Objectivity and efficacy in constructions: The issue of truth in therapeutic practice and theory Pt. 1.

Constructions are one of the most fascinating and all but magical aspects of psychoanalytic practice. The patient, in many instances, may have their symptoms directly removed by way of a simple deduction, and a bit of talk. Severe debilitating symptoms are defeated in psychoanalysis by bringing an unconscious memory or fantasy into the sphere of consciousness. It is our repressed unconscious ideations operating as unseen pathological instigators which form much mental illness. If the memory or fantasy can not be located, the events and impressions can be deduced, much as a sort of psychical archeology where the symptom becomes analogous to an artifact from which the real objective facts can be inferred with certainty. I say with certainty, because unlike archeology, psychoanalysis, in some instances, can confirm the truth of its deductions, as the illness and its symptoms evaporate before our eyes in the very instant the correct facts have been deduced, communicated and accepted. In this first of a two part series, I will spell out the proper and correct relationship between objective fact and constructions as related to specific unconscious material, and in the next, outline a new technique for deducing the levels of determinacy and importance of various psychical elements in correspondence to their energetic cathexis across the lifetime of demonstrable active symptomatology.

I will make the lesson I have learned so many times regarding the efficacious therapeutic use of unconscious content clear from the start, and state in the most condensed and precise form:

Accuracy = Efficacy.

This most unpopular view has served me well in ridding myself, and some few others, of all sorts of symptoms—eliminating entire pathogenic structures so as to reclaim their energies. In those cases where a true overcoming of the illness is a valid prospect, the absence of strict adherence to this proposition: Accuracy = Efficacy, yields the certain elongation and failure of the therapeutic process. Briefly put: it is tempting to believe that the murk and resistance we MUST rightly pierce, obscures not "a truth," so unattractive and hideous, but, "a maybe," a shifting pile of sand, an ineffable substrate, or, unnamable dread (Brown, 2011, p. 73, 134). These are wishes, wishes not to see this thing we must see. In every case without exception, unconscious content is invariably specific. To deduce the wrong unconscious aspect, is to fail to gain a single step forward. The result is always the same: failure to eliminate the problem for good. It will return, perhaps

transformed, and torture you yet again. No exceptions: unconscious content is always specific.

Today, the subjective viewpoint has been used to weaken, obscure, and by death of a thousand cuts, make Freudian theory ineffective. This is exactly as one would expect, as the very precepts and design of this theory move directly against the construction of personality in terms of its defenses. The result of the subjective pluralism characteristic of today's psychoanalysis is that the theory is not used properly (Tuckett, 2011). Indeed, the basic fundamental ideas of psychoanalysis have been purposively misunderstood to accommodate these confusions. In one example of the new psychoanalytic subjective "viewpoint" (Collins, 2011), printed in the top psychoanalytic journal, *The International Journal of Psychoanalysis*, we see severe and obvious theoretical distortions. In substitution for the difficult task of unearthing the biographical facts, we find the idea that we need not bother to be objectively correct! It also appears as if *the patient* (not in self-analysis) can accomplish the task of discovering what *the therapist* must deduce and present, such as a construction involving fetish and the phallic mother. (If this were so, the therapist would not be needed). To conclude, as doctor Collins does, that we are conducting an "authentic" piece of analysis to get it wrong, to lie to ourselves and others, as James Frey did with his disgraceful self-representation in *A Million Little Pieces*—to believe this fake has value, and even more so, that this approach will cure…this is error (Collins, 2011). Whatever the patient's relationship to the therapeutic situation and the countertransference, if the construction is in any way erroneous, it will fail. It is not a composite creation, it is a deductive near certainty, or a farce. To lie, is not as valuable as to get it right…period. *Truth is.* E.g., if you are suffering conversion hysteria such as that illustrated in Norman (2011a/2013; 2011) [see *Native Psychoanalysis: A Non-Elliptical Technique*, p. 35, and Norman, (2011)] and you guess the construction wrongly, you will suffer. Please see example number three in *The Tangible Self* (Norman, 2011). Every guess of whatever sort will fail, unless it is precisely accurate.

If the correct construction is obtained, the deduction is validated in seconds or minutes, and the symptoms ease as quickly as that, sometimes taking longer to disappear completely, sometimes not! Later, memory retrieval may recover the actual memory, and in those cases, the construction will be validated to a tee. Truth = Relief. (Information will be provided in the second part of this series which will allow the sure and reliable deductive separation of fantasy from actual recovered memory). In short: when treating a neurotic or psychotic symptom, the correct answer is the only one which has any validity or efficacy. Accuracy = Efficacy. If you deviate from this point in any way, the patient will remain sick. Simply reverse each main point relating to constructions in Collins (2011), and you will be sure to succeed. To be fair, Dr. Collins is most insightful and correct in every aspect of the analysis, except, the role of truth in autobiography and construction. Or in the words of Freud (1937) referring to the goal of a rightly founded construction: "What we are in search of is a picture of the patient's forgotten years that shall be alike trustworthy and in all essential respects complete" (Freud, 1937, p. 258).

Due to the reduction in repression which causes the artificial psychosis/neurosis from SSRI withdrawal, a permanent change in the function of the repressive system results, and, the condition of substantially reduced repression will become in some degree, permanent. I.e., a condition which presented as OCD will now, after SSRI withdrawal from extended treatment, even years later, show permanent change (repressive damage) and demonstrate a large admixture of overtly hysterical symptoms, to present predominantly as an hysteria. This is not entirely without advantage, as the symptoms, although perhaps quite prolific, can be easily understood, hysteria being more transparent than OCD. Likewise, the repressive damage leaves the entire system at a low enough level of functioning that it can be observed in operation, as the pathogenic unconscious elements which cause the conscious end of the transference are in part, available to direct observation. This is no small thing for us psychologists, for now, we can end the debate throughout the psychological community about the reality and dynamic pathological contributions of unconscious ideations, so eloquently put by doctors Talvitie and Ihanus (2005).

As the symptom presents, each part of its presentation should be carefully noted. Nothing is from general systemic states of chaos or nonspecific imbalance, but instead, each piece of the strange seemingly inexplicable symptomatology will be revealed to be quite purposeful. Pieces of the unconscious fantasy or memory, will show through in an undistorted form, and when the memory is retrieved, or the fantasy made conscious later, it will conform to the symptomatic presentation precisely, and show some unusual characteristics which are quite consistent as well. The fantasy or memory, will often be temporally asynchronous compared to its original form (if it is a memory), and instead, will demonstrate an adjustment, often a slowing, so as to exactly coincide with the symptom. Please reread the example in: *The General Relation Between Unconscious Ideation and Conscious Symptomatology* from the *Nine Essays* paper available for download from the archive at: www.thejournalofunconsciouspsychology.com. The memory in the example was slowed to exactly reflect the shifting symptomatic presentation, just as a magnet under a table would turn at the exact speed of a magnet on top of a table. One can observe, as a matter of symptomatic examination correlated with directly observed unconscious content, to find a sure deduction: unconscious content, both memory and fantasy, is indeed, an active unconscious positive, working actively from the unconscious, replaying over and over, to cause many neurotic/psychotic symptoms. Unconscious fantasy is demonstrable, and not a mere conceptual nicety. One may simply watch it work, and end the useless debate. Certain symptoms of a deeply personal character have demonstrated the notion countless times, pieces of actual unconscious memory erupting through in synchronous observable accompaniment to the active symptoms, and in my *The Tangible Self*, you can read of a thought experiment which I have carried out many thousands of times, which allows the piercing of the repressive veil in mid-symptom via the Open Emotional Posture (OEP) (Norman, 2010, 2011, 2011a/2013), so as to observe the state of unconscious activity, which will be more often than not, caught mid-stream, observed part-way in, as a deeply familiar piece of

pathogenic fantasy is being represented. The deduction is plain enough: The fantasy was already running, and by doing so, causing the symptom. After a few thousand examples directly observed, even this skeptical author is sure: unconscious fantasy, memory and ideation, is active in the unconscious as a source of transference, moving at a tempo adjusted to form-fit the symptom, as the unconscious element (determinant) asserts its pathogenic influence from unconscious sources. Indeed: *The neurosis is the negative of the perversion.* [Freud, 1905]

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