emphasize also that it was not necessary at any point to interpret the dream to the patient; rather the therapist merely made use of her construction in guiding and interpreting the subsequent interviews.

C

was reading the night before, and whose photograph looked like the person dreamed of. I use it as a kind of litmus test on my Minnesota colleagues to diagnose who is totally closed-minded against psychoanalytic thinking. If this sort of instance doesn't at least mobilize a rat psychologist's or psychometrician's intellectual curiosity to look into the matter further, he is a case of what the Roman Church would call "Invincible Ignorance."

Businessman, late thirties, wife had been a patient of mine; he refused to pay for her psychotherapy because "didn't believe in it, nothing to it." (She cashed an old insurance policy for payment.) Wife benefited greatly, to the point he became interested. Bright, verbal man of lower-class background (father was a junk-dealer). Patient went to University of Minnesota for almost two years, premedical course. Quit ostensibly because family needed money (in depression years), but he was flunking physics at the time and his overall grades would not get him into Medical School. Older brother Herman used to reprimand him for laziness. Brother got top grades, Ph.D. in chemistry. For a while patient worked in brother's drugstore. Brother was a pharmacist, who finished graduate school while continuing in drugstore business to make a living. I knew (from wife's therapy) that the brother had mysteriously died during surgery in what was thought to be a fairly routine operation for stomach ulcer, the family having been greatly impressed by the fact that on the night before the surgery, Herman expressed with great dread an unshakeable conviction that he would die on the operating table. (Some physician colleagues have told me that—whatever the explanation of this phenomenon, which has been reported in medical folklore before—they would have considered it undesirable to operate on the patient under those circumstances.) During the first interview the patient related to me in a mixed fashion, including: a) nonchalance, unconcern, "minor problems"; b) jocularity; c) deference; d) competitiveness. (I won't fully document these impressions as noted after the first hour, but an example: He fluctuates between addressing me as "Dr." and "Mr.," and once corrects himself twice in row—"Dr.,—uh, Mr.,—uh, Dr. Meehl.")

In the fourth session he had reported a dream that was quite transparent, even prior to associations, about a waiter who provided poor service, making the patient "wait a long time before providing anything. Also, I couldn't say much for the meal [= Meehl; I have learned, as have most analytic therapists whose names readily lend themselves to punning, that dreams about food, meals, dinners, lunches, etc. frequently are dreams of

transference nature—as in my own analysis, I learned that, like some of my analyst's previous patients, if I dreamed about "buses," it likely referred to him because 'Bus' was his nickname]; and the bill was exorbitant, so I refused to pay it." He went off on discussion of ways his wife had and had not improved, alluded to the parking inconvenience on campus, time taken coming over here, expressed "hope we can get this thing over with fairly rapidly." At end of hour asked what bill was [\$10—my modest fee back in the ancient days before inflation!] and "tell me something about the waiter" (blond, blue-eyed, crew-cut, mustached—an exact description of me in those days). I asked directly what thoughts he had about our sessions. He said he had wondered why I wasn't saying anything much. He contrasted our sessions disappointedly with some sessions his wife had told him about, in which she had been fascinated by interpretations of her dream material. I then interpreted the dream and summarized the corroborating associations. He asked "When did you figure out what I had on my mind?" I said I guessed it at the beginning, as soon as he reported the dream. (Debated matter of technique: Because of my Radovian analyst and supervisor, I frequently depart from the classical technique, following the practice of Freud himself and some of his early colleagues that part of the "educative" phase early on is to gain leverage by establishing a conviction in the patient that the process has a meaning, even if that involves saying something about the therapist's inferential processes and when they occurred. The dangers of this are obvious, but doing it carefully to avoid gross one-upmanship is part of what I believe to be involved in intellectually mobilizing suitable patients by engaging their cognitive needs, their need to understand themselves, and the sheer element of intellectual interest that is part of what aligns the observing ego to enter into the therapeutic alliance. Part of what one does early on is to engage the patient's reality-based, mature cognitive interest in the psyche and its machinery. Persons who cannot think psychologically and cannot distance themselves from their own puzzling experiences are unsuitable for psychoanalytic therapy; even patients who are able to think psychologically about themselves and others usually lack a firm, concrete, gut-level conviction about the unconscious. Any professional in psychiatry or clinical psychology who has had analysis can report his surprise during early sessions at the fact that "all this stuff is really true, even for me!") My patient seemed to be very impressed by this, chuckling and repeating, "By God, that's fascinating," and, "To think I didn't know what I was talking about, and you did!"

In the fifth session, following the session about the waiter dream, patient enters smiling, remarks before reclining, "Sure was interesting last time, *you knew* [emphasis!] all along what was going on and I didn't." First dream: *An Oriental, some kind of big shot, Chinese ambassador or prime minister or something—he's hurt—he has a big bloody gash in his abdomen.* Second dream: *I am measuring out some pills from a bottle.*

His associations continued as follows: Drugstore with brother—patient was partner but not registered pharmacist—at times he put up prescriptions when brother not in—nothing to some of them—silly to take the task so seriously—brother's Ph.D. degree—"he studied—I was lazy—lacked ambition—still do—make more money if I had more ambition—brother also brighter to start with—how bright am I, really?—always caught on to things quickly—poor work habits—wanted to be a physician, but not hard enough—I don't like doctors much—haven't seen one in years—some are pretty dumb"—(long discussion of wife's gynecologist who missed her diagnosis when patient got it right)—in drugstore patient used to advise customers about medication—often felt confident he had diagnosed a condition their doctor wasn't treating them for—(rambles on about various incompetent physicians he has known, detailed anecdotes with use of medical terminology, including narrative of brother Herman's unexplained surgical death, insensitivity of surgeon in pool-pooling Herman's fear, then back reference to Herman's getting the Ph.D. by his brains and hard work). Comments on "experts who don't necessarily know much more than an intelligent amateur." But doesn't want to "overgeneralize that." (Pause—the first even short pause in the stream of the associations. Here one asks the tactical question whether to wait the silence out, which is sometimes appropriate, but in my experience, frequently not. I believe the tendency to wait it out regularly, as developed in this country during the twenties and thirties, is one reason for interminable analyses of people who are actually good prospects for help. We want to know what the patient is thinking that makes him pause, and I know of no really persuasive technical reason not to ask.) (Q Thinking?) "Still can't get over our last session—that *you knew* what was on my mind when I didn't—not just that I didn't—that's to be expected—but that *you knew*, that really gets me!"

Here, after the third over-stressed phrase "You knew," I had an association. The previous night I had been reading TIME, and saw a photo of the Burmese prime minister U Nu. So one hypothesizes a pun, mispronouncing the name, hence there is a linkage to me via this pun: Meehl = "You knew" = U Nu = Oriental in dream.

So I asked him for further thoughts about last session. "Surprised" [Pause] (Q Go on) "Impressed—what else can I say? [Pause] (Q Just keep talking) "Taken aback, sort of—why didn't I recognize it, if you did?—pretty obvious—then the \$10 bill and all that stuff—shouldn't take an expert to see that!" [Laughs] (Q Any negative feelings at all?) "No—no negative feelings—irked with myself." (No resentment at all, toward me?) [At such moments one must be persistent] "No—or if so, very faint—I'd hardly call it resentment even." (Q But a feeling as if I had sort of won a round, or had one up on you, perhaps?) [Laughs] "A bit of that, sure—it's kind of humiliating to go yackety-yacketing along and then find out *you knew* all along—so I suppose you could say there was a little element of resentment there, yes."

I then asked if he was reading last night ("Yes, TIME"). Pressed for recall—"business, foreign affairs" (Q Picture in foreign affairs?) "Hey! By God—that oriental in the dream was a photo in TIME". Patient can't recall name—I tell him "U Nu" and point out that again, as last session, a play on words is involved. The dream shows how strong this reluctantly reported and allegedly faint resentment is, in that he has me wounded (killed, castrated, made into a woman?), linked perhaps by the associations to his wife's vaginal problem and the professional's misdiagnosis; then there is the obvious connection with the abdominal wound that surgically killed his competitor, harder-working Ph.D. brother Herman. The interpretation of this material led to some further fruitful associations regarding his competitive feelings toward his business partner, whom he had originally described to me as "entirely compatible" and "a sympathetic person." I had external evidence, not discussed with him before this session, from his wife that in fact the business partner tended constantly to put down the patient, to underestimate his abilities, to pontificate to him about cultural matters in which the patient was as well informed as he (the business partner, like brother Herman, had completed his college education with high grades). As a result of this interpretation, some of that ambivalence toward the business partner came out, and several subsequent sessions were especially fruitful in this regard.

I should be surprised if any psychoanalytically experienced readers disagreed about the essentials of this dream's meaning. (As stated earlier, I bypass here questions of optimal technique, the "output" side of therapist interpretation, except to remind ourselves how *avoiding* intervention helps avoid theory-contamination of the patient's associations). I have found in every audience of nonanalysts several listeners whose sudden

facial "Aha!"-expressions showed the moment they "got it," sometimes with the irresistible bubbling up of laughter that so often accompanies a good interpretation (thus fitting Freud's theory of wit). It is equally clear that the lay audience (that includes some clinical psychologists in this context) displays wide individual differences in how soon various members begin to "catch on." And, of course, some tough-minded behaviorists or psychometrists (while smiling willy-nilly) shake their heads at the gullibility of Meehl and the other audience members. So Achensee—justifiably—is with us yet! The two diagrams say most of what needs saying by way of reconstruction. In Figure 1, the session's associative material is presented running sequentially (as it occurred) along the left and bottom. My first intervention (neglecting any unintended signals of changed breathing, throat-clearings, or chair squeakings) occurs after the first short pause by

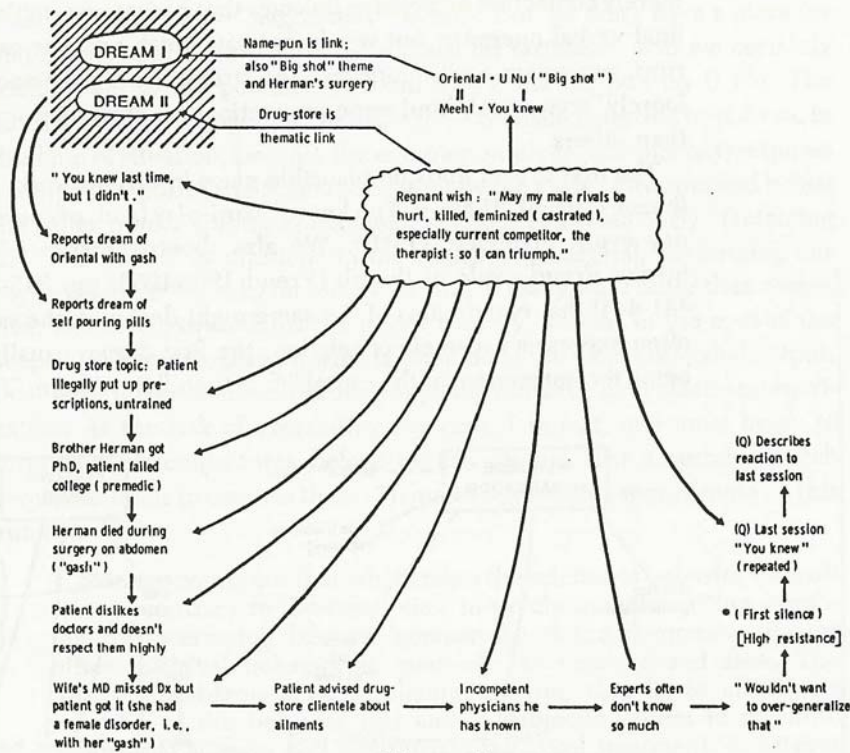


Figure 1.

the patient ("editing," in violation of the Fundamental Rule), after his mentioning not-so-knowledgeable experts he "wouldn't want to overgeneralize about." The postulated guiding theme ("unconscious wish-fulfilling fantasy," if you will) is shown at center. One sees that associations viewed as "topics" are all loosely connected with the second dream's manifest content, and with each other. In Figure 2, I have avoided the "causal arrow" in favor of nondirectional lines (without arrowheads), as here we merely conjecture associative linkages that perhaps strengthen some of the final verbal operants; but we do not say which way the causal influence runs, nor assign any time-order. The strengthening of associations here is loosely "contextual," and some connections are obviously more speculative than others.

The first dream finds no plausible place in this network, except via the (hence crucial) "U Nu = You knew" word-play (and, of course, the dream-day event involving TIME). We also, bootstrapping (Glymour 1980), invoke Freud's rule of thumb (Freud 1900/1953, pp. 315-316, 333-335, 441-444) that two dreams of the same night deal with the same thing and often express a cause-effect relation, the first dream usually (not always) being the antecedent of the causal "if... then." Read here: "If Meehl [= U

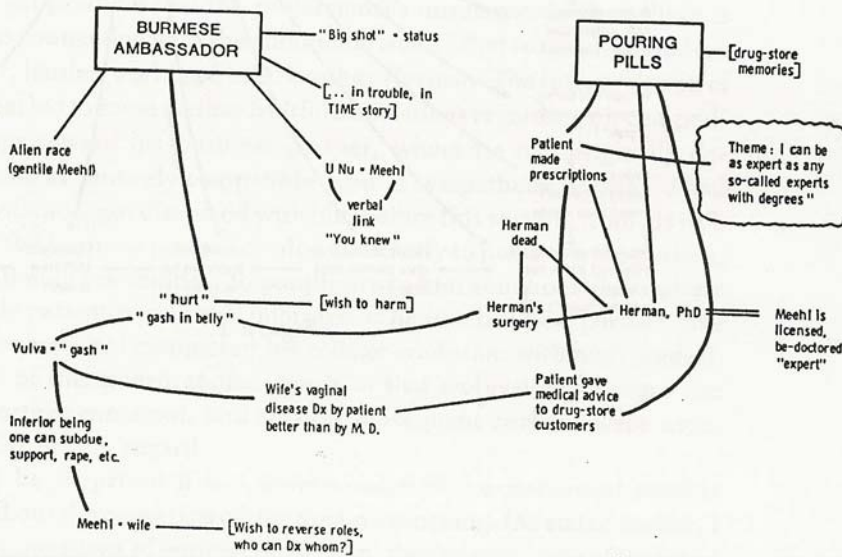


Figure 2.

Nu = "you knew"] is killed, like my earlier sibling competitor Herman, *then* I will be the triumphant, learned, be-doctored expert who is perfectly capable of prescribing pills, etc." This inferred latent structure I do not here pretend to "quantify," and I am not convinced it needs to be quantified. All that the theme-tracing method to be proposed would perhaps do for us is to reduce somewhat the "subjective ad hockery" component in the skilled clinician's discerning the "red thread" allegedly woven into the associations. (For a similar approach to a non-psychoanalytic interpretative problem of psychology see Meehl, Lykken, et. al., 1971).

What is nomothetic and, in principle, "computerizable" contributes to our understanding, but is rather feeble here unless combined with the idiographic components. A male figure with an abdominal wound would presumably occur in a psychoanalytic content analysis dictionary tagged with "castration" and "aggression" themes. But we don't have a place for pouring out pills, we don't have a place for Orientals, and we certainly couldn't get to the postdiction about TIME via the pun on U Nu. The pincers that "close together" to make the Achensee Question hurt do so, in this kind of situation, because the complex ontology (one pincher) requires a complex imposition of thematic content by the analytic listener and hence the other pincer (subtle epistemology) closes simultaneously. Detecting the "red thread" of allusions in the associative material, performing our psychoanalytic Vigotsky on blocks varying in many ways other than shape, size, and color, invalidates the jigsaw analogy, at least in the eyes of the skeptic. We have to discern what is common in the blocks of verbal output, but "what is common" resists any simplistic semantic or syntactic categorization. At the risk of overstating my case, I repeat, one must begin to formulate his conjectures before he can discern that a certain speech sequence tends to confirm them. To quote a previous paper of mine on this subject:

Skinner points out that what makes the science of behavior difficult is not—contrary to the usual view in psychoanalytic writing—problems of observation, because (compared with the phenomena of most other sciences) behavior is relatively macroscopic and slow. The difficult problems arise in slicing the pie, that is, in classifying intervals of the behavior flux and in subjecting them to powerful conceptual analysis and appropriate statistical treatment. Whatever one may think of Popper's view that theory subtly infects even so-called observation statements in physics, this is pretty obviously true

in psychology because of the trivial fact that an interval of the behavior flux can be sliced up or categorized in different ways. Even in the animal case the problems of response class and stimulus equivalence arise, although less acutely. A patient in an analytic session says, "I suppose you are thinking that this is really about my father, but you're mistaken, because it's not." We can readily conceive of a variety of rubrics under which this chunk of verbal behavior could be plausibly subsumed. We might classify it syntactically, as a complex-compound sentence, or as a negative sentence; or as resistance, since it rejects a possible interpretation; or as negative transference, because it is an attribution of error to the analyst; or, in case the analyst hasn't been having any such associations as he listens, we can classify it as an instance of projection; or as an instance of "father theme"; or we might classify it as self-referential, because its subject is the patient's thoughts rather than the thoughts or actions of some third party; and so on and on. The problem here is not mainly one of "reliability" in categorizing, although goodness knows that's a tough one too. Thorough training to achieve perfect interjudge scoring agreement per rubric would still leave us with the problem I am raising. (Meehl 1970, p. 406)

~~I say again, we require the subsuming powers of the clinical brain, but we need a reply to the skeptic who says that there is so much play in the system that we can subsume arbitrarily, any way we want, by some mixture of general theoretical preconceptions and the prematurely frozen conjectures that we arrived at from listening to the dream and first association. My fifth proposal for making a dent in this problem is not very elegant, and I have not worked out any fancy statistics for doing it, partly because I think that they will not be necessary. We first have a clinically naive but intelligent reader break the patient's discourse into consecutive blocks, which I shall label "topics." This initial crude categorizing is done without reference to inferred motives by someone ignorant of such things as defense mechanisms, symbols, and the like, essentially in the way a high-school English teacher instructs students to paragraph a theme by topics. Passing intrusions from the manifest content of some other block are simply ignored (e.g., a one-sentence allusion "as I said, Jones was the sergeant" does not fractionate a block of discourse dealing with a single "non-Jones" episode of barracks gambling). In Table 1 I have done this by three crude topic designations running along the top of the table. The purpose of this breaking up by crude manifest topics is essentially to provide separable chunks of material sufficiently large for a clinician to discern possible themes, but sufficiently small to prevent his contaminating himself by~~

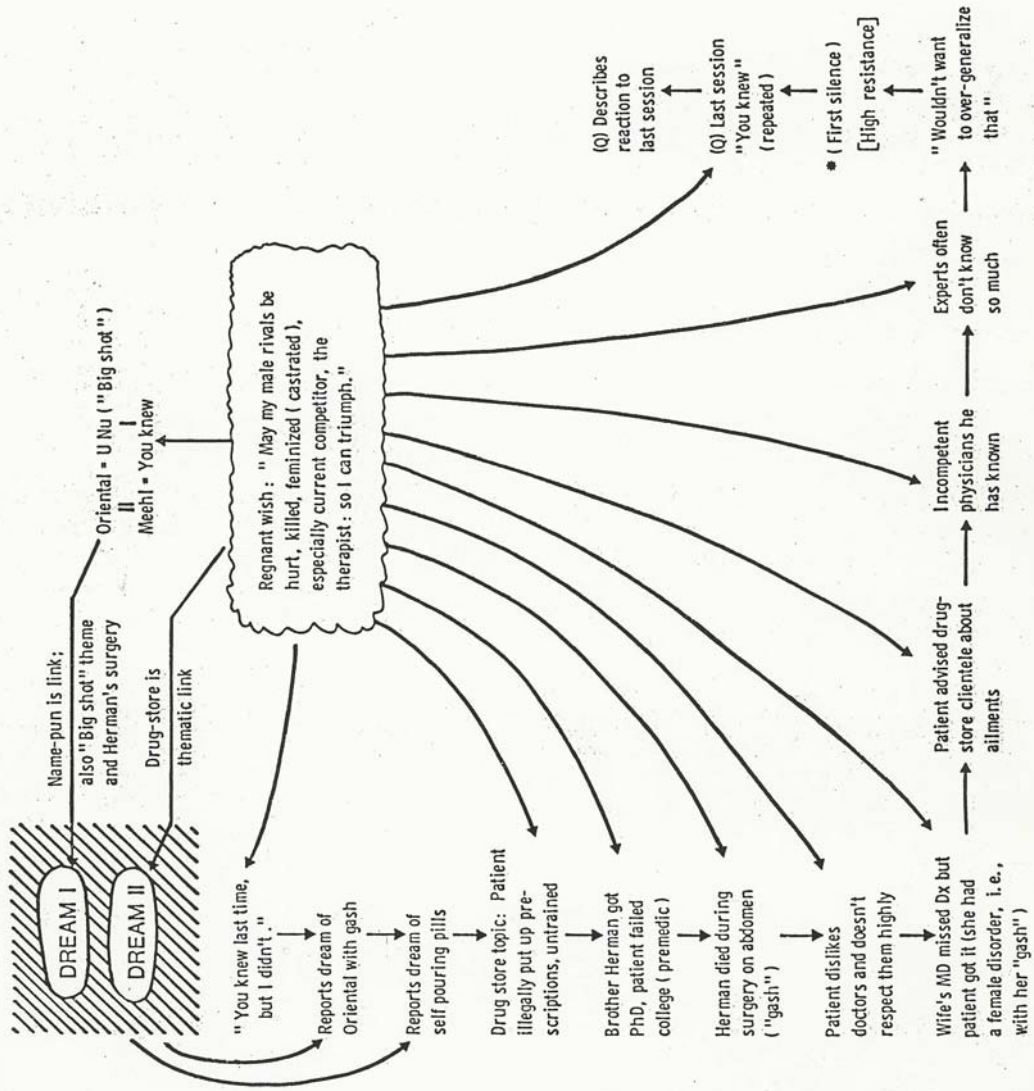


Figure 1.

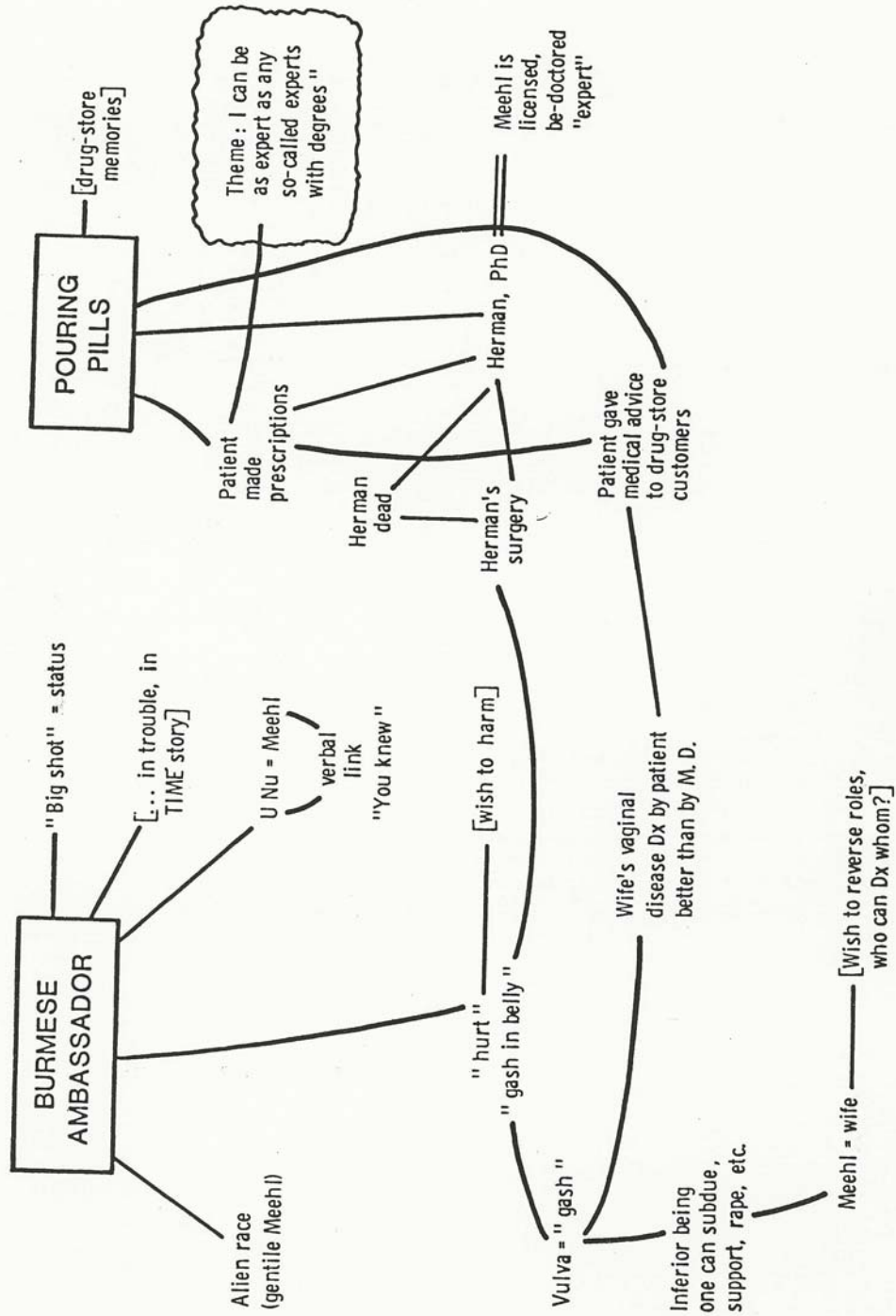


Figure 2.



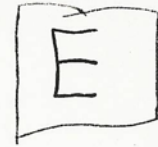
have determined relative frequencies empirically as the initial numbers that get plugged into Bayes's Theorem. (See Carnap's discussion of the two kinds of probability, Carnap 1950/1962, passim.) For someone who is uncomfortable even with that weak a use of a widely accepted formalism (which is, after all, a high-school truth of combinatorics and does not require one to be a "strong Bayesian" in the sense of current statistical controversy), at the very least one can point to a list of separate causal hypotheses to explain half a dozen interview phenomena and then to a single causal hypothesis—the psychoanalytic one—as doing the job that it takes half a dozen others to do as its joint competitors.

Example: A patient drops her wedding ring down the toilet. In speaking of her husband, Henry, she mistakenly refers to him as George, the name of an old flame of hers. An evening dining out in celebration of their wedding anniversary was prevented because the patient came down with a severe headache. Without any kinds of challenge to the contrary, she "spontaneously" makes four statements at different times in the interview about what a fine man her husband is, how fortunate she is that she married him, and so on. Now you don't have to go through any elaborate psycholinguistics or even any of that "within-safe-bounds" application of Bayes's Theorem, to argue that it may be simpler and more plausible to attribute these four phenomena to the unreported guiding influence of a single psychological entity, namely, some ambivalence about her husband, than to deal with the four of them "separately." In the latter case we would be, say, attributing the wedding ring parapraxis to nondynamic clumsiness (the patient happens to be at the low end of the O'Connor Finger Dexterity Test); the anniversary headache to insufficient sleep and oversmoking; the misnaming George-for-Henry to the fact that old George was in town recently and called her up; and the unprovoked overemphasis on her happy marriage to some recent observations on the unhappy wives that are her neighbors on either side. Setting aside the independent testing of those alternatives, it's basically a simple matter. We have four competing hypotheses whose separate prior probabilities are not much higher than that of the marital ambivalence hypothesis, although some of them might be a little higher and others a little lower. We think that the conditional probabilities are also roughly in the same ballpark numerically as the conditional probability of each of the four observations upon the ambivalence hypothesis. The argument that one would make if he knew nothing about statistics, Bayesian inference, or inductive logic but did know legal

practice, or common sense, or diagnosing what's the matter with somebody's carburetor, would be: "We can easily explain these four facts with one simple hypothesis, so why not prefer doing it that way?"

It is not difficult to tighten this example up a bit and make it semi-formal, to such an extent that it is the skeptic who is put on the spot—provided, of course, that he will accept certain reasonable bounds or tolerances on the estimated numbers. Thus, suppose the average value of the four priors is not greater than the prior on the ambivalence hypothesis; and suppose the average value of the four conditionals required to mediate an explanation of each of the four observations is not greater than the average conditional of the four observations on the ambivalence theory. Since the "expectedness" in the denominator of Bayes's Theorem is some unknown but determinate true value (however we break it up into the explanatory components associated with the possibilities), and since a dispersion of four probabilities yields a product less than the fourth power of their average, then when we compute a likelihood ratio for the ambivalence hypothesis against the conjunction of the separate four (assuming these can be treated as essentially independent with respect to their priors, quite apart from whether they are explanations of the four explananda), things cancel out, and we have a ratio of the prior on the ambivalence hypothesis to the product of the other four priors. If, as assumed above, the dynamic hypothesis is at least as probable antecedently as the other four average priors, a lower bound on this likelihood ratio is the reciprocal of the prior cubed. So that even if the priors were all given as one-half—an unreasonably large value for this kind of material—we still get a likelihood ratio, on the four facts, of around eight to one in favor of the psychodynamic construction.

~~Before setting out my fifth (and, as I think, most hopeful) approach to psychoanalytic theme-tracing, it will help clarify a proposed method to say a bit more about theory and observation, at the risk of boringly repetitious overkill. I think our characterization of the theory/observation relation is especially important here because (a) both critics and defenders of psychoanalytic inference have tended to misformulate the issue in such a way as to prevent fruitful conversation, and (b) the pervasive influence of the antipositivist line that all observations are theory-infected (Kuhn, Feyerabend, and Popper) lends itself readily to obscurantist abuse in fields like psychopathology. Having mentioned Popper in this connection, I must make clear that I do not impute to him or his followers any such abuse;~~



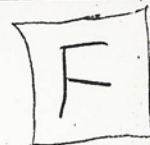
interpretation is cognitively valid before investigating these other matters. But without some probabilistic statement as to content correctness, it is hard to imagine an investigation into the comparative therapeutic efficacy of the two interpretative tactics. The usual statement that an interpretation is "psychologically valid" when it results in a detectable dynamic and economic change may be all right as a rule of thumb, but it does not satisfy a Hessian critic, and I cannot convince myself that it should. Although there occur striking experiences on the couch or behind it in which the quality, quantity, and temporal immediacy of an effect will persuade all but the most anti-Freudian skeptic that something is going on, these are not the mode. Furthermore, "Something important happened here" is hardly the same as "What happened here is that a properly timed and phrased interpretation also had substantive validity and hence the impulse-defense equilibrium underwent a marked quantitative change."

There are few phenomena—and I do mean *phenomena*, that is, virtually uninterpreted raw observations of speech and gesture, not even first-level thematic inferences—that are so persuasive to the skeptic when he is himself on the couch, or so convincing (even when related without tape recordings or verbatim protocol) to clinical students, as the *sudden* and *marked* alteration in some clearly manifested mental state or ongoing behavior immediately following an analytic interpretation. For readers without psychoanalytic experience, I present a couple of brief examples.

When I was in analysis, I was walking about a half block from the University Hospitals to keep my analytic appointment and was in a more or less "neutral" mood, neither up nor down and with no particular line of thought occupying me, but rather observing the cars and people as they passed. I perceived approaching me a man and woman in their late thirties, both with distinctly troubled facial expressions and the woman weeping. The man was carrying a brown paper sack and over his arm a large Raggedy Ann doll. It is not, of course, in the least surprising (or requiring any special psychodynamic interpretation) that the thought occurred to me from their behavior, the doll, and the fact that they were leaving the University Hospital, that a child was very ill or possibly had just died. It would not be pathological for a person of ordinary human sympathy, and especially a parent, to feel a twinge of sympathetic grieving at such a sight. That is not what befell me on this occasion, however. I was suddenly flooded with a deep and terrible grieving and began to weep as I walked. I don't mean by that that I was a little teary; I mean that I had difficulty restraining audible

sobs as I passed people, and that tears were pouring down my face. I told myself this was absurd. I must be reacting to something else, and so on and so forth, none of which self-talk had the slightest discernible effect. On the elevator to go up to my analyst's office were two of our clinical psychology trainees who looked at me somewhat embarrassedly, saying "Good morning, Dr. Meehl," vainly trying to appear as if they had not noticed the state I was in. Even under those circumstances, in an elevator full of people, I literally could not control the weeping, including muffled sobbing sounds. I did not have to wait more than a minute or two for my analyst to appear. Trying to ignore the puzzled expression of a psychiatric social worker whose hour preceded mine, I went in, lay down, and at that point began to sob so loudly that I was unable to begin speaking. After acquiring enough control to talk, I described briefly the people I had met, whereupon my analyst (who, while he had had analysis with Helene Deutsch and Nathan Ackerman, had been exposed to strong Radovian influences in his training institute) intercepted with the brief question, "Were you harsh with Karen [my five-year-old daughter] this morning?" This question produced an immediate, abrupt, and total cessation of the inner state and its external signs. (I had spoken crossly to Karen at the breakfast table for some minor naughtiness, and remembered leaving the house, feeling bad that I hadn't told her I was sorry before she went off to kindergarten.) I emphasize for the nonclinical reader, what readers who have had some couch time will know, that the important points here are the *immediacy* and the disappearance of any problem of *control*—no need for counterforces, "inhibition" of the state, or its overt expression. That is, the moment the analyst's words were perceived, the affective state immediately vanished. I don't suppose anyone has experienced this kind of phenomenon in his own analysis without finding it one of the most striking direct behavioral and introspective evidences of the concepts of "mental conflict," "opposing psychic forces," and "unconscious influences"—the way in which a properly timed and formulated interpretation (sometimes!) produces an immediate dynamic and economic change, as the jargon has it.

~~Comparable experiences when one is behind the couch rather than on it, usually carry less punch. The reason is not that analysis is a "religious experience," as my behaviorist friends object when I point it out, but that the analysand is connected with his inner events more closely and in more modalities than the analyst is, which fact confers an evidentiary weight of a different qualitative sort from what is given by the analyst's theoretical~~



knowledge and his relative freedom from the patient's defensive maneuvers. True, it is generally recognized that we see considerably fewer "sudden transformations" today than apparently were found in the early days of the analytic movement. We do not know to what extent this reduced incidence of sudden lifting of repression with immediate effects, especially dramatic and permanent symptomatic relief, is attributable to the cultural influence of psychoanalytic thinking itself (a development Freud predicted in one of his prewar papers). There are doubtless additional cultural reasons for changes in the modal character neurosis. There was perhaps some clinical peculiarity (that still remains to be fathomed) in some of the clientele studied during the early days, such that true "Breuer-Freud repression," the existence of a kind of "cold abscess in the mind" that could be lanced by an analytic interpretation-cum-construction that lifted the repression all at once, was commoner in the 1890s than today. These are deep questions, still poorly understood. But it remains true that from time to time symptomatic phenomena that have been present for months or years, and have shown no appreciable alteration despite the noninterpretative adjuvant and auxiliary influences of the therapeutic process (e.g. reassurance, desensitization, and the mere fact that you are talking to a helper) do occur and help to maintain therapist confidence in the basic Freudian ideas.

I recall a patient who had among her presenting complaints a full-blown physician phobia, which had prevented her from having a physical examination for several years, despite cogent medical reasons why she should have done so. She was a professionally trained person who realized the "silliness" of the phobia and its danger to her physical health, and attributed the phobia—no doubt rightly, but only in part—to the psychic trauma of a hysterectomy. Her efforts to overcome it were unsuccessful. Repeatedly she had, after working herself up to a high state of drive and talking to herself and her husband about the urgency of an examination, started to call one or another physician (one of whom was also a trusted personal friend who knew a lot about her) but found herself literally unable to complete even the dialing of the telephone number. Now, after seventy-five or eighty sessions, during which many kinds of material had been worked through and her overall anxiety level markedly reduced, the doctor phobia itself remained completely untouched. From themes and associations, I had inferred, but not communicated, a specific experience of a physical examination when she was a child in which the physician

unearthed the fact of her masturbation, which had unusually strong conflictful elements because of the rigid puritanical religiosity of her childhood home (and of the physician also). During a session in which fragments of visual and auditory memory and a fairly pronounced intense recall of the doctor's examining table and so on came back to her, and in which she had intense anxiety as well as a feeling of nausea (sufficient to lead her to ask me to move a wastebasket over in case she should have to vomit), she recalled, with only minimal assistance on my part, the physician's question and her answer. This occurred about ten minutes before the end of the hour. She spent the last few minutes vacillating between thinking that she had been "docile," that I had implanted this memory, but then saying that she recalled clearly enough, in enough sense modalities, to have a concrete certainty that it was, if imperfectly recalled, essentially accurate. As one would expect in a sophisticated patient of this sort, she saw the experience as the earlier traumatic happening that potentiated the effect of the adult hysterectomy and led to her doctor phobia. She called me up the following morning to report cheerily, although a bit breathlessly, that she had refrained from making a doctor's appointment after the session yesterday, wondering whether her feeling of fear would return. But when, on awakening in the morning, she detected only a faint anxiety, she found it possible without any vacillation to make a phone call, and now reported that she was about to leave for her appointment and was confident that she would be able to keep it. I think most fairminded persons would agree that it takes an unusual skeptical resistance for us to say that this step-function in clinical status was "purely a suggestive effect," or a reassurance effect, or due to some other transference leverage or whatever (75th hour!) rather than that the remote memory was truly repressed and the lifting of repression efficacious.

~~Some argue simply that "clinical experience will suffice to produce conviction in an open minded listener." We are entitled to say, with Freud, that if one does not conduct the session in such and such a way, then he will very likely not hear the kind of thing that he might find persuasive. But the skeptic then reminds us of a number of persons of high intelligence and vast clinical experience, who surely cannot be thought unfamiliar with the way to conduct a psychoanalytic session, who subsequently came to reject sizable portions of the received theoretical corpus, and in some instances (e.g., Wilhelm Reich, Albert Ellis, Melitta Schmideberg, and Kenneth Mark Colby) abandoned the psychoanalytic enterprise. Nobody familiar~~

G

A patient begins the session by reporting: *I dreamed there was a peculiar water pipe sticking into my kitchen.* My Radovian training suggests a minor intervention here, for clarification only, so I ask, "Peculiar?" to which the patient responds, "Yes, it was a peculiar water pipe because it seemed to have some kind of a cap on it, I couldn't understand how it could work." The standard symbology here [*waterpipe* = penis, *kitchen* = female genitals] is familiar to undergraduates, but knowing it would only permit the trained clerk or the supertrained clerk (e.g., the General Inquirer) to infer a heterosexual wish. What makes it interesting is the "peculiar cap," juxtaposed with the word "work" [= coitus, at least semi-standard]. Here an idiographic low-frequency consideration enters our minds, mediated by the fact that the patient is Jewish and I am gentile. I conjecture that the capped pipe is an uncircumcised (i.e., gentile) penis, and that the dream expresses an erotic positive transference impulse. I further conjecture (more tentatively) that the current manifestation of these transference feelings involves negative feelings towards her husband, unfavorable fantasied comparisons of me with him, and that the focus of these invidious comparisons will be something in the Jewish/gentile domain. Except for the one word, "Peculiar?" I remain silent until the last five minutes of the session. Everything the patient talked about during that period alluded directly, or almost directly, to the conjectured theme. Space does not permit me to present all of the associations, but to give you an example: She recounted a recent episode in which she and her husband visited a drugstore with whose proprietor the husband had formerly done business, and the patient was irritated with her husband because he slapped the counter and put his hand on the druggist's shoulder and asked in a loud voice how his profits were going. The patient noted the presence in the store of a slightly familiar neighbor woman named Stenquist, who the patient mentions is a Norwegian Lutheran. (She knew from the newspapers and other sources that I was a Lutheran and of Norse origins.) She had the conscious thought in the drugstore that her husband was "carrying on in exactly the way anti-Semites have the stereotype of the way Jewish people talk and act in public." She then talked about a non-Jewish boy she had gone with briefly in high school but quit because her parents disapproved, emphasizing that he was "quiet" and "somewhat shy" and had "very nice manners." She went on to say she liked men who were gentle (note further phonetic link between "gentle" and "gentile"), and after a bit of silence said that she realized it was my business to be gentle in my treatment of her but that she imagined I was the same way in real life. Some more hesitation, then a complaint that sometimes her husband was not gentle in bed; and then finally a reluctant expression of the thought that I would no doubt be gentle in bed.



the two situations. First we have pure convergence, in which the theorist has concocted hypothesis H in the presence of f_1, f_2, f_3 and now presents us with the pure argument from convergence; second, we have a mixed argument from convergence and prediction, in which the theorist has concocted hypothesis H in the presence of facts f_1, f_2 and then predicted the third fact f_3 , which was duly found. Every working scientist (in any field!) that I have asked about this says that Carnap was wrong and Popper is right. That is, the second case is a stronger one in favor of the hypothesis, despite the fact that precisely the same data are present in both instances at the time of the assessment, and their "logical" relationship to the theory is the same. If the logicians and philosophers of science cannot provide us with a rational reconstruction of why scientists give greater weight to a mixed argument from convergence and prediction than to a pure argument from convergence (given identical fact/theory content), I think they had better work at it until they can.

The danger of content-implantation and the subtler, more pervasive danger of differential reinforcement of selective intervention, combine here with the epistemological superiority of prediction over (after-the-fact) convergence to urge, "Wait, don't intervene, keep listening, get more uninfluenced evidence." But our recognition of the factor of resistance often argues the other way, as, e.g., to get a few associations to a seemingly unconnected passing association, especially when the patient seems anxious to get past it. We simply won't get certain thoughts if we never intervene selectively, and those never-spoken thoughts may be crucial to our theme-tracing. The technical problem posed by these countervailing considerations is unsolved.

In my own practice, I usually follow a crude rule of thumb to avoid an intervention (whether requesting further associations to an item or voicing a conjecture) until I receive at least two fairly strong corroborator associations. If the corroborators are weak or middling, I wait for three. *Clinical example:* The manifest content of a male patient's dream involves reference to a urinal, so one conjecture, doubtless at higher strength in my associations because of his previous material, is that the ambition-achievement-triumph-shame theme is cooking. (Cf. Freud 1974, p. 397, index item "Urethral erotism.") Half-way through the hour he passingly alludes to someone's headgear and suddenly recalls an unreported element of the dream's manifest content, to wit, that hanging on a wall peg in the urinal was a "green hat." This recalls to my mind, although not (unless he is

editing) to his mind, a reference several weeks ago to a green hat. The patient had an uncle of whom he was fond and who used to be an avid mountaineer, given to recounting his mountain-climbing exploits to the boy. Sometimes when the uncle was a bit in his cups, he would don a green Tyrolean hat that he had brought back from Austria. The uncle had several times told the boy the story about how Mallory, when asked why he wanted so much to conquer the Matterhorn, responded, "Because it's there." The uncle would then usually go on to say that this answer showed the true spirit of the dedicated mountain climber, and that it should be the attitude of everybody toward life generally. We may choose to classify the passing allusion to a green hat as belonging to the same thematic cluster as this material. Later in the session, if it doesn't emerge spontaneously by a return to that element in the associations, we may decide (how?) to ask the patient to say more about the hat, ascertaining whether he says it was a Tyrolean hat and, even better, a Tyrolean hat "such as my uncle used to wear." I call this a strong corroborator for the obvious reason that the base rate of green-hat associations for patients in general, and even for this patient, is small. That generalization isn't negated by the fact that he *once before* had this thought. Once in scores or hundreds of hours is still a pretty low base rate. But more important is the fact that the sole previous mention is what enables us to link up a green hat with the achievement motive.

On the other hand, the presence of alternative and competing hypotheses tends to lower the corroborative power of our short-term prediction. How much it is lowered depends on how many competitors there are, how good a job they do of subsuming it, and, especially, on the antecedent or prior probability we attach to them. This prior probability is based upon general experience with persons in our clinical clientele but also, of course, upon the base rate for the particular patient. For example, in the present instance the patient, although not an alcoholic, has reported having a minor drinking problem; he has also revealed—although it has not been interpreted—a linkage between alcohol and the homoerotic theme. The uncle's tendency to tell this story when in his cups, and his further tendency to get a little boy to take a sip of beer, produces an unwelcome combination of competing hypotheses.

~~We have also the possibility, frequently criticized by antipsychoanalytic skeptics as a form of "fudging," that what appear at one level of analysis to be competing hypotheses are, at another level (or one could say, "when properly characterized thematically"), not competitors but aspects or facets~~

1. The kidnaper's ransom notes indicate their author was a German, as is Hauptmann.
2. The ladder used to reach the baby's nursery was made by a man accustomed to fashioning wood joints expertly. Hauptmann is a carpenter.
3. The lumber used to make the ladder was traced to the National Mill Work & Lumber Co., in the Bronx. Hauptmann worked there, bought lumber there for neighborhood jobs.
4. The nails used in the ladder are said to have the same grooving as nails of the same size found in Hauptmann's home.
5. The print of a shoeless or wrapped foot outside the Lindbergh home is "similar" to Hauptmann's footprint.
6. The writing on the ransom notes has been identified by an expert as Hauptmann's.
7. Paper like that used for the ransom notes has been found in his home.
8. Hauptmann worked near the Lindbergh home in Hunterdon County, N. J., not long before the kidnaping.
9. An automobile seen near the Lindbergh home shortly before the abduction was the same make, model, and color as Hauptmann's.
10. The kidnaper apparently injured a leg in making his getaway. Hauptmann walked with a cane a few weeks after the crime. About 10 months later he was treated by a doctor for chronic inflammation of the legs.
11. The kidnaper and the recipient of the ransom were one and the same because the writing and signature on the ransom notes and that left in the nursery are the same, and because the extortioner delivered the baby's sleeping garment to prove his "right" to the ransom.
There are these additional reasons for believing Hauptmann got the \$20,000:
12. A gasoline station attendant identified Hauptmann as the man who gave him one of the ransom bills, leading to his arrest.
13. Hidden in the garage by Hauptmann's home was \$13,750 of the ransom loot. In his pocket was \$20 more.

14. A taxi driver identified Hauptmann as the man who gave him \$1 to deliver a note to "Jafsie," Dr. J. F. Condon.
15. Dr. Condon dealt with a man who had a German accent, as has Hauptmann.
16. Hauptmann quit his job the month the ransom was paid, opened a brokerage account and spent money on hunting trips.
17. By his own word he lent \$2000 to Isador Fisch, the man who he contends gave him the ransom money to keep.
18. His wife quit her job in a bakery and made a trip to Germany.
19. His reluctance to answer questions is viewed as "consciousness of guilt."
20. Hauptmann has a criminal record dating back to his days in Germany.
21. The footprint left by "John," who got the ransom, closely resembles that of Hauptmann.
22. On a beard in his home officers found Dr. Condon's address and telephone number penciled. Other numbers, including that of a ransom bill, were there.
23. Hauptmann said he got the telephone number from a newspaper. It was not published.
24. Hauptmann said the bill number was that of one given him by Fisch, but it was before the time he said he first met Fisch.

(from Castell, A. A college logic: An introduction to the study of argument and proof. New York: Macmillan, 1935.

(Protocol form of dream section [pp. 24-28] in Chapter 5 of Millen Brand's THE OUTWARD ROOM, New York: Simon & Schuster, 1937. Reproduced by permission of Mr. Brand, the copyright owner.)

T: . . . But first I'm interested in your dream.

P: How can I think?

T: You can. Don't think of when you woke up. Think back into the night.

P: [Long pause] Yes. I did dream. I was acting in a play, in costume, and I was taking two parts, at the same time.

T: [Pause] Go on.

P: As one person I was very tall, a giant--as the other I was very small. No, that isn't it.

T: Yes it is! Go on.

P: I felt really that I was the tall person and somebody else was the small person, but it was myself too. Is that possible?

T: Yes. It's all just as you remember. Go on.

P: The small person was my servant and I felt very scornful towards her. No--.

T: Yes, you were scornful. But tell me, was there anything--why, in what way did you feel scornful?

P: I don't know.

T: This is important. Did you express it in any way?

P: [Pause] Yes. [Pause] I took my servant's mail and opened it. I think I even read it to her and she couldn't do anything about it.

T: That's very interesting. Was there anything else? Think of the dream carefully.

P: We, that is both of us, were wearing a strange kind of clothing.

T: What kind?

P: It was like a costume, like historical plays.

T: Good. Can you remember anything else?

P: No.

T: All right, let's see what we can do with it--does it mean anything to you?

P: No.

T: Let's go over it. You're a giant and the servant is very small, what can that mean?

P: I can't think--no, I can't think of anything.

T: How about the dress?

P: I don't think of anything.

T: Try.

P: Yes. Gulliver's Travels.

T: That's very interesting. [Pause] Yes, that must be it.

P: But I didn't think of Gulliver's Travels in the dream.

T: No. You just thought of it now. But there is some connection.

P: Why? Anybody might have thought of it.

T: Perhaps. But why Gulliver? Why not David and Goliath, or Jack and the Giant Killer--you see it isn't so simple. No, you thought of it because it really is connected with your dream. That's how it works, the laws are rather strong.

[Pause] Now let's see if perhaps there isn't some connection. A giant--. [Pause] Is the giant Gulliver in Lilliput, or is it a Brobdignagian?

P: I don't know.

T: I'd say a Brobdignagian, do you know why?

P: No.

T: Perhaps you do. Think.

P: The Brobdignagians made Gulliver a kind of servant, a slave. They kept him in a cage.

T: Yes, that's what I was thinking of. By the way, you know your Gulliver very well. Did you read it as a child?

P: Yes.

T: When?

P: When I was five or six, I guess.

T: Did your father or mother ever read it to you?

P: My father.

T: Were there pictures in the book?

P: Yes--oh, I remember. There was one picture, the hat, yes I can see it--it's the same as in the dream.

T: What?

P: The servant looked like Gulliver in this picture.

T: Well, now we're getting somewhere. [Pause] Then let's go back. Why did you think you were the same person?

P: I don't know.

T: This may be rather important. Try association.

P: [Long pause] One flesh.

T: Why "one flesh"?

P: We were the same person.

T: Any more associations?

P: My father used to say to my mother, "You're my better half."

T: How young were you when you first heard your father make that remark, about the "better half"?

P: I don't know, I can't remember that.

T: Tell me this. You've mentioned before that your father was weaker than your mother. Could you have felt it when you were five, six?

P: Maybe.

T: How did he seem weaker, at that time?

P: My mother always ordered him around. I can remember her doing that. Oh, I remember--the mail. She used to open his letters and read them--.

T: So that's the letters.

P: It made him angry.

T: Is there anything more about the dream?

P: Yes, there's something. But I don't know whether it's worth mentioning.

T: You know everything is worth mentioning.

P: I remember how as the giant I wasn't entirely sure I was superior to the servant.

T: Yes, that's good. It all fits together. Gulliver in the

story had a good mind, he knew more than the giant. And haven't you sometimes admitted to me your father was a remarkable man, that he had a quality of mind, not practical, but still superior somehow to your mother's?

P: Yes--.

T: You realize it now better than you did as a child.

P: Yes, I do.

T: Well, you've explained the dream to me. And I haven't forced you to, have I, except to make you tell me?

P: No, I agree that that's the meaning of the dream.

MANIFEST:
CONTENT:

"I went to a meeting this morning, it wasn't important."

"The car needs greasing, I'll have to take it in."

"I don't seem to be able to think of any dreams."

"You looked sort of annoyed when I came in."

"It's beautiful weather these days."

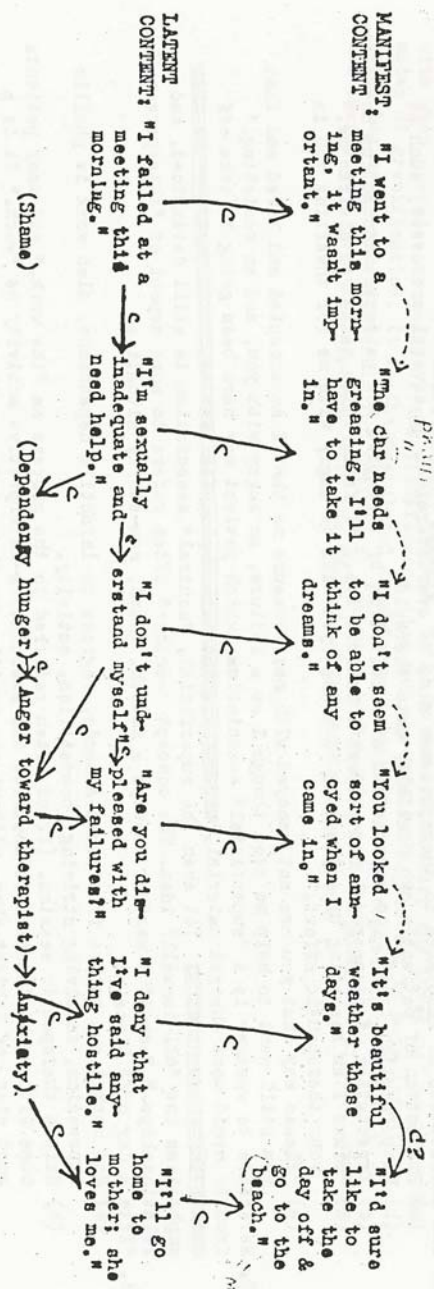
"I'd sure like to take the day off and go to the beach."

LATENT
CONTENT:

Example of the "latent-manifest" aspect of analytic psychotherapy

Manifest sequence above. The broken dotted lines indicate the associative "gaps" which require explanation because ordinary verbal linkages between them are not strong. Thematic linkages are found only if we move down to the latent content.

Content is in quotes; effects are in parentheses. Causal arrows are indicated with solid lines and letter "c" on arrow. Red equality signs indicate symbolic or allusive relations between a manifest and latent element.



Notes on connections:

- "Car" is phallic. I would say that if a patient dreams of a car e.g., his car is damaged, her car has been stolen, etc., your base-rates are at least 9 to 1 that a phallic meaning is to be given. Further corroborators are reference of "greasing" (coital lubrication) and phrase "take it in" as reflecting the penetrative component of phallic theme. In reporting no dreams, ~~manifest~~ note location "I don't seem to be able to think of any dreams" instead of "I didn't dream" or "I recall no dreams." Since patient by now knows the importance of dreams in analytic psychotherapy, there is a quality of "I am unable" (i.e., impotent, incapable) to perform in the way I know you want me to."

3. The same response, however, reflects the patient's cognitive confusion, his puzzlement about "what is the matter with me, actually."
4. Hence the response contains an implicit reference to the succorant theme which precedes, and which also follows in the reference to mother. It says "I can't understand myself (ergo, you must help me because you can understand what's going on)."
5. At still another level the report "no dreams" is a resistance. The best available evidence indicates that everybody dreams nightly, and—contrary to the older opinion about short duration—we spend around 20% of sleeping time dreaming. This 1/5 figure is remarkably constant from night to night and from one person to another.
6. The attribution of annoyance to therapist can also be overdetermined by several processes, such as
 - (a) Projection of patient's own hostility onto therapist
 - (b) Misperception based upon expectation of retaliation by therapist for patient's unconscious hostility
 - (c) Expectation of disapproval for patient's failure i.e., "I fail, which makes you dislike me."
 - (d) "Since I am resisting by repressing dreams you will be angry with me for thwarting you in your therapeutic effort."
 - (e) "Please say that you are not annoyed with me; reassure me that I am accepted and loved and that you still want to help me even though I am a failure, am angry with you, and am resisting."
7. Reference to weather is a "superficial" association, which patient may have been going to take off from to avoid more charged material. ~~Yet even the superficial, "neutral" association is still determined, and emphasizes the "all-is-well" idea. The concept "weather" often refers to some aspect of "interpersonal relationships." Beautiful weather conveys a smooth, bland, non-stormy situation.~~
8. "Take a day off" hints at
 - (a) Not work i.e., retire from adult demands, regress to infantile dependence. Also work is phallic expression, involving striving, competition, activity.
 - (b) Skip a therapeutic session. (Freud often referred to the process as "the work," and many patients come with sophistication to describe the associative-interpretive activity as "work." It is a good sign of insight when, without any prodding by therapist, a patient spontaneously interrupts a string of superficial, repetitive, or intellectualizing associations by saying "I know I am not really working today.")
9. The beach reference is mother-symbol partly because of the standard symbolism of entering water, or of being rescued from water, as a birth-symbol. A body of water is usually the mother. Here the added feature of "taking a day off and going to the beach" corroborates this, involving the abandoning of responsibility in favor of loafing, taking it easy, basking passively in the warm sun, etc.
10. "Mother loves me" is an unconscious contrast to "even if you don't."

General Comment on Causal Sequence

The causal connections go two directions. First, they run horizontally between the elements of the latent sequence. These are the causal laws of the unconscious processes themselves. Secondly, there must

be causal arrows running vertically, from the latent events to the manifest events. There are no such causal arrows connecting the manifest events with one another. This is where the idea of "gaps" comes into the interpretive process. Taken alone, the manifest sequence appears chaotic, because neither the formal (word-similarity) nor thematic ("meaning"-relation) between the manifest elements suffice to provide associative linkages. The linkages are at the latent level instead.

Note also that there is a sequence of latent themes which in turn requires more general guiding principles. Thus, the latent transition from "Are you displeased with my failures?" to "I deny that I've said anything hostile" would itself be mysterious without the principles of defense and transference. Similarly the final latent element ~~XXXXXXXX~~ "I'll go home to mother; she loves me" is connected with what precedes by means of the transference idea and the idea of regression to more infantile modes of gratification. It is the postulated transference attitude to therapist which makes it psychologically understandable for patient to follow a series of latent thoughts and affects regarding the therapist's love and approval with the fantasy of returning to mother.

