Looking back into the future of psychoanalisis: a second chance

Mirando atrás con la vista en el futuro del psicoanálisis: Una segunda oportunidad

Rückschau mit der Blick in die Zukunft der Psychoanalyse: Eine zweite Chance [1]

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I feel very honored and grateful for the invitation of the German Psychoanalytic Association and the Arbeitsgemeinschaft Ulm to present at this conference some ideas on future of psychoanalysis. The five years of my stay in Ulm, where I arrived 32 years ago with a scholarship from the Alexander von Humboldt Foundation, and where I completed my doctorate with a dissertation on research in psychoanalytic process, were decisive, not only in professional and academic, but also in my personal and family life. I became an integral part of the Department of Psychotherapy of the University Ulm, under the lead of Prof. Helmut Thomä and Prof. Horst Kächele, and of the psychoanalytic work group, and for some years I was a full member of the German Psychoanalytic Association. During those days I made good friendships, some of them I cultivate to the present.

Certainly, the situation of psychoanalysis has changed enormously in recent times. Probably, the most important change in the past 30 years may have been, precisely, the increasing collective awareness that psychoanalysis does not constitute a unified field, neither in theory nor in practice. During the last decade of the past century, this consciousness originated the debate around the so-called 'crisis of psychoanalysis'. From his position as Chairman of the International Psychoanalytic Association (IPA), Robert Wallerstein (1988, 1990) challenged the assumption that there was just one theoretical perspective behind psychoanalysis.

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Freud always considered the possibility of a unified psychoanalytic science; for decades, the building of a psychoanalytic theory was dominated by the assumption that the accumulation of knowledge, the third pillar of the Freudian definition of psychoanalysis, would lead to the construction of a unified scientific discipline (Freud, 1923a). From a current perspective, however, the possibility of that becoming a reality was never real; from its birth, psychoanalysis evidenced divergent theoretical and practical points of view (Makari, 2008). From the moment the psychoanalytic movement reached an agreement on what has come to be known as 'the psychoanalytic method', the institutional authority promoted the illusion of epistemological monism drawing from external definition criteria to define what 'true' psychoanalysis is (use of the couch, frequency of weekly sessions, training standards, etc.). This monist epistemological instance was supported by the authoritative environment surrounding psychoanalytic institutions, where each psychoanalytic school claimed to possess the 'real' Freudian legacy (Jiménez, 2006). In this context, the confrontation between different or contradicting psychoanalytic theory and practice became increasingly difficult, in the tenor of verbal attack and disqualification (Green [2005] speaks of 'bloody duels') and mutual isolation. For my generation, psychoanalytic training was inevitable painful. With a group of colleagues candidates we managed to describe our experience under the title "Regression and persecution in analytic training" (Bruzzone, et al., 1985).

Theoretical unity was not the only to reveal itself as an illusion, but also the practical 'common ground proved to be a mirage. The core topic of the 46th Congress of the International Psychoanalytic Association, held in Chicago in 2009, is self-revealing: 'Psychoanalytic Practice: Convergences and Divergences'. It is not only the theoretical unity of psychoanalysis that is now being questioned, but also the unity of its practice (Jiménez, 2009).

Essentially, the illusion of the practical common ground was supported by the restricted definition of *psychoanalysis*, defined as a form of therapy characterized

by the use of the couch, a high frequency of weekly sessions, and centered on transference interpretation; it excluded any deviation from this ideal as 'psychotherapy, understood as a degraded form of psychoanalysis. The artificial character of this restriction became evident when we showed, as we did in 1997 in the IPA Committee 'Psychoanalysis and Allied Therapies', that most psychoanalysts devoted not as much to psychoanalysis as to psychotherapy (Israel, 1999; Jiménez, 1999). Even today, few IPA training institutes incorporate the different form of psychoanalytic psychotherapy in their training programs; the idea that psychoanalysts should be trained to practice psychoanalysis according the classical definition prevails, even though they will certainly not do so in their professional life.

Over the past twenty years, therefore, psychoanalytic societies member of the International Psychoanalytic Association (IPA) have become aware of the crisis, which can be summarized as 'fewer patients, fewer people interested in training as psychoanalysts'. There is vast literature trying to explain the nature of the crisis. My personal standing as regards the crisis was presented 14 years ago in the IPA Newsletter (Jiménez, 2003) under the optimistic title "from threat to opportunity," where I call for creativity and flexibility in the face of inevitable change. In that publication I stated that institutions, overwhelmed by the new demands of a rapidly changing environment, often see themselves immersed in crises; the postmodern society, I claimed, has affected psychoanalytic practice to such extent, that we have been rendered at the verge of obsolescence, and almost outside the 'psychotherapeutic market', as regards both potential patients and young professionals interested in training as psychoanalysts. Currently, I feel more pessimistic as to the capacity of IPA-affiliated psychoanalytic institutions to adapt to change. Even though in the past two decades many experts (see Kernberg, 2012; Kernberg & Michels 2016; Schachter & Kächele 2017; Thomä 2015) have advocated the recommendation to insert psychoanalysis within universities, to bring innovation into psychoanalytic education, to broaden the conception of

psychoanalysis in order to include the diversity of psychoanalytic psychotherapies, to establish theoretical bridges with cognitive psychology and the neurosciences, to eliminate once and for all the training analysis system, to widen the basis of the theory beyond the clinical method towards the social sciences research methods, to name but a few, the most psychoanalysts, who work in the isolation of their private practice, have not been persuaded. Joe Schachter and Horst Kächele in a recently launched Kindle book (2017) are even more specific: They speak of "Decline in Psychoanalysis" supported by evidence showing that, at least in the USA, the "average number of analytic patients per member [of the American Psychoanalytic Association] continues steadily to decline. Follow-up studies of recent analytic graduates at three institutes, Columbia University Center, New York indicate that four out of five graduates devoted almost all their practice to other-than-four-sessions per week analytic treatment. The number of new candidates continues to decline; several pairs of institutes have merged in the hope of attracting a combined number of candidates sufficient to start a class". This evidence confirms once again what we found in 1997 as result of a survey sent to all IPA societies by the Committee 'Psychoanalysis and Allied Therapies'.

In these 'postmodern times' we have become aware of a trend towards fragmentation lying at the root of the psychoanalytic method (Jiménez, 2015). Accordingly, practical and theoretical diversity constitutes an inevitable fact in psychoanalysis. For a century this diversity was repressed by resorting to authoritarian definitions meant only to place the inherent tendency to diversification into a straightjacket. However, sharp questions emerge: What can we do in the face of the growing plurality of orientations and positions in psychoanalysis? Is psychoanalytic knowledge doomed to an endless fragmentation? Can a constructive dialogue between psychoanalysts adhering to different orientations and traditions take place so that the boundaries between theoretical and practical divergence may be outlined? This would make it possible to describe a field within which we could still be called psychoanalysts. In more

than 100 years, experts have been unable to agree on how to define core concepts such as 'psychoanalytic process' or even the very concept of 'psychoanalysis'. What are the tasks involved in the construction of psychoanalytic pluralism? Is psychoanalysis doomed to disappear as a discipline or as a unified 'branch of knowledge, typically one studied in higher education', as defined by *The Oxford English Dictionary*? In the university tradition an academic discipline supposes some central elements like the presence of a community of scholars; a tradition or history of inquiry; a mode of inquiry that defines how data is collected and interpreted, as well as a definition of the requirements for what constitutes new knowledge; and the existence of a communications network. But, to what extent does contemporary psychoanalysis meet these requirements? Precisely, the contemporary controversy in psychoanalysis centers around the mode of inquiry, hermeneutic or scientific, or both, that defines how data is collected and interpreted, and the requirements for what constitutes new knowledge in psychoanalysis. All these are questions that continue without definitive answers. Along with many, I have come to the conviction that in order to develop as an academic discipline and as a recognized and legitimated profession, psychoanalysis must cultivate not only its hermeneutic aspect, but also its scientific side. This means a simultaneous emphasis on process and outcome research but above all, on the interdisciplinary study of the mind/brain relationship. It is my contention that only the interdisciplinary scientific study of psychoanalytic insights may contain within limits the tendency to fragmentation inherent in the interpretive psychoanalytic method.

But, before continuing, allow me to highlight some distinctions. Even when closely related, psychoanalysis as a profession is not the same as psychoanalysis as a science or, better, as an academic discipline. I say this because for 40 years I have developed two careers simultaneously, as a psychoanalyst and as a psychiatrist and university professor. As a learned psychoanalyst, I have been part-time practicing psychoanalyst, psychotherapist and dynamic psychiatrist, training and

supervising psychoanalyst, president of my society, member of the executive board of the IPA, president of Fepal, the Psychoanalytic Federation of Latin America, and member of various IPA committees. As a university psychiatrist I became full professor and head for 13 years of the Department of Psychiatry and Mental Health at the most ancient Chilean university.

In this way, since 37 years ago I joined the Institute of the Chilean Psychoanalytical Association as a candidate, I have never stopped being an active participant and passionate observer of the development of psychoanalysis. Throughout the years I have gathered experience which is the product of the interaction within me of the analyst and dynamic psychiatrist working with patients in the consulting room and the scholar involved in teaching and research. Thereby, the attainment of a professional identity has demanded the constant analysis and integration of the differences and controversies that plague the relationship of psychoanalysis with psychiatry, as well as with the academia world. As an academic psychiatrist, and for over a decade head of a university department, I consider that the task of integrating information of diverse origin is a necessary condition, particularly in the training of psychiatrists and psychologists who are just beginning. As a legacy of my Philosophy studies, which I completed before I studied Medicine, I have a need to clear up the epistemological viewpoints involved in discussions. At the time I found out that in the history of science, novel solutions often arise as answers to questions made on the edges between disciplines. My inexhaustible fascination with psychoanalysis has its roots in precisely this borderline feature, as said by Carlo Strenger (1991) a psychoanalysis 'between hermeneutics and science'. Such a twilight position, however, is not easy to hold.

Regarding the relationship between scientific research and psychoanalysis, Peter Fonagy published a paper under the suggestive title of "Grabbing nettles or on why psychanalytic research is vexing" (2000), meaning with this metaphor the difficult situation in which we, psychoanalysts committed with research, find ourselves vis-

à-vis with the rest of our clinical colleagues. We are frequently frustrated, with a sense of futility, facing the passionate rejection with which these colleagues often receive our arguments and the results of our research. Of course, research is not for all. Research – Fonagy says – "is for those who want to live in the chiasm, in no man's land professionally, those who can tolerate to be considered suspects or even as traitors by both sides, those who want to work harder than most, like children of estranged parents who try hard to prove their loyalty to both, those who can endure the feeling of incompetence in both professions (the clinician and the researcher), all this surviving with only a meager portion of conviction" (p.195). This dramatic statement describes very closely my life experience for many years, trying to honoured simultaneously the psychoanalytic clinical identity and the identity as researcher and university professor. It is likely that the bridges between the clinical and the scientific in psychoanalysis are built, firstly, in the mind of some restless clinicians, dissatisfied with the traditional methods to obtain knowledge, who escape from the isolation of the psychoanalyst who works alone in the consulting room using theories that find no other validation than the individual response of the patient. Psychoanalytic researchers are clinicians who express urgent issues that the clinic cannot answer.

As I trained as a psychiatrist I started my own personal analysis that soon became a training analysis, after I was accepted as candidate for psychoanalytic training. Concerning my personal and training analysis, I can say that it has been one of the most important undertakings of my life, it simply changed in a positive way the manner in which I relate to the world and myself. However, with the benefit of hindsight, I cannot help saying that, together with the rest of psychoanalytic training, my training analysis made the integration task with activities other than my work as psychoanalyst painful and difficult. As was probably the case everywhere at the time, training analysis, theoretical and clinical seminars, were infiltrated, sometimes not very subtly, with the aim of achieving the so-called 'psychoanalytic identity'. In order to do this, psychiatry and psychoanalysis, as well

as psychoanalysis and psychotherapy had to be clearly differentiated. To put it plainly 'splendid isolation' was encouraged. In the faculty of my psychoanalytic institute a monist conception was at that time actually dominant, i.e., the supposition of the existence of a 'unique' psychoanalytic truth. In our case, we had to accept the Kleinian way of psychoanalysis. Other orientations were practically ignored or subtly dismissed as not psychoanalytic.

I finished my training as a psychiatrist together with the group that had taught me dynamic psychiatry at medical college. Later, my work as a liaison psychiatrist at a general hospital, especially in the area of internal medicine and neurology, triggered in me a great interest in the study of the articulation of the different models applied in psychiatry, and the issue of the multicausality in dynamic psychiatry (Jiménez, 1979). The work as liaison psychiatrist in the neurology department awoke my interest in the psychotherapeutic treatment of focal epileptic patients resistant to anti-convulsant treatment. In numerous cases of resistant focal epilepsy that I treated psychotherapeutically, I found that unconscious conflicts and some family dynamics were factors that prevented the anti-convulsant action of the medication (Jiménez, 1984).

Now I'd like to present a case that I treated at the time, that was decisive in my way of understanding, up to now, the epistemological position of psychoanalysis and which dramatically illustrates the possibilities and difficulties of interdisciplinary dialogue under the notion that mind and brain are two faces that, not because they are different, cease to belong to the same coin.

Rosa, a 25-year-old single woman, was sent to me by a neurologist with the diagnosis of focal epilepsy, with predominantly partial crises of the psychomotor type. She had been presenting seizures since she was 5 years old and had been closely studied regarding the brain variables. Multiple EEGs showed a left occipital spicular focal point, consistent with the visual aura that normally preceded the crisis. In the 20 years of the disease she had tried all the well-known anti-

convulsant drugs, and by then these had been controlled by means of serialized tests of plasmatic levels. The tomographic research, in its early stages at that time, did not show any structural lesion that could explain her resistance to the treatment, which had only prevented the generalization of the crisis and had managed to reduce the seizures to once a month. Throughout their evolution, the pattern of the crises had not changed, nor had psychometric signs of associated organic brain damage appeared. There was evidence that the patient did have the medicines and she did follow the instructions. We were then in the presence of refractory epilepsy, and self-induction of the crises was out of the question.

In the face of this case history, we decided to investigate her ailment within a wider context and proposed open-ended, three times a week, psychoanalytic therapy, which was agreed with Rosa, her neurologist and family. What was most striking about this patient – a pleasant looking young woman, somewhat fragile, of average intelligence, quite concerned about her personal appearance, though sober and soft both of manner and voice – was that, together with her conscious attitude of collaboration, she showed a particular incapacity to express her emotional state. All exploration based on conscious data, which attempted to relate her crises to some personal conflict, fail systematically because of the tremendous inhibition of her emotions and fantasy life. In this way, I paid special attention to the shape of her verbal and non-verbal behaviour during the sessions, trying to make emotional contact with her, beyond her ailment and symptoms. Little by little a divided way of functioning began to take shape. Behind that personality impoverished by massive disavowal and repression, there was a glimpse of a different personality with extremely intensive emotions, with violent and chaotic fantasies, which showed up with her crises. Her signal sign, the visual aura, was variable within the same theme, and seemed to be a basic fantasy of a structural value in the make-up of her inner self. Generally, it was shaped as follows: She saw herself going up to a house. She was curious to see what was inside. She went up to the window and could only see indistinctly. Her curiosity became

anxiety first, and then fear. She frenetically cleaned the windowpanes unable to clear up her vision of the inside of the house. Her fear turned into terror; at that point she heard a very loud noise like an earthquake that surrounded her and she then lost consciousness, on occasions completely and on others only for a brief moment that followed with the partial convulsion of the right half of her body, to which she attended with fear and dysphoria, followed by a subsequent sensation of disorientation. Her aura, a dreamy-state, matched well by her attitude towards her treatment, herself and others. There was a mixture of interest and strong resistance to insight, which suggested that terrifying anxieties were hidden under her placid appearance.

The treatment lasted 8 months, when her parents interrupted it. After the fourth month the patient's seizures stopped, and they reappeared dramatically at the end, a fact that I will mention at a later time.

At the beginning, the seizures occurred just as before, regularly once a month unrelated to her menstruation. It was evident during the second seizure that it had occurred in connection with family conflicts, particularly with her mother. The patient complained that her mother did not allow her to work or go out with boys, and warned her that if she did she would suffer a crisis. In fact, I noticed that the seizures occurred when the patient transgressed certain established limits related to her independence, such as going out to look for work or to dance. When she went back home there was silent tension between mother and daughter, which on occasions became open discussion that concluded, if not immediately, at least after a few hours, in a seizure. After the crisis, the patient woke up in bed with a lovingly attentive mother by her side. On those occasions, her mother left the conjugal room and went to sleep beside her daughter. After a few days, in which she was treated as a small child, Rosa's efforts to persuade her mother to let her go free began again, and in this way a new cycle of independence and crisis was also set in motion.

This mother-daughter relationship that suggested a structure capable of making sudden regressions pointed out an intense conflict between independence and symbiosis. We analysed this conflict in a systematic manner with the aim of moving this ambivalence to her inner: She was the one afraid to become independent, the one afraid of separating from her mother. This interpretive work was made easier when Rosa started to bring dreams of transference content where she was in the street, sometimes with me, in seriously dangerous situations, deadly accidents, or in the midst of a pack of rabid hounds, and where her tendency was to run to her home in search of protection. These dreams were the counterpart of her dreamy-states. Interpretive work contributed plenty of data on the underlying family myth and on how the patient's ailment was inserted at the center of balance of the entire family, data that, due to time, I will not address.

At any rate, the interpretive work was seemingly confirmed when on the fourth month the vicious circle mentioned did not end up in a seizure. Rosa, who had started to work as a secretary, in spite of maternal warnings, felt afraid of her new independence and began to use her mother as a pretext to stop working. Simultaneously, her mother warned her of the dangers of work and had discussions with her husband for his lack of concern about their daughter. The patient's blame increased, which we analysed in the sessions. All this increased until one day Rosa openly argued with her mother. As on previous occasions, though this time without ending up in a crisis, she said she felt such an intense rage against her mother that she had locked herself in her room and had destroyed the plant her mother had given her. She had cried and kicked until she was exhausted. She had then felt calmer, but overwhelmed with guilt at having destroyed the Rubber plant she had taken care of with such affection. She planted the pieces she rescued in a new pot. She said: "I planted a child." I told her that she had been able to direct her rage towards her outer self, attacking her Rubber plant which represented her mother instead of instigating a seizure. I added that the cutting/child represented her person, somebody who was able to survive the

breakup of the close relationship with her mother. She had no seizures during the following four months.

However, her improvement triggered some reactions in the whole family. Her father tried to interrupt her treatment on the fifth month claiming that the girl was doing better. I noticed he was anxious on account of the mother's pressure who realised her daughter was becoming more and more independent. As Rosa's independence increased, the relationship between her parents worsened, which in turn increased the pressure to make her abandon her therapy. Things came to a head when the mother started to show physical symptoms of what I thought was Diabetes Mellitus. Rosa felt more and more guilty. Her mother made her subtly responsible for her state, but did not see a doctor. Finally, what was going to happen happened, her mother suffered a diabetic coma, so she had to be urgently hospitalized, and the accurate treatment quickly compensated her. Not only her mother, but also the whole family pressured Rosa to stay next to her mother, and they even tried to stop her from leaving her to attend her sessions. Despite all this, Rosa resisted and we went on working until her mother was sent back home. Two days later, a dramatic scene took place: At the time of the session Rosa and her parents arrived looking very agitated. Rosa had been for about half an hour in a state of sub-entrant seizures which became epileptic status in my surgery. In her presence they blamed me for the state of their daughter. Fortunately, I was ready and was able to inject her intravenous Diazepam, which stopped the seizure. That was the last time I saw her parents. I was able to set up one more appointment for her and with the promise that the treatment was to finish.

In the analysis I made 33 years ago, when I published my experience on the psychotherapeutic treatment of epileptic patients, I indicated that regardless of the apparent therapeutic failure – I say apparent because 20 years later I learned, by chance, that Rosa had never again had any more seizures – and of the possible criticism towards the interpretive strategy carried out, this case shows a great deal about the relationship between the biological and psychosocial levels of behavior. I

stated that, as expressed by Freud, we found ourselves with the psychodynamics of parricide or, rather, matricide. The seizure represented the simultaneous realization of two opposite desires: That of killing the mother, and that of trying to prevent it. The seizure is the enactment of the solution of the conflict. At the very moment the patient raises the disavowal of her emotions and the massive repression of the cognitive contents, and is able to talk emotionally of her conflict and the conditions to continue with the growth process towards a greater individuation are established. I, as analyst was the one who sustained her inter-subjectively in that process. The independence attempt failed, probably because the mother's disease, that she (the mother) unconsciously manipulated to recover the previous family balance, highlighted the killing desires of her daughter, making even more difficult the differentiation between the fantasy and reality, needed to escape from the symbiosis. Despite all this, I finished the presentation of the case stating that this psychodynamic interpretation says nothing about the psychobiological mechanisms that allowed the seizures to stop in this patient and to reappear with such intensity, but it does suggest that we should do more research into this field. This case taught me dramatically that, in therapy, content and process are two different things; that the significance of symptoms says little, if anything, about the mechanism of disease. With this insight, and some years before reading Grünbaum, I questioned the psychoanalytic theory of pathogenesis and therapeutic change.

But my job with epileptics did not last long. As I read through the literature, I found that the early psychoanalytic interest in the study of epilepsy, where Freud, Stekel, Pierce Clark, Kardiner, Greenson and, in Latin America, Pichon Rivière were prominent, was soon abandoned. It is likely that this interest was rather theoretical, as it seemed to be a search for evidence for the economic aspects of the theory of the libido. Impressed by the energetic discharge in epileptic seizures and in the search for an understanding of the crises of emotional discharge, the tendency to enact, the compulsion for repetition, etc., these authors may have

seen in epilepsy a good example of the theory. The progressive desertion of the theory of the libido, the lack of effectiveness of the purely psychotherapeutic treatment, as well as the appearance of the EEG, caused the interest for the psychoanalytic study of epilepsy to wane drastically in the forties of the last century. When I noticed I was the only one drawn to this study, and that neither psychoanalysts of my society nor neurologists of my university showed any interest in the psychodynamic study of epilepsy, I also dropped out of that field of clinical research and left for Ulm, Germany, to train into empirical research in the psychoanalytic process. My decision was based on the idea that it was necessary to build a common ground where hermeneutics could converse with the natural sciences, and in order to make that conversation possible, psychoanalysis should begin the attempt to operationalize its constructs. In the late seventies of the past century the gap between psychoanalysis and neurosciences was too wide, a situation that from the work of Eric Kandel and other neuroscientists during the last 30 years and the discoveries of the last decade on gene environment interaction has started to change. As shown by the emergence of neuro-psychoanalysis, this rapprochement has made the psychoanalytic study of neurological conditions an interesting field once again. In any case, my integration into the Ulm's group made me discover a widely open psychoanalytic world. The university group, led by Helmut Thomä, was at the time a cauldron of critical thinking, and soon I felt the intellectual benefits of such a creative atmosphere.

During the twentieth century, the field of psychiatry experienced what Kenneth Kendler (2005) rightly called the *battle of paradigms*. At the start of the last century, psychiatry was just establishing itself as a medical branch and as a discipline, especially in the German-speaking world. Among others, Kraepelin, Bleuler, and even Freud were discussing which etiopathogenic principles should organize the nascent psychiatry. As George Makari convincingly shown in his book *Revolution in Mind: The Creation of Psychoanalysis* (2006), psychoanalysis was, among other things, the proposal that Freud and his group made to the academic

world in response to the question of what mental disease is, what causes it, what its mechanisms of production are, and how it should be treated. The story that followed is well known. During the twentieth century, the rejection by academia of unconscious mental processes and of the notion that it is also possible to become ill due to biographical reasons led to the development of psychoanalysis as an independent hermeneutic discipline, which sought to become epistemologically autonomous. However, the illusion of autarky has resulted in a psychoanalysis that is isolated from natural science and the rest of the disciplines of the mind. This situation may have been inevitable, given that even though Freud never abandoned the idea that mind and brain are two sides of the same coin and that at some point we would eventually discover drugs that could modify pathological behavior, the knowledge about the brain that academia had in the early twentieth century was not on a level with the central discovery of psychoanalysis: a dynamic mind with unconscious motivations. The neurology of the time had yet to finish describing the macroscopic anatomy of the brain; neurons and synapses were just being discovered. In this context, the main intellectual framework of psychiatry could not go beyond the anatomo-functional paradigm advanced by the German neuropsychiatrist Wilhem Griesinger some decades before: *mental illnesses are brain diseases*. By the way, taking advantage of current knowledge we do not object to the assertion that mental illnesses are brain diseases, with the difference that the definition of brain has changed radically. Neuroscience has discovered that the most relevant brain for mental disorders is the so-called 'social brain', which only develops within the context of personal relationships; thus, we speak about mind/brain as two sides of the same coin.

The problem of the twentieth century, then, seems to have been that each orientation defended its own paradigm as the only valid explanation and disregarded all others as mistaken or irrelevant. There was a mainstream psychiatry, the biomedical, and others more or less marginal psychiatries, like a psychoanalytical or psychodynamic psychiatry, a phenomenological psychiatry, a

behavioral psychiatry, etc., without epistemological and methodological interconnections making constructive dialog between them possible. A similar phenomenon occurred within psychoanalysis, where the various schools and orientations fought for the right to be Freud's true heirs, and where anything outside of the scholastic canon was labeled as *not psychoanalysis*. In the context of paradigmatic crisis in psychoanalysis, where the experts cannot reach a consensus about what is true psychoanalysis, the developments of the last decades in process and outcome research in psychotherapy and in neuroscience of psychological change, have added pressure and sharpened the controversy on theory construction in psychoanalysis.

But times have changed also for mainstream psychiatry. DSM/ICD as diagnostic systems, the gold standard of psychopathology, is now under intense criticism, and psychiatry is going through a stage of deep reformulation. One reason behind this is that research in psychiatry has targeted mental disorders defined according to the criteria of DSM and/or ICD. The central criticism points to the fact that DSM is a diagnostic system based upon clinical presentation of sign and symptom, with reasonable reliability but with a dubious validity. For example, the DSM-IV diagnosis of major depression, a highly prevalent disorder, does not meet any of the commonly accepted standards of validity (Maj 2012). So, research in psychiatry faces the major challenge of the enormous clinical pleomorphism (Mann 2012). Conversely, it is highly likely that heterogeneous syndromes grouped into one disorder include different pathophysiological mechanisms.

Considering this situation, the National Institute of Mental Health has recently launched the *Research Domain Criteria Initiative* (RdoC) with the aim to "develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures." (Cutberth & Insel 2013, p.4) The RdoC Project proposes that future psychiatric and psychotherapeutic research should focus on systems underlying basic psychological capacities (such as reward neurocircuitry, and the neural systems implicated in

self-representation, theory of mind, attachment/separation fear, and positive and negative valence systems), rather than on discrete DSM disorders. "Rather than starting with symptom-based definitions of disorders and working toward their pathophysiology, RDoC inverts this process. Basic science – in genetics, other areas of neuroscience and behavioral science – serves as the starting point, and disorders are considered in terms of disruptions of the normal-range operation of these systems, with an emphasis on the mechanisms that serve to result in dysfunctions of varying degrees" (Cuthberth & Insel 2014, p.4). Therefore, RDoC is a transdiagnostic approach. At a first glance RDoC seems to be a reductionist initiative insofar seems to consider mental diseases as brain diseases. But a careful look shows a more sophisticated view. Actually, RDoC does "not suppose that neural dysfunctions are the only causes of mental disorders, but rather recognize developments in mental health sciences showing that causes or risks of mental disorders may operate at many levels, including the genetic and the neural, the individual, the family environment, and the social context. Crucially, this view of multifactorial or multilevel view of causation (or risk) acknowledges and is intended to accommodate the fact that interventions at these various levels may affect onset and course, playing parts in primary prevention and management and treatment after" (Bolton 2013, p.24). RDoC is a transdiagnostic and multilevel approach that recognizes "bottom up" causation, as well as "top-down" causation. In my view, RDocs opens a window of opportunity for collaboration between neuroscience and a research-minded psychoanalysis; the 21st century may represent a second opportunity for Psychoanalysis, as a discipline of the mind unconsciously motivated, to build bridges with natural science and psychiatry

My contention is that psychoanalysis will benefit from an active dialogue with related disciplines. But, for this dialogue to be fruitful, psychoanalysis not only must incorporate the contributions from other disciplines into its development of theory and practice, but in turn it must contribute to defining and signaling relevant areas for other disciplines to develop important research and scientific

knowledge. In the case of neurosciences, Kandel (1998) has stressed the need for psychoanalysis to "*define for biology the mental functions* that need to be studied for a meaningful and sophisticated understanding of the biology of the human being" (p. 459; my italics). Through this contribution psychoanalysis can become an active participant, together with other related disciplines, in the attempt to understanding the mind (Kandel, 1998). From another edge, more recent psychoanalytic theories and conceptualizations of clinical intervention can define clinically relevant areas of study for psychotherapy research to develop lines of study. In turn, psychoanalysis can help organize and make sense of the empirical findings within psychotherapy research, thus strengthening in turn the development of psychoanalytic theory in such a way that it be in permanent contact with the current developments of related disciplines. Furthermore, serious and systematic research on psychoanalytically driven therapeutic processes constitutes an opportunity for a further practice-bound and systematic development of psychoanalytic theory as well.

Interdisciplinary research can also serve as a framework for dialogue between psychoanalytic orientations and, thus, as a mean of building a *real* pluralism in psychoanalysis. In this line, Fonagy and Target (2003) have reviewed the main psychoanalytic theories systematically comparing them to the results of empirical research in developmental psychopathology. This emerging branch of developmental psychology offers a good comparative perspective (from *the observed infant*) to limit the scope of what Daniel Stern (1985) called the *clinical infant*. However, we are fully aware that this is not an easy task. Carlo Strenger (1991) reminds us – taking psychotherapy outcome research as an exemplary case – that, in psychoanalysis:

> The comparison between alternative theories and practices [...] is [...] more complicated than a non-pluralist might assume. It involves different types of intellectual operations. One of them can of course be the empirical investigation of the relative therapeutic efficiency of the approaches. Even

> here, however, an added complexity comes into play. Given that the forms of therapy may be guided by different perspectives, it may not be possible to translate their terminology on standards of mental health into each other. Direct empirical comparison must therefore be preceded by careful conceptual investigation into the questions on which the approaches are commensurable. The pluralist position implies that the result of such an investigation can be quite frustrating, and it even possible that no common ground for comparison be found [p.160f].

In my presentation, which is approaching its end, I have presented to you how I have experienced and worked-through the tensions that plague contemporary psychoanalysis, especially in its relation with allied disciplines of the mind and with psychiatry. Now, you expect me to talk about the future of psychoanalysis. I am afraid I will disappoint you. The future depends on what we do in the present. In any case, as a result of 30 years of involvement in IPA politics trying to draw attention to critical issues, the future scenario for the profession and for psychoanalysis as a scientific discipline seems to me not particularly auspicious. The current president of the IPA, in his last year-end message, did not highlight any of these critical issues; he drew rather an exceedingly optimistic panorama of the current and future development of psychoanalysis. After an extended period in which IPA leaders fought for a renewal, it seems that we are witnessing a counter-reform period. Personally, I decided to withdraw from the psychoanalytical politics and concentrate, during the last years of my academic career, on developing lines of interdisciplinary research in epigenetics and psychotherapy.

At any rate, the 21st century proposes for psychoanalysis a gigantic task, namely, to take the opportunity for building new bridges with natural sciences and with the recently emergent psychiatric paradigm, that in principle doesn't reject unconscious motivation. However, in order for this task to be accomplished, psychoanalytic discipline and profession must live up to it. In effective interaction with other disciplines, psychoanalysis must be prepared for important changes in

its own theorizing and in the practice of psychoanalytic treatments, which requires flexibility, and political and intellectual leadership. The proposals for action are there. Eminent colleagues, such as Kernberg & Michels (2016), Schachter & Kächele (2017), and Thomä himself in a posthumous work (2015), among others, have offered paths to follow. If we are not able to change course, I fear our profession will follow the development of decline that so many have described; In addition, the most appreciated insights of our discipline will be absorbed by psychology within a context that makes possible its scientific validation; This is already happening with the idea of the unconscious. Psychoanalysis may prevail as a general deep hermeneutic, but the clinical psychoanalytic activity, which is increasingly subject to scrutiny by evidence-based medicine, will continue in a process of marginalization. To paraphrase Freud, I can only hope that in the struggle between renewal and psychoanalytic petrification, "the other of the two heavenly forces, eternal Eros, will put forth his strength to maintain himself alongside his equally immortal adversary" (Freud 1929, 144).

Thank you very much for your attention.

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