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DIALECTICAL THINKING AND THERAPEUTIC ACTION IN THE PSYCHOANALYTIC PROCESS

BY IRWIN Z. HOFFMAN, PH.D.

The therapeutic action of the psychoanalytic process depends upon a special kind of power with which the analyst is invested by the patient and by society, a power that is enhanced by adherence to psychoanalytic rituals, including the asymmetrical aspects of the arrangement. It is important, however, that the analyst also engage with the patient in a way that is sufficiently self-expressive and spontaneous so that a bond of mutual identification can develop between the participants. At the core of the generic "good object" is an element of uncertainty as the analyst struggles to find an optimal position relative to this dialectic between formal psychoanalytic authority and personal responsivity and self-expression. At the core of the generic "bad object" is an uncritical commitment to one side of the dialectic at the expense of the other. An extended clinical vignette illustrates how the analyst's struggle with this dialectic has great therapeutic potential.

ON THROWING AWAY "THE BOOK"

The movement toward full appreciation of the inevitability and usefulness of the personal involvement of the analyst in the analytic process has accumulated a lot of momentum. Sometimes knowing of each other's work, sometimes not, many analysts, going back to Racker and others in the fifties, have been reporting the ways in which they have been able to use their emotional experience or countertransference, broadly defined, to enhance their understanding of their patients and to open up new therapeutic potentials in the process. It is important to

recognize that the contributions to this movement have come from analysts with diverse backgrounds cutting across many of the major psychoanalytic schools: classical Freudian, Kleinian, object relations, and interpersonal. To be sure, there are many important and interesting differences among the authors contributing to this current of thought. But one of the commonalities among them that has struck me is the extent to which the clinical experiences that they report include, at some juncture, implicitly or explicitly, a *feeling of deviation* from a way of working which they view as more commonly accepted, more a part of their own training, more traditional in one sense or another. There is a feeling of "throwing away the book," one that Jacobs (e.g., 1990, pp. 450-451; 1991), Natterson (1991), Ehrenberg (1992), Mitchell (1991), and others mention or allude to in a number of their papers. Moreover, that feeling is not restricted to the analyst. One gets the impression that patients are often aware that there is a good deal of tension between, on the one hand, the analyst's more customary attitude, or the one the analyst may regard as more acceptable within his or her particular analytic community, and, on the other hand, the moments of deviation from it.

So I began to wonder to what extent a sense of deviation from tradition or from a stance that seemed more "psychoanalytically correct" was an important or even essential part of the therapeutic action of the experience. If it was, it seemed to me that those of us who were part of the movement were in for trouble. After all, how often could we throw away, retrieve, and throw away the same book? One would imagine that over time the vividness if not the credibility of our sense of defiance and liberation would be eroded. After all, it is not as if we are keeping our own iconoclastic ideas hidden. On the contrary, a new composite Book on the process seems to be emerging, made up of such works as *Collected Papers on Schizophrenia and Related Subjects* by Searles (1965), *Transference and Countertransference* by Racker (1968), *Analysis of Transference* by Gill (1982), *The Ambiguity of Change* by Levenson (1983), *The Matrix of the Mind* by Ogden

(1986), *The Shadow of the Object* by Bollas (1987), *Relational Concepts in Psychoanalysis* by Mitchell (1988), *Understanding Countertransference* by Tansey and Burke (1989), *Other Times, Other Realities* by Modell (1990), *The Use of the Self* by Jacobs (1991), *Beyond Countertransference* by Natterson (1991), *The Intimate Edge* by Ehrenberg (1992), and *Contexts of Being* by Stolorow and Atwood (1992). When the general spirit of these books becomes The Book, what Book shall we discard? How can we spontaneously and creatively defy tradition once a new tradition emerges that seems to require at least a modicum of defiance as a matter of principle? Then to defy the old would be to conform to the new, a conformity that might well diminish the flavor of creative rebellion, spontaneity, and discovery that an important sector of our community has managed to sustain for thirty or forty years.

There are good theoretical and common sense reasons, moreover, to think that a sense of spontaneous deviation, shared by patient and analyst, may be a central or even crucial feature of whatever corrective experience may be afforded by the emergence of the analyst's subjectivity in the process. When the patient senses that the analyst, in becoming more personally expressive and involved, is departing from an internalized convention of some kind, the patient has reason to *feel recognized* in a special way. The deviation, whatever its content and whatever the nature of the pressure from the patient, may reflect an emotional engagement on the analyst's part that is responsive in a unique way to this particular patient. It is not that the content is irrelevant. Certainly each instance of use or expression of countertransference would have to be examined individually to weigh the relative contributions of therapeutic, nontherapeutic, and anti-therapeutic factors. But I would argue that there is something about the deviation itself, regardless of content, that has therapeutic potential. Indeed, it is possible that even when the affective reactions of the analyst seem to implicate him or her in the enactment of old, pathogenic object ties, meeting what Ghent (1992) has referred to as malignant as opposed to benign needs, the *context of deviation* from a standard technical

stance, in favor of immediate responsiveness to the patient, can transform one's apparent participation as the "bad object" into that of a "good object" in the current situation. Conversely, when the analyst adheres religiously to a particular stance in order, ostensibly, to ensure *contrast* with the patient's bad objects, the *context of conformity* to the technical stance, at the expense of immediate responsiveness to the patient, can transform one's apparent participation as the good object into that of the bad object in the present.

It is commonplace to recognize the narcissistic, exhibitionistic, and exploitative potential of overtly self-revealing behavior. But any automatic routine might also be viewed, plausibly, by the patient as a resistance on the analyst's part to an individualized engagement with the patient and as a form of self-indulgence of one sort or another. The patient might view the analyst as content to sit back and pat him- or herself on the back for doing "the right thing," according to whatever the Book requires, at the expense of attending in a creative way to the patient's needs. Alternatively, or simultaneously, the patient might view the analyst as fearful of any kind of personal engagement. Thus, for example, if the patient felt overburdened or exploited by needy parents, a line of correspondence might be drawn between that history and an analyst who never openly conveys anything at all about his or her own needs. The common factor in that case could be the patient's sense that the behavior of the parent or the analyst is propelled by fixed, predetermined, internal pressures rather than by responsiveness to the patient's immediate experience and communications. So, again, to be the good-enough object, the analyst sometimes has to show a willingness, on a manifest level, to be pulled somewhat in the direction of the bad object, whereas a determined effort to avoid any behavior that might be similar in its content to that of the bad object might be precisely what constitutes the bad object in the analytic situation.

Regarding adherence to the rituals of classical technique, here is what Searles wrote in 1949 in a paper, twice rejected for

publication, that Robert Langs (1978-1979) finally discovered and published:

> The analyst who attempts to adhere to the classical behavior of unvarying "dispassionate interest" toward his patients regularly finds the patients to be irritated by such behavior which, after all, they have to cope with in everyday life only in so far as they may deal with schizoid other persons. It seems that such dispassionate behavior all too often merely repeats the patient's discouraging childhood relationship with one or another schizoid parent, and lends itself to unconscious employment by the analyst as a way of expressing hostility to the patient. For the analyst to reveal, always in a controlled way, his own feelings toward the patient would thus do away with what is often the source of our patients' strongest resistance: the need to force the analyst to admit that the patient is having an emotional effect on him (Searles, 1978-1979, p. 183).

But classical technique, especially when practiced in a rigid way, is a familiar target of criticism for its seeming coldness. I would say it is actually a scapegoat, a whipping boy, for a problem that cuts across most of the major theoretical positions, sort of like the identified patient in a disturbed family. It is more difficult but equally important to locate the expression of disturbance in points of view that advertise themselves explicitly as warmer or more "human" alternatives to the classical position. Self psychology is one such point of view. The central principle of technique in self psychology is "sustained empathic inquiry." Can conformity to such a "benign" principle cast the shadow of the bad object on the analyst? I think it can. Consider the argument of Slavin and Kriegman (1992):

> . . . it is quite possible for empathy to be practiced with a fair degree of verisimilitude, as a technique, rather than as the genuine intimate act and sign of mutuality that is so profoundly, intrinsically valued. Indeed, patients know, or come to know, that another human being whose only substantial utterances take the form of validating affirmations of the patient's own subjective world and developmental strivings are

> likely, themselves, to be engaged in one or another form of self-deception and deception (p. 250).
>
> The attempt to remain exclusively attuned to what appear to the therapist to be the dominant themes and meanings in the patient's subjective world is, in fact, sensed by many patients as a self-protective strategy on the part of the therapist. . . . Over and above any particular individual defensiveness that we may attribute to the therapist, the overly consistent use of the empathic mode will, for some patients, be sensed as the therapist's hiding some aspect of him- or herself, or pursuit of his or her own interests—interests that, as the patient well knows but therapists are loath to face, indeed, diverge in some significant ways from those of the patient. We must, thus, clearly face the fact that an immersion in the patient's subjective world . . . must be complemented, at times, by what is, in effect, the open expression of the analyst's reality (pp. 252-253).

Some patients more than others are particularly sensitive to and intolerant of anything that smacks of psychoanalytic clichés, or of going by the Book in one way or another, or even of a measured, unvarying psychoanalytic tone of voice, whether it is coolly detached or warmly "empathic." Those patients often have a therapeutic effect on *me* because they do not let me get away with the party line or tone. Instead, they challenge me to think things through in a fresh way, to be myself, and to respond to them as unique individuals. Of course intolerance of stereotypic behavior can sometimes be excessive and defensive. Some acceptance by the patient of the recognizably technical aspects of the analyst's behavior is essential. However, the conspicuously formal, role-related aspects of the analyst's participation, however much they may contribute to a safe analytic environment, can also be powerful magnets for the patient's mistrust. And, of course, for every patient who complains *explicitly* about something artificial in the analyst's behavior there are countless patients who would not say a word about it or who would deny it. With them, one would have to look for disguised references to the issue in dreams and other associations (Hoff-

man, 1983). In some cases the patient might simply identify with the aggressor (as perceived) and go through the motions for a long time, sometimes years, without feeling touched or reached. In this connection Lipton (1977) has suggested that there may be some patients who are thought to have narcissistic personality disorders who are actually identifying defensively and unconsciously with analysts who do not make themselves available for a personal relationship.

PSYCHOANALYTIC DISCIPLINE IN A NEW KEY

So the question arises: If we appreciate the dangers inherent in uncritical systematic application of psychoanalytic technical stances and rules of conduct and the potential benefits that can come from spontaneous personal engagement with the patient, why not simply get rid of the former and cultivate the latter to the hilt? Well of course that will not do at all. We would then simply be entering personal relationships with our patients with the arrogant claim, masked as egalitarianism, that to spend time with us will somehow be therapeutic. Also, we would be promoting allegedly "authentic" personal involvement as an encompassing technique, an approach that would be just as suspect in terms of its genuineness as any fanatically ascetic stance. No, clearly there is much wisdom in the requirement that the analyst abstain from the kind of personal involvement with patients that might develop in an ordinary social situation.

How then, in light of the current emphasis on the importance of acknowledging and making constructive use of the analyst's emotional participation, *should* we conceptualize the special sense of analytic restraint that undoubtedly remains indispensable to practice? Perhaps a key abstract principle to which we would all subscribe can be stated as follows: *analysts, assuming adequate monetary (or other) compensation, must try, in a relatively consistent way, to subordinate their own personal responsivity and im-*

mediate desires to the long-term interests of their patients. Such consistent subordination can be optimized only in the context of the analyst's ongoing critical scrutiny of his or her participation in the process. Well, even if the money is good, that is a lot to ask, perhaps more than what we would expect of good-enough parents (Slavin and Kriegman, 1992, p. 234). Fortunately, the principle has to be qualified as stated because we now have more conviction about the interdependence of the patient's and the analyst's needs. If the analyst is too abstinent or too self-negating, the patient's healthy need for the analyst to survive, and even to benefit from, the patient's impact (Winnicott, 1971; Searles, 1975) will not be met. So, on the one hand, a sense of psychoanalytic discipline, which includes restrictions on the extent and nature of the analyst's involvement, provides the backdrop for whatever spontaneous, personal interactions the participants engage in. On the other hand, given our current understanding of how important it is that analysts allow themselves to be affected and known to some significant degree by their patients, the restrictions themselves are more qualified than they once were. Thus, the moment in which the analyst allows himself or herself to surface as a desiring subject (Benjamin, 1988) is not experienced with the same sharp edge of deviation that characterized it before. Now, instead of *throwing away* the Book, we place it temporarily in the background while the analyst's distinctive self-expression moves into the foreground. The opposite holds as well. When the analyst's more standard, formal, detached, reflective, and interpretive stance is in the foreground, the aspect of the relationship that reflects his or her more personal engagement can still be sensed in the background.

DIALECTICAL THINKING

What I have just said amounts to a dialectical way of thinking about the analyst's participation in the process, one that others, including Benjamin (1988), Ghent (1989), Mitchell (1988), Og-

den (1986), Pizer (1992), and Stern (1983), have been trying to articulate and develop. The term "dialectic" has a long history in philosophy involving a variety of meanings.[1] For my purposes, the following definition by Ogden (1986) has been useful:

> A dialectic is a process in which each of two opposing concepts creates, informs, preserves, and negates the other, each standing in a dynamic (ever changing) relationship with the other (p. 208).

To think and speak in a dialectical way is difficult and sometimes confusing. Many of our concepts in psychoanalysis imply dichotomous thinking. Fantasy versus reality, repetition versus new experience, self-expression versus responsivity to others, technique versus personal relationship, interpretation versus enactment, individual versus social, intrapsychic versus interpersonal, construction versus discovery, even analyst versus patient. There is a sense that these polarities constitute a series of mutually exclusive opposites. But when we think about the poles within each pairing in dialectical terms, we are challenged not only to recognize their obviously contrasting features, but also to find the effects of each pole on the other, and even aspects of each pole represented within the other. One might think in terms of two mirrors positioned opposite each other so that we can see the endless series of reflections of the two within each. The relationship between psychoanalytic discipline and expressive participation is dialectical in that sense.

On the side of analytic discipline, first, however much it is learned and internalized in a process of professional socialization, such an attitude gets into the analyst's bones so that it expresses a very important aspect of him- or herself. Second, that discipline, to begin with, is not simply imposed from outside

[1] Ghent (1992, p. 156) has decided to eschew the term "dialectic" because of the connotation of a movement toward synthesis in which tensions are dissolved. He prefers the term paradox. I think dialectic has the advantage, however, of implying an interactive dynamic between opposites, whereas paradox seems more static. In any case, I intend the connotation of tension, not resolution.

but represents a special kind of development of the analyst's potential for attention to the experience of others. And third, although the analyst speaks partly in the context of the role of disciplined expert, his or her *voice* can and should remain personally expressive. The effect of the dialectic is to encourage what Schafer in 1974 called "talking to patients," as opposed to the "impersonal diction" that the author found to be so pervasive among analytic therapists following a "pseudoanalytic model."[2] With regard to the other pole in the dialectic, moments of personal self-revelation or spontaneous action on the part of the analyst can be located within, and intuitively guided by, a sense of their place in the process as a whole. The latter involves a complex mosaic of interdependent, overtly interpretive, and overtly noninterpretive interactions (Pizer, 1992). So, on the one hand, psychoanalytic discipline can be self-expressive and, on the other hand, the analyst's self-expression may reflect a complex, intuitive kind of psychoanalytic discipline (Hoffman, 1992a).

The analyst's personal, emotional response to the patient, when expressed, may or may not entail some form of gratification of the patient's needs or wishes. Because of the valuing of abstinence in classical psychoanalytic theory of technique, a withholding attitude tends to be associated with a more "correct" posture, whereas "giving in" to pressures from the patient tends to be associated with the unfortunate intrusion of something from within the analyst. Deficit theories such as those of Kohut and Winnicott have legitimized certain kinds of gratification as an intrinsic part of the psychoanalytic process. At the same time

[2] In the paper cited, republished in Schafer's recent book (1992), no explanation is offered for the prevalence of impersonal diction aside from its conformity to a "pseudoanalytic model." In my view this way of speaking is grounded in an objectivistic, "technically rational" (cf. Schön, 1983) perspective on the process. Conversely, "talking to patients" needs to be anchored in a different model, one that I have referred to as "social constructivist" (Hoffman, 1991, 1992a, 1992b). By "constructivism" I mean something quite different from the perspective Schafer has articulated (see Hoffman, 1992b, for discussion of this difference).

they have introduced a new kind of institutionalized disguise for personal, countertransferential tendencies. Mitchell (1991) has discussed the influence of the analyst's personal attitudes upon the classification of the patient's desires into those that qualify as "needs" for responses that are developmentally necessary and those that amount to "wishes" for gratifications that have forbidden, incestuous meaning. He argues that such assessments are never simply "diagnostic" of what is objectively true of the patient. Instead, they express complex organizations of transference and countertransference that can often be explored usefully only in retrospect, that is, after certain enactments have occurred. Elsewhere, Mitchell (1988) provides us with an excellent example of dialectical thinking in his account of the optimal posture of the analyst dealing with narcissistic issues in the transference. With respect to the patient's invitation to the analyst to participate in a "mutually admiring relationship," Mitchell writes:

> Responding to such an invitation in a way that is analytically constructive is tricky, and difficult to capture in a simple formula. What is most useful frequently is not the words, but the tone in which they are spoken. The most useful response entails a subtle dialectic between joining the analysand in the narcissistic integration and simultaneously questioning the nature and purpose of that integration, both a playful participation in the analysand's illusions and a puzzled curiosity about how and why they came to be so serious, the sine qua non of the analysand's sense of security and involvement with others (p. 205).

It is important to emphasize that my interest in this paper is in the dialectic between the analyst's personal emotional presence and the analyst's role-determined behavior, whatever their respective contents. Either could be ostensibly gratifying or frustrating with respect to the patient's desires. In the broad sense one could think of the tension as that between a pull that both participants are likely to feel, in varying degrees, toward a qual-

ity of interaction akin to what they would experience (or imagine they would experience) outside of the analytic situation and the sense that both may have, in varying degrees, of the need for a special kind of restraint that is peculiar to the analytic situation itself (*cf.* Modell, 1990). To the extent that the patient wants a personal relationship with the analyst, one could think of a pressure from the patient for a generic kind of "gratification" (Searles, 1978-1979, see above p. 191). When I speak of analysts participating in a "self-expressive" or "personally responsive" way, I have in mind their own inclinations to respond to the patient, in part, as they might imagine they would outside of the analytic situation. However, the point of appreciating the dialectic between personal responsivity and analytic discipline is to recognize that, despite the tension between them, each tendency is also reflected in a substantial way in the other. Thus, the analyst who behaves "naturally" would be incorporating in his or her actions the sense of discipline that is intrinsic to his or her sense of identity as an analyst. The possibility of such integrative action does not do away with potential tensions arising from discrepancies between types of reactions that antedate psychoanalytic training (in the broad sense) and those that directly reflect its influence.

PSYCHOANALYTIC AUTHORITY, MUTUALITY, AND AUTHENTICITY

The analytic situation is a unique setup, a ritual, in which the analyst is invested by society and by the patient with a special kind of power, one that the analyst accepts as part of his or her role. I believe that power has psychological continuity with the power of parents to shape their children's sense of themselves and their worlds. The magical aspect of the analyst's authority is enhanced by his or her relative inaccessibility and anonymity. There is a kind of mystique about the analyst that I doubt we want to dispel completely. It is noteworthy in that regard that

however much we, as analysts, may interpret and attempt to deconstruct our authority through the analysis of transference, we do not generally dismantle the analytic frame during the analysis or even after it. We do not usually invite our patients to our homes for dinner or visit them in theirs. Instead, we take pains to protect the special kind of moral presence that we have in our patients' lives.

With regard to therapeutic action, I think there is something to the simple idea that the analyst is an authority whose regard for the patient matters in a special way, one that, again, we do not try to analyze away, nor could we, perhaps, even if we did try. In some cases it may take a lot of work to get to the point where that regard can be conveyed by the analyst and received and integrated by the patient. But I doubt many of us have felt, as patients or as therapists, that the process, when it has been helpful, has not included that factor of affirmation (Bromberg, 1983; Schafer, 1983, pp. 43-48). I think the likelihood of that happening in an authentic way is increased not only because the analyst is in a position conducive to eliciting a certain quality of regard, but also because the patient is in an analogous position. Regard for the *analyst* is fostered partly by the fact that the patient knows so much *less* about him or her than the analyst knows about the patient. The factor of relative anonymity contributes not only to the irrational aspect of the analyst's power but also to a more rational aspect. The analyst is in a relatively protected position, after all, one that is likely to promote the most tolerant, understanding, and generous aspects of his or her personality. I think of "idealization" partly in interactional terms (as in "making the other more ideal") because the analytic situation and often the patient actually do nourish some of the analyst's more "ideal" qualities as a person—what Schafer (1983) has referred to as the analyst's "second self." Conversely, however, the analyst's regard for *the patient* is fostered by the fact that he or she knows *so much* about the patient, including the origins of the patient's difficulties and his or her struggles to deal with them. Moreover, of course, neither party has to live with the

other or even engage the other outside of the circumscribed analytic situation, so that each is afforded quite a bit of protection from the other's more difficult qualities.

Corresponding with what several authors have discussed in terms of an interplay between the "principle of mutuality" and the "principle of asymmetry" (Aron, 1991; Modell, 1991; Hoffman, 1991; Burke, 1992), there is an ongoing dialectic between the patient's perception of the analyst as *a person like himself or herself* and the patient's perception of the analyst *as a person with superior knowledge, wisdom, judgment, and power*. Each way of viewing the analyst is very much colored by the other. Whichever is in the foreground, the other is always in the background. So, those of us who are interested in developing more mutual and egalitarian relationships with our patients should not deny or forget the extent to which we are drawing upon the ritualized *asymmetry* of the analytic situation to give that mutuality its power. The asymmetry, the hierarchical arrangement, makes our participation in the spirit of mutuality *matter* to our patients in an intensified way, one that helps to build or construct our patients' views of themselves as creative agents and as persons ultimately deserving of their own and other people's love. What the balance should be between asymmetry and mutuality for any particular analytic dyad, at any particular moment or over time, is very difficult to determine or control. Also, it must emerge from an authentic kind of participation by the analyst rather than from adherence to a technical formula. To affect the patient's representations of self and other, what is necessary is that the analyst's authority be sufficiently authentic, on the one hand, and that his or her authenticity be sufficiently authoritative on the other. The fact that analysts cannot know exactly how they should position themselves with respect to the dialectic of overtly expressive participation and relatively standard, authority-enhancing technique is precisely the wellspring for an overarchingly authentic way of being with the patient, one that is marked by a sense of struggle with uncertainty, by a willingness to "play it both ways," and by an openness to consideration

of the unconscious meanings, for the analyst and patient, of whatever course has been taken.

CLINICAL ILLUSTRATION

Now let's look at these ideas as they bear upon a piece of clinical experience.

I was seeing Diane, a single medical student in her late twenties. We were in the midst of an analysis that I was conducting as a candidate at the local Institute for Psychoanalysis. The Institute was there with us in the process, like a concrete representation (and externalization) of a somewhat forbidding psychoanalytic superego. Since sometime in the second year, Diane had refused to lie on the couch, sitting up on it instead. Ordinarily, I sit in a chair opposite the couch when patients sit up. But in this case, I dutifully sat in the chair behind the couch (actually at a 45° angle), as if to say: "You're the one who is violating the rules, not me. I've got nothing to do with it." I am not sure how it came about that she started sitting up. I remember it being a gradual and insidious change, one that I was against. At least I said I was against it and told her so. I cannot deny, however, that even as I stated my objections, her mischievous smile, when she began turning around, sometimes elicited a slight smile in return. And when she asked me point blank: "Are you sure the couch is necessary for the process? I think the eye contact is more important for me," I bluntly replied, "Well, I don't know about the process, but it might be necessary for me to graduate."[3] My conviction about that was somewhat diminished by the fact that the supervisor, one I had chosen, had a propensity for independent thinking. (The supervisor, of course, does not al-

[3] Over time I conveyed to her the various rationales for the use of the couch. I also admitted that my convictions about it were hardly absolute. Nevertheless, I said that I had a serious interest in gaining experience with that arrangement and that I considered such experience to be one of the benefits of the Institute training program.

ways have the last word on such matters.) Although he thought it was preferable that Diane lie down, he did not think her sitting up was a major problem. The important thing, he thought, was that we try to explore the meaning of whatever was going on. But for reasons that were undoubtedly related to those that accounted for Diane not lying on the couch, she was not always enthused about analyzing things either. She had real troubles in her life, and she wanted to talk about them and have me understand their importance. She did not think of herself as offering associations as grist for my psychoanalytic mill. She thought of herself as talking to me about things that really mattered in their own right, things that she wanted me to take at face value and help her deal with in a direct way.

So maybe she was "unanalyzable," a candidate for psychotherapy at best, not for psychoanalysis. (See Gill [1991] for a discussion of the distinction between psychotherapy and psychoanalysis, and Bromberg [1983], Gill [1991], and Ehrenberg [1992] for challenges to traditional views of "analyzability.") This, however, was not the whole story. What I discovered, and what was so important for the analytic process, was that if I met the patient "halfway" (that is, what seemed to her to be a quarter of the way and to me three quarters of the way), she could do a lot of very hard work in the standard analytic sense. If I showed genuine and extended interest in the manifest issues first, joint exploration of latent meaning would often come later. Not only that, but whatever was learned was always lived out in a very vivid way. Interpretations had to stew with other kinds of interactions or the patient would not chew on them at all, much less swallow or digest them.

About the not lying down, we came gradually to appreciate how much humiliating submission[4] there already was in Diane just getting herself to the office for her appointments. Lying down while I sat up added too much insult to injury. Her father,

[4] Ghent (1990) draws a useful distinction between "surrender" as a benign form of yielding and "submission" as a malignant subjugation of self.

a Holocaust survivor, had been compulsive and tyrannical about all kinds of trivial matters in the home. Things had to be in place, wife and children (two older brothers and a younger sister) had to be on time, the waiter or waitress in the restaurant had to provide quick service or he would get enraged. At times he seemed identified with his Nazi persecutors in his rigid, authoritarian ways. He was also a very charismatic, energetic man, successful in his business and a dedicated athlete and outdoorsman. Diane, seeing him as a powerful and exciting figure, worshiped him in her early years, only to become bitterly disappointed and disillusioned as she came to regard him as extraordinarily self-centered and stingy with his time, his money, and his demonstrations of affection. In my nonverbal acceptance of Diane's sitting up, I was consciously disidentifying with her father. The presence of the Institute made the departure from convention both harder and easier for me to accept and participate in. Harder because of a fear of real consequences for my training, easier because I was able defensively to externalize my own real interest in doing it the conventional way. If I did not really care, I did not have to feel cheated by the patient or angry with her. Instead I could restrict my attention to enjoying being a renegade with the patient's appreciation and approval.

To say that I was disidentifying with the patient's father is not precisely correct, in that, needless to say, there were other aspects to the father's personality. It would be more precise to say that I was disidentifying with the father's persecutory superego, one that governed his behavior and that of the people around him rather mercilessly and also one that was internalized to a significant degree by the patient herself. But there was another side to the father that was also in evidence at times, however faintly. The father had great difficulty, as I said, showing affection. At moments of greeting or parting, for example, he would position himself near the patient in a way that would suggest interest in some contact, but he could not initiate it himself. It was always she who had to take the lead. Sometimes the patient felt that her father had a lot of feeling bottled up inside that he

just could not express. So with her gradual move from lying down to sitting up, in an attenuated way, the patient and I enacted this aspect of the patient's experience with her father: it was her initiative to have face-to-face contact, and I was the one, like her father, complying in an inhibited, ambivalent manner.

When I say the enactment was attenuated, I have in mind subtle but crucial differences between the original scene and the analytic one. In the first place, although these things are impossible to quantify, I am fairly sure (or I like to think) that my conflict was less intense than that of the father and that there was more pleasure than pain and more playfulness than fear in "succumbing" to the patient's will.[5] The fact that we could laugh about it at times, I at the patient for her intolerance of analytic rituals and she at me for my interest in them, was evidence of that. In the second place, the enactment itself was embedded in a context in which it was generally recognized as an object for reflection. Whether we were actually reflecting on it at any given time or not, just the fact that the atmosphere was one in which it was understood that what was going on had more meanings than what we might be seeing or acknowledging, and the fact that I was actively curious about those meanings made the whole situation very different from its prototype in the patient's history. All in all, I would say that there was enough sense of similarity between the patient's psychological situation and my own to foster strong mutual identifications, and enough differences so that subtly new ways of being and relating could be explored.

In saying that I was disidentifying with the father's persecutory superego there is another imprecision that amounts to a kind of shorthand. I could only identify with the father to begin with to the extent that he had qualities akin to some objects of identification in my own life. Similarly, of course, the disidenti-

[5] In the background the enactment may well have had the reverse meaning. The patient might have been identified with the father demanding that I, in the position she was in as a child, submit to her will.

fication could only occur in my own experience relative to those internalized objects. No externalization (Sandler, et al., 1969) of internal object relations in the patient can occur unless it finds a "mate" in the internal object relations of the analyst. I recognize that this is the juncture at which some authors, like Jacobs (1991) or McLaughlin (1981, 1988) might become aware of stories in their lives that dovetail with the patient's story. While I have the conviction, one that I hope I convey to my patients, that my experience in the analytic process reflects directly on my own history even as it may shed light on something in theirs, my attention does not necessarily gravitate toward specific details in my childhood that complement or parallel those in the patient's experience. Instead, my focus, to the extent that it is on myself, often stays on my own immediate experience as it relates to the patient's immediate experience and to the patient's history. Of course my experience outside of the analytic situation is often affected by the patient and that part of my life automatically comes under scrutiny as an aspect of the countertransference (Feinsilver, 1983, 1990). In this instance, the Institute affiliation, whatever its intrapsychic-historical meanings for me, parallels the patient's relationship with her father.

There is a difference here that surely has as much to do with personality as it does with a chosen approach (*cf.*, Jacobs, 1991, p. 44). Nevertheless, whatever its benefits, I would think that attention to the specific historical bases for the countertransference may sometimes detract from struggling with the nuances of the immediate experience with the patient, particularly in a way that involves the patient directly. It is important to remember that within a given psychoanalytic hour the process is continuous and the analyst is continuously called upon to respond without the benefit of being able to call "time out" to reflect on his or her past. The clinical experiences reported by Racker back in the 1950's and in recent years by Gill, Ehrenberg, Donnel Stern, Mitchell, and others illustrate intensive work on the transference and the countertransference with the patient in the here-and-now without reference to particulars in the analyst's

personal history. However, over the course of an analysis, an integration of the kind of reflection that these authors describe in their work and the kind described by Jacobs and McLaughlin would probably be ideal.

All that I have said serves partly as introduction to the following episode in my work with Diane. I think the episode illustrates further the way therapeutic action can be born of the dialectical interplay between analytic discipline and personal participation and between formal analytic authority (which operates silently in the background) and an atmosphere of spontaneity and mutuality.

We were in the third year of the analysis. An aspect of the transference that was becoming increasingly prominent was the patient's demand for a kind of maternal preoccupation with her needs, one which the patient felt her mother reserved for the patient's younger sister Louise at the patient's expense. In fact, it was possible to understand some things that happened in the analysis as a demand that I be consumed with anxious worry about the patient's well-being to the point of being frantic, "hysterical," or "crazy," just as the patient's mother seemed to be about Louise from the time of her birth when the patient was about two years old. Allegedly, Louise was an abnormally small, sickly, and vulnerable infant. Implied suggestions by me that Diane could function at a high level without feeling overwhelmed when she was hurt or disappointed about something were often associated in Diane's mind with the mother's underestimation of Diane's difficulties and overestimation of Louise's needs. The problem was compounded by the fact that because Diane felt she had been so intensely jealous of Louise and so hostile toward both her and her mother, she also felt that she herself had been an unlovable, greedy, ungrateful, and even hateful child, and she hated herself for it. The derivative of this in the analysis was that she often felt she was an impossibly difficult patient and that I wanted to be rid of her.

After a recent move to a new apartment, the patient became obsessed with a noise she could hear from a garbage chute ad-

jacent to her new residence. An advanced medical student going through a stressful rotation, Diane suddenly could not sleep or study. She was beside herself with anger and anxiety. In addition to recognizing the manifestly disturbing nature of the noise, we explored various meanings that it may have had within and outside of the transference. Among other things we understood that the patient was reacting to it just the way she thought her father would under similar circumstances, with total, half-crazed preoccupation and furious intolerance.

One morning the patient called asking for an appointment early in the day rather than her regular late afternoon time. I could not arrange it, however. When she came in at her regular time, she announced in the waiting room, as soon as I opened the door: "I'm here for one reason and one reason only, and that is to get some Valium. If you can't help me get some, I might as well leave right now!" Nevertheless, she grudgingly trudged in. She knew, of course, that I am a psychologist, but there must be someone I knew to whom I could refer her for medication if not get it directly from that person myself. She much preferred the latter alternative because she did not want to go through the ordeal of having to see someone for an evaluation, a solution that I also thought would be too burdensome under these circumstances. She was just so agitated she had to have something *now* to help her relax, sleep, etc. We could worry about what it all meant later. In the meantime she had to go to work, she had to attend classes, she had to study. What did I care about more, her well-being or my analytic purity? Was I worried about what people would think, or about what she really needed? I tried to maintain a "proper" analytic attitude toward all this, pointing out, among other things, that even if it were true that some sort of tranquilizer might help right now, the idea that she had to get it from *me* was irrational considering the many other resources she had. So the demand that *I* give it to her must represent something else, something very important, but to get her a pill might obscure more than it would clarify what that need was. She would have none of this, except in the

most intellectual sense, and persisted relentlessly in her demand that I address the issue at face value.

Now let us consider the position of the analyst at this juncture. What kinds of options do I have and how should they be conceptualized? Do we take for granted that as an analyst I am restricted to trying to explore the meaning of the patient's behavior? I think that most of our theories of the process do take this position. If the patient reacts with frustration and anger, so be it. Those are precisely the affects that need to be understood analytically. Those are the states, allegedly, that are most clearly reflective of the patient's internal dynamics without excessive influence from the analyst. If we take the view, however, that the analyst is always implicated in "constructing" whatever the patient experiences, and that insisting on playing it by the rules can be as provocative as deviating from them, the door is opened to consider other ways of interacting. Also, now the analyst has to struggle with a sense of uncertainty, risk, and responsibility for whatever he or she elects to do (Hoffman, 1987, 1991; Mitchell, 1988, 1991; Moraitis, 1981, 1987; Stern, 1983, 1989). I believe that this struggle, one that is located within the dialectic of spontaneous expressiveness and technical rigor, has, in itself, great therapeutic potential. It is at the heart of what it means to be a new, good object because it is the most open to the multiple potentials within the patient and the analyst.

So what ensued with Diane was the following. Under the patient's pressure and out of my own need and, perhaps, intuition, however "implicit" (Gendlin, 1973), "unthought" (Bollas, 1987), or "unformulated" (Donnel Stern, 1983), I asked Diane whether she had an internist whom she could ask for a prescription. She said she did but was not so sure how he would feel about it since she had not been in for a check-up in a long time. I said, "Well, if you give me his number I'll call him right now." She replied, "Really?!" sort of delighted and floored at the same time. She gave me the number, and I called. While I waited for the doctor to come to the phone, Diane began whispering in an animated

way, "This is crazy; I could get a friend to do this; I could do this myself." She was smiling but seemed somewhat embarrassed. I thought of hanging up just as her doctor picked up the receiver, but decided to go through with it. I identified myself and said I thought it would be okay if the patient called that she be given some mild tranquilizer. He said, essentially, that it was no problem and that Diane should call him. After I hung up, the patient and I started to talk and she was receptive for the first time to exploring the meaning of the whole transaction.

Now let us stop again and think about what went on. Why is the patient suddenly freed of the grip of her own compulsion to force our interaction into a particular mold? Why is she suddenly able to get out of the prisonhouse of projective identification? Ogden (1986) has described projective identification and the alternative to it in terms of dialectics:

> Interpersonally, projective identification is the negative of playing; it is the coercive enlistment of another person to perform a role in the projector's externalized unconscious fantasy. The effect of this process on the recipient is to threaten his ability to experience his subjective state as psychic reality. Instead, his perceptions are experienced as "reality" as opposed to a personal construction. This process represents a limitation of the recipient's psychological dialectical processes by which symbolic meanings are generated and understood. Neither the projector nor the recipient of the projective identification is able to experience a range of personal meanings. On the contrary, there is only a powerful sense of inevitability. Neither party can conceive of himself or of the other, any differently or less intensely than he does at present (p. 228).

In the work with Diane, I think that the key is to think, again, in terms of reversal of figure and ground. What is in the foreground is the way the patient, as she enters the office, is aggressively and unreflectively shaping the interaction. She is saying, in effect, "This is who I am and this is who you are when you are with me. It's the bottom line and there are no options." What is in the background, however, is a projective identification that

originates with *me*. Because to the extent that I am uncritically committed to exploring the meaning of the patient's experiences at every turn, it is I who am saying to her: "This is who I am and this is who you must be when you are with me. Me analyst, you analysand! Those are the terms. Take them or leave them." It is a case of tyrannical father locking horns with tyrannical father. So when I say, "I'll call your internist right now," I am saying, "Look, there is nothing sacrosanct about this way of being in the relationship. You and I together have other potentials that we can realize." I am also saying; "I may *resist* your demands and I may not be sure what is in your best interests, but I'm confident that for me to yield to *some* of those demands will not kill me. I can find a way to yield that is also expressive of my own will." In this instance my "yielding" involves an initiative on my part that has an aggressive component, a kind of calling the patient's bluff that takes her by surprise. The patient, in turn, is out from under her sense of submission to the requirement that she do it *my* way and can now freely find *within herself* an interest in doing it that very way, that is, in reflecting and analyzing and seeing her role in shaping the interaction. The episode conforms to the formula stated simply by Benjamin (1988), drawing on Winnicott: "When I act upon the other it is vital that he be affected, so that I know that I exist—but not completely destroyed, so that I know that he also exists" (p. 38; see also Fourcher, 1975, p. 417).

All this is happening with the ritually based power of the analyst operating silently in the background to give the moment of mutual recognition and responsiveness the intensified impact that it must have to stand any chance of overcoming the profoundly damaging effects of those early object relations in which domination of the other or masochistic submission seemed like the only alternatives available (Benjamin, 1988; Ghent, 1990). When the patient reacts to my getting on the phone, it matters that it is I, the analyst, who is doing this, a person who occupies a special position in the patient's mental life. Again the asymmetrical and hierarchical aspects of the arrangement provide

the backdrop, the element of idealization, that gives such moments of mutuality, cumulatively, their power to affect deeply entrenched and longstanding patterns of internal and external object relations (*cf.*, Berger and Luckmann, 1967).

When the patient starts whispering while I am waiting for her doctor to come to the phone, "This is crazy, I could do this myself," I go through with the call. Why? Maybe it is a bit of playful tit for tat, as if to say, "You tortured me for a half hour, now it's your turn." The aggression on my part borders on a frame violation, a piece of acting out, perhaps, retaliating for the patient's challenges to the frame, challenges that may have carried particularly aggressive implications in light of Diane's knowledge of my status as a candidate (Perl, 1993). Nevertheless, the playful aspect of the exchange reflects our entry into a new kind of transitional space. Also, the shift that I make reflects my movement from one stance to the other, which, in turn, demonstrates the element of uncertainty and struggle that I am suggesting is a central component of the therapeutic action.

So, to continue with the story in the clinical situation, exploration of the meaning of this episode continued sporadically over several weeks of work, and a number of important insights emerged. In the first place Diane acknowledged that she had been very angry because I could not see her earlier in the day. She said, smiling, "Really, I don't ask for that much. Was that too much to ask?" I said, it was one thing to ask and another to be enraged if I could not arrange it, something she undoubtedly recognized herself; otherwise, I said, she would have come in angry about *that* rather than about my anticipated reluctance to get her Valium. She needed something to help legitimize what she recognized as childish: the demand that I see her whenever she wanted to see me.

This demand was linked to another very important issue, another bit of enactment that we had not sufficiently examined because it had been so emphatically presented as a reality issue. I pointed out that the obsessional preoccupation with the noise in her apartment had, in fact, been associated with quite a few

phone calls, not just the one mentioned. This was interesting in light of the fact that during that month we had been meeting only three times per week because the patient insisted she could not make the fourth hour due to her hectic schedule. I had agreed to this most reluctantly and "under protest," with the understanding that we would continue to search for a mutually agreeable fourth hour. Now the patient admitted, much to my surprise, that she actually felt that I had given in "too easily." She expected me to put up more of a fight. Here, as in the case of the demand for Valium, the sense of necessity that characterized the transference demand (we must cut down to three times per week) is undone when the sense of necessity in the countertransference (we must meet four times per week) is undone. She agreed that it was a no-win situation for me (and her), in that if I had been more rigid about it, she would have thought I was doing merely what was best for *me*, at her expense. But the fact was that now she thought I was just relieved to not have to spend so much time with her. She figured that she was as annoying to me as the garbage noise in her apartment was to her. Or, from another point of view, she felt deserted, left alone to cope with all her miseries, condensed symbolically into the sound of the garbage in the chute. The whole sequence recreated the patient's experience with her mother who, for example, was all *too* ready, the patient felt, to stay home (in a distant suburb) and not come to visit if the patient said that she was busy and that it was not a convenient time. Shortly after this, incidentally (and for the record), we resumed meeting four times per week and continued on that basis to the end of the analysis about three years later.

With regard to my calling the internist, the patient said she really liked that and appreciated it because it meant I had become "a little crazy," which somehow meant I understood something about her own sense of desperation at times. This meant both that I sensed her desperation and wanted to do something for her and that I felt desperate myself and was willing to show it, if only temporarily. The enactment helped me and the pa-

tient to begin to see how much she wanted me to be frantic about her in a way similar to how she thought her mother was frantic about Louise, the difference being that my "getting hysterical" was also an object of curiosity and critical reflection. Thus there was reason to believe that the quality of my attention, taken as a whole, was better than what either the patient or Louise got from their mother.

CONCLUSION: OEDIPAL AND PREOEDIPAL DIALECTICS AND THERAPEUTIC ACTION

When the patient makes her aggressive demands for an earlier session, for Valium, for cutting back the frequency of our meetings, and for direct "help" with her life, one might say that she is threatening to "destroy" the analyst-object, and I am in a position of having to decide how far I should go in defending that part of myself that is under fire. It is, of course, only a part of myself. It is not even the part of myself that I would designate as my "true self," not entirely anyway. In working with this patient some part of my "true self," I would say, wants to abandon the standard analytic position even while another part wants to hold on to it. Conversely, despite her protests to the contrary, there is a part of the patient that does not want to lose me as her analyst, as the person with a unique, encompassing perspective, special expertise, and special power to affect her life.

One could translate this situation into oedipal terms and say that the patient (like any patient?) has an investment in my remaining "wedded" to the Institute, to the Book, and to analytic principles, including the principle of abstinence that helps protect my capacity to subordinate my own personal responsivity and immediate desire to the patient's long-term interests in the course of the work. Even as she attempts to lure me away from that marriage, capitalizing, perhaps, on points of vulnerability in it that she detects, she knows at some level that such

an oedipal triumph would be a pyrrhic victory. In that respect, she would rather that, in the long run, her assaults on that part of me not succeed. She would like to win a few battles, perhaps, but not the war. In the last analysis, the child wants to love and be loved by both parents (or their surrogates) and to feel that the parents love each other. Similarly, the patient's deepest need is for the synergy of my personal involvement and the relatively detached, theoretically informed, and interpretive aspect of my analytic attitude.

Abstracting further, to a level that encompasses preoedipal as well as oedipal issues, the "triangle" consists of the patient, the analyst as one who is preoccupied with responding to the patient's immediately expressed desires, and the analyst as one who has other narcissistic and object-related investments. Just as a parent's investments in other objects of interest are inextricably linked to the parent's abstaining from engulfing emotional or incestuous involvement with the child, so too is the analyst's attachment to other objects, including psychoanalytic theories and the "Book of Abstinence" itself, linked to the analyst's avoidance of excessive, suffocating personal involvement with his or her patients. The patient, in turn, although he or she may seem to try to destroy the analyst as a separate subject—which means forcing a collapse of the analyst's internal dialectic—also has a vital interest in the analyst's survival. Here we return to the *patient's* ambivalence. The tension within the analyst has its counterpart in a similar tension within the patient. The patient, like the analyst, has an aspect of self that is preoccupied with the other and a side that excludes him or her and has other interests, narcissistic and object related. In effect, the patient as a whole person cannot survive, much less grow, unless both of these aspects survive and grow together in a dialectical relationship, one that has its counterpart in a complementary, living dynamic tension within the analyst. The tolerance of the tension within each participant goes hand-in-hand with tolerating and nourishing the creative potentials of the tension in the other (*cf.*, Benjamin, 1988).

As the analyst, I cannot know just what balance I should strike at any given moment between my own conflicting allegiances and inclinations. Indeed, relevant aspects of my own conflicts at any given time are likely to be unconscious. In fact, analytic therapists in general can safely assume that they do not have privileged access to their own motives, nor are they able, despite their advantageous position, to know exactly what is best for their patients. That is why the attitude that is the most integrative and authentic must be an alloy of doubt and openness (Hoffman, 1987). At any given moment the sense of uncertainty might be in the background, as the analyst engages in one or another mode of relating with a good deal of conviction (Hoffman, 1992b). Moreover, whatever the analyst does, we must not forget, in our enthusiasm about "the meanings and uses of countertransference" (Racker, 1968), that his or her influence has real impact in real time. It is not merely a bit of manifest content, like that of a dream, that stands in need of interpretation (although it certainly is that too). There is a dialectic between the analyst's participation understood as figurative (or symbolic) and the same participation understood as literal (or actual) and as consequential in the patient's life (Hoffman, 1992c). In either case, the work requires an underlying tolerance of uncertainty and with it a radical, yet critical kind of openness that is conveyed over time in various ways, including a readiness to soul-search, to negotiate, and to change.

The bad object that is lurking in every analytic situation is the one that pulls either of the participants into absolute commitment to one side of his or her conflict (for example, the side that wants to analyze) with the result that the other side (for example, the side that wants to respond in a more spontaneous, personal way) must be abandoned and repressed. The good-enough parent maintains a balance among investments in each child, in spouse (or others), and in self. He or she recognizes the inevitable tensions among these interdependent yet rivalrous attachments but does not abandon any of them. The quality of the attention to the child (and to each of the others), moreover,

respects and *fosters* the same kind of balance and tolerance of tension within him or her. Similarly, analysts, through their capacity to uphold both sides of multiple polarities, can combat the threat of the "single-minded" bad object in themselves and in their patients and create the basis for new experience. Thinking dialectically can be a powerful expression, in itself, of the analyst's struggle to come to grips with the complexity of the patient's multiple aims and potentials as they interface with the analyst's own. Potentiated by the ritually based mystique and authority of the analyst's role, that struggle assumes a position that is at the heart of therapeutic action in the psychoanalytic process.

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THE CONCEPT OF INTERPRETIVE ACTION

BY THOMAS H. OGDEN, M.D.

Interpretive action is understood as the analyst's use of action (other than verbally symbolic speech) to convey to the analysand specific aspects of the analyst's understanding of the transference-countertransference which cannot at that juncture in the analysis be conveyed by the semantic content of words alone. An interpretation-in-action accrues its specific symbolic meaning from the experiential context of the analytic intersubjectivity in which it is generated. The understanding of the transference-countertransference conveyed by the analyst's interpretive action must simultaneously be silently formulated in words by the analyst. Three clinical vignettes are presented which illustrate different forms of interpretation-in-action.

> We say ourselves in syllables that rise
> From the floor, saying ourselves in
> speech we do not speak.
>
> WALLACE STEVENS (1947)

At this point in the development of psychoanalytic thought, it is generally accepted that action (other than verbal symbolization) constitutes an important medium through which the analysand communicates specific unconscious meanings to the analyst, for example, through the actions mediating projective identifications (Ogden, 1982; Rosenfeld, 1971), "role responsiveness" (Sandler, 1976), "evocation by proxy" (Wangh, 1962), "enactments" (McLaughlin, 1991), and so on. However, it has been very little recognized that many of the analyst's most critical transference interpretations are conveyed to the analysand by means of the analyst's actions. It is this aspect of the analytic

process, the analyst's "interpretive actions," that will be the focus of the present paper.

By "interpretive action" (or "interpretation-in-action") I mean the analyst's communication of his or her understanding of an aspect of the transference-countertransference to the analysand by means of activity other than that of verbal symbolization.[1] At times such activity is disconnected from words (e.g., the facial expression of the analyst as a patient lingers at the consulting room door); at times the analyst's activity (as medium for interpretation) takes the form of "verbal action," (e.g., the setting of the fee, the announcement of the ending of the hour, or the insistence that the analysand put a stop to a given form of acting in or acting out); at times interpretive action involves the voice, but not words (e.g., the analyst's laughter).

The significance of interpretive action lies in its capacity to convey to the analysand aspects of the analyst's understanding of unconscious transference-countertransference meanings when they cannot be communicated to the patient in the form of verbally symbolized interpretation alone. Of course, an action in itself (in isolation from a matrix of intersubjectively generated symbols) is without meaning; an interpretive action acquires specific meaning from the way in which it is generated within the context of the experience of analyst and analysand in the "intersubjective analytic third."

I have discussed my conception of "the intersubjective analytic third" (or "the analytic third") in a recent series of papers (Ogden, 1992a, 1992b, 1994a, 1994b). In brief, I view the analytic experience as a process in which a new subjectivity is created. This new subjectivity (the intersubjective analytic third) stands in dialectical tension with the individual subjectivities of analyst and analysand, who are engaged in a mutually creating, negating, and preserving form of relatedness. The analytic third

[1] In this paper, the notion of interpretation will be used to refer to a "procedure [which] . . . brings out the latent meaning in what the subject says and does" (Laplanche and Pontalis, 1967, p. 227).

is not conceived of as a static entity, but as an evolving experience that is in a perpetual state of flux as the intersubjectivity of the analytic process evolves and is transformed by the understandings (interpretations) generated by analyst and analysand.

At the same time that the intersubjective analytic third is created by the dialectical interplay of their two subjectivities, analyst and analysand (*qua* analyst and analysand) are, in turn, created by the analytic third. In its absence, there is no analysis and therefore no analyst or analysand, merely two people in a room together.

The analytic third is experienced through the individual subjectivities of analyst and analysand; therefore, the experience is not identical for each. However, the experience in and of the analytic third constitutes the intersubjective matrix of meanings in which all analytic understanding is grounded.

In this paper I am focusing not on the conveying of affect or the creation of a mutative emotional "climate" (Balint, 1968, p. 160) or "atmosphere" (*ibid.*) through the analyst's actions; rather, my focus is on the use of action as *an interpretive medium* through which the analyst conveys specific aspects of his or her understanding of unconscious transference-countertransference meaning. There has been considerable discussion of the analyst's actions (other than verbal interpretation) as agents for therapeutic change (see, for example, Alexander and French, 1946; Balint, 1968; Casement, 1982; Coltart, 1986; Ferenczi, 1920; Klauber, 1976; Little, 1960; Mitchell, 1993; Rosenfeld, 1978; Stewart, 1990; Symington, 1983; and Winnicott, 1949). However, the idea of the analyst's actions as a medium for the interpretation of the transference-countertransference has been very little explored. Contributions by Coltart (1986), Rosenfeld (1978), and Stewart (1977, 1987, 1990) have discussed the impact of the analyst's actions in ways that overlap with my own conception of interpretive action. However, the emphasis in these latter papers is on the use of the analyst's actions in the service of (re-)establishing conditions in which analyst and analysand might reflect on the events (often an acting out or

acting in) that have been occurring in the analysis. In contrast, my own focus is on the analyst's actions as an interpretive vehicle for conveying to the patient specific aspects of the analyst's understanding of unconscious transference-countertransference meanings, an understanding derived from the analyst's experience in and of the analytic third.

I shall attempt to frame the discussion of the concept of interpretation-in-action in such a way that it does not fall prey to forms of reductionism that are regularly so large a part of the discussion of the question of whether interpretation or object relationship is the greater (or exclusive) therapeutic agent in psychoanalysis. I take it for granted that interpretation is a form of object relationship and that object relationship is a form of interpretation (in the sense that every object relationship conveys an aspect of the subject's understanding of the latent content of the interaction with the object).

I shall attempt to illustrate the importance of the way in which aspects of the interpretive process take the form of symbolic action, and the ways in which these forms of interpretation are drawn from experiences in and of the analytic third. To this end, I shall offer three clinical vignettes, each of which highlights a different aspect of interpretive action. In selecting this clinical material, I have made an effort to offer illustrations of the everyday and commonplace in analytic practice. Interpretive action is not an exceptional analytic event, but simply part of the fabric of ordinary interpretive work.

CLINICAL ILLUSTRATION 1

Silence as Interpretation of a Perversion of Language and Thought

Dr. M, an English-born research scientist in her early forties, entered analysis because she was experiencing overwhelming anxiety that she would lose her job and "end up disgraced and in the gutter." She feared that it would be discovered that for

years she had been getting by at work by "piecing together" bits of advice and information gleaned from conversations with her colleagues. Her entire career felt like a sham that was in imminent danger of unraveling.

In the years preceding the beginning of analysis, the patient had been twice married (and twice divorced), both times to men who were from socially prominent families and who she thought were extremely handsome. The patient felt no arousal of her own during sexual activity, but took great pleasure in the power she experienced in arousing her husband to a great pitch of sexual excitement. Having succeeded in doing so, she would then consciously imagine that she was stealing his erect penis in the act of intercourse. In this fantasy, Dr. M silently observed the scene from a great psychological distance. Proof of the intensity of her husband's sexual excitement was so critical a part of intercourse for her that she would encourage her sexual partner to physical extremes, once leading her second husband to accidentally fracture one of her ribs.

In the initial year of the analysis, Dr. M, at the end of each meeting, would tell me that she would see me the next day and name the specific time of our meeting. This was done with the conscious intention of reminding me that we had a meeting scheduled for the following day and what time that meeting was to begin. This "reminder" (an unspoken accusation that I might forget) served as a powerful way of provoking anger in me. The patient held the conscious conviction that causing me to become angry was one of the few ways she had of eliciting interest in her, or even memory of her.

As the analysis proceeded, it became increasingly apparent that Dr. M did not speak for the sake of reflecting on her internal life, or of commenting on present or past experience. She seemed to have virtually no interest in anything that she might think, feel, or say. The act of talking seemed to serve only one function: to get *me* to talk. When I pointed this out to Dr. M, she, without hesitation acknowledged that this was so. The patient felt that the only events in the analysis that held any importance

for her were the interventions I made, whether they be confrontations, interpretations, or clarifications. Even my questions were felt to be of value because they reflected the way I thought and what I considered to be important. The patient kept a journal in which she recorded the events of every meeting. Years later, she told me that she wrote down only what she could remember of what I had said, without a single reference to any of her own thoughts or comments. I experienced Dr. M's ready confirmation of my interpretations as maddening; her unswerving, unreflective matter-of-factness served as still another manifestation of her exclusive interest in ferreting out my thoughts and comments.

Over time, I was able to interpret that the patient felt it was impossible for her to create anything of value and that this belief led her to behave as if the entire worth of the analysis lay in me. Moreover, the patient's fantasy of the analytic process involved a vision of her passively absorbing my internal strength through the ideas and feelings that I conveyed to her. She readily concurred that this was what she wanted and expected from analysis.

A history was presented in bits and pieces over several years. Dr. M told me about childhood memories and fantasies in a way that suggested that the information was being given to me in order for me to help her with her difficulties while she remained utterly passive. In other words, these were not memories upon which she reflected, or about which she experienced curiosity; rather, they were data handed over to me for the purpose of my making sense of them and interpreting them for her.

Dr. M reported having had conscious childhood fantasies in which her idealized father (described at times as "wonderful" and at other times as depressed, withdrawn, and utterly dominated by his wife and his mother) was felt to be the sole source of her value and strength. However, this strength was borrowed and could only be held briefly, never becoming the patient's possession in any permanent, integrated way. As a child, Dr. M developed a compulsively repeated form of "play" in which slips

of paper, paper clips, bottle caps, etc., were distributed in hiding places around the house and were used to represent "spells" that had been given to her by her father. Each spell would provide her with a particular form of power, for example, the ability to run fast in a given fantasized race, to act bravely in the face of a specific danger, to demonstrate intelligence at a key moment, etc. The temporary and unintegrated nature of the "internalization" was reflected by the fact that the fragments of the father's power were named "spells," i.e., magical, externally generated ego-dystonic forces.

Dr. M, the middle of three children, experienced her mother as hatefully withholding love for her while generously bestowing it on her brother and sister. The patient was thought to be mentally retarded by her first grade teacher, who suggested to her parents that she undergo psychological testing. Although the tests revealed that the patient was of superior intelligence, she showed no signs of being able to read until she was in the third grade. (The patient had in fact learned to read in the second grade, but took pleasure in keeping this knowledge secret.)

For the sake of brevity, I shall describe what I came to understand in the course of the succeeding several years of work with Dr. M, without providing a detailed account of the analytic process within which this understanding developed. The patient seemed to experience my interpretations (and everything else I said) as "spells," magical acts through which idealized (and at the same time, denigrated) internal contents were momentarily lent to her, only to be immediately exhausted, leaving her as empty and impotent as before. Dr. M attempted to conceal the joy and excitement with which she received an interpretation in order to hide her feeling that she had succeeded in deceptively extracting, stealing, wooing, seducing, it from me. She feared that if I were to sense the quality of her satisfaction and excitement, I would understand how desperately dependent on me she was, and would be either revolted and frightened by the enormity of her greed, or would sadistically torment her, holding her hostage forever while stealing her money (her life) from her.

At the same time, Dr. M resented the borrowed/stolen magical internal objects acquired from me. She regarded me as hateful for tantalizing her with these borrowed/stolen objects while remaining unwilling to release her from her dependence on me. She experienced me as cruelly refusing to recognize her strengths (e.g., a sense of humor) other than those borrowed from me. Dr. M's angry attacks on the introjected parts of me (my interpretations) helped to establish a vicious cycle in which she remained unable to learn or to make use of anything I might say. (Each aspect of this form of relatedness and the underlying fantasies were fully and repeatedly interpreted and received by the patient in the way I have described.)

I came to view Dr. M's use of interpretation as a form of perversion in which she compulsively and excitedly transformed each of my interpretations into an eroticized magical spell. (Only much later in the analysis did the patient become fully aware of the nature of the excitement she felt in receiving an interpretation, which she described as being "like an electric charge through me that makes my body tingle." Eventually, she recognized this feeling to be a form of sexual excitement.)

I understood the patient's use of my interventions as an unconscious attempt to create a sense of a living self from the borrowed/stolen contents of her parents. Even interpretations concerning her use of interpretation (i.e., interpretation of the transference "in terms of *total situations*" [Klein, 1952; see also Joseph, 1985, and Ogden, 1991]) were immediately incorporated into the perverse drama. In other words, every attempt I made to interpret the patient's use of my talk for the purpose of bringing herself to life was in turn transformed by the patient into still another scene in the drama.

It took me quite some time to fully appreciate the extent to which this form of relatedness prevented Dr. M from generating a single original thought in the analytic discourse. I had underestimated the extent of the patient's paralysis of thought. My blindness to this aspect of the therapeutic interaction resulted in part from the fact that Dr. M described her experience in a way

that often gave the appearance of insight and self-reflection. She was extremely attentive to certain kinds of detail about the analytic setting, for example, noticing if the cushion on my office armchair was rumpled in a way that suggested someone had been reclining in it in a manner she had not seen before: "There must have been a new female patient 'lounging' seductively in your chair." Such fantasies at first seemed rich, but over time it became clear that the patient's fantasies were restricted to a single theme with slight variations: she imagined a continual party going on in my interpersonal life (e.g., my amorous relationship with my wife, my romantic and intellectual enjoyment of my patients, my flirtations and affairs with supervisees, etc.) and in my internal life (the interesting and insightful thoughts I had and the richness of my creativity).

In the course of the first five years of analysis, Dr. M made substantial progress in several aspects of her life. For instance, she developed the capacity to learn in an academic setting, thus allowing her for the first time to engage in research activity that reflected her own ideas. She made great strides in becoming a successful, creative, and respected member of her field. Her capacity to make decisions and manage her life improved dramatically. However, her capacity to develop relationships with both men and women remained stunted. The satisfaction she derived from the interpersonal aspects of her work made her aware in a new way of how unable she was to develop either romantic relationships with men or close friendships with women. Despite the fact that Dr. M had developed the capacity to experience sexual excitement that she felt to be her own, and was able to experience orgasm for the first time in her life, she was unable to have intimate, exciting relationships with men whom she liked and respected.

Dr. M had become aware of her loneliness in a way that she described as "agonizing." She could now more fully experience and observe aspects of the central conflict constituting the transference-countertransference: she felt unbearably lonely and desperately wanted to "let me in," but at the same time felt so

enraged at me for my "unwillingness to help" her (i.e., to think for her) that she vowed she would never allow herself to submit to me by treating me as a "real person." At times she said she felt so furious at me that she was genuinely surprised that none of my patients had yet murdered me.

Despite the psychological changes that had occurred in some areas of the patient's life, perversion of the interpretive process continued in the analysis and resulted in the foreclosure of a generative discourse of a sustained sort. When such discourse would briefly take place, it was invariably followed by weeks or months of withdrawal on the part of the patient into an intensified attack on the analytic discourse through enactment of a now consciously fantasied "arid" discourse/intercourse involving a tantalizing and ultimately powerless father and an untouchable mother. Dr. M observed this lifeless discourse/intercourse from afar in her role as excluded and excited child, pretending not to understand what she was seeing (her "pseudo mental retardation").

In a meeting during this phase of work, I offered an interpretation concerning this sequence of engagement and anxious withdrawal. Dr. M responded with a series of questions about my interpretation: Did I feel this was something she did every time she came into the room with me? How could she prevent herself from withdrawing in the way that I described? Did I think she had done this from the beginning of the analysis, or was I referring only to the current meeting or perhaps to the last few meetings? At this point I felt an emotional shift that led me to respond differently from the way I had previously. Instead of experiencing anger, I felt sadness and a deep sense of despair. This transference-countertransference shift contributed to my decision to embark on a course of interpretation conveyed largely in the form of action.

I met each of the patient's questions with a form of silence that both the patient and I experienced as having an unmistakably different quality from previous instances of silence. The silences in the current hour were filled with an intensity of feel-

ing which served as an interpretation that could not have been made in words because of the perversion of language and thought that was being enacted in the analysis. This new form of silence constituted an interpretive action, an interpretation that was not comprised of words and therefore lay to some degree outside the domain of the power of the perverse transformation of language. In the transference-countertransference, the perversion involved my playing the role of the idealized/impotent father while the patient predominantly identified with the impenetrable mother and the hidden, observing, envious, excluded, over-excited child.

The silences under discussion were intended to convey an understanding that had been developed and presented to the patient many times in the course of the analysis, but which until now had been immediately and systematically transformed and rendered ineffectual as the patient incorporated them into the next scene of the perverse drama. The meanings conveyed by my deliberate silence (which meanings I articulated for myself) included the idea that the patient knew full well that her questions were not offered as part of a discourse in which she was attempting to develop greater self-understanding for purposes of psychological growth; rather, her questions represented an angry accusation that I was hatefully excluding her from the riches of my internal world (in the maternal and paternal transference) which she wished to plunder and hoard, and, at the same time, enviously to attack and spoil. She also knew that if I were to answer her questions, she would feel momentary relief in possessing a part of me (one of my spells), but that relief would almost immediately turn to fury. Her anger reflected her feeling that I was forcing her to become enslaved to me by preventing her from developing the capacity to create thoughts, feelings, and sensations that she could experience as her own.

Dr. M's initial response to my silence (interpretation) was to fire at me more and more angry, provocative questions. She then shifted to a series of affectless descriptions of current events in her life, as if attempting to comply with what she felt

was a demand on her to conduct the analysis by herself without any help from me. My sadness and despair continued, increasingly accompanied by a deep sense of loneliness. I could feel the futility of the patient's frenzied thrashing about. For the first time, I was not at all convinced I could help her.

Dr. M began the next hour by announcing that she was having great financial difficulties and would have to diminish the frequency of our sessions from five to four meetings per week. This represented a rather transparent provocation in an effort to extract words (spells) from me. I felt that any effort that I might make at interpreting her anger and feelings of isolation in conjunction with her efforts at extracting spells from me would simply perpetuate the perverse drama. Consequently, I chose to interpret with silence, despite the danger that I might be exchanging one form of perverse drama for another, i.e., reversing the roles in a sadomasochistic relationship and further intensifying the patient's (and my own) feelings of isolation. I also for the first time considered the possibility of the patient's committing suicide. Again, the silence was meant to convey my sense that the patient could make an interpretation of the transference for herself and that her not doing so reflected a form of perversion of language and thought which was currently being enacted between us. The value of the silence as interpretive action would be measured by the degree to which it served to expand analytic space. In other words, would the silence facilitate the capacity for symbolization of conscious and unconscious experience (enrich the "dialectic of modes of generating experience" [Ogden, 1989]), or would the silence foreclose the use of symbols, reducing the analytic interaction to a series of reflexive evacuations of unmediated experiences of isolation (that the patient was not yet capable of experiencing as sadness)? Intermittently during this period, I told Dr. M that I thought we both knew that my thinking for her would create the illusion of analytic work, but that nothing could come of repeatedly and endlessly substituting my thoughts and feelings for what might become her own capacity to think and feel. This was an idea that

I had discussed with her many times over the previous years. Nonetheless, I felt that it was important that I continue to present to her my understanding of my reasons for conducting myself in the analysis in the way that I was (Boyer, 1983).

A meeting several months later was unique, in that silence as interpretive action became the principal context for, as well as the content of, the meeting. Dr. M experienced in a much fuller and clearer way than she had at any previous time in the analysis the elements of the internal conflict that to this point had been given shape almost exclusively in the form of the perversion of language and thought that has been discussed. Dr. M talked about events in her current work life that were undergoing change for the better as a result of her ability to experience herself as a person who had the right to speak and behave as an authority, as someone who could think and speak her own thoughts. She interrupted herself by saying, "Okay, I've wanted a response from you at every moment today. I *am* curious about why I need to hear your response to every single one of the sentences that I utter."(In a previous meeting, I had asked Dr. M whether she had felt curious about her behavior in a situation that she was describing.) After three minutes of silence, the patient again protested that she could not think—she could sleep, but she could not think. I was interested by her reference to sleep and (silently) wondered if she had begun to be able to remember her dreams. She had reported very few dreams to this point in the analysis, and those she had reported were presented either with no associations at all or with mechanical imitations of associations.

Dr. M went through her usual maneuvers in an effort to get me to talk, but there was something subtly different about her that I could not name. In the middle of the meeting, she looked around the office without turning on the couch to look at me, and asked, "Have you changed your office?" I made no reply. "It looks like it's been moving laterally. The cracks on the wall have gotten bigger. What do you think?"

Despite the fact that half of her sentences were questions, she

did not seem to expect or demand any response from me. More important, there was something quite imaginative and humorously self-mocking in what she was saying and in the way she was saying it. Her sense of the change in our relationship was being described in the physical-sensory experience of change in the analytic space—there was movement occurring in the present moment that had the quality of a "lateral" movement (a pun on "literal" movement) in the analytic space and of decrease in the density of the barriers to reflective discourse (the widening cracks in the wall). To have offered my understanding of the meaning of these comments would have usurped the beginning of Dr. M's capacity for imaginative thought, and most likely would have caused her to return to a perverse dependence on me as the source of all that is good and valuable.

Dr. M began the following day's meeting by saying that she had had a dream the previous night. When she awoke from it in the middle of the night she considered writing it down, but felt that it was so vivid that she could not possibly forget it. She said that she was now unable to remember anything of the dream.

I said that it seemed she had begun to think in her sleep, but was anxious about the prospect of thinking in my presence. She said she was certain that the dream was about being unable to think, but did not know why she felt convinced of this. Dr. M went on to say that she was losing weight and was approaching a weight where she "loses her breasts." (I felt she was accusing me of willfully shrinking my own breasts so that there would be no milk for her. I imagined that she felt that both of us would rather starve to death—kill the analysis—than give anything—or lose anything—to the other.) Dr. M added that she was certain that I had not noticed her weight loss. The session was filled with angry attempts to get me to give her interpretations. At one point she demanded that I tell her how much time we had left in the hour despite the fact that she was wearing a watch. I said that reading the time on her own watch would not be the same as my telling her the time. She barked back, "No, that

wouldn't help me. I want to know *your* time. My time isn't of any help to me. Your time is the only time that counts." (Dr. M had previously told me that she never knows the correct time because she keeps every clock and watch she owns at slightly different times.)

The session continued with more questions from the patient that were "interpreted" to her with silence and to myself in words. (An important aspect of interpretive action is the analyst's consistent, silent, verbal formulation of the evolving interpretation. In the absence of such efforts, the idea of interpretive action can degenerate into the analyst's rationalization for impulsive, unreflective acting out.)

Near the end of the meeting, Dr. M recounted having seen a homeless person begging for money the previous evening as she and her parents were about to enter a very elegant restaurant. (In my own mind I understood the scene as a description of the patient's feeling of intense deprivation in her meeting with me.) Dr. M then said she could now remember the dream that she had had the previous night: a man in the elegant restaurant was pouring expensive champagne into her glass; the champagne was glamorous and sparkling, but went flat a moment after it entered the glass. She said she awoke from the dream in a state of intense anxiety. Dr. M said, "That's how I feel with you, I feel desperate, like a homeless person, and would kill you if I had the guts. When you give me something, it feels flat almost immediately after you give it to me. I must kill it in some way, but I don't know how I do it or why." (Although there was remarkable vitality in the initial part of her statement, her latter comments regarding her own role in attacking my interpretations seemed rote and compliant.)

Dr. M did not immediately follow her comment with a question as she had consistently done in the past, but after a short pause returned to asking me for the time in a way that invited me to interpret the connection between this demand, the imagery of her dream, and the account of the homeless person. I

again responded with silence that was intended to renew the interpretive working through of the perversion of language and thought.

The analytic movement (experienced by the patient as the physical movement of my office) continued in this phase of the work. Striking among the changes occurring in the analytic process was the appearance for the first time of several slips of the tongue in almost every meeting. The patient was not only embarrassed by the slips, but also seemed to welcome them and to experience interest in them. For instance, in talking about the incomparable pleasure she derived from her feeling of power in succeeding to extract an interpretation from me, Dr. M unconsciously substituted the word "powder" for "power." She associated "powder" to the ashes resulting from cremation and the feeling of deadness and extreme detachment that were inseparable, and at times indistinguishable, from the sexual excitement connected with acquiring one of my spells. Most important, there was a distinct sense in this exchange that these thoughts were the patient's thoughts, although I made no comment about this in an effort not to change her thoughts into something other than what she had created. It seemed that "despite herself," in these slips Dr. M was unconsciously allowing herself to begin to experience and to create a voice for aspects of herself that had been present, but to this point in the analysis, only in a strangulated, stillborn form, i.e., in the form of the transference-countertransference relationship organized around the perversion of language and thought that has been discussed.

CLINICAL ILLUSTRATION II

Interpretive Action as an Early Stage of Interpretation

During the telephone call prior to our first meeting, Mr. P told me that his marriage of eighteen years was in shambles, that he was in love with and having an "intensely passionate" affair

with the wife of his best friend, and that his life was "in a downhill spiral." As the patient entered my consulting room for the initial meeting, he had the look of a broken man. The intensity of his desperateness and anxiety filled the room. Mr. P handed me a sheaf of papers and explained that these were love poems he had collected which he thought would help me to understand the feelings he was having in relation to this woman. The abject surrender conveyed in the patient's facial expression and bodily movements as he handed me the papers had the effect of a plea: it felt as if it would be cruel and inhumane not to accept his gesture. I was aware that there was something slightly effeminate about the patient's appearance and manner of speech.

Immediately following these momentary initial impressions, but still within the period of seconds during which the patient's hand was outstretched, I developed a distinct sense that the patient was inviting me to engage in a type of sadomasochistic homosexual scene. In this scene, I imagined that I would either submit to him and have his "loving" contents (concretely represented by the poems) forced into me, or I would be moved to sadistically refuse them and thereby demonstrate my power over him (perhaps through a "forceful" interpretation of the patient's wish to dump his destructive internal objects into me).

On the basis of these extremely rapid (hardly apprehended) responses to what was unfolding in the opening seconds of the analysis, I told Mr. P that it would take some time to understand something of what had just transpired between us and suggested he keep the poems for the time being. In the minutes that followed, I became increasingly aware that I had not even wanted to touch the papers that he had offered me, and had felt an even stronger aversion to the idea of touching his hand. It seemed to me that to have accepted the papers would have been to have taken part in the particular form of sexual fantasy that I sensed underlay what was being enacted in Mr. P's occupying the bed of his best friend. I hypothesized in a highly condensed, hardly articulated way that in having an affair with his best friend's wife, Mr. P had in unconscious fantasy put his penis

where his best friend's/father's penis had been. In this way, he had had sex with his father while avoiding conscious awareness of the homosexuality of this act because the meeting of his father's penis and his own took place in his mother's vagina.

I view my thoughts/hypotheses about the incestuous/homosexual meaning of what had just occurred in the meeting as a form of "reverie" (Bion, 1962) that reflected experience in (of) an intersubjective analytic third that was being generated by Mr. P and myself in the course of his introducing himself to me. I mention these thoughts for two reasons: first, they formed the basis for more fully elaborated transference interpretations that were gradually discussed with the patient later in the hour and in the succeeding several meetings regarding the patient's anxiety about beginning analysis. The conscious level of the patient's anxieties, which he discussed later in the hour, related to his fears of breaches of confidentiality, the fantasy of meeting me in situations outside of the analytic setting, and his already knowing things about me from my writing that excited him and made him feel we could have a special relationship with one another.

Secondly, I mention these reveries/hypotheses because I feel that these thoughts and feelings would not have been discernible to me had I reflexively acceded to Mr. P's offer of the poems in an "empathic" effort to accept his expression of his need to be understood. Not accepting them allowed for the creation of a psychological space in which the poems could be recognized (and eventually understood) as an "analytic object" (Green, 1975; Ogden, 1994a). The intervention (the act of not accepting the poems, in conjunction with the tone and content of my comments about my reasons for refusing them), represented not simply an attempt to create "analytic space" (Ogden, 1986; Viderman, 1979), it also represented an early stage of interpretation which communicated the essential elements of what would eventually be offered as a set of verbally symbolized interpretations. The interpretation-in-action communicated my initial, tentative understanding of the following unconscious

transference-countertransference meanings: the intensity and desperateness of the patient's need to put something into me (the papers into my hand, the poetry into my mind and body) reflected his feeling that he could not bear to live with the destructive, out-of-control passion and fear that he felt were consuming him. It was imperative that the destructive passion be evacuated into me so that he could be freed of it while remaining connected with it through me. At the same time, I felt that Mr. P wished to make use of me as an analyst in his effort to extricate himself from the web of painful internal and external object relationships in which he felt hopelessly trapped. All of this was discussed with the patient gradually over the course of the first few meetings, in language very similar to that which I have used here.

To summarize, my rather prosaic statement that it would take some time to understand something of what had transpired between Mr. P and myself, and my suggestion that he keep his poems for the time being, represented more than an effort to establish analytic space within which to think about what was being enacted. As important, the statement represented a form of transference interpretation in the form of action that emerged from my experience in (and of) the intersubjective analytic third. This experience led me to formulate the opening interaction of the analysis as the patient's enactment of unconscious incestuous/homosexual fantasies by which he felt in danger of being overwhelmed. His attempt to hand me the love poems was a highly specific communication about his internal object world.

The semantic content of my refusal did not delineate my hypothesis concerning the incestuous/homosexual nature of the unconscious fantasy in which I was being invited to participate. To have offered this interpretation to the patient in a verbally symbolized form at that point would have been to participate in the fantasied sexual drama in the role of invasive homosexual partner. Nonetheless, my refusal to accept the poems was more than a generic refusal to engage in an acting-in with a patient;

it was a refusal to take part in the particular unconscious fantasy being experienced in the analytic third (which experience I was formulating for myself in words). As a result, my refusal carried meanings (tentative understandings of the transference-countertransference) that constituted an early stage of what would later be offered to the patient as an explicit transference interpretation. (The subsequent verbal elaboration of an understanding initially offered only in the form of an interpretive action and the exploration of the analysand's experience of the interpretive action are inextricable parts of this form of interpretive intervention.)

CLINICAL ILLUSTRATION III

Interpretive Action in the Area of Transitional Phenomena

In the following example, interpretation-in-action was offered in the context of a transference-countertransference field in which transitional phenomena (Winnicott, 1953) were of central importance. Although the interpretation that will be discussed was presented in the form of a question, the meaning of the interpretation was carried as much by *the experience of the intervention as a transitional phenomenon* as it was by the semantic content of the words.

Dr. L, an analyst in consultation with me, had presented a rather difficult case over a period of years. The patient, Ms. D, an extremely intelligent woman in her early thirties, had been so crippled by phobias (particularly claustrophobia) and anxiety about her inability to think that she had never been able to work or to pursue graduate-level education. (It had taken her eight years to complete an undergraduate degree.) In addition to the phobic symptoms, the patient engaged in compulsive masturbation in which the central fantasy involved being sexually stimulated by several men against her will, usually while she was bound or being threatened. Although the patient occasionally

entered into relationships with men, she had had no sexual experience other than masturbation.

In her fourth year of analysis, Ms. D arrived at a session saying that a friend had given her one of the analyst's published articles on psychoanalysis. The friend, a graduate student in psychology, had not known the identity of Ms. D's analyst, because for the patient it was a closely guarded (shameful) secret. Ms. D said that she had not yet read the article because she wanted to discuss her feelings about it, and to hear the analyst's thoughts with regard to her reading it, before going ahead.

The patient said that she would like to read the paper although she was afraid that she would not understand it. The analyst was aware of feeling anxious about the patient's viewing a discourse (between herself and her colleagues) that felt private. Dr. L told me that she had had the fantasy that she would never again be able to write once this private area had been invaded by the patient. The analyst also had fantasies that the patient would recognize herself in the article despite the fact that Dr. L had never written about her work with Ms. D.

In the consultation in which Dr. L discussed this meeting with me, these countertransference feelings were understood as a reflection of an unconscious fantasy (on the part of Dr. L) that Ms. D had discovered Dr. L's shameful secret of wishing to observe in an excited state her own parents' intercourse. The result would be not only the punishment of being paralyzed in her writing (the recording of her "insights"), but also being "found out" by the patient.

Ms. D's feelings of shame about being in analysis had been tentatively understood and interpreted over time as having roots in her unconsciously fantasied equation of the analytic space and the parental bedroom into which she felt she was secretly and excitedly entering. Although Ms. D discussed elements of this understanding with considerable interest, it seemed to Dr. L that the patient was "viewing the interpretations from the outside." In a meeting some weeks after the patient had been given the journal article, Ms. D said that she

had read the paper and had found it interesting to hear the analyst's voice in this different form. Ms. D's excitement and her feelings of competitiveness, envy, and guilt were discussed in some detail. The patient then said that there were several terms and ideas she had not understood and that she would like to know more about them. The analyst asked the patient, "What would you like to know?" Dr. L became aware of the ambiguity of her question only after she had posed it. Did she intend to answer any and all of the patient's questions, or was she simply inquiring about the nature of the questions? Dr. L told me that in the moment of asking this question she had created in her own mind the imaginative possibility of directly answering the patient's questions, although she had felt no pressure to make a decision about whether or not she would actually do so.

Ms. D was startled by the analyst's question (responding to the same ambiguity of which the analyst had become aware) and said that she did not know if the analyst really meant what she had said. (Ms. D had, during the course of the analysis, repeatedly described the loneliness that she had felt during childhood in not being able to talk to either of her parents or to her siblings about "What the hell is going on?" "What did you mean by that?" "Why did he [her father] say that?" etc. Ms. D went on to say that she felt that something important had changed between Dr. L and herself as a result of Dr. L's response (which she had not at all expected). The patient said that she no longer knew what to ask or even if she wanted to ask anything. Ms. D paused and said that mostly what she had wanted to know was whether the analyst would be willing to talk to her about the things she was confused about and, surprisingly, the answers to the questions no longer seemed to matter.

Dr. L understood the patient's response in terms of Ms. D's conflicted wish to be curious about the private discourse (including the sexual intercourse) of her parents without feeling consumed by it or entrapped in it. The patient was struggling to create in the transference-countertransference an intersubjec-

tive "potential space" (Winnicott, 1971; see also Ogden, 1985) in which imagined participation in the parental discourse/intercourse could take place in a different way. In other words, Ms. D was attempting to be curious (to imagine and think about the parental discourse/intercourse) without becoming caught in a perverse, overstimulating psychological event which would have to be either compulsively and excitedly repeated (as in the compulsive masturbation) or fearfully warded off (e.g., by a paralysis of the capacity for thought).

Dr. L's response, "What would you like to know?," was spontaneous and highly informed by her experience in the intersubjective analytic third. This intervention stands in contrast to an inquiry into or interpretation of the nature of the patient's conflicted unconscious wish to participate in the extra-analytic (sexual) life of the analyst. Dr. L's response represented an interpretation-in-action which was generated in a potential space between reality and fantasy. Her response (interpretive action) conveyed understandings that could be utilized by the patient in a way that had previously been impossible because the response itself represented a form of transitional phenomenon, i.e., an intersubjectively generated experience in which an emotionally important paradox was created and maintained without having to be resolved. In this instance the paradox related to the *latent* question (within Dr. L's manifest question): "Do you 'really' want to participate in the private intercourse/discourse of your parents/analyst?" The question in both its manifest and latent content was re-created intersubjectively in such a way that both analyst and analysand came to experience and understand it as a question (more accurately, a set of questions) for which no answer was required.

Under other circumstances, Dr. L's response/interpretive action might have been heard as a frightening, overstimulating invitation to "break the law of the father" (Lacan, 1958), i.e., to violate the prohibition against breaches of personal boundaries that are at the foundation of the analytic relationship. The fact

that Ms. D experienced the analyst's interpretive action/question as having the qualities of a transitional phenomenon (an intersubjectively created paradox in the form of a question that need not be answered) was reflected in Ms. D's response to the intervention: she did not attempt to compulsively enact voyeuristic fantasies or to actually enter further into the professional discourse of the analyst (for example, by anxiously seeking out Dr. L's other writings).

In this instance, the analyst's silent verbal formulation of the interpretation evolved over time. There was a spontaneous, unplanned quality to the intervention/question, whose meanings the analyst began to recognize and consciously and silently verbalize only after (or perhaps as) the question was being posed. This type of interpretive action might be thought of as representing "the spontaneous gesture of the analytic third." Dr. L's understanding of her question as a type of transitional phenomenon which generated paradoxical, imaginative possibilities became fully articulated for herself only in the course of consultation.

To conclude, the interpretive action under discussion conveyed an understanding of the patient's unconscious conflict (as experienced in and through the intersubjective analytic third) and represented an experience in the area of transitional phenomena. In this instance, it was necessary for *the experience of the interpretive action itself* to occupy a transitional space wherein new imaginative (as opposed to compulsively fantasied) possibilities could be created intersubjectively. The question, "What would you like to know?," represented an interpretive action that conveyed an understanding of the patient's leading unconscious conflict, resulting in a psychological shift in which the primal scene (and the oedipal drama) could be safely (re-)created and explored in an area between reality and fantasy. In that "third area of experiencing" (Winnicott, 1953), neither Dr. L's nor the patient's (manifest and latent) questions needed to be answered. In fact, conveying this understanding (i.e., that the questions required no answer) constituted the interpretation.

SUMMARY

In this paper, the concept of interpretive action was understood as the analyst's use of activity to reveal to the patient specific aspects of his or her understanding of the transference-countertransference which cannot be communicated at that juncture through symbolic speech alone. The understanding of the transference-countertransference conveyed by an interpretive action was derived from the experience of analyst and analysand in the intersubjective analytic third. Although the analyst used action to communicate aspects of this understanding to the analysand, the analyst simultaneously and silently formulated the interpretation in words.

The three clinical illustrations of interpretive action that have been presented were selected not because they represent remarkable or unusual psychoanalytic events. Rather, they have been presented in an effort to illustrate the way in which interpretation-in-action represents a fundamental, and yet insufficiently explored aspect of the interpretive process.

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The Tendency to Neglect Therapeutic Aims in Psychoanalysis

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THE TENDENCY TO NEGLECT THERAPEUTIC AIMS IN PSYCHOANALYSIS

BY MICHAEL J. BADER, D.M.H.

In our theory and practice as psychoanalysts, we have a tendency to idealize and elevate process goals over therapeutic outcome. This tendency is problematic because it deprives us of a vital check and balance in our technique and can lead to an implicit pessimism about our ability to systemically evaluate and modify our theory of therapeutic action. This trend in analytic thinking is traced, and vignettes are presented to illustrate it. Speculations about the reasons for the tilt toward process goals and away from therapeutic goals are offered.

Psychoanalysis is under attack today by a wide range of critics who dispute its efficacy and condemn its length and cost. Our own attempts empirically to study exactly what we do—and how well—have been plagued by serious flaws in our methodology (Bachrach, et al., 1991). Many of our research programs, for instance, have not reliably demonstrated a strong correlation between the development of an analytic process and therapeutic change or clearly superior comparative long-term cures.

In addition, the qualitative methodology for validating our clinical propositions has come under intense scrutiny and criticism. Psychoanalysts' preferred method for substantiating clinical formulations has always been the case report. As critics such as Grünbaum (1984), Spence (1987), and Edelson (1988) have pointed out, this format and our general style of argumentation are riddled with epistemological and logical problems, e.g., arguing by appeal to authority or by tautology, the use of a priori reasoning, etc. As psychoanalysts, we are having increasing dif-

ficulty defending our results and the logic of how we achieve them.

I believe that our critics are regularly aided by the presence of a "fifth column" within psychoanalytic theory and culture. This "enemy within" is a particular attitude toward therapeutic outcome and symptom relief that tends to make it harder than it might otherwise be to validate our propositions and defend our therapeutic efficacy. Specifically, I believe that as a result of a wide range of factors, psychoanalysts can become distracted from their focus on therapeutic change and symptom relief (outcome goals) in favor of a too-narrow focus on the goals of insight and other variables *within* the psychoanalytic situation (so-called "process goals"). Our reluctance to use therapeutic improvements—or a lack thereof—as important signposts guiding our technique has complex and justifiable determinants, but if this hesitation about focusing on outcome becomes extreme, we leave ourselves open to the charge that our claims to truth are solipsistic, immune to refutation, and self-justifying.

In its extreme form, this tendency can create disturbing tensions and confusions. Analysts want to cure their patients but tend to regard this therapeutic ambition as a potential obstacle in their work. If viewed with too much suspicion, however, therapeutic ambition can be suppressed so much, and therapeutic gains or stalemates granted so little bearing on technique, that the analyst can lose an important source of feedback with which to measure the validity of his or her interventions. The fact that patients can get better in nonanalytic therapies and can get worse over long periods in good analytic treatments can lead to a potentially exaggerated tendency to regard a patient's symptomatic improvement as independent of the analytic process.

The issue here is clearly one of degree, for analysts have long known that there is not a simple linear relationship between the analytic process and therapeutic outcome. As Bibring (quoted in Wallerstein, 1965) acknowledged, " 'A procedure and its results have, in a certain sense, to be treated independently: for differ-

ent procedures often have the same or nearly the same results; or a procedure may not lead to any success . . .' " (p. 763).

The tendency to treat therapeutic progress as only an inevitable *by-product* of good analytic technique and to view outcome goals as secondary to "process goals" leads to several potential problems. First, the analyst is deprived of a variety of evidence that can confirm or disconfirm his/her working hypotheses and technical approaches. Second, ignoring such patient-specific information may tend to weight the analyst's clinical theory in the direction of received authority. And third, opportunities for the exploration of alternative clinical strategies that might enhance the efficacy of psychoanalysis are needlessly limited.

However, even if one agrees that there are potential problems associated with an undue "tilt" among some analysts away from therapeutic aims, one is immediately confronted with the enormous complexity and confusion that surround defining, assessing, and interpreting outcome in any form. What does it mean to say that a patient is "getting better"? How does one measure it? Who decides? Using whose values? There is clearly no consensus among analysts about what constitutes a good analytic process, much less a good therapeutic outcome, and the methodological problems in assessing change and its relationship to technique are daunting. All analysts struggle with these issues. Some (e.g., Weiss and Sampson, 1986) have attempted to correlate outcome variables with specific therapeutic strategies, while others have written about the importance of using therapeutic stalemates as particular spurs to changing technique (e.g., Renik, 1990, 1992).

In spite of the fact that most analysts are concerned with these issues, and against the background of the methodological difficulties in thinking about outcome, there continues to be a tendency to turn away from a rigorous attempt to keep therapeutic outcome in our analytic cross-hairs and, instead, to focus more and more on those small units of intra-analytic behavior that can be studied. I am suggesting that a persistent effort to use out-

come as an important source of validation for our propositions and technique is needed, even if the methodology for doing so is problematic. In the discussion that follows, I hope to show that the potential costs of failing to do so are too high. The data to be presented will consist of several public discussions of clinical material presented in scientific meetings. Since the bias I am discussing is a tendency and not a theoretical or technical position, it cannot be "proven" to exist. Instead, I will attempt to paint various portraits of this bias in my vignettes, which I hope will be recognizable to the reader. I will then trace some of the currents and tensions in our literature about therapeutic versus analytic aims in order to suggest that this antitherapeutic bias in practice can claim sponsorship in theory, even if one could argue that this represents a *misreading* of the theory. And finally, I hope to suggest several factors in addition to the methodological ones mentioned above that might have contributed to this attitude toward cure.

THE ANTITHERAPEUTIC TILT IN PRACTICE

At a recent meeting of a local analytic society, a male analyst presented his work with a depressed and underemployed female patient. The patient had an intense, erotic transference to the analyst, which frequently led her to masturbate in the analyst's bathroom after the sessions. The analyst described his—and the patient's—understandings of the complex meanings of these transference fantasies and enactments. His interpretations were sophisticated and sensitively conveyed, and our discussion group contributed our understandings of the case as well. At the end of the discussion the presenter mentioned, almost incidentally, that the patient's depression and marriage problems were unchanged and that he had recently referred her to both a psychopharmacologist and a vocational counselor for help with these symptoms.

The point I am making is not simply to note that the analyst's formulations and interpretations had not helped the patient with her symptoms, but to underline the fact that this was not mentioned by the presenter, except as an afterthought, nor was it information sought by the seminar participants. The formulations of the treating analyst and of our group might well have been correct. But it was clearly crucial to try to explain the fact that they did not help the patient, and yet this was not addressed—not by the treating analyst or by the conference participants. There was no sense in the group that anything was missing.

On the one hand, this might legitimately be viewed as simply a bad case conference in which intellectualized insight was isolated from affect, or insight had not been internalized by the patient because of unanalyzed resistances. However, my experience of the discussion was that the presenter and the group were distracted from a focus on the therapeutic impasse by the vividness of the sexual fantasies and behavior within the transference, a phenomenon that I believe is more common than we would like to admit. Elegant and complex case formulations are often presented and discussed, focusing on the nuances of the transference/countertransference matrix, without consistent regard to whether the patient's symptoms are being addressed. It sometimes appears as if we can share the work-appropriate satisfactions of *understanding* the dynamics of a case more comfortably than the satisfactions of helping the patient get better in his or her outside life. Further, the possibility that we might be able to discern causative connections between our interventions and outcome variables, offering us a method of validating our propositions, is not adequately exploited. Despite the difficulty in evaluating the scope and meaning of therapeutic outcome, analysts should nevertheless consistently attempt to use it as a means of validating technique.

At a recent scientific meeting of experienced analysts, an analyst presented a paper in which he argued that when a patient's perceptions and theories about us conform to our own sense of

ourselves and our technique, we are more likely to overlook the important transference and/or resistance functions of those perceptions and theories. He argued that this oversight on the part of the analyst can convey an unspoken sense of permission and gratification that can interfere with analytic work. To illustrate this problem, he presented his work with a woman from a troubled family who used her analysis to make substantial therapeutic gains. The patient was eventually able to tell the analyst that she was gratified that his attention did not have to be earned. The analyst did not interpretively pursue or challenge this comment. Five years later, the patient returned with some new symptoms. Upon re-analysis, the analyst discovered that his patient had harbored an idealization of him during the first analysis and over the intervening years, an idealization that had been hinted at in her earlier expression of gratitude, but had not been analyzed because it conformed to the analyst's self-representation as nonjudgmental.

While the analyst acknowledged in his paper that this idealization was, in fact, a probable key to the patient's earlier therapeutic success and had been used as a source of comfort in the intervening years, he presented his failure to analyze it as a mistake, a blind spot that had limited the earlier effort and was a probable ingredient in the patient's later difficulties. He briefly explained how the idealization became absorbed into the patient's later symptoms, but he did not present the clinical data that led to this assertion. Although he was careful to caution the audience that "mistakes" are inevitable—and even useful—in clinical work, the audience could easily have been left with the impression that this particular "mistake" was problematic mainly *because it was not analyzed*. If it was left unanalyzed, it was—almost by definition—a problem. The various *process* goals involving maximum exploration of transference fantasies were incompletely attained and this was necessarily problematic. On the other hand, the patient had actually appeared to make good *therapeutic* use of the idealization. Since no clinical data were presented to suggest that either (1) greater therapeutic gains

could have been made had the analyst not made his "mistake," or (2) that the patient's later symptoms were causally related to this error, then it could easily appear as if the analyst were implicitly favoring an ideal of total understanding over that of therapeutic ambition. If the goal is mainly to understand, then a failure to do so is always suggestive of a problem.

The final vignette I will present involves a paper given to a local society meeting by a visiting analyst. The analyst was arguing strongly against certain recent interpretations of the working alliance. She felt that specific interventions outside the analytic frame which were intended to promote a working alliance detracted from a true analytic process. She gave, as an example, a candidate in her local institute who presented a case to her progression committee, a case in which the candidate reported that she had visited her analytic patient in the hospital after the latter had undergone cardiac surgery. The candidate justified the action with the clinical rationale that this had been necessary to maintain a working alliance.

The senior analyst presented this in her lecture as clear evidence of an action taken by an analyst that, to the speaker's mind, rendered the work nonanalytic. It might well have been the case that the training analyst had a great deal of evidence that the subsequent course of the analysis in question was grossly skewed and that the patient did not benefit from the work. Instead, she offered this example as prima facie support for her definition of analysis. She did not feel the necessity of presenting any evidence. The audience might have construed that it did not matter, at that moment, whether the patient got better, gained insight, etc. What seemed to matter was that the case did not conform to the *formal* requirements of an analysis.

This example highlights a phenomenon that can sometimes be seen in our field—a treatment is designated a "true" analysis by reference to certain formal parameters, derived from theory and a certain implied authority, and not necessarily related to what is occurring in the patient. In this case, for instance, a hospital visit might have been essential for the maintenance of

an analytic process—from the patient's point of view—and might have helped her move forward therapeutically. Again, this could reasonably be understood as simply a bad paper in which a claim is made without supporting evidence. However, other claims *were* supported with evidence in this case, and it appeared rather that the presenter felt the behavior in question was so "far out" that it warranted the judgment of nonanalytic on its face. Too often, one hears a case subtly criticized by virtue of pronouncing it "not an analysis." Although these judgments are sometimes based on the critics' prior experience with such cases, at other times it turns out that the analyst's technique falls short of an ideal derived mainly from theory, rather than from what is actually occurring in the patient's mind and life. In either case, there can emerge a reluctance to maintain an empirical and open-minded attitude toward the clinical consequences of deviations in technique.

These vignettes—highly selective accounts, subjectively filtered through my own sensibilities—are offered not as proof, but as suggestive or illustrative of an attitude that can often hover around discussions of clinical material and technique in our scientific meetings and training environments. This attitude suggests that therapeutic outcome is either mysterious and unpredictable (in which case we are on safer ground paying attention to micro-processes within the analysis), or else it is an inevitable and natural result of an analytic focus on the resistances to self-understanding (in which case we are most efficient if we singularly focus on insight within the analysis). In either case, there is a tendency, in the analyst's mind, to de-emphasize the functional importance of concrete therapeutic change in the patient's life in favor of the operational priority of deepening the patient's experience of the analytic relationship. Since most analysts would reasonably maintain that their primary professional purpose is to help the patient get rid of his or her symptoms, it seems more accurate to describe this phenomenon as a tendency in our attitude toward technique rather than a formal theory of technique. And yet, I believe that most analysts will

still recognize the kinds of intellectual and attitudinal "reflexes" toward cure that are illustrated in these vignettes. Thus, these reflexes, and what I believe to be the problematic attitudes and sensibilities that subsume them, continue to be operative in psychoanalytic culture.

This conceptual relegation of therapeutic ambitions to a secondary status at its worst leads to a caricature—interminable analyses that are preoccupied with the minutiae of the transference or countertransference relationship without regard to the patient's real life. This image of the endless analytic quest for knowledge unrelated to living has been pilloried—at times unfairly—by the popular media. Consider the portrait of the analyst, "Aaron Green," for instance, that emerges from Janet Malcolm's (1981) book, *Psychoanalysis: The Impossible Profession*. Green, clearly still quite symptomatic, confides to Malcolm that after fifteen years of analysis, he discovered that his most secret and formative wish, determinative of his personality, was to be a beautiful woman. This insight, given Green's continued psychological angst, is recounted by Malcolm in such a way as to make many readers cringe. The germ of truth, though, in such a caricature of analysis was also invoked and criticized by Rose (1974), who said, "To understand everything to the point of doing nothing, rather than to understand enough to do something realistic, is a miscarriage of analysis" (p. 515).

Even in its more subtle manifestations, this idealization of process over outcome can sometimes hamper our ability to study how our technique helps people. We tend to be too suspicious of and estranged from empirical efforts to track and explain the change process. Of course, as I mentioned above, the outcome and process research that is available to us is often methodologically primitive and not reliably able to identify good cause and effect relationships between process and outcome. The effort to study the micro-relationships between our interventions and therapeutic changes is thus often stymied. We are left with a *theory* that encourages us to look exclusively at the current interaction within the analysis and leave the patient's

difficulties in his or her life to resolve themselves as a natural consequence of our work. The danger of this is that our approach can become too theory-driven and not responsive enough to the patient's actual need for help. As Freud (1893) once said, quoting Charcot, " 'Theory is good; but it doesn't prevent things from existing' " (p. 13, n. 2).

THE THEORETICAL BACKGROUND

While many analysts will recognize the presence of the tilt in our field away from the therapeutic, it is difficult to find justification for it in our literature. Generally, theories of psychoanalytic technique assume a link between process and outcome goals and thus cannot be seen as sponsoring an antitherapeutic bias. However, it is possible to trace a theoretical current within psychoanalysis from the beginning that could be interpreted as reinforcing such a bias. Sometimes this point has been made explicitly; other times, it is only implied. Sometimes, it appears as a warning against therapeutic zeal; other times, *knowing* is counterposed to *helping* as contradictory and analytic goals. And sometimes, the presence of this bias is evidenced only by the arguments raised against it.

I will attempt to document, with extensive quotations, the presence of this antitherapeutic bias in psychoanalysis and suggest that the appearance of this bias in practice is not simply an aberration of technique but could be seen as a logical, although distorted extension of one line of thought in our theory. Each individual quotation cannot be seen as sponsoring this tendency, but I believe that, taken as a whole, there is enough antitherapeutic sentiment in our literature to at least make its expression in practice seem theoretically comprehensible, if not explicitly dictated.

As with most controversies within psychoanalytic theory, Freud can be used as an authority for opposite sides of this conflict. He clearly believed that psychoanalysis was the most

ambitious of the psychotherapies and had the greatest chance of producing permanent and far-reaching characterological change in its patients. He stated that the aim of analysis was to bring about "permanent results and viable changes in its subjects" (1913a, p. 329), changes that "under favourable conditions . . . are second to no others in the field of internal medicine" (1917, p. 256). Although he always understood that these changes were a *by-product* of analysis, he also was clear that the success of the treatment could be forfeited if the analyst "from the start takes up any standpoint other than one of sympathetic understanding" (1913b, p. 140). On the other hand, Freud himself eschewed a strong motive to "cure" his patients, because of factors of both temperament and principle. In his polemic against the medicalization of analysis, for instance, Freud (1926) asserted that he, himself, had "no knowledge of having had any craving in my early childhood to help suffering humanity" (p. 253). Theoretically, he was adamant that any hint of therapeutic zeal or overt expression of physicianly sympathy or helpfulness could hinder the analytic task. His famous remark that "it is not greatly to the advantage of patients if their doctor's therapeutic interest has too marked an emotional emphasis" (1926, p. 254) was entirely consistent with his discovery that the key to alleviating symptoms was to help the patient understand the unconscious conflicts that produced them and not to aim or aspire to eliminate the symptoms directly. Thus, in discussing the Little Hans case, Freud stated, "Therapeutic success . . . is not our primary aim; we endeavour rather to enable the patient to obtain a conscious grasp of his unconscious wishes" (1909, p. 120). In addition, it is well known that, with advancing age and experience, Freud began to counsel modesty about the extent to which profound therapeutic objectives could be achieved at all.

In the *New Introductory Lectures* (1933), he argued that the

> therapeutic ambition of some of my adherents has made the greatest efforts to overcome these obstacles so that every sort of neurotic disorder might be curable by psycho-analysis. They have endeavoured to compress the work of analysis into a

> shorter duration, to intensify transference so that it may be able to overcome any resistance, to unite other forms of influence with it so as to compel a cure. These efforts are certainly praiseworthy, but, in my opinion, they are vain. They bring with them, too, a danger of being oneself forced away from analysis and drawn into a boundless course of experimentation (p. 153).

Culminating in his essay, "Analysis Terminable and Interminable" (1937), Freud's therapeutic conservatism and caution set the stage for later theorists to define the ideal analytic attitude as incompatible with therapeutic ambition.

Freud's model was simple and powerful. Symptoms and neurotic suffering were caused by unconscious conflict. The goal of psychoanalysis was to cure the patient's symptoms. The means to this goal was insight and understanding—making the unconscious conscious. Therefore, the most important focus of the analyst was to increase the patient's self-understanding; symptom relief would be a necessary by-product. Deliberate attempts, such as those proposed by Ferenzci, to increase the therapeutic efficacy of the technique were misplaced, according to Freud, because they substituted authoritarian manipulations for the slower, but more permanent, increases in self-awareness that were the goal of proper psychoanalytic technique. The analyst's overall goal was still to cure the sick, but the operational goal was to increase the patient's conscious awareness and insight with the faith that the overall goal would naturally follow. An analyst's wish to cure or to be therapeutic was thus both asserted and cautioned against. Wallerstein (1965) described this as a paradox between

> goallessness (or desirelessness) as a technical tool marking the proper therapeutic posture of analytic work and the fact that psychoanalysis differentiates itself from all other psychotherapies, analytically oriented or not, by positing the most ambitious and far-reaching goals in terms of the possibilities of fundamental personality reorganization. In regard to the first side . . . Freud and classical analysts following him have been

> most explicit; the analyst analyzes; the patient gets where he wants, and can (p. 749).

In the decades following Freud's death, many analysts have addressed the issue of the merits of therapeutic intent and outcome in psychoanalytic technique. On one side of the question, various authors have inveighed against the dangers of therapeutic zeal, reformist passions, and impulses to cure and heal. Sharpe (1950) stated:

> The desire to cure, educate and reform, useful and valuable enough when employed in certain environments with specific people, is not the motivating power that produces the most efficient psycho-analyst. Cure and re-education, or stated more analytically, psychical readjustment, happens as a result of the analytical process. It does not occur because of the analyst's desire to cure and reform, but because of his understanding and ability to deal with his patient's psychical mechanisms (p. 116).

Greenacre (1948) singled out undue therapeutic zeal for criticism when she cautioned the analyst who "has too great a stake in the patient's recovery, not actually for the patient's sake but for the analyst's own comfort, either for prestige gain or even for the feeling of power in curing" (p. 622). Eissler (1963), in discussing a case vignette, argued that "a principle such as 'Nothing succeeds like success' has no place in a psychoanalytic approach. If anything, the patient's success prevented her from ever taking a further step on that road of: know thyself" (p. 461).

Modern writers have added their voices to this tradition of skepticism and caution about the place of therapeutic ambitions in the analytic attitude. Grinberg (1980) argued against the tendency to " 'saturate' the development of the analytical relationship with the aprioristic idea of 'leading' our patients to achieve the 'therapeutic goals' which we had already fixed for them from the very beginning" (p. 25). Skolnikoff (1990), in defining the difference in stance between the psychotherapist and the

psychoanalyst, described the difference as one in which the therapist aims to *help* and the analyst to *understand*. Oremland (1991) asserted that "the psychoanalytic orientation attempts to understand" and "not offer the promise of relief, healing, or cure (medical concepts) or salvation (a religious concept)" (p. 11). Schafer (1983) seemed to be arguing against therapeutic zeal when he reminded us that "analysts do not view their role as one of offering or promising remedies, cures, complete mental health, philosophies of life, rescue, emergency room intervention, emotional Band Aids or self-sacrificing or self-aggrandizing heroics. . . . It is more than likely that each of these alternatives to a primarily interpretive approach manifests countertransference" (p. 11). Brenner (1976) takes the position that " 'to analyze' can only mean to help a patient to know himself better. Any other form of psychotherapy is not analysis. . . . It may be even more successful than analysis in some cases, but it is not psychoanalysis" (p. 49). Joseph (1979) summarized the general position around which these authors clustered as follows:

> Another approach to the therapeutic effectiveness of psychoanalysis is to state that therapy is not the goal of psychoanalysis. Rather, it is a procedure designed to explore mental life in depth and to extend the range of understanding of mental processes. Anyone undertaking psychoanalysis should understand that goal and, to the extent that it is achieved, has gained from the experience regardless of any therapeutic benefit (p. 73).

Effectiveness, symptom relief, therapeutic aims—these are by-products of analysis, but, for some, do not define its essential goal, or, for most, the operational intent of its practitioners.

This position can be seen in various forms in other theoretical traditions. Bion's aphoristic paper, "Notes on Memory and Desires" (1967), attempts to elaborate on Freud's discussion of the analyst's attitude of evenly hovering attention by advising the analyst to approach each session without "memory, desire or

understanding." The most powerful desire that Bion believes interferes with the analyst's ability to "hear" the unconscious of his or her patient is the desire to "cure" the patient. The Lacanians have explored and made centrally important the danger of the analyst's enacting the role of "the one who knows," an alienated transference authority with whose projected desires the patient can defensively identify, much as he or she did with the original object. For Lacan, the desire to "do good" functions as an alibi covering a misuse of authority with which the patient, out of a need for love, defensively complies. As Lacan (1977) said:

> So we have now reached the cunning principle of the power that is even open to a blind direction. It is the power to do good—no power has any other end—and that is why the power has no end. But it is a question here of something else, it is a question of truth, of the only truth, of the truth about the effects of truth (p. 275).

Further evidence of the prevalence of this kind of critical attitude toward therapeutic cure can be adduced from the passionate counterarguments that this attitude provoked. In the 1960's Leo Stone and Ralph Greenson, among others, made important contributions to broadening the psychoanalytic theory of technique, and sought to incorporate certain noninterpretive activities of the analyst and relational dimensions of the clinical encounter into the realm of acceptable analytic technique. One aspect of this liberalization of technique included a strong defense of the centrality of the analyst's desire to heal the analysand, relieve his or her suffering, and achieve therapeutic aims. Stone (1961), for instance, described what he believed was the unfortunate legacy of traditional technique—the fact that " 'only to analyze' or an equivalent phrase became a sort of catchword or slogan for the definition and circumscription of the analyst's function, and often, by implication, of his personal attitude" (p. 28). Stone (1984) argued, instead, that the analyst's basic attitude should primarily be a physicianly commitment to

the relief of the patient's suffering. He summarized his view of the problem in the following way:

> Now as to the therapeutic purposes of psychoanalysis: I cannot give serious recognition to any conception of psychoanalytic practice in which these purposes are not the primary and central consideration of the analyst, however highly developed his other interests, including scientific interest, may be. . . . Our knowledge and our methods were born in therapy. I know of no adequate rational motivation for turning to analysis—and persisting in it through its deeper vicissitudes—other than the hope for relief of personal suffering (p. 425).

In his now-classic book on technique, Ralph Greenson (1967) argued against what he, like Stone, saw as a legacy of rigidity when it came to the role of therapeutic ambition in psychoanalytic technique. He complained that "from time to time in the psychoanalytic literature one gets the impression that the wish to relieve a patient's misery is fundamentally antagonistic to analyzing and understanding his problems . . . at other times it seems that analysts are more concerned with preserving the purity of psychoanalysis than with improving their therapeutic results" (p. 404). Greenson, himself, took a clear stand on behalf of therapeutic ambition:

> Freud's attitude notwithstanding, I contend that the therapeutic intent in the analyst is a vital element in his makeup if he is to practice psychoanalysis as a method of treatment. . . . In my personal experience, I have never known an effective psychoanalytic therapist who did not feel strongly a desire to relieve the suffering of his patients. I have met M.D. psychoanalysts who were essentially misplaced researchers or data-collectors, and their therapeutic results were below expectations (p. 404).

Stone and Greenson were clearly grappling with the difficult issues involved in understanding the role of therapeutic aims in psychoanalytic technique. Although they were not specifically arguing that therapeutic improvements, or the lack thereof, should be used as a barometer of the correctness of analytic

technique or propositions, they were certainly in the forefront of those analysts who sought to place the wish and intent to heal at the center of our professional ambition.

Many other analysts have also contributed to this project. My attempt to trace the theoretical roots of and debates over the role of therapeutic aims in psychoanalysis deliberately neglects those authors, past and present, who argue that therapeutic and analytic aims completely coincide in a well-conducted clinical analysis. Freud (1926), after all, reminded his readers that "in psycho-analysis there has existed from the very first an inseparable bond between cure and research" (p. 256). Most modern analysts would probably subscribe to a theory of technique that assumes such a synthesis. As Weinshel and Renik (1992) put it, there is likely a manifest analytic consensus that "no distinction can or need be made between investigation of the analysand's self-observational difficulties and investigation of his psychopathology," and that "insight into the manner in which the analysand interferes with his self-examination is also insight into the causes of his pain" (p. 97). Sophisticated analysts are clearly concerned with the complex relationships that exist between process and outcome and certainly should have no need to defend the extent to which they care about their patients' welfare, work toward the alleviation of their symptoms, and are thoroughly convinced, on the basis of experience, that the best route to that end lies in attending primarily to the process goals of expanding the patient's self-awareness and capacity for self-inquiry (see also Boesky, 1990).

Notwithstanding this manifest consensus, there continues to be a tendency within analysis to split off and subtly devalue the therapeutic aims of analytic work. The hints of skepticism and distrust toward therapeutic ambition that run through some of our literature, with the concomitant elevation of intra-analytic process goals over outcome goals, continue to be influential in our field. The fact that this imbalance occurs as frequently as it does in spite of a theoretical position that promotes the simultaneity of understanding and cure is itself an important phe-

nomenon worth explaining. In other words, while almost all analysts would share Weinshel and Renik's assertion that analysis should always primarily serve therapeutic aims, we still see evidence of confusion over or neglect of these aims in practice. Almost by definition, then, this is a tendency that is easier to see in others than in oneself. It is also tempting to attribute this bias *only* to inexperience or to a misunderstanding of proper analytic technique. However, even if this were true, I believe that this misunderstanding is prevalent enough in our professional culture, and consistent enough with certain theoretical traditions, to deserve to be identified and debated.

FACTORS CONTRIBUTING TO AN ANTITHERAPEUTIC BIAS

It seems likely that there are many sources of this tendency to de-emphasize the role of therapeutics. I have already mentioned the significant methodological problems that all of us face in our attempts to use outcome criteria as a source of validation of our technique. Freud, by temperament and by theoretical conviction, embraced a spirit of scientific rationalism that sought to strip away illusions, whether they appeared as self-deceptions in a patient or as the mysticism behind religious faith. From the standpoint of theory, one of the ways that Freud courageously broke with prevailing medical/therapeutic approaches to the treatment of mental illness was to substitute *understanding* for strategies at symptom elimination that relied on direct suggestion and/or physical and somatic manipulations. Gay (1988) sees in Freud's various self-appraisals a consistent image of the "researcher more interested in science than healing" (p. 278). As my earlier discussion of Freud indicated, this negative attitude toward therapeutic aims always conflicted with the desire to cure illness. According to Gay, even while a medical student, Freud confessed to Eduard Silberstein that his greatest wish in life vacillated between "a laboratory and free time . . . with all the

instruments the researcher needs" and "a large hospital and plenty of money, to curtail some of the evils which befall our bodies" (p. 26). Notwithstanding this ambivalence and a formal theory of psychopathology that explicitly sought to combine analytic and therapeutic aims, it could be argued that the current within Freud's thought and temperament which regarded helping as secondary to knowing and which posited the image of the analyst-as-surgeon contributed to a certain bias that still exists today. So-called classical technique, implying a special fidelity to Freud, is often equated—with approval or disdain—with this identity of the psychoanalyst/scientist as opposed to the psychoanalyst/healer.

The debate over the relative weight to be given to process versus outcome goals inevitably became embroiled in psychoanalytic politics and conflicts over what constituted "true" psychoanalysis. In the 1950's, for instance, Franz Alexander claimed that he had improved his therapeutic results by strategically altering certain elements of the analytic frame, thereby providing a "corrective emotional experience." In the ensuing years, these ideas were hotly debated within American psychoanalysis, debates that have since been rekindled in various forms in response to other challenges to so-called "classical" technique (for the relevant history, see Wallerstein, 1990). At no point during the debates over Alexander's controversial technique, did his critics seriously engage him in print about his claims that this technique produced superior results. The arguments were purely theoretical and focused exclusively on the question of what differentiated "true" psychoanalysis from mere psychotherapy. Alexander's claims to results were simply irrelevant compared to his claims that his means were psychoanalytic. The main interest of Alexander's critics was in establishing the error of his ways, and not his goals. In this spirit, Gill (as quoted in Wallerstein, 1990) wrote:

> I think that there is little doubt that Alexander is correct in stating that by overt behavior toward the patient one can more

> quickly get him to change some aspects of his behavior. But what is the meaning of such a change? It is an adaptation to this particular interpersonal relationship—as it exists between patient and analyst. *But this is not the goal of analysis*. The goal of analysis is an intrapsychic modification in the patient . . . (p. 296, italics added).

Gill's argument here, echoed by many other analysts at the time, was that only one very particular analytic technique could produce intrapsychic modifications that were durable and, therefore, if a divergent technique appeared to demonstrate therapeutic results, these results had to be suspect. As far as I have been able to determine, clinical material was never seriously presented as evidence for these claims. Although undoubtedly derived from clinical experience, these arguments tended to read as if they were theory-driven and based on notions of analytic purity. A prescribed and proper technique leads to good and durable results. Considerations of results should never, therefore, significantly alter the definition of good technique.

Within certain sectors of American psychoanalysis in the post-World War II era, debates over "correct" technique were often passionate enough to result in ideological splits. Most analysts are familiar with this history and the extent to which irrational and heated conflicts over loyalty and authority rendered the debates more religious than scientific in nature. This history also suggests how psychoanalytic and institutional politics may have contributed to skewing our interest away from outcome and cure. Analysts might, at times, be tempted to elevate the process of analysis over therapeutic outcome because it is in the analytic *process* that we can define our professional and ideological boundaries, and establish what makes our approach unique and distinguishes us from other therapists, as well as from other analysts. It is in our need to distinguish our analytic approach from others within our own profession—often from within our own institutes—that the danger of losing sight of our primary goal of helping the patient arises. When loyalties to Freud, to

other authorities in our institute and field, to our own teachers and training analysts, lead to an exaggerated need to define who practices "true" psychoanalysis and who does not, then there is a heightened tendency to focus on small differences in one's formal theory of technique and neglect the real results and outcome of that technique. In this discussion, it should be clear that I am attempting to describe an institutional or group phenomenon that has at times marked our field and not a primary intention of individual analysts.

An additional factor underlying this attitude toward cure is the doubt that some analysts have about the extent to which cure is even possible. There is an understandable, although not necessary, tendency to increase one's emphasis on intra-analytic processes and decrease one's focus on extra-analytic change in proportion to one's disillusionment about the therapeutic effectiveness of analysis. Freud certainly took various positions over the course of his career about the limitations of his method, including the dark assessment at the end of his life in "Analysis Terminable and Interminable" (1937). Various historical periods have witnessed expressions of extreme optimism as well as more cautionary voices. Weinshel (1990) has traced the gradual movement within the psychoanalytic theory of technique away from "the myth of perfectibility" to the more modest and "relative" goal of helping the patient develop more adaptive compromise formations. Weinshel argued that "a conspicuous therapeutic overoptimism must reflect not so much an idealization of Sigmund Freud, as an overidealization of psychoanalysis as a therapeutic instrument" (p. 277).

It can sometimes be seen, however, that while modesty is essential to the effective functioning, as well as temperament, of the analyst, it is also possible for modesty about outcome to function to inhibit our openness to change and improvements in our technique. In other words, if therapeutic outcome remains our primary goal, and we find ourselves frustrated or disappointed in the results that our technique yields, this conflict *could* productively confront us with the opportunity and need to

re-evaluate and improve our technique, and not simply challenge us to work through and accept the reality of our limitations. I believe that too often this frustration with results can lead us back to a study of the process, to an idealization of that process, and we miss a potential opportunity to improve our clinical theory and practice.

This is an extremely complex issue and my treatment of it begs the important questions of what constitutes change, what are the differences between focusing on short-term and long-term change, and the serious problems that Weinshel rightly points out of idealizing the therapeutic power of analysis and our own narcissistic investment in that power. However, it is also possible to argue that what is reasonable caution for one analyst is, for another, a resignation about analysis which can inadvertently justify a rigidity of technique.

Psychoanalysts aim to help their patients with their suffering. They bring to this task a theory of the mind and a theory of how the analytic process will help their patients overcome their symptoms. Various pressures—ideological, psychological, and social—have often weighed heavily on these therapeutic intentions and subtly shifted them, in practice, toward an imbalanced and often exclusive emphasis on the study of the complex dynamics within the analytic encounter and the formal requirements of this encounter. It is certainly crucial to understand and theorize about intra-analytic processes. However, I have tried to illustrate the ways that, as psychoanalysts, we can sometimes lose sight of and neglect our primary goal of helping patients solve the problems that bring them to treatment.

SUMMARY

There is a tendency in our theory and practice as psychoanalysts, to idealize and elevate process goals over therapeutic outcome in psychoanalysis. At times, we tend to retreat from our manifest goal of helping to alleviate our patients' suffering un-

der the banner of studying and interpreting aspects of the analytic process. This tendency creates problems because it deprives the analyst of a vital check and balance on his or her technique, namely, the fact that a patient's therapeutic improvement, or lack thereof, should be one indicator of the validity of our formulations and technique. In addition, it tends to lead to a relatively pessimistic attitude about our ability to improve our technique, since improvements are often regarded with caution or skepticism.

I have attempted to trace the origins of this attitude in psychoanalytic theory by a review of certain writings of Freud's and other notable historical figures who have cautioned against therapeutic zeal or ambition. Modern writers have also written in this spirit, although more often it is assumed that, as analysts, we simultaneously seek to expand our patients' insight *and* cure their symptoms. It is interesting that, despite this theoretical axiom, there continues to be a tilt within our field away from a focus on therapeutic aims. I have presented three illustrative vignettes to try to illustrate how this "tilt" is manifested in practice and how it can unnecessarily confuse or inhibit our efforts to help our patients. Finally, I have suggested that complex theoretical, institutional, and social factors have contributed to the antitherapeutic bias within some of our circles.

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Aspects of Primary and Secondary Genital Feelings and Anxieties in Girls During the Preoedipal and Early Oedipal Phases

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ASPECTS OF PRIMARY AND SECONDARY GENITAL FEELINGS AND ANXIETIES IN GIRLS DURING THE PREOEDIPAL AND EARLY OEDIPAL PHASES

BY RUTH F. LAX, PH.D.

The author examines the development of the girl's psychosexual feminine self-image during the preoedipal and early oedipal phases, as well as the accompanying primary and secondary genital feelings and anxieties. The connection between the little girl's discovery and pleasure in self-exploration and masturbation and related anxieties about being "closed-up" is discussed. The nature of the corresponding object relationships is elucidated, especially the narcissistic significance of being like mother.

There are two types of genital anxieties that a little girl may develop as a consequence of her erotic feelings. These occur during different developmental subphases. The first relates to the girl's fear that her genitals will be mutilated. The second develops during the negative oedipal subphase when the girl recognizes the significance of the penis she lacks. There is a temporal sequence in the development of these fears, but once both come into play, their vicissitudes commingle, and the dominant focus depends on various factors impinging on the girl's life.

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Bearing in mind Freud's dictum that "anatomy is destiny" (1924, p. 178), I will attempt to show that for a girl it is essentially her own anatomy, and not her reaction to the male anatomy, that plays the decisive role for the vicissitudes of her psychosexuality.

The Formation and the Significance of the Body Image

Although Freud's concept of the body ego (1923) has been seriously considered by his followers, psychoanalysts did not, until the 1960's, apply it to both sexes. Thus, they did not acknowledge that the unique anatomic characteristics of each sex must register in the ego with their specificity from the beginning of the ego's formation. A careful reading of Freud's papers in which femininity is discussed (1905, 1925, 1931, 1933, 1937) indicates that he did not acknowledge that the uniquely female genitals of the little girl must have a different impact on her body ego than the boy's have on his body ego. Freud maintained, in spite of evidence to the contrary (e.g., Horney, 1924; Jones, 1927, 1935; Klein, 1932; Müller, 1932), that both sexes are unaware of the existence of the vagina. Freud did not acknowledge that the sensations a little girl experiences from all parts of her genitals must become part of her body ego, even if they are repressed, denied, and/or distorted. He did not apply his own theory to this aspect of a little girl's development. This was probably due to the unavoidable limitations imposed by the phallocentric *Zeitgeist* that influenced Freud (Gay, 1988; Young-Bruehl, 1988, 1991).

Aspects of Primary Genital Feelings and Anxieties

Freud's view that the little girl's psychosexual development is an inferior variant of the boy's development, and that femininity begins with the momentous, narcissistic trauma of the girl's discovery of anatomic differences, has been questioned, chal-

lenged, and disproved by many, among them Applegarth (1976), Barglow and Schaefer (1976), Chasseguet-Smirgel (1976), Chehrazi (1986), Fast (1978, 1979, 1984, 1990), Kleeman (1976), Mayer (1985, 1991a), Renik (1992), Stoller (1964, 1968), etc., etc. The list is long and impressive.

Stoller (1968, 1976) postulates a core female gender identity that exists well before the discovery of anatomic differences and the "phallic" phase. He indicates that sex assignment occurs at birth and that parental attitudes are crucial for the establishment of the child's core gender identity. Early endogenous sensations emanating from the genitals and increasing with the maturation of the infant combine with exogenous stimulations stemming from parenting body care. The genital sensations resulting from these sensuous experiences cue the body ego of the infant of each sex differently. According to Stoller (1976), the early experiences of infant girls, which, due to anatomy, are different from those of boys, result in a primary, unquestioned acceptance by girls of their femaleness. This is supported by a research report (Mayer, 1991b) in which twenty-two-month-old girls who were given a choice between dolls with male or female genitals invariably chose the female doll as representing themselves and indicated that this was the doll they "liked better."

The infant may experience as erotic stimulation the mother's ministrations during the daily routines of washing, dressing, diapering, and holding (Freud, 1933; Bonaparte, 1948). The touch of the mother's hands on its skin, especially the genitals which are attended to more frequently, is usually experienced by the child as pleasuring. Under optimal circumstances, these repetitive mother/infant events become a love game, during which the infant feels admired, mirrored, and cherished. In time they begin to represent maternal love tokens. They may be experienced as maternal seductions when the child starts fantasizing. This was postulated by Freud (1905) and Brunswick (1940), and is now generally accepted. Some researchers have found that vaginal lubrication in female infants corresponds in frequency to spontaneous erection in male babies (Kleeman,

1976; Masters and Johnson, 1966). One may speculate that these manifestations of sexual arousal are in part responses to mother's ministrations.

With increased motor coordination and the beginning of body exploration, the child experiences the pleasure of self-touching. During these explorations the genitals are discovered, and the child learns that it can give itself the kind of pleasure that it had passively experienced during mother's caregiving.

The toddler girl, during such explorations, discovers the different parts of her genitals: the clitoris, the labia, perineum, and eventually the vaginal entrance and introitus. When there is no interference by adults, these are pleasurable experiences that give the little girl a sense of mastery. She learns that she can give herself pleasure, and this stimulates the development of independence. When the little girl finds that her fingers can push around and into the lower part of her vagina, she knows and begins to fantasize about the special place she has "inside." She experiences a sense of "possession." Erikson (1968) speaks of an "inner potential." Erikson (1950), and Roiphe and Galenson (1981) report on the preference for enclosed-space structures in the spontaneous block play of fourteen- to sixteen-month-old girls. It can be surmised that such block play symbolically expresses the little girl's psychic awareness of the structure of her genitals, indicating the progressive formation of the body image.

The little girl's self-explorations, the excitement of discovering and self-pleasuring, are possible only when the mother is accepting of her female child and delights in her. Under such circumstances, the little girl, with her mother's help, learns what her genitals are called, and her pleasure in herself increases. The mother's correct labeling of her daughter's genitals functions as an affirmation of what the little girl has and treasures (Lerner, 1976; Mayer, 1985, 1991a).

The little girl, like the little boy, starts out with the egocentric assumption: "Everyone must be just like me" (Freud, 1905; Mayer, 1985). For the little girl, as contrasted with the little boy,

this notion is enhanced by her awareness that she and mother are alike. This knowledge is of momentous significance. Because of the "we" of mother and daughter, the little girl can fuse her infantile grandiosity with the omnipotent grandeur she ascribes to her mother. The sense of sameness with the powerful, loved (and also hated) mother precedes and supersedes later selective identifications. It is the source of pride in self and the root of the girl's healthy narcissism. It becomes the nucleus of healthy, non-submissive object relations. Knowing herself to be the "same as mother" enables the little girl to mitigate the feelings of her own limitations and frustrations, since she can "bask in her mother's glory." The mother invites identification with herself to the extent to which she enjoys a healthy self-acceptance that in turn enables her to delight in her daughter.[1]

For the healthy girl toddler during the practicing subphase, she and mother are focal. The toddler's exploration is turned toward the outside world as well as toward the self. There is a spurt of independence and separation, with an insistence on "do it myself," but when the child becomes frightened by feeling alone and finding herself small and sometimes helpless, she returns to her mother for "refueling" (Mahler, et al., 1975). Such refueling reinforces not only the little girl's sense of sameness with mother; it also increases her sense of strength because she identifies with mother's strength.

The growing independence from mother manifests itself in increased genital exploration and active volitional masturbation. Arlene Richards (1992) indicated the role that voluntary perineal muscular contractions play in contributing to increased awareness and definition of inner genital structures and inner and outer genital sensations in the developing girl. During masturbation, which involves the whole genital area, lubrication oc-

[1] Such an optimal outcome is rather infrequent. As is well known, women and girl babies are devalued in most societies. This is typified by female infanticide practiced in China (*The New York Times*, 1992), the selling of girls into brothels, etc. According to a survey of expectant parents, 98% expressed a wish for a boy child (Frenkiel, 1993).

curs. The little girl now becomes more aware of a smell of her own and of her own pleasurable inner space. Eventually, her awareness that she can tighten and loosen the vulva and perineum contributes to her feeling of mastery and control. For discussions of masturbation in girls, see: Bonaparte (1948), Brunswick (1940), Clower (1975, 1976), Greenacre (1950), Kleeman (1971, 1975), and Spitz (1949, 1952, 1962).

However, even under optimal circumstances, a little girl develops a fear that something may occur to interfere with the pleasure she derives from playing with her genitals. This may be due in part to conscious and unconscious memories of unpleasurable genital sensations resulting from parental cleansing practices, such as burning from soap or other disinfectants or "rough handling," or from minor genital irritations, etc. The little girl's fears may also be due to seeing a boy's genitals, which lack a vulva with an opening, and to her fantasizing that this is due to the boy's being "closed-up" (Mayer, 1985). Or fears may result from guilt stimulated by incestuous fantasies. In addition, the limitations a parent may set on masturbation can become a source of acute fear. It must be remembered that in the prevailing atmosphere, a little girl, probably more so than a little boy, is still discouraged and intimidated by verbal threats and sometimes even physically forced to desist from masturbation.

The little girl's *primary genital anxiety*[2] is the fear of being "closed-up," "sealed-over"—of losing access to or a part of the genitals she has, enjoys, and wants to continue enjoying freely (Glover and Mendell, 1982; Jacobson, 1976; Mayer, 1985; Wilkinson, 1991). This is understandable since the little girl's enjoyment of sexuality depends on her free access to an intact vulva, with its opening between the labia as well as its vaginal opening.

[2] Mayer (1985) refers to the girl's fears that *her own* genitals may be damaged as "true castration anxiety." I use the phrase "primary genital anxiety" for semantic reasons, since neither the fantasied mutilations nor those inflicted upon girls in reality constitute a castration. I am indebted to Mayer for the attention she drew to this neglected topic of psychoanalysis.

Clinical Vignettes

I. A three-year-old patient, who had great masturbation conflicts, expressed in a dream her fear and horror at what would happen if she could not "play with herself." In the dream, her thighs were sewn together. When she told the dream, she whispered, "I couldn't touch anything. I was so scared." She spent a number of sessions playing with a doll whose thighs she tied together, and who then sat and cried. The patient, by the end of the hours, sometimes "set the doll free" and sometimes left her tied up.

II. The following dream was reported by a patient who was a student in a course on contemporary views regarding female psychosexual development. "I was masturbating and getting excited and suddenly I was changed into a mermaid—there was no opening whatsoever, there was no way I could touch myself—I felt terrified." The patient was silent for awhile and then remarked, "I guess it was to teach me a lesson . . . I mean to acknowledge . . . I felt it was so much nonsense . . . all this talk about women 'being open,' having an 'inner space.' Imagine being like a mermaid, all closed up."

III. The following vignette, reported by a colleague, indicates how a healthy three-year-old attempts to resolve her concerns about the nature of her genitals.

"Franny lately has been most enamored with the Little Mermaid, wearing a Little Mermaid nightgown, loving the video story, pretending she is Ariel, etc. We were riding in the car one day and Franny said she had to peepee. We asked if she could wait a little while to get to a convenient stopping point. As she waited with mild impatience, she made up a song about peepee, enjoying being silly: 'Animals peepee, cars peepee, trucks peepee,' etc. So I asked her, 'How does Ariel [the Mermaid] peepee?' Franny's cheerful answer was: 'She first turns into a person, then she sits down on the toilet and just does a peepee.' She added a further explanation: 'And her tail goes up over her chest.' "

In contrast to the patient who dreamed she was changed into a mermaid and "closed up," Franny only played at being a mermaid. She had the healthy conviction of being a person, i.e., having genitals and excretory organs.

IV. An outstandingly beautiful and totally frigid patient in her late twenties spent many hours recalling the ritualized punishment inflicted on her in childhood for having repeatedly been caught masturbating before going to sleep. She was about ten when it happened. At bedtime, under supervision, after she washed she had to kneel and confess her depravity of having masturbated. She then had to beg God to keep her from sinning again and pray for forgiveness. To "help her," so she was told, each evening the girl was slapped on her genitals with a wet towel, then a kind of chastity belt made of bandages was put on her. She had to sleep on her back, "spread-eagle," her feet and hands loosely tied to the bedposts. Both parents and a governess participated in these nightly rituals. The patient reported that she initially struggled "to get free," but finally submitted. Somehow her sexual feelings disappeared. She became listless and docile. Her parents considered this behavior appropriate for a "good girl." Ostensibly, docility brought this patient into treatment: her husband wanted her "cured of frigidity." The patient, who recalled having had sexual feelings as a child, said: "They closed me up and it worked." The patient was referring to the "chastity belt" put on her each evening.

In Western society, even to this day, two myths prevail about little girls' psychosexuality. The popular view has it that little girls are "sugar and spice and everything nice," i.e., pure, sweet, and asexual. "Sleeping Beauty" depicted this fantasy of the chaste girl who "sleeps" until a man awakens her sexuality. On the other hand, Freud (1933, p. 118) maintained that through the "phallic" phase "a little girl is a little man" in her psychosexual development, a doctrine until recently espoused by his followers. Thus psychoanalysis endowed the little girl with sexuality, though not with feminine sexuality. According to Freud,

little girls masturbated, but less often than boys, and they did so by exclusively stimulating the clitoris. However, Freud maintained that when girls discover the inferiority of the clitoris to the penis, they suffer a narcissistic trauma which in most instances results in the repression of their masturbation and active sexuality. Clower's (1975, 1976) findings, however, indicate that girls continue to masturbate through latency and adolescence. This disproves Freud's contention.

Freud's postulations about the sexuality of little girls were rejected by Victorian and twentieth century society not for lack of accuracy, but rather to maintain the age-old mythic ideal of the virtuous little girl, pure and docile, who was an asexual little angel. In order for society to maintain this ideal, masturbation by girls was strongly disapproved of, severely punished, its very existence cloaked in secrecy.

I shall present data on female genital mutilations in Western and other societies, as well as some comments by Freud, to depict the cultural, unspoken motivations underlying attitudes toward female sexuality, and the means used to curtail it. The clergy and the medical profession, especially during the Victorian era, regarded masturbation and manifestations of female sexuality as a "medical problem." This problem was often "treated" and "corrected" in little girls, adolescents, and even grown women by amputation or cautery of the clitoris, or by "miniature chastity belts" achieved by "sewing the labia together to get the clitoris out of reach" (Gornick and Moran, 1972). The history of clitoridectomies performed in the United States, England, and Western Europe in past centuries and the early part of this century has been discussed by Spitz (1952), Barker-Benfield (1975), and Scull and Faureau (1986). In the United States, the last recorded clitoridectomy for curing masturbation was performed on a five-year-old girl in 1948 (Ehrenreich and English, 1978, p. 111). As late as 1985, female circumcisions have been reported in England and France (Shaw, 1985).

Clitoridectomies were introduced in England in the 1850's by Isaac Baker Brown, a gynecologist surgeon, as a cure for mas-

turbation, which was thought to bring about insanity, hysteria, epilepsy, etc. The operation was performed on thousands of girls and women. Medical documents give clear evidence that clitoridectomies were advocated explicitly to reduce female sexual impulses and masturbation, both of which were viewed as dangerous, unwanted, and unfeminine. Regarding clitoridectomies, Showalter (1985), in *The Female Malady*, states that "the mutilation, sedation, and psychological intimidation . . . seem to have been an efficient if brutal form of reprogramming . . . of girls and women" (p. 68).

The *British Medical Journal* (1867) reports the following procedure of the genital operation performed under chloroform anesthesia to prevent masturbation:

> Two instruments were used: the pair of hooked forceps which Mr. Brown always uses in a clitoridectomy, and a cautery iron. . . . The clitoris was seized by the forceps in the usual manner. The thin edge of the red hot iron was then passed around its base until the organ was severed from its attachments, being partly cut or sawn, and partly torn away. After the clitoris was removed, the nymphae were got rid of, the operation was brought to a close by taking the back of the iron and sawing the surfaces of the labia and the other parts of the vulva which had escaped the cautery, and the instrument was rubbed down backwards and forwards till the parts were more effectually destroyed than when Mr. Brown uses the scissors to effect the same result (pp. 407-408).

Whereas clitoridectomies in the Western world were performed selectively, at the behest of fathers and/or husbands, ritual genital mutilations on *all* girls were performed for millennia and are still practiced in Africa, Australia, South America, and the Arab world (Williams, 1990, p. 39). These mutilations are of various kinds:

> *circumcision* (sunna), in which the labia minora and the tip or part of the clitoris are removed;

excision or clitoridectomy, in which the labia and the entire clitoris are removed;
infibulation, in which, after complete excision, both sides of the vulva are sewn together (Barry, 1984, pp. 519, 520). Thus the vagina is completely sealed. Only a small opening is left for urine and/or menstrual flow. Access to the vagina can only be gained again by tearing the vulva apart with the husband's penis, more often his flint or knife. When infibulation is practiced, the vulva is sewn up after each childbirth.

These practices, according to the 1993 Hosken Report, affect ninety million women (see also, *The New York Times*, 1990). Female genital mutilations, in spite of their traumatic, destructive, crippling consequences for female sexuality and psychic well-being (Konner, 1990; Williams, 1990), have mostly been kept secret by anthropologists and the Western medical profession. Among psychoanalysts, Spitz (1952) and Bonaparte (1948) are the only ones known to me to have reported on these practices before the 1960's, and Kulish (1991) reports on them currently.

Bonaparte considered female genital mutilations, and clitoridectomies in particular, as ways employed to feminize the female. Her thinking was influenced by Freud's "transfer theory" of female sexuality. Bonaparte (1948) stated:

> The excision of the clitoris, which many tribes practice, seemed to Freud a way of seeking to further "feminize" the female by removing this cardinal vestige of her masculinity. Such operations, as he once said to me, must be intended to complete the "biological castration" of the female which Nature, in the eyes of these tribes, has not sufficiently effected (p. 153).

Róheim (1945) presents clinical material indicating that adult Western males react to the clitoris with castration anxiety. According to anthropologists and psychoanalysts (Assaad, 1980; Bachofen, 1861; Barry, 1984; Bettelheim, 1954; Bonaparte, 1948; Lightfoot-Klein, 1989; Shaw, 1985, etc.), the predominant reason for the mutilation of the external female genitals is

the intention to curb or abolish female sexual desire and sexuality, which is viewed by males (and women who identify with them) as unbound, uncontrollable, and dangerous. In addition, the older woman's unconscious or preconscious envy of the young, maturing girl may be a factor in the perpetuation of female genital mutilation. Clitoridectomies assuage male castration anxieties and the fear of female masculine aggression. As can be seen, for the Western as well as the so-called "primitive" world, the conscious and unconscious motivations for the mutilations of female genitals are the same, the fear of female sexuality.

These views find an echo in Helene Deutsch's (1944-1945) and Bonaparte's (1948) descriptions and proscriptions for proper female sexual behavior. The "threatening atmosphere" with which the little girl's sexuality was and frequently still is greeted reinforces the internalization of forbidding parental attitudes. It leads to unconscious and conscious fantasies which find expression in girls' fears of being "closed-up," "sealed-over," or deprived of parts of their genitals. Girls' fears have the same psychic roots as boys' castration anxiety, namely, actual terror (Rangell, 1991) that their genitals might be mutilated or destroyed. Seeing the genitals of the opposite sex may, for girls *and* boys, serve to confirm unconsciously or consciously the potential validity of their fears. Although children's terror may be reinforced by repeated parental threats, it may also be fueled by children's guilt over unconscious wishes to rob the parent of each sex of his or her valuable sexual organs, and by sadistic fantasies of their destruction. There is, however, a significant difference between the boy's reality and the girl's. The castration of boys belongs to the remote past and has always been limited in number. In contradistinction, genital mutilation of all girls is a current actuality in many parts of the world, and genital mutilations on a limited scale have been practiced on girls in the Western world until quite recently. It is even possible that such practices still continue.

Psychoanalytic thought has for many years addressed itself to

the boy's complex castration fears, developing theoretical explanations and curative technical procedures. This has not occurred with regard to the girl's primary genital anxiety, namely, her fear about the safety of her *own* genitals, and the consequences of such anxiety. I suspect this "neglect" was in part due to the phallocentric concepts of Freud's psychoanalytic theory, to his misunderstanding of early female psychosexual development, and to the impact of the general disavowal of feminine sexuality in little girls. The current study of feminine psychosexuality began only with the recognition of primary femininity and the acknowledgment of infantile feminine sexuality, which involves the whole external genital area (Blum, 1976; Mayer, 1985, 1991; Renik, 1992; Schuker and Levinson, 1991; Stoller, 1968, 1976, 1986).

Primary genital anxiety in girls has to be distinguished from secondary genital anxiety which develops toward the end of the negative oedipal subphase. Primary genital anxiety derives from current overt or veiled threats directed toward girls' sexuality or measures taken to prevent their masturbation. These threats are internalized. The intrapsychic prohibitions are reinforced by tales and cultural mores concerning the enactments of genital mutilations which are consciously and unconsciously transmitted from generation to generation (Blum, 1988). We must acknowledge that major segments of society worldwide still do not recognize and accept the existence of sexuality in infants, toddlers, and young girls. Thus infantile accidental self-exploration, which in time leads to the intentional exploration of all genitals and brings about orgastic masturbation in three-year-old girls (Kleeman, 1975, 1976), is usually denied if not actively interfered with and forbidden. These societal and parental attitudes, frequently forcefully imposed by actions, lead to the toddler girl's primary genital anxiety.

The little girl, like the little boy, has a narcissistic investment in "her source of self-pleasure." Consequently, the danger of losing it at the behest of her love object, and the internalization of this threat, leads to serious intrapsychic conflicts. Some of the

grave pathological consequences which may occur are hysteria (Rangell, 1991), frigidity, and in some cases, the deadening of the self.

Clinical Vignettes

I. The following dream[3] fragment and associations depict dread of genital mutilation related to conflict and fear of punishment for masturbation. The patient, Ann, is in the third year of her analysis; she is in her early twenties.

The dream: "My friend, Jan, is showing me with great excitement a pair of shoes which she bought. The shoes are fancy, elaborate, Indian-like. They are cut off, the toe is cut off and it is square. They are an exceptional pair of shoes: at the cut-off toe they have a simulated Hope diamond." Ann said, "I knew it could not be the real Hope diamond because the shoes were bought on sale. Nevertheless, it still was wonderful."

Associations: Jan did not get the diamond as a love gift—she got it on sale. Ann implies it has a diminished value. Ann cannot make up her mind about whether she values or devalues this Hope diamond. The Hope diamond is also associated with hope, but what is the hope? Ann implies the hope is not a real hope. Ann refers to the shoes as "circumcised," and then denies it. She says:

> Remember there is no tip of the shoe, the shoe is circumcised—the source of pleasure is taken away. If the clitoris is removed and the labia are closed up, then there certainly is not going to be any pleasure. When I masturbated, the labia became enlarged. This was bad since it was a visible proof of masturbation. The doctors could see it—I feel ashamed of my labia, ashamed of my body, ashamed of masturbation. The doctors, by seeing the longer labia, would know I masturbated. Maybe I will have an operation on my genitals, a type of circumcision

[3] I wish to thank Rosemarie Gaeta, CSW, for sharing this material with me.

> to make me into a girl—corrective surgery, a punishment for masturbation. I have an anxiety that something will happen to my genitals as a punishment. My fantasy came true, I had to have a hymenectomy.[4] There was something wrong with my genitals, with my vagina, it was closed up, a kind of chastity belt.

II. Beth, a patient in her thirties, does not have an orgasm during coitus but has orgasms while masturbating with the following fantasy.

> They are preparing the girl for the master by getting her to be extremely aroused sexually. While she is so excited, they put a chastity belt on her and tie her spread eagle to the bed. The girl is almost frantic with excitement and can do nothing to get relief. They and the master enjoy watching her sexual torment.

Analysis revealed threats during childhood about the evils of masturbation. Beth recalls irrigations of the genital area with some mildly burning fluid. These were done by her father. She submitted to these with embarrassment but did not struggle. She says, "It was unpleasant-pleasant." It occurred, she thinks, between the ages of six and eight. In the masturbation fantasy Beth is deprived and tormented; yet she gets from others the sexual excitement she craves, so she bears no responsibility. The chastity belt assures her innocence.

III. Linda, a married, childless woman in her forties has had fantasies since childhood that her genitals are deformed. While visiting, Linda noticed that the twelve-year-old daughter of her friend had blood-stained panties. Linda looked at the panties with fascination and horror. She fantasized that her friend mutilated the daughter's genitals. Linda felt agitated, extremely anxious, and cut the visit short. She describes her own mother as "prim and lady-like." She used to admonish Linda by saying, "If you touch yourself 'down there,' your fingers will fall off." Linda never touched or looked "down there." She masturbated by rub-

[4] This surgical intervention was performed when the patient was twenty, at her request, because she could not have coitus.

bing a pillow against the whole genital area. She was always conflicted about "doing it," and afraid she would be discovered. Linda's fantasies that her genitals are deformed appear to be a displacement stemming from her mother's threat that "her fingers will fall off," thus deforming her hands and revealing her transgression.

Bonaparte (1948), discussing actual ritual genital mutilation of females, states that in Western societies on the whole "anatomic integrity of females is maintained, *but in the psychic domain our civilization practices mutilations*" (p. 160, italics added).

Aspects of Secondary Genital Feelings and Anxieties

During the negative oedipal subphase under optimal circumstances, when self-pleasuring is not interfered with, the masturbation fantasies of the two- to three-year-old girl have mother as her erotic object. These fantasies can have active and passive aims, the girl taking various roles in her erotic interactions with mother (Brunswick, 1940; Laufer, 1986). This is a period of intense erotic feelings, great angers, attachment, and spurts of autonomy. It usually coincides with the rapprochement subphase (Mahler, et al., 1975). Because of her sense of sameness with mother, the little girl ascribes to her mother a genital which is like her own and the sexual excitement with which she is familiar.

An experience becomes meaningful to the extent that one is able to absorb it by connecting and integrating it with one's conscious reality and unconscious psychic world. Thus, the anatomic differences between herself and the boy become a psychic reality for the little girl when she is ready to perceive and acknowledge the significance of these differences. She then recognizes, on the basis of her experience with protruding objects during masturbation, that "father/boy has 'that' [penis] which can be put in, and which will fit into the hole [vagina]" which

mother and she have (quotation from a patient). Since this recognition occurs during the girl's phase of erotic strivings toward mother, the negative oedipal subphase, the girl feels envious, deprived, and sad because "he has and can give to mother" what she lacks (quotation from same patient). This also is the time the little girl cannot avoid recognizing the uniqueness of the father/mother relationship. Thus she can no longer deny, and therefore is forced to acknowledge consciously or unconsciously, that the boy has the potential she lacks for the type of relationship with mother she would like to have. The desire for a penis derives from these psychic experiences which result in penis envy.

The so-called depression observed in a little girl subsequent to her discovery that she lacks a penis (Galenson and Roiphe, 1976; Mahler, 1966) appears primarily related to her awareness of what it means, in terms of her relationship with mother, not to have a penis—namely, to the unconscious or preconscious fantasy that she cannot give her erotically loved mother the genital satisfaction a boy could. This may also evoke the girl's fears, conscious or unconscious, of losing mother's love to those who can satisfy her, those who have penises. Thus, the desire for a penis and consequent penis envy seem primarily related to a fear of losing the love of the mother.

Under optimal circumstances, the girl does not feel incomplete or damaged. She values her genitals because she derives pleasure from them and she knows she is "made" like mother, whom she admires and whom she has endowed with potency. However, at this juncture in her development, the girl's psychic focus is on what she lacks. She now knows that she does not have "everything" (Fast, 1990), especially that she does not have "what it takes" to gratify mother sexually as father does and the boy could.

Following her recognition of the consequences of genital differences, the girl experiences her relationship with mother as having changed. She attributes this change to her lack of a pe-

nis. This assumption usually evokes in the girl a sense of narcissistic injury, envy, and feelings of inferiority. The girl's fantasies at this time, though replete with a multitude of variations, have as their predominant theme "explanations" as to why, how, and when she was deprived of a penis. These fantasies are defensive as well as adaptive measures to cope with the intrapsychic sense of catastrophe brought about by the simultaneously experienced narcissistic injury and by the imagined loss of her love object.

At the waning of the negative oedipal subphase, changes in the psychic reality of the little girl may bring forth a profound sense of sadness. This feeling state may include elements of mourning. Even under optimal circumstances the sense of "we" the little girl felt in relation to mother now gives way to an overwhelming recognition of "they, the couple, he and she," with the girl feeling left out. No wonder the little girl seems "downcast," sometimes irritable, unable to find a place for herself, frequently "invading" the parental bedroom. Her feeling state at this time, however, does not represent a true depression unless the assumption or observation is made that the hostile and aggressive feelings the girl experiences toward the father/boy have been repressed and turned against the self.

Secondary genital feelings and anxieties thus relate to a belief, or unconscious fantasy, held by the girl, that she was deprived of a penis. Consequently, she may fear the loss of her mother's love and possibly even the loss of her love object.

Clinical Vignettes

The following material comes from lesbian patients who have entered analysis for reasons other than a wish to change their sexual orientation. These cases highlight the muted dynamic shifts which take place in the course of normal psychosexual development during the negative oedipal phase.

I. M,[5] now in her early thirties, recalls having idealized her mother and having good feelings about herself until the birth of a brother who became mother's favorite. M was about four or five at the time. She felt envious and wanted to be a boy because mother preferred a boy, not because she, M, devalued girls/women. M felt that her valuation of women was attested to by her choice of her love object, a woman. To become heterosexual had the following unconscious meanings for M. It meant, first and foremost, giving up mother as the erotic love object. It also implied identifying with mother in the choice of a man (brother/father) as a preferred erotic love object. Such a change signified to M a devaluation of women, to which she refused to subscribe. M experienced her mother's attitude as a narcissistic blow. In spite of herself, however, and unknowingly, M unconsciously did identify with what she fantasied and perceived as mother's attitude. She became a "tomboy" and thus "a son to her father" in the role she played as his companion. M chose a predominantly "masculine"[6] career in which she was extremely successful.

II. J, a woman in her thirties, sought treatment because she suffered from an extreme writing inhibition. Telling her history, J recalled her envy of her brother, who became the "head of the house" when the father abandoned the family. She was seven and the brother was fifteen. After the father deserted them, the mother not only favored the brother as she always had, but now she also consulted him in making decisions. J felt envious, jealous, and unwanted. She felt there was no place for her, and she felt worthless. She continued, however, to idealize her mother, whose devotion to the children bordered on self-sacrifice. The brother at eighteen left to join the merchant marine. Shortly thereafter, his contact with the family stopped. J

[5] I wish to thank Dr. Phyllis Hopkins for sharing this material with me.

[6] By which I mean that mostly men are members of this profession, although it does not require any "masculine" traits, such as extraordinary strength, etc.

used her ingenuity to dispel her mother's sadness, which she shared. Mother and daughter now slept in one bed. Mother intensified her work to provide J with the best possible education. J started wearing her brother's discarded clothes.

When analysis began, J looked and dressed like a young sailor. She was not consciously aware of her masculine identification and the conflicts this engendered. Consciously, she felt anger at men, who she believed betrayed mother and her, and who could not be trusted. She highly esteemed her mother and identified with her values. J spoke with great pain about her mother's continued hope that the brother would return. She, J, felt he was a scoundrel, like all men. Prompted by an unconscious identification with mother's wishes, J assumed a protective role toward her mother, which J and mother considered "masculine." After a brief heterosexual relationship with a married man who exploited her, J chose women as her love objects. In these relationships, J's role alternated: she was both the child and the mother.

The so-called "turning away from mother" (Freud, 1931, 1933) is a defensive attempt by the girl to turn a passive experience—the fantasy of mother leaving her for father/brother—into an active seeking of the love object who could satisfy her just as he satisfies mother. This is the impetus for the girl's changed relationship to her father: the onset of the positive oedipal phase. The erotic feelings and longings of which mother was the object are now transferred to father. The little girl fantasizes and wants father to give to her what he gives to mother, the satisfaction only possible by the use of his penis. The little girl who had wanted to bear mother's child and give mother a child (Brunswick, 1940), and who heretofore regarded mother as the sole creator, now knows that the baby comes from what mother and father "do together." She, too, wants to do "that" with father, and she now wants a baby with him and by him.

The hostility toward mother is primarily related at this time to the narcissistic pain evoked by the unconscious or conscious fantasy that mother "devalues the girl because she lacks the

penis necessary to gratify mother" (patient's comment). At this time, even under optimal circumstances, the girl's sense of denigration stems from her self-comparison with the boy, "who has what it takes."

The girl, unable to clearly distinguish between fantasy and reality, attributes the origin and cause of her sense of debasement to mother's preference for the man/boy (father/brother) who has the penis. Hurt and angry, the girl eventually projects onto mother the feelings she attributes to mother. After this psychic process occurs, the girl considers the penisless mother—the way she believes the mother considers her—as "inferior to the father," who has the penis which can satisfy either of them. The fantasy of being spurned by mother fuels the girl's angry, dejected feelings toward herself and mother. During this period, such feelings frequently find expression in violent temper tantrums.

Penis envy, devaluation, dejection, and loss of maternal love are specific psychic experiences of little girls, culminating when the "negative oedipal" constellation comes to an end. They are evoked when the erotic longings and fantasies which the little girl has directed toward her mother are confronted by the reality of mother's unattainability as an erotic object. This state of psychic conflagration is experienced by the girl during the conflictual rapprochement subphase, which adds intensity to the mother/daughter loving and hostile interactions. The merging tendencies of the girl, which were reinforced by the sense of "sameness with mother" and by having had mother as her erotic object, are now curtailed when the girl painfully discovers she "doesn't have what it takes" to gratify mother.

The fantasied rejection by mother, which pains and angers the girl and makes her turn toward father as a new erotic object, can also, under optimal circumstances, promote a spurt in the girl's growth toward individuation and autonomy. Such a beneficial outcome, however, is only possible when the girl's primary sense of intactness as a female is sufficiently strong to overcome secondary genital feelings and anxieties highlighted

by penis envy. Father's loving and positive acknowledgment of the girl's femaleness, and therefore her desirability as a female, is essential in this process, and his valuation of the mother is necessary to enable the girl once again to identify with mother and her womanly qualities. Also crucial at this time is mother's affirmation of the girl's femininity, and mother's loving acceptance of the girl in spite of her hostility and ambivalence.

The little girl traverses the father-related oedipal phase with these dynamic constellations. During this phase both primary and secondary genital feelings and anxieties will be manifest and commingle. The ascendancy of one or the other complex of feelings, and the defensive use of either, will depend on the specific vicissitudes of the positive oedipal phase. Although both primary and secondary genital feelings and anxieties are present during the positive oedipal phase, their latent and manifest focus varies, depending upon the girl's reality and psychic experiences. The interplay and vicissitudes of primary and secondary genital feelings and anxieties during the positive oedipal phase determine whether the outcome will be normal or pathological, possibly even the specific type of pathology. A certain type of female homosexuality may be related to anxieties and/or regression to the negative oedipal phase.

CONCLUSION

In the present analytic climate, long-held doctrinaire Freudian views regarding female psychosexual development and sexuality are undergoing re-examination. An open-minded and open-ended approach to child observation has developed. In addition, analytic material of female patients is given a hearing freed from interpretations and conclusions that are inferential leaps based on previously established Freudian theory. The prevalent recognition that the human mind has an almost unlimited capacity for pluralism leads to the acknowledgment that the great variety of fantasies about which we are analytically informed is *multidetermined*.

Contemporary views on female psychosexual development do not question Freud's observations. They differ with his monistic understanding and interpretation of same. His statement that "a little girl is a little man" (Freud, 1933, p. 118) and his assertion that penis envy is the "bed-rock" a woman's analysis can reach (Freud, 1937, p. 252) have been the focus of many analytic investigations (Bernstein, 1988; Fast, 1984, 1990; Horney, 1924; Karme, 1981; Moore and Fine, 1990; Torok, 1970; Wilkinson, 1991). These have led to a new understanding of a girl's evolving body-ego, self-representation, and femininity. Listening to women's analytic material without a theoretical bias reveals a variety of unconscious conflicts and motivations accounting for penis envy which, when worked through, can bring about more successful clinical outcomes than Freud's pessimism envisioned.

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My Grand-Patient, My Chief Tormentor: A Hitherto Unnoticed Case of Freud's and the Consequences

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MY GRAND-PATIENT, MY CHIEF TORMENTOR: A HITHERTO UNNOTICED CASE OF FREUD'S AND THE CONSEQUENCES

BY ERNST FALZEDER, Ph.D.

For many years Freud treated a woman patient who meant very much to him and for whose treatment he made the most extraordinary sacrifices. He wrote down her case history, and he described her case in at least six articles. In addition, this woman played a major role in the conflict between Freud and Jung. This paper sketches the case history, presents Freud's interpretation of her neurosis, and outlines the important consequences of this classical case in the history of psychoanalysis for theory and technique.

> I should decide today to send that essay into the world, and should not flinch from the scandal it would inevitably evoke. But there is the insuperable obstacle of the limitation of medical discretion. . . . distortions are not permissible, nor would any sort of weakening help. If fate brings about the death of the two people [in question] . . . before my own death, the obstacle would vanish.
>
> FREUD (letter of 15 February 1925, in Jones, 1957, pp. 392-393)

Suppose that for many years Freud had treated a hitherto hardly noticed woman patient who had meant very much to him

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and for whose treatment he had made the most extraordinary sacrifices; suppose he had written down her case history; suppose he had described the case in at least six articles; and suppose this woman had played a major role in the conflict between Freud and Jung—would this case not deserve our attention? But, should it really exist, why has it not, until this day, aroused the interest of psychoanalysts and Freud scholars?

Well, this case does exist. Although it has been mentioned by some authors in passing (e.g., by Peters, 1977, pp. 35-36; Krutzenbichler and Essers, 1991, p. 69; Grubrich-Simitis, 1993, pp. 265-268), the identity of the patient has not been disclosed, nor has her case been subjected to closer study. And although Freud mentioned her not only in various writings, but also in many letters, published and unpublished, no attempt has so far been made to put together the pieces of the puzzle.

Two facts have contributed to this. (1) The editors of the various Freud correspondences did not use the same pseudonyms for the same patients; thus, the woman in question is called, in Freud's correspondence with Abraham, "Frau A.," in the one with Pfister, "Frau H.," in that with Jung, "Frau C-," and in Freud's letters to Binswanger, "Frau Gi." (2) As for the unpublished Freud letters (this case plays a central role in the unpublished part of the Freud/Pfister correspondence), it has been the policy of the Freud Archives (Library of Congress, Manuscript Division, Washington, DC) to obliterate patients' names in the accessible copies of the original letters. The starting point of my research was the idea that these different pseudonyms and certain obliterated names in the unpublished letters might refer to the same person—and, in fact, a compilation of the paragraphs in question has made it clear that this is the case.

In what follows I will try to sketch the case history of this extraordinary woman, to show Freud's affection for her, to present his interpretation of her neurosis, and, above all, to outline the *important consequences* her treatment had for the theory and technique of psychoanalysis. This is indeed one of the *classical cases* in the history of psychoanalysis, on a par with the

cases of Anna O., Cäcilie M., Dora, the Rat Man, the Wolf Man, and R.N. (see Dupont, 1985). Like these cases, it significantly contributes to a better understanding of pivotal elements of a psychoanalytic history of ideas and the development of central theoretical and technical concepts. And like these, it shows Freud's capacity to advance theory in spite of therapeutic failures. Apart from being a fascinating history of the past, this story might also stimulate contemporary analytic thinking. Is it not true that we, too, learn more from our failures and blunders than from our successes? I do not attempt to present a full biographical account; further research will, I hope, complete this part of the picture.

Stages in a Life of Suffering

Frau Elfriede Hirschfeld was born around 1873 and grew up in Frankfurt, Germany (Freud to Pfister,[1] unpublished letter of 28 May 1911, Library of Congress [LOC]; *cf.*, Freud, 1941, p. 185) as the eldest of five girls. Her mother "had married late—not till she was over thirty" (Freud, 1933, pp. 41-42); she "was older than her father and not an agreeable person. Her father—and it was not in years only that he was the younger—saw a lot of the little girls and impressed them by his many dexterities" (Freud, 1941, p. 185), for example, he "was an excellent draughtsman, and had often enough excited the delight and admiration of the children by exhibitions of his skill" (Freud, 1913d, p. 308). "Unfortunately he was not impressive in any other way; he was incompetent at business and was unable to support the family without help from relatives. The eldest girl became at an early age the repository of all the worries that

[1] Passages quoted from Freud's correspondence were written by him if not indicated otherwise. The volumes of correspondence are listed in References and cited in my text under the various editors' names. Translations from unpublished letters and from the Freud/Binswanger correspondence, not yet published in English, are mine.

arose from his lack of earning power" (Freud, 1941, p. 185). Nevertheless—or therefore—she "had grown up with an extremely strong attachment to her father" (Freud, 1933, pp. 40-41), an "excessive fondness" for him (Freud, 1913d, p. 308). This love, however, "was destined when she was grown up to wreck her happiness in life" (*ibid.*).

"[I]n the first years of her life, she had been a wilful and discontented child" (Freud, 1913d, p. 307), but "[o]nce she had left behind the rigid and passionate character of her childhood, she grew up into a regular mirror of all the virtues" (Freud, 1941, p. 186), and became "a particularly capable, truth-loving, serious and virtuous girl . . . excessively good and conscientious" (Freud, 1913d, p. 307). It is not astonishing, however, that these virtues were counterbalanced by certain "occurrences in her schooldays, which, when she fell ill, caused her deep self-reproaches, and were regarded by her as proofs of fundamental depravity. Her memory told her that in those days she had often bragged and lied" (*ibid.*). When she was about eleven years old, she dropped her youngest sibling "out of her arms when it was a baby; later she called it 'her child' " (Freud, 1941, p. 185).

> Her high moral feelings were accompanied by a narrowly limited intelligence. She became a teacher in an elementary school and was much respected. The timid homage paid to her by a young relation who was a music teacher left her unmoved. No other man had hitherto attracted her notice.
>
> One day a relative of her mother's appeared on the scene, considerably older than she was, but still (for she was only nineteen) a youngish man. He was a foreigner[2] who lived in Russia as the head of a large commercial undertaking and had grown very rich. It took nothing less than a world war and the overthrow of a great despotism to impoverish him. He fell in love with his young and severe cousin and asked her to be his wife. Her parents put no pressure on her, but she understood

[2] In the original manuscript of this paper (LOC) Freud states that he was an Englishman.

their wishes. Behind all her moral ideals she felt the attraction of the fulfillment of a wishful phantasy of helping her father and rescuing him from his necessitous state. She calculated that her cousin would give her father financial support so long as he carried on his business and pension him when he finally gave it up, and that he would provide her sisters with dowries and *trousseaux* so that they could get married. And she fell in love with him, married him soon afterwards and followed him to Russia.[3]

Except for a few occurrences which were not entirely understandable at first sight and whose significance only became evident in retrospect, everything went very well in the marriage. She grew into an affectionate wife, sexually satisfied,[4] and a providential support to her family. Only one thing was wanting: she was childless. She was now 27 years old[5] and in the eighth year of her marriage. She lived in Germany, and after overcoming every kind of hesitation she went for a consultation to a German gynaecologist.With the usual thoughtlessness of a specialist, he assured her of recovery if she underwent a small operation. She agreed, and on the eve of the operation discussed the matter with her husband. It was the hour of twilight and she was about to turn on the lights when her husband asked her not to: he had something to say to her and he would prefer to be in darkness. He told her to countermand the operation, as the blame for their childlessness was his. During a medical congress two years earlier he had learnt that certain illnesses can deprive a man of the capacity to procreate children. An examination had shown that such was the case with him (Freud, 1941, pp. 186-187).

"[B]efore their marriage" (Freud, 1933, p. 42) he had been

[3] To Moscow (letter to Pfister, 28 May 1911, LOC).

[4] A "happy and almost completely satisfied wife" (Freud, 1913b, p. 320). In another context, Freud even stated that she "had found entire satisfaction in her marriage" (1933, p. 41). However, he seemed to have had some reservations about this, because after he had written in 1913 that she became "an affectionate and happy wife," he let drop the words "and happy" in all subsequent editions (1913d, p. 307, n.).

[5] But "looked much younger" (1925, p. 137; 1933, p. 41).

rendered sterile by epididymitis (letter of 29 November 1908, McGuire, p. 183).

> After this revelation the operation was abandoned. She herself suffered from a temporary collapse, which she vainly sought to disguise. She had only been able to love him as a substitute father, and she had now learnt that he never could be a father. Three paths were open to her, all equally impassable: unfaithfulness, renunciation of her wish for a child, or separation from her husband. The last of them was excluded for the best practical reasons and the middle one for the strongest unconscious ones, which you can easily guess: her whole childhood had been dominated by the thrice disappointed wish to get a child from her father (Freud, 1941, p. 187).

Freud did not discuss the first possibility—unfaithfulness—here, but he stated in another context that she "clearly suffered from fears of being tempted [into unfaithfulness to her husband]" (Freud, 1933, p. 41, brackets in original). And although separation seemed to be excluded for the best practical—i.e., financial—reasons, "she vacillated at that time about whether she shouldn't leave her husband" (letter of 3 January 1911, Brabant, et al., p. 249). In reality, however, there remained only "one . . . way out. . . . She fell seriously ill of a neurosis" (Freud, 1941, p. 187).

She developed an *anxiety hysteria*[6] that "corresponded," according to Freud, "to the repudiation of phantasies of seduction in which her firmly implanted wish for a child found expression" (1913b, p. 320). One of her symptoms was "a pathological dread of pieces or splinters of glass" (1913d, p. 308). "She now did all she could to prevent her husband from guessing that she had fallen ill owing to the frustration of which he was the cause" (1913b, p. 320).

Through a second traumatic event, this anxiety neurosis changed into a severe *obsessional neurosis*.

[6] Freud also speaks of her "*Verstimmung*" (ill humor; irritation), which was translated misleadingly as "depression" (1941, p. 187).

> Her husband understood, without any admission or explanation on her part, what his wife's anxiety meant; he felt hurt, without showing it, and in his turn reacted neurotically by—for the first time—failing in sexual intercourse with her. Immediately afterwards he started on a journey. His wife believed that he had become permanently impotent, and produced her first obsessional symptoms on the day before his expected return. The content of her obsessional neurosis was a compulsion for scrupulous washing and cleanliness and extremely energetic protective measures against severe injuries which she thought other people had reason to fear from her (Freud, 1913d, p. 320).

> Her most striking symptom was that when she was in bed she used to fasten [*anstecken* = bring in contact] her sheets to the blankets with safety-pins. In this way she was revealing the secret of her husband's contagion [*Ansteckung*], to which her childlessness was due (Freud, 1941, p. 187, brackets in original).

From this time on, a never-ending sequence of therapies ensued, all of them failing in the end, although some of the very best psychiatrists, psychotherapists, and psychoanalysts of the time did their best to help her. "For years" she was "the major person" in a German clinic (letter of 24 April 1915, Fichtner, p. 149), she was treated by Pierre Janet, by Carl Gustav Jung, by Oskar Pfister, and by Ludwig Binswanger; Eugen Bleuler, too, was consulted (*ibid.*). But, above all, "after her illness had lasted for ten years" (Freud, 1941, p. 187), she came to Freud and was in analysis with him for nearly seven years (although there were some interruptions). To my knowledge, only very few analysands of Freud's were treated for a comparable span of time—all of them women, by the way, such as Dorothy Burlingham, Ruth Mack Brunswick, and Marie Bonaparte.

"When I heard her case history, I did not want to take her at first," Freud told his closest collaborators[7] in 1921; "later I was

[7] In late September 1921, the seven members of the Secret Committee met in the

sufficiently curious, ignorant, and interested in earning money to start an analysis free of compulsion with her nevertheless" (Grubrich-Simitis, 1993, p. 265). Frau Hirschfeld's analysis with Freud started in October 1908.

Freud reported to Jung on 8 November: "Frau C- did actually come to me a fortnight ago; a very serious case of obsessional neurosis, improvement is bound to be very slow. The reason for her preference for me was that Thomsen[8] had advised her against me, saying that treatment by me would only make her condition much worse. But that fell in with her need for punishment" (McGuire, pp. 175-176). In the following months and years, Freud kept Jung informed about the analysis (see the letters of 17 January 1909, 22 April 1910, 27 April 1911, in McGuire, pp. 197, 310, 417). But only after two and a half years did the first manifest effects of the treatment become evident: of all things, "her symptoms have grown much worse. Of course this is part of the process, but there is no certainty that I can get her any farther. I have come very close to her central conflict, as her reaction shows" (12 May 1911, *op. cit.*, p. 423).

On 28 May 1911 Freud asked Oskar Pfister in Zurich whether he would be willing to take over the case during Freud's vacation in the summer months. It is not quite clear who had actually taken the initiative for this arrangement; Freud, for his part, attributed it to Frau Hirschfeld herself, who would "thus act out her compulsion to leave her husband for a youthful friend" (LOC). At first Freud asked Pfister to take charge of her only for a short time. However, when it became obvious that the two of

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Harz Mountains in Germany (Grosskurth, 1991, pp. 19-23), for which occasion Freud had prepared a talk on "psychoanalysis and telepathy," largely based on the case of Frau Hirschfeld. This text was published posthumously in an abbreviated form in both the *Gesammelte Werke* and the *Standard Edition* (1941); the original manuscript that I consulted in the Library of Congress contains substantial further information about both case histories treated in the paper. Some of the pertinent passages have recently been published by Ilse Grubrich-Simitis (1993, pp. 265-266).

[8] According to William McGuire, editor of the Freud/Jung correspondence, probably Robert Thomsen (1858-1914), directing psychiatrist of the Hertz private sanatorium, Bonn.

them had begun a regular analysis, Freud would have liked to "hand over this burden permanently (i.e., for a couple of years)" to Pfister; above all, Pfister should by no means urge her to go back to Freud (*ibid.*)! But this is exactly what Frau Hirschfeld did. She left Pfister on 3 December 1911, was not heard of for a few weeks, and then, around Christmas, she turned up in Vienna again. Freud, despite his objections, took her into analysis again (letter of 17 December 1911, McGuire, pp. 473-474). From this time on Freud kept Pfister informed about the analysis, as he had Jung before him. On 15 June 1912 he even sent a telegram to Pfister (LOC), urging him to come to Vienna for a week to help Frau Hirschfeld in her attempt "to do without custody," or, as he wrote to Ferenczi, "to help . . . with a withdrawal process [*Entwöhnung*]" (23 June 1912, Brabant, et al., p. 386).[9] After Pfister's visit to Vienna, the prospects for an improvement in Frau Hirschfeld's condition seemed to rise.

On 10 July 1914, Freud wrote to Karl Abraham in Berlin (unpublished; Freud Museum, London) that Frau Hirschfeld might move from Vienna to Berlin, in which case Abraham should continue her treatment. Freud would then do what he could to inform Abraham; yet, he warned Abraham that in all likelihood he would not find much pleasure in her. Frau Hirschfeld paid a short visit to Berlin, during which Abraham went to see her in her hotel (Abraham to Freud, 23 July 1914, in Abraham and Freud, p. 185), but she did not settle there.

Instead, she went to Zurich after the outbreak of World War I. From there, from January 1915 onward, she spoke with Binswanger by telephone a few times, "arguing that she would like to come here [to Binswanger's sanatorium, Bellevue, in Kreuzlingen on Lake Konstanz] or that I [Binswanger] should go to Zurich some time to look after her," but "she does not want

[9] Probably an allusion to the fact that Frau Hirschfeld "insisted that her nurses should never let her out of their sight for a single moment: otherwise she would begin to brood about forbidden actions that she might have committed while she was not being watched" (1913a, p. 269). There are no indications she was addicted to drugs.

to consider analysis" (Binswanger to Freud, 19 April 1915, Fichtner, pp. 147-148). Binswanger asked for further details, and Freud answered with a long letter. "There is so much to say about the patient," he began his account of her, and he ended it with "in short, one would not be able to stop talking about her" (24 April 1915, *op. cit.*, pp. 148-150).

At the end of April 1915, Binswanger went to Zurich to see Frau Hirschfeld. Their talk centered on the Freud/Jung conflict; Frau Hirschfeld spoke disapprovingly of Jung and wanted to know whether Binswanger was still a disciple of Freud's (Binswanger to Freud, 18 May 1915, Fichtner, p. 150). Despite her claims that she could not afford a stay in Binswanger's sanatorium, she did go there some time later. Freud included her, possibly, in his address to the "friends on Lake Konstanz" (7 May 1916, Fichtner, p. 153) on the occasion of his sixtieth birthday. Gerhard Fichtner, editor of the Freud/Binswanger correspondence, also quotes a letter from Pfister to Binswanger (8 November 1916, Fichtner, p. 149), in which Pfister mentions Freud's appreciative remarks about Binswanger's merits in this case.

From this time on, the traces of Frau Hirschfeld in those documents that are accessible to me become scarce. Only sporadically does she re-emerge in Freud's letters—for example, in letters to Pfister on 9 May 1920 and 29 July 1921 (LOC). In these, Freud refused to take her again into analysis and recommended treatment as a clinical inpatient, and he defended himself against the reproach that he might have used an inappropriate therapeutic technique. In any case, no later than November 1921 we find Frau Hirschfeld again in Binswanger's clinic, where she stayed at least until 1923 (interrupted by a stay in Berlin) (see Fichtner, pp. 175, 176, 178-179, 182, 186).

During the following summer, Pfister asked Freud's advice on whether he should once again start analysis with Frau Hirschfeld. On 11 July 1924 Freud answered that he saw no reason why Pfister should not, adding that he could not comment upon Eugen Bleuler's diagnosis of imminent schizophre-

nia—what he had seen so far would undoubtedly have been a case of obsessional neurosis. I could not find out whether she did, in fact, return to analysis with Pfister, but she kept in touch with him, with Binswanger, and with Freud. Freud mentioned her for the last time, as far as I know, in a letter to Pfister on 1 June 1927 (Meng and Freud, p. 108); she had apparently paid a visit to Freud and told him of Pfister's wish that Freud should destroy certain letters (pertaining to marital troubles and a love affair of Pfister's). Finally, Binswanger related his visit to Freud on 17 September 1927, on Semmering Mountain near Vienna, when they talked "also about the case Gi. and about the reasons for the failure of the cure" (Fichtner, p. 267).

My Grand-Patient, My Chief Tormentor

Beyond any doubt, Freud had an extraordinary affection for this woman. For him, she was "extremely interesting" (17 January 1909, McGuire, p. 197), a "particularly fine, good and serious woman" (letter to Pfister, 10 July 1910, LOC), an "impossible personality of highest standing" (28 May 1911, *ibid.*). He found her "more than sympathetic, rather of high principles and refined" (15 June 1911, *ibid.*); she and her husband were "seriously noble people" (13 December 1911, *ibid.*); her "case is surely more interesting and her person more valuable than others" (*ibid.*); she was "the poor thing" (10 January 1912, McGuire, p. 479), whom Freud sometimes called by her first name (10 May 1923, Fichtner, p. 186); he found her a "lovable, more than considerate, ingeniously refined personality" (24 April 1915, Fichtner, p. 149); "she is also a daughter who wants to help her father, like Jeanne d'Arc" (Fichtner, p. 150). She was indeed Freud's "*grand-patient*" (*Grosspatientin,* italics added), as he called her at least twice (23 June 1912, Brabant, et al., p. 386; Freud to Abraham, 10 July 1914, Freud Museum).

But despite Freud's efforts, Frau Hirschfeld's condition did not improve. Thus, she was not only his "grand-patient," but

also his "*chief tormentor*" (*Hauptplage,* italics added), as he wrote to Jung (27 April 1911, McGuire, p. 417). This "very serious case" (8 November 1908, *op. cit.,* p. 175) was "a hardly digestible morsel," and although for Freud she was "easy to see through,"[10] she did not want to or was not able to accept his interpretations: "It's so clear it makes your hair stand on end. Nevertheless, the therapy is bringing meagre results. She pins herself up at night to make her genitals inaccessible; you can imagine how accessible she is intellectually" (29 November 1908, *op. cit.,* pp. 183-184). Freud felt relieved when she interrupted her analysis for a couple of months: "I was saved just short of the final point of exhaustion by the departure of my *main client* for Frankfurt yesterday" (25 February 1910, Brabant, et al., p. 146, italics added; *cf.,* McGuire, p. 310). "She is a grave case, perhaps incurable" (12 May 1911, McGuire, p. 423). "She has no chances of getting cured" (letter to Pfister, 2 January 1912, LOC). "She can be entrancing until the moment when she has achieved her goal that one no longer makes any demands" (9 October 1911, *ibid.*). And she made Freud utter that heartfelt sigh: "We must never let our poor neurotics drive us crazy" (31 December 1911, McGuire, p. 476)!

Freud fought to retain his equanimity; he found it hard to be "[o]nce again ... tolerant and patient" (28 December 1911, McGuire, p. 474). He kept "cruelly reminding her" that what she wanted most would be "an intellectual flirtation that would enable her to forget her illness for a while" (10 January 1912, *op. cit.,* p. 479), and he was "determined to treat her very harshly" (letter to Pfister, 9 February 1912, LOC). But then Frau Hirschfeld's "completely changed behavior" caused Freud to be "on a much better footing with her than before. So I also gain therapeutic hope again, despite the seriousness of the case" (*ibid.*).[11] She "continues to make efforts and enthusiastically

[10] My translation of "*ein schwerer Bissen*" and "*leicht zu durchschauen.*"

[11] *Cf.,* a similar passage in Freud's letter to Wilhelm Fliess of 16 May 1900, in which he wrote about his efforts in his then "most difficult case," also a woman

stands by me; also, she has revealed nearly the complete structure of her case. But it is still obvious that she wants to get over the stones in her path rather with the wings of transference than with the laborious steps of work. Nous verrons!" (4 July 1912, *ibid.*).

Freud's hopes were to be proved deceptive. We can deduce the failure of the therapy from his letter to Binswanger, written about three years afterward: "She is a most severe case of obsessional neurosis, analyzed *nearly* [italics in original] to the end, which turned into an incurable state. She withstood all efforts due to the particularly unfavorable factual circumstances. Allegedly, she is still dependent on me; in reality, she runs away from me since I could tell her the last word of the secret of her illness. *Analytically of no use for anybody* [italics added]. Of Pfister, she is making a fool" (24 April 1915, Fichtner, p. 148).

The only measure that might be of use in this severe case of obsessional neurosis would be compulsion itself (8 November 1916, Fichtner, p. 149), combined with in-clinic treatment (letter to Pfister, 29 July 1921, LOC). Freud's final conclusion is found in a letter to Binswanger on 27 April 1922: "I would like to express as my judgment in the case of Frau Gi. that one could perhaps achieve something with her only through a combination of analysis and prohibition (*counter-compulsion*). I deeply regret that I could, at that time, only make use of the first, the other one can only be enforced in a clinic" (Fichtner, pp. 178-179, italics added).

There is a postscript to Frau Hirschfeld's therapy with Freud. In the fall of 1921 she again wanted to be analyzed by him—but Freud declined, giving no fewer than four arguments, all of them of an allegedly "rational" and not of a personal nature (letter to Pfister, 29 July 1921, LOC). But his "whole plea," to quote Freud himself, "remind[s] one vividly of the defence put forward by the man who was charged by one of his neighbours

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patient. The turning point in the cure came only after four years, when Freud "began to get on good terms with her" (Masson, 1985, p. 413).

with having given him back a borrowed kettle in a damaged condition. The defendant asserted first, that he had given it back undamaged; secondly, that the kettle had a hole in it when he borrowed it; and thirdly, that he had never borrowed a kettle from his neighbour at all. So much the better: if only a single one of these three lines of defence were to be accepted as valid, the man would have to be acquitted" (Freud, 1900, pp. 119-120). Moreover, his main argument—that he would not have the time to take her on, having a full schedule with other patients—seems to be groundless, particularly in this case. He had already brought this same argument forward in 1911, only to take her on nevertheless, and this even though he already considered her "beyond any possibility of therapy" (17 December 1911, McGuire, p. 474). One cannot help being reminded of the fact that on a previous occasion Freud had also refused to take an important patient of his into analysis for a second time; this patient, too, had run away from him once he had been about to tell her "the last word of the secret of her illness," and she, too, had been reproached by Freud with being responsible for the failure of the cure.[12]

Learning Awfully Much without Losing One's Skin

Freud once told Max Eitingon that "the secret of therapy is to cure through love, and . . . with greatest personal effort one could perhaps overcome more difficulties in treatment, but one would 'lose his skin by doing so' " (Grotjahn, 1967, p. 445). Freud, however, instead of "losing his skin," finally preferred "*to develop the thick skin we need*" in order to "dominate 'countertransference,' which is after all a permanent problem for us" (7 June 1909, McGuire, p. 231, italics added).

[12] Dora's breaking off the treatment "just when my hopes of a successful termination of the treatment were at their highest . . . was an unmistakable act of vengeance on her part" (1905a, p. 109; Decker, 1991). Freud also refused to treat the Wolf Man for a third time.

It is not only the analyst who does not like losing his or her skin; a few months after his letter to Jung, Freud used the same skin metaphor[13] for describing the emotional situation of the patient:

> It seems to me that in influencing the sexual drives, we can bring about nothing more than exchanges, displacements; never renunciation, giving up, the resolution of a complex. (Strictest secret!) When someone delivers up his infantile complexes, then in their place he has salvaged a piece of them (the affect) and put it into a present configuration (transference). He has shed his skin and leaves the stripped-off skin for the analyst; God forbid that he is now naked, skinless! Our therapeutic gain is a substitutive gain, similar to the one that Hans im Glück makes. The last piece doesn't fall into the fountain until death[14] (10 January 1910, Brabant, et al., p. 123).

Seldom before or afterward did Freud so strikingly describe the affective involvement of *both* partners in analysis, a situation that really goes "underneath one's skin." He might well have been inspired to this statement by his "grand-patient" and "chief tormentor," who was, moreover, his "main client" at that time.

Freud's conclusion was that, in any case, one "has to remain consistent, these are the very circumstances under which one can *learn awfully much*"[15] (12 May 1911, McGuire, p. 423, italics

[13] See also Freud's letter to his fiancée, Martha Bernays: "The poor, the common people, could not exist without their thick skins and their easygoing ways" (Jones, 1953, p. 191). That a thick skin should prevent *sexual* arousal can also be inferred from Freud's opinion that "the skin . . . is . . . the erotogenic zone *par excellence*" (1905c, p. 169).

[14] In the fairy tale from the brothers Grimm, Hans, as a reward for his work, receives a piece of gold which becomes a burden to him. He trades it for a horse, the horse for a cow, etc., until he is finally in possession of two stones. Because they press him, he puts them on the edge of a fountain, pushes them, and they fall in. Hans thanks God and, free of all burdens, bounds home to his mother. Incidentally, when Freud was about to emigrate, he looked at his suitcases and exclaimed: "Now, I am *Hans im Glück!*" (Puner, 1947, p. 257).

[15] My translation of ". . . *konsequent bleiben und hat gerade unter solchen Umständen*

added)—provided one displayed the "necessary roughness" (letter to Pfister, 14 December 1911, LOC).

This conclusion, drawn from Freud's experience with his grand-patient, can also be seen in the background of another highly emotionally charged episode—the love affair between Carl Gustav Jung and his patient, Sabina Spielrein (Kerr, 1993). The two episodes overlapped to some extent, and both contributed in an important way to the conflict between Freud and Jung. Without going into detail, let us remember that it was while alluding to Jung and Spielrein that Freud talked of "the thick skin we need" and that for the first time ever he used the term "countertransference" (7 June 1909, McGuire, p. 231). Given Freud's affection for Frau Hirschfeld, it becomes apparent that he was warning not only Jung, but also himself against the dangers inherent in too much emotional involvement. The mistakes for which he reproached Pfister in a letter of 2 January 1912 were the same he himself had made or had at least been tempted to make:

> Whether you made mistakes in the analysis? In my opinion: two. Firstly, that you scrambled too much for her, that you set too high a value on her staying [in analysis] (surely you meant to be very unselfish)—otherwise she would have probably stayed longer with you; secondly, that you, in your kindness and in your ambition, yielded too much of yourself. I myself have *given this up* completely; in my opinion, the technique of "countertransference" advises against it (LOC, italics added).

In theory, this was to remain Freud's position; in practice, however, we see him vacillating between sensitive and sympathetic empathy on the one hand and a distant and sometimes harsh and crude behavior on the other.

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fürchterlich viel zu lernen." The published translation ("But we must be consistent with ourselves, these are the very cases from which we have most to learn") is imprecise.

Abstract Behavior or a Little Bit of Sympathy: The Conflict between Freud and Jung

The question of how to react to a patient demanding sympathy and concern is also at the center of the personal conflict between Freud and Jung—around the turn of the year 1911/1912—which was triggered by Frau Hirschfeld. Although it is not easy, in the light of the material hitherto available, to reconstruct the facts and the ensuing controversy in much detail, the following can be stated.

Freud and Jung criticized each other, using the case of Frau Hirschfeld as the ostensible motive. Unfortunately, a crucial letter from Jung seems to be missing, so that his criticism can only be inferred from Freud's answers. On 14 December 1911, Freud declared in a letter to Pfister that "this time, our friend Jung . . . is rather mistaken," because Frau Hirschfeld and her husband were "seriously noble people; I have never yet looked through the appearance, and nevertheless know much about them. I can easily explain their behavior to myself, if I put together your proclamation not to accept any money, and the excessive delicacy of the other side" (LOC). Two weeks later, he wrote to Jung: "It is all settled with Pfister; your interpretation [in a missing letter of Jung's] was unjustified; they were really at a loss, they had to consult me" (28 December 1911, McGuire, p. 525). It seems that all this refers to Frau Hirschfeld's change of therapist in December 1911, from Pfister back again to Freud (see above). Jung, and perhaps also Pfister, had apparently criticized the circumstances under which Freud had accepted her again as a patient.

Frau Hirschfeld, restarting her analysis with Freud, told him "all sorts of things about you [Jung] and Pfister, if you can call the hints she drops 'telling' " (31 December 1911, McGuire, p. 475). Now it was Freud's turn to reproach Pfister and, above all, Jung; his pertinent remarks have been quoted many times, but they are even more revealing in the present context:

> I gather . . . that neither of you [Jung and Pfister] has yet acquired the necessary coolness in practice, that you still engage yourselves, give away a good deal of yourselves in order to demand a similar response. Permit me, the venerable old master, to warn that one is invariably mistaken in applying this technique, that one should rather remain unapproachable, and insist upon receiving. Never let us be driven crazy by our poor neurotics. The article on "counter-transference," which I find necessary, should, however, not be published, it should have to circulate in copies among ourselves (McGuire, pp. 475-476, my translation[16]).

The controversy between Freud and Jung revolved around a talk Frau Hirschfeld and Jung had sometime in late 1911. There are mainly two sources from which the contents of this talk can be deduced, the Freud/Jung correspondence and Freud's account of it ten years later. As for the first source, Freud went on in his letter to Jung: "If you really feel any resentment towards me, there is no need to use Frau C- as an occasion for venting it. If she asks you to tell me about your conversation with her, I beg you, don't let her influence you or browbeat you; just wait for my next misdeed and have it out with me directly" (McGuire, pp. 476-477). Jung's answer is particularly interesting and is therefore quoted at some length:

> I have waited for a long time for Frau C- to inform you, as arranged, about this awkward situation. It has been weighing on my mind. I don't know what she has told you. This is what happened: she asked me about her sister, and came to see me. Then she put the crucial question.[17] Sensing a trap, I evaded it as long as I could. It seemed to me that she was not in a fit condition to go back to Vienna. To make things easier for her I told her how disagreeable it was for me to find myself involved. I said she had given me the impression that she ex-

[16] Freud used much stronger words than come through in the official translation. "Venerable old master" is an allusion to Goethe's poem, *Der Zauberlehrling* (*The Sorcerer's Apprentice*).

[17] *Gewissensfrage*—literally, question of conscience.

> pected some sign of encouragement from you, and this seemed like a personal sacrifice on your part. I also told her that I did not pretend my view was right, since I don't know what was going on. As far as I could make out, I said, all she wanted was *a little bit of sympathy* [italics added] which you, for very good reasons best known to yourself, may have withheld. Such sympathy would ease things for the moment, but whether it would lead to good results in the end seemed to me doubtful, to say the least. I myself was unable, often very much *malgré moi* [italics and French in original], to keep my distance,[18] because sometimes I couldn't withhold my sympathy, and, since it was there anyway, I gladly offered it to the patient, telling myself that as a human being he was entitled to as much esteem and personal concern as the doctor saw fit to grant him. I told her, further, that this was how it *seemed* [italics in original] to me; I might be mistaken, since my experience could in no way be measured against yours. Afterwards I felt very much annoyed at having allowed myself to be dragged into this discussion. I would gladly have avoided it had not my pity for her wretched condition seduced me into giving her the advantage, even at the risk of sending her off with a flea in her ear. I comforted myself with the thought that, once she was with you, she would soon be on the right track again. My chief concern was to do the right thing and get her back to Vienna, which has in fact been done. I only hope the end justifies the means (Jung to Freud, 2 January 1912, McGuire, pp. 476-477).

Freud answered: "What you write about the Frau C- incident almost makes me feel sorry. You mustn't feel guilty towards me; if anything, you might modify your technique a little and show more reserve towards the patient" (10 January 1912, *op. cit.*, p. 479).

Now to the second source. When Freud and the members of the Secret Committee met in 1921, Freud chose to talk about this case, and he spoke about its significance for his relationship with Jung:

[18] "*Ich persönlich verhielte mich, oft sehr malgré moi, nicht so abstrakt*"—"I myself would not, often very much malgré moi, behave in such an *abstract* way."

> She also was the first occasion when Jung revealed his doubtful character. . . . During a holiday stay in Zurich she once let him come to make his acquaintance. On this occasion he expressed his amazement that she could endure being in an analysis with me without warmth and sympathy, and he recommended himself for a treatment in a higher temperature and with more verve. When she reminded him that she would have to report this statement to me, he was alarmed and asked her not to. The first and not yet sublimated attempt to compete with the father for the woman-object was a failure for the tender son (Grubrich-Simitis, 1993, p. 266).

Evidently, this discussion is about countertransference and the "little bit of sympathy" that the therapist should or must not display. Freud's criticism, however, has to be reconsidered in the light of his own feelings toward Frau Hirschfeld, which involved more than just a little bit of sympathy. On the other hand, Jung's words must have reminded him of Jung's affair with his patient Sabina Spielrein, in which Jung had definitely not behaved in a very "abstract" way, and where his "little bit of sympathy" had led to a scandal. Finally, the turn of the year 1911/1912 was also the climax of the triangular relationship between Sándor Ferenczi, his lover Gizella Pálos, and her daughter Elma, who was at the same time his patient (Haynal and Falzeder, 1991).

Ferenczi knew of Jung's letter about the latter's talk with Frau Hirschfeld, and he commented on it in a letter to Freud. He suspected in Jung

> an unlimited and uncontrolled ambition, which manifests itself in petty hate and envy toward you, who are so superior to him. The case of Hirschfeld is proof of that. His unsatisfied ambition makes him *dangerous* under certain conditions.
>
> He is also not very tactful in choosing his methods; the manner in which he responded to you is very significant.
>
> Even so, it would be a mistake for you to be too resentful of him on account of this "*gaminerie*" [mischievousness, French in original]. The best solution would, of course, be a free discus-

> sion (with ψα openness). For this it would also certainly be necessary that you take Jung into psychoanalytic treatment from now on (20 January 1912, Brabant, et al., p. 332).

"It cannot be a matter of ψα openness on my part," Freud answered,

> since he is silent and hasn't been giving honest information, and I am not inclined toward "treatment". . . . But I will not give rise to anything that indicates that I am taking offense; I will gladly forgive, only I can't keep my feelings unchanged. The ψα habit of drawing important conclusions from small signs is also difficult to overcome. His ambition was familiar to me, but I was hoping, through the position that I had created and was still preparing for him, to force this power into my service. The prospect, as long as I live, of doing everything myself and then not leaving behind any sterling successor is not very consoling. So I admit to you that I am by no means cheerful and have *a heavy burden to bear with this triviality* (23 January 1912, Brabant, et al., pp. 333-334, italics added).

The triviality, as Freud later wrote to Binswanger, was that Frau Hirschfeld "was one of the objects, where Jung acted his incorrectness" (24 April 1915, Fichtner, p. 149).

So far I have summarized what her therapists said *about* Frau Hirschfeld, using her on occasion for reciprocal reproaches. Unfortunately, we know hardly anything about her own feelings and motives. For example, what was the "crucial question," the question of conscience, that she put to Jung? What were her motives in taking Freud's part in the conflict with Jung?

Freud, although finding Frau Hirschfeld "analytically of no use for anybody," nevertheless considered it "her duty to sacrifice herself to science" (17 December 1911, McGuire, p. 474)! Although she had "no chances of getting cured . . . at least psychoanalysis should learn from her case and profit by her" (letter to Pfister, 2 January 1912, LOC). And, in fact, psychoanalysis has profited by her to a great extent, whether in the field of therapeutic technique and the theory of the analytic process or in that of the psychoanalytic theory of libidinal development.

Indifferent toward the Incomparable Fascination

The treatment of Frau Hirschfeld and its final failure mark a turning point in Freud's evaluation of the curative power of psychoanalysis. Hers was one of the cases in which he made a strong personal effort to overcome the resistances and to influence the outcome. But this "substitute for love" (Breuer and Freud, 1893-1895, p. 301), this "substitute for the affection she longed for" (Freud, 1905a, p. 109), did not help; evidently, for Freud she belonged to that "class of women with whom this attempt to preserve the erotic transference for the purposes of analytic work without satisfying it will not succeed. These are women of elemental passionateness who tolerate no surrogates. They are children of nature who refuse to accept the psychical in place of the material, who, in the poet's words, are accessible only to 'the logic of soup, with dumplings for arguments' "[19] (Freud, 1915a, p. 166-167). In these cases it is not "always easy for the doctor to keep within the limits prescribed by ethics and technique. . . . Again, when a woman sues for love, to reject and refuse is a distressing part for a man to play; and, in spite of neurosis and resistance, there is *an incomparable fascination* in a woman of high principles who confesses her passion" (*op. cit.*, pp. 169-170, italics added). And was Frau Hirschfeld not "more than sympathetic, rather of high principles and refined"? (letter to Pfister, 15 June 1911, LOC).

In any case, at the time when Freud wrote his technical papers of the years 1911-1915, in which he introduced or redefined crucial concepts of the analytic process (countertransference, distinction between positive and negative transference, the similes of the surgeon and the mirror, analysis of resistance, compulsion to repeat, transference neurosis, working through, rule of abstinence), Frau Hirschfeld was one of his most important patients, if not *the* most important.

[19] Allusion to Heinrich Heine's poem, "*Wanderratten.*" Freud used this same comparison in a letter to Pfister of 10 May 1909 (Meng and Freud, p. 24), i.e., during the treatment of Frau Hirschfeld.

In order to evaluate the possible influence her treatment had on Freud's technical concepts, let us briefly reconsider some aspects discussed in these papers. In general, Freud took up the lead where he had left it in the penultimate section of his chapter, "The Psychotherapy of Hysteria," in *Studies on Hysteria* (Breuer and Freud, 1893-1895) and in his discussion of Dora (1905a)[20] and the Rat Man (1909, 1955 [1907-1908]). He already knew that *transference*—"this latest creation of the disease"—is "by far the hardest part of the whole task," but at the same time "an inevitable necessity" (1905a, p. 116). He knew that this transference contained not only positive feelings, but "all the patient's tendencies, including hostile ones" (p. 117), that is, *negative* transference, whose vigorous and consistent interpretation was regarded by Freud as the "turning-point"[21] in the analysis of the Rat Man (1909, p. 209, *cf.*, pp. 199-200; 1955 [1907-1908], p. 281). He knew that "personal concern for the patients" and "human sympathy" (Breuer and Freud, 1893-1895, p. 265) are required from the analyst, but had already been warned against the danger of *countertransference love,* as experienced by some of his closest collaborators and friends: Josef Breuer, Carl Gustav Jung, and Sándor Ferenczi (for a further elaboration, see Haynal and Falzeder, 1993).

What Freud tried in the 1910-1915 period was at first an attempt to systematize his views of analytic technique in a "General Methodology of Psychoanalysis." When this failed, he laid down his ideas in a loosely structured way in the above mentioned papers, which he later considered as being for "beginners" (Blanton, 1971, p. 48) and "essentially negative" (letter to Ferenczi, 4 January 1928, LOC). He stressed the limits of the therapeutic power of analysis, he warned against the affective implication of the analyst, and allowed a strictly limited role to the analyst. In other words he pointed out the forces that com-

[20] There are some striking similarities in Freud's attitudes toward Ida Bauer and Frau Hirschfeld, and in the conclusions he drew from their cases; see in particular the "Postscript" to the Dora case (1905a, pp. 112-122).

[21] In the original: "*Höhe der Kur,*" i.e., the climax of the cure.

plicate and impede the cure (transference resistance, compulsion to repeat, acting out), and highlighted what the analyst should *not* get implicated in (countertransference love, emotional involvement, therapeutic ambition). The voice of reason, a certain trust in the fundamental rules of analysis, and patience should suffice as the analyst's tools. All these recommendations "have been arrived at from my own experience in the course of many years, after I had been led, to my own cost, to abandon other ways"[22] (1912b, p. 111).

While in the Dora case, for example, he had still maintained that it would have been sufficient simply to tell Dora that "it is from Herr K. that you have made a transference on to me" (1905a, p. 118) to clear everything up and obtain access to new memories, more than ten years later he declared that "in analysis transference emerges as *the most powerful resistance* to the treatment" (1912a, p. 101, italics in original), particularly "in so far as it is a negative transference or a positive transference of repressed erotic impulses" (p. 105). The phenomena of transference become the battlefield of a constant "struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act" (p. 108). While in previous years, he "often had occasion to find that the premature communication of a solution brought the treatment to an untimely end" (1913c, p. 140), he now placed "the emphasis on the resistances which had in the past brought about the state of not knowing and which were still ready to defend that state" (p. 142). The analyst, representing intellect and understanding, should model himself on the surgeon, putting "aside *all* his feelings," the most dangerous of them being "the therapeutic ambition" (1912b, p. 115, italics added). "The emotional coldness in the analyst" also creates "for the doctor a desirable protection for his own emotional life" (*ibid.*).

In "Remembering, Repeating and Working-Through"

[22] My translation of ". . . *nachdem ich durch eigenen Schaden von der Verfolgung anderer Wege zurückgekommen bin.*"

(1914), Freud dealt with at least five important concepts: compulsion to repeat, transference neurosis, acting out, negative therapeutic reaction, and working through. The *compulsion to repeat* (p. 150) would manifest itself particularly in the transference situation and help to establish a *transference neurosis:*

> We admit it [the compulsion to repeat] into the transference as a playground in which it is allowed to expand in almost complete freedom and in which it is expected to display to us everything in the way of pathogenic instincts that is hidden in the patient's mind. . . . [Thus] we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a 'transference-neurosis' of which he can be cured by the therapeutic work. The transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made (1914, p. 154).

Although Freud had quite early recognized the phenomenon of *acting out* (e.g., in the Dora case, 1905a, p. 119), only now did he make it a central notion of his theory of therapy. He also pointed out the problem of "deterioration during treatment" (1914, p. 152), which was later to be called "negative therapeutic reaction."[23] Finally, Freud introduced the idea of *working through the unconscious resistance*—that "part of the work which effects the greatest changes in the patient" (p. 155). And although Freud dealt with this issue in only a few sentences, it is quintessential for approaching the question of what really effects a *change* in the analysand—a question with which he was also confronted by Frau Hirschfeld. Had his first answer, in 1895, been that this change is brought about by "the 'abreacting' of the quotas of affect strangulated by repression" (1914, p. 156), he was, in 1914, of the opinion that one "must allow the

[23] In this context, note Freud's statement about Frau Hirschfeld when she had left Freud for Pfister; according to Freud, she had "acted out" a "compulsion." He had also interpreted the exacerbation of her illness during the analysis as a sign that he had "come very close to her central conflict."

patient time to become more conversant with this resistance . . . to *work through* it, to overcome it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis" (p. 155). "The voice of the intellect is a soft one," as he put it in another context, "but it does not rest till it has gained a hearing. Finally, after a countless succession of rebuffs, it succeeds" (1927, p. 53).

But "the voice of reason [which] should at least gain a hearing in her monastic cell" (letter to Pfister, 2 January 1912, LOC) did not succeed in helping Frau Hirschfeld. The battle "between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act," was lost by the forces of enlightenment. This led Freud to a still more pessimistic view of the curative power of psychoanalysis in severe cases. In 1914, he was still of the rather optimistic opinion that the "doctor has nothing else to do than to wait and let things take their course, a course which cannot be avoided nor always hastened. If he holds fast to this conviction he will often be spared the illusion of having failed" (1914, p. 155); but four years later, evidently drawing his conclusions from the failed analyses of Frau Hirschfeld and the Wolf Man, Freud discarded this method: "In severe cases of obsessive acts a passive waiting attitude seems even less indicated. . . . I think there is little doubt that here the correct technique can only be to wait until the treatment itself has become a compulsion, and then with this *counter-compulsion* forcibly to suppress the compulsion of the disease" (1919, p. 166, italics added). "Psychic influence alone" would not help; it would have to be combined with "active therapy, i.e. prevention" (letter to Pfister, 29 July 1921, LOC).

Personal concern, human sympathy, then "narrow escapes" (17 June 1909, McGuire, p. 230), warning against emotional involvement and therapeutic ambition, waiting and letting things take their course, and, finally, active countercompulsion as a last resort: a sequence of ever more pessimistic views, paralleled by a sequence of analyses with extraordinary patients, among whom Frau Hirschfeld might well be the missing link to

Freud's final words on analytic technique in this period. From 1918 onward, Freud seems to have preferred to leave this question to his intellectual circle—above all, to Ferenczi and Otto Rank.

Freud's warnings against the dangers of *countertransference love* in particular seem to be influenced by his feelings toward Frau Hirschfeld. He was confronted with this phenomenon not only at the beginning of psychoanalysis and not only through experiences and reports of three of his closest friends and followers (Breuer, Jung, Ferenczi), but also in his own practice as late as in the 1910-1915 period. Freud's notion of countertransference originated as a defensive concept, which should protect from being "taken in" (7 June 1909, McGuire, p. 230). *Each* time Freud used the word "countertransference" he emphasized that it must be kept in check. The analyst should "dominate" it (*op. cit.*, p. 231), "surmount" it (*op. cit.*, p. 291), "overcome it" (Freud, 1910, p. 145), even "overcome" it "completely" (Nunberg and Federn, 1967, p. 447), and "conquer" it to become "free" (Fichtner, p. 126). Freud used the word for the very last time in his "Observations on Transference-Love" (1915a), written just after Frau Hirschfeld had terminated her analysis with him: "In my opinion, therefore, one must not disavow the indifference one has developed by keeping the counter-transference in check" (p. 164, my translation[24]). From then on, this chapter—as, indeed, the case of Frau Hirschfeld, who was "analytically of no use for anybody"—seems to be closed for Freud, and never again did he use the word "countertransference."

There are several similarities between the case of Frau Hirschfeld and those of the Rat Man (1909) and the Wolf Man (1918).[25] It is interesting to note that Freud developed his technical "recommendations" while—or shortly after—his most important patients were, at least according to Freud, cases of se-

[24] Again, the published translation does not do justice to Freud's emphatic words.

[25] Like Frau Hirschfeld, the Wolf Man also consulted the leading therapists of his day (Mahony, 1984, pp. 17-18).

vere obsessional neurosis. Thus, they are also influenced by a struggle between a therapist who openly claimed that he himself was "the 'obsessional' type" (2 September 1907, McGuire, p. 82) and patients whom he considered to be of this same type—a struggle for power that left in Freud the conviction that, in these cases, regular analysis would not be of help, only the method of waiting "until the treatment itself has become a compulsion, and then with this counter-compulsion forcibly to suppress the compulsion of the disease" (Freud, 1919, p. 166).

In 1925, we find Freud even more pessimistic. After having affirmed that "[o]bsessional neurosis is unquestionably the most interesting and repaying subject of analytic research," he stated: "But as a problem it has not yet been mastered." He attributed its therapeutic resistance "to a *constitutional* factor" (italics added), a "feeble and insufficiently resistant" genital organization (1926, p. 113). He added, in words nearly identical to those used (1913b, p. 320) when describing Frau Hirschfeld: "[W]hen the ego begins its defensive efforts the first thing it succeeds in doing is to throw back the genital organization (of the phallic phase), in whole or part, to the earlier sadistic-anal level. This fact of regression is decisive for all that follows" (1926, p. 113).

In a way, Frau Hirschfeld's analysis was Freud's therapeutic swan song, the legacy of which has influenced psychoanalysis up to the present day. His recommendations have been taken by many as the "last word" on psychoanalytic technique, although the problems of countertransference, of the analyst's role in general, of his or her "neutrality" or emotional involvement, of "experience" or "insight" as mutative factors in therapy, are still at the core of the present discussions on psychoanalytic technique.

Psychoanalysis Is Indebted to Her: A Small New Fragment of Theory

"In the literature, she occupies a prominent place," wrote Freud to Binswanger on 24 May 1915 (Fichtner, p. 150), and "analysis is indebted to her" (Grubrich-Simitis, 1993, p. 265).

Unfortunately, possibly the most interesting text has been destroyed or is missing: Freud had written her "secret history for her" (letter to Pfister, 3 July 1911, LOC), an "essay about her illness" (9 February 1912, *ibid.*). And he discussed her case in at least six texts: "An Evidential Dream" (1913a), "Two Lies Told by Children" (1913d), "The Disposition to Obsessional Neuroses" (1913b),[26] "Psycho-Analysis and Telepathy" (1941), "Some Additional Notes on Dream-Interpretation as a Whole" (1925), and in the thirtieth of his *New Introductory Lectures* (1933).

"An Evidential Dream" came out in early 1913. "[T]his paper was the first of several by various authors included under a general caption 'Beiträge zur Traumdeutung' ('Contributions to Dream-Interpretation'). The paper presents the peculiarity of being a dream-analysis at second hand. Apart from this, it is noteworthy for containing a remarkably clear account of the part played by the latent dream-thoughts in the formation of dreams and for its insistence on the necessity for keeping in mind the distinction between the dream-thoughts and the dream itself" (Strachey, 1958a, p. 268). Even though it may not be an important paper, it is interesting to note that Frau Hirschfeld is its unnamed co-author. She tells and analyzes a dream of hers that proves to her—and to Freud—that her nurse, despite her denial, had fallen asleep on guard. Freud made only a few additions, and he made it clear that he had repeatedly talked over the text with Frau Hirschfeld (1913a, p. 276) and that he went "through [the] draft" with her (p. 271, n.).

In "Two Lies Told by Children" (1913d, pp. 307-309), Freud dealt with Frau Hirschfeld's "hidden incestuous love" as a schoolgirl (p. 309) for her father coming into conflict with "the discovery that her beloved father was not so great a personage as

[26] See Abraham's letter to Freud, 23 July 1914: "I was surprised to learn from her that she is the subject of the 'Predisposition to Obsessional Neurosis' " (Abraham and Freud, p. 185); and Binswanger's letter to Freud from 19 April 1915: "I also know that she is the subject of 'An Evidential Dream' " (Fichtner, p. 148). Binswanger published these facts in 1956 (Binswanger, 1956, p. 74); he had also mentioned the case in "Freud und die Verfassung der klinischen Psychiatrie" (Binswanger, 1936).

she was inclined to think him. . . . But she could not put up with this departure from her ideal. Since, as women do, she based all her ambition on the man she loved, she became too strongly dominated by the motive of supporting her father against the world. . . . [I]n order not to have to belittle her father," she produced two little lies revealing her wish "to boast: 'Look at what my father can do!' " (p. 308). One cannot help thinking that this constellation must have been conjured up again in the transference and countertransference situation of her later analyses, adding to the controversy between the "father" Freud, his "tender son" Jung (Grubrich-Simitis, 1993, p. 266), and her "youthful friend" (letter to Pfister, 28 May 1911, LOC), Oskar Pfister. Each of them was driven to identify, in a "complementary attitude" in countertransference (Deutsch, 1926, p. 137), with certain transference *imagines,* joining in an acting out of her nuclear neurotic structure. Succumbing to her "incomparable fascination," Freud rather accepted than analyzed her supporting him "against the world" and her basing "all her ambition on the man she loved."

In three papers dealing with the question of psychoanalysis and telepathy (1925, 1933, 1941), Freud used an experience of Frau Hirschfeld's with a fortuneteller in order to demonstrate that a strong unconscious wish can be directly transmitted to the unconscious of another person. The fortuneteller's prediction that she would "have two children before she was thirty-two" (1925, p. 137) did express "the strongest unconscious wish, in fact, of her whole emotional life and the motive force of her impending neurosis" (p. 138).

It is not without deeper significance that Frau Hirschfeld played a central role in Freud's writings about those two unsettling, intertwined phenomena that always made him uneasy: countertransference and thought transference. His contradictory and ambivalent statements about these phenomena mirror his fluctuating moods in his relationship with Frau Hirschfeld, oscillating between a deep mutual understanding and empathic

devotion—a situation in which "dialogues between the unconsciouses" (Ferenczi, 1915, p. 109) can occur, in which "the *Ucs.* of one human being can react upon that of another" (Freud, 1915b, p. 194)—and periods of time when Freud fought to keep his countertransference in check, and was determined to treat his patient harshly. As with other patients in whom Freud invested a strong personal interest (e.g., the case of A.B., a psychotic man treated by Freud from 1925 until 1930, recently brought to our attention by David Lynn [1993]), one "can see Freud alternately experiencing a wish for attachment to A.B. and a wish to withdraw or to be withdrawn from" (Lynn, 1993, p. 72). One can also observe an interdependence between ameliorations and deteriorations of the patients' conditions and Freud's *attitude* toward them. Although Freud was well aware of this, it was not him but Sándor Ferenczi who systematically investigated this connection between the analyst's emotional attitude and the patient's state as an important factor in psychoanalytic therapy.

The most important of Freud's surviving texts about Frau Hirschfeld is arguably his paper, "The Disposition to Obsessional Neuroses (A Contribution to the Problem of Choice of Neurosis)" (1913b). It "was read by Freud before the Fourth International Psycho-Analytical Congress, held at Munich on September 7 and 8, 1913, and was published at the end of that year. Two topics of special importance are discussed in it. First, there is the problem of 'choice of neurosis', which gives the work its sub-heading. . . . [The second topic is the one] of pregenital 'organizations' of the libido" (Strachey, 1958b, pp. 313, 315). The editor of the *Standard Edition* adds that this "notion is now such a familiar one that we are surprised to learn that it made its first appearance here" (p. 315). This paper—and Frau Hirschfeld, on whose treatment it was based—did indeed open the door to the whole realm of developmental stages of the libido "before" the oedipus complex. In fact, Freud introduced in it the idea of an *anal sadistic phase;* only later would he propose

the existence of an oral phase (in the 1915 edition of *Three Essays on the Theory of Sexuality* [1905c]) and, in 1923, of a phallic phase.

In this paper, Freud discussed the change of Frau Hirschfeld's anxiety neurosis into a severe obsessional neurosis. From the content of her obsessional neurosis (scrupulous washing and cleanliness and counterprotective measures), he drew the conclusion that these phenomena were

> reaction-formations against her own *anal-erotic* and *sadistic* impulses. Her sexual need was obliged to find expression in these shapes after her genital life had lost all its value owing to the impotence of the only man of whom there could be any question for her.
>
> This is *the starting-point of the small new fragment of theory* [italics added] which I have formulated. It is of course only in appearance that it is based on this one observation; actually it brings together a large number of earlier impressions, though an understanding of them was only made possible by this last experience. I told myself that my schematic picture of the development of the libidinal function called for an extra insertion in it. . . . And now we see the need for yet another stage [in addition to narcissism] to be inserted before the final shape is reached—a stage in which the component instincts have already come together for the choice of an object and that object is already something extraneous in contrast to the subject's own self, but in which *the primacy of the genital zones has not yet been established.* On the contrary, the component instincts which dominate this *pregenital organization* of sexual life are the anal-erotic and sadistic ones (1913b, pp. 320-321).

Having discussed some difficulties and complications arising from the new concept, Freud made the point that these could "be avoided by denying that there is any pregenital organization of sexual life and by holding that sexual life coincides with the genital and reproductive function and begins with it," but that "[p]sycho-analysis stands or falls with the recognition of the sexual component instincts, of the erotogenic zones and of the extension thus made possible of the concept of a 'sexual func-

tion' in contrast to the narrower 'genital function' " (pp. 322-323).[27]

It has to be borne in mind that this was the time of Freud's argument with the theories of Alfred Adler, and of his discussion with Carl Gustav Jung concerning the libido theory. Freud spoke the above quoted words at the last psychoanalytic congress that Jung attended, he chose to speak about a patient whose treatment had been a source of serious personal conflict between him and Jung, and he used her case as an occasion to draw a line between his own views and those of Adler and Jung. Freud repudiated Jung's extended libido concept, Jung's stress on the "here and now" in practice and theory, and, in opposition to Adler, Freud assigned aggression to a *libidinal* developmental phase.

Freud's introduction of a pregenital developmental stage was pivotal for the further development of psychoanalytic theory. It represented a breakthrough in the understanding of severe, "deep" disturbances, in a psychoanalytic developmental theory, in opening the perspective of early object relations, and in the discussion of the role of aggression. An unfortunate woman, caught within the limits of her neurosis and society, with no real chance of being cured, greatly contributed to this. Perhaps we, too, owe her some of the affection that Freud showed toward his "grand-patient" and "chief tormentor."

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[27] See Freud's letter to Pfister, 9 October 1918: "Why on earth do you dispute the splitting up of the sex instinct into its component parts which analysis imposes on us every day?" (Meng and Freud, p. 62).

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DREAMING ABOUT THE SESSION

BY FRANÇOIS SIROIS, M.D.

Dreams about the analytic session in which the analyst appears undisguised but the setting is changed are reported by most analysands. Such dreams are studied here as indicators of sensitive moments in the analysis. They are counterproposals by the analysand to the analytic activity of the analyst. They occur when the analyst's activity needs to be denied because it is experienced traumatically. Two particular disruptions are explored: the challenging of a narcissistic resistance, and one countertransferentially inspired deep interpretation.

Dreaming about the session is a typical occurrence in most analyses. The dream's manifest content may be described as follows. The analysand dreams that he or she comes to the session. The setting is never as it usually is. It is always changed, be it in time, space, physical surroundings, the number of actors on the analytic scene, or the nature of their interactions. By contrast, neither the analysand nor the analyst is disguised, although the latter occasionally is.

The hypothesis put forward here to account for the typical organization of the manifest content of such dreams is the following. The dream is a counterproposal offered by the patient to the analyst's interpretative activity. The dream depicts a fantasy aimed at denying the analytic activity of the analyst, and

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showing the way the dreamer would like to be treated. Such a dream indicates an upset in the transference situation coming from either an effective interpretation that challenges narcissistic resistances or a countertransferentially inspired "deep" interpretation.

Despite its ubiquity, this sort of dream has not been much studied. So far, Neyraut (1974) has provided the best description in his book, *Le Transfert*. He suggests that further study of this topic would be useful to see if such dreams can be utilized to follow the unfolding of an analysis. I intend to take up Neyraut's idea in relation to two clinical vignettes. Each one focuses on the dream as an indicator of sensitive moments in the development of the transference.

VIGNETTE A

A thirty-year-old man is in his first year of analysis. A certain amount about his feminine position and his need for paternal affection has already been explored. For some time, what strikes me is his pleasure, his excitement with words; speaking to me is like masturbating. Shortly after I tell him that, for him, speaking has something to do with his own excitement, the analysis becomes no longer a honeymoon. Resistances become prominent. The patient feels his treatment is going nowhere, that he is speaking for nothing. He comes in late, stressing there is no hurry. He obviously does not like to be deprived of his sexual satisfaction in speaking with me. He tries to fall back on playing with words, to coax me into guessing if what he says is true or false. Most of the time, he takes on a story-telling attitude.

A few sessions after my intervention and the shift in his attitude, he tells me the following dream. "When I arrived here, you had done away with the couch, only for one session, and decided you had to talk to me. There were two chairs and a table covered with cleansing tissues. You showed me a plastic card with Japanese characters; it was presented as the periodic chart

of elements. I had a blue pencil and was drawing lines on some paper. You said it was a turning point; you asked me to choose among the characters. I was sitting on the floor."

He comments on his being late and my being kind enough to wait. The plastic card leads him to think of an ancient book used by a friend for his work. Then he thinks about a chat with a friend whom he told about the usefulness of his treatment. He next associates to the foreign language characters and mentions a personal computer at his disposal that has Japanese characters. He likes to play with it. This leads him to the "plastic" picture in the waiting room displaying hieroglyphs, and the idea that he likes to play with his analyst.

PATIENT: I look at the picture quite often. It is a declaration in hieroglyphics for the protection of children; someone who hangs it there must be good.

ANALYST: You are referring to my intentions.

PATIENT: I have been wondering lately about what you want to do with me.

ANALYST: In the dream you change the session into something else.

PATIENT: We were face to face, taking time out to check something. I had to choose a character and I could not figure out what you had in mind. This makes me think of the 5-BX exercise books by the Canadian Army belonging to my father, with small human drawings, a mixture of yoga and gymnastics. I disappointed my father by not being interested in all that. He likes strong men; he taught me stretching movements; when I was still young, I was already stooped. I did not like what he intended to show me . . . Words are not coming . . . How could he not see that I did not want to have anything to do with that? But it is difficult to be against physical fitness. I wanted to avoid embracing my father's values. As if he were grasping my body. I come back to the question: what does he

want for me? I bring you in line with my father and that question.

ANALYST: You are telling me about these ideas and feelings because of what has occurred between us lately.

PATIENT: It has something to do with words.

ANALYST: Which we have started to look into.

PATIENT: It is strange, I feel guilty. I do not know anyone as haunted as I am by my parents' way of talking. It is a matter of discourse. At times words come; often I have already prepared sentences for you. [End of session.]

In the dream, I seem to be revealing myself as a child's protector, as the picture in the waiting room shows; I should not be like his father and propose a program that does not suit him. He is afraid that I will do with his mind what his father tried to do with his body. The dream is not explored further because the analysand is annoyed and does not want to come back to it. He tries to pursue his wish by finding reasons for me to protect children, and later by asking me to let him excite himself with words.

My work with the dream was restricted to commenting on the impact of my previous interpretation upon the patient. That interpretation had been correct as far as it went. However, I did not include myself in the wording, which had two effects. First, the interpretation touched upon only those aspects of the paternal transference pertaining to me as a superego figure. I left out any reference to the invitation sent out by the analysand to me that we should share a pleasure together. Second, the interpretation put me in a voyeuristic position. It enacted an exhibitionistic-voyeuristic fantasy and helped push it out of awareness. Thus, my interpretation had facilitated the patient's repression of his wish to please me and show himself. His dream depicted the encounter that I avoided in my interpretation. The dream represents the return of the invitation to share pleasure that I had taken away from the patient by this interpretation.

The patient may have taken my interpretation as a warning: "Make up your mind about what you are doing here." His dream answered: "Let's talk about it. I am, like you, fond of playing with strange languages. There's no rush to get down to work."

VIGNETTE B

A man in his early thirties had two dreams of the kind I am discussing. The first one occurred at the beginning of his treatment and was linked to his reaction to initiation of the analytic situation. The second one followed an intervention by me concerning the enactment of a central transference fantasy.

The first dream. In the beginning of the analysis, the patient neglected to pay for his sessions. Instead of reminding him of the agreed-upon arrangement, I decided to wait for him to bring up the subject. After a few sessions, he spoke of his wife's blaming him for not seeing into her, not guessing her thoughts. I compared what he was saying about himself and his wife to his relationship with me; perhaps he was suggesting I should guess something that he was not speaking about. He reacted to my comment with fear. After some silence, he told me of a dream in which a friend in a backyard threw a wrench at him. I took this association to mean that he was both afraid of and expecting something. He was waiting for me to talk about the unpaid sessions, without having to do so himself. I stated this to him.

He appeared surprised by my interpretation, and indicated that he had thought about it earlier in the day. The next day he told me the following dream: "I had come to my sessions and realized I had forgotten to pay; I felt bad, somewhat guilty, almost anxious." He had thought of picking a fight about paying for his sessions, of saying he would pay only when it suited him. The dream seemed to announce a forthcoming battle with me. However, he reassured both of us by telling me that he had nonetheless brought his check to pay me on that day, and by actually paying.

It is evident that the dream was a reaction to the interventions of the previous day, an effort to work out a compromise: first, by separating the current situation, where he abides by the rule of the contract, from the infantile one, where he upholds his desire to do as he wishes; and second, by fooling his superego with the excuse of having forgotten.

The main purpose of the dream seems to be to allay anxiety about retaliation that had been stirred up by my interpretation. By pleading his good faith, he can avoid punishment. It is interesting to note here that I did not offer an interpretation of the dream to the dreamer, probably because I did not want to stir up more anxiety. Also, a reassuring transaction took place between the analyst and the analysand just after the telling of the dream. Both of us feared some possible fighting.

One might argue that my interpretation had been too deep, stirring too much anxiety and necessitating further defense through the dream. Perhaps I should have focused more on his desire to withhold and less on his underlying feminine identification. One can see the dream as an attempt to find an acceptable way to re-establish the withholding as a defense against his unconscious feminine homosexual urges. Those came to the surface afterward.

The second dream. About one year later, the patient behaved in ways that indicated an underlying pregnancy fantasy. There were alternating transference enactments. First, he would play the role of a baby, lying passively on the couch, at times falling asleep while I watched over him. After we analyzed this for a while, a fantasy of being pregnant came to the fore. He elaborated upon his concern about being dissatisfied with his stoutness, and spoke about various diets. He seemed to unconsciously compare the analysis to dieting. He gave me the impression he was afraid I would suggest that he lose weight, or force him into some deprivation.

PATIENT: My belly gives me the feeling I am not worthy. There is something there, the weight, the food,

eating to offset something, some frustration. Maybe I did not enjoy my mother's belly. She has always had an anxiety which I could not stand; it's hard for her to be affectionate. A woman's belly. It is somewhat crazy, as if something were blended between being a man and a woman.

ANALYST: What would be crazy would be to think of yourself as pregnant.

PATIENT: While my wife was pregnant for the first time, I thought it should be so enjoyable to bear a baby. A good paunch to make up for a big penis. I often felt that I would like to be better equipped.

The link between his fantasy of being pregnant and his identification with his mother, as well as his underlying motive, remained somewhat hidden. He then told the following dream: "Insects were crawling out of a wall and I was trying to kill them." The day residue was a transient microbial infection caught by his wife that prevented him from sexual activity. He elaborated on his ambivalence about having an additional child, then on his uncertainty about a third session. (We had agreed on three sessions a week, but because I was less available, we had started with two hours a week.) I made a general comment on his mixed feelings about his freedom being interfered with.

At the next session, he remained silent first of all and then told the second dream: "It was in a lounge or an office; it could have been here, but not necessarily. There were one or two people, and you were there. I don't know what I was saying. It wasn't quite an analytic session, but a debate in a faraway place. I was not sure how to get there. We were eating together, steak with potatoes mashed with carrots as when I was a youngster. I asked you if you wanted some; you said no. Other people joined in." He elaborated on some business clients being referred to him by a friend, as if the analysis were helping to provide him a decent living. Then followed some sterile repetition of the dream elements without any new associations. At the end, he described a quarrel with his young daughter who was making a

fuss about getting dressed. He was quite uncomfortable about the incident. I commented about his being in the same type of encounter with me: he was fussing about analyzing his dream, just as his daughter fussed about getting dressed. I did not offer him any other intervention.

One aspect of the dream is to seduce the analyst by placating him with food. There is something similar to the first dream, if one assumes that the analyst represents the superego of the analysand. The maneuver is covered with a kind of incomplete offer: I play mother with you—I feed you my food. The transaction could be completed: you play father with me—you feed me (with your penis). Analysis for the patient is a way to stuff his interior rather than explore it. The potatoes mashed with carrots seemed to refer to some infantile satisfaction, the precise nature of which remained unclear.

Something was different about the countertransference portrayed in the first dream and in the second one. In the first, the analyst was fearing a fight, whereas in the second dream, he joined in. Pontalis (1977), spelling out ways in which dreams are used as resistance, pointed out that the competitive way in which some analysands try to explain their dreams betrays their castration anxiety. They do all they can to keep the analyst from analyzing. It is interesting to note here that the frustration and bad feelings associated with the insect dream were sealed over by the enactment with the analyst pictured in the second dream about a session.

DISCUSSION

Previous work on this kind of dream is scant. Most of it comes under related topics, like dreams about the undisguised analyst. Dreams about the undisguised analyst do not necessarily refer to the treatment setting; whereas the dreams about the session that I presented include both the undisguised analyst and distortions of the setting: distortion about time, e.g., just before or just after

the session; distortion about space, e.g., the session takes place in the street, or the consulting room is transformed into a restaurant or something else; distortion about the nature of the transaction (see Feldman, 1945).

With regard to the nature of the dream work, I think the image of the "real" analyst in the manifest content has been somewhat misunderstood. It has been taken to reflect deficient symbolization, a wish for a corrective emotional experience, an effort to obtain gratification at all costs, or a mistrust of the analyst. One must remember that in addition to all this, it may also represent a reality, an activity of the analyst that needs to be denied in order to preserve the wish to be gratified by the "real one."

However, the inclusion of the analytic setting and its distortion in the dream betray the dreamer. It reveals the dream to be a counterproposal offered by the patient to the denied interpretative activity of the analyst, a desire on the patient's part to transform the analytic encounter but not the analyst. It is a way to say: "I am not changing you, so do not change me. The way in which we deal with each other does not suit me." The analytic process at some points recapitulates infantile trauma which the dreamer wants to master. It is therefore not warranted to infer that the representation of the undisguised analyst comes from a lack of dream work. The reality of the analyst is part of a representation denying another reality—the analyst's actual analytic activity.

We can go a step further. The figure of the undisguised analyst in the manifest content represents the dreamer's ideal ego: "If I were you, I would treat myself this way." As Hanly (1984) puts it, the ideal ego "retains the status of a guardian angel of the ego" (p. 260). The dream is therefore a narcissistic counterproposal designed to secure the dreamer against a threat embodied in the analytic activity of the analyst. The dream denial in fantasy is an attempt to re-establish a pure pleasure ego. J.-B. Pontalis (personal communication) suggested to me that this type of dream might be a daydream reported as a night dream,

since often it lacks visual elements and is presented more like a scenario of action.

I believe such dreams are organized around a preconscious fantasy of distortion of the analytic setting. The fantasy depicts the dreamer's ideal ego, not his or her ego ideal (see Hanly, 1984). It is not a narcissistic identification of the dreamer with the analyst as would be the case if the dreamer's ego ideal were represented. Then we would expect in the representation of the analyst in the dream some conspicuous quality looked for by the dreamer.

My view of dreaming about the session differs from what some other authors have written. Gitelson (1952) suggested that such dreams are indications of countertransference. He used examples of dreams in which the analyst appeared undisguised following a stimulation of the analysand by a seductive analyst. I agree with Gitelson when he states that something from the analyst disturbs the patient. It can certainly be a countertransference-based intervention that creates the disturbance; but it can just as easily be a balanced, effective interpretation, as suggested by my first vignette. The positions of Gitelson, for whom this kind of dream springs from the analyst's countertransference, and Harris (1962), who sees it proceeding from the patient's transference, can be integrated if we think of the dream as deriving from the interaction of the resistance of the patient with the work of the analyst.

Lester (1985) described dreams about the analyst undisguised occurring early while the analytic framework is being set up in the treatment. I have in this paper described such dreams occurring in the middle phase of the analysis when an interpretation challenges an important transference fantasy. Oremland (1973) has reported such dreams in the terminal phase of the treatment as being linked with an interpretation about the ending of the analysis. He suggested that this type of dream often takes up again the dreamer's initial complaints, transforming them into lesser ones. I agree with Oremland in seeing the occurrence of this type of dream as a confirmation of the analytic

process. The mourning of an infantile wish can contribute to the formation of the dream. Evocations of regressive states would find their way into such dreams when they are no longer clung to, but have become objects of nostalgia (Quinodoz, 1987).

I do not agree with Rappaport (1959) when he states that an early dream of the undisguised analyst is the sign of an erotized transference and heralds a potentially unmanageable analysis. Rappaport stresses that the patient is unable to differentiate between the analyst and an important person of the past. While such a dream might indeed indicate a forthcoming intense transference, or an intense defense against the transference (Yazmajian, 1964), Rosenbaum's (1965) outcome study does not confirm Rappaport's proposition. More recently, Bradlow and Coen (1975) carried Rappaport's stand a step further, suggesting that this kind of dream is a sign that the analysand suffers from serious psychopathology and is unanalyzable.

I follow Feldman and Neyraut, who describe how the session dream often occurs for the first time a few months after the analysis is under way. It is not usually the first dream. It is brought about by the challenging of the transference neurosis through an interpretation that upsets the patient for some reason. The nucleus of the dream is a protest against this interpretation. This protest follows one of three paths: a wish to be gratified by the analyst, a wish to change the analytic situation, or a wish to block the analytic process. I would add that the dream is an attempt to bribe, fool, lure, or force the analyst to change his or her attitude toward the analysand, who feels threatened or deprived by the activity of the analyst. The dream work denies this attempt precisely by shifting attention to the reality of the analysis. The dream is the analysand's counterproposal, put forth because the analytic work is closing in on an infantile traumatic nucleus. Hence, the analysis is experienced as a threat, or confused with the trauma itself at this point. This threat is a narcissistic one.

Many aspects of a dream about the session make it relevant to the matter of trauma. The manifest content suggests a kind of

typical dream. One can assume that the analysis is experienced as a trauma. What needs to be sorted out is the nature of the traumatic experience. The analytic process is felt as traumatic insofar as it touches on an unpleasant reality, against which the analysand defends him/herself by denial in fantasy. In the first vignette, a sophisticated man came to overcome his hesitation to accept a promotion. He presented himself as a dilettante—a passive, coprophilic little boy, identifying with his mother. He displayed a character defense which seemed perverse. The intervention of the analyst about it reminded the patient of how his father ended playtime. The ensuing session dream was a countermove designed to curb anxiety. There was access to the negative transference through analysis of the dream, as well as an opening to explore the analysand's enormous anxiety about women.

This brings us to countertransference issues. The manifest content of the dream seduces the analyst by appealing to his curiosity. It seeks to distract the analyst from what was going on in the analysis. This solicitation of the analyst to recognize him/herself occurs precisely when the analysand no longer recognizes the analyst because of what the analyst did. The analysand is saying: "It could not be you who did that." This seduction is meant to neutralize the analytic activity of the analyst, to prevent the analyst from going deeper.

We are facing a double-sided issue. The dream can be a reaction to a (too) deep interpretation that bypassed a more careful analysis of the defensive organization. In the first vignette, for instance, some attention could have been paid first to the analysand's insistence about the analysis being fun as a way to reassure himself that there was no reason to be afraid of the analyst. In the second vignette, it could have been more useful to handle the material at the anal defensive level. At the same time, the dream can be a manifestation of the deepening of the transference in response to an effective interpretation—a regressive opening showing that the analysand received the interpretation.

The organization of this kind of typical dream can be an emergency measure to tame the analyst when intervention is both feared and hoped for. It usually occurs when there is a move by one member of the analytic pair to go deeper into the process, a move which is resented by the other. Perhaps a counterpart could be found in the study of the analyst's countertransferential dreams.

By way of conclusion, I turn to Freud. He did not identify dreaming about the session as such. However, he discussed other dreams related to the process of analysis to which we could compare session dreams. Freud talked about corroborative dreams (1911) and dreams of recovery (1923), relating them to transference.

Because dreams about the session can be seen as opposing the analyst, they may seem the opposite of corroborative dreams. Freud (1923, p. 115) noted that a corroborative dream "tags along behind" the analysis, and he placed it with resistance, calling it a dream of convenience. The wish is to please the analyst, to maintain a bond with the analyst. By contrast, a dream about the session presents a fantasy that clashes with the tie to the analyst. These two kinds of dreams carry two different facets of the resistance. The dream of convenience expresses the infantile tie to the parental object at the expense of the dreamer's narcissistic wishes, and a dream about the session expresses the dreamer's infantile gratifications at the expense of his or her tie to the parental object.

The dream of recovery, according to Freud (1923), is a dream of convenience aimed at sparing oneself the work of analysis that lies ahead. It is the equivalent of a transference cure; it is a *flight* from the analysis. By contrast, dreaming about the session is a *fight* to change the analysis into what the analysand thinks it should be.

The dream of convenience is brought about by imperative body needs. It is often straightforward, like a child's dream of fulfilling basic desires. This infantile type of dream appears in an adult when he or she is placed in unusual conditions of

deprivation. Freud (1900, pp. 131-132, n.) gave the example of a Scandinavian expedition to the Antarctic. The men dreamed of copious meals, tobacco, or mail being delivered to them. Dreaming about the session is a kind of childish dream occurring in reaction to analytic events. The frustration of analytic work makes every analysand at some point like an explorer of some desolate and lonely area.

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Dale Boesky

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BOOK REVIEWS

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PSYCHOANALYSIS: CLINICAL THEORY AND PRACTICE. By Jacob A. Arlow, M.D. Madison, CT: International Universities Press, Inc., 1991. 444 pp.

This is a remarkable volume. In his classic paper, "Unconscious Fantasy and Disturbances of Conscious Experience" (Chapter 10), Arlow stated quietly: "It is my impression that a clearer understanding of the functioning of the mind may be achieved from examining the role that certain aspects of unconscious fantasy play in mental life" (p. 158). This volume testifies to the validity of that claim. The classic core theoretic papers in this book are actually a potential text of clinical theory based on the modern structural hypothesis. In fact, these core papers with suitable emendation would constitute a unique syllabus for a seminar on modern structural theory.

One can see Arlow's methodology slowly emerging as one reads on. He has chosen the unconscious fantasy as the clinical and theoretic unit for his explication of structural theory. He has from the outset studied the vicissitudes of the dynamic equilibrium between the wish and defense as these are manifested in unconscious fantasies. He demonstrates repeatedly that the unconscious fantasy actively establishes the mental set against which the data of sensory registration are selectively perceived, inhibited, transformed, or disregarded. He provides a wealth of persuasively documented clinical illustrations of his views about focusing on unconscious fantasy as the herald of crucially important dynamic shifts in the associations of the patient throughout the course of a psychoanalytic treatment. What makes his mordant clinical examples so valuable is that they offer such coherent, lucid, and persuasive illustrations of his theoretic views.

It should be emphasized that it is one thing to say that all analysts listen differently and quite another to say that all analysts listen with equal care to everything that the patient says. Arlow's papers are a forceful argument for meticulous attention to the patient's associations. This alone is a topic which deserves further research because our literature and meetings demonstrate abundantly that many analysts are in disagreement about the value of very close readings of their patient's associations.

I hope it is now clear that this is not just another "Collected Papers" volume. Rather, Arlow has selected from his entire *oeuvre* only this group of papers which share the common theme of clinical theoretical considerations. There are numerous valuable cross references. I would like to demonstrate the cumulative impact of this book by giving a serial summary of the major themes of the papers.

In Chapter 1, "Anal Sensations and Feelings of Persecution," we can observe the author's first clinical report of the advantage of a close study of an unconscious fantasy. The technical consequence of this study was to advise that analysts be alert to detecting references or associations to anal sensations whenever patients reveal derivatives of fantasies of persecution or assault. This paper not only heralds Arlow's later interests in fantasies. It is notable also because even at this very early point, he had already found his "voice," if I may introduce a literary consideration. I refer to his unique concision. He rarely wastes a word. One has a sense that in his own writing he has always demanded of himself the clarity of thought, the economy of expression, and the nuance of observation that he used to such advantage in his editorial work.

In Chapters 2 and 7, Arlow discusses the methodology of applied psychoanalysis. In the former, a psychoanalytic study of the Bar Mitzvah rite, he introduces the important view that clinical psychoanalytic data should be used whenever possible to support the application of psychoanalytic principles to cultural processes. The reader will recall that prior to 1950 the basic methodology of applied psychoanalysis was to view a cultural phenomenon as the analog of a manifest dream and to "decode" the cultural phenomenon in terms of the topographic theory of dreams. In his classic study of mythology (Chapter 7) Arlow explicitly demonstrates the parallels between myth and unconscious fantasy, but in structural terms. He points out how the direct translation of symbols in the topographic model preceded the understanding of the importance of the alteration of defenses in the later structural model. Unconscious fantasy again serves him as the focus for his discussion. Myths represent universally shared unconscious fantasies related also to the unique individual hierarchy of fantasies for every person. These fantasies are grouped around certain basic wishes in various versions, each of which represents a resolution of conflicts

evoked by those wishes at a given "psychic moment." He discusses the important parallels between personal and social myths and the socially adaptive functions of myths that permit partial gratification of forbidden wishes.

Chapter 3 is entitled "Masturbation and Symptom Formation." By this time (1953) it is obvious, in retrospect, that the unconscious fantasy was to become Arlow's basic methodological instrument and that he was destined to become its preeminent virtuoso performer. In this classic paper he demonstrates that masturbation is not a simple discharge of instinctual energy but, because of the associated unconscious masturbation fantasy, masturbation is itself a compromise formation. He further demonstrates that the physical act and its correlative fantasy can undergo separate fates. With richly detailed and persuasive clinical examples, he demonstrates that dreams, masturbation, and symptom formation are reciprocally related.

Chapters 4, 5, and 6 are highly important demonstrations of the effectiveness of presenting detailed clinical evidence in support of a specific hypothesis. There is also in Chapter 6 a remarkable summation of Arlow's views on the significance of unconscious fantasies in his work to this point, as well as a theoretic program for his subsequent career. He states:

> Fantasies represent a distillate or a continuing precipitate of the effects of the earliest wishes related to the drives. Fantasy systems grow and develop in their concrete expressions, although the underlying instinctual wish may remain unchanged. The concrete terms in which the current version of the fantasy or its predecessors are expressed demonstrate the effects of the various components of the psychic structure as they mature, and how they transform the deepest instinctual strivings of the individual. Derivative representation of the wishes and the images representing the objects involved undergo many defensive vicissitudes in the course of development, and at various phases in the life of the individual the defensive function of the ego may be observed in operation by comparing the unconscious version of the fantasy with the daydream or with that part of the fantasy which contributes toward acting out and symptom formation (pp. 80-81).

Chapter 8, "Conflict, Regression, and Symptom Formation," is the first of the papers I have designated as core theoretic papers. It is with this paper that I would propose to begin a basic concepts seminar for first-year candidates in my own imaginary curriculum. In this paper, written thirty years ago, one can already view Arlow

as the discoverer of a method to preserve the vitality of drive theory while at the same time freeing our views of drives from the encumbrance of notions of psychic energy. Here we find the clearest first expression of his anchoring his views of the structural theory in what is clinically observable. He preserves the integrity of the essential notions of Freud's structural theory, firmly based on drives and conflict, by choosing unconscious fantasies both as a clinically inferred and a theoretically basic unit of conflict.

Fantasy as a concept is the hub of this classic formulation of the process of symptom formation as viewed in the structural hypothesis. Arlow demonstrates the importance of the developmental vicissitudes of intrapsychic conflict in relation to the pressure of persistent unconscious fantasies, unique for each person. He discusses the elements which govern the ego's capacity for integration: the development of object relations, maturation of danger signals, predisposition to anxiety, and selective preference for certain defenses. Central to his views is the relation of the drive dangers which produce symptoms to unconscious fantasy. The fantasy as a compromise formation is the vehicle for the expression of the emerging danger. The fantasy expresses not only the instinctual wish (the topographic definition) but also the molding influence of ego and superego. Without conflict over reactivated wishes, no symptoms would appear. Arlow clearly and forcefully demonstrates in this paper the danger of taking the patient's explanation for his or her fears at face value, and to the present day his clarifying formulation is still insufficiently appreciated. Patients are not afraid because they might fail. They defensively wish to fail to avoid an unconscious fantasy danger, and are still frightened in spite of their professed fear that they might fail. There are numerous current instances in our literature where this basic fact is ignored.

Arlow demonstrates that there is a hierarchy of fantasies unique for each individual. His clinical reports are beautiful documents attesting to this inference, and they are also literary gems which eloquently express the individuality of his patients. Fantasies are grouped around certain basic instinctual wishes and undergo developmental changes as the person matures. Each version of the fantasy corresponds to a different "psychic moment" in the life of the individual. Not every version is pathogenic. The wish to enter mother's body may be expressed in a symptom, e.g., a tunnel pho-

bia, or in a highly sublimated rescue fantasy leading to a choice of profession. This latter example illustrates the trend throughout Arlow's writings to emphasize nuance of clinical observation rather than to indulge in highly abstract theorizing.

Chapter 9, "Depersonalization and Derealization," is an excellent example of Arlow's application of his methodology. Commencing with the views of Freud and Lewin, he extends to the phenomena of depersonalization the classic formulation that dreams and phobias manifest isomorphic dynamics. He proposes the advantages of viewing the content of the episode of depersonalization as analogous to the manifest dream and provides convincing illustrative data to document the usefulness of meticulously pursuing the associations of the patient to each separate element of the episode of depersonalization, just as one would with the manifest dream.

Chapter 10, "Unconscious Fantasy and Disturbances of Conscious Experience," is one of the author's most important papers. After comparing the structural and topographic views of unconscious fantasy, he introduces the concept of unconscious fantasy function. Fantasies reflect the persistent pressure of the drives, but each fantasy is always formed in accordance with the principle of multiple function and often serves defensive purposes. Each person has a hierarchy of basic fantasies grouped around certain instinctual wishes and conflicts which appear in a variety of editions with developmental implications. Metaphor is a clinical signal of fantasy function. Ambiguity facilitates the emergence of fantasy. It is in this paper that Arlow introduces his felicitous analogy of the movie screen on which images are projected on both sides of the screen to illustrate the interaction of perception, external reality, and unconscious fantasy.

In Chapter 11, "Character Perversion," the author states that conflicts which grow out of the oedipal period find concrete expression in a persistent unconscious fantasy which may undergo a variety of subsequent fates and may result in a symptom, a character trait, or a perversion; indeed, all three may be manifest in any one person. The perversion is the fantasy acted out. Once again, Arlow presents highly persuasive clinical material to illustrate that certain "unrealistic" characters, practical jokers, and petty liars are examples of the link between unconscious fantasy, perversion, and character traits.

Chapter 12, "The Only Child," illustrates an unconscious fantasy highly important in the mental lives of many only children: the person has eliminated all other siblings in the mother's womb by devouring or injuring them and fears their retaliation. His assertions are richly documented in beautifully written vignettes.

Chapter 13, co-authored with David Beres, is entitled, "Fantasy and Identification in Empathy." Here the author discusses the signal affects which epitomize the empathic understanding of the analyst. These signal affects portend the emergence of an unconscious fantasy by which the affect is evoked. In fact, it is a measure of the analyst's capacity for empathy to be able to respond to or be stimulated by the patient's unconscious fantasy.

Chapter 14, "Communication and Character," is a clinical study of a man with normal hearing raised by deaf-mute parents which challenges the conventional expectation of severe ensuing pathology in the children of such parents.

Chapter 15, "Affects and the Psychoanalytic Situation," is another of the core theoretic papers illustrating the advantages of linking affects to the unconscious fantasies which have evoked them. Affects, Arlow points out, consist of ideational content as well as feeling tone and concomitant physiologic reactions, and any of these three components of every affect may be either conscious or unconscious. He reconfigures an earlier Freudian pivotal idea with profound clinical significance. To restore the organic unity of affects it is necessary to place each of these individual components in relation to the unconscious fantasy which is its usual concomitant and determining influence.

Chapter 16, "The Genesis of Interpretation," is also one of the core theoretic chapters. In a remarkably concise manner, Arlow defines a methodology for clinical validation:

> Most important is the context in which the specific material appears. Contiguity usually suggests dynamic relevance. The configurations of the material, the form and sequence in which the associations appear, represent substantive and interpretable connections. Other criteria are to be seen in the repetition and the convergence of certain themes within the organized body of associations. The repetition of similarities or opposites is always striking and suggestive. Material in context appearing in related sequence, multiple representations of the same theme, repetition in similarity, and a convergence of the data into one comprehensible hypothesis constitute the specific methodological approach in psycho-

> analysis used to validate insights obtained in an immediate, intuitive fashion in the analytic interchange (p. 287).

It was in 1979 and in this paper that the author also stated prophetically: "Much work remains to be done delineating the finer details of the analyst's subjective experience while listening to his patient" (p. 287).

To return to the advantages of introducing this book early in the curriculum, it has been my experience in supervision that many candidates do not fully appreciate how helpful it is to use these ideas of Arlow's in one's daily work. To cite one example, many candidates are insufficiently aware of the importance of the idea that context and contiguity can operate as a compass for one's technique. During supervision we ask the candidate: Why do you think the patient voiced this particular idea at precisely that point in his associations? Do you think the patient was really changing the subject? What is the possible relation of this new idea to the preceding association? When we ask these questions we are applying Arlow's methodology.

Chapter 17, "Metaphor and the Psychoanalytic Situation," is a basic paper with profound technical implications. That the lessons of this paper are still unappreciated is evidenced by the common tendency of many analysts to ignore the patient's use of a metaphor. For example, I recently heard a clinical report in which the patient stated that doing a certain thing would be like going to the gallows. It did not occur to the analyst to be impressed by that simile or to inquire for associations. Arlow stated in this paper that metaphors cannot be restricted to standardized meanings. Metaphors are derivatives of persistent unconscious fantasies in the life of the patient. Psychoanalysis, in fact, is basically a metaphorical enterprise. The unconscious fantasy itself represents a metaphoric apprehension of childhood experience that has remained dynamically active into adult life. Metaphoric expressions may be said to relate to each other as the syntax of unconscious fantasy. For a fine example of Arlow's concision, consider this:

> Transference, perhaps the most significant instrumentality of psychoanalytic technique, and metaphor both mean exactly the same thing. They both refer to the carrying over of meaning from one set of situations to another. Transfer-

> ence in the analytic situation is a particularly intense, lived-out metaphor of the patient's neurosis (p. 304).

Chapter 18, "Object Concept and Object Choice," is notable for the distinction between object relations and interpersonal relations. Arlow uses unconscious fantasy to elaborate this widely neglected distinction.

In Chapter 19, "Theories of Pathogenesis," Arlow demonstrates that the patient's own explanations of his or her neurotic suffering are influenced by unconscious fantasies. He further explores the possibility that in certain recent trends in our literature, the analyst colludes with such a fantasy: the neurosis is the consequence of a crime in which the villain is often a parent and the analyst is the investigative detective who, via replacement, undoes the harm.

Chapter 20, "Disturbances of the Sense of Time," illustrates how this topic may be understood by analyzing the concomitant affect, sense of self, unconscious fantasies, and the fear of death. It is documented with two brilliantly written case histories.

Chapter 21, "Problems of the Superego Concept," is another of the core theoretic chapters. The superego concept has been confused by the recent (early eighties) emphasis on archaic idealizations. Arlow agrees with Brenner that the classic view of the singular role of the oedipal phase should be re-examined. This seems to have escaped the attention of those who view Arlow as advocating exclusive importance for oedipal conflicts in theory and pathogenesis. He further adds that the path from outer conflict to inner control is not simply a set of coherent identifications. He again uses unconscious fantasy as a theoretic tool when he explains that the clinical patterns of superego functioning are usually comprehensible in terms of very specific unconscious fantasies, e.g., beating fantasies.

Chapter 22, "The Dynamics of Interpretation," is a remarkable synthesis of many of Arlow's prior views, now extended in a novel direction. He especially emphasizes the importance of refining our understanding of the immediate effect of the analyst's interventions. He illustrates the value of doing so for technique, for clinical theory, and for the methodology of validation. There has been an overemphasis on the content of interpretations and the content of repressed memories and a neglect of the structural change ensuing

after the analyst's intervention disrupts a prior dynamic equilibrium between wish, defense, and guilt. The content of the analyst's communication is less important than the dynamic potential. This means we must study the dynamic effect of the intervention rather than be guided by the patient's assent or disagreement.

What a bountiful legacy Arlow gives us in this unique volume. Only by reading these particular papers together and sequentially can we fully appreciate his unique contribution to modern psychoanalytic clinical theory. He more than any other author deserves to be credited with firmly anchoring unconscious fantasy as the key conceptual link between that which is most abstract in our theories and that which is most observable in our daily work with patients. With this volume Arlow fills an important gap between theory and practice and sets forth a program for further research for which generations of future psychoanalysts will be grateful.

DALE BOESKY (TROY, MI)

THE CONCEPT OF STRUCTURE IN PSYCHOANALYSIS. Edited by Theodore Shapiro, M.D. Madison, CT: International Universities Press, Inc., 1991. 400 pp.

On the occasion of the 75th Anniversary of the American Psychoanalytic Association in 1986, the Program Committee selected the topic of psychic structure for panel discussions. This was chosen to highlight the intellectual and clinical efforts of American psychoanalysis during the last twenty-five years. The papers presented at those panels have been edited into a book divided into four sections: development of psychic structure; current concepts of adult psychic structure; changing psychic structure through treatment; and disciplines such as language theory and neuroscience that interface with psychoanalysis.

One of the surprises is the amount of disagreement among authors regarding the definition of the concept of structure. Disparate frames of reference and different theoretical perspectives and definitions for the same concept make for difficult scientific discourse. Obstacles to effective communication are best expressed by panelist Phyllis Tyson: "Those who think of psychoanalysis as a

monolithic structure of ideas and a group of practitioners who adhere to the same point of view should be at this panel. They would be very much surprised. People were talking past each other, holding widely different views and frames of reference" (p. 283).

The problem dates back to Freud himself, who employed the term structure in varied technical contexts to refer to different constructs. "Structure" might refer to a system of neurons, or characterize the organization of a group of interrelated and dynamically operative thoughts, or signify psychological formations. Because the term was never defined clearly, it has acquired various meanings. To make matters worse, reification and concretization have added to the confusion. Because the idea of structure is abstract, it is not readily applied to clinical data. Structures of the mind are only useful explanatory constructs; they are not palpable or visible like structures in the body. Psychic structures are theory-bound and therefore will be presented differently according to different theoretical perspectives. In Roy Schafer's words: "Structure is simply not out there in the world waiting for analysts and others to find it" (p. 308). Because psychic structures are theory-guided, they can be conceptualized in a variety of ways: in an ego psychological framework in terms of impulse-defense; in Kleinian theory in terms of good and bad part objects; and within a self psychology framework in terms of a varyingly cohesive or vulnerable bipolar self. These widely diverging constructs, each claiming to be an extension of Freud's work, use totally different paradigms despite the fact that the overarching theory within which all these constructs have meaning is declared to be the same psychoanalysis (Robert Wallerstein).

Modern structural theory has evolved considerably from Freud's initial formulation of the tripartite model. It has freed itself for the most part from the carry-over of libido theory which characterized the 1923 distinction of the three agencies by virtue of the vicissitudes of psychic energy and its modes of discharge. When Freud first formulated the structural theory in 1923, he used two definitions for the ego, id, and superego. The first distinguished the agencies by their functions; the second was an energic definition. This inclusion of psychic energy as a carry-over from the topographic theory continues to cause confusion.

In the section, "Changing Psychic Structure through Treatment," Dale Boesky highlights disagreement about the pathogenesis and therapy of certain forms of psychopathology which are more severe than the neuroses. The argument centers around tension between the view that pathology is caused by a deficit in structure formation which precedes the capacity for conflict and a view in which conflict pathology is supposed to arise when the three agencies of the mind are present. Boesky's views are close to Charles Brenner's, emphasizing that the superego is itself a compromise formation resulting from the interaction of oedipal conflicts, sexual and aggressive drives, defenses, painful affects, and reality considerations. From the object relations perspective, Arnold Modell maintains that it is extremely difficult to identify specific elements within the psychoanalytic situation that promote structural change because that change is set in motion by means of the interaction of two participants. Each panelist, representing a different psychoanalytic paradigm, holds a different view of how treatment changes psychic structure.

One of the papers in the last section of the book discussing complementary viewpoints presents Otto Kernberg's ideas of how psychic structure should be conceptualized differently. Instead of thinking only of impulse-defense configurations, one should also include internalized object relations, which Kernberg sees as building blocks of the tripartite structure. This is yet another radically different formulation of the concept of structure.

Every analyst would do well to read the interesting concepts presented in Theodore Shapiro's paper on language structure and psychoanalysis and in Andrew Schwartz's paper on neurobiologically filtered views of psychic structures. The fact that neuroscientists can now demonstrate lasting neuronal responses to sensory experience and that mental representation now has visible biologic cellular foundation has considerable import for psychoanalysis.

This is a fascinating book that conveys vividly to the reader the ferment in our discipline. It highlights the different theoretical approaches and leads the reader to the inescapable conclusion that psychoanalysis is a long way from being static in its thinking. Pointing this out may be the greatest merit of this book.

H. GUNTHER PERDIGÃO (NEW ORLEANS)

ILLNESS IN THE ANALYST. IMPLICATIONS FOR THE TREATMENT RELATIONSHIP. Edited by Harvey J. Schwartz, M.D. and Ann-Louise S. Silver. Madison, CT: International Universities Press, Inc., 1990. 347 pp.

Parts of this book should be required reading for all analysts. The issue of illness in the analyst has hardly been dealt with in our literature, and several of these essays are remarkably helpful.

After reading the essays one can no longer deny the reality that psychoanalysts can suddenly become ill and die without any opportunity to prepare their patients. Most analysts will recognize themselves in some papers, as I did, in regard to their own tendencies toward denial and wishes for omnipotence. Very important is the suggestion made by Abraham Freedman that analysts should have a preplanned procedure for saving their patients as much grief as possible in the event of an emergency. He suggests that in a place easily found, probably the appointment book or daily log, there should be information readily available for a family member or colleague. For example, many analysts indicate their patients' names by some kind of code in their appointment books, and therefore it is essential that a decoder be easily available. Freedman also makes the point that psychoanalysts should make provision in their wills for the disposal of patient files.

The necessity for such preparations is shockingly demonstrated by Stephen Firestein's research into the fate of fifteen patients whose analyst or therapist died. The general tendency of analysts to deny the seriousness of their conditions and to rationalize delay in informing their patients was clearly shown in his study. Firestein makes the specific, very important suggestion that "as part of usual practice managment an analyst or therapist develop an understanding with two trusted friends that they will intervene if the analyst (1) shows signs of impairment in his work life; or (2) experiences sudden total incapacitation, or dies" (p. 338).

Firestein, in a separate document,[1] has made explicit the need for a "professional will" and has proposed terms for such a will. His

[1] Firestein, S. K. (1993): Memo: "Your Professional Will, or Thinking the Unthinkable." Document made available to members of The Psychoanalytic Institute, New York University Medical Center.

most important recommendation is that analysts designate and discuss this issue with two specific colleagues *before* the advent of a disaster. His outline for a professional will makes the salient point that at least one of the responsible persons should be a younger colleague. He also emphasized that experience strongly suggests that the tasks of dealing with patients' needs should be taken over by the designated colleagues and not left as a burden for family members, who are understandably preoccupied with their own distress.

This review began with a discussion of two essays from the last section of the book which deals with the death of the analyst. My focus on these important ways in which analysts need to be prepared for the future optimal care of their patients stems from my conviction that many, if not most of us have not made such plans.

The first section of the book contains three papers grouped under the heading, "Personal Reflections." These are interesting and well written, dealing with individual circumstances, but not of general usefulness for thinking about the analytic situation.

The middle section of the book contains a group of essays under the heading, "Clinical Implications." Here we come to the more interesting issue of the technical problems that arise when there is serious illness in the analyst. A few of these papers are especially useful. Sander Abend states the issues most clearly in his paper, "Serious Illness in the Analyst: Countertransference Considerations." He suggests, and my own experience supports his view, that countertransference issues "play a role greater than hitherto suspected in determining both the technical handling and the reluctance to write about such events" (p. 105). Analysts struggle with the question of how much factual information to provide their patients. Abend's central point is that "the chief significance of the powerful countertransference elements mobilized by the analyst's experience of serious illness is their tendency to influence analytic technique." He goes on to say that "the very clinical judgment relied upon to assess the specific needs of patients . . . is exactly what is under pressure from the countertransference; at no other time is the analyst's judgment about this technical problem *less* likely to be objective and reliable" (p. 104).

Several of the other essays illustrate Abend's points in moving and specific detail. Richard Lasky's paper, "Keeping the Analysis

Intact When the Analyst Has Suffered a Catastrophic Illness: Clinical Considerations," deals with his having fallen seriously ill on a Friday after finishing work, being hospitalized in an ICU in preparation for surgical intervention, and being told that he would be able to resume work only after three months. He tells us that he was fortunate that he was able to contact his patients the next day without having to use an intermediary when he found himself in the position of having to cancel all appointments with no preparation and to reschedule them for three months in the future.

He presents a thoughtful discussion about how he arrived at a decision about what he would tell his patients. He mentions his usual view of the Freudian model "to be as noninformative as possible about oneself and one's circumstances." He thinks that analysts are obligated "not to inhibit the production of fantasy and transference material by informing patients about their personal realities" (p. 179). However, these principles may not be easy to apply in the presence of unexpected, extremely disruptive circumstances. Lasky's overriding consideration in arriving at his compromise was to give enough information to make the situation comprehensible without being more self-revealing than seemed necessary.

He discusses the issue of whether or not the analyst should introduce material about the interruption if the patient does not do so. He considers the point of view that the analyst should show patients how the unusual circumstances are represented in derivative forms in their material. Lasky himself is concerned that the patient may derive only intellectual benefits when unconscious rather than preconscious material becomes identified for the patient by the analyst. He makes an eloquent case for the view that "when the patient is so strongly defended that the material is not yet even preconsciously represented, I think it may be premature to force the issue by immediately interpreting" (p. 189). He chose to let each patient talk about the situation at his or her own pace, and believes that his patients who delayed explicit examination of it ultimately analyzed it just as effectively as those patients who brought it up immediately.

Amy Lichtblau Morrison's paper, "Doing Psychotherapy While Living with a Life-Threatening Illness," deals with psychotherapy, but her ability to render in meaningful and vivid detail the ways in

which her countertransference influenced her interactions with patients makes her paper useful for psychoanalysts as well. Six years before she wrote this manuscript she "was stunned and my life disrupted by a diagnosis of breast cancer." She has had two local recurrences and has had treatment with surgery, radiation, and chemotherapy. The worst effect of her treatments was hair loss, which necessitated the wearing of a wig. Interruptions in her work varied from no time to five weeks. For the last three years she has felt well and has had no recurrence. She describes her reactions and different kinds of interactions with patients during these various phases of her illness. She also raises and discusses the ethical question of whether a new patient should be told about her cancer history before starting treatment, perhaps especially if a prospective patient has particular vulnerabilities to loss.

This brief, dry summary in no way does justice to the richness and thoughtfulness of her discussion. One cannot help admiring her courage and candor. Her paper has to be read in its entirety to be appreciated.

Susan Lazar's paper, "Patients' Responses to Pregnancy and Miscarriage in the Analyst," is very valuable in regard to that specific area which, until recently, had little literature devoted to it. In fact, most of the authors in this book who write about their experiences mention the fact that they had very little to guide them when their catastrophe struck.

In summary, although this book concerns a subject we would all rather avoid, it is a very valuable contribution and parts of it should be mandatory reading.

MARIANNE GOLDBERGER (NEW YORK)

REMEMBERING THE PERSONAL PAST. DESCRIPTIONS OF AUTOBIOGRAPHICAL MEMORY. By Bruce M. Ross. New York/Oxford: Oxford University Press, 1991. 244 pp.

Bruce M. Ross, Professor of Psychology and Fellow of the Life Cycle Institute of Catholic University, has enhanced both his own stature and that of the Life Cycle Institute with this scholarly tour de force. Within the space of 244 pages he has managed to include a complete survey, both encyclopedic and critical, of the major contributions to the study of human memory (with special refer-

ence to autobiographical memory). The survey ranges in time from the mid-nineteenth century to the present, and in latitude of discipline from the early philosophers of memory to the modern sociologists, historians, and anthropologists. Included, of course, are searching summaries of contributions from the fields of psychology and psychoanalysis.

Ordinarily such a work, which is of the nature of a critical encyclopedia, would not merit such high praise, nor any particular comment from a psychoanalytic reviewer, other than a brief notice of its publication and content. But this book is of special interest to psychoanalysts for two reasons, one parochial, the other ecumenical.

So far as this reviewer is aware, this is the first volume in recent memory, concerning itself with a topic in general psychology, that devotes the bulk of its pages to an exposition of the relevant contribution of psychoanalysis. For, after two introductory chapters, which set out the purpose of the book and survey in depth the nonpsychoanalytic students of memory (e.g., William James, Titchener, Piaget), Ross devotes nearly half of his volume (pp. 45-132) to psychoanalysis. Chapter 3 critically reviews Freud's theory of memory. Chapter 4 expands on some additional Freudian memory concepts—i.e., some of Freud's writings which are relatively obscure but of importance to the study of memory, e.g., "Ideational Mimetics" (p. 73) and "Mnemic Symbols" (p. 75). Ross offers the interesting suggestion that it was Freud's own extraordinary powers of memory which attracted him to the subject ("Freud's Personal Memory," pp. 81-82).

By way of explaining his detailed exposition of Freud and also to sound a note echoing the subtheme of his volume, Ross observes, "Except for an overly simplified concept of repression . . . it can be safely concluded that the general public has remained largely unaware of most of Freud's range of ideas about memory functioning, and this is to a considerable extent true of most of academic psychology as well" (p. 83). This reviewer will offer a group confession as to the reverse situation: most psychoanalysts—apart from a small group of serious scholars—remain unaware of the studies of memory generated by colleagues outside of psychoanalysis.

I shall make little attempt to summarize the specific content of this extraordinary intellectual survey: it is a series of summaries that defy summary. Moreover, the psychoanalytic content (e.g.,

"Screen Memories," "Infantile Amnesia") will be familiar to most analytic readers. In Chapter 5, "Psychoanalytic Continuations," Ross, it seems to me, breaks new ground for a nonanalytic scholar of psychoanalysis: he goes beyond the writings of Freud to consider the contributions of those who came after him. Ross points out,

> Critics who are outside psychoanalytic circles often ignore this literature. Even for many psychologists interested in memory, simply to be acquainted with Freud's major concepts, albeit with intricacies omitted, is thought to be sufficient. Yet if they looked, nonanalytic critics would find that many of their criticisms and revisions have been anticipated by analytic theorists after Freud. . . . The present paradoxical situation is that, generally speaking, only those investigators who are skeptical of psychoanalytic theories are interested in preserving Freud's theories in their original, unmodified form (p. 7).

Recent assaults on Freud and psychoanalysis have amply confirmed Ross's observations. Chapter 5 begins with a consideration of the work of Ernst Kris. It continues with the subject of memory and recollection as elaborated both by the Kris Study Groups, which tended to downplay the recovery of memory, and by Phyllis Greenacre, who emphasized its importance. Ross traces psychoanalytic thinking on the subject through a "Sampling of Contemporary Psychoanalytic Theories." These theories and their authors are familiar to readers of *The Psychoanalytic Quarterly*: Roy Schafer, Stanley Leavy, Anton Kris, Samuel Novey, Donald Spence, and somewhat off to the philosophical side, Paul Ricoeur. In this survey, Ross disarms the critic by stating, "My aim is to present a representative sampling of ideas rather than to attempt completeness" (p. 5). However, there are some major omissions, notably the work of Arlow and of Brenner. Arlow, in particular, has contributed to the psychoanalytic study of memory and reconstruction in a series of papers over the years. Brenner's views of memory as a compromise formation (expressed in various papers) are also important. Perhaps Ross has relied too much on monographs and too little on journals in compiling his survey. In any case, these omissions, although important, do not detract from the value of Ross's efforts to accurately convey psychoanalytic thinking to the nonanalyst.

In Chapter 6, "Some Psychoanalytic Offshoots," Ross continues his survey of psychoanalytic thinking by including some non-Freudian contributors: Alfred Adler, D. Ewen Cameron, and

William Sargent. In his notes, (p. 221, ff.) he explains why he has omitted other workers, especially Klein, Kohut, Mahler, Jung, et al. These theoreticians have not, in his opinion, either focused on or contributed much to the topic of autobiographical memory, as narrowly defined. I feel that it might have been better to expand the definition and widen the survey, particularly with regard to Kohut and Mahler, but this is but a quibble.

At the end of this chapter, Ross offers a critical quadripartite categorization of Freud's memory concepts: "Potentially Fruitful," "Vaguely Defined or Inadequately Stated," "Currently Deemphasized," "Later Freudian" (p. 123). Although some analysts will argue with Ross's categorization, it provides a refreshing opportunity to view the field through the mind of a searching and sophisticated nonanalytic worker.

In Chapter 7 Ross offers three examples of developmental memory theories: Baldwin, Piaget, and Pierre Janet (who is enjoying something of a revival in academic psychological circles). Chapters 8 and 9 are devoted to "Sociological and Historical Perspectives" and "Memory Transmission and Cultivation" (oral history). It is the author's contention, with which this reviewer agrees, that autobiographical memory is importantly influenced by the individual's cultural and sociological contexts, which cannot be omitted from the study of the subject.

In Chapter 10 Ross sums up "Conclusions and Possibilities." He notes the multiplicity of theories offered by a multiplicity of disciplines: none is complete, and the goal of final understanding of autobiographical memory remains elusive. He speculates that further understanding may be gained by a study of the *procedures* of memory formation: "Arrays of qualitatively different memory procedures were found in each of the developmental, social, and subjective spheres" (p. 214). On this basis he suspects that it is the "mix of procedures" rather than the "content" which will prove to be the individualizing factor in autobiographical memories.

The second aspect of this book which will be of interest to psychoanalysts is that it is representative of the new *interdisciplinary* approach. It is of inestimable value to the analyst to examine the phenomena of analytic work through the eyes of other disciplines. An example is the "Effort Paradox" (pp. 38-41). Freud noted that the greater the conscious effort to remember, the less likely is the

memory to be recovered. Hence in sequence the discovery of "resistance," the abandonment of forehead-pressing, and the discovery of "free" association. However, Freud was not the first to observe the "effort paradox," which was already well known among psychologists of the time. Ross traces the fate of this observation in nonanalytic fields throughout the years.

In recent years, the barriers between disciplines have been falling slowly, but nonetheless surely. Ross wisely avoids any effort to explore why these barriers have existed. Instead, he contents himself with the following observation and statement of purpose:

> Separate academic disciplines, with their special vantage points, often produce unique and valuable insights pertaining to autobiographical memories. However, each discipline has been willing to go only so far as satisfying some of its subject-matter interests before stating that a boundary has been reached where expertise is the province of some other discipline. Continuing compartmentalization will achieve only fore-ordained, limited results until it is recognized that the study of autobiographical memory is necessarily an interdisciplinary endeavor. A major aim of this presentation is to illustrate what a preliminary mapping of a widened theoretical landscape can produce in terms of unified results (p. 11).

With this statement, and with this book, Ross places himself and his institution in the vanguard of the interdisciplinary movement.

HERBERT M. WYMAN (SCARSDALE, NY)

THE WORK AND PLAY OF WINNICOTT. By Simon A. Grolnick, M.D. Northvale, NJ/London: Jason Aronson, Inc., 1990. 222 pp.

This book is an entertaining, readable introduction to the burgeoning field of Winnicott studies. The author, a psychiatric educator and psychoanalyst, held the position of Chairman of the Winnicott Committee supervising Winnicott Archives for the Oskar Diethelm History of Psychiatry Library of the Payne Whitney Psychiatric Clinic. In part, his book reflects a concern about the wider dissemination of Winnicott's ideas that the committee is helping to bring about. This concern is expressed in the first chapter of the book entitled, "Why Winnicott Now?": "The obvious danger with the arrival of any new body of ideas is that they become fashionable and the surface of the ideas is mistaken for the substance. In Winnicott's instance, since the ideas are at the same time disarmingly common-

sensical, yet quite complex, it would be most ironic but very possible for this to occur" (p. 6). Grolnick therefore offers a framework within which Winnicott's ideas can be appreciated simply but without loss of subtlety. The title of the book already hints at this perspective, placing the accent equally on work and play, or perhaps hinting that Winnicott's contribution inhabits the area between work and play. The book's style reflects a balanced mingling of work and play, neither pedantically academic nor "disarmingly" simplistic. Grolnick never loses sight of his serious purpose of helping the uninitiated reader to "use" Winnicott's writings in much the same way as Winnicott suggested we "use" an object.

In Chapter 2 Grolnick attempts to place Winnicott's work in the context of his life, and especially in the English psychoanalytic milieu of the '30's and '40's. Within this historical context, Grolnick draws some original insights from Winnicott's two personal analyses. The significant point is that both were relative failures. Winnicott's first analyst, James Strachey, apparently hid his countertransference behind a rigid technique derived from his own powerful identification with Freud. His second analyst, Joan Riviere, although brilliant in her own right, served mainly as an introduction to the ideas and person of Melanie Klein, with whom he formed a lasting professional relationship. Thus, a key component of Winnicott's transference was directed at Freud and Klein—his analytic parents. A letter to Melanie Klein, quoted in the book, expresses both his professional credo and his unresolved transference: "I personally think that it is very important that your work should be restated by people discovering in their own way and presenting what they discover in their own language. It is in this way that language will be kept alive" (p. 20).

In this letter, Winnicott is obviously talking about himself. He is in effect formulating the aim of his own future analytic writing. Grolnick clarifies that aim as one of "completing his own analysis" through his clinical work and writing. On one level, his papers are addressed to his former analysts, and through them to Freud and Klein (Grolnick documents that certain papers were specifically aimed at getting Klein to modify her ideas). But on a deeper level, they are all addressed to his future readers and collaborators. Winnicott's writings invite dialogue and collaboration. Their effect is not one of persuading readers of their correctness, but rather of

stimulating them to "contribute-in," ultimately to rethink the problem in their own way. In a chapter called "Reading Winnicott," Grolnick states his intention of establishing a dialogue with the reader that is at the same time a living example of a dialogue with Winnicott's ideas and discoveries.

In the body of the book, Grolnick presents Winnicott's contributions as an "interweaving series of developmental lines," which he extends and extrapolates. References to others such as Kohut, Mahler, Emde, Stern, Deri, etc., are interspersed throughout the text. Winnicott left this task to others, partly because of his conflicts about acknowledging the work of others, and partly out of his own need to reinvent the psychoanalytic field. Grolnick treats the other authors mentioned in the book as potential collaborators like himself. The excellent annotated bibliography at the end of the book guides the reader into the burgeoning new field of "Winnicottian studies."

Nevertheless, Grolnick stops short of a full comparison with other psychoanalytic thinkers, probably because of his stated concern that Winnicott's concepts could be lost in translation. Mindful of this danger, Grolnick maintains a fine ear for the nuances of his subject's idiosyncratic use of language. He cautions, for example, against too closed a definition of Winnicott's use of the word "self," which lies "between the poles of definition and nondefinition." And he shows how words beginning with the prefix "de" or "dis," as in depersonalization, deprivation, and disintegration, take on a new twist when contrasted with terms like "personalization," "privation," and "unintegration." Each of these terms assumes its full significance only within the context of Winnicott's own discourse.

Such difficulties in translating Winnicott—perhaps the key theme of the book—lead logically to a chapter entitled "Caveats for the Therapist." Many of the problems of applying Winnicott to matters of technique are linguistic: taking his concepts (holding environment, for example) too literally, or too poetically, or just too simplistically. Thus "holding" might become "gratifying the patient," and "playing together" could degenerate into an intellectual game. Any of these errors could lead to a crude caricature of Winnicott's permissive style.

If the book has a weakness, it is too slight an emphasis on integrating Winnicott's concepts and technical innovations with main-

stream Freudian terms like alterations of the ego, transference, and resistance. Despite Winnicott's own reluctance to engage in a dialogue with Freud, he always gave a hint of a connection between his own ideas and Freudian concepts, for example, the link between his own "false self" and Freud's ego distortion. This is in keeping with the point emphasized by Grolnick that all of Winnicott's innovations take place against a background of tradition.

With this "caveat," however, *The Work and Play of Winnicott* remains an excellent example of the new genre of "Winnicottian studies." It is directed primarily at beginning therapists, but still has a rich sprinkling of clinical pearls for experienced analysts to savor.

THOMAS WOLMAN (PHILADELPHIA)

THE TRAUMA OF TRANSGRESSION. PSYCHOTHERAPY OF INCEST VICTIMS. Edited by Selma Kramer, M.D. and Salman Akhtar, M.D. Northvale, NJ/London: Jason Aronson, Inc., 1991. 186 pp.

Our work with patients who have experienced incest has made many of us aware of the need to re-explore the ways in which childhood trauma and developmental disturbance contribute to pathogenesis and affect personality development. We have taken up again the clinical investigation of the psychological consequences of an experience. *The Trauma of Transgression* is an excellent and much needed contribution to our understanding of incest as it affects each of the participants. The authors include eminent pioneers in the study of childhood sexual abuse. The chapters originated as papers presented at the Twenty-First Margaret S. Mahler Symposium on Child Development, and the book has preserved the format of an academic dialogue with a discussant. The book's emphasis is on incest as it interacts with developmental sequences and psychic structure formation. The authors ask: What leads an adult and child to incest? How common is it? If it is more common than we thought, why haven't we seen it or recognized it in our consulting rooms? When we recognize it, how do we best treat those who have experienced it?

We are at a new beginning in our investigation of these patients and of others who have experienced trauma. Freud's relative abandonment of his seduction hypothesis and more broadly, his traumatogenic theory of neurosis, as well as our increasingly elaborated

appreciation of innate, maturational, fantasy and meaning structure aspects of psychic reality, have left us skeptical about isolating the role of "the real" in psychic life. The diminishing role of reconstruction and remembering in psychoanalysis attests to this. There are only a few case histories involving incest published in the psychoanalytic literature. One of these, a case of mother-adolescent son incest, is expanded by Marvin Margolis in this volume to include two five-year follow-ups and a later analytic psychotherapy. The authors want to call our attention to this paucity of analytic data, present their own, and urge us to study these cases. Can it only be that we have not been seeing these cases? The authors think not. They think we may be misinterpreting or ignoring data for reasons we must come to understand.

What allows incest to occur? Incest occurs in a context of disturbed family relationships that are often transgenerational. It involves a breach of trust and exploitation by primary love objects who transgress societal, moral, generational, and body boundaries and fail in their protective parental function. The authors differ in understanding the motivation for incest as primarily "an act of unmodulated aggression against the child," as Ruth Fischer sees it, or as an expression of primary attachment needs, in Brandt Steele's view. Steele believes that what leads an adult and child into incest is the wish for company, as described by Anna Freud. The sexual behavior of the incest participant is a form of sexualized attention-seeking that expresses the yearning for a symbiotic-like relationship with the primary attachment figure. When maternal care has not been adequate, separation-individuation remains incomplete, and this need persists with drive-like quality.

Steele describes different effects of the failure of maternal care in father-daughter and mother-son incest. Father and daughter seek each other in the wake of maternal neglect. A son is prevented from separating by a mother who seductively sexualizes their interactions. Fischer, however, objects to this exclusive emphasis on the mother-child interaction. Incest can occur only with the participation of both parents, and she considers the disempowerment of the father in this model to be an over-reaction in our theorizing to our previous neglect of the role of the mother. She stresses the need for the preoedipal father to aid the child in the modulation of drives and in the separation from the powerful preoedipal mother. With-

out the father's protection, either because he initiates incest or colludes with the mother's incestuous activity, the child is left alone to deal with overwhelming overstimulation. Aroused, enraged, and helpless, the child will resort to splitting, dissociation, denial, and self-doubt in order to preserve ego integrity and vital attachments. This, too, allows incest to continue.

Are there constellations or configurations in psychic structure or functioning that are associated with incest or that would alert us to the possibility of incest? Split ego organizations in which primitive and more mature ego functioning exist side by side, lack of symbolic capacity, blurring of the fantasy/reality boundary, doubting of perceptions, an inability to experience rage or unmodulated expressions of sexuality and aggression, distrust of libidinal attachments, excessive fear of object loss, a basic depressive affect, feelings of worthlessness, and unusually intense castration anxiety and compulsion to repeat have been described as characteristic by those who have worked with adults who have experienced sexual abuse as children. The authors try to go further, to describe at a level of more elaborated detail. Kramer believes that a transference phenomenon, object coercive doubting, is a specific indicator of maternal incest that has taken place prior to differentiation of self and object. Object coercive doubting is a disturbance of thinking in which the patient, who is unable to be certain about what is perceived or known in transference fantasies or enactments that derive from the incest experience because of the developmental stage at which it occurred, will attempt to coerce the therapist to take a side in the conflict, as if this could remove the doubt. Kramer distinguishes this from obsessional doubting which results from structural conflict. She also describes somatic memory in which the patient represents the incest experience via conversion-like hypo- or hyperaesthetic sensation or perception.

Fischer, citing the work of Leonard Shengold, focuses on the psychological consequences of rage combined with helplessness that is inevitable when overstimulation occurs in the relationship with an essential other. The remarkable use of defenses allowing idealization and forgetting, to preserve the possibility of a bond with a loving and protecting parental figure, leads to the characteristic absence of memory, inability to feel anger, and liability to expression by nonverbal and somatic channels. Although Margolis

thinks it is not possible to isolate the specific effects of childhood incest on adult personality, he notes the severity of unconscious guilt and the need for punishment, which, when combined with the need to repeat the trauma, can lead to sadomasochistic phenomena of unusual and dangerous intensity, even when incest has provided the basis for the psychology of the exception.

What is the impact of incest on development and psychic structure formation? The timing, frequency, duration, and nature of the incest are crucial variables, as are the relationship with the perpetrator and with significant others. The authors, here, are primarily concerned with the effect on separation and individuation in childhood and adolescence, ego development, impulse and affect regulation, and superego formation. Kramer and Fischer point to a particularly disruptive effect on the rapprochement subphase. Akhtar thinks important variables are whether the child is preverbal or verbal, preoedipal or oedipal, and has or has not achieved the capacity for orgasm when the incest occurs. He raises the interesting question of the relationship of incest to perversion.

The book suffers, as the authors knew it would, from the attempt to isolate an experience in order to explore its impact. Incest becomes a defining conceptualization which is overly organizing. The authors knowingly set aside detailed consideration of such complex matters as the role of multiple function, change of function, and construction in memory and recollection. Despite this, *The Trauma of Transgression* is rich in clinical material and insight and offers a renewed perspective on the dynamic interaction between fantasy and reality in the co-construction of our inner world. The authors are attempting to formulate the questions we might ask and are offering tentative hypotheses suggested by the work they have done in order to further our work with, and our study of, these difficult patients.

ELLEN R. PEYSER (NEW YORK)

CLINICAL INTERACTION AND THE ANALYSIS OF MEANING. A NEW PSYCHOANALYTIC THEORY. By Theodore L. Dorpat and Michael L. Miller. Hillsdale, NJ/London: The Analytic Press, 1992. 283 pp.

The authors argue that modern research has yielded an understanding of cognition and cognitive development that is inconsis-

tent with major aspects of Freudian psychology and invalidates the theoretical underpinnings of traditional psychoanalytic practice. Exploring the implications for psychodynamic theory of new insights into cognition and learning is obviously a valuable exercise, and the present text makes some very useful contributions toward integrating modern learning theory into psychoanalytic psychology. But, as in many such efforts, the authors are working from a particular viewpoint regarding currently competing schools of psychoanalytic thought, and, in arguing that modern research on cognition and learning supports their viewpoint and disproves others, they overstate their case.

Dorpat, in his opening chapters, notes that according to the work of Piaget and others, cognition based on object representations and object memory develops rather late in early childhood and evolves out of a more primitive cognition involving sensorimotor action patterns. Dorpat argues that this newer understanding of cognitive development contradicts not only Freud's thesis of very early representational memory but also his concepts of primitive wishes and unconscious fantasies, which Freud saw as entailing pursuit of imagined variations on early-encountered and veridically and representationally remembered experiences of satisfaction.

Dorpat also argues that modern insights into cognition and learning contradict Freud's notion of primary process as mental activity that entails the primitive expression of early-engendered unconscious wishes and fantasies. Dorpat suggests that early sensorimotor action patterns are the most basic representations of experience of the self in interaction with the non-self and that alongside later-developed representational memory and conscious mental processes, the individual continues to weigh every experience through an unconscious assigning of meaning to that experience in light of the individual's accumulated reservoir of sensorimotor action patterns and later related schemata. Dorpat maintains that "primary process" would be better understood as entailing the ongoing unconscious "meaning analysis" of current interactions in light of sensorimotor and affective memory of previous interactions, rather than as the extraneous intrusion of primitive wishes and fantasies into current experience.

In the book's middle chapters, Miller looks more systematically at current concepts of cognitive development and what he and Dorpat

believe to be their clinical implications. Citing research ranging from the early work of Piaget to Daniel Stern's studies of infants, Miller notes that a consistent implication of this research is that the individual, from earliest life, is actively engaged in interacting with the world and rendering his or her interactions "meaningful" by integrating them into a coherent system of sensorimotor and then of more sophisticated, subsequently evolved "operational schemata." Miller suggests that pathology occurs when the meaning assigned to interactions converges with comprehensions of earlier, traumatic experiences and the current interactions are consequently defended against rather than being integrated into one's system of operational schemata. Miller and Dorpat's major thesis regarding clinical technique is that modern cognitive theory supports the understanding of transference phenomena not as intrusions of primitive wishes and fantasies into the patient-analyst rapport via an atavistic primary process, but rather as the patient's absorption of transactions with the analyst and unconcious assignation of meanings to those transactions via Dorpat's redefined primary process. That is, meanings are assigned according to the patient's past experiences and consequent operational schemata. The task of the analyst, the authors maintain, is to look at these assignings of meaning and use them to cast light on problematic operational schemata and, ultimately, to help the patient modify those schemata.

In discussing therapeutic technique and in interpreting patient-analyst exchanges in a number of clinical vignettes, the authors endorse interpretative perspectives and techniques commonly associated with so-called "transactional analysis"; and Miller offers what is at many points an elegant integration of modern cognitive theory and transactional perspectives. At various points the authors also use modern cognitive theory to good effect in offering alternative views of particular psychological phenomena, as in Dorpat's discussion of dreams at the end of the book.

But the authors claim too much. Dorpat, in particular, liberally uses such terms as "seriously impaired," "fundamental error," "mistakes and defects," and "misguided efforts" to characterize psychoanalytic concepts which, he argues, are contradicted by modern cognitive theory. For the most part, however, those concepts can be readily reconciled to the new understanding of cognition. For ex-

ample, the notion of transference being based entirely on the distortion-laden confounding of the therapeutic relationship with old relationships is no less consistent with modern cognitive theory than Dorpat and Miller's transactional interpretations of transference. If the latter understanding has gained ground in recent psychoanalytic thought, it has done so because of its clinical explanatory power and not because of any supposed greater consistency with Piaget.

Similarly, while Dorpat emphatically dismisses "unconscious fantasies" as a concept demolished by the current understanding of cognition, it, too, is easily reconcilable with modern cognitive theory. Indeed, elsewhere in the book Miller notes how fantasies can emerge from operational schemata. He also cites Joseph Sandler's reconciliation of the concept of unconscious fantasy with an understanding of cognition that is similar to that of the authors. For unconscious fantasies, as for other psychodynamic concepts, the measure of validity is clinical utility. Can the phenomenon of repetition compulsion, for example, be explicated entirely, as the authors attempt to do, by a supposed "need" to recapitulate old patterns, perhaps for the sake of preserving a sense of identity or for some gratification in re-experiencing the comfortably familiar, or do at least some instances of repetition compulsion seem more explicable as reflecting the pursuit of unconscious fantasies, with the individual repeating old scenarios in the hope of obtaining a new, desired denouement?

The discussion of repetition compulsion touches particularly sharply on the arbitrariness of many of the authors' declarations concerning the psychodynamic and clinical implications of modern cognitive theory. They ascribe repetition compulsion to the individual's need to shape experience so that it conforms to established schemata, a need supposedly demonstrated by cognitive theory. But in rejecting interpretations of transference as entailing distortions of the patient-analyst rapport, the authors argue for limits to how thoroughly the need to have experience conform to established schemata actually works to mold the comprehension of experience. The authors' shifts in the relative weight they give, on the one hand, to pressures to comprehend the present in terms of the past and potentially to repeat the past, and, on the other, to attentiveness to distinguishing elements of the present, do not follow

from their understanding of current theories of cognition. They reflect, rather, extraneous views on psychodynamics and the work of analysis.

Whatever new insights into cognition emerge from the efforts of research psychologists and others, psychoanalysts will be ingenious enough to shape arguments demonstrating how those insights support their particular perspectives on psychodynamics and analytic technique. How profound such arguments are judged to be will almost inevitably have less to do with any compelling derivation of psychodynamic formulations and technique from new understandings of cognition than with other factors. It will have more to do with the clinical utility and interpretative elegance of the psychodynamics and technique, and with psychoanalysts' consequent degree of sympathy for their linkage to current cognitive theory.

KENNETH LEVIN (BROOKLINE, MA)

LOVE AND ITS PLACE IN NATURE. A PHILOSOPHICAL INTERPRETATION OF FREUDIAN PSYCHOANALYSIS. By Jonathan Lear. New York: Farrar, Straus & Giroux, 1990. 243 pp.

Lear sets out four principal arguments in *Love and Its Place in Nature*, a title that seems to owe something of its inspiration to the title of Broad's 1925 work, *The Mind and Its Place in Nature*.[1] First, it is argued that Freud's understanding of affects was inadequate to his own discoveries, leaving behind theoretical problems posed by his discoveries that he could not solve. For example, Freud's theory of affects cannot account for the developmental advance that accompanies the resolution of neurosis. Second, since psychoanalysis assumes that the ego does not exist in a finished form at birth, but develops gradually (or fails to develop properly), and since this entails that the world is not experienced by an infant and child in the same way as it is by adults whose egos have matured, psychoanalysis is epistemologically committed to some form of nonobservational phenomenology that locates itself between subjectivity and objectivity. Third, Freud abandoned his understanding of human

[1] Broad, C. D. (1925): *The Mind and Its Place in Nature*. London: K. Paul, Trench, Trubner.

sexuality as libido and "metamorphosed" it "into love," conceived as a "cosmological principle" (p. 147). Fourth, once the primacy of love in human nature is grasped, it can be established that the world is lovable by means of an adaptation of Kant's[2] transcendental deduction of the pure forms of intuition and the categories of the understanding in the *Critique of Pure Reason*.

I have not followed Lear's use of "I," "it," and "ideal-I" for "ego," "id," and "superego" because the terms of the *Standard Edition* in English have become so saturated with the connotations that Lear wants his own terms to capture that I experience his use of these terms as being artificial and abstract.

Lear is critical of the importance Freud attached to the drive discharge aspect of affects—to the pain generated by mounting drive demand and to the pleasure attendant upon its eventual discharge—even though, for example, intensifying sexual arousal is pleasurable in foreplay so long as discharge is expected. Lear, drawing on Aristotle, prefers to think of affects as ways of perceiving the world. (Sixty-year-old men are more frequently reminded of the rudimentary form of the pleasure principle by the action of their enlarging prostates than are forty-year-olds.) Freud's clinical discovery—that it is only when an unconscious affect can find its proper object and the individual can form a true belief about him/herself and his/her feelings about the object—cannot, it is argued, be comprehended by the theory of emotion with which Freud worked. Lear proposes that the essential thing about an emotion is that it is an attempt at a rational orientation toward the world and the self. The archaic thinking inherently organizing irrational and symptomatic emotions are failed attempts at rational thinking which contain the seeds of a rational orientation to appropriate objects. Thus, according to Lear, there is a developmental thrust toward a rational orientation to the world that Freud happened upon but did not correctly identify or construe because of the continuing influence of the homeostatic neurobiological discharge model of the *Project for a Scientific Psychology* and *Studies on Hysteria* in Freud's metapsychology.

Phenomenological epistemology is itself difficult to define philo-

[2] Kant, I. (1781): *Critique of Pure Reason*. Translated by N. K. Smith. London: MacMillan, 1925.

sophically, for there are scarcely fewer variations of it than there are phenomenological philosophers. I find Lear's views to be most akin to those of Merleau-Ponty, who has had a considerable influence upon the thinking of many contemporary French analytic theorists, although Merleau-Ponty does not appear in the bibliography, and his descriptive methods of reflection owed nothing to Kant's philosophy or to Kant's transcendental deduction of the categories, in particular. But like Merleau-Ponty, Lear gives epistemic primacy to experience, not in the empiricist sense of its being our only access to the world and ourselves through the scientific use of it to construct objective knowledge, but as the only encounter that the human mind has with the reality of itself and the world, from which science is only one departure into abstraction, and religion another. Lear's "internalist" position involves a subject-object differentiation that still lies within the unity of an experience of self and world that he believes is lost in scientific objectification or in idealist subjectivism. Accordingly, Lear has philosophical difficulty with Freud's language whenever he seeks either to formulate the nonpsychological factors in human psychological functioning, or when he describes or explains human psychology from an impersonal, observational point of view. Lear does not share Freud's and Waelder's view that the great epistemic achievement of the human mind brought about by the development of the superego is its capacity to objectify itself and thereby gain awareness of its own contribution to the objects it studies, including itself. Lear claims that Freud's "idea of a science of subjectivity" casts doubt upon the idea of what a science is, and leaves it uncertain as to whether psychoanalysis would be a science or a religion if we could figure out what science is and what religion is, both of which he finds more obscure and problematic than many philosophers do or than Freud did.

Lear argues that Freud eventually began to catch up to the meaning of his own discoveries when he transformed sex into love or, in Strachey's translation, into mighty Eros. The libido that causes the adherence of the infant to the breast, the submission of the child to the mother, the rivalry of the son with the father, and the reproductive sexual love of women in the male adult was renamed Eros by Freud when he attributed to it the multifarious tasks of unifying living matter at every level of organization, from cells to civiliza-

tions. Lear quite rightly points out that there is no psychological evidence for Freud's Thanatos hypothesis. Despite his valiant effort to adduce adult clinical and infant observational evidence, Freud acknowledged his failure[3] and proceeded to carry on in his theorizing[4] as though there were evidence. Accordingly, Lear does not feel that he has to take the Thanatos hypothesis seriously. *However, there is no psychological evidence for Freud's Eros hypothesis either.* Of course, Freud did not actually assert Eros to be a cosmological principle as had the pre-Socratic shaman philosopher Empedocles, claimed by Freud as an authoritative anticipation of his own speculation; he restricted his hypothesis to living matter and did not claim, as Empedocles would have, that everything in nature is alive. But none of the facts of human sexuality, for example, the adherence of the infant to the breast, offers any evidence that the same force is at work at a cellular level in the body of the infant.

It is here that the "Kantian deduction" of love as a cosmological principle is brought into service. Kant's deduction goes, roughly, as follows: nature must be subject to causality because otherwise the human mind could not know it. The consequence of the deduction is that the human mind can only know nature as it appears and not as it is in itself, because the mind cannot comprehend nature apart from this and from other epistemic conditions. Lear's variant on this argument is that "it is a condition of there being a world that it be lovable by beings like us." And, one should add, Kant's caveat that what this proves, if it proves anything at all, is that the world must be *experienced* by humans as being lovable; whether it is lovable in itself is a question that a creature who has no alternative but to experience the world as lovable could ever answer.

If Kant's deduction works, his skepticism must follow. Yet Lear goes on to assert, "There is no content to the idea of a world that is not a possible world for us. And a world that is not lovable (by beings like us) is not a possible world" (p. 142). In the language of philosophers, if something is impossible, it cannot exist; for example, a square circle cannot exist. It appears that Lear is making an ontological statement—a statement about the nature of the world—something like, the world is constrained by human existence to be lovable, for otherwise it could not exist. But what if there is an

[3] Freud, S. (1920): Beyond the pleasure principle. *S.E.*, 18.
[4] Freud, S. (1923): The ego and the id. *S.E.*, 19.

unconscious imperative behind this apparently descriptive assertion? "Be lovable, world, for otherwise you will not exist!"

Once one takes the proposition out of the abstract language of philosophy and puts it in an affectively significant form, one hears the human voice of longing, the voice of the helpless, unloved child who in one way or another was, is, and will be each of us, reduced by despair to the narcissistic illusion of omnipotence. The world of Auschwitz was not lovable, yet for those who were trapped there and died there, it was the only world they had, for the lovable world had abandoned them. The child who has an abusive mother cannot, it is true, do other than find her lovable and acceptingly suffer the consequent maldevelopment. This sad truth does not make the mother lovable, nor, tragically, does it make the traumatized child very lovable either. Perhaps the affirmation that the world *must* be lovable is an affective denial of our repeated discovery of the extent to which it is not.

Given that there is no psychological evidence for either Freud's Eros or Thanatos hypotheses, why should one not construct a like Kantian deduction for Thanatos? Such an argument might go as follows: it is a condition of there being a world that it be hateable (destructible) by beings like us. Do human beings ever exult in their capacity to lay waste, experience awe at the destructive power of nature as well as serenity at its manifestations of order? To be sure, this deduction applies only to the secondary, sadistic form of Thanatos. Its original masochistic structure would not lend itself to such a derivation. However, given Freud's hypothesis of instinct fusion and the urgency of the redirection of Thanatos from the self to the world, it would appear that if the first form of the deduction is sound, there are no grounds for not affirming the second, except for the attribution of contrary predicates to the world, which leaves something to be desired philosophically and would suggest, perhaps, that there may be a problem with the enterprise itself. The Kantian deduction in its original form is itself without epistemic merit despite its philosophical ingenuity (see Einstein, 1921[5]) and Lear's ontological variant is no more convincing.

These are some of the larger arguments of the work. This outline and probing of them is not intended to be comprehensive. There

[5] Einstein, A. (1921): *The Meaning of Relativity: Four Lectures Delivered at Princeton.* Translated by P. Adams. London: Methuen, 1922.

are many smaller scale arguments of great interest, which this reviewer finds much more convincing than the larger, main lines of argument. And even the arguments with which I find myself in disagreement raise some interesting questions which are worth inquiry. I conclude with a sample.

If an affect is an orientation toward the world, which it is, how does it differ from an idea, which also can function as an orientation toward the world?

Could not one find in Freud's definition of drives, which includes affects (since they are governed by the pleasure principle), an account of the ways in which affects orient us, for example, by seeking an object that can give pleasure in a particular way and involving a specific sort of activity?

Do not libidinal organizations involve orientations toward the world, including ways of thinking as well as ways of valuing actions and objects, as in the sexual and cosmological speculations of children?

Do not the identificatory libidinal bonds by means of which Freud[6] explained the formation of groups entail important orientations in social life?

If affects are different from ideas as well as similar to them, could it be because affects motivate, put us to work, seek discharge?

If Freud modified his discharge model of treatment, as he certainly did, did he also need to alter his idea that affects and, more especially, drives seek discharge?

Does not Freud have an explanation of why it is that the resolution of a neurosis involves development long before he postulated a role for Eros in building psychic structure?

Did not Freud abandon the cathartic method because he realized that sexual life begins at infancy and that an abreactive therapy that merely discharges the derivatives of regressed or fixated drive organizations does not remedy the fixation?

Do not repeating, remembering, and working through seek to facilitate a sufficient maturation of the drive organizations to bring about advances in all psychic agencies, in their interrelations, and in object relations?

Why not replace the Kantian deduction of the importance of love with a less grand but also less ambiguous assertion such as that the more people are able to love and to be loved, the better their lives tend to be?

But do we not need more clarification of the various kinds of love and what their effects in and upon us are before we make such a sweeping assertion?

Is not Freud's contribution to this clarification one of his most important legacies?

Although Freud engaged in theoretical speculation in his later work, how would the Freud who wrote the devastating critique of brotherly love and defense of family love and friendship in *Civilization and Its Discontents* react to Lear's concept of love (Lear equates love with interpretation)?

[6] Freud, S. (1921). Group psychology and the analysis of the ego. *S.E.*, 18.

Does not Lear's "epistemological internalism" provide an a priori defense against any criticism of his interpretation of Freud's sexual theory or any other philosophical or psychoanalytic theory?

Does not this defense against refutation also deprive it of any possibility of proof?

Some, at least, of these questions go to the heart of certain controversies, doubts, and uncertainties in contemporary psychoanalysis. If I cannot recommend *Love and Its Place in Nature* with much enthusiasm for the assertions it makes, I can do so for the questions it raises and the way in which it raises them.

CHARLES HANLY (TORONTO)

FREUD'S MOSES: JUDAISM TERMINABLE AND INTERMINABLE. By Yosef Hayim Yerushalmi. New Haven/London: Yale University Press, 1991. 159 pp.

This is a book written with a mission. It is not simply a critique of Freud's *Moses and Monotheism*, but rather an intriguing exploration of the author behind the work, specifically, the nature of his Jewish identity. Yerushalmi was inspired to write his book as he reread Freud's work while attending a series of meetings on anti-Semitism. He then posed the question of what Freud's intent and feelings were when he advanced the thesis that Moses was not Jewish but rather an Egyptian prince and that he was murdered by the Jews.

According to Freud, Moses was influenced by the monotheistic philosophy of one of the pharaohs, Amenhotep IV, and attempted to spread the idea among the Egyptian people. When they refused to accept his message, Moses (not God) chose the Hebrew slaves to be his followers. He led them out of bondage in Egypt, only to be horrified at their continued idolatry. The Hebrews did not accept Moses' reproaches, but murdered him instead.

In this view, the slaying of Moses by the Jewish idol-worshippers was repressed and therefore doomed to repetition. In the Christian era, we find the slaying of Jesus Christ, again by the Jews. Paul had a notion that the Jews were unhappy because they killed God (Jesus Christ). He said the Christians are free of guilt because Christ sacrificed his life to absolve their guilt. The Christians charge that the Jews "will not *admit* that you murdered God. . . . We did the same

thing, to be sure, but we have *admitted* it."[1] The Jews deny their guilt and therefore suffer more for it. Thus, in Freud's view the guilt is correctly placed upon the Jews.

Freud does not, however, totally absolve the Christians. He portrays Christianity as a son religion in which the son has usurped the father's throne. Later, Freud is concerned about offending the Christians with such comments. He does not, Yerushalmi points out, have the same consideration for the sensitivity of the Jews. Yerushalmi criticizes Freud's willingness to offend the Jews, and, even more adamantly, he attacks the validity of Freud's thesis. He suggests that Freud, in writing this book and in other public acts, was repudiating his Jewish identity. However, he finds evidence of Freud's private commitment to (or expression of) a secular form of Jewish identity.

Yerushalmi approaches his topic, Freud, with an almost filial piety. He appears to see Freud as one whose greatness inspires loyalty and only reluctant criticism. However, the book is quite clearly a critique as well as an exploration.

The first three chapters reproduce the author's lectures at Yale and other universities. The fourth chapter is a case history of Freud as a Jew. The fifth and last chapter is an imaginary monologue with Freud. There are voluminous notes and appendices containing the manuscript draft of Freud's introduction to *Der Mann Moses*, written in 1934. The appendix also includes Freud's father's inscription in the Philippson Bible, which he gave Freud on his thirty-fifth birthday, and some unpublished correspondence of Freud regarding his Jewishness. The illustrations in the book include a menorah and two Kiddush cups of Freud's, as well as pictures relating to Judaism from Freud's collection (which for some unknown reason were not included in the first exhibit of Freud's antiquities in the Jewish Museum of New York City).

In the book's introduction, the author quotes excerpts from "Death of Moses Cycle," in the Roman Jewish liturgy, which describe how Moses pleads with God for his life, but then, apparently reconciled to his death, takes leave of his people. This would appear to suggest that Moses died a natural and expected death. However, Yerushalmi also points out that Moses was buried in a

[1] Freud, S. (1939): Moses and monotheism. *S.E.*, 23:90.

valley in Moab, but to this day no one knows his burial place—perhaps a suspicious circumstance. However, on the whole Yerushalmi finds little to support Freud's thesis or his methods. He notes that Freud never quoted Abraham, who wrote a paper on Amenhotep IV,[2] the founder of a monotheistic religion in Egypt, and he questions other references used by Freud. Yerushalmi claims that in general Freud employed a blatantly ahistorical method in his work (p. 19). His approach, Yerushalmi feels, represents a telescoping of a series of analogies. Freud, of course, was not a historian. In fact, he wrote to his son in a 1934 letter that this was his first adventure as a historian. The original title, *Der Mann Moses: ein historischer Roman* (*The Man Moses, A Historical Novel*) clearly evidences Freud's doubt about his discoveries.

Yerushalmi points out that in the Bible no deed, no matter how vile, has been forgotten. Therefore, could a murder of Moses be repressed (perhaps at one time revealed) and then forgotten? Freud appears to realize that the claim of foreign influence on the Bible would not be sufficient to support his view.

Yerushalmi is particularly critical of Freud's underlying Lamarckian-based view that there is a mass unconscious which perpetuates itself in mankind not through teaching but through inheritance of acquired knowledge. Freud, the author objects, makes an analogy between the individual neurotic and the mass psyche, things which have different meanings. Freud suggests that people repressed the memory of Moses' murder, remembered it, and then repressed it again. However, Yerushalmi points out that the continuous oscillation between memory and forgetting is a major theme through all narratives of historical events. Such a process of reinterpretations of history in different eras is to be expected. However, Freud replaces the process of tradition with the process of unconscious repetition. In short, the criticisms leveled against Freud's *Totem and Taboo* are similarly relevant to *Moses and Monotheism*.

Now let us turn to the author's consideration of Freud's Jewish identity. According to Yerushalmi, the difficulty in interpreting

[2] Abraham, K. (1912): Amenhotep IV (Ikhnaton). A psychoanalytic contribution to the understanding of his personality and the monotheistic cult of Aton. *Psychoanal. Q.*, 1935, 4:537-569.

Moses and Monotheism arises in part from Freud's ambivalent Jewish identity. Freud on one hand depicts himself as embedded in German identity. He wrote in 1926 that his language is German, as is his culture, and he is a German intellectually. However, he continues that since encountering German and Austrian anti-Semitism, he now prefers to call himself a Jew (p. 41).

Freud's involvement with or separation from Jewish identity was very much caught up in his concern for the fate of psychoanalysis. He befriended Jung partly to help promote a nonsectarian image of psychoanalysis. He refrained from publishing the third part of his book, *Moses and Monotheism*, in the belief that the book would offer material to the Austrians to use against Jews and, by association, against psychoanalysis. He was concerned that psychoanalysis would be seen as sacrilegious. He did publish this section in England. Why, the author asks, was Freud not concerned with the sensitivity of the Jews? The answer is that although the Jews might have been critical, they would not have extended their criticism of Freud to the whole practice of psychoanalysis as Schuschnigg might have done.

The above material suggests that Freud's main concern was with the fate of psychoanalysis and was little with Jewish identity. In fact, it might appear that his main concern with Judaism was its possible negative impact on the acceptance of his science. However, the author points to some evidence that privately Freud had an emotional investment in Judaism. Yerushalmi offers a discussion of Freud's complex relationship with Jung and with Abraham. He tells us that when Freud was disappointed in Jung because of his rejection of Freud's libido theory and because of Jung's affair with Sabina Spielrein, Freud wrote to Spielrein, "We are and remain Jews. The others will only exploit us and will never understand and appreciate us" (p. 45). The author suggests that the powerful emotions that were triggered by his break with Jung were sufficient to help Freud understand that he was a Jew and that this remained with him in later years. The increase in anti-Semitism acted to accentuate these feelings and led Freud to choose 1934 as the year to publish his most Jewish work, *Moses and Monotheism*. Thus he sees this publication as a declaration of Freud's Judaism as well as a critique of Jewish history.

Yerushalmi concludes that in numerous ways Freud proclaimed

his Jewish identity as inalienably his and that it formed an integral part of his work. He asks whether indeed psychoanalysis would not be considered by Freud as an essentially Jewish science.

This is a fascinating book, yet one which will surely meet with objections from those who are more accepting of Freud's perspectives. On the other hand, it raises some important questions about the interrelationship of Freud the individual and Freud the theorist. Can we ever separate the theory of psychoanalysis from its author or from the era in which it was formulated?

This reviewer was pleased to see the extent to which Freud, who appears in his writings to be so oblivious to his Jewish identity and the Nazi era, is concerned with these issues in his private life. He was placed in the ironic situation of finding his Jewishness more compelling because of the anti-Semitism of the time, yet finding it necessary to de-emphasize the same Judaism in order to protect his theoretical work from the anti-Semites. This revelation adds an important dimension to our understanding not only of Freud but of the background of the evolution of psychoanalysis.

JUDITH S. KESTENBERG (SANDS POINT, NY)

PENELOPE'S WEB. GENDER, MODERNITY, H.D.'S FICTION. By Susan Stanford Friedman. Cambridge/New York: Cambridge University Press, 1990. 451 pp.

Susan Stanford Friedman has written an exemplary book in which she uses her knowledge of psychoanalysis to illuminate the life and writing of H.D.—the nom de plume of Hilda Doolittle. Among psychoanalysts, H.D. is known for her accounts of her analysis with Freud. In literary academia, she is recognized as a twentieth century poet important in the development of modernism. Among feminists, she is renowned as a woman writer, who, in her life and career, dealt with major issues of feminism.

Friedman derives the title of her book from what H.D. said concerning her lifelong autobiographical project: "It must be Penelope's web I'm weaving." Friedman concentrates on H.D.'s prose creations—novels, novellas, short stories, essays, memoirs, and letters—which have not received as much critical appraisal as her poetry. These prose works, many of which remain unpublished, are

more overtly autobiographical than her poetry and therefore more accessible to an analytic understanding.

Friedman's main thesis is that H.D. exemplified conflicts particular to women, especially creative women in the post-Victorian male world of letters. To simplify, the issue is: can a woman be a writer? Friedman richly details H.D.'s attempt to deal with the limits imposed by cultural forces and her own intrapsychic conflicts. She draws on a wide variety of critical theory, ranging from traditional Freudian to post-structuralist feminist. For the reader with a clinical psychoanalytic background, rather than an academic literary background, these multiple, interrelated viewpoints may cause some disequilibrium. However, for those readers who may wish to learn about current literary application of psychoanalytic theory (filtered through such theorists as Lacan) rather than struggling through a book about theory, the reading of *Penelope's Web* will provide an excellent introduction to the application of such theory.

In the first chapter, "H.D.—Who is She? Discourses of Self Creation," Friedman compares H.D.'s prose and poetry and then provides an overview of the themes in her book. Unlike some earlier biographers, Friedman directly addresses the issue of H.D.'s bisexuality—an aspect of her personality crucial to understanding the conflicts within her psyche. From the beginning of her career, her gender was at issue. Her genderless monogram, "H.D.: Imagiste," was bestowed on her by a man—her one-time mentor and lover, Ezra Pound. Her early lyric poems in *Sea Garden* were impersonal, and Friedman considers that this style of discourse represented H.D.'s first attempt to solve the problem of gender. However, after severe stresses during World War I, including a miscarriage, the death of her brother and of her father, the dissolution of her marriage, and a risk of death from influenza during the end of her second pregnancy, H.D. suffered an emotional breakdown. Friedman contends that writing about these traumas was essential in her attempt at recovery. However, H.D. needed a more personal medium than her lyric poetry to do this.

Chapter Two, "Origins: Rescriptions of Desire in *HER*," focuses on the novel *HER*, written in 1926-1927. In *HER*, H.D. dealt with the issues of how women move from being the passive objects of male desire to being active subjects who desire and create. In *HER*, "the muse speaks" and refuses to be the object of the male gaze.

Through an examination of H.D.'s heroine, Hermione, Friedman proposes that a major dynamic in H.D.'s personality involved conflicted identifications. Identification with her mother would mean a loss of creativity; identification with her father would mean giving up motherhood.

The following chapter, "Madrigal: Love, War and the Return of the Repressed," deals with the three autobiographical novels that comprise H.D.'s Madrigal cycle. Friedman asserts that these novels represent the return of her unresolved, repressed wartime traumas. (However, Friedman emphasizes the tragedies during H.D.'s adult years, giving little connection with her childhood conflicts, which one usually considers "the repressed.") Friedman uses her extensive knowledge of H.D.'s relations with her literary contemporaries, such as Pound, D. H. Lawrence, and Virginia Woolf, to clarify the complexities of H.D.'s writings, showing how her texts reflect and play upon the life and work of her contemporaries.

In "Borderlines: Diaspora in the History Novels and Dijon Series," Friedman writes of H.D.'s struggle to integrate a fragmented self. However, her attempt to heal a split between her masculine and feminine identifications through her writing was not successful. As she searched for "the primal mother of fantasy," she became increasingly despairing. She regressed to the border of madness, and wrote of her wish for death in her autobiographical writings. It was a derivative of these suicidal impulses that resulted in a writing block—a symptom that brought her to analysis with Freud.

"Rebirths: Re/Member the Father and Mother," is the most intriguing chapter for psychoanalysts. In it, Friedman examines H.D.'s reports of her analysis with Freud. H.D. saw him from March 1 to June 12, 1933 and again from October 31 to December 2, 1934. Many analysts are familiar with her two published texts, *Tribute to Freud*, written in 1944, and "Advent," written in 1948. However, Friedman also uses H.D.'s unpublished letters to Bryher, H.D.'s confidante and once-lover, which were written at the time of her analysis.

Friedman divides her examination of H.D.'s relationship to Freud into the paternal and maternal transferences. She further examines the texts in terms of H.D. writing about her transference and in terms of H.D.'s writing as transference.

H.D. recognized her intense positive paternal transference to

Freud—Freud was an idealized father she never had—but, as Friedman rightly argues, her inability to talk to Freud of the current Nazi persecution of the Jews was a serious resistance against expressing her negative transference. Freud on occasion interpreted H.D.'s wish for his death, but the analysis went in other directions. Because Freud told her not to write about her analysis, Friedman concludes that her later writing about it was a resistance to Freud's paternal authority. Friedman uses resistance in its broadest definition, equating resistance with defiance, which is not necessarily resistance to uncovering transference. But, as Friedman points out, H.D.'s increased self-reflective, free association style shows a positive identification with Freud.

Although Freud reportedly told H.D. that he disliked being the object of maternal transference, a significant amount of work of the analysis involved preoedipal issues. Friedman is convincing when she connects H.D.'s maternal conflicts to her lesbianism, creativity, and writing block. In fantasy, H.D.'s writing was a way of performing in order to attract the lost primal mother.

Friedman is at her best in her examination of *The Gift*, written by H.D. in 1941-1943. Although *The Gift* does not recount H.D.'s analysis, it demonstrates H.D.'s ability to use her analytic understanding in creative self-analysis. In it, H.D. writes of a once repressed memory of a severe head injury suffered by her father. Friedman understands this as a derivative of H.D.'s fear of the phallic father and the fantasy of the resurrection of a castrated father with whom she is on more equal terms. (She once described Freud as Christ after the resurrection!) Also in *The Gift*, H.D. finds the comforting recollection of her powerful, preoedipal grandmother which helps offset her fears of feminine identification with the castrated, oedipal mother.

In 1946, she suffered an episode of psychosis about which little has been written. After her recovery she led a reclusive but creative and productive life. Her analysis helped H.D. develop a new literary form: "the personal essay that integrates autobiography and meditation, dream and history, the self and the other, poetics and psychology, lyric and narrative" (p. 285).

As with any book, there are some aspects with which I disagree. Questionable is the position that the "scene of autobiographical writing can correspond to the scene of analysis" (p. 83). Friedman

contends that "the self-reflexivity of H.D.'s texts reproduces the psychodynamics of repression, transference, resistance, and working through" (p. 284). Friedman's analyses of H.D.'s texts are certainly plausible and often quite convincing, but in "analyzing" written texts there is always a great degree of uncertainty, since an analytic process does not exist and hypotheses cannot be confirmed.

Friedman emphasizes that one goal of analysis is to recover lost memories and that H.D.'s analysis resulted in Freud's becoming the parental figures H.D. had not actually had. Friedman relates, but could have further emphasized, the more important aspect of analysis that was accomplished by H.D.—developing insight into how these memories affected her personality.

Unfortunately, a brief review does not do justice to Friedman's wide-ranging, multifaceted, and analytically deep book. In addition to admiring her scholarship, as psychoanalysts, we owe the author a debt of gratitude. Too easily, some feminists have made Freud a *bête noire*. Friedman's book is a tribute to an analytic relationship that lasted but a short time, yet resulted in a lifelong benefit to a talented but troubled writer.

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Neurobiology of Visual Perception

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ABSTRACTS

NEUROBIOLOGY OF VISUAL PERCEPTION

Abstracted by Julia Matthews.

The past two decades have seen an explosion of knowledge in the field of neuroscience, and a parallel resurgence of interest in the biology of mind. Many psychoanalysts and neuroscientists alike have begun to explore ways in which observations from each field may complement or even direct research in the other field. Since few would hold to a strict mind-brain dualism, most anticipate that such cross-fertilization will be ultimately fruitful. Freud's original hopes for a biologically based depth psychology may begin to be realized a century later.

Because the material may be new to many readers, I have chosen to present several related abstracts in one area of neuroscience research of potential interest to psychoanalysts. It is hoped that these selections will provide context for each other, and that taken together, they will "tell a story." As a starting place I have chosen to focus on sensory perception, particularly vision. Other areas will be taken up in future issues of this journal.

The neurophysiological basis of perception has intrigued neurobiologists for decades. How is the rich and integrated world of perceptual experience built from elemental cellular activity? Vision is the most extensively studied sensory system, and its explication promises to shed light on the general problem of perception, as well as on the larger issues of awareness, selective attention (and inattention), and consciousness. Furthermore, visual phenomena are intrinsic to a wide array of human experience, ranging from veridical perception to fantasy, illusion, hallucinosis, and dreaming. A theory of vision may yield greater understanding of these experiences as well, and may thereby provide a bridge to the exploration of unconscious operations.

A Direct Demonstration of Functional Specialization in Human Visual Cortex. S. Zeki, et al. **Journal of Neuroscience.** XI, 1991. Pp. 641-649.

Our understanding of visual processing in the cerebral cortex has undergone major revision since the 1970's. The primary visual cortex of the occipital lobe (also called striate cortex, area 17, or V1), which receives topographically arranged binocular input from the retinas via the lateral geniculate nuclei of the thalamus, was traditionally identified as the region of primary visual perception. Visual association areas adjacent to the striate cortex were assumed to function in higher order processing of the visual percepts formed in the striate cortex (V1), for example, comparison with past visual impressions, or the "interpretation" of images. However, since the 1970's, electrophysiological studies largely in the cat and the macaque monkey have demonstrated numerous anatomically distinct areas outside the striate cortex that are involved in the analysis of specific perceptual attributes such as motion, color, or depth perception. Parallel pathways funnel through V1 to these separate areas, with V1 acting as a segregator of signals to relevant extrastriate areas.

In the macaque brain, for example, color perception occurs in area V_4 and motion in area V_5.

This study used positron emission tomography (PET) to demonstrate regional subspecialization in human extrastriate visual cortex. PET scanning visualizes dynamic changes in regional blood flow by detecting the changing distribution of trace amounts of inhaled isotopic $^{15}CO_2$. Localized blood flow is strongly correlated with the intensity of activity, providing a means to assess changes in local activity in response to different types of visual stimuli.

Nine normal male volunteers were studied under two paradigms of visual stimulation, one chosen to emphasize color features and the other chosen for motion features. The color stimulus, a color Land Mondrian figure (nonrepresentational color block pattern), was compared to an isoluminous gray shaded version of the Mondrian, and to the resting condition with eyes closed. The motion pattern, consisting of black squares moving on a white field, was compared to a stationary pattern of squares and to the resting condition. All nonresting conditions demonstrated activation in the striate cortex (co-extensive with areas V1 and V2). The color stimulus also activated a distinct area in the fusiform and lingual gyri of extrastriate cortex (V_4), whereas the motion stimulus demonstrated enhanced activity in a region at the occipital-parietal-temporal junction (V_5).

These results are consistent with the view that various attributes of the visual scene are analyzed in anatomically discrete regions, and that the subjective perception of a coherent scene requires integration of information from widely separated cortical areas.

Neuronal Correlates of a Perceptual Decision. W. T. Newsome; K. H. Britten; J. A. Movshon. **Nature.** 341, 1989. Pp. 52-54.

Cortical Microstimulation Influences Perceptual Judgments of Motion Direction. C. D. Salzman; K. H. Britten; W. T. Newsome. **Nature.** 346, 1990. Pp. 174-177.

To understand the basis of this feature-selective response, numerous electrophysiological studies have investigated the stimulus selectivity of single neurons and neuron groups in different cortical areas. Many neurons in the primary visual cortex are optimally responsive to simple stimuli such as light bars with a particular orientation, while single neurons in area V_4 (color) respond maximally to stimuli of specific wavelength. Single neurons in the middle temporal area (MT, V_5) of the extrastriate cortex are selectively responsive to motion in a preferred direction, and conversely are nonresponsive to motion in the opposite direction. As is the case for other sensory areas, neurons in V_5 are arranged in columns such that there exists a series of cell columns selectively responsive to each motion direction for each region of the visual field.

Newsome and colleagues have begun to explore the relationship between neuronal activity and perception. The first of these papers correlates single cell responses to moving stimuli with the perceptual judgment of alert behaving monkeys. Macaque monkeys were trained to search for coherent movement of a subset of dots within a visual display of dots moving in random directions, and to "report" the

direction of movement by a directed eye movement following the cessation of the visual stimulus. Single cell recordings were obtained from cells in area V_5 while the alert monkey performed this discrimination task. The visual stimulus was matched to the field position and motion selectivity of each neuron examined. The strength of the motion stimulus was varied by altering the proportion of dots moving coherently in the defined direction, allowing determination of a probability function for correct responses as a function of percent dot coherence (the psychometric function). A comparable function was derived for the single neuron response by determining the threshold level of coherent dot movement at which the neuron selectively responded. This neurometric function for a single cell typically paralleled the psychometric function and had a similar response threshold.

In a second study, Salzman, et al., investigated the effect of simultaneous cortical microstimulation on the performance of the monkeys on the same motion discrimination task. Once again the visual stimulus was matched to the selective sensitivity of the cortical neurons under study. Bursts of 10 microamp pulses were applied coincident with the visual stimulus (sufficient to activate neurons locally within an area of approximately 85 microns). The psychometric function for motion discrimination was significantly shifted when bursts of microstimuli were applied to the area of cortex identified as maximally sensitive to the visual stimulus under study. In other words, the microstimulation lowered the perceptual threshold, biasing the monkey's judgment in favor of detecting the motion.

These studies demonstrate that activity in small clusters of neurons can affect perceptual discrimination at the preconscious or conscious level, i.e., at the level of behavior.

The above findings have the important implication that the visual image as subjectively perceived is not localizable to any single site. Visual perception is a construction within the brain rather than a photographic replica of the external world. Since the various perceptual features are analyzed in anatomically distinct areas, there must be a mechanism to integrate these features into a coherent perception, commonly referred to as the "binding problem." A leading hypothesis builds on the observation that visually stimulated neuronal activity tends to occur with a characteristic spike frequency of around 40 cycles per second (40 Hz). Synchronized oscillation may "bind" the components of the visual image and form the basis of perception, as described below.

Oscillatory Responses in Cat Visual Cortex Exhibit Inter-Columnar Synchronization Which Reflects Global Stimulus Properties. C. M. Gray; P. Konig; A. Engel; W. Singer. **Nature.** 338, 1989. Pp. 334-337.

Synchronization of Oscillatory Neuronal Responses in Cat Striate Cortex: Temporal Properties. C. M. Gray; A. Engel; P. Konig; W. Singer. **Visual Neurosciences.** VIII, 1992. Pp. 337-347.

Previous work by this group and others has demonstrated that neurons of the cat striate cortex respond to their preferred stimuli with rhythmic spike activity at a frequency of 40-60 cycles per second (40-60 Hz). Furthermore, nearby neurons which share the same stimulus selectivity have synchronized oscillatory responses

(hence the extracellular local field potentials also show stimulus-selective oscillatory activity which is strongly correlated with the single or multiunit response).

The first study examines the degree of response synchronization between neurons in separate cortical columns as a function of both stimulus characteristics and the distance of cortical separation. Multiunit activity and local field potentials were recorded by extracellular electrodes in the striate cortex of anesthetized adult cats. Of 199 recording sites, 132 were judged to show oscillatory activity. Cross-correlational analysis for pairs of sites with oscillatory responses often demonstrated synchronization of this oscillatory activity at spatially separate cortical sites. The probability of synchronization between sites depended on the distance between sites and the similarity of preferred stimulus orientation of the sites. Sites with different visual fields but common orientation preference were observed to respond with phase-locked oscillatory activity, especially if the presented stimulus bridged both visual fields. These data are consistent with the notion that synchronization provides a mechanism for "extraction and representation of global and coherent features" of a visual stimulus.

The second study builds on these observations of synchrony by investigating in detail the fine temporal patterns for episodes of phase-locked oscillatory activity at distant sites. Once again multiunit activity and local field potentials were simultaneously recorded at several sites in cat striate cortex. Twenty pairs of sites were selected for temporal analysis of the local field potentials. Within each pair the sites were at least 5 mm apart (representing different areas of the visual field), and each site showed robust stimulus-dependent oscillatory response. The analysis used a moving-window technique to sequentially examine a series of 100 msec epochs, shifted stepwise by 30 msec increments, to examine the entire 6 sec stimulus period. This allowed a determination of the frequency, duration, and phase of episodes of correlated activity between paired sites. Synchronized oscillation events were transient, often forming, collapsing, and reforming during a stimulus period. The authors suggest that these events reflect transient linkages between distributed cell assemblies that form and dissolve as different aspects of the visual image are processed.

Some Reflections on Visual Awareness. F. Crick and C. Koch. **Cold Spring Harbor Symposium on Quantitative Biology.** LV, 1990. Pp. 953-962.

As described above, clusters of neurons responding to the same stimulus tend to exhibit phase-locked synchronized oscillatory activity at 40-60 Hz. (Subsequent reports have shown that this effect can occur over large cortical distances, between cortical areas, and even between cerebral hemispheres.) The authors speculate that the synchronization of activity in widely distributed cell assemblies serves to "bind" the perceptual image and create the experience of "vivid visual awareness." In developing this theory, they correlate the neurobiological data to psychophysiological data on visual processing. Visual perception has traditionally been broken into two phases, an initial rapid parallel processing, thought to reflect "hard wired" analysis of simple features and elements, followed by a slower serial phase of analysis. The former process does not elicit "vivid awareness." However, in the latter phase, termed "focal attention," selected aspects of the visual scene are interpreted

using constraints which are built into the neural system by both genetics and experience. It is proposed that this process of neural "computation" results in the establishment of phase-locked oscillation in a distributed cell assembly.

Since synaptic linkages reflect genetic programming, epigenetic shaping, and experience-based modulations, the probability that a particular functional cell assembly will emerge depends on both the stimulus characteristics and past experience. When the visual scene is ambiguous, rival sets of neurons set up competing oscillations, and the "strongest" (highest amplitude, most coherent) oscillation "wins." Others have previously suggested the existence of a topographic "saliency map" within the visual system which guides attentional focus within the visual field. "Saliency" here is a broad term; a visual stimulus may be salient as a result of lower level features such as motion, or as a reflection of higher level search for more complex features. The presence of salient features may "spotlight" certain aspects of the visual scene by facilitating the formation of coherent oscillation, thus favoring certain perceptions. (Extending this notion of saliency, one might also imagine that the affective valence of certain features could contribute to the establishment of attentional focus, and could either favor or inhibit perception. Such a mechanism would allow for selective perception based on psychodynamic principles.)

Finally, the authors propose that the coherent oscillatory activity activates "working memory," which holds a trace of the perceived image for several seconds after the oscillation (and vivid awareness) has ceased. This working memory may depend on persistent nonoscillatory activity within the subset of distributed neurons, transient synaptic modification, or both. When the distributed oscillation ceases, the core neuronal set will have a decreased threshold for reactivation, facilitating the re-establishment of coherent oscillation and thus the re-emergence of vivid visual awareness. (Although working memory lasts only a few seconds, a similar but more persistent effect could explain the ubiquity of "day residue" in nocturnal dream images.)

These speculations suggest mechanisms for visual selective attention and subjectivity. Some aspects of visual perception are expected to be highly accurate because of the continuous feedback corrections and adaptive pressures. However, more ambiguous situations, such as visual aspects of social cues, are subject to varied interpretations, and the dominant interpretation depends on individual experience. The perceptual world is internally created through the lens of personal history, as is continuously confirmed in psychoanalytic experience.

INFANT OBSERVATION

Abstracted by Stephen Seligman.

Infant observation research is providing perspectives on the development of psychic structure that augment existing psychoanalytic models, especially in the area of prerepresentational domains of experience that have not been previously well described. From related but subtly varied perspectives, these writers emphasize the centrality of the infant's experience of the intertwining rhythms and routines of both early somatopsychic states and caregiving interactions. While the specific nature of the relationship of the earliest experiences to adult personality remains somewhat problematic, these descriptions suggest new directions for conceptualizing aspects of adult treatment and psychopathology.

The Contribution of Mother-Infant Mutual Influence to the Origins of Self- and Object-Representations. B. Beebe and F. M. Lachmann. **Psychoanalytic Psychology.** V, 1988. Pp. 305-337.

Mother-infant interaction is characterized in terms of patterns of mutual influence, although these patterns are not necessarily symmetrical. Since these patterns are typically recurrent, they are generalized as "expectancies [which are] characteristic patterns that the infant recognizes, expects and predicts"; these structures are understood as "interactive representations." These social representations provide a basic context for the development of experiences of self and other, which are developed simultaneously. The authors propose that these processes be combined with other models of psychic structure development "to yield a fuller picture of the complexity of the early organization of experience."

The specific nature of these patterns is demonstrated through direct observation of mother-infant interactions. Split-screen films and videotapes that simultaneously show the mother's and the infant's facial and bodily reactions during interactions are carefully timed and dramatically reflect specific patterns of interaction. Both "matches" and "derailments" between infants and parents can be obsèrved in detail. The article includes useful photographic reproductions.

Affect and the Development of the Self: A New Frontier. E.V. Demos. In **Frontiers in Self Psychology: Progress in Self Psychology, Volume 3,** ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, 1988. Pp. 27-53.

The author argues that most previous discussions of early development — both psychoanalytic and empirical — have underestimated the sophistication of the neonate's capacity to process and use affects, and, consequently, the role of affect in early psychic development. Basic research on affect, including that of Tomkins, Ekman and Izard, is interpreted to suggest that very young infants are aware of specific affects as well as of such general properties of affects as the hedonic tone and the level and rate of change of stimulation. With such capacities, the infant's efforts to regulate affect states are an essential motivation and provide the basis for senses of personal organization, continuity, agency, and stability; since affect has both proprioceptive and communicational value, it forms an essential bridge in the infant's experience of coherence and organization in both the individual domain (an essential part of "self") and in interaction with caregiver environment as it supports the infant's regulatory capacities.

Demos presents her approach as an elaboration and extension of Sander's overall regulatory systems approach and his particular emphasis on infant state organization as the earliest organizer. Two extended examples of "affect biographies," starting with very early infancy, are offered.

Psyche. Zeitschrift für Psychoanalyse und ihre Anwendungen. XL, 1986.

Abstracted by Emmett Wilson, Jr.

Freud's Paper: The Unconscious. Gernot Böhme. Pp. 761-779.

A peculiar urgency characterized the writing of Freud's 1915-1917 metapsychological papers. Not least among his several motives was his belief in the need for a synthesis of his work, since he feared that the end of his life was near. Böhme

discusses philosophical and methodological aspects of Freud's all-important paper on the unconscious, a paper in which Freud essentially expounds his first theory of the psyche, also called the first topographical theory to distinguish it from the structural theory introduced in 1923 in *The Ego and the Id.*

Freud's paper began with epistemological and scientific justifications for introducing the concept of the unconscious, stressing that it is a *psychic* unconscious. On the one hand, all neurophysiological and somatic speculations were held in abeyance, which permitted Freud to develop his metapsychology in its topical, dynamic, and structural aspects within a purely psychological field. On the other hand, Freud was concerned to defend his concept of the unconscious against philosophical objections which would equate "conscious" with "mental." Freud justified the introduction of the notion of the unconscious as a necessary hypothesis to explain the continuity of mental life.

Böhme considers Freud's references to Kant's unknowable thing-in-itself in attempting to make his concept plausible and acceptable. This appeal to Kant has been criticized both for trivializing Kant's thought, and for endangering psychoanalytic theory by rendering the unconscious essentially unknowable. However, the author feels that the Kantian notion can help clarify Freud's concept of the unconscious. The main criticism is that the thing-in-itself cannot be an appearance and cannot participate in a causal series, while Freud had explicitly introduced the unconscious to do precisely that. This objection is correct insofar as it goes, but Kant made it clear that we can only *think* of the thing-in-itself but cannot know it because it is not a given. Böhme feels this is consistent with Freud's claim that the unconscious is a metapsychological hypothesis, but is unknown to us as unconscious. He comments that this epistemological situation is, incidentally, precisely why Freud introduced the term "metapsychology," which signifies not a theoretical psychology but what is "beyond" or "after" psychology.

It is, however, clear that Freud's view of the unconscious as the complement to conscious psychic life, providing continuity and coherence, does lead to problems about its knowability. His insistence on the psychic aspects of the unconscious, his denial that it is the somatic, and his insistence on our knowing the unconscious only through the mediation of consciousness led Freud to the basic concept that the psychic processes are unconscious, while consciousness is the perception of these unconscious processes, a position which he never fully abandoned even after realizing its insufficiency. Freud used the notion of perception to introduce the concept of the preconscious, but for the understanding of conscious and unconscious it was a catastrophic move, for it shifted the important differences characterizing mental life to the difference between the unconscious and the preconscious.

This differentiation between conscious and unconscious remained a problem for Freud, even though he tried to dismiss it by sweeping it aside in his first topography of the mind. One aspect of the problem was the vexed question of dual registration, that is, whether a representation can occur separately in two places, at both unconscious and preconscious levels in the mind. The question still remained unanswered: in what does becoming conscious consist? Freud ultimately returned to his view of consciousness as perception, introducing the notion of hypercathexis, that is, an appended, additional quota of energy. Thus Freud arrived at a simple theory of attention.

In the final paragraphs of his paper Freud proposed a solution: the link between thing- and word-presentations. But this did little to help the rehabilitation of consciousness, for Freud continued: "As we can see, being linked with word-presentations is not yet the same thing as becoming conscious, but only makes it possible to become so; it is therefore characteristic of the system *Pcs.* and of that system alone." The outcome of Freud's paper is that recognition of the unconscious contributes to the disruption of the self-certainty of consciousness.

We do not have to be satisfied with this answer. In the paper Freud gave several indications of another solution: the multiple unconsciousnesses created through repression. And the answer to the question of what differentiates conscious from unconscious seems to be in the establishment of the censoring agency, which not only separates, but produces the difference, allowing through only moral, logical, reality- and social-oriented impulses. This process becomes automatic in the course of development into adulthood, leading to the growth of a realm of the preconscious, consisting of those elements of psychic life that are in principle conscious.

Böhme acknowledges that this still leaves the question of the knowledge of the unconscious. This is a paradox, in that knowledge of the unconscious has as its data only conscious representations. In attempting to characterize specific knowledge of the unconscious, Böhme criticizes any attempt to equate "latent dream thoughts," for example, with unconscious thoughts, for the latent dream thoughts are from the preconscious. He utilizes an analogy from linguistics, found in Benjamin Whorf's attempts to convey how the Nootka Indian language works. Whorf constructed sentences in English according to the rules of the Indian language. Böhme believes that the analogy with the preconscious latent dream thoughts lies in the following: what we have from the unconscious (the manifest dream) is similar in construction to Whorf's tortured English-words-in-Nootka-syntax sentences. We can formulate what is in the unconscious in our language and to our awareness only in a similarly bizarre fashion. Thus the manifest dream does not provide direct knowledge of the unconscious, but can help us construct its grammar. Rather than identifying the self in a mirror, or through a transmutation, Freud's mode of knowing the unconscious provided us with a new kind of oblique self-knowledge, in which claims of autonomy for the rational ego are shown to be delusional and illusory. Freud's discovery was not the unconscious, which was known in Herbart, Schelling, E. von Hartmann, and Nietzsche. What Freud discovered was the dynamic unconscious with its own grammar and rules.

The Archaeology and Teleology of the Unconscious Wish. On the Conceptual Differentiation between Need, Wish and Desire in Psychoanalysis. Robert Heim. Pp. 819-851.

This is a closely argued discussion of conceptual questions concerning unconscious wish, need, and desire. It relies heavily on the philosophical positions of Habermas and Ricoeur to delineate a view of the mixed nature of psychoanalytic discourse, as a combination of energic and hermeneutic explanations. It also attempts to delineate the manner in which unconscious instinctual urges acquire significance and can be understood in the course of psychoanalytic work.

Heim notes the tension between the accepted sciences and psychoanalysis, with its rebellious undercutting of the established order. Freud recognized this same conflict

in the contrast he felt between his scientific training and his novel-like case histories. It is no wonder Freud eventually wanted to include literature and theory of language in the curriculum of his ideal analytic institute.

Meanwhile, the degree to which language and literature are involved in the objects of psychoanalysis has been widely recognized. Lacan spoke of the unconscious as structured like a language. Lorenzer, though decidedly different in his approach, spoke of the unconscious as a matrix of desymbolized forms of interaction, and stressed its eloquent absence of speech. In both expositions of Freud's science the unconscious is defined as an inscription. The combination of speech and body also appears in Ricoeur's phenomenological interpretation of psychoanalysis as a mixed discourse, as a demystified hermeneutic of the body and its instinctual life.

The concept of inscription is taken from Derrida's *De la grammatologie*. Derrida was critical of Lévi-Strauss, and of occidental metaphysics and its logocentrism in general. By inscription these authors meant to indicate that whenever one talks of speech, literature is also meant — the ordering of letters according to specific rules of grammar, syntax, and semantics to encode and decode the semiotic universe. The letter is the smallest unit in writing and literature, as the phoneme is the smallest phonetic unit in speech.

The author shows the close structural relations between psychoanalysis and literature. If grammar is a system of rules for the generation of understandable sentences and expressions, talk of the grammar of repressed wishes, etc., implies linguistic mediation of these wishes to make them analytically accessible. Heim alludes to Habermas's concept of reconstructive science to clarify this notion. The unconscious is seen as a system of rules analogous to grammar, but with a deep structure in Chomsky's sense, a structure that is discovered through the reconstructive science of psychoanalysis.

This leads to a discussion of the differences in the rationality of primary and secondary process. The unconscious, not "irrational" in itself, with its own rules and grammar, can be regarded as "irrational" only in contrast to secondary process. Otherwise it could not be understood through the psychoanalytic reconstruction of unconscious processes.

The Obsessional-Compulsive as an "Inhibited Rebel." Hermann Lang. Pp. 953-970.

Lang discusses the case of a female obsessive-compulsive patient who seemed to fit all the typical patterns, an almost textbook case. However, there were some unexplained aspects of the case, in particular, the focus of the patient on her father, rather than on her mother as required by classical theory. The author feels these aspects are better handled from a structural (in the sense of Lévi-Strauss and Lacan) perspective, rather than from the customary psychoanalytic view of regression from the oedipal conflict to the anal level.

Compared to animals, humans are rather poor in instinct; given their weakness and shortcomings, they are oriented toward communication. The mediators in this process of individual socialization are the primary objects, who are representatives of culture and linguistic communication, the *ordre symbolique* of Lacan and Lévi-Strauss. Because of this organization, we do not encounter instinct per se. The so-called

partial instincts of the oral and anal phases are therefore abstractions, and appear interwoven with the communicative processes, and articulated in symbolic references. From the beginning, sucking is a mode of communication — between mother and child, child and family, child and environment. This understanding of the communicative nature of early interactions was evident to Freud also, for instance, in his recognition of the bowel movement as a "gift." Feces become a symbol, a speech element in the conversation between infant and caretaker. Freud's concept of the oedipus complex is a subjective realization of what sociologists have found structured in other cultures as the avunculate, the special relation of a man over his sister's children.

From this standpoint, the obsessive-compulsive individual may be seen as attempting to gain autonomy through the destruction of this human, social order of communication. The death wishes of the obsessive-compulsive against the parents, and the resulting anxiety, guilt, and fear of talionic punishment can be understood in this fashion. The struggle of the obsessive-compulsive patient can be seen as a battle of autonomy versus obedience, first fought out in the struggle over feces as gift, or compliance. The attempts to cleanse and undo represent guilt over the defiance that had achievement of autonomy as its basic goal. In this sense, the obsessive-compulsive may be seen as a rebel, and in treatment the same rebellion comes into play. Progress in treatment involves the institution of the struggle for autonomy and compliance around the treatment framework.

Emancipation and Method. Alfred Lorenzer. Pp. 1051-1062.

In *Madness and Civilization* Foucault saw psychoanalysis as a part of the power game with patients. He argued that the shift from virtual incarceration of mental patients in asylums, to the treatment of mental illness, was merely a revision in the power relationship between doctor and patient, but not a real change in attitude. The physician was still the dominating figure in the relationship, the omnipotent and omniscient participant in their interactions. In Foucault's very convincing presentation, this dominance was depicted as a virtual apotheosis of the physician.

Lorenzer disagrees with Foucault and feels that he did not note the major differences in Freud's approach, and the way Freud diverged from Janet, Charcot, and Liebeault. He points out that in the pivotal case of Anna O. came a major shift in the doctor-patient relationship. This time the patient led the way, both in showing the physician how the treatment should be conducted and in setting the theme and topic of their interaction. Now the doctor simply sat by and listened, and it was the patient's feelings and recollections, not physical complaints, that were of utmost importance.

But the question arises whether Freud's accomplishment cannot be reduced to his readiness to recognize the nature of the subject. Was Freud's decisive contribution to the new "science of understanding" merely his sensitivity? Certainly not, as a comparison with the equally sensitive Breuer will show. The proclivity to sensitivity and the willingness to learn were alone not enough to solve the riddle of the unconscious. As a comparison, Lorenzer considers the devotion of Clemens Brentano to Anna Katharina Emmerich, who occasionally exhibited the stigmata; or the interest of the physician, Justinus Kerner, in the visions of the psychic, Fredericke Hauffe, about whom he wrote the book, *The Prophetess of Prevorst.*

In a 1932 letter to Stefan Zweig, Freud commented that Breuer failed to recognize what he had before him because of the lack of anything "Faust-like" in his character. Perhaps it is this Faust-like aspect that enabled Freud to deal with the irrational. It had its dangers, as the relationship to Fliess showed, but Freud's scientific nature was a strong antidote to any foolhardiness. Perhaps Freud's greatness lay in his ability to change his orientation, to shift from biological studies on planaria, from his many and quite excellent neurological publications, to his novel-like case histories, from being a researcher to becoming an interpreter of lives. Habermas has referred to this as "scientific self-misunderstanding." Freud proposed understanding the patient, but what was understood he construed in scientific terms. There was a paradoxical effect to Freud's search for the origins of the phenomena he was investigating. He did not find them, but instead delineated the structure of the unconscious, formulated the mechanism of the unconscious process, and sketched the scaffolding of metapsychology. The sufferings of humanity were wrested from ecstasy and were not regarded as manifestations of otherworldly beings, but as dynamic and energic forces organized in a structure. Had Freud's scientific orientation not prevailed, we might have a psychoanalysis consisting of mandalas and mythologies.

Was Freud's lifelong dedication to a scientific understanding of psychoanalysis not, in the last analysis, a relic from the time of his work on planaria? A study of the metapsychological works of 1915-1917 is thought-provoking. There is an undeniable identification of the basic psychoanalytic statements with clearly neurophysiological formulae from the 1891 study of aphasia. But a deeper look at Freud's mode of thinking indicates that in spite of his merciless pursuit of science, he established a new paradigm that Lorenzer calls the "hermeneutics of the body." The two viewpoints — of the science of culture and of the natural sciences — cannot be reduced to each other, but they intersect in the metapsychological concepts introduced by Freud. The decisive metapsychological concepts have a striking capacity to be read in either direction: to reflect the natural sciences and physiology, as well as to reflect psychological and sociological meaning. And while they have these strong links with both types of science, they are not reducible to either, but maintain their own discourse. Psychoanalysis is a natural science, yet at the same time an analysis of the structure of meaning. In the words of Ricoeur, psychoanalysis is the combination of hermeneutics and energy.

The Collection of Evidence. The "Psychoanalytic Movement" and the Poverty of the Psychoanalytic Institution. Johannes Cremerius. Pp. 1063-1091.

This is a resounding critique of the process by which psychoanalysis has been institutionalized, at the cost of compromise and forfeiture of its scientific goals. These compromises include some embarrassing and unfortunate ones made by Freud himself — not only his treatment of independent thinkers among his followers, but even opportunistic political ones vis-à-vis the military during World War I with respect to the treatment of war neuroses, and with the National Socialist regime concerning the Berlin Institute. Cremerius has made a detailed study of the documents relating to these events and feels that the compromises that developed, with their emphasis on the end justifying the means, reflect generally on the development of psychoanalysis as an institution.

Cremerius criticizes the admission process, which frequently excludes the gifted researcher and the seeker after truth rather than the believers. He criticizes the power politics involved in institutions, and the training analysis as a function of this political process. He claims that lay analysis is another victim of this institutionalization. By this collection of evidence about the connections between the psychoanalytic movement and its institutionalization, Cremerius sees consequences that Freud did not foresee. It is his hope that we can discover the reasons for the deterioration of psychoanalysis as a method of critical inquiry, and anticipate possible revision.

The Demise of an Institution. Mario Erdheim. Pp. 1092-1104.

By "demise" of an institution Erdheim means the painful failure to die, the failure of death. The psychological equivalent is melancholia, which is the failure of the mourning process. Institutions seldom die a quick death; they hang on and on, even after becoming anachronistic. Their structure and sometimes function and purpose are often taken over in a new edition by the institutions set up to replace them, just as Napoleon, starting out as a hero of the Revolution, eventually crowned himself emperor instead. Erdheim's historical review reveals this process of slow demise as characteristic of organized psychoanalysis.

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Meeting of the Psychoanalytic Association of New York

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NOTES

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

October 19, 1992. CHILD ABUSE AND THE CONCENTRATION CAMP. Leonard Shengold, M.D.

Dr. Shengold stated that it was his intention to use the concentration camp metaphor to describe similarities to the child's experience of abuse. "Soul murder" has long been Dr. Shengold's characterization of adult crimes against children which crush the victim's individuality and dignity, stifle the ability to think rationally, and destroy the capacity to feel the joy and love (and even hate) that living affords. Freud remained aware of the reality of cruelty and child seduction, despite his recognition of unconscious fantasy and childhood sexuality. The struggle between reality and fantasy remains a difficult challenge to this day: legal authorities and psychological workers are familiar with the daunting task, itself a potential damage to the child, of ascertaining the "historical truth." Dr. Shengold cautioned against the recent tendency to *assume* that child abuse has occurred and to prepare lists of ways to find it out, thus making it almost the subject of a cult. On the other hand, there exists "a formidable universal psychological resistance" to the idea of a depriving or abusing parent, since "unconscious identifications with parents are the cornerstones of our identities and our self-esteem." The cultivation of denial (brainwashing) comes both from the abuser's need to deny and to evade detection ("this didn't happen") and from the child victim's need of good parenting ("this couldn't have happened").

There still exist those who deny or minimize the concentration camp atrocities. The tortured Winston Smith of Orwell's *1984* ends up "loving" the Big Brother who has destroyed his soul. The neglected and abused child "usually has no one else to turn to for rescue but the very person, the concentration camp guard, as it were, who has done the damage." The dependent child is subject to the "household totalitarianism" of a tyrannical adult. Dr. Shengold cited the poet Randall Jarrell's description of Rudyard Kipling's terrible experiences when his loving parents left him (at the age of six) and his sister (aged three) in the care of a foster family ruled by a sadistic, capricious woman whom the children were forced to call "Auntie Rosa." Kipling called the home that he lived in for the next six years "the House of Desolation," and Jarrell labeled it "one of God's concentration camps." Kipling's intense hatred toward his abandoning parents and Auntie Rosa was often hidden beneath the overt celebration of authority in his writings. In part he identified with the righteous tormentor and, as Jarrell argued, "had to spend the rest of his life justifying or explaining out of existence what he could not forget." The Austrian philosopher Jean Amery and the Italian writer Primo Levi, both concentration camp victims and eventual suicides, wrote about the everlasting loss of faith in humanity that torture victims sustain. The concentration camp inmate, like the tortured child, tries to create a benevolent world even while his or her faith is being destroyed, tries to turn the persecutor/parent into a rescuer, tries to deny what can never be forgotten.

It is hard to generalize about former victims of child abuse only from the study of those healthy enough to sustain intensive therapy or analysis. Such victims cut across diagnostic categories — predominantly neurotic, but occasionally psychotic. They all desperately cling either to fragments of real benevolent parental functioning or to the delusion of having a concerned, loving parent. An identification with the aggressor parent makes the victim more likely to assume the role of abuser, thus repeating the process across generations.

In *The Drowned and the Saved,* the last book before his suicide, Primo Levi described the "crematorium ravens" of Auschwitz, special squads of prisoners who could temporarily forestall their own destruction by accepting the horrible task of running the crematoria themselves. This eliminated the distinction between the abused and the abuser and destroyed the souls along with the bodies of the inmates by passing the murderer's guilt along to the victims. Any self-esteem was viewed by the Nazis as a threat to the order of the camp, and so new arrivals were immediately subjected to humiliating, dehumanizing rituals. Such brutal initiation, however, was also inflicted by senior inmates who envied the newcomers for "smelling like home" and who made them into figures "of a lower rank on whom to discharge the burden of offenses received from above." (The arrival of younger siblings often presents a similar opportunity in family "concentration camps.") Levi illustrated how the concentration camp degraded its victims to its own infernal level. Dr. Shengold suggested that it was Levi's own degrading identification with the aggressor that resulted in a breakthrough of masochistic, suicidal shame and guilt.

The compulsion to repeat the overwhelming stimulation of traumatic events with the fantasized hope of a different outcome is another source of masochistic behavior in abuse victims. The overstimulation of childhood abuse evokes enormous anxiety and rage, as does the understimulation of neglect. Again, Dr. Shengold emphasized the victim's overwhelming need to assume a parental benevolence which would rescue the helpless victim from the rage and anxiety. The victim's craving for denial, for self-brainwashing, is a great obstacle to treatment. As victims examine feelings of rage and anxiety in treatment, they risk losing the delusion of a benevolent parent. A trusting, loving therapeutic atmosphere threatens to lift denial and repression and paradoxically turns the doctor into a perceived enemy. Patients fight a double battle in containing their aggression; they fear not only the immediate destructive potential of their wrath, but also the loss of the image of the good parent when they begin to acknowledge their hostility. Love and trust are the very emotions that led the victim to be susceptible to abuse in the first place. To trust the doctor would be to make oneself open to further torment.

The therapist's ability to tolerate the patient's sadomasochistic behavior benevolently, predictably, and reliably challenges the patient's terror of losing the caring parental image. If the patient learns to tolerate murderous rage within the transference, the need for denial slowly diminishes, and the capacity to remember, to love, and to feel can return. Dr. Shengold compared the work of therapy to Levi's description of the philosopher in the concentration camp who is able to acknowledge the monstrous side of reality. Of course, while in the concentration camp (or while in one of "God's concentration camps"), denial is generally more adaptive than such stark insight. In fact, Levi wrote that the uncultivated usually survived better than the thinkers and intellectuals, precisely because they did not try as hard to under-

stand. Dr. Shengold remarked that he has "the easier task" of working with adults who are no longer children actively being abused. In essence, therapy helps the victim learn how to feel again, breaking through the defensive dehumanization that protects any feeling from being a feeling of torture.

DISCUSSION: Dr. Kerry Sulkowicz noted that Dr. Shengold's approach to the two forms of soul murder — child abuse and the concentration camp experience — was from the structural point of view, focusing on ego and superego functioning with great clarity and clinical usefulness. Dr. Sulkowicz suggested that if the perspective is shifted to the developmental and genetic points of view, some significant differences between these two types of soul murder can be seen. First, adult concentration camp victims have already passed through childhood developmental stages, as opposed to the victims of child abuse who have had their very development molded by such experiences. How did early developmental factors (i.e., pre-war personality structure) affect one's response to the concentration camp? Would survival be abetted by the relative psychological health stemming from positive childhood experiences, or, paradoxically, could pathological defenses derived from early trauma increase the camp prisoner's adaptiveness? Whereas parents are ethically, biologically, even evolutionally impelled to care for their children, the Nazis were living up to their collective ego ideal in trying to exterminate the Jews. And while abused children must struggle with profound disappointment in their parents, Levi and other writers have shown how victims of the Holocaust were more often disappointed with their fellow victims (who became abusers in the name of their own survival) than they were with their tormentors. Another difference between the two experiences is that the abused child eventually mourns the introjected bad parent and the fantasized good parent, but the Holocaust survivor is involved in mourning the real loss of parents and other loved ones. Dr. Sulkowicz said that child abuse and especially the Holocaust have become powerful cultural metaphors which transcend their individual meanings. He advised us to listen for these metaphorical meanings and presented a brief clinical example of a patient who used the Holocaust to express his own aggressive fantasies and fears of attack. Dr. Sulkowicz ended with some further thoughts of Primo Levi, agreeing with Dr. Shengold that the source of ego strengths and endowments in soul murder patients remains a mystery. Levi, without wanting to glorify it, referred to Auschwitz as "my real university," and he described the act of writing as "equivalent to lying down on Freud's couch." Levi related a recurring dream he had while in the concentration camp: in the dream he returned home to tell his family about the concentration camp, but nobody listened. Dr. Sulkowicz compared the dream to the common plight of the abused child and concluded by thanking Dr. Shengold, who, by not turning away, has reminded us that as analysts our "work is to listen, and stay to hear."

Dr. Howard Welsh stated that child abuse and neglect have been rising in association with increases in poverty and drug abuse. Dr. Shengold's work on soul murder has been well received by the lay public, but perhaps underappreciated within psychoanalysis as being an unnecessary poetic or literary dramatization. He suggested that Dr. Shengold's unique contribution really amounts to an introduction of a new defense mechanism, a state of "mental deadening" of the capacities to feel and to think. All defense mechanisms, to a lesser extent, result in some such

sacrifices. Although mass exterminations and genocide may not be readily comprehensible within a psychoanalytic paradigm, Dr. Welsh affirmed the apt analogy between extreme child abuse and the Nazi concentration camps. He compared the innocent, law-abiding Jew's helplessness in the face of the German government's "final solution" and the plight of the child who may be scapegoated and singled out for abuse in a family. The perpetrators of child abuse (as was the case with Schreber's father) believe they are acting for the child's good ("to teach him a lesson"), similar to the Nazis' belief that they were "purifying" the culture and preparing the foundation for the "1000 year Reich." Dr. Welsh described how the abusing parent uses the child as a paranoid projection of his own murderous rage. The child whom the parent is attempting to subjugate is the one with whom the parent most closely identifies. Hitler's *Mein Kampf,* which blamed the Jews for being conspirators against the state and enemies of the German people, was written precisely at the time when he himself was imprisoned as a revolutionary for those very crimes. According to Dr. Welsh, Hitler had a distorted unconscious identification with his Jewish victims. On the other hand, the "soul deadening" of the victims can be viewed as an identification with the compassionless abuser. Victims learn not to show emotion or ask for pity. A sure way for an inmate to anger a German guard was to try to evoke compassion in him, just as the tears of an abused child evoke further abuse. Dr. Welsh ended with thoughts about survivor guilt. Primo Levi wrote in his last book that the best people did not survive the camps. Dr. Welsh described a patient who had survived Auschwitz, but suffered paranoid guilt over the tactics she had used, such as hoarding food, while others perished. This patient had been encouraged to go into hiding by her Orthodox Jewish parents, who were killed. She was eventually caught and sent to Auschwitz. Her chronic guilt about abandoning her parents caused her to have delusional episodes of feeling persecuted by rabbis. Her guilt also came from unconscious rage at her sense of abandonment by her parents, who were not there to protect her in the concentration camp. Dr. Welsh compared this to the anger that children feel at the passive, "good" parent who fails to protect them from the abuse. He observed how often Holocaust and child abuse victims displace their anger on to others.

Dr. Shengold agreed that there are many differences between child abuse and the concentration camp, as suggested by the discussants and the audience. He added that he has heard the most unbelievable, horrible stories, and that soul murder can very easily lead to real murder, as in the case of a former patient who watched her psychotic parent feed her sister lye and kill her. With respect to Dr. Sulkowicz's curiosity about the role that pre-existing personality plays in torture victims, Dr. Shengold somberly reminded us that *anyone's* soul can be crushed, even the healthiest and strongest, or the most hardened revolutionary (the protagonist of *1984* ends up begging his captors to torture his lover instead).

LAWRENCE CHALIF

THE SIGMUND FREUD PROFESSORSHIP OF PSYCHOANALYSIS, an endowed Chair at the Hebrew University of Jerusalem, Israel, will become available for a 5-year period as of January 1995. The Freud Professor also serves as Director of the Sigmund Freud

Center for Psychoanalytic Study and Research. He/she lectures and holds seminars for graduate and postgraduate students on theories of psychoanalysis and, if applicable, on clinical and applied analysis. He/she is also associated with the Department of Psychiatry at Hadassah Hospital, where the Medical School of the Hebrew University is located. Inquiries should be addressed to Professor Y. Bilu, Department of Psychology, Hebrew University of Jerusalem, Mount Scopus, Jerusalem 91905, Israel. Deadline for applications is 15 October 1994.

THE INTERNATIONAL ASSOCIATION FOR THE HISTORY OF PSYCHOANALYSIS and THE BERLINER FORUM FÜR GESCHICHTE DER PSYCHOANALYSE announce the 5th International Meeting of the I.A.H.P. in connection with the Zentrum für Antisemitismusforschung TU Berlin and the Berliner Psychoanalytisches Institut/Karl Abraham Institut. The meeting will be held July 21-24, 1994, at Technische Universität Berlin. The topic will be "Schisms in the History of the Psychoanalytic Movement." For further information, contact: The Conference Secretary I.A.H.P.-Tagung Berlin, Eva Lange, Berliner Psychoanalytisches Institut, Sulzaerstrasse 3, D-14199 Berlin, Germany. Fax: 0049-30-8256550.