

Interview With Edgar A. Levenson January 24, 2004

Edgar Levenson, M.D. , Irwin Hirsch, Ph.D. and Victor Iannuzzi, Ph.D.

Hirsch: I want to start by saying that it's an honor for both of us to do this interview with you. As do many, we consider you the key interpersonal theorist following Sullivan, Fromm, and Clara Thompson—the Willie Mays or perhaps the Michael Jordan [laughter] of interpersonal analysts. Seriously, you are the key interpersonal theorist responsible for bringing interpersonal psychoanalysis from them [Sullivan, Fromm, Thompson] to contemporary times. Your uncompromising attention to the inclusion of the analyst's subjectivity has played a seminal role in laying the groundwork for opening up psychoanalysis to include the study of perspectivism, postmodernism, and for what's now widely called the “relational turn” in psychoanalysis. With that said, we feel there is a lot of ground to cover in the interview and so we decided not to focus too much on your personal life history. However, I would like to begin by asking what your personal reasons for becoming a psychoanalyst were?

*Levenson: I arrived at it in a rather desultory way. I had gone to medical school, as a lot of middle-class Jewish kids did, because there weren't an awful lot of things one could do professionally in the 1940s. Once I got through medical school I really wasn't particularly sure what I was going to do with it, since I hadn't figured out what I was interested in really. At that point I went into the army for two years and was stationed overseas during the occupation. When I went in, I'd had a neurology residency, so the army gave me a neuropsychiatry specialty rating, and when I came out I was, *mirabile dictu*, a psychiatrist. I went on to get my boards in psychiatry, and then I went into analysis because I needed an analysis. In those days analysis was a little like syphilology in that it was okay to treat the disease but not to have it. It was still considered*

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somehow moderately embarrassing for me to be in analysis, so I sugarcoated it as a training requirement and it became a lot more acceptable. I went into analysis with Ed Tauber and from there I applied to the White Institute where Ed was one of the people who interviewed me. In other words, I sort of backed into becoming an analyst. It was never anything I'd really planned to do. Probably, if I'd had the analysis earlier I would've been an insurance salesman.

Iannuzzi: You were in training during the early 1950s, which were pretty exciting times at White. Sullivan died in 1949, but Clara Thompson was around and Fromm was, I guess, in and out. Can you talk a little bit about who your major influences were, both within and outside of the Institute?

Levenson: Sullivan had died the year before, so I never worked with Sullivan or knew him. Clara Thompson was around, Fromm-Reichmann was around a lot, and I think she was a bigger influence than people tend to consider now. She was working directly with schizophrenics and everybody was fascinated by that. Fromm, living in Mexico, was in and out; I had some group supervision with him. I think the biggest influence—I was thinking about this before—the influences were kind of implicit. I really didn't have a theoretical position, so it wasn't like I was trying to bounce my theories off people. I was simply absorbing a lot of what everybody did clinically. I think probably the biggest influences were Ed Tauber and Meyer Maskin, who was my first supervisor. There were a couple of other things that were floating around at White, but not directly connected. One of them was a lot of this stuff coming out in family therapy, which was extremely lively back in those days. And then the other factor which I've been thinking about, and I'm not really sure how this came about, was Count Alfred Korzybski. Do you know much about Korzybski?

Iannuzzi: You've written about him, I know.

*Levenson: Korzybski was the founder of General Semantics. The journal is still around and so is the organization. I can't remember how I got to Korzybski exactly. Actually, I think I had a patient who was in the General Semantics group and he got me interested in it and I read some, and the first paper I ever gave was at the General Semantics Society, and the first paper I ever wrote (**Levenson, 1961**) was published in ETC [ETC: A Review of General Semantics], which was the General Semantics journal. I can't remember how much interest there was in him [Korzybski] at White, but he had studied for two years with William Alanson White and*

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he had also spent a summer with Sullivan and [Edward] Sapir, studying psycholinguistics. He was a major influence on me because he developed the concept that as the levels of anxiety go up the levels of abstraction go up. When I was in supervision with Clara Thompson, she used to say that if you started with a patient, and after the first week you found yourself thinking in terms of diagnosis, look to your countertransference. The idea being that the uneasier you became the more you began to diagnose,

*abstract, generalize, and so forth so. Fromm was at that time a more temporary sort of influence, because he was very characterologically oriented. That was about the time that Wilhelm Reich's book *Character Analysis* (1933) was popular and everybody was very stimulated because it was the first move away from Freudian dynamics to something that had to do with character structure. Fromm was very much interested in character structure too. He was very denunciatory really. So that for a while everybody went around sort of saying to their patients, "Look here, you know, you're the kind of person who blah-blah-blah-blah ..." It worked for Fromm, but we all lost our patients doing it!*

Hirsch: *Erwin Singer was a lot like that, and although I never knew Ed Tauber, I believe he had a similar reputation.*

Levenson: *Erwin Singer had a lot of that quality as you say, and so did Ed Tauber who had been analyzed first by Clara Thompson and then by Fromm. He thought of himself as a Frommian and he very much acted as a Frommian. But conceptually he was very much influenced by both Clara Thompson and Ferenczi. So Tauber's [and Green's] (1959) book on prelogical experience really comes down through Ferenczi and Clara Thompson. This whole effort to understand your own participation and the nature of participation really came from Clara Thompson. There was a funny tradition at White of disowning your first analyst I think.*

Hirsch: *Was Clara Thompson a big influence on you?*

Levenson: *She wasn't really, at least not overtly. Erwin [Singer] and I shared supervision time with her for two years, and actually she didn't say very much! [laughs] We used to go afterwards and sit in the coffee shop and discuss cases. If she was an influence, it was through some kind of silent infusion. It wasn't anything that she said very directly. I think it was more the basic structure of White that was influential—there were three things going on at White during that time. One is that the original contingent of White people had left the American, and so they were very companionable, collegial, and interested in getting people to work with them. They were kind of grateful you came to the place and*

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they weren't so judgmental. The whole sense of things was—well, it was very egalitarian I think. Patients were considered human beings, including schizophrenic patients who were treated as people, and candidates—lowest on the pecking order ordinarily—as well were considered people. There was a much stronger sense of egalitarianism than was current in the American. The second thing is that there really wasn't any theoretical coherence. There wasn't a unified theory at White because Fromm and Sullivan were absolutely incompatible really, if you

stop to think about it. Clara was presenting a version of Ferenczi's psychoanalytic perspective. So you had the influences of Ferenczi, Sullivan, Fromm, none of whom really fit together, although nobody ever quite said that. Third, the candidates were left, I think, trying to bring these incompatible views together. We all became intuitively postmodern. The feeling around the Institute was very much that there was no system of interpretations that really had hegemony over any of the others. I think the feeling came out that there must be something in what we do. There must be something we all do in common; why else are these people all in the same institute.

Hirsch: *I think that the White Institute still has that quality; the “interpersonal” continues as the key strain, although many analysts have other theoretical allegiances at the same time.*

Levenson: *Yes, well, the theoretical allegiances, though, are to metapsychology, really. It seems to me that what the interpersonalists hold in common is something about a belief in the process: that it depends in some way on analysts bringing themselves to the engagement with the patient, in some relatively authentic way. In other words, you aren't working toward some kind of idealized performance such as neutrality or maybe empathy or mothering. Instead, you're going to bring yourself into the room in some very imperfect human way, and the work requires a lot of monitoring of your own imperfect flawed participation. Instead of eliminating the flaws of participation, one tried to actualize them. I think that's still true around White.*

Hirsch: *Did any of your contemporaries or juniors have an important impact in your thinking or in how you worked?*

Levenson: *Actually I think they had more impact—we were all impacted more by each other than by the people who were teaching us, because of the wide diversity of what was being taught. Erwin Singer had a tremendous amount of influence on me; we worked very closely together. Actually Erwin, Ben Wolstein, and I spent a lot of time together,*

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particularly on the Cape, with Ed Tauber present. Ben always managed to somehow leave out that his first analysis was with Ed Tauber. He had a real falling out with Ed years later and he sort of made him persona non grata and claimed his major influence was from Clara Thompson. But we used to spend a lot of time sitting around on the Cape talking about theoretical stuff. I'm trying to think—I think Dave Schecter was one of the major, maybe the major theoretician in our peer group, because Dave was the one most interested in and most knowledgeable about early developmental theory. At that time, White was very much

underplaying early development. Sullivan had been more interested in adolescence and so there really wasn't much in the way of early developmental theory. So he [Schechter] brought that to play. I'm trying to think—I think those were mostly the people.

Hirsch: *What about your juniors?*

Levenson: *Well, this is embarrassing, but nobody comes to mind, [laughs] I don't—I'm trying to think for a minute.*

Hirsch: *If you have to think then there's probably nobody.*

Iannuzzi: *I'm curious about whether you were at all influenced during your training at White by Fromm's interest in Zen and its relationship to psychoanalysis? In your writings you have made scattered references to Eastern psychological perspectives and to Zen.*

Levenson: *Well, Fromm was interested in Suzuki, and what was his name—Watts, wasn't it?*

Iannuzzi: *Yes. Alan Watts.*

Levenson: *I think partly it was sort of in the air, just like the interest in anthropology and [Margaret] Mead and [Ruth] Benedict and cultural relativism. I don't know that anybody at White was particularly influenced by it. I'm not sure Fromm was directly influenced by it. God knows, he never believed in nonaction—at least not with his patients. It was after World War II and it was a time when everything was opening up, particularly Asia. People were very interested in Asian studies and in Mead's work, and this was opening up a new world. I'm trying to remember—it was early in the fifties and sixties—it [Zen] was a metaphor for what now we would call postmodern relativism, and non-Aristotelian logic. At that time it was an attractive metaphor. I think what happened, at least for me, is that really I never had a coherent theoretical position. I was very, very interested in what was happening clinically, and I was following it as closely as I could. As the decades changed I shifted paradigms to whatever seemed at the time to illustrate my position. First I*

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started with Korzybski, and then became interested in Zen, Sufism, and the Tao—they all have the greatest teaching stories and aphorisms. And then I became interested in General Systems Theory and Chaos Theory. Now I've moved onto using current neurobiological images, but more paradigmatically or metaphorically than in any very specific, concrete way. So I think the only continuity has been my interest in the clinical process. The metaphors have shifted over the years, but my vision of the praxis remains consistent

Hirsch: Speaking of your clinical interest: certainly throughout your writing you've made it very clear that the early Freudians were too driven by metapsychology. Still, don't all therapists have to have at least what Joseph Sandler (1983) called a private theory, and doesn't that make us all guilty to some degree of what you have called "persuasion"? Can you really have a theory of praxis without a theory of motivation and development?

Levenson: Well, I think there are two different questions. One is whether you can be free of a metapsychological structure, and the other is to what extent you're inevitably imposing it on the patient and to what extent that matters. It seems to me there is now a very wide variety of metapsychological theories, developmental and motivational and so forth. If you think therapeutic effectiveness depends on getting across some sense of understanding, then I think you really are involved with persuasion; you're laying on the patient a particular conceptual set about what matters. I've always said that there's a commonly held praxis of therapy. There's something all therapists do and essentially I think it is to get involved in a deconstruction of the patient's narrative. Whenever the patient tells you the story of his or her life, you either expand it by free association or by a detailed inquiry. In the process of working through, I think the patient is getting better, not because your metapsychology works, but because somewhere in that process you're doing a real deconstructive inquiry. The detailed inquiry isn't intended to make it all clearer, but to open things up: to unpack the story in such a way that it gets more complicated and more enriched and more interesting, clinically. Now it seems to me that what happens at that point makes a significant difference because patients are then more open to reorganizing their experience. The therapeutic act lies somewhere in this kind of enrichment of the data. You and/or the patient may then formulate it in a variety of ways, trying to have it make sense. But that's an effort to

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take what's essentially a nonlinear process and then to superimpose a linear explanation on it. There are many ways that it's been put, for example, putting a left-brain explanation on a right brain process. A lot of people, including neuropsychologists like [Daniel J.] Siegel (1999) and [Allan N.] Schore (1994), feel that therapy consists of a right brain to right brain interaction, bracketed or parenthesized with some kind of a coherent explanation which is a linear, language-oriented, left brain explanation. But the explanation isn't the therapy. Ergo Korzybski's (1933) famous aphorism, "The map is not the territory." Or, another way of putting it is you can't make a cake by baking the recipe! Way back

at White, people like Clara Thompson used to say that you made an interpretation to bracket the clinical experience. In other words the interpretation always followed the clinical experience and the interpretation really wasn't the mutative event. It wasn't the formulation that made therapy work; the formulation was simply a comment on something that had already taken place. Another way of putting it is what [John] Gedo (1999) talks about—that the future of psychoanalysis is going to be in the examination of self-organization. What's now going on in neurology has to do with ideas of mind, memory, consciousness, and self-organization. I think it leads to the idea that as an analyst you are doing something which impinges on the patient's self-organization. The patient, in the black box of his head, then processes that through in some way that you have no direct connection to and then uses it. In other words it reorganizes their perception of things. It isn't a linear process wherein exclusively or even largely, you and the patient are talking about something and getting it clear, but rather that you're operating to keep unpacking or opening the inquiry in such a way that the patient's formulations are loosened and opened up, and then the patient does something with it, which you have no direct connection to. That's got to be true, because if you listen to clinical material, you can see the way you get into something. Let's say you begin to explore something and it's interesting and you're beginning to work with it, and then the patient comes in with a dream that just unfolds—still on the same topic—but opens a whole other area. You have this feeling when working with patients that you're really tapping into some kind of conscious flow that you have no direct control over.

Hirsch: Well, from what you just said about self-organization, it almost seems as if the analyst is somewhat out of the picture, except perhaps as

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a catalyst or facilitator. Wouldn't that contradict your basic tenet that the analyst is always participating with the patient, including whatever theoretical predisposition the analyst has? Does that make sense?

Levenson: Yes, you're making a lot of sense; it's a very good point and I have to elaborate. See, I'm against the idea—which I think was a phase of the interpersonal movement—that you cure a patient through the impact of your experience, through a holding milieu or correction of countertransference. In other words, that if you kept working through your countertransference, the patient would get better because of some essentially corrective experience with you. I have to clarify what I mean by a “deconstructive inquiry.” I think you could say that neurosis is a kind of cliché, in other words, the patient knows only one way of doing

something, and it doesn't really work. This gets kind of complicated; it gets me back to Korzybski and the levels of awareness. If you really think about it, people from early in their lives are trying to figure out some way to maneuver in the world, to make sense of the world. It seems to me what happens all the way through your life is that you're constantly having experiences and then trying to measure the experience and make formulations about what works in the world and what you can and can't do. To maneuver successfully requires a balance between having formulations (maps, schemata) that permit flexible and rapid responses to events in the world. For that to happen, the schemata of experience must not be so rigid and stereotyped nor so immersed in detail that flexible response and decision is not possible.

Hirsch: *You're talking about the process that occurs within the patient, moving somehow from stereotyped or narrow ways of looking at the world, is that right?*

Levenson: *They're not simply narrow, they're abstracted. I would make a distinction between "stereotyped," which is an abstraction (e.g., all Italians love opera), and "concretized," which is to be lost in a mass of unaccentuated data. I think that people, if they're not too neurotic, have configurations or formulations that are fairly flexible. As your level of anxiety goes up, you tend to go to more and more stereotyped, abstracted formulations. Or you can do the opposite, which is to stay extremely concrete and close to the data. What tends to happen is that people either operate very concretely with massive data but little ability to abstract or distinguish experience; or they have extreme abstractions, which sort of work but really don't have enough flexibility. For example, it seems to me that people who are paranoid are essentially using a*

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strategy for dealing with the world. They're not semiotically sophisticated enough to know who's reliable and who isn't. What they do is to use an abstract strategy; they assume everybody's out to get them. Now, if you do that, you're essentially safe. You're not going to be taken advantage of by anybody if you assume everybody's out to get you. You're not going to have much intimacy either, but that's probably a reasonable price to pay for feeling safe. So the more anxious or semiotically mystified people are the more they tend to move to a higher level of abstraction. Often in therapy you're listening to peoples' sense of their life experience and trying to move them from clichéd abstractions to something much more complicated, but also much more flexible. In the process of doing that, you're bringing yourself into it, because you're inevitably making yourself a participant in the stories they're telling you.

You really have to listen to the story, virtually seeing it, and then notice what other ways it could be seen. In the relationship with the patient, countertransference is a very powerful instrument, in that as much as you can, you're bringing into awareness your own distortions, which I think is a way of educating the patient to a way of being that is more flexible and sophisticated.

Hirsch: *By bringing in your own distortions, do you mean telling the patient or being aware of them yourself?*

Levenson: *Being aware means it impacts on you and your behavior even without active effort on your part. I think there's a continuum from simply being aware to actually telling the patient about it; that's argued a great deal among people at White. It does seem to me that the cardinal issue is to be aware of countertransference. If a patient has a dream and sees the therapist undisguised, very carefully folding up and neatly putting away her laundry, the therapist has to think that maybe the patient feels the therapist is organizing the therapy in some very neat, self-serving, theoretical way that has nothing to do with the patient. So if you are aware of it, you would inevitably change the way you're listening; or you might decide to tell the patient—that's a matter of how you want to work. What it says to the patient is that if she's had a marginal fleeting sense of something, she should listen to it—maybe there's something to it. Also, it's getting away from the idea of the analyst as always a benevolent and concerned person.*

Hirsch: *Would you be inclined, just as an example, to say to the patient “You seem to see me as being too weak and too stereotyped in what I'm doing, that I'm folding laundry in the same way?”*

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Levenson: *No, I wouldn't say, “You seem to see me...” That's the kind of thing that [Evelyne] Schwaber might say. What that implies to the patient is, “I'm very interested in your perceptions of reality, because we're interested in how the world looks to you, but I'm not saying it's true. It doesn't matter whether it's true, I only care what your experience is.” The effect is for the patient to have the feeling that you're very interested in analyzing their fantasies, but you don't believe they're veridical. But I'm more interested in the patient getting a sense that there is a more nuanced way to look at events throughout life. So if you say to the patient, for example, “It sounds like you have some feeling I'm not paying any attention to you, I'm just doing my own thing,” then the analyst is acknowledging his participation, and it seems to me what the patient thinks is, “I have an instrument. I have a way of looking at what people are doing, so I can feel this one time, and then something else the*

next time. I can feel that maybe she's damaging even if she doesn't intend to be." So it seems to me the process is one of getting to that enrichment of awareness. I don't think that's directly curative by the way, or mutative. I think what happens is that it permits patients to begin to reorganize their experience and, as I've said before, that involves some kind of selforganizing, self-system. I think nobody has even the slightest idea of how that really works, although the neuroscientists seem to be working in that direction. Essentially it seems to me the real issue is that the analyst is saying to the patient "Your dream is a legitimate comment on the interpersonal field. You're having an experience, you picked something up, use it." I think there is a continuum of self-exposure, isn't that right? So it's also quite possible that you could say to the patient, "I guess I've been being too, blah-blah-blah," and the patient could have a faint feeling of annoyance with that, which might have to do with the idea that you're so in love with your own honesty, let's say, or you're deflecting any kind of anger. So the working through usually is that you're going to bring something to that exchange. You're moving to the next level of the unraveling, which is the working through for you and the patient. At that point the patient is then dealing with who you are and what you're bringing to it in your own defensive operations. Sullivan said that patients, like children, very carefully monitor the anxiety of the therapist. I think you're just making explicit something that's really there; it makes it possible for the patient to come to terms with it.

One of the problems with theory—and it's been my problem with it too—is the feeling that this process of demystification is what really has

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the therapeutic leverage. I think it does, but I don't think it's direct. I really think what happens is it impinges on a nonlinear system in the patient's mind. If you do clinical work, you're always struck by two things. One, is how really effective it is when you pick up something countertransferential on your own and you catch on to the fact that you've been blind to something you've been feeling about the patient, and you work that through and you find that's a tremendous help. But you also find that you get flows of associations or dreams from a patient that seem to not be originating from you or anything you're doing. They seem to be tapping into a Jamesian flow of consciousness in the patient. You know what I mean? In other words, let's say you have a patient where you're having a chronic countertransference feeling. I was thinking of a woman where I always felt uneasy in the sessions in a way that was very difficult to delineate. And then she goes on to talk about something with her daughter, and she makes very clear a kind of manipulative coercive

thing her daughter is doing with her, and she tells me how she feels, and I think listening to her, "I know, it's exactly what I feel with her," and you suddenly see how she does this with you. Now you have countertransference and you have a lot of interpersonal data, but it also came from some flow she was introducing.

Hirsch: *What do you then do with that? Similar to the question regarding the dream about folding the laundry, what are you likely to do? Are you likely to say, "Yes, I think you're right. I've been too neat." Or to say something like, "I know what your daughter feels like because I ..."*

Levenson: *What I would do first of all is I would express some degree of amazement that this had been picked up by the patient and I hadn't seen it. I think you can have a repertoire of grunts where you say, "hum." And I think you have to say, "I didn't see this. So now I'm willing to listen to you."*

Hirsch: *You'd say explicitly?*

Levenson: *Yes and no. I might not say so explicitly, but I would indicate, "It's interesting. I didn't think of it." It's what Don Stern talked about when he talked about curiosity and novelty, the ability to be astonished by something the patient tells you. So what you're really saying to the patient to begin with is, "This is very interesting. You are bringing in something I didn't see. You're making me aware of things in me that I'm not aware of," which immediately gets rid of this idea that you're on top of everything. And then I would listen and I think I would try to play with it. I wouldn't think, "Is this true?" I wouldn't say to the patient, "You*

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know, yes, you're right," because I feel like that's getting on top of the patient. It's like saying to the patient, "Well yes, you see something, but I see it too, and I see it more clearly than you see it." So you have to leave it, so the patient thinks "I can use my own perceptions more than I thought I could." Again, that's relieving, but I don't think that's directly curative. I think then something begins to happen. If the patient is able to pick up something about you and identify it, the way you're likely to deal with it is going to be an extension of the interaction. The moment it becomes "technique" one is trying to effect a change, and willy nilly it becomes one-upping the patient. The possibility that the patient is learning to listen to and use her own perceptions is undercut.

Hirsch: *Well, what's your style?*

Levenson: *My style would be to be surprised and to admit it, if I didn't see it, and to welcome it. I'm less inclined to welcome it if it's extremely*

hostile. [laughs] But I would try to deal with that.

Iannuzzi: *The sense I get of the detailed inquiry as you've just elaborated it as a process of active deconstruction is very different than what I think Irwin addressed earlier on—namely this sense of not being a participant. As you've just described it, it feels to me very much like the analyst relaxes into the narrative ...*

Levenson: *Yes. Absolutely. There's a big difference between being a participant-observer and the mutative element. The therapist deconstructs, the patient's self-system integrates. There isn't a way to inquire deconstructively without visualizing it or playing it out or being part of it. So, if somebody says, "I came home and my mother blah-blah-blah and ...," you really have to be able to see it, to get a feeling of what it is to even raise questions about it. I guess you could figure that there might be some way you could—and it probably would work to some extent—you could program a machine just to keep asking questions, a little Rogerian, in a way, and that works to an extent. But for an analyst it would be almost impossible, and not desirable, not to bring yourself into it. In a paper I wrote, "Seeing What Is Said" (2003), I made the point that as you listen to [patients] you try to visualize what they're talking about, and that raises the kind of questions you might really ask about something—it isn't detached at all.*

Iannuzzi: *Sometimes the detailed inquiry gets criticized as an inquiry into reality, and because that smacks of objectivity, it troubles people. Is what you're saying here that the analyst gets pulled into the narrative, pulled into the experience of the patient—the deconstruction is from*

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within the experience with the patient? This feels less like a deconstruction to me, and more like a co-construction of what's then happening, of what the experience has been or is in the patient's life.

Levenson: *Yes, it emerges from the interaction of the patient and therapist, but it's not a co-construction as I would use the term—you see, it's not a co-construction because you're not trying to arrive at a coherent narrative. I think that's the thing. A co-construction would make it a coherent, jointly arrived at, emergent narrative. "Co-construction" sounds too collaborative to me. Much of the work is in analyzing resistances and inattentions. The thing about psychoanalysis is that there's something miraculous about free association. Bollas has written about the odd, magical quality of free-association. Clara Thompson thought so too. She said that the reason she gave up free-association with patients is they couldn't do it. They'd lie on the couch and just natter on about stuff. And when they gave up free-association—Clara because of*

that, and Sullivan because he was dealing with very disturbed people—this concept of the participant observer and the detailed inquiry came in. Sullivan, however, really was using it to clarify events, because he was dealing with people who were basically very mystified, and it was very important to be able to get clear and identify what was going on in their life. And I did that too. I thought demystification was the big thing for a while; it was a time when Ronnie Laing was popular. But I now feel it isn't the point. I want to use the inquiry to take the story apart in some way that begins to mobilize the patient's flow of consciousness so that other data begins to emerge. What I want to do is to inquire into a story and then hear the patient begin to take it somewhere else. For example, you see a patient for the first time and he comes in reporting that he has this irrational rage with his girlfriend or his wife. You listen to his story and let's say you can really hear how she's setting him off and provoking him. If you inquire into it in detail, by the end of the session he sees that he's feeling totally impotent, that it's a kind of impotent rage, and he leaves and he's relieved. Okay? That's sort of the Sullivanian approach. The next time he comes in I'm beginning to feel like Scheherazade. "Okay, what do we do this time, now that we've got that resolved?" I begin to feel that I'm trapped. What I really want is for the wheels to start turning in this guy's head; if not, it's just going to be a reframing psychotherapy for a couple of sessions, he'll feel better and he'll get along and so forth. So I begin to go into one of the stories in a less focused way and just open it up. Perhaps then he has a dream and other associations, past and present,

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begin to come up and then the guy is really talking about himself. You have a whole different feeling; it's like you've mobilized a—it always reminds me of Dune (Herbert, 1984), one of the science fiction novels.

Hirsch: Dune?

Levenson: Well it was a very popular science fiction series that contained under the sand giant worms that people rode. The therapy process always seems to me like you're sitting on this invisible thing and all of a sudden you feel it start to move; you're being carried by this ineffable process. It was more than simply a response to what you were doing. But it was there. I think that's coming up in many of these concepts of self-organization now. Jay Greenberg (1996) has written about it. Gedo (1999) has a lot about it in his last book and also Dorpat and Miller (1992). People are formulating new concepts of how the brain reorganizes itself—not just cognitively, but in terms of the neurobiology. In other words, schemata are constantly being reorganized and reset. It

seems to me it really is true that if you look at neurotic behavior, it's always an effort on the patient's part to have some clear, fast-working way of dealing with events in the world. You have to have something that's reasonably efficient, that's abstract enough so that it covers a lot of situations, so you can function quickly in the world. You can't take every situation and deal with it as new. On the other hand, if it gets so abstract, it's so arbitrary that you have no flexibility at all.

Hirsch: *Is that one way of defining the severity of people's limitations, the degree to which they abstract?*

Levenson: *Right. You could take an analytic session—I tried this once years ago—and simply value each person's talking in terms of its level of abstraction, and then match that against the content. I think you would see that as people get anxious they talk about things in a more and more abstract way. I tell people I'm supervising that when you're listening to somebody talk about something and you find yourself sitting and thinking what can this mean, how can I formulate this, and what can this be about—that's the time to look to your countertransference. What is making the analyst feel that she has to make sense out of the patient's output? In any therapy, from Freudian to Kohutian, therapy proceeds by incremental failures of the patient's expectations.*

Hirsch: *When you notice that the dialogue is abstract and you're aware that you're trying to make sense of it, what would you be likely to do? Would you say something to the patient about his level of abstraction?*

Levenson: *Don't forget, abstraction occurs in the patient's presentation*

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and the analyst's participation. I would think to myself first, "Something's gone wrong. I'm feeling tense about this. Why don't I just find out more? I might shift back to the inquiry to bring down the level of abstraction. I might look for what there is in the material being presented that could be anxiety-provoking to the patient. But, I think whatever I do is not a matter of correct technique because it's still going to be coming out of my own anxiety and my own sense of participation. There's no right way to do therapy; one simply accepts being continually and increasingly aware of effects. I think if you do that, it works. Beyond that, however you go about it, is going to be another level of examination.

Hirsch: *Right, but part of why Victor and I are asking is that in so much of your writing you use examples by other analysts and critique them.*

Levenson: *Well I've actually stopped doing that. Years ago, it seemed the only way to make my point. If one presents clinical material, the universal response is, "Of course, sure. We all saw that." The only way*

to demonstrate countertransferential blind spots was to take other people's published material and to show what has been left out, inattended, and to what extent the canonical interpretations served the therapist's anxiety. These days, the concept is not so novel; then it was perceived as an attack on the skill of the therapist. Now we know everyone misses material, it's the nature of the process. Psychoanalysis is the science of omissions.

Hirsch: Yes, okay. But my point is that in critiquing others in the past, often we did not know exactly what you did. So while our questions here may seem overly specific, we're trying to get at what you would do. In this example, when you're aware of the abstraction and you're pondering it and trying to understand it, are you saying that the awareness alone would somehow shift something?

Levenson: Sure.

Hirsch: Without any verbal intervention?

Levenson: Absolutely. I think it might even shift it even if you're only marginally aware of it. You know what I mean? You might not even have quite formulated it to yourself, but I think it could still shift awareness. I think the extent to which you make that explicit is a matter of tactics. And again, I don't think there's a right or wrong. For example, if I made my participation explicit with one patient, I would worry to myself whether I was using that seductively. Or again, if I felt some need to spell everything out in some clear way. Or I'm leaning on the patient to cut it out because it's really making me uncomfortable week after week.

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None of which is wrong but it would be important to think, "I'm coming into it this way because ..." The important thing is, whatever you do, the patient will respond—positively, negatively, indifferently—and that will define your interaction as part of an ongoing process. The meaning of the event is its consequences. In other words, I think awareness is the thing, because you don't become aware of something until you've sorted it out in your head. If you're very anxious about it, you won't be aware. I think by the time you are aware, the field has to some extent already shifted and you begin to—something else begins to happen.

Iannuzzi: So, this awareness—I know it's hard to pin down or to pin you down on what you would do or what you would say—but listening to you now it feels that the awareness you're describing is an awareness of the analyst's own countertransferential anxiety that signals that something in the patient's narrative is mystifying to you. Is there something about it being mystifying that explains why you don't have a pat answer to what

you would do?

Levenson: *I don't have a pat answer, because I don't believe in pat answers. Why is a pat answer desirable? Why should good technique be following a script? Why can't good therapy be something like jazz—innovative, flexible, riffing off the content? It seems to me you would do something different with every patient. You know what I mean? I don't think there's a—you see, because I think the minute you say “What I would do is,” that's a very high level abstraction. You find yourself saying something like, “I have categorized the patient as borderline. This is the way I deal with borderline patients.” I'm really trying to avoid that.*

Iannuzzi: *So you want to avoid propagandizing or persuading the patient? You don't want the patient to be pulled into your way of organizing his experience?*

Hirsch: *Or to operate stereotypically.*

Levenson: *Yes. Right. That's true. But the more immediate thing is it goes against what I'm trying to do, which is I don't want things reduced to an abstract, formulaic, clear understanding. I want the patient to be able to tolerate, with me, a whole level of unclarity, of anxiety that opens up the patient and gets the patient's wheels turning, so she begins to reorganize her own experience. And I think when a therapy is going well, a lot of the time you are following and listening to what's coming up in the patient's material. You're not, all the time, working with your own participation. That becomes a kind of narcissism. I'm sure you've all had this experience. It's very striking when you're supervising or*

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working with patients, when it seems so clear that something you're doing makes a difference, that you say to yourself, “This is the leverage in therapy. Now this is what works.” And then other times you listen and you think, “Where the hell did that come from?” You'll have a patient who'll come up with classic Freudian phallic material that's coming way out of left field, and you think, “I surely had nothing to do with this. Where is this coming from?” And so then you think, “No, it isn't all about what I'm doing. It's about really listening to the patient.” And I think that the debate between the Freudians and the interpersonalists, years ago, was over that schism. The interpersonalists said that the Freudians didn't pay any attention to their own participation. And the Freudians said that the interpersonalists act as if it's all about what they do—it's a kind of narcissism. They don't believe anything's going on inside the patient, it's all interaction. By the way, at one point Steve Mitchell made similar comments about me—namely that I didn't believe that there was anything going on inside the patient. He also said I didn't

believe in history. Apparently I lend myself to being misunderstood.

Hirsch: *The “I don't think anything's going on within the patient” criticism seems very far away from what you're describing now.*

Levenson: *I hope so. Yes, miles away.*

Hirsch: *You think that was true at one time?*

Levenson: *Yes. I think so. I think I moved through a ...*

Hirsch: *A blue period or a red period.*

Levenson: *It's very much like that. I really do think so. It's like a painter trying different palates, but always the same subject. It is like a blue period or a red period because what I've always tried to do is try to organize and understand my own clinical experience, and then use whatever metaphor or paradigm seemed to match that at the time. So over the years I've gone back and forth between interest in the flow of the patient's material and interest in this very powerful kind of interpersonal thing. Then, of course, when you write—it happens I think to everybody—you get stuck in a position because people expect you to stay predictable. So you're invited to panels because of what you're expected to say. You can't really suddenly turn around and say the opposite. So you get reified into a certain position, like an actor who always plays heavies or ingénues. I think it's like learning anything, you try something for a while and then you drop it and you try the opposite. Psychoanalysis, like all creative acts, is about holding in your head and using mutually incompatible concepts. It's this play, this dialectic that*

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makes the wheels turn. Not, I'll say again, arriving at a clear destination. I believe it was Lacan who said that at the end of a therapy the patient knows, what the analyst knows, which is what the patient has always known. And meanwhile, it all gets integrated by the self-organizing capacity of the patient. That integration, by the way, may operate out of the conscious awareness of the patient.

Hirsch: *Do you think there have been distinct shifts in your thinking, in the way you actually practice?*

Levenson: *I think so. I think there have been shifts in my emphases that have varied very considerably. But I think you can integrate it all if you think of them as an interpersonal process impinging on an intrapsychic, self-organizing process—that patients will take what's happening between the two of you and then reorganize their own way of thinking about things. And that either happens or it doesn't. You have really no direct control over it. I think what you hope is that if the anxiety level is*

low enough, the patient will be comfortable enough to do that, because people will reach out for a more flexible, nuanced way of seeing the world—they need only to be comfortable enough to take the risk.

Iannuzzi: *You've talked about shifts and periods that you have gone through over the last fifty or so years. Has there been a shift away from structuralism?*

Levenson: *I think structuralism was a paradigm I used. I don't think any of those early positions constituted very clear theoretical positions. I've used them as paradigms and metaphors, as ways of looking at the analytic process for two reasons. One reason was simply because it's partly a pedagogic device. And the other was it always seemed to me that analytic theory shifted with the zeitgeist and the culture. So, I was trying to point out as the paradigms are changing, the way people think changes too.*

Hirsch: *You've always been clear about that.*

Levenson: *Yes. I've always been clear, but I never wanted it to be clear. I mean that literally because I don't think the clinical process has anything to do with getting anything clear. You can put events in to a theoretical framework, for the fun of it. Or you can do it because the patient's very anxious. Or you can do it because you're made anxious and the patient is leaning on you to be clear about something. At any rate, the patient will learn your catechism, and work around it.*

Iannuzzi: *I'm curious about just how much may have shifted around. Clearly, from what you've been saying this morning, you have shifted*

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away from the notion that the work of an analyst is the inquiry into and delineation of patterns of experience. What about your notion of the self as a unique, enduring organization? Something that I think you've rejected in the past. Have you shifted on that?

Levenson: *Well, essentially, Victor, I really haven't rejected much of anything. I think I haven't paid attention to it. I don't know how I'd reject a concept of the self. I don't know that I ever believed, except very early in the Sullivanian days, that the purpose of therapy was to delineate and make clear patterns of being in the world that were making trouble. The implication then is that once you see that, you can do it another way which will work. Now, I think that's closer to a kind of cognitive reeducation. As I said, it's the kind of thing I'm really trying to avoid. It isn't that I'm hard to pin down, it's that—the implication that I'm hard to pin down is that I “do something” I'm not telling you. [laughs] What's wrong with the idea that what you're interested in is the nature of your*

participation with the other person, and that's going to depend on what's going on between you and the other person? And there is not a clear way to do it. There are certain things that seem very clear to me. One, I don't want to listen to somebody tell a story and then make it clear. As I suggested earlier, I think if you focus somebody in such a way that the patient can understand there's another way to do things that works better, that's pragmatically very helpful. But it really undercuts the analytic process and you wind up stuck, doing a kind of cognitive reeducation. See, like this guy, one session and he's no longer enraged at the girlfriend. Well that's terrific. And now the next time she does it, he comes in and says, "I see what happened there, and I didn't feel that angry." Okay. So that's a big improvement, but that's not where I want it to be. Now, if he came in and said, "So the next time I saw it and I stopped it and I felt immensely relieved." Then he has a dream that his mother just deserted him, and then I would think, "Gosh, that's interesting. Now, having resolved that, he's feeling somehow lost that she's not screaming at him. That's interesting." In other words, it opened to the next thing.

Iannuzzi: But wait. In the body of your work this idea of recursive patterns has been persistent. I didn't think you were saying at any point that the analyst attempts to cognitively restructure these recursive patterns, or order them in a cohesive way along the lines of what she thinks is reasonable or rational. My sense of what you've said is that these recursive patterns repeat themselves in the therapy. And that the analyst is unwittingly pulled into a recursive pattern and becomes a part of it, observing

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the other person's pattern and her own participation in it, and then at some point, in some way, calls attention to or tries to explicate that pattern or the enactment of that pattern in the room.

Levenson: Well, yes. But it's important to understand to what end and to know why this helps. Again, the idea is not to get behavior to stop or to correct itself, but to open up the inquiry. If the patient stops the problematic behavior, it is reform, not change. Freud said that an interpretation worked if the patient responded with new material, not, you will note, new behavior. Certainly by observing it and becoming aware of it, it tends to shift somewhat automatically because you'll do something differently. You could then explicate it, if you wanted to. That's, I think, a matter of the way you work. I don't believe there is a necessary downside to putting the interaction into words. I'm saying that awareness of the interaction in itself shifts the field. One can simply

proceed without words—the interaction will still have shifted. Or, one can formulate it or point it out. There is not a clear therapeutic imperative. Although verbalizing the interaction reassures the patient and interests her, it makes it self-conscious and tends to interrupt the unreflective flow. Whether one formulates or not depends on what's going on between the two. The success of the process doesn't depend on formulating it, putting it into words. Formulating is a way of parenthesizing or putting brackets around it. The mutative event is the awareness of the therapist. It isn't what you do with what you see—that occurs almost automatically. It is what you don't see that gets you.

Hirsch: *What about the question of self? Because Victor started off asking if these enduring patterns that get played out in the analysis constitute something that you would call a self. Have you ignored the concept?*

Levenson: *It was what Sullivan called the “self-system,” not at all the same thing. Concepts of the self, as currently used, seem to me more about the nature of personal consciousness and mind. I have written about the current neurobiologists' interest in self-regulating systems and chaos theory. Sullivan was not much interested in the Self. At least, he felt it fell outside the purview of therapy.*

Hirsch: *Well, I know what Sullivan said; but there is so much in the current literature about the concept of self, multiple selves, and multiple self organizations—we're interested in your thinking about the use of the term “self” to describe these recurrent patterns that are unique to each person.*

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Levenson: *Well, that's what I was saying, that I think that the mind is a self-organizing system. The concept of the mind as self-organizing, the concept of the mind as a nonlinear system, the concept of self in general, are all versions or varieties of the same thing. Namely, the idea that there is something autonomous within the person, organizing, experiencing, using it and taking it away, and reorganizing it. I don't know that you can impinge on that directly. In other words, you can do a lot with engaging the reiterative patterns and so forth, but if somebody said, “Well why do they finally shift?” or “Why do they shift the way they do?” I think that depends on some working through of the material in the patient's mind, which is something of a black box. It's a little like asking, why does one patient dream and another not? Or why are some dreams so extremely useful in certain people? Why do they open doors for you all the time? I think something's going on in the patient's mind. I wouldn't deny that. I don't know how one directly addresses the self clinically.*

Hirsch: How would that be? I guess in some way, following your question, it would be based on some observation or some articulation of these recurring patterns that constitute something essential about the person.

Iannuzzi: I guess it would depend on whether you locate self within the individual or in the interpersonal field.

Levenson: No. I think you would locate it in the individual.

Iannuzzi: Not in the interpersonal field?

Levenson: No, not at all. No. I don't think so. I think there are two people in the room and there is a field between the two of them, but there's something going on in the patient's mind that has nothing to do with you. It's influenced by being in the room with you, but it's got its own—it seems to me it has its own mechanism.

Hirsch: Philip Bromberg has been writing a lot about internalized self-other configurations and in many ways extending Sullivan. He has been developing the idea that rather than a singular self, the self is comprised of internalized self-other identifications that are somewhat disparate within the larger self organization. Do you think of recurring patterns as internalized self-other configurations or identifications? Does developmental thinking play a role in how you formulate? Is the question clear?

Levenson: Yes. The question's clear, but the answer isn't—at least to me. The fact is that he's [Bromberg] coming from a particular position and a particular vocabulary—"self-state" is not a thing, it is a process. There is a danger in reifying it, talking about self-states as though they

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were real things. I don't know how you can debate on the relationship between multiple selves and a single core self, which Sullivan denied and Ben Wolstein and a lot of people strongly supported. You can theorize about it, but it seems to me, pragmatically, it's not available to you in any way. It's just a different way of looking at the experience. It seems to me very clear that if you think about it, the outside world is an interpretation to begin with, beginning with infancy. In other words, there's no contact with the outside world that's direct. Everything goes through some neurological filter. So that with vision, I'm not looking at you directly. In other words, there are translations of neuron impulses into visual experience. It seems perfectly reasonable to me that from the very beginning we're trying to make sense of the world. And we're going to make sense of the world by using schemata of the world (configurations of self and object, if you wish) that are defined by neurological

*development and social experience. I don't know what a nipple looks like to a four-month-old baby. Klein had one idea. But the fact is somewhere the baby is going to be making sense out of this because it is connected with food, and so forth. So as he goes along, the schemata get more and more complicated in terms of dealing with the world. You have to work out a series of schemata that are sufficiently flexible to fit different circumstances and sufficiently abstract to be useable in time, because you can't sit each time and figure out what to do. There's a wonderful literature on Asperger's and mnemonists that is relevant to this topic. Asperger's Syndrome is, of course, a mild version or cousin of autism. Mnemonists are memory artists. Temple Grandin is a very high level Asperger's who's written a number of books (*Thinking in Pictures*, **Grandin, 1996**) about what it's like. And then there are a number of books on mnemonists, these people who can remember every fact. There's a great short story by [Jorge Luis] Borges called "Funes the Memorious" (**Borges, 1941**) about this guy who falls off a horse and, after that, he can remember everything, but can't forget anything. [A. R.] Luria has a book called *The Mind of a Mnemonist* (**Luria, 1968**). The point is these people remember everything but they cannot abstract anything. They cannot generalize. So if you say "dog," they will remember every single dog they ever met, everything about the dog, but they have no category, dog. Now the consequence is they're incapable of empathy. They cannot understand what is going on in another human being because they can't abstract it.*

If you go to the other extreme, which is to get things more and more abstract, which is what people do as they get anxious, they need something

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that works very fast and doesn't require a lot of questioning. It becomes more and more inflexible. So, for example, if you've been bitten by a dog when you're five-years old, you're afraid of all dogs. On the other hand, most people can look at a dog and tell whether it's friendly. I have a little dog, about this big, and it plays very carefully with children and toddlers. You see mothers saying to their kid, "Ask the man if you can pat the dog. See, the dog is wagging its tail. It wants to play with you. Put out your hand and let it sniff your hand." In other words, they're showing them ways of arriving at whether the dog is pat-able and friendly. So, if you're really anxious, you have an abstract principle— "Stay away from dogs and they won't bite." If you're extremely concretized, you know Ed Levenson's dog doesn't bite, but you don't know about the next little shihtzu, so you'd better stay away from that one. Do you know what I

mean?

*So it seems to me that what happens all through life is what Korzybski said, "All life is a dance between levels of abstraction." I think it's a wonderful thing because all your life you're trying to find out some way of grasping the world and dealing with it that's not so abstract that it limits you, and not so concrete that you can't move from one instance to another. And so I think it's what's irritating you about what I'm saying about the use of countertransference—each time, in each patient, I would deal with it differently. You're saying, "But there must be some principle." It seems like an obvious developmental thing. Now, what the internal fantasy system is, I don't really know. I don't even know what "self" really means. I think certainly there is something going on in the person. What does it mean to argue whether there are multiple selves? I saw that William James said, "There are as many selves as there are situations in life." This was back in 1890. So if you want to say that there is no core self, there are multiple selves—do you watch *The Sopranos*?*

Hirsch: *Oh, religiously.*

Levenson: *You know the thing about Tony Soprano is you can never quite figure him out. Just when you think he's a total brute, he does something very attuned and sensitive and intelligent. So you could postulate multiple selves, "Well he's this and he's that—depending on the context." But then it's very hard not to think, who is this guy really? You keep looking. Is he just really a nice guy who grew up in this brutal culture? On the other hand, you see pictures of him laughing when they're beating somebody, so you think, that's pretty brutal. And so it's very postmodern in a way, because you cannot grasp the guy. So I think*

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it's very postmodern to say there are multiple selves. It's the postmodern solution to things. Everybody is different in different circumstances, there's no core person.

Hirsch: *Is there a core person?*

Levenson: *Tony Soprano seems to me to be a sentimental bully. But maybe he's a sociopath, maybe he's just a tough blue-collar guy trying his best to make a go of it. I don't know. Neither apparently does his psychiatrist. I really don't know. How would anybody know? I don't know whether there is a core person. I think there are probably core temperaments, in a certain sense. I think, if you're an irritable person or a benign person, it's sort of there from the word go. But I don't know what the core self is. People have affairs and break up marriages because they are different with the next person. Isn't that right? You*

know, at age forty-five and they fall madly in love. Maybe it's not so much that they are madly in love with the other person, but that they love who they are with the other person. It isn't that they're thinking, "I can have a different life." They're thinking, "There's another me dying to get out—I could be tender, I could be warm, I wouldn't be angry." Sometimes they sustain it, sometimes they go back to being who they were—their core self? It's not really predictable. People can surprise you by the choices they make and how they sustain them.

Hirsch: I want to try to get something clear. Wasn't there a point in your writing when you said that the core analytic skill was delineating pattern within or outside of the transference?

Levenson: Well, I don't think I've been really consistent about that, and I'm still not. I wavered back and forth—between thinking that it's a matter of getting something clear as against a matter of letting things get more confused.

Hirsch: That was your clarity period?

Levenson: Yes, that was my clarity period. Again, I feel that delineating pattern is a core analytic skill, but that delineation is not enough for cure. The patient has to use it, incorporate it. How that happens, how that working-through takes place is at the heart of my current interest. You might say I've spent a lifetime being interested in interpersonal process. Now, for my own interest, I'm trying to look at how patients learn and change—that is, how they integrate with the interpersonal process. We need that participation from the patient: it is the age-old inquiry into resistance. I must say, I'm getting a lot less clear, but I think the road to the palace of wisdom is paved with confusion—to paraphrase Blake.

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Iannuzzi: Can you say something more about clarifying patterns in terms of how you work with it clinically?

Levenson: Yes. Essentially, I don't want to delineate patterns so that the patient can see clearly. I saw a guy once years ago—in my clarity period—a consultation who was brought in because he was up on the roof of his house with a gun, and the police had surrounded the place. He'd become so frantic because he had a fight with his wife. They sent him into therapy, and it took about four sessions to show him how she absolutely literally drove him up the wall, and he never did it again. That was the end of that. It all quieted down and he was perfectly fine. So one can say, "Isn't that a way of clarifying a particular pattern?" I think you could ask what is it that keeps people from having schemata that are

reasonably flexible, not too abstract, and not too concrete. I think there are a lot of things. Maybe some of it is genetic—you know, they just don't get certain things. It's like being color blind. Some of it is interpersonal anxiety in the sense that you realize if you see things a certain way, you're going to make somebody very upset, and so you learn to screen out certain kinds of stuff. Some of it is cultural and it's in the general culture; some of it is in the family. I'll give you a simple example of this. It's always amused me that you see women come in and they say, "I went out with this guy and the first thing he did is he spent the whole time talking about himself." And I think well, I understand that perfectly, because when I grew up, you had the idea that if you wanted girls to be interested in you, you made yourself sound interesting. The fact that it never worked didn't occur to me! [laughter] Now, it seems to me that's a simple cultural thing; this guy keeps going out, over and over, selling himself to women, and nobody's interested, and he really doesn't understand why. See, the first thing I think I would do is I would say to him, "That doesn't work," and I would point out that I think he's going against the grain of the culture. I think then, something's going to happen. Either he'll change it and it will work, and I'll think, "Okay, it was a simple cultural thing," or it isn't going work at all, and we'll get more data. See, I think the only thing it actually could have done is open up the process. I think on the process of praxis, I'm absolutely clear about what you have to do, what works and what doesn't work. I think when you do it you can see it working clearly. So, I'm convinced about that. All the theoretical stuff is to me just as you say, my red phase or blue phase. It's kind of window dressing and a way to communicate with other people and maybe just a way to make one's communications respectable.

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People distrust simple things. Yet, it's a wonderful therapeutic device to think to yourself when you're sitting with a patient—what would I do if this person was sitting in my living room? Not a "patient." Surprising insights may ensue.

Hirsch: *You may think we're asking you to be redundant about praxis, but when you said the only thing you're clear about—what it is that you're clear about?*

Levenson: *I'm clear that the process does not consist of healing the patient through some superior system of clear formulations, or a way of being with the patient that is therapeutic. Not that I don't think those work to some extent, but they're not my idea of analysis. I don't think helping somebody simply by being caring or liking them or by being*

consistently holding—I think that's useful, but I don't really think that's the core of the analytic process. Nor do I think it's as Masud Khan ironically put it—that the patient tells us what is true, so that we can tell him the metatruth—that is, making something clear in such a way that [he] can then use it. I think analysis consists of a kind of interaction which is some variant of the free-associative detailed-inquiry interaction. The effect of that is to make the patient's schemata of experience more complex, and in a way more confusing, so that then something can happen that's a self-operation, wherein the patient reorganizes in a more flexible and useable way. The function of the interaction is two-fold: one that the analyst is the agent, the catalyst of that deconstructive unpacking, and the analyst is a participant with the patient so the patient has a relationship with the analyst that can be examined first hand. In other words, there's a source of looking at those schemata first-hand as it occurs between the two of you. For example, a patient where you have a wonderful session announces two minutes before the session ends that nothing is happening and it's a waste of time. Now, first of all, at that point you have to become aware of that. A lot of the times you feel mildly depressed and you don't know why. Let's say you become aware of it. If you say to yourself at that point, "It's because she's frightened about separation of loss and it was a good session," or if you say to yourself, "You know, she's castrating, this person can never let me have any power" or ... or ... or ... or ... I think that the moving from the experience to that kind of formulation is a countertransferential abstraction—it's like looking for an explanation, and there are as many explanations at that moment as there are people in a seminar, isn't that right? The moment you become aware of the experience you could simply point

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out the experience. That would be what Gill called an interpretation of awareness of transference, instead of an interpretation of content. You can say "I've noticed in the last couple of sessions, the session is lively till just at the end, and then you indicate some feeling of hopelessness, at the end of the session." So, it's in awareness. Now she can then say, "Well, it's because it really isn't bearing directly on my problem about staying with my boyfriend." Then the session's over and you see what happens next time. You'd have to think to yourself also, "What does it feel like to have this experience in there? Do I feel—does she make me feel—impotent, depressed, sad, amused, confident?"

Hirsch: *And so, what do you do with that awareness?*

Levenson: *Probably I would just keep it to myself, but it depends who I'm*

talking to, and that's not avoiding—that's not really dodging the issue. It's saying the one thing that's constant is becoming aware. What you do with the awareness depends then on your interaction with the person. You're very likely to do one thing with one person and another thing with somebody else, because it is a flexible interpersonal feel. If you want to say, "I want to have a way of doing this, I want to have a way I do"—

Hirsch: *I would think of it more as an inclination, not as a rigid way of interacting—as Ben Wolstein said, each dyad is unique—and while I believe that, I think we have inclinations and tendencies.*

Levenson: *Yes, okay. My tendency would be to say something because I have a lot of trouble keeping quiet. I've had the experience that if I keep my mouth shut, two minutes later the patient says it: it comes out. I think you could establish a working rule for yourself, with the assumption that you can violate it if you want to. For example, I think Darlene Ehrenberg would probably say, "You should use your experience actively." That doesn't mean there might be times that she didn't hold back. And I think it depends a lot on whether you're more comfortable with a way of doing things that you can then try to be flexible about, or whether you'd rather stay totally loose. You know, that's where the Zen thing kind of comes in, too. You know, I would prefer to stay loose about it and not feel that one way is better than the other. If you read clinical material or go to clinical meetings, the thing that I find very interesting is that people have different explanations of the presented clinical material. But what really works is if somebody asks something that brings up data you didn't think of looking for in your patient. Do you know what I mean?*

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Hirsch: *Rather than the explanation—*

Levenson: *Yes. I was at—I told you this story before. I was on a panel once with Hanna Segal and a number of people of different viewpoints: Freudian, interpersonal, Lacanian, self. Everybody was presenting and then discussing each other's clinical material. And Segal presented one of these classic Kleinian perspectives of a young schizophrenic patient who recovered overnight—one interpretation about his desire for his mother's breast or something did the deed. Then she supervised me and she's wonderful; she didn't do any of that. What she did is she asked me about stuff that I hadn't asked about. It was similar to a time when I heard Joyce McDougall presenting clinical material. She was talking about a woman who confessed to her somewhere in the process of her therapy that every time the session ended she went to this little bakery downstairs and she had pastry. And I thought McDougall was going to make some interpretation about her, about her need to be mothered, or*

her hunger for something or other. Instead, she said to her, “What kind of pastry?” I thought, “That’s exactly the question I would have asked.” Because you don’t know where that’s going to lead you, because then maybe it turns out it’s a chocolate éclair that her father brought home the day before he was killed by a truck. It begins to go into something, perhaps not that dramatic, but somewhere new.

Iannuzzi: A moment ago when you mentioned the Zen thing and staying loose, I thought you captured the Zen idea of nonaction—not inaction, but nonaction—relaxing into a situation and not consciously directing it. Here your approach again seems Zen-like in the sense of the way a Zen koan is intended to steer away from a rational answer and instead to destabilize or disorient away from a pat, rational narrative, so that one uses his or her creative capacity to gain perspective. So the question about the pastry, what kind of pastry is it, seems to me to be somewhat disorienting in a creative way—that is, that it opens up possibilities.

Levenson: That’s absolutely true.

Iannuzzi: When you teach, do you teach ...

Levenson: Listen, you could call it—you know my paper, “Writing Greek and Thinking Jewish?” (**Levenson, 2001**). It’s Hasidic, you know, in a very profound sense. Fromm used to tell a joke about the two Rabbis who were arguing a point of law and they were sitting in a room, and one Rabbi says, “What God meant was ...” The other one says, “No, no, what God meant was ...” At that point, there was a peal of thunder,

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and suddenly the ceiling opens up and this voice says, “What I meant was...” And one of the Rabbis says, “Never mind, you had your chance!” [laughter] You know, so—who cares about the abstract truth of it?

Hirsch: You were asking about teaching?

Iannuzzi: Well, I was wondering if, as with your work with patients where you’ve said deconstruction is intended to destabilize, to open up creative experience, if that isn’t the way you come to your teaching. So that you don’t so much explain your work as to destabilize those that want an explanation of it. So I’m thinking they come to an understanding on their own, in their own creative way.

Levenson: I’m really not trying to be that inscrutable. It just doesn’t seem confusing to me. I say to people, “Look, when you work with patients, keep in mind a visual image of the horizon—above that horizon you’re abstracting things.” Above that line you’re abstracting things and making them clearer; below that horizon you’re extending things out and making them more diffuse and more deconstructive. When you listen to a

patient, try to stay below the line, and when you hear yourself moving up to an explanation, think to yourself, "Why am I doing that? What is the purpose and impact of the explanation?" so that if you listen to a piece of clinical material and you start to abstract, and if you think, never mind—stop, what could you ask about that? What don't you see? Edelson said that when he taught students, they asked, "Well, how do you work?" He said, "I try to see what the patient is telling me. I try to see what I don't know. I say to students, 'What don't you know about what you've been told?'" Since he's an analyst, I assume his intent is not simply to get the facts straight. As I said, Sullivan was working toward clearing up things for very mystified and confused people. However, I think it is an extension of the original use of the free-associate device of trying to see where things lead you. It seems to me that it requires a concept of self in the sense of self-organization, because the patient is doing it, the analyst isn't doing it.

Hirsch: But wouldn't it be consistent if that's what you're doing in your work, that in some way it extends to your teaching and, thinking recursively, to this interview? I hear what you're saying—you think you're being clear, and you just were. Still, the tenor of the way you interact with patients must fold over to supervision and even to an interview like this. That is, it's part of your way. Would you disagree with that?

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Levenson: No, I wouldn't disagree.

Iannuzzi: We're pulled below the horizon.

Levenson: Yes, but a lot of what you're asking me is above the horizon. That is, you say, can you formulate, what do you do, is there a principle? I think the more you can stay away from that, then in a way, the more flexibility you have in a sense of dealing with things in life.

Hirsch: So much of what we had thought of asking you about, you've probably already answered in a sense. Victor and I had talked a lot about what feels like contradictions over time in your work, which you've already explained by talking about the various periods—but some of what we, and I think most people, understood of your work at some period feels very, very different than what you're describing now. And so, can you be more specific about that?

Levenson: If I'd known I'd be taken seriously, I'd have been more careful about what I said! I wouldn't call them contradictions. Actually, I think they're more like dialectical swings really. They're not really contradictions. I've never anywhere contradicted my original feeling that

it's not a good thing to work toward mutative formulations. Or my feeling that the work of the therapist is not to solicit change, but awareness. There's no contradiction there. I have wavered between demystification and the impact of the interpersonal field.

Hirsch: *It feels there's been a shift around the idea you introduced, which people later started referring to as "enactment." Namely, that with the participation of another we unwittingly act out internalized patterns in the therapy, become aware of them, and address them. Is this recognition of repetitive, relived experience in the room with the therapist and its working through still at or very close to the heart of what makes this process mutative? First of all, do I have it right?*

Levenson: *You have it right.*

Hirsch: *Was that just a period or would you still say that?*

Levenson: *Well, (a) you have it absolutely right; (b) it's not a period in the sense that it's punctuated—that I felt that then and I don't feel that now. It's again a dialectical thing. I felt it much more strongly then than I do now. I feel like an enactment is an area for a first-hand examination of the ambiguities of the person's semiotic field, and that it's very useful and powerful. I don't really feel the way I did then, that this is exclusively the locus of the therapy. Again, I've been fluctuating back and forth with this forever, and I think if you look at some of the papers I really have moved between what I call the poetic and the pragmatic.*

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Hirsch: *Now you're more in the poetic.*

Levenson: *Yes, now I'm more in the poetic. And I was thinking, why does one have to be clear about that? You know, why can't you feel that you're dealing with it as a dialectical process in which you're holding these things in your head and shifting—one time the emphasis is here, the next time the emphasis is there—why does it have to be clear? Let me put it this way, too: I think it probably would vary from patient to patient. For example, there are a lot of patients that hardly dream—that hardly have any kind of lively unconscious life. With them the pragmatics, the interactions, would be very forceful and therapeutic. We all work with people like that where if you look at the end of the therapy and it's been successful, it's almost all been around this kind of enactment in which things have shifted. There are other people that have a very rich unconscious life where you may start to do that, but then you're led into the person's flow of consciousness. You're interested to see what they do with it, how they go with it. You get the feeling that there's more in that and more of interest in opening up their own creativity than in getting the*

thing settled. So, I don't know how you can be absolutely clear about that. I think if you have a very clear stance, a theoretical stance, one of the things that happens is the patients' self-select. You'll get patients who will work with that way of thinking. You can't sit in silence, you know, with patients who don't have a fantasy or dream life. They won't sit for it, so you have to do something else.

Hirsch: Over a fifty-year period your style of writing has lent itself to some very well-known quotes which many have felt capture your essence. I recall expressions such as (and while these aren't exact quotes, I'm sure you'll get the idea), “we don't get better, we just get clearer”; “analysis is appreciation of the aesthetics of experience”; “what matters most is what is said about what is done”; the analyst must ask “what's going on around here?” Perhaps the most well-known—the idea of “language is healing,” that is putting language around things heals or demystifies. Whether these are titles of papers or points you've held, they speak so much to the value of clarity, to the value of articulating what's going on around here and what is said about what is done. It has always seemed to me that you saw patients walking away with some articulated sense of their experience in the world and in the room with the analyst. It feels that what you're saying now is so different than what's implied in all of those quotes.

Levenson: I think that's true, but if you look at it historically you can

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see where things were changing. For example, I wrote a paper about Ruth Moulton on that issue where I made very clear how my thinking had started to shift (**Levenson, 2002**). What you're saying is absolutely correct about what I felt. I really don't feel anymore that it's an issue of getting clarity. I think demystification is extremely useful for very disturbed people. I think for most people, if you limit it to that, what happens is you just tend to get stuck—you wind up as the demystifier. How long can you keep on doing it? I think also, after thinking over, it really is over a fifty-year span of time. A lot of this stuff about demystification was in the 1960s, and patients have changed, too. Patients are not only much more sophisticated, but they're also postmodern; they think about things differently.

Hirsch: So that means, “we don't get better, we just get clearer about what's going on around here,” and “what's said about what is done,” that these no longer characterize your current essence?

Levenson: It would characterize one side of the inquiry. Interpersonal clarity was something that was significantly missing from psychoanalysis, so I took all the classic Freudian clutter—you could

really see where these guys just had no idea of where their own participation was—and tried to make things clearer. I think that's pretty much changed now; a lot of them are aware of their own participation in an entirely different sense. To some extent, the times have changed, the patients have changed, and I shifted. It's similar to playing golf or skiing—it's a lifetime of discovering what it's all about. You discover that if you do something a certain way, it works, so maybe you say now I know how to ski, moguls. Of course, the next day you go out and it doesn't work anymore. Why doesn't it work? It's because the conditions have suddenly changed. The very good skiers can do the same thing no matter what the snow is, and it isn't because they're so good they can do it in any snow: it's that they can read the snow in a way you can't. In other words, when they go out and the snow is grabby, they feel it immediately and they adjust their technique. Or if somebody's riding a horse, a very good rider, the horse is always well behaved, not through domination or physical skill, but through an ability to know the horse's mentality, to read into its semiotic system.

Iannuzzi: *You've just characterized one shift over the last fifty years as a shift away from looking for clarity toward more of a dialectical process. Is it fair to say, rather than poetic versus pragmatic, you would now*

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say you're thinking more along the lines of the poetic and pragmatic—existing mutually, in dialectical tension with one another?

Levenson: *Yes, I am. I think it is a shift—it's also something that took place in the change in the analytic climate. Part of what happened to me is it began to sink in after a while that the Freudians had something. You know, we were throwing the baby out with the bath water. There was something in the methodology which was extremely interesting and tapped into something very interesting. I've been trying for my own purposes to reexamine the back and forth and ask, "What does it feel like clinically?" You know I did a lot of reading in neurology and neuropsychology and now it seems to me it isn't even dialectic anymore, it's more like a two-step process. There is an interpersonal field where you could have a lot of impact through elucidating and examining content: demystifying or using your own interaction with [patients] to show them and you how this process worked, using your own interaction to see what you were missing because it made you anxious or bored. Then there is a second process where all this gets interpreted, shifted, and integrated in the person's mind. Something had to happen to the person to shift the schema that [he was] using, to enrich it and incorporate more data into it.*

Iannuzzi: *You're saying this happens within the patient?*

Levenson: *Yes, within the patient, right, that it was no longer processed in the interpersonal field. It is a process in [patients] that also took place when they were sleeping, when they were talking to people other than you, or when they were having experiences where they would try something slightly differently and it worked differently.*

Hirsch: *So does that reflect a greater appreciation of the Freudian perspective of paying attention to what happens “within the patient” rather than “within the field”?*

Levenson: *It's not “rather than.” That's an Aristotelian way of thinking—what do you call it—the rule of the excluded middle, you know, something either is or is not [true or false]. It really is Western Greek thinking versus Jewish. It's no problem for me to think that something can be this and that in its evolution. I have a great appreciation of the Freudian perspective because I think over the years it's been possible for me to think about it more.*

Hirsch: *Well, it's ironic because you successfully began the separation from Freudian hegemony. We think that while the roots of the relational*

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turn begin with Ferenczi and Sullivan, after them you carried the torch toward what later became relational thinking, opening up the field to consider the whole issue of subjectivity. The contrarian interpretation is that ...

Levenson: *That's not really true. Others had a tremendous influence—Tauber did.*

Hirsch: *Well, but Tauber didn't write enough that people knew about it.*

Iannuzzi: *You certainly brought it out and developed it in the literature, there's no question about that.*

Hirsch: *The current contrarian interpretation is now that you've helped initiate the relational turn and the rest of the psychoanalytic world has caught up to you—the relational movement is in a sense the new “ruling class”—and now you have taken another turn to distinguish yourself from that group—*

Iannuzzi: *It begins to feel like Groucho Marx: “I wouldn't want to belong to any club that would have me as a member.”*

[laughter]

Levenson: *Well, I think there's no question that's true—*

Hirsch: *Now that's an interpretation!*

Levenson: *I thought it was a confession! [laughter] It's true, but again, it's not the whole truth. It's true: I think I'm a negativistic, contrary person by nature. It's perfectly true, if you say black, I'll say white, but, what the hell—the theory is always an extension of your own character structure, right? So for me the difficult question in analysis is always what's left out. If you have a formulation, I'm not interested in the formulation per se; I'm interested in what is left out of the formulation. Now, I also think that the field keeps changing. I said earlier, and I've been consistent about this, I think psychoanalytic theory reflects the current paradigms. It's not a monolithic thing. The field keeps changing as the world keeps changing—it's as Marshall McLuhan said, "If it works, it's obsolete." By the time everybody has come to agree that something is true in psychoanalysis, it's gone beyond that. My feeling is that mystification was, at the time, an extremely useful concept for all sorts of reasons. But, I don't think we should be sitting here now, forty years later, talking about mystification. It's a postmodern world—Phil Bromberg is dealing with multiple personages, which is a postmodern concept. You know, he's moving the field along with the zeitgeist. Jay [Greenberg] is very much into selfregulating systems. Steve [Mitchell] was moving away—these are people trying to move along and not get reified and stuck with something. They*

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try to move where the field is moving, where the metaphors of the field are moving. So, it seems to me that the thing that's ahistorical is my Korzybskian feeling that life is a dance between different levels of abstraction, and if you can't dance you're in a lot of trouble. I've always held to that; it struck me when I first heard it in the 1940s, and it still does.

Hirsch: *Do you think that anything you've written about has not been assimilated by contemporary theorists, interpersonal or relational?*

Levenson: *I'd put it in another way: Are you saying, "Do I think there's anything I've written about that hasn't been written about in some version by other people?"*

Hirsch: *No, after you. I assume you're being modest, but the two of us, and we're not alone—many people—see you as the forerunner of a relational turn in psychoanalysis, taking it in a direction toward subjectivity, intersubjectivity, and postmodernism. You were the single most important writer leading in that direction. And so I ask, do you appreciate that? It may sound immodest to say "Yes, I believe that," but do you believe that, do you appreciate that? It's the sentiment that I'm talking about.*

Levenson: *I appreciate it, but I don't believe it! [laughter] I mean, it's nice to hear; I love to hear it. I really don't know. It's very difficult for me. I have this same split attitude; I feel on the one hand that I've said a lot of things that are very interesting and useful, but on the other hand I don't think any of it was that extraordinary. There were other people writing about this stuff or thinking about it and writing it.*

Hirsch: *Not with the same clarity or pointedness as you.*

Levenson: *Clarity doesn't seem to be my cardinal virtue. You know, the way *The Fallacy of Understanding* (Levenson, 1972) came to be?—I gave a paper at White that came out of the Young Adult Treatment Service about the College Drop-Out Program. A publisher from Basic Books was in the audience and he said he wanted to make a book out of this. He absolutely took me under his wing; he sat with me for two years. He would meet me for lunch every week and I would give him chapters and he would go over them and he would say wonderful things: you have to expand this, expand that. When the book came out, I never believed it was going to have any impact. You know, there was a part of me that had been just sort of pushed along.*

Hirsch: *So you never believed—and do you now believe?—that the book has had an impact?*

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Levenson: *It never sold like hotcakes.*

Hirsch: *Do you believe it had an impact on the field? Do you appreciate ... well, do you believe that it had an impact, an enormous impact?*

Levenson: *You know, the funny thing is, I feel it had enormous impact on a number of people like Merton Gill, who read it, and a lot of people outside the White Institute, because it was the first introduction they were getting that was easily readable. You know Ben [Wolstein] was difficult to read. This book was anecdotal and accessible. Larry Friedman of the New York Psychoanalytic many years ago came to White Clinic meetings when I was the director of the service. He was very ecumenical and open minded and he told others to read the book, and the book was passed around and I think it had a huge impact in introducing the interpersonal view. I don't know how much impact it had at White itself at that time. I would be sort of surprised if you got people who were at White in 1972, if people in that group, would have said at that time, that it was very significant. ...*

Hirsch: *I was not at White, I was at NYU. At NYU it had enormous impact in the interpersonal group.*

Levenson: *Really? Well, as I said, nothing I wrote was ever a great*

financial success, and so maybe its part of the contrariness, I don't know.

...

[laughter]

Iannuzzi: *You don't see yourself as much of a pioneer?*

Levenson: *I see myself as a pioneer, but I see it partly because I was there at a particular time. You know, there was also a time when the Freudians really wanted to talk to somebody and I started getting invited to panels and to participate. I feel I was a pioneer in the sense that I introduced a lot of this stuff to them, and they were very interested. I don't feel like a pioneer within White, within the White community.*

Hirsch: *At NYU, there is no question that you were regarded as a pioneer.*

Levenson: *Well, take a book like Erwin Singer's book ...*

Hirsch: *Key Concepts in Psychotherapy (1970)?*

Levenson: *Yes. I mean, that book was also absolutely cardinal and he was there before me, I think. I think he wrote that before ...*

Hirsch: *That was before, yes.*

Levenson: *And so why didn't it grab on there, you know? The book was very popular, very well received—well, Erwin died, for one thing, which made a difference. See, I think we're all accidents of history.*

Hirsch: *His book was a clarification of concepts and how these concepts*

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differed from the Freudian idea, for example, how transference was thought of.

Levenson: *But he also talked about the use of the self and the use of countertransference.*

Hirsch: *I think his book did have a lot of influence.*

Levenson: *It did.*

Hirsch: *But your book brought something very new to the conceptualization of the role of the analyst. Namely, you introduced the idea of the ever-presence of participation and the concept of enactment—that we are always participating. That was very new in psychoanalysis. One of our questions is whether you feel you received the credit you deserved—but I suppose it's hard to ask that question now because you don't seem to be so sure that you deserve much credit.*

Levenson: *Wasn't that concept really introduced by Ferenczi? And promulgated by Thompson? For a while in the wider psychoanalytic world I was the representative of the interpersonal position. Now they've*

gone past me. It's like Pravda, you know, under the communists—your picture disappears from the May Day photograph. And you knew you were out. At least, now no one gets executed. [laughter]

Hirsch: Do you feel you've received the credit you deserve within the broad relational movement?

Levenson: No, I guess not. I think the politics of the relational movement led them to minimize their interpersonal roots. Interpersonal was subsumed under relational. I've seen myself quoted or referred to, but any effort to explicate my position always struck me as sort of oversimplified and underelaborated.

Iannuzzi: Maybe I could ask you a question about one of your current interests. You have said that you see consciousness reemerging as a central issue of the twenty-first century—with the whole notion of the unconscious really shifting from an unconscious that is dynamic, pushed down, or repressed, to an unconscious that is enabling, that ...

Levenson: Right. Those were the words I used.

Iannuzzi: Yes, I'm sort of glomming on to your words here.

Levenson: Good, yes.

Iannuzzi: So that as it's currently conceived in the field of neuroscience, it's this right hemisphere material that gets pulled up and shifts over to the left hemisphere, which organizes it.

Levenson: Yes, it puts it into language.

Iannuzzi: Has this caused you to change your thoughts about the

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nature of the deconstructive inquiry or about the praxis in psychoanalysis?

Levenson: Sure, but I thought I wrote that very clearly in that article, "Seeing what Is Said" (2003), where I said that having read this stuff and having listened, I had the feeling that the detailed inquiry, while it looks like a largely verbal interchange, really it's actually visual, that it's dealing with imagery and that it's right brain to right brain. In other words, the whole free-associative technique is right brain to right brain. It is really the presentation of imageries.

Iannuzzi: Is the praxis, then, an unconscious to unconscious communication?

Levenson: I think to a very large extent, yes, but it's "out of awareness" to "out of awareness." It's clear that a huge amount is processed visually that you never see, but the data is getting in and it's being processed. It

never comes into conscious awareness. So I think the idea is that consciousness, mentalism, mind are all different formulations of the same thing. There's this huge, huge mechanism going on to organize and make sense of stuff. None of it is conscious and it doesn't need consciousness. Consciousness—it's as if the left brain puts a dipper in and pulls out something and puts it into awareness. It seems to me so striking when you're in the process of learning something, how explanations are absolutely useless until you've actually learned it, and then in some funny way the explanation helps you to understand what you've already learned—maybe it anchors it in some way. You don't learn anything by somebody explaining to you how to do it.

Hirsch: *What is your current thinking about how things become unconscious or why things are unconscious?*

Levenson: *I think they're unconscious because they're unconscious. I think it's the nature of things to be unconscious. The question is, why do they become conscious?*

Hirsch: *Okay, so...?*

Levenson: *It seems to me these schemata experiences work out of our awareness. When you're throwing out a piece of paper you don't have to figure out the trajectory and the weight—all this is calculated. So it seems to me consciousness is not the normal state. Consciousness is an epiphenomenon. Gerald Edelman has said that learning to ride a bike requires conscious cognition and then it becomes automatic and unconscious. I really don't agree. Learning to do any physical skill can be hung on a theoretical armature, but the learning is still unconscious. If you've*

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taught a kid to ride a bike, you know that. You hold on, they just learn. What does explanation do for them?

Hirsch: *As with Don Stern's unformulated experience, the question would be why things become formulated?*

Levenson: *Right. The Freudian idea was that things are kept down out of awareness—that each level represses the level beneath it. It was a neurological model in use at the time of Freud. In fact, it was in use when I went to medical school. The idea now is that these are really coordinating systems and something in the sub-brain can have as much impact and influence on what's going on in the cortex as the other way around. All these things are networks or matrixes. They're not layers in the way they work. So in the Freudian system, unconscious was something pushed under, you know? In current neurology,*

unconsciousness is just the way we tend to work. The question is why does anything become conscious?

Hirsch: *And what would be your answer? What would you say about that? It implies that there's no experience that's more likely to become conscious or less likely to become conscious, right? It negates the idea of selective attention—that what we don't see, we don't see for a reason, because it's destabilizing, or trouble making.*

Levenson: *No, I don't think it's random. I would assume it has to do with some kind of Darwinian efficiency. There are things that are better left unconscious. They work faster and better that way. Other things that are better brought into consciousness because there's something about the conscious mulling, formulating, and structuring which is useful. Also on the left side of your brain there's language, so there's a tendency to have things in some kind of order or sense.*

Iannuzzi: *I would have thought that the question that you'd be most interested in is not so much what becomes conscious but how it becomes conscious. The “how” referring perhaps to how experience gets organized or patterned in such and such a way—and that anxiety must, for you, play a big part in that.*

Levenson: *Yes.*

Iannuzzi: *... and how it becomes conscious.*

Levenson: *Yes. I think this is, again, a matter of field/ground. You could say that these things are kept out of consciousness because they're anxiety-provoking rather than they're pushed into the unconscious because they're anxiety-provoking. If you think about it just in terms of efficiency, it's very inefficient to have things conscious. In terms of speed*

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and dispatch and efficiency, probably the tendency is to have as many things operate unconsciously as possible. You don't have to bother with it. That doesn't mean that without awareness, complex cognition can't take place.

Hirsch: *So, speaking in terms of emotional inefficiency, to have certain things conscious is inefficient?*

Levenson: *Right. Too cumbersome or very anxiety-provoking, depending. For example, most people have learned to just disregard a certain level of hostility because it's too difficult, too much time involved in dealing with it, so you get a nasty waitress, you let her go by. We don't even notice sometimes. It just isn't worth the trouble. There must be some kind of economy involved, that is, some things are brought into*

consciousness when it's useful to have it in consciousness. But, that implies that complex cognitions can and do take place out of conscious awareness.

Iannuzzi: *It makes me wonder, if you conceive of the therapy interaction as a right-brain to right-brain communication, and since the right brain is the seat of our affective, emotional life—that would seem to suggest that the affective connection between the therapist and the patient is extremely important. Of course, many, many people have commented on the importance of affective connection, but it hasn't been something that stands out in your work.*

Levenson: *It's true. I don't explicitly focus it.*

Iannuzzi: *So is that a change?*

Levenson: *I don't ... no, it isn't a change. It's truly an angle I haven't dealt with. I've always worked with the perhaps convenient assumption that the affect was wired into the events. You didn't have to look for it or focus it or ... if someone gets into something they're very upset about, they're going to cry and you don't have to work toward—I tend to ...*

Hirsch: *I think what Victor's talking about is the affective exchange, not the patient's affect, but the affective connection that exists between the two of you. If there's not much affective connection between the two of you, felt by both of you, does the process work?*

Levenson: *Well, I think there are a couple of different questions conflated into that. You could have an affective connection with a patient where you like him and respect him and admire him and don't like other things about him. It seems to me that would work. I don't know that you have to love [him]. It depends to some extent, I think, on what you*

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consider to be the norm of your relationship. If you tend to love people that you're connected with and you don't love the patient, then that's an indication something is off. Do patients who get that kind of love do better than patients who get a cooler kind of relationship? I don't know. I think probably not, because it seems to me what tends to happen is that the working through brings all this around in some way. If you're one of these terribly warm, caring therapists who are extremely helpful and supportive, there's a point at which the patient's hatred comes in and yours does too—and if you don't see that, you're really going to miss something. I think real warmth and affection for the patient should be an emergent process, building between the two. If the therapist gives it automatically—because that's the kind of person the therapist is—then it seems to me gratuitous.

Hirsch: *We're not talking about the overt manifestation of warmth and caring. You could be extremely silent and reserved and feel a strong attachment to a person and not be at all expressive. Is that essential for you? If you work with people for years and the affective connection doesn't happen, are they likely to benefit from all the other things that happened? And, again, I'm not speaking about it as verbally expressed emotion at all.*

Levenson: *No, no, but there are two different issues. Either you're a person who's relatively cold or unrelated or distant, or it's your preferred analytic technique. That's different than if you were a reasonably warm, affectionate kind of person and there's one patient you never feel anything for. Because if there's the one patient you never feel anything for, then I would think it's a matter of countertransference. Who would persist in doing this difficult work if they didn't like the people they were working with? Of course, Freud did, on a couple of occasions, refer to his patients as "drech." Maybe he was overwrought. Does warmth cure? I don't think so. But absence of warmth is a marker for countertransference.*

Hirsch: *But even the Freudians who were very quiet or remote, because it was dictated by their technique, quietly established personal affection and feeling for the patient, although probably it was unexpressed in words.*

Levenson: *Oh, well, if you work for years with patients and you don't feel something really strong about them, there's really something off beam. For example, there are patients—false-self kind of patients—who work with you for years, and they come in with tons of material and*

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there's friendliness and you really don't feel a thing for them, and I think that might be a quite appropriate diagnostic kind of sense that these people are not really in the room with you.

Hirsch: *But then that becomes the heart of the work, right?*

Levenson: *I don't know that one can resolve it by interpretation or confrontation. As if the patient could change or even understands what change is being asked for. When change does occur, it is gradual, and usually comes from the patient—a dream, perhaps, that opens recognition of how empty the patient's affective relationships are. So there are two different things. You're always measuring the experience with the patient against your norm of experience, not theoretical but just your norm of experience. I think if you don't supply the kind of warmth and caring and so forth—it seems to me it should be less effective, but, as*

I said, I think patients maybe work around that.

Hirsch: *That's really not what we're asking about—supplying warmth and caring.*

Levenson: *You mean feeling it?*

Hirsch: *The existence of it, the feeling of it, not the overt supplying of it. So the question is could anything useful get done if that doesn't happen?*

Levenson: *Why would that even be a question, though?*

Hirsch: *Well, because it could reflect a significant level of emotional detachment when you're talking about something you describe as a right-brain to right-brain communication, so that whatever it is that we're trying to do doesn't get done because we're not sufficiently present with the person.*

Levenson: *But I think that would be in the realm of subtle countertransference, don't you? Is being present an emotive state one can reach for? It seems to imply that engagement depends more on quantitative affect than content. Also, I don't think a therapist should assume that if a therapy is not moving that it's necessarily due to a failure of empathy, or lack of engagement. The patient brings something to the room and a therapy can fail because the patient is not sufficiently committed to the effort. I hate to see the patient turned into a passive receptacle for the therapists' charismatic influence.*

Hirsch: *So the question is could anything useful get done if that doesn't happen?*

Levenson: *Sure. Again, it depends on ... resources of the patient and who they have in the outside world and what stage they are in their life.*

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It's hard to imagine that it wouldn't be better to have a therapy with a warm, respectful, caring person who really liked you. And if the person doesn't have that personality, I think you lose something, whether you can work with [him]. I mean, the world is full of analysts who are not like that and do perfectly good work—"good enough" therapists. Patients tend, at least in the old days, they tended to self-select a little. I think schizoid people, on the whole, did better with more distant therapists. You know, Sullivan did wonderful work, but he was as cold as a fish. I don't think his patients wanted to be impinged upon.

Hirsch: *But he seemed to have a tremendous affinity for schizophrenic patients like himself.*

Levenson: *He had a huge empathy for them. But I don't know that he liked them. He didn't like anybody, as far as I could see. I think what he*

communicated, just like Fromm-Reichman, was respect and the feeling that his patients weren't crazy, they just weren't understood, which is wonderful. Fromm-Reichman was moving over to this idea that it was love that healed. I heard her once at a meeting tell a story about sitting with this patient in a shit-filled room—do you know that story?

Hirsch: *I haven't heard that.*

Levenson: *The patient said “Doctor Fromm-Reichman, would you eat my shit?” and she said, “If it would cure you, I would. “Maybe she was desperate enough to cure somebody. [laughter] It was like she would do anything, you know? But I still feel like there's a subtext in the question you're asking.*

Hirsch: *Well, the only subtext is that that's not been in your writing. So we're asking, in your spirit, about addressing something that's omitted. That's the only subtext. Are you aware of any other subtext?*

Iannuzzi: *No. I think that's exactly it.*

Levenson: *Right. Possibly I just feel like affect goes along naturally with content.*

Iannuzzi: *When you were talking earlier about your current interest in right-brain to right-brain communication, and the body of unorganized experience held out of awareness in the right hemisphere of the brain, it made me think that although we knew far less about neurobiology when you first started writing, you were suggesting some time ago that unorganized material showed up in the patient's world in the form of a pattern of some sort, and it's what you have said the analyst invariably and unwittingly gets drawn into. And the patient ...*

Levenson: *Yes, I've been saying that—right. I also think it's perfectly*

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true that a neurotic system, besides being clichéd and overabstracted, is also redundant; it works extremely well. In other words, one thing about a good neurotic system, you can count on it calling out the same response. It may alienate everybody and you may have no friends left, but you can count on it—that you did it and that's how you did it. If there's another analytic aphorism: remember, patients are always better at what they do than you are. When you sit in a room with somebody in an intense therapeutic arrangement, the patient's mechanisms impinge on you a hell of a lot more than you impinge on the patient's, since you're within the structured frame. So this business of participating and becoming part of it is a natural reaction to dealing with somebody with very powerful redundant mechanisms for making the world work. It's particularly true in borderlines, you know, because they—you can sit

there and swear you won't let them, and they'll infuriate you anyhow, at least they do me. I don't know if you've had that experience, but you promise yourself you're not going to get pulled into their vortex and they come in the next time and they just push your button and you're off! And you sort of think, how the hell do they do that? But what I'm saying is that the idea of becoming part—being sucked into the system and working your way through seems, again, perfectly reasonable to me. There's nothing mysterious about it.

Hirsch: *What about in the other direction, what Lew Aron has called mutuality, or what's written about as mutuality of influence. How much of who we are as therapists impacts the patient?*

Iannuzzi: *That is, is the patient also pulled into our pattern of experience, our own recursive pattern?*

Levenson: *Yes, sure. I guess that would be true. Well, I don't—you know, that's a very interesting question. I think probably it would be only true in extremely compliant people. And that would be also their way of managing it. It seems to me the situation is basically so asymmetrical that I can't see it as mutual. Now maybe later, when you know the patient, you've been going along for a long time, it gets you more relaxed, you tell him more about yourself. The symmetry increases at the end of therapy.*

Hirsch: *That's what I've always thought you implied.*

Levenson: *If you think that a neurotic system works to maintain redundancy, then it isn't surprising when you get in a room with him, you're going to get pulled into it—because it really does work.*

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Hirsch: *So that is still a central way that you're looking at things, you haven't shifted out of that period. The idea of being pulled in is still salient to you, right? Because you just brought it up.*

Levenson: *Yes. Yes. I wouldn't use "pulled in" as much; it's a slightly different metaphor. That's just—yes, actually, yes, it's true that it's going to work. Listening to the story and asking questions is participation—I mean, how else do you participate? It seems to me it often is chaotic in the room with a patient. There's nothing wrong with something being chaotic; it's the period before reorganization. The phenomenology of learning in analysis isn't different from learning in other areas. If you're learning something, there's a period just before it sinks in when whatever you're trying to learn absolutely falls apart, isn't that right? When you study for an exam there's always a point where all of a sudden you don't remember anything—that's the time to stop, to leave it awhile and then it*

sinks in.

Iannuzzi: *Earlier you said about one of the shifts for you, that we could characterize it as a shift away from dichotomizing toward a more dialectical—toward dialectics. Is that true for how you think about reality? You have said “reality” is for you a construct, a selective reading. And you have also said in your writing that you're not a constructivist, not a relativistic perspectivist and, yes, there is a reality. I think that's one of the things, as Irwin was saying before, that stands out for some people as an apparent contradiction. And I'm wondering now, well, is it a contradiction or is it something that you see as being in dialectical tension, these two ideas? That there is a reality and it's a constructive, selective reading—both are true?*

Levenson: *I think they're both true, I'm sorry, I sort of get confused by all this. The example I used of the man and his girlfriend—and he's flying into a rage. There is clearly a veridical basis there; you can see what she is doing that is essentially provocative. So in therapy maybe he can see that and he can learn something about his own experience or he'll come to it—about his dealing with his mother and so forth. But also, if you stay with that event—just accumulating detail—it begins to extrapolate out where his getting hurt appears to be a mechanism with her. In other words, he provokes her, in effect demanding a hostile and negative response—it goes around and around and around in these kinds of reiterative circles. So you can say the first version is both real but also a selection of what you think matters in the reality.*

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Iannuzzi: *For both the analyst and the patient?*

Levenson: *Yes. That in some way the two of you are agreeing that something happened that is out of the patient's awareness, but that that is a selective reading. I agree with that. Now, I don't know exactly what perspectivism really means, you know, because the postmodern implication is that nothing can be considered more real than something else. So I don't know, you're left with the idea that it's all simply inventing a narrative and that the narrative that the patient is abused by the hostile girlfriend is the best narrative because it works for him.*

Hirsch: *But isn't that one of the things that at one point was not just compatible, but that you introduced? Now you are at a different period and you seem to speak about it more skeptically.*

Levenson: *I introduced what?*

Hirsch: *Well I hate to say it, but in psychoanalysis the notions of subjectivity and perspectivism, the idea that everything is contextual,*

reality is contextual—the way contemporary analysts tend to look at things.

Levenson: *Well, yes, but I don't think I said reality was contextual. I said that the observer views reality contextually—that one could look at things from almost an infinite number of perspectives. I didn't think of perspective as a value thing, that it meant that no one perspective is more valid than another.*

Hirsch: *Well—but you seem to mean it as not only that no one perspective is more valid than the other, but determining the absolute veridical perspective is impossible.*

Iannuzzi: *The fact that there is none, there is no objective ...*

Hirsch: *Well, not that there is no reality, it's not determinable objectively.*

Levenson: *How can there be a “veridical perspective?” It's an oxymoron. A perspective is, by definition, one of many viewpoints. Supposing a woman goes with her husband to buy a suit and he's standing there and she says, in front of the salesman, “Harry, that suit would fit better if your ass weren't so big. “Okay. That's an event. Now, would anybody argue that's not insulting? There still is a veridical reality—certainly open to interpretation and perspective. In other words, the event took place, and so I don't think anybody would deny that. Now, let's suppose the guy denied that he was upset about it. He thought it was a big joke, but he has a dream that night that somebody chopped off his penis with an axe, and he begins to come around to the idea that he felt terribly upset*

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and castrated, okay? But let's get more data. She might be angry that she has to go with him to select a suit or ... whether he owns a lot of suits, whether she buys them all with him, and what suit he was trying on when she made her crack—even which store, modish, very high style, inexpensive. Or is it that he wore the same old worn out cardigan coming through at the elbows and she insisted, they're going to their daughter's wedding, he had to go and buy a suit? Was she flirting with the salesman? Was she intimidated by him? Who pays for the suit? It seems to me as you begin to expand on it, that's where the perspectives come in. I'm not sure, but I think there is a difference between perspectism and perspectivism. I thought what I was trying to say is that all these events can be turned around and around and around. Each time you get a different level of meaning.

Hirsch: *I'm asking about your interest in talking about reality, ala*

Sullivan. The exchange you had with Irwin Hoffman about the cat? Remember that?

Levenson: Maybe. I don't remember having an exchange with Irwin.

Hirsch: In replying to your article "Whatever Happened to the Cat?" (Levenson, 1989), Hoffman (1990) addressed your emphasis on the manifest content of the patient's narrative—in a sense suggesting that in asking questions about the cat you were interested in the objective reality of the situation. The article corresponded with a period during which your perspectivist views and your focus on intersubjectivity were being embraced by a very wide audience. In your reply (Levenson, 1990) to Hoffman you stated unequivocally "there is a reality of experience." I'm saying that some of us thought you had turned toward a more Sullivanian notion of reality as reflected in his use of the detailed inquiry.

Levenson: No, I did not. It seemed to me important that they drove back from the summer house and nobody says whether the cat died or they found it or it turned up or they went back the next day. Nothing is said about the cat, and since that seems to be a major omission in the story, I would ask what happened to the cat. I'm not interested in the fact particularly. I'm interested in the way the inquiry begins to unpack the whole nature of the family and their relationships to each other. When you listen to most patients' narratives, the story strikingly often seems to end one question short of opening up the narrative. "So, what happened then?" is a simple question that usually elicits complex responses. So it seemed to me the search is to find out what is left out of the story because it begins to open up the whole thing. The business of

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perspectivism, I thought, was simply to move around the story, to get the story expanded as much as one possibly could. Why would a family leave a cat? I mean, they weren't getting on a plane, they had a car.

Hirsch: I think I see your point.

Levenson: I'm not sure; I think I'm missing the question.

Hirsch: Well, you're not missing the question. In your earlier work you did emphasize clarity, and some people may have misunderstood the shift in emphasis toward deconstruction as a shift back toward Sullivan and the detailed inquiry for the purpose of clarifying the facts. In your reply to Hoffman, you seemed to do this.

Levenson: I never went back to Sullivan. Sullivan used inquiry to clarify, as you say, and I used it to deconstruct, to confuse the simple cliché 'd version of events. One issue has to do with veridical reality and whether something is real or whether it's simply an interpretation. The other issue

has to do with the use of your own participation with the patient. I'm not sure exactly how one moves from one to the other. It just seems to me that one changes focus, depending on what happens in the room. What I was saying is that there is a reality once you know the event. Then there are a series of possible interpretations or perspectives on the event that reflect different interpersonal integrations. One wants to encompass as many of them as feasible.

Hirsch: *Weren't you at one point in agreement with the view of Spence and Schafer about questioning the analyst's role in imposing narrative coherence?*

Levenson: *But, you see, I wasn't interested in that at all. The point is, I was interested in the issue of perspectives, of turning the thing around and around because I wanted to get as much data in, so that one could create a sustainable chaotic situation. I think I've always been consistent in the idea that I'm trying to disorganize the patient's experience so it can be reorganized in a more complex subtle manner. They're interested in trying to figure out what really happened and whether it matters that it really happened.*

Hirsch: *Yes, but implicit in what you're trying to do is underscore the notion of a subjective analyst.*

Levenson: *The subjectivity of the analyst lies in the questions she asks, or doesn't think of asking. That defines the therapist's perspective, which one hopes opens up as the inquiry widens. Wouldn't you say, for example, in this reductio ad absurdum event that I gave you about the*

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suit buyer, that everybody would agree that (a) the event took place and (b) it's basically an embarrassing event in this culture? Now, let's suppose the guy's a sadomasochist and he likes to get into an embarrassing situation—so that would begin to shift you to another perspective I would think. But I don't think it would mean that the event didn't take place, or that it would make a value judgment. It would be overdetermined. It wouldn't be a question, as if there's one meaning and not another.

For example, after she made fun of him, that affects what I would say to him, how did you really feel? Because I'd be interested to know whether he felt humiliated and enraged, excited, amused, whatever, and then I would say, so what happened when you—what'd you do after you left—did you buy the suit? And then I'd ask him, so what'd you do after that? Did you go to lunch? Did you talk about it? You know, I'd like to know, is this the first time she bought a suit for you? You have a lot of suits at

home? Who bought your clothes when you were a kid? It seems to me, the more you open that up, the more interesting and complex the thing would become. Now, I don't know at the end if you can say, well, the truth is you're a sadomasochist and you really enjoyed her doing this, or that's the meaning. I would agree with Phil Bromberg at that point that there's a different meaning and a different person for every perspective of that event. I'm not even sure why that should be confusing. It seems to me, if you take the event and you arrive at an acceptable narrative, you've simply valorized one perspective over another. I don't know what you've done to the patient by doing that. Or, if that's what I was doing at the time, I don't recognize it now. It's been submerged and lost in my interest in deconstruction. So how impactful could I have been? [laughter] You see, one's always effective doing the wrong things! I thought the way to do this is to hold on to a couple of clinical observations that seem relevant and then see how do they sound different at different periods of my work. But I feel like it's changed over time, not in some neat linear development, but with all the new directions, false starts, and explorations of any creative endeavor. The Sufis say no problem is too difficult for a theoretician. I think clarity, conceptual or otherwise, is always a function of memory or reconstruction, after the fact. Real intellectual effort, I believe, is always a mess. Of course, that's a self-serving formulation. I try to see different times with different paradigms, different cultural shifts. I think it is like a blue period or a red period for an artist. It's all about play and change.

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Hirsch: Well, I suppose that's why you're always considered a perspectivist. You see things in terms of the influence of a different time, different context.

Levenson: Yes.

Hirsch: So there's no truth that transcends time. It depends on which period you're in.

Levenson: Like Pontius Pilate, "What is Truth?" I don't really see that. It seems to me all it says is that truth is veridical, but meaning is perspectivistic. I mean, why does it have to be one version of truth that has priority over another? It's the analysis of the overdetermination that makes a difference. It's not about finding which formulation is the true one. See, here's the thing. Suppose you said to a group of people, here's the incident, this is what happened. Okay. Now, what do you want to do with it? What do you do with the patient? Someone is going to ask what's he feeling? Let's say he's sitting in the office and he's just crunched down with humiliation and rage. Okay. Now, what do you do? Do you

commiserate with him? Do you tell him it's terrible of her? What do you do? Now, you can go through his history, which will indicate that he's been humiliated a lot by his mother. One might hope for an abreactive outpouring of affective memory that would, in itself, be mutative, and then suggest to him that the current event wouldn't be so devastating if he weren't already sensitized by her treatment of him. Some one else, one claims, would perhaps be annoyed, but it would not constitute a crisis.

Hirsch: *And we could point out that perhaps, in some way, it is you who unwittingly humiliates him too. You may find yourself humiliating him in some way. This is among the possibilities, right?*

Levenson: *Right. Inevitably you will. Maybe even by a wonderful, unintentionally patronizing interpretation, or a kindly empathy, or masked disdain. You can monitor your own participation and try to minimize it, but it will seep through. If you volunteer the observation gratuitously, it will be patronizing—"see how observant and generous I am—unlike your wife, I can admit what I do." If, on the other hand, the patient picks up—in a marginal awareness, a dream—your countertransferential disdain and you can acknowledge the legitimacy of his observation, and especially if it was not in your awareness at the time, then it is immensely helpful. Now, if you were sitting with Ed Tauber, Ed would have said to him," Well, you asked for it. "Why'd you let her—you knew she had this big mouth. Why did you take her along with you this time? What were*

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you doing? That would be in a way saying I'm not afraid to humiliate you because I don't think you're so fragile and pathetic. It's a whole different interpersonal interaction emerging from Ed's personality. Maybe Fromm would ask why he had to buy a suit in the first place. So it seems to me you could say that, as you go there, I don't think anything gets clearer. You begin to see many, many more aspects. I think what would happen is that, after this kind of inquiry, of just going through it, he would maybe move into something historical, or you might begin to get some kind of experience exactly that, in some ways, is set up to humiliate him. He'll tell you some self-deprecating event—and so that would be the working through, I would think. Isn't that the way it works? I don't know what else one would do.

Hirsch: *That feels consistent with how you have generally been understood.*

Levenson: *Good. I'm delighted*

Hirsch: *We should wrap up, I think. Do you have anything you want to*

conclude with, that you want on record?

Levenson: *To paraphrase an old joke, “If I’d known I’d be taken so seriously, I’d have been more careful about what I said!” I’d like to addend a quote from Gedo (1999), who is lucid about most things.*

Iannuzzi: *I’ll read it aloud.*

He [Levenson] defines psychoanalysis as a method to reach valid conclusions about the functions of mind. In the course of such an inquiry, we do not so much reveal hidden truths as we reach levels of greater complexity in understanding. This procedure permits the analysand to acquire hitherto missing cognitive and semiotic skills. ... For Levenson, symptom reduction is not enough; analysis must be able to fill the scotomata in the patient's psychological competence. This is a theory of technique novel enough to justify Levenson's conjecture that analytic success has hitherto depended on the analyst's skill in navigating against the current of the invalid theories espoused within his or her tradition. Levenson understands that his theory requires, in turn, a theory of mind congruent with how the central nervous system functions. As he conceives this, such a theory must therefore be hierarchical as well as holistic—that is, one that describes a network that may be enriched by the acquisition of new capacities. [p. 137]

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