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CLINICAL WRITING AND THE ANALYST'S SUBJECTIVITY

Laurence Spurling

In a lecture given in 1916 Freud declared to his audience of medical students that whereas they can learn about medicine by watching their teachers in action, “the talk of which psychoanalytic treatment consists brooks no listener; it cannot be demonstrated” (Freud, 1916, p.17). This is a consequence of the patient’s intense and intimate “emotional attachment” to the doctor, which would be disrupted if a third party were to observe the analysis. And so, he told his audience, you cannot be present at a psychoanalytic treatment; you can only really know about it “by hearsay”.

The position of the contemporary analytic student and practitioner may seem very different. Students now have a training analysis, giving them first hand experience of how their personal analyst or therapist works. There is also available a growing body of taped and video-taped psychoanalytic material. However being a patient and allowing oneself to be become dependent and therefore be helped in a personal analysis depends on the student giving up on the kind of critical and discursive thinking and observing which is a necessary part of learning through formal instruction or in clinical supervision. And there is little evidence that the recording of analytic sessions has had much impact on the way psychoanalysis (taken in its widest sense to mean all forms of analytic work) is taught. And so it remains the case that most analytic practitioners will graduate from their training having never seen any of their teachers actually doing psychoanalytic work. They are still having to rely “on hearsay”.

Nevertheless since Freud's lecture the quantity and quality of this "hearsay" has developed enormously. There is now a wide-ranging and rich library of case studies and clinical accounts in the psychoanalytic literature. Given the absence of any first hand experience of analytic work, these accounts play a very important role in the training and development of analytic practitioners. They function as what the literature on craft practice calls "exemplars", which consist of "a repertoire of examples, images, understandings and actions" (Schoen, 1999, p.138, Spurling, 2015, p.81). But given the vast number of clinical accounts that now exist, how does the clinician decide which should serve as examples of good practice? What turns a particular clinical account into an exemplar? Is it simply by virtue of being written by an analytically authoritative or seminal figure? Or is it something more intrinsic to the writing itself – but if so, what?

What is clinical writing trying to do?

In trying to determine what constitutes good clinical writing, we need first to agree on what its function is. Why do analysts write about their work? Freud was clear that in writing his case histories he was providing backing or evidence for the validity of his theories. In the introduction to the Dora case, for example, he refers to his theoretical ideas on "the pathogenesis of hysterical symptoms", and then asserts that he was proposing "to *substantiate* those views by giving a detailed report of the history of a case and its treatment" (Freud, 1905, p.7, italics added). This use of clinical writing as a way of validating one's theoretical ideas figures in the writing of some of the seminal psychoanalytic figures. For example Melanie Klein writes in the introduction to her "Narrative of a Child Analysis" that

“the details of this analysis *clarify* and *support* my concepts” (Klein, 1961, p.11, italics added). One can note that clarification and support are not the same, but the latter, like Freud’s “substantiation”, means using the clinical case as a form of validation of one’s ideas. This way of using clinical writing has been strongly criticized, both from outside the analytic tradition (e.g. Grunebaum, 1984) and from within (e.g. Spence, 1984), and is now largely discredited within the analytic community. The basic problem is that the analyst is not a neutral or objective observer of the interaction being described but, on the contrary, a necessary participant in the process. Furthermore this analytic process depends on the establishment of an analytic setting, which is constituted and maintained by the analyst’s way of conducting the analysis. The analyst is therefore both participant and designer of the process in which he or she is taking part. In describing his experience of listening to the clinical presentations of two different analysts, David Tuckett describes this dual role of the presenter as a “curious situation”:

what they report about what their patients said and the interpretations they made are, in a manner of speaking, two versions of the same observation: the two authors have tried to report things as they believe they happened, but there is no getting away from the fact that the sense they made of what they were told must have operated to influence both their selection of what they attended to and reported and their interpretations. One might say that they both understand and construct: they participate in making history, and then report it. (Tuckett, 1993, p.1180)

If clinical cases cannot function as a means of substantiating or supporting theoretical ideas or clinical practices, their role in what Klein called clarifying theories and ways of working seems much less problematic. Indeed once freed from the burden of proving something, one might wonder whether clinical writing needs to be tied to a description of a real patient at all. For instance David Malan, in his textbook “Individual Psychotherapy and the Science of Psychodynamics”, uses an “imaginary therapy” to illustrate the main elements of psychodynamic practice. His rationale for this is that “no real example shows either clearly or completely enough all the features that I wish to illustrate” (Malan, 1979, p.81), and so he elects to “make up an account of a fictitious therapy”, based on the kinds of things that have occurred “in countless actual therapies throughout the world”. This way of writing works by explaining to the reader what is going on in the analytic interaction.

This can be illustrated by looking at how this imaginary therapy begins. Malan sets the scene with the patient, a young man, telling the therapist, who is a trainee, that his problem is that he cannot maintain deep feelings in his relationships with girl-friends.

The therapist sees that this inability to feel must represent a *defence*. She has ideas about what this is a defence against, but in accordance with the principle of exploring gradually and allowing the patient to do as much of the work as possible, she only gives a general interpretation: ‘I think this inability to feel (defence) happens because you are afraid (anxiety) of something that might occur between you and your girl-friend if you were to become more deeply involved’ ... This interpretation can be described as *asking a question of the patient’s unconscious*... Without being fully aware of the significance of what he is saying, the patient now mentions that he had become more deeply involved with his first girl-friend than with the present one, but

that she had not really wanted him, and when she had left him he had become very depressed and had spent long periods crying. After the break-up of a subsequent relationship, however, he had found himself consciously indifferent...The patient's unconscious has now in a sense exceeded expectations, since it has not only supplied the *anxiety*, but the *hidden feeling* as well. (Malan, 1979, p.81, italics in original)

This way of writing situates the reader as an observer of a clinical encounter between patient and trainee therapist, while at the same time giving access to the teaching of the author, whose comments links the material to the relevant theoretical concepts and technical principles. It is similar to watching a tennis match between two players in the presence of a tennis coach, who is able to break down the particular strokes employed, as well as describing to you the game plan and strategy of each player. The account is given in the third person, as it is the teacher and not the therapist who directs the reader to what is relevant. We are given a small window into the therapist's subjectivity –“she had ideas about what this meant” – but her individuality is not developed but subordinated to her capacity to use theoretical ideas and follow principles of practice.

I think this clinical writing works, as it succeeds in demonstrating and explaining the concepts it aims to illustrate, while at the same time conveying the feel of a psychodynamic piece of work. Indeed Malan makes a comment that many creative writers make about their work, that he had originally intended only to illustrate a few specific principles, “but the therapy then grew of its own accord” (Malan, 1979, p.89). Malan also remarks: “I have found this piece of fiction extraordinarily easy to write, which has surprised me”, which he

thinks is because once the basic principles of psychoanalytic practice have been grasped “everything grows naturally and intelligibly” (p.89).

I think the easiness in writing which Malan describes, as well as the success of this kind of writing, is a function of its generality, its applicability to a wide range of clinical situations. But this is also its limitation, the account of the interaction and process lack specificity, and in particular what it feels like to be this particular therapist with this specific patient. So this kind of account can serve as a teaching exemplar, a well crafted illustration of general psychoanalytic principles, but it does not aim to be an exemplary description of real clinical work.

Clinical writing as a genre

If good clinical writing does not aim to substantiate or support theoretical ideas, nor to give a general account of them, what does it purport to do? Thomas Ogden, who has made a particular study of analytic writing, argues that it constitutes a “genre” of its own, one which involves “the conjunction of an interpretation and a work of art” (Ogden, 2005, p.15). It is an “interpretation” as it organizes and narrates the patient’s life and experience in a particular psychoanalytic way so as to address “the relationship between conscious and unconscious experience”. It is a work of art “as the writer must use language in an artful way if he is to create for the reader, in the experience of reading, a sense not only of the critical elements of an analytic experience that the writer has had with a patient, but also...what it felt like to be there in the experience” (pp.15-16). So the characters, patient and analyst, who are the protagonists of this clinical writing “depend for their lives on the

real people (the patient and the analyst); and bringing to life what happened between these people in the analyst setting depends on the vitality and three-dimensionality of the characters created in the story” (p. 16). But constructing these characters so as to render them vital and alive means that the clinical writer has to become “conscripted into the ranks of imaginative writers” (p. 16).

An important way of rendering the character of the analyst three-dimensional is to bring in the analyst’s countertransference, that is his or her “freely aroused emotional sensibility so as to follow the patient’s emotional movements and unconscious phantasies” (Heimann, 1950, p.81). A good example of how this can figure in clinical writing is given by Otto Kernberg, in a paper on working with “affect storms” in borderline patients. He gives a graphic description of his struggle to manage his feelings and retain his therapeutic balance with a severely acting out and provocative patient who drove him to his analytic limits. He recounts on one occasion growing so impatient with his patient’s constant interruptions, misrepresentations and refusal to listen to him that “in a strong voice I told her she was talking sheer nonsense... I illustrated, point by point, in what way she had just distorted everything that I had just said, interrupting her as loudly as she would interrupt me while I was trying to say this” (Kernberg, 2003, p.542). As soon as he had finished speaking, Kernberg described himself as having the shocking realization that he had just “enacted the hateful, persecutory object that she had unconsciously projected into me” (p.542).

While I was thinking along these lines, the patient, to my great surprise, responded in a totally natural voice, and in a thoughtful way, that I couldn't tolerate her affect storms: wasn't the treatment geared to permit her to express herself freely in the hours? After a little while, recovering from my shock, I said: “I am impressed by the

fact that you can only talk to me in a normal way if I talk to you as loudly and harshly as you talked to me before (p.542).

Kernberg utilizes the concept of projective identification as communication (and so a version of countertransference) to understand what happened in this interchange, putting it down to the patient's ability to "register, for the first time in this session, my communication to her" (p.543).

In giving such a vivid and honest account of his feelings and reactions, Kernberg creates a sense of immediacy and transparency for the reader. It is a mark of this quality that the reader can see things that might not be so obvious to the analyst/narrator. So Kernberg relies solely on the concept of projective identification, that he may have processed and detoxified the projections from the patient more than he realized so that she could take in what he said to her. But one can also wonder whether it was also his way of delivering his interpretation that had such an effect on his patient. For instance his strategy of "interrupting her as loudly as she would interrupt me", which might seem to be disruptive of communication between them, could in fact be seen as a good example of what Daniel Stern has called "affect attunement", where the mother imitates her infant's gestures or speaking in such a way as to highlight certain affects (Stern, 1985, p.138). This quality of the analyst/presenter supplying the listener or reader with more material than he or she intends is a feature of a good clinical presentation picked out by David Tuckett, in which "aspects of the investigation with his patient that are just about to become known and so permit the formulation of interpretation, may be preconsciously placed on a plate for the audience to see: the analyst knows but is not yet aware, as it were." (Tuckett, 1993, p.1181).

This position that the analyst/narrator puts himself in, of his emotional sensibility being in advance of his more intellectual understanding, is powerfully conveyed in Kernberg's account in his description of his "surprise" and "shock" at the unexpected effect of his interpretation on the patient. This seems an example of the "curious situation" described by Tuckett in which the analyst/narrator is a participant in a history which he himself constructs. So Kernberg constitutes himself as a particular kind of narrator, one who writes as though he does not know what effect his interpretation will actually have on his patient – although this is of course a fiction because, as narrator, he knows precisely what is to come. This analytic sleight of hand, which is a commonplace of fiction but might seem to be problematic in assessing the value of a piece of clinical writing, is a feature of good clinical writing emphasized by Ogden:

I find it is important not to know the shape of the story from the start, but to allow it to take form in the process of writing it. Not knowing the end of the story while at the beginning preserves for the writer as well as for the reader a sense of the utter unpredictability of every life experience: we never know what is going to happen before it happens (Ogden, 2005, p.18).

The importance of the beginning: Freud's Rat Man case

This seemingly paradoxical position of “not knowing the shape of the story from the start” makes the way the analyst/narrator actually begins his or her account of particular importance: “the opening of a clinical account, when it works, has all the feel of the inevitable. It leads the reader to feel: how else would one begin to tell this story?” (Ogden, 2005, p.17). Furthermore in choosing how to start, the analyst/writer makes an important statement about what he or she is trying to say: “the place where one starts, in addition to providing an important structural element to the story and to the paper as a whole, makes a significant implicit statement about the writer’s way of thinking, the sorts of things he notices and values, and, in particular, which of the infinite number of junctures in this human experience deserves pride of place in the telling of the story” (p.17).

These remarks of Ogden’s on how to open a clinical account provide a useful benchmark for looking further at those features that mark out a piece of clinical writing as being of high quality, and thereby capable of being thought of as an exemplar. I will look at two examples of how this has been done, one by Freud, whose case studies are prime examples of clinical exemplars, and one by a contemporary analyst.

Freud opens his case study of the Rat Man as follows:

A youngish man of university education introduced himself to me with the statement that he had suffered from obsessions ever since his childhood, but with particular intensity for the last four years. The chief features of his disorder were *fears* that something might happen to two people of whom he was very fond—his father and a lady whom he admired. Besides this he was aware of *compulsive impulses*—such as an impulse, for

instance, to cut his throat with a razor; and further he produced *prohibitions*, sometimes in connection with quite unimportant things. He had wasted years, he told me, in fighting against these ideas of his, and in this way had lost much ground in the course of his life. He had tried various treatments, but none had been of any use to him except a course of hydrotherapy at a sanatorium near—and this, he thought, had probably only been because he had made an acquaintance there which had led to regular sexual intercourse. Here he had no opportunities of the sort, and he seldom had intercourse and only at irregular intervals. He felt disgust at prostitutes. Altogether, he said, his sexual life had been stunted; masturbation had played only a small part in it, in his sixteenth or seventeenth year. His potency was normal; he had first had intercourse at the age of twenty-six.

He gave me the impression of being a clear-headed and shrewd person. When I asked him what it was that made him lay such stress upon telling me about his sexual life, he replied that that was what he knew about my theories. Actually, however, he had read none of my writings, except that a short time before he had been turning over the pages of one of my books and had come across the explanation of some curious verbal associations which had so much reminded him of *some* of his own ‘efforts of thought’ in connection with his ideas that he had decided to put himself in my hands (Freud, 1910, pp.157-8, italics in original).

At first sight this might look like a medical case history. We are given an account of the Rat Man’s main symptoms, their cost to his life, a history of previous treatments, and an account from the patient of his ideas on their origin in terms of his sexual development. It is also organized in a way not unlike Malan’s imaginary therapy, in the clear way the different types

of symptoms are described and differentiated from each other, promising a tie up with theoretical ideas which are to come. But the “feel” of this introduction to the Rat Man case is quite different. It is more like we are witnessing a drama in which the workings of the Rat Man’s mind, and the complex layering of his character, make their initial appearance in the context of this first installment of the Rat Man’s already developing relationship with Freud.

So the Rat Man’s symptoms, as described by the Rat Man, are not simply listed or enumerated in Freud’s narrative as in a medical diagnosis. In the opening of this introduction they take centre stage, they become the italicized subjects of the account, their power over the Rat Man as seemingly independent forces over which he has no control conveyed in the cumulative effect of reading them one after the other, like the beating of a drum. Their effect on the Rat Man’s life, the “wasted years”, is emphasized by putting this phrase at the beginning of the sentence which follows the account of the symptoms – “he had wasted years, he told me”, rather than putting the stress on the Rat Man’s telling this to Freud.

This insistent stress on these impersonal forces which have come to dominate the Rat Man’s personality and life goes hand in hand with a no less important emphasis on the Rat Man as a speaking subject. The very first sentence is about how the Rat Man “introduces” himself to Freud, and after telling Freud of his symptoms and the wasted years the Rat Man goes on to offer Freud his own ideas on how his symptoms originated in his sexual development. This account portrays the Rat Man as an active seeker of sexual pleasure, though in a rather passive way. So the overall effect of this opening paragraph is to convey the battle going on in the Rat Man between these impersonal and powerful symptoms which dominate his life,

and the thinking and speaking parts of his personality which are already organizing the way he is speaking to Freud.

Then we get an account of Freud's first intervention, a question about the sexual origin of his symptoms. This question can look like the kind of question that might be asked in a medical examination. But it is actually a very different kind of question, not about the origin of his symptoms *per se* but about how the Rat Man *tells* Freud about their origin: why does he put such weight on sexuality? This simple question opens up an analytic space. It shows Freud to be interested not only in the Rat Man's symptoms but also, or perhaps primarily in his character, that is how he understands his symptoms and what kind of relationship he has with them.

The Rat Man's character is brought to light in the account of how he replies to Freud's question. Freud has already described him as both "clear-headed" and "shrewd". These characteristics have, I think, a rather ambiguous relationship to each other, "clear-headed" implying straightforwardness but "shrewdness" conveying a sense of the Rat Man only saying what he wants Freud to know. This is reinforced by Freud speaking directly to the reader to supply a corrected version of the Rat Man's answer – "actually, however, he had read none of my writings". Here Freud draws on a well accepted narrative device of drawing on knowledge of what can only have come later. He does this in order to present another side to the Rat Man's character, one in which he is an unreliable author of his own story (making the Rat Man a peculiarly modern kind of subject).

What has this opening narrative accomplished? In the opening sentence the Rat Man had "introduced" himself to Freud by telling him of his symptoms. In the final sentence of this

opening section Freud tells us that the Rat Man had decided to “put himself in my hands”. So in the course of this short opening section we can see that the analysis is already underway and the outlines of the kind of relationship the Rat Man has started to develop with Freud established. We get a sense of the Rat Man’s desperate willingness, indeed perhaps desire, to submit himself to Freud. But we also know that he has spent his life in submissive thrall to the obsessive/compulsive parts of his personality, and is now desperate to free himself from their power. This ambivalence around dependence and submission is evident in the confusion, comprised of doubt and vagueness, about how Freud’s ideas have influenced him. Freud’s narrative, both through its content but also its structure, shows this transference to be already in play, and prefigures its developing intensity as the case history unfolds.

A contemporary clinical account

Turning to a contemporary account of a clinical case, I have chosen one written by an American analyst called Ayesha Abbasi, published as part of the “Analyst at Work” section of the “International Journal of Psychoanalysis”, where the author’s account of their work is sent to two other analysts, whose commentary is also published. I have chosen this example because, unusually, both commentators agree in describing this as a clinical account of high quality. The comments on the quality of her clinical work include her “excellent” use of the setting (de Posadas, 2012, p. 542), her capacity to function like “a carefully tuned instrument in the exercise of her analytic practice” (de Posadas, 2012, p. 537) and her “interpretive craft” (p. 542). Her writing is described as being narrated “in a spirit of great honesty” (Chabert, 2012, p.539), resulting in “a document of exceptional quality, in the sense that the ‘story’ of the treatment is constructed and written in such a way as to transport

us into the very scene of the analysis: this is due, presumably, to the magnetic pull of the transference in operation, as it is conveyed by the analyst's words" (Chabert, 2012, p. 545).

This is how Abbasi begins her account:

I looked at my new patient, Mr. F. He was a man of medium height, with dark hair and eyes that were a startling blue. "My brother killed himself", he told me, sitting across from me in my office on a cold and dreary October afternoon. The words hung between us, heavy with what had not yet been felt or said by him. "With my gun. The gun he asked me to show him how to load and shoot with, a few days before he committed suicide. In the shower of the house we had been sharing here in town." I felt goose bumps on my arms and wondered if the thermostat in my office was set too low. I thought : 'Fuck! Do I really have to deal with this?' and then, more soberly: 'How will I ever help this man?' I said: "I am so sorry. What a loss for you – and for your family." Mr. F looked away, as though my brief words were like harsh sunlight in his eyes. I was struck by his inability to accept my words in some useful way and by his difficulty in expressing his own feelings about her brother's terrible and tragic suicide. (Abbasi, 2012, p.515)

Unlike Freud's account, where Freud initiates the first analytic turn of the screw by his question to the Rat Man about how he is telling his story, here Abbasi's only reported comment is what sounds like a conventional expression of condolence. So it is not through her interventions but rather the way she describes her own mind and emotional sensibility, namely her countertransference, that we can see the opening up of an analytic space in her encounter with Mr. F. We see her moving from "do I have to deal with this?" – a mark of

something massively disturbing which she would rather not know about – to “how will I ever help this man?”, now demonstrating some processing of her initial feelings and reactions in order to turn her attention to the clinical task in hand. We see her as an analyst in action when, after her “normal” expression of sorrow, she tracks what Mr. F does with this communication on her part, namely his inability to cope with her ordinary expression of sorrow and his inability to find his own words.

Although in this opening paragraph Abbasi’s powerful and initially incapacitating reaction to Mr. F and his story of his brother’s suicide seems to have been resolved, we are still left with her very first thought: “fuck!” In this opening paragraph she does not comment on this, her thinking about the nature of this first thought only comes later (“ an early warning about the very tight intertwining of love/sexuality and sadism in Mr. F’s mind” [pp. 517-18]). The effect in the first paragraph of having this thought without any commentary conveys a sense of the analyst as both managing to master and process her strong reactions, and at the same time in danger of losing her analytic balance through the leaking out of reactions and parts of her personality that belong to her non-professional life.

The power of the gaze is another feature of the opening of this analytic case. Unusually for a clinical account, it begins with the first person: “I looked at my new patient...” This opening phrase frames this clinical case as a particular kind of engagement, a contest but also potentially an intimacy between them, the intensity of which might be too much for Mr. F to bear - “he looked away as if my brief words were like harsh sunlight in his eyes”.

Perhaps the most striking feature of this clinical writing is the seemingly “novelist” aspects of the account. Why does Abbasi take care to report Mr. F’s precise physical locating of his brother’s suicide? Why make reference what in most analytic accounts would be taken as irrelevant aspects of this first meeting, such as the weather or making reference to the thermostat in her office? The inclusion of her physical reactions, as manifestations of her countertransference needs no justification, but these are also narrated in ways that seem banal if not bathetic: “goose bumps” on her arm, wondering whether the thermostat had been turned on too low. And why, in her account does she choose as her opening remark to Mr. F an expression of condolence, which is not a normal way of opening an analysis? In my reading these “ordinary” descriptions serve to set off the extraordinary way Mr. F begins the session, and can be seen as another rendering of the tension implicit in this paragraph between the professional and non-professional. Perhaps what is also conveyed is Abbasi’s intimation that in order to keep her analytic balance and perhaps sanity with this patient she will need to anchor herself in her bodily reactions, the physicality of her office and the world outside, and the ordinary social conventions that bind people together.

Clinical writing and the analyst’s subjectivity

According to Ogden a mark of all good writing is that “the author disappears leaving traces” - “a writer learns in the course of becoming a writer how to get out of his own way and out of the reader’s way” (Ogden, 2005, p.22). This is reminiscent of Freud’s recommendations on analytic technique, that the analyst should keep his own personality out of the treatment (Freud, 1912, p.118) , for fear of influencing the patient through suggestion and thereby destroying the credibility and potency of the analytic process. In his famous metaphor “the

doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him” (p. 118). So good clinical writing seems to require a double effacement of the analyst’s subjectivity, firstly as clinician and then as writer.

Certainly what is conveyed in the examples in this chapter is the highly disciplined stance of the analyst, who reveals nothing of himself or herself except through the quality of attention to the patient and to the analytic work. This discipline can be seen as a putting into practice of what Freud calls the “opacity” of the analyst. The writing is also disciplined, all elements playing a part in the creation and evocation of an analytic experience, which is what Ogden appears to mean by the disappearance of the author: “good analytic writing is sparse and unassuming – just the essentials, not an extra word or repeated idea” (Ogden, 2005, p. 24).

Yet the examples of clinical writing I have given are full of the “traces” of the analyst, as both clinician and writer. Some of this, notably in the examples of Kernberg and Abbasi, is conveyed through the vivid and careful descriptions of their feelings and reactions to the patient and the analysis, what since Freud has been called countertransference. But although Freud had no analytic vocabulary to directly describe his feelings, what he felt about his patient and the effect on him of their first encounter can be traced through his way of writing. Indeed, what comes over most powerfully from all these examples is the presence of the analyst, as both participant and designer, clinician and narrator. This, I think, is the hallmark of good clinical writing.

All clinicians have struggled with the strictures laid down by Freud in the metaphor of the analyst being no more than a mirror, which seems to demand the obliteration of the analyst’s subjectivity as designer of the analytic situation. The analyst’s subjectivity has been partly

brought back in again through the concept of countertransference. However the kind of subjectivity licensed by this concept is only that deemed to have originated from the patient – countertransference literally means that which is “counter” to the patient’s “transference”. This leaves the analyst, as both practitioner and teacher, without a robust analytic vocabulary to write about the day to day “craft” of analytic practice, the kinds of ordinary skills needed to do the work. This is because to write in this way necessarily brings in the analyst’s subjectivity as designer and constructor of the analytic process, the one who holds the mirror as well as being the mirror to the patient (Spurling, 2015). From this perspective analytic writing can be seen as licensing another attempt to bring in the analyst’s subjectivity, this time through the operation of the art and craft of the writing itself in conveying the experience of an analysis. In doing so, the author/analyst shows how they go about their clinical practice. For instance the way Freud and Abbasi begin their clinical account shows a particular way of opening up an analytic space, as Kernberg’s writing shows how he preserves or regains it. This is skilled practice conveyed with narrative skill. So good analytic writing can be seen not only to provide a more substantial and inspiring kind of “hearsay”, but also a way for the analyst to narrate their own experience of becoming an analytic subject with their patient.

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