

## RECONSTRUCTION REVISITED

Robert L. Pyles, M. D.

There is probably no area of classical analytic technique so lacking in clarity, so fraught with peril, so shrouded in mystery, as that of the concept of reconstruction. Freud himself struggled with it all his life, as we have continued to do. The crux of the problem is that it is perhaps the only clinical intervention that we make that neither we, nor the patient, have direct knowledge of whether or not it represents the “truth”, or what kind of “truth”. It is a speculation, based on analytic material, and the reenacted transference, about what might have happened to the patient.

In addition, we do not know whether the speculative interpretation, even if it is accepted by the patient, represents a literal truth about events that actually happened, or whether it represents an “affective”, emotional truth, or some combination of the two. Then there is the problem of how to objectively determine that the patient has genuinely taken the interpretation in therapeutically, rather than being compliant.

Clinically, by far the most important aspect of reconstruction as a technique, and the most difficult to assess, is what probably should be defined as the “countertransference” issue, for want of a better term. Since this intervention, more than any other, is, in essence, a speculation, though an informed one, it is particularly subject to influence by the analyst’s theoretical point of view, personal biases, and actual countertransference to the patient.

When Freud began his work, he started with the assumption that what his patients were reporting, particularly about early sexual experiences and abuse, were faithful

recollections of real events. As we know, his shift to the fantasy theory was a ground-breaking turning point. As he described it, "it is psychical and not material reality" that is the proper purview of psychoanalysis. This point has remained controversial, as the widespread prevalence of sexual abuse has become more clear. However, Freud himself continued to feel ambivalent about the issue, often coming down on both sides of the question, as will be seen later.

What I want to focus on here, however, is not only the lack of clarity about what is being reconstructed, but the powerful position of the analyst acting, to some degree, as the arbiter and the historian of the patient's experience. From the patient's point of view, the analyst is now in the position formerly occupied by the parent, as the keeper and interpreter of the patient's inner experience, and more to the point, the patient's early reality. With that, I will turn to some clinical material.

The patient is a young woman who is a talented professional writer. She came into analysis because of difficulties in her relationships, but primarily because she felt blocked in her capacity to write creatively. She was able to earn an adequate living and was well regarded for her ability to write travel magazine articles about life's minor vicissitudes. Her frustration and despair were brought about, however, by her inability to write a serious, introspective work, of which she felt herself capable. Whenever she would begin work on her novel, she would feel "as though a fog was closing over my mind."

In the beginning phase of analysis, she had considerable difficulty free associating and an almost total amnesia for her childhood. As treatment proceeded, she blocked, promptly forgot material, and not infrequently forgot appointments. Gradually, however,

her sense of trust increased, the therapeutic alliance became stronger, and we were able to clarify her difficulties, both in analysis and in her writing, as a fear of remembering, or to put it another way, a need to not know. As we were able to follow her associational patterns carefully, we came to realize that the mental “fog” would descend at the point when her serious writing would bring her close to a derivative of a painful repressed conflict, and since these derivatives of conflict were precisely what she needed to write about, she was unable to deal with any topic except “safe,” superficial ones.

This highly condensed material is taken from several sessions about two years into the analysis.

Patient: “I was asked to give a couple of speeches. I suppose it’s an honor, but I hate it. It’s awful. I get so anxious, yet I can’t seem to say no. I’m so afraid people will think I’m boring. I can’t even talk here. How can I make a speech?”

(Silence)

“I was thinking about how fat I am. That’s all I thought of all weekend. He (her husband) got sick of hearing me talk about it. I diet, then I gorge myself, then I flagellate myself and loathe myself. You must think I’m fat and boring, too.”

Analyst: (If you try to think about it very carefully, how do you really feel about making the speeches?)

“It makes me anxious, but, if I really think about it, I guess I really do like it. I dread it before it happens, but then I really get into it...”

Analyst:(You know, children naturally love to show off. They show off their bodies, they show off their homework, yet you feel ashamed and frightened by your wish to show off here, in the speeches, and in your writing. When you have these feelings, you invariably put yourself down. I really have the feeling that there might have been some very specific instances in your childhood when you were badly put down for showing off.)

The patient's response showed an unusual freedom of association. "When you say that, what comes to mind is something that I had completely forgotten, a memory of my cousin. He was four, and I must have been six or seven. I took off my underpants, and he took off his. My aunt came in and took him out of the room and beat him badly, but no one said anything to me. That made me feel even more ashamed.

"A few months later, he was run over by a truck and killed. I was horrified. My aunt used to beat him a lot. My mother said that was why he was killed, that he'd be better off dead, that it was God's will."

"It's vivid now and awful. Oh, God, she used to beat him (crying). He'd say, 'I be good, I be good.' (sobbing)

"I felt it was all my fault."

The patient then goes on to recall a number of women in the family who have become illegitimately pregnant, with disastrous results, both child and mother, in the sense of inevitable doom in the family, "as though it was all part of the family fate." This was why, she said, that she had decided she would never have children, because it would be consigning both herself and her child to some unhappy fate "like signing a death warrant."

In view of the patient's almost total amnesia for her childhood, it was curious that she accepted this and other painful memories as they emerged, almost casually, as though she had known them all along, as though they existed in some split-off state parallel to consciousness. Another striking feature was the vividness and clarity of the recollections.

In the following hour, the patient went on in a torrent of emerging anger and sadness, recalling many instances of her mother's inability to help her.

Patient: "Somehow my mother found out I was giving this speech. She said, 'Why did they ask you?' Christ! Then she said, 'I remember when you went to that banquet in college. You wore the brown velvet dress I made for you.'

"I was speechless. I never had a velvet dress, and she never made anything for me. It's all made up, all for her own comfort and gratification.

"Rarely does the unvarnished truth come out of her. She has reconstructed the past in her own way (her words), totally unrelated to the truth.

"If I had confronted her, she would see it as an attack on her and would still ignore the issue.

"When the man attacked me in the theater (age 12 – another memory she repressed), she said we should never mention it. She just pretended it never happened, and no one ever mentioned it again. I almost began to wonder if it had ever happened myself.

“Even in small things. When my school work went down after that, she just lied to everyone about how well I was doing. But she never tried to understand why I was having trouble, and I didn’t know either.

“She always had to assign blame. Things were always someone else’s fault, but it was never really what happened.

“It even applied to my very existence – I was living proof she had made a mistake (the patient was illegitimate). She would never explain to me about my father. When I said the other kids wanted to know about my father, she said, ‘Tell them you don’t have a father,’ and later, ‘Tell them your father is dead.’

“It was all fairy tales, and not even consistent. I tried to remember things the way she wanted me to, but I couldn’t. I just blocked it all out.”

I have chosen to present this material because of the clarity with which it illustrates the role of the analyst and the parent as interpreter and definer of both internal and external reality for the patient and the child. Both analytic patient and child are vulnerable and questioning and must rely on the maturity and good judgment of analyst and parent for accurate feedback. The responsibility upon both analyst and parent is at once awesome and alone, because there is rarely any external check on the perceptions of either.

The responses of analyst and parent to material presented by patient and child – recollections, fantasies, observations, speculations – will have either a growth-promoting

or a splintering effect on the synthetic and integrative capacities of the ego, depending on the appropriateness of those responses.

In the preceding poignant and powerful material, we see the parent as offering a series of “reconstructions” to the patient, observations which are so wholly out of tune with the patient’s perceptions that as a child she felt she had no choice but to cloud her awareness in order to preserve the relationship. The mother’s perceptions obviously had far more to do with the needs of the mother herself than with any response to the needs of the patient, resulting in a chronic depressive compliance in the patient.

By contrast, the patient’s reaction to the analyst’s reconstructive comment was neither direct agreement nor disagreement but the recalling of an important memory and the loosening of painful and previously repressed affects, part of Freud’s criteria for the correctness of a reconstruction. Yet the reconstruction itself was not entirely accurate, or more correctly, perhaps, was “inexact,” for as we came to realize, it was not “showing off” that the patient’s mother objected to but virtually any demonstration of independent thought on her part.

What, then, is a reconstruction, and what determines whether it is effective or not?

Freud emphasized in 1937 in his last and most important paper on the subject that, first and foremost, a reconstruction is a “conjecture” about the past which “awakes examination, confirmation, or rejection.”

The central importance of this attitudinal and technical position by the analyst cannot be overemphasized, because, as a conjecture (while hopefully based on historical and

transferential data), the reconstructive remarks are particularly prone to being influenced by the theoretical and personal bias of the analyst.

Of considerable relevance is the fact that the term, “reconstruction” has an important historical meaning, in addition to the analytic one, which certainly suggests that the idea behind the word exists in a powerful parallel metaphor. Historically, the term is often used to refer to the period of rebuilding after a war. Coming from the Southern part of the United States, I am particularly aware of that period in American history following the Civil War, known as the Reconstruction Era (1867-1877). I found it interesting that the term “reconstruction” as it is used in a historical sense therefore implied both conflict and structure, as it would seem to do also when used in the analytic sense.

To carry the analogy further, one might ask, “What is reconstructed?” In the case of the South, what the Northern Secretary of War, Stanton, and others had in mind to construct (essentially, a dictatorship) was certainly nothing like there had ever been before in the South, and also was drastically at variance with the wishes of the people. One might say there was no therapeutic alliance to allow a successful reconstruction to occur. The predictable result occurs in usage number 2 under “reconstruction” in the Oxford English Dictionary (1880) – E. Kirke (“Garfield”) – “after the war was over, and reconstruction completed, the same Southern political hierarchy came back into power in Washington.”

This scenario of unsuccessful reconstruction due to resistance arising from the absence of alliance and mutuality of goals, is a familiar one to which I would like to return later.

The Oxford English Dictionary defines “reconstruct” thusly: 1) “to construct anew;” 2) “to construct anew in the mind; to restore (something past ) mentally (1962) – Marivale,

“Roman Empire”) (1965) – “It may not be impossible to reconstruct the true nature of the character of Tiberius.” (1962) – Tyndall – (“mountaineer”) – “he must regard the facts, discern their connection, and out of them reconstruct the world gone by.”

Looking further, the OED tells us that “construct” is from the Latin “construo,” meaning to “heap up together” or to “bring together.” Early English usages seem to be much closer to our “construo “ – to attribute a meaning to something, to put a particular construction on it, a “mind” definition more than an “object” definition.xxxxxxxxxxxxxx Samuel Johnson’s 1755 dictionary defined “construct” – “to form by the mind.” A second parallel meaning pertaining to physical structures seems to have gained more common usage in the eighteenth and especially the nineteenth centuries.

To return to our own analytic concept of reconstruction, ranking as equally important as the “Irma dream” (the first dream analytically interpreted) is the first known analytic reconstruction. This seemed to have produced one of the major insights in Freud’s self-analysis, and he uses portions of the result as central examples in the paper on “Screen Memories,” and the chapter on screen memories in “The Psychopathology of Everyday Life.” Its importance to him was heightened by the fact that when he wrote his definitive work on the subject in 1937, he used it (though not identifying it as his own) as his central example of a reconstruction. “Up until your nth year, you regarded yourself as the sole and unlimited possessor of your mother; then came another baby and brought your grave disillusionment. Your mother left you for some time, and ever after her reappearance she was never again devoted to you exclusively. Your feelings toward your mother became ambivalent, your father gained a new importance for you...”

Easily the best known example of Freud's reconstructive efforts occurs in the case of the Wolfman, in which Freud's analysis of the famous nightmare of wolves led to the reconstruction of a primal scene (from the rear), presumably witnessed by the Wolfman at the age of eighteen months and elaborated in great detail, including the exact time and place, and also that the Wolfman passed a bowel movement while watching. Certainly, the course of the transference (and possibly the countertransference also) was set from the first interview, when, according to Jones, the Wolfman offered to defecate on Freud's head and have anal intercourse with him.

Freud debates at considerable length in this case the question which preoccupied him throughout his career – namely, whether these reconstructions represented actual events, or ones regressively reactivated and sexualized under the impact of universal primal scene fantasies. Coming down squarely on both sides of the question, he wrote that such scenes are “unquestionably” a product of universal fantasy, “but they may be just as easily acquired by personal experience.” The present case, however, “can be most naturally and completely explained if we consider that the primal scene, which may in other cases be a fantasy, was a reality in the present one.”

In a sweeping dismissal, he wrote that the question was “not, in fact, a matter of very great importance” since a child “fills in the gaps in individual truth with prehistoric truth.”

Freud made a similar primal scene reconstruction while analyzing Princess Marie Bonaparte. Celia Bertin's biography reports, “When after five months of analysis she went back to Paris, Marie did not rest until she had obtained from Pascal (her groom), then 82 years of age, a confirmation of Freud's interpretations and constructions – after

much reticence the old man finally confirmed Freud's deductions in great detail – their affair – began when the baby was six months old – lasted till Mimi was three and a half.”

Visualizing this confrontation between the Princess and her aged groom would certainly lead one to applaud Freud's injunction against seeking historical conformation for reconstructions.

Similar reconstructions occur in the case of Katerina, Dora, and the Rat Man.

Freud's initial concept of reconstruction was based on his initial understanding of hysteria as a consequence of actual childhood trauma (seduction), the memory of which was then repressed. The reconstructive aim was to recreate and bring to consciousness the actual event, which would then result in the relief of symptoms – the cathartic method.

In his 1897 letter to Fliess, when he announced that he no longer believed in his “neurotica,” the model became one of intrapsychic conflict, with reconstructions being made along genetic, economic, and topographical lines. First in his 1898 paper on “The Psychological Mechanism of Forgetfulness,” and then a year later in his poignant article on “Screen Memories,” Freud describes the repression of important childhood memories and the displacement of affect onto more neutral ones, which then take on unusual clarity.

Here again, however, Freud says on one hand, “It may indeed be questioned whether we have any memories from our childhood; memories relating to our childhood may be all that we possess. Childhood memories show up our earliest years not as they were

but as they appear to be when our memories were aroused,” and on the other, “but I am prepared to agree with you (himself as the patient) that the scene is genuine.”

In “The Psychopathology of Everyday Life” (1901), the chapter entitled “Childhood Memories as Screen Memories,” Freud states flatly – “Childhood memories are to be regarded as screen memories.” Similarly, his 1910 work, “Leonardo da Vinci and a Memory of his Childhood,” stated, “This is often the way in which childhood memories originate. Quite unlike conscious memories from the time of maturity, they are not fixed at the moment of being experienced and afterward repeated, but are only elicited at a later age when childhood is already past; in the process they are altered and falsified and are put into the service of later trends, so that, generally speaking, they cannot be sharply distinguished from phantasies.”

By 1914, in “Remembering, Repeating, and Working Through,” analysis of resistance and transference has begun to be the analyst’s primary task. The analyst is enjoined “to fill in the gaps in memory” by overcoming resistances. Freud says, “Not only some but all of what is essential from childhood has been retained in these memories. It is simply a question of knowing how to extract it out of them by analysis.”

Action is equivalent to memory – “the patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it, not as a memory but as an action.” Repetitive action replaces memory – “as long as the patient is in the treatment, he cannot escape his compulsion to repeat, and in the end we understand that this is his way of remembering.”

Transference is a repetitive action that replaces memory – “We soon perceive that transference is itself only a piece of repetition, and that the repetition is a transference of the forgotten past, not only unto the doctor but also unto all other aspects of the current situation.”

What is it that the patient repeats? “Everything that has already made its way from the sources of the repressed into his manifest personality, his inhibitions and unserviceable attitudes and his pathological character traits.”

The transference is now “the main instrument for curbing the patient’s compulsion to repeat and for turning it into a motive for remembering.”

Freud then introduces the concept of “transference neurosis” – “we regularly succeed at giving all the symptoms of the illness a new transference meaning in replacing the ordinary neurosis by a ‘transference neurosis’ of which he can be cured by the therapeutic work... The new condition has now taken over all the features of the illness; but it represents an artificial illness, which at every point is accessible to our intervention. It is a piece of real experience.”

It is important to note here that transference is the tool, but that the goal is clearly that of recovering memory.

Yet reconstruction is only a preliminary step. In 1920, in “The Psychogenesis of a Case of Homosexuality in a Woman,” Freud wrote, “An analysis falls into two clearly distinguishable phases. In the first, the physician procures from the patient the necessary information, makes him familiar with the premises and postulates of

psychoanalysis, and unfolds to him the reconstruction of the genesis of his disorder as deduced from the material brought up in the analysis. In the second phase, the patient himself gets hold of the material put before him: he works on it, recollects what he can from the apparently repressed memories, and tries to repeat the rest as if he were in some way living it over again. In this way, he can confirm, supplement, and correct the inferences made by the physician. It is only during this work that he experiences the inner change aimed at, and acquires for himself the convictions that make him independent of the physician's authority."

In his last and most important work on the subject, "Constructions in Psychoanalysis" (1937), Freud asserts that the raw material for the recovery of lost memories may be found in the dreams, associations, and action, of the transference. Note that there again transference is regarded as a means to an end, and only one of several.

His ambivalence about reality versus fantasy, however, seems to have continued throughout. "What we are in search of is a picture of the patient's forgotten years that shall be alike, trustworthy, and -- complete."

The task of the analyst remains "to make out what has been forgotten from the traces -- or more correctly, to construct it."

He uses "construction" and "reconstruction" interchangeably, and compares the work of the analyst to that of the archaeologist, but notes the difference, in that the analyst is dealing with a past that is constantly being recreated in the present, and is therefore a living, vital force. He clarifies the differences between construction and interpretation -- "interpretation applies to something that one does to some single element of the

material, such as an association or a parapraxis. But it is a 'construction' when one lays before the subject of the analysis a piece of his early history that he has forgotten."

Freud addresses at some length the question of how one may determine whether the reconstruction is right or wrong. He feels that an incorrect reconstruction simply has no effect, unless the analyst behaves "incorrectly" by not "allowing the patients to have their say." He stresses that a reconstruction is a "conjecture" which "awaits examination, conformation, or rejection."

The correctness of the reconstruction is not determined by the agreement or disagreement of the patient, because either may be a form of resistance. Correctness is indicated instead by the further production of analogous memories or associations, or by resistance or acting out.

Freud then deals with the problem that seemingly correct reconstructions often do not produce actual memory recovery. The patient, however, should attain a "sense of conviction" about the truth of the reconstruction, which will produce the same therapeutic effect.

A series of papers by Phyllis Greenacre in the 1940s and 1950s reexamines the concept of screen memory and reconstruction, particularly from the point of view of real trauma versus purely intrapsychic conflict. She assigns an important role to real trauma in childhood development in the pathogenesis of illness. Real traumatic events, she felt, act as "organizing" experiences, and produce a greater degree of fixation, sense of guilt, and victimization, a tendency to act out, and decreased ability to experience conflict as intrapsychic. The clinical distinction can be made on the basis of credible evidence,

particularly through the transference. She considered the recovery and working through of such actual traumata (always sexual in nature) to be crucial.

Anna Freud's (1951) observations of the telescoping effect of memory and of the preformed coital play of children reared in war nurseries cast further doubt on the concept of neurosis having its origin in a single traumatic shock.

Heavily influenced by such direct observations of children, and in sharp disagreement with Greenacre, was an influential 1956 paper by Kris, which emphasized the role of long-term "strain" rather than "shock." "We are misled if we believe that we are, except in rare instances, able to find the events of the afternoon on the staircase when the seduction happened." Single experiences are transformed into "a network of overdeterminations – almost infinite" and "hopeless" to reconstruct at a later time. Kris believed that the importance of the reconstruction of specific events was exaggerated and an anachronistic holdover from the early concept of hysteria and the topographical model; this had been superseded by the structural model and ego psychology.

He concluded that actual childhood events were molded into meaningful patterns, and it was these patterns that were the proper focus of reconstructive efforts. The memory of specific events became "nodal points," which are condensations of these patterns, seemingly similar to screen memories.

The therapeutic power of reconstruction, Kris felt, lay in its lifting of "anticathexes," allowing the released energies to be utilized by the ego for integrative functions, which in turn facilitates further lifting of anticathexes. The neutralized instinctual energy "set free

by the analytic exploration of defense and repressed idea – should be discharged – in the capacity for work and love.”

In his well known paper, “The Two Analyses of Mr. Z.” Heinz Kohut reports on two analyses with the same patient, the first of which he considers to have been done from the Freudian viewpoint, and the second from his own newly arrived at theoretical position, emphasizing the concept of “self.”

In the first analysis, Kohut repeatedly refers to reconstructions and interpretations “with which I confronted the patient many times” and described “this consistent and forcefully pursued attitude on my part.” After four years of such insistence, the patient had become compliant and subdued, not unlike my patient’s experience with her mother.

Having developed his concept of an early deficit in the narcissistic investment of the self, Kohut was able to view the patient’s behavior differently in the second analysis. “While in the first analysis, I had looked upon it – as defensive – and had increasingly taken a stand against it, I now focused on it with the analyst’s respectful seriousness vis-à-vis important analytic material.” Apparently, viewing the patient as having a deficit now enabled Kohut “to set aside my goal – directed therapeutic ambitions.”

Kohut then was able to reflect that in the first analysis “my theoretical convictions had become for the patient a replica of the mother’s hidden psychosis, of a distorted outlook on the world to which he had adjusted in childhood, which he had accepted as reality – and the attitude of compliance and acceptance that he now reinstated with regard to me, and to the seemingly unshakeable conviction that I held.”

Kohut's patient experienced the analyst's insistence on his own theoretical point of view as a reenactment of the relationship with his narcissistic mother. Kohut's reconstructions and interpretations were perceived by the patient as having so little to do with himself that all he could do, in order to preserve the relationship, was to comply, similar again to my patient and her mother. Kohut concluded that the problem was caused by the theory, rather than attributing it to a dogmatic adherence on his part, to reasoning from the theory to the patient, rather than from the patient to the theory.

A number of recent authors have emphasized increasingly the role of transference, "analysis of the here and now," as being the most important element of therapeutic change, seemingly at the expense of reconstruction and genetic interpretation. In Leavy's 1980 book, *The Psychoanalytic Dialogue*, he described "a past that is being created as it is being spoken."

For Schafer, in his 1983 work, *The Analytic Attitude*, the key is the patient's acceptance of "personal agency" which is achieved by "the analyst's insightful retelling of both disclaiming and excessive claiming of agency." Shafer maintains that "accounts of the present (the here and now) are reconstructions in the same way as acts of the past – except that they feature acts of perceiving rather than remembering." Further, every perception is itself a "construction" in that it is "an interpretative selection, organization, and formulation."

Finally, "considering analytic knowledge we confront this triple circularity: conventional distinctions between subject and object, between observation and theory, and between past and present, no longer hold. From this one may conclude that reconstruction of the

infantile past is a temporally displaced and artificially linearized account of the analysis of the here and now.”

Both Shafer and Leavy heavily emphasize the role of the transference, and particularly the point of view of analysis as a two-person interactional process, in which the dynamic interplay between analyst and patient must be considered first and foremost. They do not seem to entirely disregard reconstruction of the past from a genetic point of view. The emphasis, however, is definitely tilted toward the here and now.

A series of papers by Valenstein, Rangell, and others has emphasized the distinction between “experiential “ cure, the overconcentration on transference analysis as the mutative factors in psychoanalysis, rather than ideationally explanatory interpretation and reconstruction. My own feeling is that both aspects are essential and mutually reinforcing. A reasonably correct interpretation or reconstruction that only has ideational and explanatory value, but helps the patient feel validated, valued, and carefully listened to in the analytic relationship, in contrast to the earlier parental relationship.

The crux of the controversy was explored in two 1980 papers, one by Rangell and the other, “The Concept of Classical Analysis,” by Valenstein. Both authors pointed to a current trend toward cure by “experiencing,” rather than through insight and interpretation, and both traced the origin of this movement to a 1934 paper by Strachey, in which he emphasized the interpretation of transference as being the chief “mutative” agent, seemingly at the expense of the genetic viewpoint. As Strachey put it, “Conflicts of the remote past remain concerned with dead circumstances and mummified personalities.”

Citing what he felt to be “the error of the transference being thought of not as the means but the end,” Rangell went on to discuss those who considered “past history, intrapsychic thought, and historical material – secondary and deflective of the real analysis, i.e., the analysis of the ongoing transference interplay.” As an example of one author who emphasizes transference over defense, Rangell quotes Merton Gill, “The issue is in fact that of the general model of the analytic process. Is the analysis of the transference auxiliary to the analysis of the neurosis, or does the transference become the current representation of the neurosis, so that its analysis becomes the equivalent of the analysis of the neurosis? My position is that the latter model is the better one.” Gill, in fact, defines analysis as “any therapy in which the goal is the interpretation of transference.”

Rangell differs strongly. “I felt the need to include the resolution of both the transference and the infantile transference as the goal of the analysis... I found it overwhelmingly the case that a sense of conviction is not achieved from analysis of transference alone – without a linkage to its roots.” He concludes, “For the present direction is more classical than the classical, to the extent that the external world that is eliminated includes the patient’s internal as well as external past.”

Taking up the issue, Valenstein added, “The ultimate therapeutic agent in psychoanalysis is interpretation which leads then to insight,” and went on to define interpretation as “appropriate verbal interventions of an explanatory nature which, in timing, form, and specificity, seem correct in the context of the analytic data as they have been evolving.”

Valenstein considered it important “to bring a theory of cure through insight – through ideation – into congruence with the concept of learning through the concrete – through experience. This can be so if it is recalled that thought, i.e., ideation, is token or experimental action. Through the transference there occurs a certain kind of experience, with the action being expressed as verbalized thought... This should be sufficiently action in essence and effect to bring about change through ego modification and restructuralization.”

He went on to discuss the effect of Strachey’s paper. “A good many analysts seem to have taken this paper to mean implicitly the possibility that everything should be in the transference, that everything should be viewed as occurring in the “here and now... The consequence, in my opinion, is the watering down of the significance of the genetic point of view so far as interpretation and insight are concerned.”

Valenstein points out the interest in the treatment of borderline and narcissistic character disorders and suggests that “the intention, perhaps inadvertent, is to change analysis technically so as to make patients analyzable who heretofore would have been considered unanalyzable.” He summarizes Kohut’s point of view of developmental failure or “deficit in a normal narcissistic investment of the self...”: “Technically, it apparently follows (still summarizing Kohut) that a narcissistically impoverished self-representation should be structurally modifiable through recapitulating the developmental failure in the context of an experientially corrective mirror transference”. The experiential aspects of the transference, which he terms “transmuting internalizations” will have structure-building effects in their own right.

From this point of view, therefore, “the primary intention of analysis becomes the undoing and/or completion of the faulty development through what in essence seems to be a corrective emotional experience (Alexander) in the setting of a full-fledged interpersonalization of the transference.”

Hence, “the...concept of unconscious intrapsychic conflict...would hardly seem to pertain. And presumably the theory of psychoanalytic technique as being primarily an articulate interpretive procedure which ultimately depends upon rational explanatory means of resolving psychic conflict, formerly unconscious but now made conscious, predominantly but not solely through the transference neurosis, would no longer be of cardinal importance.”

“Kohut explicitly discounts the value of insight for structure building... It is not the interpretation that cures the patient”. Valenstein suggests that such cures through “corrective emotional experience” are in fact transference cures, “cures through love,” and while beneficial, should be considered psychoanalytic psychotherapy rather than psychoanalysis.

Valenstein then discusses Kernberg, who “attributes defective ego structure to a failure to integrate split introjects during early development.” Valenstein disagrees with Kernberg that such patients can be cured through interpretation alone and states, “the treatment of such conditions during a lengthy pre-analytic phase has to be paramountly experiential and developmentally reparative.”

Thus, within analytic historic development, one is tempted to say that in the “reconstruction” of the concept of reconstruction are contained the seeds of

controversies hotly debated in the current analytic world, i.e., trauma versus fantasy, one-person psychology versus two-person, structure and conflict versus deficit, the classical “Freudian” psychology versus the Chicago school of Kohut.

Certainly, as Guntrip remarked, theory is a good servant but a bad master, especially as it applies to reconstruction. Speaking to the point that one’s metapsychology is usually based on one’s personal philosophy, Guntrip goes on to remind us that “our theory must be rooted in our own psychopathology – the idea that we can think out a theory of the structure and functioning of the personality without any relation to the structure and functioning of our own personality, should be a self-evident impossibility.” That theory is important, operating as it should as an organizing aid for the synthetic and integrative functions of the analyst’s ego, serving to bring him to a closer understanding of the patient’s experience, which is, after all, the whole point.

Surely the “sense of conviction” which Freud felt was what led to therapeutic change, can only occur if the reconstruction was factually and affectually close enough to the patient’s experience for him to derive value from both the ideational content as well as from the experience of being recognized and understood, each aspect acting to encourage further growth and exploration. Ideation and experience thus exist in reciprocal relation to each other, with the experiential reducing resistance to ideation and ideation lending meaning to experience.

Marie Balmarie’s book, *Psychoanalyzing Psychoanalysis*, while suffering from an overdose of Lacanian influence, nevertheless has an interesting discussion of the word “symbol”, which comes from the Greek word “symbolon,” signifying first a “sign of

recognition” and originally meaning “an object cut into two, of which two friends each keep half – these two halves identify the bearers when they meet one another.” The two halves of the word “sun” – “together” – and “ballo” – “to throw” – mean to throw together or to arrive at the same point. The antonym of “symbolic” in Greek is “diabolic,” which means to throw apart or separate. It is also the root for “diabolical,” or devil-like.

A similar concept can be found in several fascinating sculptures at the Rodin museum in Paris. Rodin has created two very similar images; in each a giant hand is emerging from the living rock. The first, called “The Hand of the Devil”, a single figure is depicted in the palm of the hand. In the second, “The Hand of God”, the figures of an intertwined man and woman are nestled protectively. It is as though Rodin also is telling us that isolation is diabolical (*La Main du Diable*), or devil-like, while to be united evokes a sense of connection with another, and with the split off part of one’s own past, resulting in a consequent sense of spiritual well-being.

If we remember that the Latin root of the word “construct” is “construo”, “to heap up together”, or “to bring together”, and therefore, to “reconstruct” is to “bring together again” or to reunite, it becomes clear that a reconstructive interpretation is one which both reunites the patient to their past experience, and connects him or her to the sense of feeling known and understood by the analyst. It also becomes clear why the potential healing power of a successful reconstruction is so great, as it both helps to construct a useful explanatory affective narrative, but also helps the patient to experience the healing distinction between the analytic relationship and that with the primary objects

Therefore, in view of the previous discussion, we can say that “reconstruction” is a technical device through which the patient is brought together (reunited) with the past,

ideationally with respect to the past and experientially through the analytic relationship. By experiencing the thoughtful interest and “wondering” of the analyst about himself and his past, the patient is encouraged to wonder about himself, his past, the analyst, and the world beyond. Thus it would seem that latent in the word itself is a concept of healing by bringing together – the bringing together of the patient’s present with his past, ideationally and experientially, in the context of the analytic relationship.

And what about my patient? Freed from the paralyzing ambivalence toward her intensely narcissistic and incorporative mother, she married well, and became a successful author of serious and introspective novels.

Robert L. Pyles, M.D.

367 Worcester St.

Wellesley Hills, MA., U.S. 02481

#### Bibliography

Bertin, C. (1982) *Marie Bonaparte. A Life*. New York: Harcourt Brace Jovanovich

Freud, A. (1951) Observations on Child Development, *Psychoanalytic Study of the Child*, VI:18-30.

Freud, S. (1898) The Psychological Mechanism of Forgetfulness, *S.E.* III:289-297.

\_\_\_\_\_ (1899) Screen Memories, *S.E.* III:303-322.

\_\_\_\_\_ (1901) The Psychopathology of Everyday Life, *S.E.* VI:1-279.

\_\_\_\_\_ (1901) Childhood Memories and Screen Memories, *S.E.* VI:43-52.

\_\_\_\_\_ (1910) Leonardo da Vinci and a Memory of his Childhood, *S.E.* XI:63-137.

\_\_\_\_\_ (1914) Remembering, Repeating and Working-Through, *S.E.* XII:147-156.

\_\_\_\_\_ (1918 [1914]) From the History of an Infantile Neurosis (The 'Wolf Man'), *S.E.* XVII: 7-122.

\_\_\_\_\_ (1920) The Psychogenesis of a Case of Homosexuality in a Woman, *S.E.* XVIII:147-172.

\_\_\_\_\_ (1937) Constructions in Analysis, *S.E.* XXIII:257-278.

Greenacre, P. (1949) A Contribution to the Study of Screen Memories, *Psychoanalytic Study of the Child*, III/IV:73-84.

\_\_\_\_\_ (1975) On Reconstruction, *JAPA*, 23(4):693-712.

Guntrip, H. (1975) My Experience of Analysis with Fairbairn and Winnicott, *IRPA*, 2(2):145-156.

Kernberg, O. (1975) *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson.

Kohut, H. (1979) The Two Analyses of Mr. Z, *IJP*, 60(1):3-27.

Kris, E. (1956) The Recovery of Childhood Memories in Psychoanalysis, *Psychoanalytic Study of the Child*, 11:54-88.

Ekstein, R. and Rangell, L. (1961), Reconstruction and Theory Formation, *JAPA*, 9:684-697.

Leavy, S.A. (1980) *The Psychoanalytic Dialogue*. New Haven: Yale University Press.

Schafer, R. (1982) *The Analytic Attitude*. New York: Basic Books.

Strachey, J. (1934) The Nature of the Therapeutic Action of Psycho-Analysis, *IJP*, 15:127-159.

Valenstein, A. (1979) The Concept of "Classical" Psychoanalysis, *JAPA*, 27(supp):113-136.