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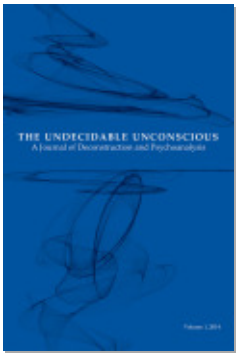

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A man's maturity—consists in having found again the seriousness one had as a child, at play.

—Nietzsche, *Beyond Good and Evil*

In a previous essay (Russell 2003) I attempted to sketch in broad outline how one might begin to integrate Derrida's project with the clinical concerns of psychoanalysis by means of the conceptual framework offered by Winnicott in terms of a thinking of time, space, play and transitionality. Here I wish to extend that effort through a more sustained interrogation of Winnicott's work and the philosophical underpinnings it carries, in order to further elaborate a theory of clinical technique informed by deconstruction. The proximity of Winnicott and Derrida where play, intermediacy, interpretation, and difference are concerned is striking and warrants extensive consideration for any attempt to think "psychoanalysis as deconstruction." Whereas my earlier effort intended to introduce Derrida to an intellectually informed clinical audience, here my concern is the reverse: to encourage a philosophical audience to look more closely at the effects that Winnicott's texts are capable of producing, in order to discover a powerful lever for extending the work of deconstruction both textually and clinically.

The title of my essay commemorates Winnicott's (1960) provocative statement, "There is no such thing as an infant" (586).

Although it appears to be the height of abstraction, the absurd product of a theoretical imagination run wild, the paradoxical assertion that "there is no such thing as an infant" allows us to glimpse what happens when the opposition of theory and practice in psychoanalysis begins to break down. Impressively frequent in Winnicott's work, but sorely lacking elsewhere in the analytic literature, such assertions indicate those areas where theory touches the experience of what it means to work clinically. I will attempt here to draw out the implications of Winnicott's statement for the theory of psychoanalytic treatment. The fact that interpretation can have such a profound, life-altering effect is not often enough the subject of analytic inquiry (Bass 2000). Instead, analysts tend to cover over this fact with cognitive and developmental explanations, in which they then too often attempt, explicitly or implicitly, to instruct their patients. Winnicott's project was to conceive the analytic relationship without these crutches, using them when necessary, but understanding all the while that they are only metaphors from among so many others we might choose. What is it, then, that analysis *is*, and what is it that analysis *does*? As simple as these questions initially may seem, it is their inherent complexity that a Winnicottian perspective—when read as an intrinsically deconstructive approach, aimed at psychoanalysis from within—allows us to unfold.

Being, Doing, Playing: Why There Is No Such Thing as an Infant

Freud's (1914) portrayal of transference as a "playground" is familiar but well worth rehearsing: "We admit [unconscious fantasy] into the transference as a *playground* in which it is allowed to expand in almost complete freedom. . . . The transference thus creates *an intermediate region* between illness and real life through which the *transition* from the one to the other is made" (154; my emphasis). Transference is a playground on or within which the emergence of unconscious fantasy is made possible and encouraged (Steingart 1983; Sanville 1991; Coen 2005). When the patient

can begin to tolerate the encounter with aspects of himself that he would rather split off, this makes interpretation of unconscious content possible as a therapeutic technique.

As a "playground" and an "intermediate region" for "transition," the general field of transference constitutes what Winnicott (1971) conceives as that space "between" the subject and the external world from which subjectivity distinguishes itself. This intermediary reality *qua* "potential space" is not a space *of* potential, but is rather an area of experience that is *potentially* spatial—on its way to being a space, but not yet a space, and not yet distinct or fully differentiated from time. We might equally speak of "potential time," as the qualifier "potential" indicates a kind of experience where space and time have yet to be completely distinguished. That is, potential space, as a space of transition, is neither a space nor a time classically understood, but potentially either and both, situated *differantially* at the transition between the two. This potential or transitional space-time is the site of what Winnicott—without any knowledge of the way this term is taken up by Nietzsche, Heidegger, and Derrida—calls "playing":

> I make my idea of play concrete by claiming that *playing has a place* and a time. It is not *inside* by any use of the word. . . . Nor is it *outside*, that is to say, it is not part of the repudiated world, the not-me, that which the individual has decided to recognize (with whatever difficulty and even pain) as truly external, which is outside magical control. To control what is outside one has to *do* things, not simply think or wish, and *doing things takes time*. Playing is doing. (1971, 41; emphasis in original)

> The essential feature of my communication is this, that playing is an experience, always a creative experience, and it is an experience in the space-time continuum, a basic form of living (1971, 50)

The achievement of developmental autonomy is oriented toward establishing an effective position within space and time,

which allows for an experience of what Winnicott calls "creativity." Most of the pathologies with which Winnicott was concerned reflect failures in this area. His conception of analysis accordingly was as an engagement with a level of experience in which subjects and objects cannot be so rigorously distinguished. In his developmental thinking, he attempted to formulate this area in terms of "being":

> In the course of the emotional development of the individual a stage is reached at which the individual can be said to have become a unit. In the language that I have used this is a stage of "I am" . . . and (whatever we call it) the stage has significance because of the need for the individual to reach *being* before *doing*. "I am" must precede "I do," otherwise "I do" has no meaning for the individual. (1971, 130)

"Being" reflects the child's having become a subject, which is the condition of possibility—yet without having preceded—its relationships with the environment. With the establishment of "I am,"

> A new capacity for object-relating has now developed, namely, one that is based on an interchange between external reality and samples from the personal psychic reality. This capacity is reflected in the child's use of symbols and in creative playing and . . . in the gradual ability of the child to use cultural potential in so far as it is available in the immediate social environment. (1971, 131)

This passage must be read against the background of Klein's account of the transition from the paranoid-schizoid position to the depressive position. What precedes Klein's depressive position is not, for Winnicott, anything like the world Klein portrays in terms of the paranoid-schizoid position; the latter describes pre-depressive functioning retroactively, in terms that belong to the depressive position having already been achieved. Klein's account of paranoid-schizoid phenomena is only what primitive experience looks like once the depressive position has been acceded to. Winnicott indicates that this is not a faithful account of the infant's

early, pre-subjective experience: "Projective and introjective identifications both stem from this place where each is the same as the other" (1971, 80). Object relations are relations of identification; where there is no identification, there is no identity, but only "a bundle of projections" (88; cf. 81). In the absence of the achievement of "being," object relations are characterized by an essential emptiness because the subject lacks "the capacity to be alone," as the capacity not just to be *alone*, but to *be* alone: to be oneself, by oneself, *as* oneself. This capacity characterizes not object relations, but what Winnicott calls "object usage" (88). The ability to use the object reflects an openness to the object as genuinely other, not simply as a mirror image of the ego that can only receive projections and from which can only be extracted identifications.

Projection and introjection presuppose a subject, an agency that carries out these psychical operations. This may be a rudimentary ego structure, but as such it presents as an essentially closed, self-contained "unit"—something that insinuates itself as present from birth. As with Hartmann's (1958) concept of a "conflict free ego sphere," this implies that the clinical relationship can in principle be approached from an external position where rational self-reflection is always, if at times only minimally, at work. The Kleinian infant is born into the world already as a unit—a very primitive unit, but bearing the form of unity fundamentally and from the beginning. This is why projecting and introjecting are from birth activities that the Kleinian infant-subject can *do*. For Winnicott, pre-depressive experiencing is not about doing; it is about being. To think this in terms of projection and introjection indicates a revision of pre-subjective experience from the register of the depressive, whole subject.

As evocative as Winnicott's thinking here may be, there is an ambiguity inherent to the relationship between being and doing as Winnicott portrays it. The basic point here is that being precedes doing. Being, however, is not a given, but an achievement. Winnicott spent his entire career exploring what happens when there is failure at this achievement, such that patients manifest an

empty set of doings without a substantial sense of being as support. What this indicates is that, despite the necessity that being precede doing—and again, Winnicott knew very well that this is not a necessity, that empty doing is possible, if not prevalent these days—being itself is not primary in any ordinary existential sense. If being is a "stage" that must be "reached," this means that there is something before being. This would not be a purely subjective, internal position, prior to a relation to external objects; rather, what is before being would constitute a dimension prior to anything like subjects or objects, or any opposition between them. So, to speak like Winnicott for a moment: what could there be before being? What is an infant before it is?

The three terms that anchor Winnicott's conceptual economy here are being, doing, and playing. It would seem that playing ought to be situated between being and doing, as the site of transition from the one to the other, through which the child must pass in order that her subjectivity (her "being") may become an effective and meaningful agent in the world (able to "do things"). If being is to precede doing, so that doing can have meaning, transitional phenomena would indicate an intermediate region between them, where being is a kind of doing, and the reverse. Playing may be doing, then, but it is equally being: playing is a kind of doing that is not distinct from being, a kind of doing that being *is*. How are we to think about something before being? This is precisely what Winnicott's expanded notion of "playing" attempts to describe: there is something before being, before doing, something that the opposition of being and doing works to conceal, and that Winnicott's concept of "playing," along with all the other terms that fall under its umbrella (transitional objects, not-me possessions, potential space/time, etc.), attempts to work out. One of the most powerful articulations of this idea is the statement, "There is no such thing as an infant."

That "being precedes doing" is, admittedly, not such an astonishing thought. With "there is no such thing as an infant," we are in uncharted territory. There is something before being, before

doing, and therefore prior to and out of which the distinction between being and doing emerges. With the advent of his being, the child arrives at a position from which he is able to announce: "Here I am. What is inside me is me and what is outside me is not me" (Winnicott 1971, 130). Prior to this, before the coordination of the inside and the outside in terms of a reliable opposition, the child is not able to say, "Here I am"—space and time ("here"), subjectivity ("I"), and being ("am") have not yet coalesced into dynamic integration, and without such integration none of these terms has any stable referent. Before being able to assert, "Here I am," there are no relations between subjects and objects, only a kind of "pure" or potential relationality. This is why there is no such thing as an infant: the mother-infant relationship is not a dyad, nor is it simply a unity; rather, it is relationality itself that is original and primary:

> What does the baby see when he or she looks at the mother's face? I am suggesting that, ordinarily, what the baby sees is himself or herself. In other words the mother is looking at the baby and *what she looks like is related to what she sees there*. All this is too easily taken for granted. (Winnicott 1971, 112; emphasis in original)

The infant's pre-subjective experience is to be understood here as fundamentally *pre*-subjective—again: not yet involving the categories of subject and object. Rather, the baby's existence is constitutively relational—it *is* the relationship to maternal care—before being a subject that can relate itself to objects, however primitive. That "there is no such thing as an infant" does not simply indicate that the baby can only survive physically and psychologically in relation to its mother; it means that the baby *is* this relation, before being anything like a subject whose relating to objects constitutes for it an activity—something a being does. "There is no such thing as an infant" because the infant is a relation prior to its being a subject, before submitting to the opposition of subjects and objects, having nothing yet to do with any such categories.

Formless Experience and the Fundamental Rule of Clinical Play

What does all this have to do with the relationship between patient and analyst? There are certainly limits to the comparisons that can be made between the patient/analyst and mother/infant relationships—limits of which Winnicott was perhaps too often in excess. If an analysis is to make it possible for the patient to "do things," this cannot be because "playing," as a clinical activity, depends on the analyst functioning in anything like a parental role. "Playing" describes not the transformation of being into doing but the possibility of establishing one's being (a subject, a self) in such a way that doing can be done in a meaningful way. This takes time: "playing and cultural experience are things that we do value in a special way; these link the past, the present, and the future; *they take up time and space*. They demand and get our concentrated deliberate attention, deliberate but without too much of the deliberateness of trying" (Winnicott 1971, 109; emphasis in original). Analysis itself is essentially a kind of "taking up" of time and space: the patient commits to coming to a particular place four or five times a week, to disclosing his thoughts, to paying the fee, and so forth, but without the deliberateness of "trying to figure himself out." For Winnicott, analysis involves not being deliberate about such an activity, "taking up time and space" instead without purpose and with abandon.

That analysis should be understood in such a way was first formulated as a question of clinical technique in terms of the practice of free association. Of all Freud's innovations, free association has enjoyed a unique and peculiar fate: subject neither to criticism nor revision, it has largely retreated into the background of contemporary debate. We take it for granted that new generations of analysts should understand why patients are to be encouraged to say what comes to mind instead of insistently trying to understand themselves. To rehearse what is involved in the practice of free association would hardly seem worthy of our attention, as if it advocated nothing controversial, nothing

that challenges our most basic assumptions about the relationship between mind and world. I think this is a serious mistake, and that thinking about Freud's historically innovative technical procedures in the light of Winnicott's understanding of the nature of the clinical relationship—and against the background of what deconstruction has to teach us about practices of reading and writing—could lead to major reconsiderations of what psychoanalysis has to offer in the busy marketplace of available therapies today.

The "neutrality" of analytic listening depends on a capacity for "freely floating" or "evenly hovering" attention, as a way of obviating what the patient consciously intends to indicate, in favor of attending to the potential meanings inherent in what is actually said. For an analytic process to occur, the patient must let himself go to the "drift" of his associations, while the analyst must "catch" the patient's associations in such a way that they are not determined by preexisting ideas about what ought to be discovered (Bollas 2002). When two people agree to engage in such a relationship, they are not just agreeing to do something that is socially unacceptable, they are actively experimenting with what it means to express oneself and with what it means to be a self capable of expression. Psychoanalysis is in this sense an experimental practice, not a formal procedure—it is a playing, not a doing.

Free association is an effort to abandon oneself to talking to an other whom one does not already know, about a self that has not been absolutely predetermined. By exercising an evenly hovering attention in the course of listening to a patient's speech, the analyst, rather than simply ignoring what the patient intends to mean, demonstrates a receptive capacity that discovers continuities of meaning (Kris 1982) where these are intended to remain hidden: in those words and ideas that seem so familiar, so unimportant and not worth tending to. In exercising neutrality, the analyst is able to associate to and to expand upon her own reactions to the patient's material, for the purpose of ascertaining those unconscious elements that insistently repeat themselves. By assuming that what the patient consciously intends is not at

all what is essentially communicated in what is said, the analyst who follows her own associative pathways is able to hear what the patient cannot bear to hear in himself. To do this is neither to reveal the contents or the defensive structure of the patient's unconscious, nor is it to point out how the patient repeats the past of his childhood in the present of the treatment. Rather, as for Winnicott, analysis intends

> to afford opportunity for formless experience, and for creative impulses, motor and sensory, which are the stuff of playing. And on the basis of playing is built the whole of man's experiential existence. No longer are we either introvert or extrovert. We experience life in the area of transitional phenomena, in the exciting interweave of subjectivity and objective observation, and in an area that is intermediate between the inner reality of the individual and the shared reality of the world that is external to individuals. (1971, 64)

Analysis is an effort at allowing for the emergence of "formless experience"—that is, experience upon which has yet to be imposed rigid oppositions between inside and outside, subjectivity and objectivity, self and other. The effort to free associate maintains the analytic frame as just such a space and time in which meaning can be insisted upon and expanded. The more the analyst can suspend judgment about what the patient "really means," the more space the patient is afforded to explore the ways in which her experience can possibly be symbolized. The insistent pressure of unconscious wishes attempts to close this space down and to express this reduction in the form of an unthinkable and obvious surface from which awareness and discussion are immediately deflected. This deflection often takes the form of a power struggle, in which the analyst attempts to tell the patient what he thinks is going on, either in the patient's life or in the treatment, and the patient generally accepts or refuses this. Analyses that proceed in this manner may just as likely be abandoned as go on forever, because they fail to "take up time and space" in an essential way.

For Winnicott, the evolution of an interpretable transference depends upon both participants rigorously abandoning themselves to purposelessness. Pre-calculated purpose on the part of either patient or analyst indicates resistance in the context of clinical play (1971, 55). The counterpart to the patient's associations is not the analyst's interpretations—free association and interpretation are not related to one another in the form of questions and answers. Treatment conceived in this way reflects the form of an object relationship, in which the patient says what comes to mind and the analyst tells the patient what it all means. Clinical play consists in the analyst responding to the patient's free associations with free associations of her own, recognizing and responding to connections as they surface in the patient's material by means of an evenly hovering attention. Of course, this cannot be what is always going on in the analytic relationship, but it is at these ideal points (Rosegrant 2005) that Winnicott situates the mutative value of an interpretive approach.

Interpretation of Transference/Interpretation as Transference

When the patient is free associating and the analyst is exercising an evenly hovering attention, transference and countertransference phenomena are properly transitional phenomena: belonging to a realm in which subject and object, inside and outside, are not formally distinguishable, existing in their absolute forms only potentially. In the intermediate, transitional region that is transference, interpretive exploration of unconscious fantasy constitutes a form of play that gives back to the patient the time that has so far been absorbed by his suffering. As is the case with the work of deconstruction, such exploration can have no precedent, it cannot be calculated in advance or managed either practically or theoretically:

> This interpreting by the analyst, if it is to have an effect, must be related to the patient's ability *to place the analyst outside the area of subjective phenomena*. What is then involved is the patient's ability to use the analyst. . . . In

> teaching, as in the feeding of a child, the capacity to use objects is taken for granted, but in [analytic] work it is necessary for us to be concerned with the development and establishment of the capacity to use objects and to recognize a patient's inability to use objects, where this is a fact. (Winnicott 1971, 87; emphasis in original)

If analysis is not like teaching or feeding, this is because it is not an imparting of a substantial knowledge that has so far remained outside the patient's capacity for conscious self-awareness.[1] To understand analysis as play is to think of the analytic situation otherwise than as a relationship between subjects and objects. Of course, at the most banal level, an analysis is a relationship between two people. But this relationship, in which one person speaks indiscriminately while the other half-listens while monitoring herself, is not like any other. Interpretation is not possible in the context of an ordinary object relationship. Interpretation can only facilitate transformation where the patient is able, again in Winnicott's sense, to use the analyst, and where the analyst is able to present herself as the potential for difference, novelty, and change. This requires that we abandon all pretensions to having mastered an objective knowledge (Winnicott 1971, 86–87). Where treatment is conceived solely in terms of (subject/) object relations, it makes no sense that interpretation could be effective as a therapeutic technique:

> Interpretation outside the ripeness of the material is indoctrination and produces compliance. A corollary is that resistance arises out of interpretation given outside the area of the overlap of the patient's and the analyst's playing together. Interpretation when the patient has no capacity to play is simply not useful, or causes confusion. (1971, 51)

Clinical Example

A female patient who had recently decided to move from a twice-per-week psychotherapy to a four-times-per-week analysis was talking about how much coming to analysis had already

helped her, especially in those weeks when she actually managed to make it to my office more than twice. She insisted that the structure and the rhythm (space and time) of our appointments helped her to organize her life, making her feel better and generally more stable. I said that an analysis is not just about structure and stability, it is also about intimacy—the intimacy that can only come with our seeing each other at least four times per week. I indicated further that what we had been doing was not analysis, not, as she believed, because she did not yet use the couch but instead continued to sit upright in the chair, but because although we had agreed to meet four days a week, not a week had gone by since we had arrived at that agreement where she had actually made it to four sessions. She complained that she had problems with intimacy and that this was what the work we had done together so far had revealed to her. I asked her what she meant by "problems with intimacy." She said she couldn't quite describe it, but she gave an example. Some nights ago, she was feeling lonely and wanted male companionship. She called a male friend who invited her over to watch a movie. This man, she said, was "just a friend," he had a girlfriend, yet he and my patient were always very physical together. This, she said, was exactly what she had been looking for: physical intimacy with the clear indication that sex was not an option. When she got to his apartment, she was shocked to find the friend's girlfriend there, and thought of leaving immediately, but stayed anyway. At one point during the evening, the girlfriend went into the bedroom to make a phone call, at which point my patient moved from the chair she was sitting in, onto the couch where her male friend was, laying her head in his lap. This, she explained, was precisely the intimacy she wanted, but which had made her anxious, and of which she was still in some way afraid. So, I asked her what she was afraid would happen when she moved from the chair to the couch. She breezed through an answer that did not address the question, until I had the opportunity to ask it again, in modified form, but repeating her words concerning the move from the chair to the couch. Suddenly she became anxious and perplexed. She said she

wasn't sure if I was talking about the previous night with her friend, or about what was going on in the room between us.

It is impossible not to hear "the transference" in this vignette. The move from the chair to the couch could not have been more explicitly linked to the question of treatment, although the patient had not heard it initially, nor had she consciously intended to indicate this. I could have said something like, "You speak of moving from the chair to the couch with your friend, but I wonder if you're not really talking about moving from the chair to the couch here with me"—something that would have indicated directly the obvious link between the two situations. To have done so, however, would have been to establish a link that in fact severed the connection between the two possibilities, by implicitly asking the patient to choose between them, as if they were alternatives. Of course, in the moment, I had my own content-oriented associations about the patient's competitiveness with regard to the girlfriend, about her efforts to seduce both her friend and me, and about how these defensively concealed the intensity of her need. An authoritarian impulse might therefore insist that, when I simply repeated her words, she understood what I "really meant," even if this was only implicit. This misses the point of the intervention by reducing interpretation of transference to the power of suggestion. Transference here consists in the fact that, unconsciously for the patient, moving to the couch with her friend and with me are the same (yet not identical). To interpret this in such a way as to force these possibilities apart would be to collapse the space of meaning in which the patient subsequently found herself, in which the excessive meaningfulness of her statements could be encountered as a function of the clinical environment itself, and about which she could begin to ask questions. Her sudden uncertainty about what I meant became an uncertainty about what she meant, and from there we were able to create more meaning by exploring the possibilities that had been opened up. My having simply repeated the words "from the chair to the couch" made it possible for her to hear their resonance in terms of our relationship, given how explicit

and on the surface this already was. This is a clinical instance of the conjunction of repetition and difference that had preoccupied Derrida from the beginning of his career: repeating the patient's words allowed her to hear herself differently, and to differentiate herself accordingly. When she then said that she wasn't sure whether I was commenting on the story about the previous night with her friend or on her feelings about starting an analysis, she was speaking from a position well within the potential space of transferential "overlap." Her anxious perplexity was not the "confusion" that Winnicott warned of; it indicated rather that she had registered the ambiguity of her own speech, as something in excess of any subjective intention. This could not be addressed directly if it was to be sustained. One cannot comment *on* or *about* transference as "formless experience" without losing its transformative potential. "Transference" as clinical "play," in this sense, begins to approximate something like Derrida's "differance" as "neither a word nor a concept" (1982, 3) designating rather that which cannot appear stabilized within the general horizon of representation.

Symbolization, Uncertainty, Illusion

By emphasizing the undecidable ambiguity that all efforts at communication contain, one is able to maintain and to expand what Freedman (1998; Lasky 2002) called "symbolizing space." For Winnicott, the clinical relationship externalizes the inner space of symbolization as the potential space of transference. This is to say that, where treatment consists in an "overlap of two areas of playing" (Winnicott 1971, 39)—that is, where patient and analyst *are* playing—interpretation is not simply an activity that one might classify alongside other possible therapeutic techniques. Rather, the analytic relationship is itself a form of interpretation, as the space and time taken up together between the two participants. The usefulness of interpretation as a therapeutic technique is otherwise problematic, as Winnicott insists, outside the context of a relationship that is not itself constitutively interpretive.

To pose questions that demand answers, or that imply something like a correct answer is possible, is to limit the space for questioning and for interpretive exploration. Such interpretations are indeed common: "You are treating me as if I . . ." which, as Laplanche and Pontalis (1968, 2) emphasize, always carries with it an implicit, ". . . and you know very well that I am not really what you think I am." To interpret in this way is to privilege actuality over possibility, objectivity over meaning. While many would wish to claim that today such interventions are rare, unfortunately they are not. In many quarters, authoritarian forms of interpretation have largely not been replaced by a more nuanced attunement, but have been reformulated to appear more palatable. For example, were one to say to a patient, "It's as if you feel your very existence is under attack here," this can sound like a very measured, caring reflection on the patient's immediate experience; nonetheless, it implicitly contains the suggestion that patient *should not* feel this way. This is not due to any failure on the part of the analyst, but because it is formulated from the position of a subject talking to an object—it is a representative statement *about* the patient's experience, rather than an interpretive disclosure *of* the patient's experience. Even when formulated most empathically, in order to reveal to the patient his distortions while not intending to pass judgment, interventions such as these may constitute a way of saying, "You are distorting reality, but do not worry, that is perfectly normal . . ." There may be instances in which just such an intervention is called for, but understanding when and where this is the case demands that analysts be more sensitive to how their most well-intentioned comments can inhibit the analytic process because they contain traditional prejudices about the nature of the relationship between mind and world. This is where Winnicott's thinking can be most helpful. At times, to speak within the transference as a subject would speak to an object would be like actually telling a child that his transitional object is not really created by him but is externally discovered. No good-enough parent would ever dream of saying such a thing, but a well-meaning parent might think it appropriate to

say something that amounts to: "Your transitional object is both created by you and discovered in the outside world. And that is fine, you do not have to choose which one is real." Of course, this is itself a way of posing questions that Winnicott insists must not be posed with regard to transitional phenomena.[2]

One way of thinking about this would be to say that transferential or transitional phenomena cannot be interpreted positively. Interpreting transference as play means not deciding what the patient is "really talking about," consciously or unconsciously, since interpretation here intends not to determine but to hold open the space in which more meaning always might be generated. A statement along the lines of, "I wonder if you don't feel with me the same way you describe feeling with your wife?"—again, even when most carefully, thoughtfully, and accurately posed—is not properly a question but an effort to force the patient into a position of deciding what he is going to consider reality; it does not address the transference symbolically, but rather collapses its symbolizing potential. Any such position *on* or *about* transference implicitly carries the indication that this is not real, because it is not shared. Transference can be conceived as that dimension of experience in which oppositions between, and final decisions about, subjects and objects, inside and outside, past and present cannot be arrived at. To treat any absolute distinction between past and present as if it were real and not a fantasy misses the opportunity to examine what emerges in this transitional area where one does not quite know what one is saying, but it seems exceedingly meaningful nonetheless.

To interpret transference as play is to maintain its potential by speaking ambiguously and without certainty so that transferential experiences are provided the opportunity for symbolization. Symbolization precludes positive knowledge. A symbolizing position cannot lend itself to an experience of rigid cognitive certainty, as it is inherently playful and indefinite, allowing for multiple meanings and always for further interpretation. To say something like, "You are experiencing me like you have always experienced your mother," or, "It must be difficult for you to tell

me about these things," is to speak as a subject of certainty and knowledge—as a being that is doing something—which is not, for Winnicott, what it means to be in the transference. These interventions seemingly belong to different (interpretive/empathic) clinical approaches, but they articulate two sides of the same instructive, objectivizing coin. To intervene from a position that does not share in the illusion of transference is precisely not to ask questions, but instead to demand that the patient choose sides in a series of either/or oppositions. This is not simply coercive, it fails to appreciate how transferential, transitional phenomena challenge ("deconstruct") commonsense notions about subjectivity, objectivity, and the relationship between them. In the analytic literature, this failure is reflected both in a classical, "one person" effort at educating the patient about the contents of his unconscious, as well as in contemporary intersubjectivist, "two person" approaches that seek to draw out of the patient the truth of his conscious experience in terms of an ongoing dialogue. Both of these approaches, from a Winnicottian perspective, effectively refuse to engage with transference symbolically—that is to say, *differantially*—by continuing to think in terms of, and thereby to impose, metaphysical structures of opposition.

Summary

If one begins to open up Winnicott's profound yet often obscure insights, transference appears to be more than just a mechanism according to which patients impose figures from their pasts onto currently real relationships. Transference is not a distortion of reality to be corrected either by instruction or empathy from a position of objectivity and knowledge occupied by the analyst. Rather, within the transferential field, the patient *is* this distortion, and must be engaged with accordingly. This is not something that might be remedied, and even our most genuinely empathic interventions can conceal just such an aim. Where treatment is conceived as playing, unconscious fantasies are not psychological contents one "has," the enactment of which constitutes an

activity one "does." Rather, patient and analyst *are* unconscious fantasy together in the form of the primitive ("formless") relationality articulated as the transference/countertransference matrix. Interpretation consists in disclosing this, so that illusion can be integrated as a positive juncture. The interpretive relationship in this sense exists then not "in" the intermediate region between being and doing, but *as* this intermediate region or this transitional relationality. This would be what transference, from a Winnicottian perspective, would describe. And it is in this sense that *there is no such thing as transference*—not in the sense we classically imagine. What Winnicott introduces is a way of thinking about clinical experience such that our concepts of treatment and of transference, interpretation and relationship, patient and analyst begin to coincide, which is not to say they lose all distinction. As potential space or as transitional phenomenon, transference must be interpreted intransitively, which is to say that it would seem inadequate to speak of "*the* transference," or of the patient's "transferences," as if this were itself some object, some circumscribed event from which one could effectively abstract oneself, and that could be managed then by means of an increased capacity for self-mastery through conscious reflection. Was this not always the indication of Derrida's most regrettably misappropriated phrase from *Of Grammatology*: "il n'y a pas d'hors texte"? With Winnicott and in terms of the clinic, deconstruction finds itself on the path toward a renewed relevance and accessibility.

NOTES

1. At certain points in his development, Winnicott succumbs to a pull to subsume the more radical aspects of his thinking to categories inherited from his training as a pediatrician, much like Freud did with respect to his medical training. This is particularly evident in his portrayal of interpretation in terms of the "good feed" (1960, 592), which seems to have been further encouraged by his attachment to Klein (see Ehrlich 2004).

2. The question that must never be posed to the child concerning his transitional object is whether that object is something he has discovered in the outside world or something he has created from out of himself. According to Winnicott, it is crucial that this question never even be *formulated* (1971, 12).

The problem with this question is not its content, but its form—its traumatizing potential is due to the fact that it imposes a structure of opposition on the child's organization of reality, forcing him to take up a position within this structure prematurely. Such an imposition is equally restrictive when it is introduced into clinical process. Rodman (2003) quotes Susanna Isaacs having said of Winnicott, "he knew that you could only disturb people by trying to force knowledge on them" (47).

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