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Autotheory, Critical and Clinical

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ABSTRACT

It is in the spirit of viewing autotheory as an unsettled genre that dramatizes the mind's own unsettlement, that I want to experiment with the implications for clinical writing. In this paper, I include a clinical case that I wrote in two channels – one is a straightforward clinical style, while the other is a series of more personal reflections. I italicized the personal voice in order to experiment with rhythms and tones that would have been lost if the piece had to cohere in a stylistically continuous way. After my experiment with clinical writing, I will offer some thoughts on Lyndon's own contributions to this emerging genre.

Autotheory, critical and clinical

Thankfully there is no definitive agreement on what "autotheory" looks like or means.[1] In her recent panorama of the emerging genre, the literary critic Robin Wiegman observes that, given how multifaceted and contested both "autobiography" and "theory" are, "it is not surprising that the burgeoning attention to autotheory carries no collectively assumed aesthetic, historical, or theoretical definition. On the contrary, the picture that is emerging – through dissertations, undergraduate and MA theses, conference sessions, blogs, author interviews, marketing material, and a handful of published essays – demonstrates a variety of critical investments in the concept as commentators emphasize different aspects of the term's hybridity" (Wiegman, 2020, p. 7). In another recent paper, this time from within clinical theory, Daria Colombo considers the term to represent a genre that is slightly more settled, claiming that it "insists that all theory is infused with the desires of the theorizer, who herself is at least in part defined by the complex sociopolitical matrix in which she is immersed and has developed" (Colombo, 2022, p. 259). From within different theoretical

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[1]Originally introduced in 1997 by Stacey Young to describe queer women of color texts published in the 1980s, the designation "autotheory" really took off in 2015 when Nelson said in an interview that she didn't like thinking of her book as "memoir," and preferred "autotheory" instead. Although Nelson says, "I flat out stole this term from Paul Preciado's amazing *Testo Junkie*," Lauren Fournier situates the genre in a broader history of feminist practice. Fournier writes, "the term 'autotheory' emerged in the early part of the twenty-first century to describe works of literature, writing, and criticism that integrate autobiography with theory and philosophy in ways that are direct and self-aware. The 'memoir with footnotes' would be one example. Most simply, the term refers to the integration of theory and philosophy with autobiography, the body, and other so-called personal and explicitly subjective modes. It is a term that describes a self-conscious way of engaging with theory – as a discourse, frame, or mode of thinking and practice – alongside lived experience and subjective embodiment, something very much in the *Zeitgeist* of cultural production today – especially in feminist, queer, and BIPOC – Black, Indigenous, and people of color – spaces that lives on the edges of art and academia" (Fournier, 2021, p. 7). In a sense, "autotheory" performed the encounter between "auto" and "theory" that so many radical academics had been experiencing anyway, or at least since the "first person innovations of such second wave [feminist] writers as Audre Lorde, Cherrie Moraga, and Gloria Anzaldua" (Wiegman, 2020).

idioms, both of these popular essays contend that autotheory represents a fresh integration of self-writing and abstract theorizing, inviting the reader to consider how innovations in the genre might disrupt existing arrangements of the body, politics, analysis, self-disclosure, the frame and desire (Fournier, 2018)

But if Wiegman's essay emphasizes the ways in which autotheory dramatizes the tension between selfhood and theory, and Colombo situates the genre within an existing feminist tradition of political and embodied life-writing, I want to suggest yet another possible way of conceptualizing what autotheory enacts, and that is, the drama of the self's *relation* to theory. I am thinking specifically of Beatriz Preciado's, *Testo Junkie* (2013) and Maggie Nelson's, *The Argonauts* (2015) – widely considered to be foundational examples of the emerging genre – as texts that stage an encounter between Theory and the narrator's personal relation to it (Nelson, 2015; Rose et al., 2016, Young, 2016). Another way to put this would be to say that, in many of the texts that consider themselves autotheoretical, the reader is invited to witness the narrator's argument with theory, an argument about what is wrong and problematic with a given theory but one that is not framed as a counter-theory or critique, as such. Indeed, if one could speculate on the wide appeal of this encounter, it might be that it offers readers a view to the subjective channel through which theory is digested, assessed, and spit out. While more formal critical engagements are required to articulate their positions in the language of rational and methodical argumentation, when we read Preciado or Nelson, we are watching a thinker wrestle with the implications of certain ideas, trying to see if certain compelling ideas actually fit or distort their particular experiences.

It is in the spirit of viewing autotheory as an unsettled genre that dramatizes the mind's own unsettlement, that I want to experiment with the implications for clinical writing. In what follows, I include a clinical case that I wrote in two channels – one is a straightforward clinical style, while the other is a series of more personal reflections. I italicized the personal voice in order to experiment with rhythms and tones that would have been lost if the piece had to cohere in a stylistically continuous way. After my experiment with clinical writing, I will offer some thoughts on Lyndon's own contributions to this emerging genre.

An experiment in clinical autotheory

Chloe was twenty-three years old when she sought treatment for dizziness and nausea. "I know you're not *that* kind of doctor who treats medical conditions" she explained in our first session, "but I don't know what else to do. I've had MRIs and blood tests, and everything is clear. So now my mom is finally fed up and telling me that maybe it's all in my head and I should try a head-doctor. I don't know, she could be right, I have no idea." Like Ogden's "cautionary tales" (1998) in which the patient "predicts" exactly how you'll fail them, Chloe's preemptive dismissal served to warn me that she was skeptical of therapy, and, although certain that something was wrong with her, doubtful that "head-doctors" knew what it was. This boldness in her rhetoric was camouflaged by her presentation – she wore a monochromatic beige skirt and blouse, beige flats and a beige purse that seemed chosen to conceal lively expressions of her personality. She never made eye contact and sat upright and tensely across from me. She told me that she had been suffering from dizziness and exhaustion for several months and was finally fed up with the medical establishment. "They don't know anything," she tells me, this time more emphatically, and "so even though

my mom thinks your entire profession is useless – no offense to you – she actually wanted me to come here, figured I have nothing else to lose." I am amused by her repeated endeavors to tell me that I'm useless and can't help her. I'm also confused by the dissonance between how she speaks – performatively, with obvious cleverness and personality – and her appearance, which seems buried under a mound of beige blandness. On the one hand, she is meek, neat, very controlled, while on the other hand, I notice I feel panicked as she's speaking, that I'm waiting for something to explode, anticipating destruction. It's as though she wants to seem invisible, like she has no taste or personality, like she can blend right in, but every time she speaks, the outfit seems like camouflage to me: there is someone else beneath this demonstration, someone screaming for attention, but where she is or what she's like feels vague and imperceptible.

As we are nearing the end of our first session, I interrupt the laconic flow of technical information – what she's suffering from, when the symptoms started, what she's looking for – by observing that regardless of what the doctors say, *I* can see she's suffering and not okay. She looks right at me, surprised by this, and asks me what I mean. I tell her that she seems to be in hiding but also very good at keeping other people out, that I feel pretty sure she is a flight risk – that if I come toward her, she'll run away. She starts to cry a little and asks if I think therapy can help her? I say maybe, it depends on if she stays. I say it will be hard for her to stay. She seems taken aback. I tell her she should come multiple times a week, it will be too difficult to stay connected otherwise, but I also understand if she's not ready for such intense work. After a few minutes she nods and says that no one has ever talked to her like that before, perceived her to be suffering. She wants to come in, wants to try it. I am relieved that she is moved by what I've said and not infuriated. It was a risk to intervene so soon and without sufficient information, but I felt it was imperative to get her attention, felt certain that if I didn't find a way to address the pain she implied but could not express, I would lose her for good. I also felt compelled to match her intensity and at that moment, immersive treatment was the way to do it. She didn't indicate she necessarily wanted this, nor did I have a preliminary sense that this was diagnostically indicated. But it was my way of saying, "maybe you need to be pulled into this. There's room for you, come in."

> The panic that I feel with her is immediate and raw. I feel certain that she's dangerous – to herself, perhaps to me – and I marvel at the disconnect between her quiet, monochromatic presentation and the fear she generates in me each time she speaks. It feels like a lion is thumping around in a pastel colored nursery while the mobile spins and twinkle twinkle little stars is playing in the background, that everybody thinks the room is innocent, adorable and I can barely breathe because all I see is a restless lion pacing back and forth across the room. I know we have a lot of complex words for this experience – projective identification, dissociation, disavowal, counter-transference (think Klein, Bromberg, Kernberg, Bass). From where I'm sitting, they all amount to saying that the patient is projecting something menacing into the room but her defenses are protecting her from seeing what she does. She splits off parts of herself that she doesn't want to know, or disavows how threatening she feels, or induces terror in me so that I can feel how she feels in these circumstances. But none of this feels like a sufficient explanation. Because while sitting across from her in a dark office in the middle of the afternoon, all I can think is that I recognize a lion because I've grown up in a zoo. I recognize this particular combination of suffering, aggression, helplessness, charisma, and cruelty. I have no doubt that she is suffering, that she knows how cold, alone, and terrifying the world can be, that she can be ruthless, that she can cause real harm. Would I call these feelings countertransferential, if by that word we mean, reactions to a patient's transference to me? I hardly think the word describes what is transpiring. It feels more like a lion has roamed its way into the office of a former zookeeper, and on some

level, we both know it. Certainly, the zookeeper does. What I feel about sitting in my office with a lion is intimately bound with years of experience tending to wild and dependent things, none of which feels "countertransferential."

Chloe

Raised as an only child by parents who were alcoholics, Chloe complains of struggling with the basic requirements of adulthood. She lives alone in an apartment that her mother pays for, and although she's worked several odd jobs as a waitress and in gyms, she can't stay in these jobs for long; eventually, she just gives up because she hates it, and doesn't really see the point. Her mother's fury at her daughter's failure to work or reach other developmentally appropriate milestones are counterbalanced by her mother's overindulgence; not only does she pay for everything Chloe needs, but when Chloe complains about work, school, or something in the apartment, her mother responds frantically and hysterically to try to fix it, reflecting to Chloe that her discomfort is an urgent problem that demands (what is often) an extreme solution.

I see Chloe four times a week and initially, the symptoms are quite physical. She is dizzy all the time, exhausted, and nauseous. She tells me that her activities are limited. She wakes up late, goes for a walk, tries to see a friend, and then comes home feeling depleted. She says she knows she's probably depressed because she's felt lethargic and indifferent for as long as she can remember. She doesn't want to find a job, or go to school, even though her mother is threatening to cut her off financially if she doesn't "smarten up" soon. She is extremely bright, articulate, and clever, always noticing and clarifying what she's saying, using creative metaphors to get her points across. She is very sexually active, but it doesn't seem that she particularly enjoys any of it. She has sex with many different men on a regular basis, and works on and off as a sex worker as well. She relates all this information nonchalantly, without empathy or curiosity about herself. She repeatedly says she's just "crazy," "self-destructive" and "idiotic" for being such a "mess" and ruining her life, but that she can't prevent her self-sabotaging behavior. She doesn't know why she is so unable to form healthy relationships, keep a job, or find something she cares about, so she insists that she is a "lost cause," "hopeless," and "too far gone to help or save."

Several months into treatment, Chloe tells me about a sexually traumatic relationship she had when she was fourteen years old. At first she is affectless, expressing her usual stoicism and self-effacement about her childhood suffering but as she talks over several sessions, and as I express my shock, pain, and anger, Chloe's tone starts to change and she begins to feel sad, crying for the first time in session. She tells me that when she was fourteen years old, she started "dating" a handyman who helped in the apartment. She says the word "dating" in air quotes because she was fourteen and he was thirty-one, and much of it had been abusive. He ordered her around, humiliated her, forced her to have rough sex, cook and clean for him, pay for things with her parents' money. It went on for three years. At the time, her mother was furious and terrified that her teenage daughter was with an older adult and tried to convince her to break up, but Chloe refused to listen. Her mother then arranged for Chloe to see a child therapist but after several months, the therapist reported to the mother that there was nothing she could do because "when Chloe gets something in mind, there's nothing anyone can do to stop her." Chloe interpreted this as confirmation of her

harmfulness and grandiosity. She shrugged and told me that she was impossible to help because she was too "broken," and everywhere she turned she was told that helping herself was a prerequisite to being helped by others.

As the treatment progressed, it seemed increasingly clear that our work was situated between these two mothers – the one, frantic and hysterical, who neglected her daughter's emotional needs but then overcompensated by trying to stop her discomfort, and the other, rational and distant, who saw her role as limited and technical by virtue of not being a "real" world caregiver. These two mothers defined the bounds of treatment as she continually told me about risky and dangerous things she was doing – sex work, difficulty eating, dangerous relationships, overspending – and waited to see what I would do. Would I react frantically and hysterically, trying to assuage my guilt at neglecting her by swooping in to save her, or would I be like her previous therapist, professional and unmoved, inviting her to talk about self-harm but unwilling to intervene?

I sat at the edge of my seat during our sessions, if not physically than certainly it felt that way emotionally. I felt like every fiber of my being had to be attentive, as if clues could come in things said, unsaid, felt, smelled, dreamed about, heard. When she told me stories about a violence or humiliation she endured – in her sex work, with a boyfriend, at the gym – I felt that she demanded a reaction, not necessarily that I do something right away, but that I convey to her that she was someone whose suffering required and deserved an adult's intervention. On the surface, I conveyed this in the usual ways – shaking my head, sighing, mirroring, and amplifying her pain and indignation. But at a deeper level, I also thought a lot about what action would be asked of me. Would I need to one day pick her up from a violent boyfriend's house because this would be the only way to prove that someone cared enough about her to protect her? Would nothing less than a rescue mission in the real-world satisfy her unconscious fantasies?

> We are taught and trained to safeguard the separation between reality and fantasy. A patient needs us to be mother-like to them, and we facilitate this fantasy by making clear (to them, to us) that we can play with this wish, satisfy it through symbolic and emotional communication, but we cannot be their mothers in actuality. Our analytic credibility depends on our ability to demonstrate (repeatedly, over the span of different cases) that we understand the difference between what our patients want and what we are willing to give them. But with Chloe, I felt certain that our work was taking place in fantasy and in the real world. For example, I tried to anticipate the different things she'd ask of me – to pick her up from somewhere dangerous, to drop her off somewhere safe, to have a session somewhere that was not my office, to answer her call whenever it came (weekends, vacation, middle of the night) and go to where she was to help her. I tried to calculate my level of discomfort with altering the frame by anticipating the level of urgency and risk. How unsafe would she have to be to require a real-world intervention What level of harm justified the descent from symbolic wishes to material action?
>
> I know how we are trained to think about these things. Even Freudians believe in enactment these days (think Jacobs, Katz, Levine). Chloe solicited my worry in order to recreate scenes of repeated neglect and misattunement. She needed to put me in a role where I could be either her mother or her former therapist, overreactive or unreactive, there was nothing in between. But what about my own susceptibility to her confusion? It was easy enough for me to recognize that she needed me to model a different way of caring for herself (think Bollas' self-as-object-relation), but how was I supposed to know what was "too much" or "not enough"? What if my compass was compromised as well? I had tended to lions after all,

which made me prone to being, both very still and very jumpy. I could inhabit different rhythms with equal comfort and familiarity. What if, because of this, I entertained the question of my actual involvement for longer than I was required to? The truth was that I had always been impatient with the fantasy/reality binary because I had questions – intellectual, personal, deep, and abstract – about what therapy could do, like, could it save everyone? How could it help people who needed something to happen that was more powerful, urgent, real? Who needed to feel they had been pulled back from a ledge, carried down a flight of stairs, held onto, held tightly, held? Are we really to believe that language alone could recreate the sensation of caretaking when someone had been dropped and left so many times before? Is language really all we were supposed to use?

Action and reaction

Chloe exhibited many of the traits we have come to associate with "difficult" patients; she had a history of acting out, somatization, impulsivity, and emotional lability. Although since the field's inception there have been protracted debates about whether a patient with Chloe's diagnostic profile is a legitimate candidate for psychoanalytic treatment,[2]in what follows I'm less interesting in debating Chloe's eligibility than in exploring the emergence of action/reaction in our particular transference-countertransference constellation. For the purposes of keeping this relatively brief, I'm going to refer to one specific instances of acting out during year two of the treatment. I should also mention here that the discourse on acting-out and enactment is robust and contradictory, meaning that while many use these words freely and often interchangeably, their individual meanings and the differences between them continue to be the subject of intense debate (Boesky, 1982; Bohleber et al., 2013; Katz, 2014). For our purposes, I am going to refer to Chloe's behavior as acting out because I think it most accurately captures its qualities as a series of behaviors that were resistant to verbalization, inaccessible to symbolization and unconsciously oriented toward a violation of the frame (Bettelheim, 2022).[3]

The episode occurred a short while after I told Chloe that I was pregnant and would be away for a maternity leave. At first Chloe said "congratulations!" but a few sessions later, Chloe began to talk obsessively about her upcoming plans for elaborate cosmetic surgery. "I'm obsessed!" she would proclaim at the start of every session. "I found this clinic that can do cosmetic surgeries, *fast*, like, right away, if I want them to. Normally you have to wait a year for these procedures, but I talked to the secretary and told her that I *need* these things to happen right away, and, well, she felt bad for me, I guess, so she said that she could schedule something soon, like, at the end of April" (it was now December). In addition to a rhinoplasty (nose job) she talked extensively about other intrusive surgeries, which she assured me were

[2]Andre Green writes: "for over twenty years we have seen the vicissitudes of an endless written and spoken debate between those analysts who want to restrict the scope of classical psychoanalytic technique (Eissler, 1953); (Fenichel, 1941); (A. Freud, 1954); (Greenson, 1967); (Lampl-de Groot, 1967); (Loewenstein, 1958); (Neyraut, 1974); (Sandler et al, 1973); (Zetzel, 1956) and those who support its extension (Balint, Bion, Fairbairn, Giovacchini, Kernberg, Khan, M. Klein, Little, Milner, Modell, Rosenfeld, Searles, Segal, Stone, Winnicott) (Green, 4, 1975)

[3]In the psychoanalytic literature, enactment has gained widespread use and is often used interchangeably with acting out to describe instances where the patient transgresses the norms of treatment by taking action instead of verbalizing their emotions (Bettelheim, 2022; Boesky, 1982). However, although acting out has mostly been replaced by enactment in contemporary theory, it may be valuable to distinguish acting out and enactment according to whether the analyst's subjectivity becomes involved (Bohleber et al., 2013, p. 520). Following Bettelheim (2022), I would suggest that "acting out can be defined as the motor expression of verbally inaccessible traumatic memory by either past or therapist. Enactment can be defined as their mutual acting out of coincident unresolved material" (80).

"extraordinarily dangerous." I immediately felt panicked and dizzy as she started to describe the logistics of setting up these surgeries. Firstly, she was describing a series of extreme and expensive procedures that would alter her body in permanent ways. And secondly, she was scheduling these surgeries to coincide with my upcoming maternity leave, meaning that we only had several months to work with this before I had to leave. My upcoming maternity leave meant I had a hard deadline that I couldn't extend and suddenly it felt like the clock was ticking for me to neutralize the bomb before it exploded in her lap. I felt simultaneously worried for her safety – what if she went ahead with these surgeries as planned and she got permanently disfigured? – as well as angry at the position I was in – how could I remain analytically useful if I was preoccupied with trying to prevent her from doing something physically dangerous? At first, I tried to encourage her to reflect on what prompted the sudden urgency she felt about surgery by asking questions about *why* she became obsessed with these procedures and whether she thought it had anything to do with therapy. In session after session, my questions were greeted with indifference, disinterest and dismissal.

Countertransferentially, I felt extremely helpless, frustrated, angry, worried, and guilty. It seemed as though my having a baby was very literally endangering her and also that my hands were tied. I was especially preoccupied with questions about what reaction/action was required of me. Should I call her mother? Call the clinic where she is doing the surgeries? Give her an ultimatum that she either stop her plans for these procedures or stop coming to treatment? Am I complicit in her self-destructiveness, facilitating it even, by sitting by and waiting for these compulsions to be accessible by self-reflective means? Is it even ethical to witness these dangerous behaviors without actively intervening? I felt much like the therapist Chloe had when she was fourteen years old and was involved in an abusive relationship; naïve, useless, and complicit with her self-destruction. As such, I also felt the pull of an enactment, as though Chloe was forcing me to *do* something, whether I took action or not. That is, not only did I feel compelled to intervene in her self-harming plans, but I also felt that by *not* intervening, I was acting as well, and that she was watching carefully to see what I would do.

> I wondered constantly if "this" was the moment she needed me to "do" something beyond interpretation. I fantasized about what this could look like but the interventions all seemed extreme and potentially overwhelming. Of course, cosmetic surgery was extreme and therefore anything I did to stop it might seem warranted but I couldn't shake the sense that she was testing my commitment as well as my endurance. Did she really need me to infantilize her, call the clinic or her mom, convey to her there was a limit to her self-destruction? Or did she need to see how strong my stomach was, if I could witness the depth of her self-harm without flinching or fleeing into action?

Although I felt propelled to take some kind of action, I couldn't find a way to do something that wouldn't, I feared, compromise the complicated dynamic she set up. I didn't want to sit idly on the sidelines while she engaged in obvious self-harm, but I also didn't want to overreact in ways that foreclosed the fantasy she had been carefully elaborating. I told her that I would take an abbreviated maternity leave, returning to in-person sessions after 6 weeks. I hoped this kind of reaction signaled the depth of my worry and concern without requiring her to change her actions. I wanted to convey that I was indeed affected by her actions – that I would change my plans to accommodate her needs – and hoping that the intensity of what this meant for me could signal to her, symbolically but also in reality, that I was in it with her, that I was neither safe, nor unperturbed.

> I was impatient with the Freudians who said I should remain in place and analyze from where I stood, not giving in too much for fear that gratifying a patient's needs shuts down the fantasy, but I was irritated by Relationalists as well, insofar as their embrace of enactment as an ordinary and inevitable feature of treatment relinquished the power of the frame to facilitate fantasy's safe elaboration.

When I came back from my abbreviated leave, Chloe told me that the surgeries had been a "failure." They couldn't go through with most of them for technical or physiological reasons that were vague and unclear. Immediately, I began to wonder about her defenses. For months I had assumed that she simply *could not* formulate an awareness of her own behavior but seeing her on the other side of these "failed" and anti-climactic surgeries, I began to consider if acting out was really the most accurate description of what she was doing. After all, one of the primary ways we distinguish acting out from verbalization is by imagining that motor activity results from insufficient symbolization as a result of trauma, but hearing that these surgeries could not take place suddenly cast them in a different light. Did she even want to do the surgeries? Were they ever likely to take place? Was she rushing headlong into a dangerous scenario and needing me to stop her, or were the surgeries a decoy that allowed her to play with me around ideas of risk, need, safety, and care? In other words, I took the dangers literally – worried about what she was doing to her body and thought my interventions needed to be physical as well – but was it possible that she was learning what the boundaries were, what constituted safety, what counted as actual harm?

> I wonder what this means for the differences between traditional and relational paradigms. If I had absolutely ruled out taking any action in reaction to her needs, perhaps I would have seen that all of it had been symbolic. But on the other hand, didn't she need to feel like action was an option that I could or couldn't take? Didn't her fantasy depend on not knowing what I'd do? Didn't my participation require that I, too, not know exactly what I'd do? How can we keep a patient's questions and fantasies alive if we are so certain, in advance of the relationship, everything we will and will not do for them? Sure, Chloe was provocative, but there were reasons of my own that I was so provoked. The treatment as a frame for provocation.

Narrative and dissolution

Lyndon's contribution to this emergent genre invites us to wonder what the popularity of "autotheory" might potentially reveal about our patients and ourselves. Can "autotheory" be considered from a clinical dimension, and if so, how do we understand it? Daria Colombo has recently suggested that, although the term currently has little traction in the clinical domain, it "approaches something already intuited by a number of psychoanalysts, predominantly in the feminist and relational traditions" who insist "both on the body's primacy and on its relation to theory, rejecting the hierarchy that would place the body below theory" (Colombo, 2022, p. 267). For Colombo, "autotheory" "does not mean merely grafting autobiography into a discussion of theory. Nor is adding select self-disclosure to analytic writing or analytic work the same as autotheory" but instead refers to the "*embodied nature of framing*" implicit in clinical processes, further enriching the "insistence that it [is] an individual, not a school, that is framing, and this individual is embodied and somehow gendered" (268). According to this view, "autotheory" is another word for the clinical activity of "framing" that introduces "the physical, sexed, and variously gendered body of the theorizer" (274). Stephen Hartmann similarly hails the promise of "autotheory"

to clinical discourse, but not necessarily because it affirms existing relational knowledge, as for how it pushes the boundaries of clinical writing and defamiliarizes entrenched hierarchical positions (2023).

In my brief response to Lyndon's evocative piece, I want to venture another possible account of the relationship between clinical practice and "autotheoretical" writing, one that considers how the genre's particular formal characteristics exemplify a crucial dimension of psychoanalytic experience. I am thinking specifically of how Lyndon's essay resists the *narrative* impulse to make connections between disparate feelings or events, instead drawing vivid vignettes – from skating, about alcohol, with her therapist – that do not cohere neatly into a unified portrait of who the narrator is, what she suffers from, what she desires. Like so much of the writing that travels under the banner of "autotheory," Lyndon's writing offers pieces of the puzzle but does not assemble them into a *story* about what's happening or what the pieces mean. Instead of more traditional autobiographical accounts that orient the reader to an "appropriate" interpretation of events, here the reader is responsible for establishing the links between unconnected fragments. Is the figure skating foreshadowing the alcohol abuse, and if so, what is their connection? Does the narrator believe her analyst knew something about her alcohol addiction that she could not express except through the recommendation to attend "a meeting?" What is the narrator asking us to make of these unlinked vestiges of biopsychic life? And furthermore, what is the value in requiring the *reader* to facilitate these links? Is unlinking inherently pathological, or is there a version of *de*linking that can be psychologically generative?

When Laplanche describes the mutative force in therapy, he routinely talks about the process of unbinding, "deconstruction," "*Losung*," "analysis," "dissolution." Laplanche writes: "analysis offers . . . a reopening of the dimension of alterity . . . taking up a place to open things out, but also to analyze things. For what is new in analysis, in relation to culture, is not transference, it is . . . analysis – that is, *Losung* . . . .*Losung*: analysis, solution and resolution, dissolution" (1999, p. 230). As Laplanche explains elsewhere, the patient arrives at treatment with a vast archive of ideas that have been already translated, already converted into narrative form. The task of analysis isn't to adjudicate the facticity of these interpretations but to gradually enable their undoing so as to make way for less knowing, and eventually, new translations of old messages. "The aim here is not to restore a more intact past *(whatever would one do with that?)* but to allow in turn a deconstruction of the old, insufficient, partial and erroneous construction, and hence to open the way to the new translation which the patient, in his compulsion to synthesize (or, as the German Romantics might have put it, in his 'drive to translate,') will not fail to produce" (Laplanche & Fletcher, 1999, p. 164). Therefore, although so much of psychotherapy necessarily concerns itself with aiding the patient in their grasping for meaning, in effect helping them create narratives where they lack sufficient explanation (Laplanche, 2011), "analysis is first and foremost a method of deconstruction (ana-lysis), with the aim of clearing the way for a new construction, which is the task of the analysand" (Laplanche & Fletcher, 1999, p. 165). Since the patient is fundamentally hermeneutic – oriented, from its origins, toward the establishment of narrative[4] – what she needs from treatment isn't merely "more" or "better" narratives, but space and structure for the *dissolution* of these narratives, opportunities for the narratives that bind us to come gradually, or even suddenly, undone.

[4]I discuss the baby as the "original hermeneut" in my essay on the subject (Ashtor, 2023).

Perhaps one way to conceptualize what "autotheory" offers is as an exercise in dissolution, an instance of unlinking that enacts what happens (if we're lucky) in analysis. Perhaps the task is not really to rewrite what we're doing as "autotheoretical," but to think of the genre as a literary enactment of our analytic aims. For as Laplanche repeatedly explains, our patients are already filled with narratives about their own experiences, and what they need from us are not just better, smarter narratives, but freedom to *deconstruct* the story, for a moment. Writing in a fragmentary, mediated way, Lyndon's piece enacts the tension between narrative and analysis, reminding us that the analytic task requires us to move between these different poles, to bind meaning to enigma, and then dissolve the meaning we have made. Neither of these modes – narrative or analysis – dominates indefinitely, because "*all psychoanalysis* is devoted primarily to psychotherapy: to the self-narration of the subject, with the more or less active assistance of the analyst. But the psychoanalytic *act* – sometimes quite rare – is something else. A work of unbinding, it tries to make new materials surface for a profoundly renewed narration; and, of course, we shall not be surprised that the psychoanalyst is also cautious and sparing: for isn't his work of unbinding allied with that of the sexual death drive?" (Laplanche, 2011, p. 282). Perhaps it is okay to be uncomfortable with the momentary absences of narrative, to surrender to it when we can. Lyndon's writing is showing us the way.

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