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ENVY AND MALIGNANT ENVY

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Envy begins early in psychic development and is initially characterized by destructive primal hatred. With maturation, envy becomes modified in intensity. Its primal murderous quality is attenuated, and, as object relationships develop, it becomes partly transformed into jealousy. Malignant envy is a retention of, or regression to, the original primal murderous affective mix. Clinically, one sees in malignant envy the phenomenon of the subject feeling with delusional intensity that what the envied one has is not only urgently wanted but has been stolen from the self—an intensity that is reacted to defensively by projection and delusion formation. This operates as a formidable resistance in analytic work.

This paper is a condensation of a chapter of a book I am working on called *The Delusions of Everyday Life.* It is based on a simplified overview of Freudian developmental theory—one stressed in a recent book, *Love and Its Place in Nature*, by Jonathan Lear (1990). The mind's primitive functioning, starting in the very early narcissistic period of psychic development (featuring primary process thinking, intense contradictory primal affects, and primal defenses), becomes, in the course of the development of object relations and psychic maturation, partially transformed into mature psychic functioning (secondary process, etc.). Primal functioning never completely disappears, and there are fixation points that do not get transformed; it can be returned to predominantly in transient or lasting regressions. We are all left with fragments of the originally hallucinatory and delusional ways of operating. Hallucinations tend to disappear for most people (except in dreams and in psychotic and toxic pathological states). But delusions or near-delusions (quasi-

delusions) continue in all of us neurotics (="normals") in individually different extents and intensities.

These "everyday" delusions are seldom clamorous, but they powerfully influence our motivations for thought, feeling, and action. I am not at all comfortable with my use of the term delusions or even quasi-delusions; mentioning both does properly denote a range of delusional intensity—say, from prejudices through transient to fixed delusions. Perhaps a better term might be "fixed conviction," but that lacks the motive power connoted by delusion. The chapters in my book include: 1) narcissistic delusions—delusions involving self and parent, of omnipotence, of immortality (the denial of death), of perfection, of being the favorite of parent and of God; 2) paranoid delusions of everyday life; 3) delusions associated with perversions; and 4) delusions derived from identification with delusional parents. All of these can, of course, overlap.

This paper on envy centers around why the delusions are needed defensively: the central preoedipal psychic burden furnished by the intensity of the drives, especially by destructiveness, murder, and cannibalism.

"Envy and wrath shorten the life . . . " (Apocrypha: Ecclesiasticus, XXX:24). The wise author of this proverb couples envy and anger and implies that envy can have a murderous intensity. Freud (1927) sees envy as part of our nature and connects it with the wish to murder:

> When civilization laid down the commandment that a man shall not kill the neighbour whom he hates or who is in his way or whose property he covets, this was clearly done in the interest of man's communal existence, which would not otherwise be practicable. For the murderer would draw down on himself the vengeance of the murdered man's kinsmen and the secret *envy* of others, who within themselves feel as much inclined as he does for such acts of violence (p. 40, italics added).

Freud had noted earlier (1909, pp. 226-227) that the Rat Man's envy led him to expect the death of the person he envied.

Melanie Klein, in her monograph, *Envy and Gratitude* (1957), writes: "I consider that envy is an oral-sadistic and anal-sadistic expression of destructive impulses, operative from the beginning of life, and that it has a constitutional basis" (p. ix). She attributes her opinion here to Karl Abraham's work on the destructive impulses and to Freud's hypothesis of the life and death instincts. Abraham (1920) had discussed envy as beginning in

> the narcissistic period of its development [when] the child carefully watches over its possessions and regards those of others with jealousy. . . . If anyone has an advantage over it two reactions occur which are closely associated with each other: a hostile feeling against the other person associated with the impulse to deprive him of what he possesses. The union of these two reactions constitutes *envy*, which represents a typical expression of the sadistic-anal developmental phase of the libido (p. 340, italics in original).

A year later Abraham modified his statement about the origins of envy, pushing its roots further back into infancy, into the oral libidinal period, thereby also connecting it with cannibalism and greed:

> But we will only make a passing reference to the sadistic and anal roots of envy, since both are of minor and auxiliary significance in the production of that character-trait, which originates in the earlier, oral phase of libido-development (1921, pp. 382-383).

Envy is one of the seven deadly sins—connected with the work of Satan and his creature, the ancient serpent in the Garden of Eden with whom he has been identified. These primal malignant "Adversaries" are envious of the favored position of the two new innocents in the esteem of the Maker and therefore desire their fall. Satan and the serpent force their own evil upon Eve and Adam by external seduction (while mentally projecting it upon them); so that the first two human beings identify with them in part and are cast out of Paradise (as Lucifer, the head of

the fallen angels with whom Satan[1] has been identified, was cast out of Heaven). Envy leads to the first murder; it is what Cain feels toward Abel, whom he regards as Adam's and Jehovah's favorite.

Envy is often depicted as a hideous woman—a hag having outlived or been deprived of her fruitful femininity. She possesses phallic attributes (snakes and rods), like Medusa or the Theban Sphinx, and is usually accompanied by carnivorous cannibalistic creatures (see Callot's "Invidia" [Envy] in his series of prints, *Les Sept Péchés Cardinaux*). In art, she is embodied as wanting bodily attributes she no longer has or never did have.

I am being loosely descriptive rather than scientific in my using envy, following Freud, Abraham, and Klein, to denote the emotional representations of destructive aggression in the earliest period of psychic development. This primal, "bad" emotional mix, whatever it is called, can (still somewhat arbitrarily) be meaningfully differentiated into more distinct affects in later development. The envy, hatred, and greed of later childhood and adult life have undergone enough modification and differentiation to be qualitatively unlike the diffuse early affect I am calling primal envy, from which they arise. We can conceive of this primal emotion as a blend of hatred and greed as well as envy, which leads to cannibalistic and murderous impulses (biting, swallowing, spitting out, tearing, killing) associated with teething and the teeth, and, later with the cloaca, anus, and vagina regarded as crushing, biting, castrating sphincters. Psychoanalysts have spoken of narcissistic destructiveness, greed, primal rage, or envy as representing these innate forces of death and evil (which, of course, also arise from reaction to abuse and frustration; for a balanced view on the controversy about aggression as a drive, see W. Grossman [1991]). There is really no

[1] Satan (the word is the English translation for the Hebrew word for enemy or adversary; in the Book of Job he is The Adversary) is not present in Genesis; he comes mainly from the Hebrew Talmud and has, of course, been made much of in the New Testament and in Christian theology.

correct, exact term and probably no need for one. Envy has, I believe, the best historical case to be made for it in the psychoanalytic literature, and I am trying to make the concept of early destructive affect (whether derived from endogenous drive or reactive to pain and frustration—see Mitchell [1993]) more specific when I use the terms primal or malignant envy. But it is the concept and not the term that counts.

Klein differentiated envy from jealousy. She was not the first to do so; poets had done so before her. But she is the psychoanalyst who has paid the most attention to envy and the first to try to sketch out its developmental line, as Anna Freud might put it. Klein sees envy as being there earlier than jealousy. Envy, wanting what the other has or is, involves (as Klein points out) two people, or at least two entities. It is characterized chiefly by an overwhelming conscious feeling of hatred, although it can be directed against someone who is also loved. Klein views it as being there at birth, first directed against the mother's breast and then against the mother. Jealousy (as Klein reminds us) involves three people; and its presence shows that there has been enough psychic development to have at least three people represented in the mind's inner world. "Jealousy is based on love and aims at the possession of the loved object and the removal of the rival" (Segal, 1964, p. 40).

I think it would be better to describe jealousy as being based on an individually varying mixture of hate and love, in which the accompanying love is usually more obvious than it is in envy. Still, "Jealousy," Shakespeare's "green-ey'd monster" (from *Othello*) also is full of hate, akin to the murderous hate of primal envy, toward the "loved" or loved object. (Othello, who kills his beloved Desdemona, shows both envy and jealousy of her—he wants, unconsciously, to be her as well as to have her.) Experientially, jealousy exists in an ambience of ambivalence toward both others, but in consciousness one other is wanted (needed and/or loved), and the other one is dispensable and to be eliminated. There are various admixtures of envy and jealousy in a

three-person relationship, but these are phenomena occurring after the earliest psychic development.[2]

I do not think we can be certain about what we are born with, and I feel that some of Klein's ideas about how early psychic contents are present are too definite; they seem to have an almost mythical flavor that leaves little room for development from a primitive, chaotic beginning. Klein is a pioneer in viewing envy as the first externalized manifestation of Freud's death instinct. But I would question her concept of envy as present (except, of course, *in potentia*) from the very beginning of life. I speculate that some glimmering of psychic awareness and differentiation must be present for envy to exist. And, conceiving of envy as present at the beginning of differentiation and identity (that is, developing from the time Freud [1941, p. 299] has empathically characterized as " 'The breast is a part of me, I am the breast' ") both keeps it early enough and goes along with Klein's idea that it is first directed against the breast that is beginning to be felt (or, better, vaguely sensed) as outside the boundaries of the self.

Clinically, we are familiar with envy as directed against an other. Envy also can, perhaps with even more primitive derivation, be directed at the sexual parts or functioning of the other—both of the same and of the other gender: breast envy, penis envy, vagina (or, earlier, cloaca) envy, envy of the beginning or the more developed stages of passivity and activity and femininity and masculinity in the other. This would go along with bisexual myths: wanting everything, especially what one does not have—all the holes and all the fillers of holes, the attributes of both sexes at every developmental libidinal stage, as in the myth of the godlike, original human, spherical, bisexual creatures described by Aristophanes in Plato's *Symposium*.

Most of Freud's comments on envy are about penis envy in

[2] In the development of the psychic registration of others in the early infantile representational world (Sandler and Rosenblatt, 1962), as in the early development of Greek drama, the third actor is not there at the beginning.

the female. That penis envy exists, developmentally, for little boys as well as for little girls seems to me beyond doubt, but I feel that Freud downplayed the boy's envy toward the father's penis and ignored the male's envy of the female. Here is a typical series of quotations that show Freud's anti-female prejudices (but indignation over these should not lead to denial of the existence and power of penis envy—for both girls and boys):

> One cannot very well doubt the importance of envy for the penis. You may take it as an instance of male injustice if I assert that envy and jealousy play an even greater part in the mental life of women than of men. It is not that I think these characteristics are absent in men or that I think they have no other roots in women than envy for the penis; but I am inclined to attribute their greater amount in women to this latter influence (1933, p. 125).

> The fact that women must be regarded as having little sense of justice is no doubt related to the predominance of envy in their mental life; for the demand for justice is a modification of envy and lays down the condition subject to which one can put envy aside (1933, p. 134).

> . . . we attribute a larger amount of narcissism to femininity, which also affects women's choice of object, so that to be loved is a stronger need for them than to love. The effect of penis-envy has a share, further, in the physical vanity of women, since they are bound to value their charms more highly as a late compensation of their original sexual inferiority (1933, p. 132).

We know that sibling rivalry—the reaction to the arrival of a newborn displacer (again, Cain's experience in relation to Abel), or to an older brother or sister who is already there[3]—contains

[3] Freud says of Napoleon's feeling for his elder brother Joseph: "The elder brother is the natural rival; the younger one feels for him an elemental, unfathomably deep hostility for which in later life the expressions 'death wish' and 'murderous intent' may be found appropriate" (E. L. Freud, 1960, p. 432).

murderous rage that mixes envy and jealousy. Freud (1900) wrote of this early on:

> . . . instances of hostility between adult brothers and sisters force themselves upon everyone's experience and we can often establish the fact that the disunity originated in childhood or has always existed. But it is further true that a great many adults, who are on affectionate terms with their brothers and sisters and are ready to stand by them to-day, passed their childhood in almost unbroken terms of enmity with them. The elder child ill-treats the younger, maligns him and robs him of his toys; while the younger is consumed with impotent rage against the elder, envies and fears him, or meets his oppressor with the first stirrings of a love of liberty and a sense of justice (p. 250).

Freud later attributes not only the feeling for justice but communal and group spirit in large part to reaction formations against envy and, specifically, envy of siblings, although envy of parents would, of course, also be involved. He speaks of

> the initial envy with which the elder child receives the younger one. The elder child would certainly like to put his successor jealously aside, to keep it away from the parents, and to rob it of all its privileges; but in the face of the fact that this younger child (like all that come later) is loved by the parents as much as he himself is, and in consequence of the impossibility of his maintaining his hostile attitude without damaging himself, he is forced into identifying himself with the other children. So there grows up in the troop of children a communal or group feeling, which is then further developed at school. The first demand made by this reaction-formation is for justice, for equal treatment for all. . . .
>
> What appears later on in society in the shape of *Gemeingeist, esprit de corps*, 'group spirit', etc., does not belie its derivation from what was originally envy. No one must want to put himself forward, every one must be the same and have the same. Social justice means that we deny ourselves many things so that others may have to do without them as well, or, what is the

same thing, may not be able to ask for them. This demand for equality is the root of social conscience and the sense of duty (1921, pp. 120-121).

There is also for the adult the commonplace envy of the poor toward the rich, the lower classes toward the upper classes:

> If we turn to those restrictions that apply only to certain classes of society, we meet with a state of things which is flagrant and which always has been recognized. It is to be expected that these underprivileged classes will *envy* the favoured ones their privileges and will do all they can to free themselves from their own surplus of privation. . . . It goes without saying that a civilization which leaves so large a number of its participants unsatisfied and drives them into revolt neither has nor deserves the prospect of a lasting existence (1927, p. 12, italics added).

There is the more basic envy between the generations, the parents envying the child, the child the parents (the old envying the young, the young the old):

> When an adult recalls his childhood it seems to him to have been a happy time, in which one enjoyed the moment and looked to the future without any wishes; it is for this reason that he *envies* children. But if children themselves were able to give us information earlier they would probably tell a different story. It seems that childhood is not the blissful idyll into which we distort it in retrospect, and that, on the contrary, children are goaded on through the years of childhood by the one wish to get big and do what grown-ups do (1910, p. 126, italics added).

So children envy adults as adults envy children. Freud cites an instance of envy toward one of his sons whom he sees in a dream as having had an accident and wearing false teeth:

> Deeper analysis at last enabled me to discover what the concealed impulse was which might have found satisfaction in the dreaded accident to my son: it was the envy which is felt for the young by those who have grown old, but which they believe they have completely stifled (1900, p. 560).

A displacement of envy toward parents is the envy of superiors: lords and the Lord:

> The king or chief arouses envy on account of his privileges: everyone, perhaps, would like to be a king (1913, p. 33).
>
> After the totem animal had ceased to serve as a substitute for him, the primal father, at once feared and hated, revered and envied, became the prototype of God himself (1925, p. 68).

Freud writes of the universality of hostile envy toward those we call perverts, thereby condemning them in large part because they act out what we all want to do too, consciously or unconsciously:

> . . . these sexual perversions are subject to a quite special ban. . . . It is as though no one could forget that they are not only something disgusting but also something monstrous and dangerous—as though people felt them as seductive, and had at bottom to fight down a secret *envy* of those who were enjoying them (1916-1917, p. 321, italics added).

Freud then quotes Nestroy's "famous *Tannhäuser* parody," translated (p. 321, n.) as:

> The Venusberg made him forget
> Honour and Duty thus!—
> Strange how these things don't happen
> To people such as us.
>
> In reality perverts are poor wretches . . . who have to pay extremely dear for their hard-won satisfaction (p. 321).

All of these envies start from primal murderous cannibalistic hate and rage at the other (although gradually there develops a more ambivalent modification that can become compatible with need and love for the other). The envious hatred of the other (beginning as the first other that is a lost part of the merged self ["The breast is a part of me, I am the breast"]) can be seen as an externally directed proto-experiential beginning of the aggressive drive (our theory is still speculative here) and feeling (the

feeling can perhaps obtain clinical access through memory and transference, and be validated). The unmodifiably murderous rage at being past one's narcissistic beginnings and driven from the mythical paradise of the womb begins, then, to be directed at the first other, and, subsequently—still early on—at all others.

It is essential to narcissism that one wants everything—but especially what one does not have and even cannot have (what one has is usually depreciated) so that so much intensity of want and inability to satisfy it results in intense frustration and rage that is part of envy. Similarly, the narcissist wants to be not where he is but where he is not. This is beautifully expressed in Schubert's (1816) "Der Wanderer." The poet (Georg Philipp Schmidt von Luebeck) has the Wanderer say:

> The sun *here* seems so cold,
> The blossoms wilted, the life old,
> And what men say, hollow sound,
> I am a stranger everywhere.
>
> Where are you, my beloved country?
> Sought for, sensed, but never known!
> The land, the land so green with hope,
> The country where my roses bloom. . . .
>
> I wander silently, with little joy,
> My sighs always ask: where?
> A ghostly breath answers back:
> "*There, where you are not, there is happiness*!"
> (my translation, my italics).

The Wanderer, whom I see as unhappy, narcissistic, envious, is seeking for the mother's breast, the mother's body—the lost place that the other has, where the other is.

A "there must be no others," consisting of a developmentally unavoidable traumatic potential (it involves more than can be borne in consciousness), is the implicit genetic underpinning of one of my favorite quotations from Lionel Trilling, who states that the essence of moral life is "making a willing suspension of disbelief in the selfhood of someone else" (1955, p. 94). What is

fundamental in this definition is a suspension of primal narcissism[4] (its promise of bliss disguising its murderous propensities: Narcissus waning away at the mirroring spring).

Morality and the capacity to love begin with giving up the insistence on being the only one who exists or whose existence matters. We come to be, to varying and ever-changeable extent, increasingly capable of abandoning narcissistic positions transiently, on the road toward love. We initially allow others (and again, at first parts of others) to exist insofar as they fulfill our needs. And allowing them a separate actuality beyond this is to begin to value the separate existence of others. The further from our earliest needs and wishes (which center on the universe of the body and its need-fulfilling family extensions), the harder and less meaningful is the reality of these others.

After much development, and always subject to frequent regression, love is achieved. It starts in relation to the parents and the family. Love is the conviction of the dearness of the other that, with maturity, we can hold onto for longer and longer periods—but probably never without frequent, sometimes considerable, narcissistic regressions. Of course, sleep is a physiological prototype of such regressions, although our dream contents also contain functioning from later developmental periods that allows for some expression of love. Fundamentally, though, self-centeredness reigns and every character in one's dreams is at least in part one's self as well as potentially an other.

Regressive narcissistic rage at the other—the feeling that the other has no right to be—is the essence of envy. The emotional mix I am calling primal envy (or, viewed clinically, malignant envy) has a terrible intensity and a truly murderous (and cannibalistic) quality. One sees, in Chekhov's character, Solyony,

[4] By primal narcissism I mean simply the narcissism of early infancy. It should not be confused with Freud's (1914) theoretical concept of primary narcissism: the initial investment of sexual energy by the infant in the ego or self. (Secondary narcissism is defined by Freud as that energy invested first in the mother and then the rest of the external world that is subsequently withdrawn and reinvested in the ego or self.)

from *The Three Sisters* (1904), the hate-filled claim to be the only one, which characterizes malignant envy. He is a killer; and he suffers from an amalgam of jealousy and primitive malignant envy. Chekhov makes Solyony's cannibalistic nature clear. When the obnoxious Natasha (the other active soul murderer in the play—see Orgel [1994]) brags about the wonderful specialness of her baby, Bobik, Solyony responds (with a primal malignancy that perhaps stems from sibling rivalry):

> Solyony: If that child were mine, I'd fry him in a pan and eat him (p. 224).

Solyony loves and idealizes Irina:

> Solyony: I can't live without you. [Follows her.] Oh, it's so wonderful just to look at you. [With tears.]. Oh, my joy! Your glorious, marvelous, bewitching eyes—the most beautiful eyes in the world. . . .
>
> Irina [coldly]: Vassily Vassilyevich, stop it!

He seems to be able to accept that she will not love him. But there must be no others:

> Solyony: I've never spoken to you of my love before . . . it's as if I were living on a different planet. . . . [Rubs his forehead.] Forget it! I can't make you love me. But there will be no successful rivals. . . . I swear to you by all that's sacred that if there's anyone else, I'll kill him. Oh, how wonderful, how wonderful you are! (p. 228).

And he does kill the Baron when Irina is about to marry him.

Feelings of this destructive intensity are more than a young child can bear, leading to what Freud (1926) calls traumatic anxiety. That means that, experientially, simply the feeling of such rage itself amounts to the basic danger situation of too-much-ness which evokes a terrifying expectation of loss of the sense of identity. Since it is (speculatively) first directed at the breast that is "a part of me" and then at (clinically verifiable) the separate part of the parent and ultimately the separate person

of the parent, such rage leads to wanting to get rid of both the separating self and the separable parent. So in addition to traumatic anxiety, there is the danger situation of loss of the parent and of parental care.

This inescapable developmental trauma becomes the universal and truly terrible trap of primal psychic development, a trap inherent in our initial absolute dependency on the parenting other: wanting to kill off the one we feel we cannot live without—the one who starts off as part of one's self. ("I want to kill you, but without you I am Nothing!") Narcissus tries delusionally to become his own other, but insistence on this deprives him of emotional and physical nurturance, and so he dies. To remain Narcissus means insisting that there are no meaningful others, and this cannot be maintained without delusion. The delusion is given up at the price of being threatened with the awareness of death and of the wish to kill off others. (It is my conviction that we all, neurotics and psychotics alike, are left with remnants of these narcissistic delusions that punctuate our adult psychic functioning; I have written about this elsewhere (Shengold, 1994; see also Cooper, 1993; L. Grossman, 1993).

MALIGNANT ENVY

In patients one sees this primitive, regressive, murderous manifestation of envy as quite different from the more ordinary envy that expresses wanting what the other has—his or her accomplishments—or even (more malignant and more intense) what the other is—his or her identity. *The most primitive kind of envy seems to me to be manifested in the associations of a patient by the feeling that what the other has or is has been taken away from oneself.* And this primitive feeling has the quality that I have termed, not altogether happily, delusional (Shengold, 1994). An otherwise predominantly rational and mature person can, at least transiently, be full of irrational conviction that, for example, the analyst's achievements or gifts (e.g., intellectual power) have

been robbed from, have impoverished or deprived, the patient. ("You have everything! And I have Nothing!"[5]) This cry, when expressive of "what you have has been taken from me" is truly narcissistic envy, in that it is directed unconsciously toward an other who, like the mother of early psychic development, is regarded or claimed as a barely separable part of the self. It follows that, with separation, what the separated other has depletes the self, and contact with an other who is now perceived as separate is felt as a narcissistic injury. Only with merger can the loss be undone, and a wish for merger is always present. This wish, sometimes conscious, is accompanied by a fear of merger (which again involves a loss of the sense of identity). These are contradictory feelings of terrible intensity, and to feel both in consciousness appears to be unbearable. The unresolvable conflict is frequently handled by recourse to projection of part of the conflictual feelings (and projection always means delusion) or by the regressive delusional insistence on blissful merger through idealization: again Narcissus, deluded by Promise, trapped at the mirror/pool.

Oral physiological mechanisms provide a model for the earliest psychological mechanisms of identification (trying to take in the good) and projection (trying to cast out the bad). A regressive return to this kind of primal functioning (common enough even in the "normal") will give rise to a paranoid-like (delusional) reaction involving the projection of something that belongs to the self (idea, feeling, defensive maneuver—separately or in combinations) onto an other. Projection is always delusional, in that a part of the self (usually felt as "bad") is no longer acknowledged and felt as self. It is no longer *owned*.

A patient, X, shortly after I had published my first book,

[5] But remember the accompanying counterpoint of "You have everything and without you I am Nothing!" At some point in early psychic development when the danger of loss begins to operate, the child is in the impossible situation (escapable only by delusion) of wanting to kill and eat and thereby eliminate the object without whom continuation of life feels impossible. Adults can easily regress to this double bind.

found herself increasingly unable to work on her Ph.D. thesis. She had been writing a series of papers which would form a book, and she found that she was unable to finish any of them. There was increasing anxiety and paralysis, and X was under great external pressure from her professor-sponsors to get on with her project. She said to me: "If I write a paper, you won't be able to stand it—it will kill you." This was a rather typical projection of part of the patient's envy onto me (and, I repeat, what is projected is not "owned"—it has delusional quality). That she wanted to kill me as part of her envy was rejected from consciousness, reversed, and put onto me. About her "conviction that this is true," she said:

> The murderous feeling leaves no room for even the possibility of coexistence. You will want me to die. I feel it! I know that this feeling is illogical, but it is only my mind that says that.

Several months later X reported that she was about to leave for an unscheduled vacation in order to be with her mother, whom she had repeatedly declared herself to have separated from emotionally. This action followed her doing well in the analysis and in her life. X seemed aware of needing to run away from her gains; but it was not clear whether she was really feeling what she was saying. She was much more certain about the anxiety over not having told me about her plans, which she had made weeks before. She had arranged for the trip after having finally been able to finish one of the chapters for her thesis. This too she had postponed telling me about.

> I have become panicky. I really expect you will throw me out now. I really can't think about this. I could say I know better than to expect you to be angry with me, but I am absolutely convinced that you are. I am acting and it is stopping my thinking. I am scared.

This was followed by a long silence. I felt that the patient was struggling with her anxiety and rage, trying her best not to feel it. This was confirmed by a cry from the heart, "I hate you!"

Then there was silence again. This time, when she resumed communicating, it was to express narcissistic regression:

> I suddenly have a strange feeling in my whole body. It is as if part of me has become very small here on the couch. I have this heightened sensation of my tiny hand on my enormous chest. And I almost feel as if you are not in the room.

I concluded that in order to protect me from her murderous envy, she had transiently become both child and parent/breast. This was a regressive defense for her feeling about to be depleted by me in retaliation (having projected onto me her own murderous reaction to the separation, and robbing me of my substance in her having dared to finish her own chapter). X had become "The breast is a part of me, I am the breast." During the session, this was the temporary reaction to her dealing with me as the primal parent from whom she was trying to separate, but was terrified of losing.

At the same time, my previously standing for the parent who supported her separation and individuation, which had been expressed by her allowing herself to complete her paper and advance toward maturation, had evoked a primitive terror of losing her mother and concomitant destructive hatred of me. X was going back to the original primal parent, her mother, in order to merge with her again. There was murderous destructive envy in transference toward me. (Since I too could be felt as indispensable, this was also hard to maintain.) These murderous feelings had originally been aimed at her mother's separate big breast, at the big belly her mother had developed before the sibling rival was born, and at that rival (my book was a sibling equivalent). At this point in the analysis, X was not able to bear feeling this rage and connecting it with the past (mother) *and* the present (analyst). But she could not help feeling it for at least short, terrifying periods, especially when idealization and sometimes delusional denial failed, *either* toward me or toward her parents. X first projected her hatred (partly in the form of delusion-filled malignant envy) onto me, and then had, at first

secretly, set out to return to an idealized mother. This sequence was repeated in the session through feelings and symptoms. (There are obvious coexistent competitive negative oedipal dynamics from later development present in this material that I am not dealing with at this time.)

Malignant envy is most likely a potential for everyone, but I have had patients in whom it did not seem to be consciously present. Although everyone feels some sort of "ordinary" envy,[6] most people rarely feel consciously envious with the kind of hatred that, with its murderous, cannibalistic intensity and the delusional certainty that hedges it, dissolves away all kindly and loving feeling (which might at other times be there in sufficient quantity to "neutralize" the terrible feelings). But malignant envy lurks in the unconscious and can potentially be evoked in everyone.

A very successful man, H, a leader in his field, was always complaining that things were too much for him. He had the delusional conviction that almost everyone else, and certainly his analyst, was much better off than he was. Although he performed well at his work and headed his own firm, he was subject to a Board of Directors, and this minimally dependent relationship was a torment to him. He feared rivalry and expected to be replaced by someone whom the Board would prefer to him. He was aware that this reflected a terrible rivalry with a younger brother who, he felt, had completely robbed him of his mother's love. He was aware that his brother was convinced that H had always been the favorite of both parents. Clearly, they couldn't both be right, said H, and perhaps he was favored—but he had no choice but to feel it the way it came through. As H talked about his childhood, it was apparent that there was not enough love and caring in the home for anyone. The parents were constantly quarreling; the father kept away as much as he could, returning home from his business late at night seemingly only to

[6] This "ordinary envy," of course, represents a range of feeling—I am lumping together what is actually qualitatively and quantitatively different for each of us.

quarrel, eat, and go to sleep. The mother had been depressed and "crazy"—impulsive, unpredictable, and illogical. She was like a willful and quarrelsome child most of the time, convinced that she was always right. Occasionally, she would collapse and could not function. She alternately smothered H with affection and overstimulation, and sometimes became furious and, even worse, sometimes treated him with what seemed like complete indifference.

At work, H characteristically did too much. He couldn't say no to any offer that contained any element of promise, whether this was a gift or some obligation that involved work and payment; he was therefore constantly overcommitting himself. He would then become furious, have a temper tantrum modeled on his mother's, and often had to find one of his subordinates to fulfill his obligations. H (like Ibsen's "Master Builder") would hate this substitute, and fear that the man or woman would somehow achieve success which would eventually displace him as leader. Every bit of publicity, every speech that had to be made, every honor that was proffered, had to be H's. He was talented and successful enough to be able to get away with this; but he was often disliked, and, in order to be the "only one," he had surrounded himself with weak and masochistic people who sometimes jeopardized the good functioning of his business.

He was constantly furious with me because he felt that, whereas he often hated or was bored with his work, I enjoyed what I did and obviously had no difficulty doing it; I was fabulously successful; my parents must have been very rich and bought me a place in medical school. I, then a very young and inexperienced psychiatrist, asked H how he knew these things:

H: I just know them. They are so and you can't tell me different. There are things I am just sure of.
I: And your being sure makes them so?
H: Yes!

And he meant it. He had taken on the absolute assurance with which his crazy mother had so frequently tormented and puz-

zled him—a narcissistic regression in her that had so often distanced her intermittent frightened uncertainty and depressive doubting. This predominant certainty had a momentum that made her, for the most part, the dominant leader of the family, steamrollering over any opposition and specifically crushing her husband. He had been consistently degraded and humiliated by her, and she had passionately turned to H as a controllable and compliant substitute. H had, in a most confusing fashion, also been crushed by his mother—and yet had (despite his jealousy of his brother) regarded himself as the most important person in the family, since she treated him with so much indulgence. He became increasingly like his mother, identified with her, with both her domineering and her self-doubting qualities. He hated all rivals and suppressed the hatred of his mother that was evoked by her overstimulation which frustrated him so, by her forcing him to comply with her whims, and by his feeling that he had to take on her distorted view of the world.

As H matured and tried to rebel against his mother, her terrible weaknesses and instability which her rigid and dominating behavior could not always conceal made his hatred of her increasingly untenable. She developed a chronic illness that made her even more vulnerable but no less willful and difficult. H largely suppressed all feeling and became what he later called "a competing machine." There was no empathy for his rivals; he could not love; and the "machine" defense broke down whenever he was filled with the malignant envy I described. Good-looking and very talented and intelligent, he was able to cover over much by an ability to be charming and to act *as if* he cared about others, but this was never enough to sustain any kind of loving relationship. He could succeed, but he could not care.

In the course of years of treatment, much of this emotional deadness was modified, and some of the hate-filled affects could register and be acknowledged as his own. He became astonished, in retrospect, that when he had started treatment, he had declared his obviously miserable childhood to have been happy. Some work was accomplished in relation to the transference of

his feelings onto me; the past was reconstituted in a more meaningful way. When, after some years of analysis, he left to take a job in another city, I felt that he was just starting to come alive as a human being who could relate emotionally. He had become able to experience more of his anxious and depressive feelings and even some joy in things. He had some old acquaintances toward whom he began to feel closer. He still was not able to care about women except insofar as they fulfilled his sexual and dependent needs. The malignant quality of his envy, especially toward subordinates and beginners, seemed little changed. He did marry. I wondered if he could sustain his marriage and felt he probably would not be able to tolerate having his own children as rivals. This was, of course, not communicated.

H returned to New York City and to treatment many years later, and I discovered that I had been wrong. Not completely wrong: in many ways he had aged but not changed. But there had been a general amelioration of the terrible compulsions that had previously reduced so much of his emotional life. The envy could still, regressively, assume its old terrible intensity. He was much more depressed than he had been. But, almost miraculously, he had continued to emerge as a sentient human being who had to struggle to do so but could care about other people. Ambivalence reigned, but he was definitely able to love his wife and especially his children. He had moments of impossible behavior when his mother seemed to re-emerge in him, but he had become a predominantly good father. (I have published a paper about this [Shengold, 1993] that shows how H's envy had become less malignant and modified by love for his son, and also how envy had been overtaken in large part by jealousy—still a "green-ey'd monster" but making for a less destructive mixture of feeling than what he had experienced earlier in his life.)

One sees the direct opposite of malignant envy (as a manifestation of malignant narcissism) in the wonderful book that Rilke (1907) wrote about Cézanne. It has the form of a series of letters from Paris and Prague that Rilke sent to his wife, Clara, over a period of five months in 1907, during which he spent

much of his time visiting and revisiting exhibitions of Cézanne's paintings. This was shortly after the painter's death. Rilke declared that Cézanne was one of the chief influences on his poetry. One sees in these letters the moving spectacle of Rilke staring at Cézanne's paintings, interpreting and absorbing the painter's method, defining the essence of Cézanne's art and Cézanne's relationship to his art. Rilke creates Rilke's Cézanne in a manner that profoundly increases the reader's understanding of the painter. Cézanne's paintings and the artist's relation to them are re-created for the reader by Rilke's words in a manner analogous to Cézanne himself staring at a table top covered with apples and, in his art, transforming and re-creating them as Cézanne's apples—a transfigured and edifying new reality expressing something essential, "like the kernel in the flesh of the fruit" (Rilke).

The poet's absorption in the work and life of the painter makes the poet grow; Rilke's healthy narcissism burgeons by way of an empathic identificatory relationship to another. Cézanne, as Rilke's Cézanne, becomes a part of Rilke, his ego ideal (see Shengold, 1993). But there is no depletion for the other, for Cézanne, in this swallowing up. It is sublimated cannibalism: eating as loving[7]—a consumption without destruction. What is taken in, identified with, by Rilke is then projected outward to enlarge in turn the image of the other. Whatever envy Rilke has toward Cézanne, whatever narcissistic claim he makes on the artist, the result is an enhancement of both men and their work in the mind of the poet and in the reader's awareness of the poet's words and in the viewer's awareness of the painter's art.

We grow by taking on attributes of the other and suppressing rivalry so that both self and other can coexist. In Rilke's making Cézanne an ego ideal, one senses a healthy and creative narcissism transformed into a partial identification which still permits

[7] Samuel Butler: "I have often said that there is no true love short of eating and consequent assimilation" (Keynes and Hill, 1951, p. 258).

a relationship with the other, resulting in enhanced self-esteem and self-definition on Rilke's part—just as a child creatively identifies with a parent. Cézanne is left intact, if anything his significance enlarged in the mind of the reader and not reductively defined, by Rilke's loving interpretive descriptions. Instead of envy, one sees admiration (Melanie Klein talks of the capacity for gratitude) as a derivative of love. Love is the enemy of narcissism and of envy.

There are people who appear to be comparatively free of envy, either of the ordinary or of the malignant variety. I do regard envy, primal as well as later envy, as a universal emotion; but in every person, emotions of anxiety, rage, and depression have their individual developmental vicissitudes—leaving everyone with his or her idiosyncratic dynamic range of intensities. These intensities and the quality of the emotions would, of course, also vary with the differing individual achievements of mastery that should accompany psychic development—subject to regressions which would revive earlier balances that can include, for some, a potential preponderance of primal functioning. The achievement of the ability to love is essential in taming primal malignant envy, so that it can be neutralized by love and subjected to integrative mastery that comes with the development of the capacity to relate to others (what psychoanalysts call object relationships). As the other becomes precious, the child wants that other to have what the child has, even the primal wish to have everything. This is a reversal of malignant envy, but few can attain it completely, and none can maintain it without regressions.

The possession from the start, or subsequent development of, great gifts and accomplishments ought to, and frequently does, help to ameliorate envy. But, of course, this does not always happen. As an old man, Goethe said (in 1825; he was seventy-six years old) of his old friend and rival, Schiller:

> For twenty years the public has been disputing which is the greater, Schiller or I; and it ought to be glad that it has got a

> couple of fellows about whom it can dispute (Eckermann, 1836-1848, p. 116).

Considering the apparent Olympian tranquility of the old man, we should remember the murderous sibling rivalry of this spoiled favorite of a strong mother that Freud interpreted in his paper, "A Childhood Recollection from [Goethe's] *Dichtung und Wahrheit*" (1917). The quotation does suggest that, in the main, Goethe had conquered his envy—he did not need to be the only one; there could be others. This kind of thing would seem easy to say if one had the gifts and the achievements of a Goethe. But contrast this with a story told of the also superlatively gifted and great Michelangelo in relation to *his* chief rival, the older Leonardo da Vinci. I will quote an account that Robert Fliess (1956) used to illustrate the existence of aggression relatively unmixed with libido (primitive aggression):

> According to the story, Leonardo da Vinci was passing the Spini bank, hard by the church of Santa Trinita, [where] several notables were there assembled, who were discussing a passage in Dante, and seeing Leonardo, they bade him come and explain it to them. At the same time Michelangelo passed, and on one of the crowd calling to him, Leonardo said, "Michelangelo will be able to tell you what it means." To which the latter, thinking this had been said to entrap him, replied, "Nay, do thou explain it thyself, horsemodeller that thou art—who, unable to cast a statue in bronze, was forced with shame to give up the attempt." So saying, he turned his back on them and departed (Fliess, 1956, p. 7; he is quoting from A. Gaddiano's *Life of Leonardo*).

Fliess adds:

> The example contains all the distinctive elements of the aggressive outbreak under consideration: the subject (Michelangelo) is singularly qualified to appreciate the superiority of the object (Leonardo) whom he must not only attack, but "destroy." Leonardo's existence as an artist is negated; what is left of him is an artisan, and an unsuccessful one at that (p. 7).

This is malignant envy; it has murderous intensity.

Although envy always involves aggression and potentially murder, malignant envy has an overt murderous intensity. Envy begins, as Klein insisted, with hatred of the breast developing into hatred of the other. Without an admixture of love, the aim would be elimination of the other. Love, fueled by libidinal drive, of course also starts at the breast and aims at reunion with the separated other. Without some admixture of hate, there would be no separateness, no drive toward individuality. Balance and integration are necessary.

SUMMARY

I have defined envy and jealousy, following Freud and M. Klein. Envy is depicted as starting in the earliest period of psychic development and having at first the characteristics of primal psychic functioning. As envy (a two-person process) develops along with the maturing psyche, it gets modified by loving feeling and is accompanied by jealousy (a three-person process). But malignant envy is a retention of, or a regression to, the infant's original primal murderous intensity ("There must be no others!")—an intensity that is reacted to defensively by projection and delusion formation. Descriptively and clinically, malignant envy involves feeling specifically that what the envied other has or is has been robbed from the self. It has a delusional quality that makes it a formidable resistance to treatment; this has to be acknowledged by the patient before it can be "owned" and analyzed toward its attenuation.

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A Psychoanalyst Looks at a Hypnotist: A Study of *Folie à Deux*

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A PSYCHOANALYST LOOKS AT A HYPNOTIST: A STUDY OF *FOLIE À DEUX*

BY A. A. MASON

This paper traces my personal development from anesthetist to hypnotist, psychotherapist, and, finally, psychoanalyst. The change was precipitated by the successful treatment of a patient with congenital organic skin disease by hypnotism. Alongside my change of profession, I attempt to illustrate my change of ideas and the change of my relationship to patients which accompanies these other changes. I feel that my personal experience throws some light on the nature of suggestion and hypnotism and how they differ from each other and from psychoanalysis. I believe that observations support the idea that hypnotism is a folie à deux *caused by mutual projective identification between two people and that in a less dramatic form this condition commonly occurs in normal development as well as in pathological psychological states. Several cases illustrate these ideas.*

Folie à deux has been described many times in psychiatric and other literatures. I believe that Melanie Klein's (1946) concept of projective identification illuminates how and why this syndrome arises, and while projective identification has been described extensively since Klein, I cannot recall that it has been described as occurring simultaneously between two persons with similar fantasies. This is the main thrust of this paper.

My appreciation of Klein's ideas in relation to the *folie à deux* phenomenon grew out of my experience practicing hypnosis between 1950 and 1964, my later experiences seeing patients in psychoanalysis, and my attempts to understand my own motivations and development.

In the working-class neighborhood of my childhood, the most

elegant and awe-inspiring man was the "Doctor" who worked in the Christian Mission. He wore dark suits, drove a horse and carriage, and made house calls, and his powerful combination of prayer and medicine left nothing to chance. The aim of the mission, while treating the body, was to capture the soul, and the risk of being converted to Christianity—while naked and shivering and therefore highly suggestible—was high, but mitigated by the fact that treatment was free. I was convinced that I had avoided conversion, although sometimes when it is very cold, I catch myself whistling a tune which sounds suspiciously like "Onward Christian Soldiers." The doctor's monoauricular stethoscope was carried in a top hat, which seemed to be its only function, since I never saw him wear it; but easily the most impressive thing he did was to take my mother into the bedroom, remove all her clothing, and lay his head tenderly on her chest. After that, how could I possibly have entered any other profession? All of this occurred while I was under the age of three years and was not supposed to notice primal scenes.

During my adolescence the books of Freud and Havelock Ellis were my choice of reading, for they wrote about matters of sex which I read breathlessly and, for the most part, uncomprehendingly. One book contained a wonderful sepia lithograph of the great Charcot demonstrating hypnotism (Jones, 1953, opposite p. 144). I was with Freud, too, in lurid fantasy if not in actual fact. There stood Charcot, the great man, solid, with bow tie and dark suit and with a willowy young girl draped over his arm, one breast teasingly half-exposed and her eyes firmly closed. The fantasies stirred by the graceful image of surrender and compliance, as well as the half-revealed breast, were very compelling. These three figures, the mission doctor, Charcot, and Freud, thus became my early heroes. All three were imposing doctors; all three seemed magical; and no doubt my belief that they could do as they pleased with women was a highly important factor in my wish to be just like them.

The other important theme in my early life was suffering and its cures, for both my parents suffered painful and dramatic

illnesses. Moreover, their suffering was not a private affair, and I still recall loud and unnerving groans, and my longing for something stronger than the remedies of vinegar, aspirins, hot compresses, and mustard plaster, which never seemed to stem the noise.

It is no surprise to me today that my first residency should have been in anesthesiology, where the prevention of pain was the primary concern. I was especially concerned with obstetric analgesia and the fact that all systemic drugs produced respiratory depression in the newborn. My need to prevent this dangerous complication of childbirth was doubtless due to the death of a baby sister when I was six, and my guilt and restorative wishes toward her.

Having witnessed the use of hypnosis by a dentist who removed several teeth under hypnotic anesthesia, I decided to try this in obstetrics, as hypnosis, being nonchemical, would not cause respiratory depression in the newborn. In 1950, in Pembury Hospital, Kent, I proceeded to deliver some twenty babies using hypnosis as the sole maternal anesthetic. It was a successful but time-consuming procedure.

A paper I published (Mason and Pelmore, 1953) was concerned with the production of bloodless surgical fields through the use of hypotension produced by hexamethonium bromide. Surgery without blood as well as without chemical anesthesia was "magic" that the mission doctor would surely have appreciated.

In 1954 and 1955 (Mason, 1955b), I used hypnotism for major surgery, apparently for the first time since the days of Esdaile in 1846. At the time, I believed it was a valuable piece of research, but since, in 1955, chemical anesthesia was so efficient and safe, I can see today the research I was doing was more for my unconscious personal reasons than as a contribution to medicine.

As a hypnotist working in a large National Health Service Hospital, I was soon in demand for the treatment of hypochondriacal, psychological, and psychosomatic disorders. These are

conditions in which there is both a high spontaneous recovery rate and frequent conversion to other conditions, so that any practitioner of suggestion, however bizarre, has "success" in a fair proportion of cases. In fact, it may well be that the more bizarre the treatment, the better the result appears to be. There will always be a fair recovery rate for magnets and leeches, and the modern equivalents, joint cracking and vitamins. Practitioners of suggestion do not control their work with double blind trials and so can count on at least a 50% recovery rate. In fact, all medical practitioners, including psychoanalysts, employ suggestion more than they know or care to admit.

The startling phenomenon of wart removal by hypnotic suggestion was extremely impressive to all who witnessed it, and most of all to me in producing it (Mason, 1960a), for while the abolition of pain and blood is dramatic, the removal of growths that can be actually seen appears to be a more significant demonstration of power. The unilateral removal of multiple warts, which I also did, however, is more than showmanship and can claim to be an interesting scientific phenomenon. It demonstrates that the curative stimulus is transmitted directly from the central nervous system and cannot be systemic. A "tour de force" was the treatment of a national rugby player whose multiple warts had recurred several times following diathermy, and who was prevented from playing for his country by this disability. Two weeks following treatment by hypnosis, his warts vanished and he was again able to play. This cure was heady wine indeed.

It was approximately two years later when I tried to fulfill Koch's postulates by attempting to *produce* warts by hypnotic suggestion on several volunteers, but I never once succeeded. I note with some embarrassment that I never published my failure to grow warts, so I put it on record here, as well as the acute disappointment I recall feeling. The failure was clearly a blow to my omnipotence, and so was suppressed. To make something living appear that was not there to begin with does seem more

powerful than making something disappear that is there. It must feel like the real thing.

About one month after my success with the rugby player, I was asked to give an anesthetic to a fifteen-year-old boy whose arms were literally covered, as I then believed, by thousands of hard black warts. The surgeon was attempting to graft the palms of the patient's hands with skin from his chest, as the hands were virtually useless as working tools. This was an even more severe case than the rugby player, and more of a challenge, so I asked the surgeon if I could attempt treatment with hypnosis. Such was my ignorance and eagerness to show off my skill at the time that I failed to differentiate between the common wart—a viral tumor—and what was, in fact, a totally different condition, and since I was now the wart king, I was eager to extend my domain.

The surgeon told me I could try anything I pleased. He had finally decided, I later learned, to abandon the attempt at surgery. The next day I hypnotized the patient and told him that the warts on his right arm would shrivel up and die, leaving normal skin underneath. I then sent him away and told him to return in a week. One week later he came back and showed me his right arm, which was about 80% cleared (Mason, 1952). I was pleased, and in the folly of ignorance, not totally surprised to see the improvement. The surgeon, on the other hand, was literally struck dumb. On recovering, he informed me with some exasperation that his patient was not suffering from warts at all (he was trying to instruct me in hubris, I believe), but had a *congenital* deformity known as congenital ichthyosiform erythrodermia of Brocq. It was structural and organic, sometimes with a genetic basis, and had never in fact been affected by any treatment previously, organic or psychiatric. As I learned later, it remains the only properly recorded case of a congenital-structural deformity improving in the history of medicine.

With considerable excitement, the case was presented the very next day at the Royal Society of Medicine to some sixty dermatologists, where the diagnosis was confirmed. Later, a skin sec-

tion performed by Professor Magnus of King's College Hospital confirmed the diagnosis histologically as ichthyosis congenita.

Over the next six weeks, I treated the rest of the patient with the result that approximately 70% of the condition disappeared and the case and photographs were published (Mason, 1952).

Three years later I published a follow-up of the case (Mason, 1955a). The 70% improvement had been maintained, but when I attempted to re-hypnotize the boy in the hope of clearing up the remainder of his skin condition, he was resistant to going into a trance state. This, I found out later, was because of his fear that I might cause a reversal of his illness to his original condition.

Following the original report, Dr. T. Ray Bettley (1952, p. 996), President of the Dermatological Society, RSM, summarized everyone's bewilderment at this extraordinary event by writing: "That improvement occurred in a case of this nature demands revision of current concepts of the relation between mind and body." And, "The improvement was as incomprehensible as if a club foot had, in fact, improved."

Publication of this case was followed by a worldwide spate of publicity, including an article in *Time*, thousands of calls and letters, and hundreds of patients, most of them incurable, from all over the world, making a pilgrimage to see me in the hope of a similar cure.

The personal consequences of this case were considerable, and I decided to give up my career as an anesthesiologist and devote my time to treatment by hypnosis, particularly of skin and respiratory diseases, and the investigation of hypnotic phenomena. This was made possible initially by my being awarded research fellowships at two London teaching hospitals, St. George's and King's College Hospital.

I did also see and attempted to treat several other congenital ichthyotic patients, but had no success whatsoever. Of course, I knew by then that these patients were "incurable" and that the case I had treated had "no right" to have been affected by treatment. It is difficult when one is a young resident, not to believe

what one is told by the President of the Royal Society of Medicine as well as what one reads in all the learned books, whatever the facts. One case of congenital epidermolysis bullosa did improve after three weeks' treatment, and on follow-up some ten years later, the patient had maintained his improvement. This was also somewhat atypical and dramatic, as I was flown halfway around the world to Lima, Peru, amidst considerable fuss and expectation, and was treated on arrival like a junior messiah. Awe and idealization can sometimes produce dramatic results which mere mortals may find hard to duplicate.

I next attempted, together with K. Cohen, M.D., to treat a series of mixed skin disorders selected on the basis of their chronicity at the Department of Dermatology at St. George's Hospital, London. These cases had a history of at least five years' treatment with various classic remedies. There were over one hundred patients in all treated by straightforward hypnotic suggestion. Approximately 70% of these cases showed marked improvement, and this series was presented at the International Dermatological Congress in London (Gordon, et al., 1952). I later had the good (or bad) luck to discuss the results of this work with Clifford Scott, an analysand of Melanie Klein, who later became Professor of Psychoanalysis at McGill University. Scott pointed out that my cases had been seen for close to an hour for each treatment, compared with the five to ten minutes per treatment given in the skin clinics. "So," said Scott, "what you may have demonstrated is that the more time and trouble you spend on each patient, the better the results you produce!" At one stroke I had *lost* a paper demonstrating the value of hypnosis alone in the treatment of chronic skin disorders, but I had gained an important lesson in thinking. I also discussed my congenital ichthyotic case with Ernest Jones who told me not to be too impressed with therapeutic success! A consequence of my wish to understand what I was doing was that I undertook a training in the British Institute of Psychoanalysis. At that time I had no idea that it would take thirty-five years for a few glimmers of light to occur.

In the period 1958-1964, I produced two papers related to allergic phenomena. In one (Mason, et al., 1964), I treated forty-seven patients who suffered from various allergic conditions such as asthma, hay fever, and skin rashes, and found that hypnotism did measurably diminish the symptomatology in over thirty of the patients. In another paper (Mason and Black, 1958), one case was investigated in a more detailed way, with weekly skin tests during the treatment. In this case, the allergic skin response gradually diminished and finally totally disappeared. When, however, the serum from the patient was injected subcutaneously into a nonallergic volunteer, a positive skin reaction was obtained from this volunteer at the site of the injection and nowhere else on the volunteer's body. This is known as a positive Prausnitz-Küstner reaction. Thus, the symptoms of the physical illness, as well as the skin response, had been removed by psychological treatment, even though the patient's blood still contained the serological basis of her hypersensitivity in the form of passively transferable antibodies. Therefore, by direct suggestion under hypnosis, it had been possible to establish an overriding psychic system of control which not only kept the patient symptom-free but could also inhibit selectively the allergic reaction in the skin.

If one assumes that there are at least three factors in the production of allergic asthma and hay fever—1) foreign proteins; 2) sensitized tissue; 3) some state of mind—then presumably the allergic attack can be influenced by any of these factors. What I had demonstrated was how an altered state of mind could override the other two factors in this particular case. While this experiment did not have the dramatic significance of the case of congenital ichthyosis, the whole question of the state of mind which can raise or diminish skin or tissue sensitivity has to be important for psychiatrist and physician alike.

Allergy is obviously complex, and it seems that both organic and psychological factors can play a part. A "sensitive" or "hypersensitive" person is one who reacts unduly to a stimulus—again either physically or mentally. The term "hypersensitive"

when used to describe a state of mind could be likened to a paranoid state. I believe, in addition, that this frequently describes the general condition we loosely call "tension." An analytic patient of mine throws some light on these phenomena. She was so hypersensitive to sound that she could hear, quite accurately, when two coins click together in my trouser pocket. As a baby, she could not sleep unless her bedroom door was closed, as her father's snoring kept her awake, and when she came for treatment originally, wind chimes two blocks away so disturbed her sleep that she put on a ski mask and crept out at night to cut them down! She once leaped off my couch fully two seconds before I felt the first tremor of an earthquake; like my cat, she can hear it long before anyone else. In addition to her hyperacuity and multiple allergic phenomena, this patient is terrified of radiation, asbestos, smog, and cancer, which she, despite her knowledge to the contrary, is convinced is contagious. She will not enter a building until she checks it out for asbestos. She is objectively physically hypersensitive to an exquisite degree, but is also clinically paranoid to a serious degree. As a child she had terrors that her mother was poisoning her and would stab her with a knife. She appears to have a too thin protective filtering mechanism for all her physical senses as well as for the "sense organ of consciousness" called her mind.

Analysis has diminished the persecutory nature of her anxieties. This has been achieved by diminution of both her omnipotence and the concreteness of her feelings of hostility and aggression. In Segal's (1957) terms, symbolization has replaced symbolic equation. In addition, her capacity for containment of her feelings has improved, probably due to her introjection of and identification with a better container, myself as her analyst, than her parents, who were very uncontrolled. They also divorced when she was two years old. Both the diminution of concreteness which produced the delusion that her "bad" feelings were "bad" things inside her that had to be evacuated and the improvement of her containing capacity diminish her need to evacuate her internal persecutors. Her hypersensitivity can be

understood as a product of some real external irritating factor (noise, pollen, etc.), along with internal persecutors felt to be intolerable and which have been split and projected into the external reality, thus adding in fantasy to its persecutory effect on her. As the projection of her internal persecutors has lessened, so the persecution of external factors has lessened simultaneously. Today, she no longer fears asbestos, radiation, and cancer, but instead she watches my face anxiously and acutely for signs of my "hostility and displeasure." Her hypersensitivity has now become more object-oriented and is closer to paranoia, as it was originally in childhood. More significantly, it can now be analyzed as a transference manifestation. Her allergic reactions have simultaneously all but disappeared.

In my publication of 1964 (Mason, et al., 1964), I demonstrated the effect of hypnosis on skin sensitivity tests in forty-seven subjects who were divided into an experimental group and a control group. A statistically significant diminution of the skin reaction of the group that was hypnotized was demonstrated.

I also took part in an investigation on three more groups (Maher-Loughnan, et al., 1962). One group was told under hypnosis that one arm would not respond to skin testing. Another group was told that both arms would not respond, and a third group was merely hypnotized, and no direct suggestion was made regarding the skin response. All three groups experienced diminished skin weals and the diminution was *unrelated* to the suggestions made. It was clear that the relationship to the hypnotist alone produced a significant response heedless of the specificity of the suggestions. The result I had obtained in the first case I published (Mason and Black, 1958), where skin weals were totally abolished along with the physical symptomatology, was not duplicated in this much larger series, where the skin responses were diminished but not totally abolished. This was probably due to the fact that in this larger series, the experimental measurements were obtained by different physicians from those performing the hypnosis. In the first *Lancet* case

(Mason and Black, 1958) I personally conducted both parts of the experiment and, in fact, developed a much closer relationship with the subject than with any of the subjects of the larger groups in the 1962 (Maher-Loughnan, et al.) and 1964 (Mason, et al.) papers. It was evident that "better" results occurred when the emotional relationship between hypnotist and patient was more intense.

In the 1962 series (Maher-Loughnan, et al.), the treatment was conducted by three groups of physicians, and in all three groups hypnotism was shown to be superior to other symptomatic procedures. However, one other important point emerged. The results of the two groups in which the hypnotism was performed by the patient's physician were superior to the third group in which the hypnotist did not have any contact with the patients other than that of doing hypnotism. It was once again evident that in the groups which had the superior results, the patients and physicians had a more intimate relationship and were therefore more heavily involved and more emotionally invested in the outcome. The relationship between patient and doctor clearly plays an enormous part in the production (and probably even the evaluation) of results.

I would like to quote a letter I wrote to the *British Medical Journal* (Mason, 1963), as it raises certain points which I believe are still important:

> In my own research, I found I was using a small group of subjects over and over again because of the excellence of their responses. The original case reported by Black and myself in 1958 was one of these; and a second case, in which I inhibited a Mantoux test, was another. It took some time for me to realize that subjects' responses got better all the time, and they had unconsciously, and at times, consciously learned and could produce what was required of them (p. 1675).

I now believe that the deep trance is a somewhat uncommon and unusual psychical state which occurs only in fairly abnormal personalities, and that the phenomena which occur are due en-

tirely to the special unconscious relationship which exists between the hypnotist and the subject, and are not properties inherent to the hypnotic state.

The confidence of the "Miracle Worker" of 1951 was being severely shaken.

In his preface to a book I wrote on hypnosis (Mason, 1960a), Professor Alexander Kennedy (1960) said of hypnotism, "In that a physical response can occur to a purely sensory experience, the phenomena of hypnotism resemble those of the conditioned reflex" (p. 9). I used to believe the same as Kennedy, but am now aware that "purely sensory" experiences cannot exist in human beings. The mind will always add its quota to every experience. In fact, it was becoming clear to me that like all human phenomena, the state of hypnosis was extremely complex and differed greatly from subject to subject.

In 1964, Halliday and I (Mason and Halliday, 1964a, 1964b) investigated the effect of hypnotic anesthesia on cortical responses following Dawson's (1958) suggestion that anesthesia produced by hypnosis might be associated with blocking or gross attenuation of the afferent sensory volley before it reached the cortex. In fact, Dawson's idea was compatible with all the current beliefs about hypnotic anesthesia, i.e., that hypnotic suggestions actually *diminish* or prevent pain impulses from reaching the brain.

Nine subjects were investigated, and their cortical-evoked potentials were observed before and after hypnosis and while the subjects reported that they could not perceive the stimulus following suggestions of anesthesia during the hypnotic state. The cortical-evoked potentials are the actual quantitative record of pain impulses reaching the brain.

In five subjects, the average responses to electrical stimulation of the contralateral hand showed *no reduction* in amplitude despite the subjects' reporting that they *could not* feel the stimulus. The same result was obtained in three other subjects in whom the mechanical taps were the stimulus in place of electric shock. In four subjects, the nonspecific response to auditory stimuli

(clicks) was recorded from a surface electrode over the vertex, and an attempt was made to induce deafness under hypnosis. At a time when the clicks were reported as *unheard* or very faint and far away, *normal* nonspecific responses were being evoked by them at the cortex.

These results suggest that no part of the loss of sensation in a hypnotic anesthesia can be attributed to attenuation of the sensory messages in the afferent pathways on their way to the cortex.

I now found myself in a state of considerable doubt and confusion. Hypnotism was effective in removing certain symptoms and pathological phenomena—pain, warts, congenital ichthyosis, and allergic symptoms such as weals, rhinitis, and bronchospasm. Then I demonstrated that while certain symptoms such as pain and weals could be ablated, the pain was still being recorded and presumably experienced at cortical sites; also, certain symptoms were being denied while still physically demonstrably present. It had also become clear that hypnotic phenomena were not just a concomitant of the hypnotic state, but were also tied up with the interpersonal relationship between hypnotist and subject. This had troubling inferences; hypnotism was not, as I had first believed, similar to chemical anesthesia, which did have a clearly defined phenomenology. Many questions were being raised, such as: 1) Why use hypnotism if suggestion had the same effect? 2) Did suggestion have the same effect and if not, what was the difference? 3) What, in fact, was hypnosis? And as a corollary to the question, could it be harmful? The literature did not give convincing answers to any of these questions.

It was not easy to dismiss the phenomenon of certain asthmatic patients assuring me gratefully, after treatment with hypnotism, that they were now healthy and their asthma *had gone,* when vital capacity testing showed their illness to be *unchanged* and bronchospasm was still present. Even three out of four *cardiac* asthmatics treated by hypnosis claimed to be improved, including one who went into cardiac failure. These patients all *acted* as though they were better in order to fulfill some uncon-

scious fantasy that they had about the therapist or the therapy, and they pushed themselves beyond the limits of their physical capacity. There were also significant disparities in positive results between different practitioners, and it was evident that unconscious wishes could color the observations of doctors as well as patients. I often seriously wondered whether it was patient or doctor who was hypnotized, and was convinced at times that it was both. Medical practitioners can need the compliance and success of their patients as much as the patients need relief of their symptoms. There is often a profound emotional investment in getting the patient well for unconscious reasons, and while this may be the case in many forms of therapy, I believe that this need is even greater after one has performed hypnosis on the patient. While asthma may be the patient's symptom, the need to cure it can be the doctor's symptom.

Omnipotence is, of course, not confined to hypnotists, and can be detected in all the healing arts: the link which has always been present between medicine and religion is not fortuitous.

During the practice of psychoanalysis, one is often confronted with the spontaneous occurrence of the same phenomena one produces in hypnosis; for example, one of my patients whose husband had died produced a circular anesthesia below the waist in order to ablate sexual feelings that made her feel guilty. Another patient produced a chronic weal on his face as a "mark of Cain" which was connected to unconscious murderous feelings of jealousy toward a younger brother. Regression and memory recovery are common in analysis, but they are also the stock-in-trade tricks of the stage hypnotist.

My feelings of doubt about the nature of hypnotism and my growing conviction that it had little to do with physiology and lots to do with transference, has been paralleled by my belief that some so-called psychoanalyses are in fact really exercises in suggestion, and that in fact all psychoanalysis is a mixture of the two. One hopes that the analyst is aware of this and will gradually analyze the element of suggestion present, so that it diminishes and finally disappears as the analysis proceeds. (I also

believe that an anomalous process is true of normal infantile development, as I will restate later.) It is certainly important to ask ourselves why the patient *has* to lie on the couch. Why for fifty minutes? Why five times weekly? Are these really valuable tools, or are they rituals that we are all caught up in like religious observances, helping our converts by the comfort and security we give them because they are *in* analysis whether they are being analyzed or not. We, the analysts, are also comforted and reassured by being followers of Freud or Klein. The patients are being looked after by us, and we are being looked after by our theories and institutes of psychoanalysis.

There are serious observers who say that all the different theories produce similar results and that, in effect, it hardly matters what you say to the patient. These critics, with whom I totally disagree, are clearly talking about suggestion and not differentiating it from psychoanalysis, which is able to change psychic structure through the modification of unconscious fantasy and anxieties. But they are cautioning us to observe what we believe we do; and at times we may have to acknowledge that despite our sophistication, we may be performing sophisticated hypnotism.

I was frequently sorry that I had given up the relatively safe world of anesthesia, where at least the patients slept and generally woke up with something bad removed, and I sometimes wished the doctor of my childhood had not been so impressive a figure! What was still clear was that I did not understand the nature of suggestion, let alone hypnotism.

In the midst of my confusional state, a group of phenomena continuously intrigued, puzzled, and fascinated me. I suppose it all began with my misinterpretation of what I had witnessed as a child, and my later fantasies of what passed between Charcot and his yielding patient in that famous lithograph. What could make a human being give up his or her body, mind, or pain to another? What produces the phenomenon of "possession" by the devil, vampires, voodoo, or by other human beings? What, at times, enables one part of our mind (our internal objects) to take

possession of the whole? What are these forces that exist between two or more human beings that seem at times so powerful that they appear more than human? I recalled those delicious and terrifying hours at the cinema as a child, squealing with terror and delight at zombies, Count Dracula, and of course, good old Svengali and Rasputin, of the popping eyes, magic fingers, and those lines of comely wenches transfixed and helpless to resist! How was it done? Call it science, call it hypnotism, call it psychoanalysis—I suspected that underneath all my work lay the fascination with, and the wish to understand, and certainly to *possess*, this kind of power. Remember, too, I had had proof that even a congenital illness can yield to Svengali if only he knows the magic word. It is not wheat, not corn, not barley, but sesame, and Aladdin's cave opens with all its treasures waiting for you!

Frequently, understanding will come from the couch if we can resist the impulse to "possess the understanding" and wait patiently for it to emerge in its own good time. I was analyzing a young patient previously diagnosed as a catatonic schizophrenic who brought me a dream of being raped. This was an anxiety she suffered from frequently. The startling feature of the rape was that there were eight girls in a row raped by an intruder, one after the other. They stood transfixed and powerless to resist even though they numbered eight and the rapist was slight and weaponless. My patient said, "He had baby blue eyes which rendered me powerless. They were the same color as my own."

This patient had a sister four years her senior who had been institutionalized for spastic cerebral paresis ever since my patient was a child of three or four. My patient's so-called "catatonia" occurred the day following her first sexual intercourse, which she found extremely exciting. She recalled having the painful thought the same night that her sister would never be able to have sex, or any other relationship for that matter. It later became clear that the so-called "catatonia" was in fact a state of identification with the stiffness of her spastic elder sister.

The patient had many feelings of hate toward and jealousy of this sister for the inordinate love she believed the parents had for her, and for the comparisons they made between the impaired sister's "wonderful" nature and the patient who complained ungratefully and yet "had everything." The "catatonic" identification with the spastic sister was an expression of unconscious guilt and an attempt to omnipotently repair the sister by taking into herself her sister's illness, the spasticity. A dream the patient had illustrated the unconscious process. "There were two trees side by side—one alive and one dead. The dead tree began to sprout a few leaves." Now the patient knew that the live tree would die in its turn as the dead one returned to life. Her catatonia was her "dying" to save her sister.

Some two years later the patient's mother died of ovarian neoplasm, and three months after her mother's death, my patient, at the age of twenty-two, developed a carcinoma in situ of the cervix, necessitating surgery. I cannot help wondering if once again identification, this time with her mother, as with her sister six years previously, played some part in this unusual occurrence.

It now seemed clear to me why this patient feared and felt she could not resist rape. She herself wished, believed, and unconsciously "insisted" that she could magically invade her objects—sister, mother, and later, me, in the transference. The motives for the intrusion differed and included possession, destruction, or repair. In addition, the patient had the fervent conviction, again omnipotent, that nothing could stop her. If one has this omnipotent conviction about one's own power, one has of necessity to believe, and therefore fear, that others possess similar power and will be able to penetrate one's own body or mind and take possession of these in their turn. Invasive omnipotent fantasies are always accompanied by ideas of reference as a mirror image consequence. In fact, *acting out this fantasy and permitting someone to take possession of oneself, supports one's own omnipotent wishes that it is possible to do the same and to possess others.* The

religious disciple prays for God to enter and take possession of him or her and then pursues the conversion and conviction of others just as ardently.

Following Klein's (1932) ideas, I believe that the wish to possess begins initially with the infant's wish to possess the body and breast of the mother for many reasons. This fantasy is frequently accompanied by the use in reverse of an organ of perception (i.e., introjection) as an organ of projection (looking daggers!). I have described this mechanism in greater detail in my paper, "The Suffocating Superego" (Mason, 1981). This patient used her "baby blue" eyes as projective organs, and voyeurism accompanied by omniscient fantasies was one of her prominent symptoms. The mother's body originally is the source of all the infant's needs and security, and possessing it is therefore the most powerful defense against total helplessness. Little "Count Dracula" who sinks his teeth into the soft female body and sucks her life-giving fluids, now takes total possession of her and forces her to follow him as a living food store forever. Surely this is every child's fantasy wish fulfillment, about his or her mother.

This fantasy, labeled by Melanie Klein "projective identification," was first described by her in 1946. It consists of projecting in fantasy parts of the self into an object for the purpose usually of ridding the self of some unwanted aspect, say infantile characteristics, and simultaneously taking possession in fantasy of some envied and desirable quality of the object, say wisdom or strength. It is frequently used to defend against the terror and despair of helplessness. Realistic modification of this terror through trust in one's good object and dependency on it, leading to growth and development through normal introjective processes, takes time and work, while the relief that projective identification produces is immediate. Under healthy conditions, this universal defense is gradually given up and replaced by less omnipotent procedures.

The most dramatic and powerful effects of this fantasy are produced when it exists in its most primitive, i.e., magical or

omnipotent, form in a patient, and when the patient meets a therapist in whom this fantasy is also powerfully present. Then, "I wish to possess" and the corollary and mirror image of this wish, i.e., "I can be possessed," has found a practitioner who also wishes and believes he or she can possess another human being. A duet such as this is what I believe to be the basis of the hypnotic state. This highly charged *folie à deux* takes many forms in medicine, religion, and politics, for messiahs will always find devoted disciples. I believe that some fantasies of invasive possessiveness are universal and part of normal development, but when the fantasies are extreme and are colluded with by a parent with similar fantasies, then a *folie à deux* can result between mother and child. It may be seen in an extreme form when a little boy's envy of girls is excessive and he coincidentally has a mother who also wishes strongly that he were a girl and behaves accordingly, such as dressing him in girls' clothing; then a delusional state like transsexualism may be produced. The transvestite is less delusional than the transsexual, and perhaps this may be due to the identification with the opposite sex not receiving support and collusion from a parental figure. Also less flagrant but still damaging fantasies of the "entitled prince" or "princess" type are extremely common when the omnipotent fantasies *of* the child are met with equally omnipotent fantasies *for* the child by its parent. I believe that a less flagrant form of *folie à deux* exists when a narcissistic object relationship is "welcomed" unconsciously by both partners. The "dominant" partner uses the apparently less dominant one as a "thing," a possession or a part of itself. However, when the "thing" willingly gives up its individuality and gladly accepts being used or possessed, a *folie* exists, and the duet—sometimes in love and sometimes in hate—becomes of one mind. (Enter into me O Lord,—I am your devoted vessel.)

Projective identification which occurs throughout normal development enables the infant to deal with early overwhelming anxieties either of a persecutory or depressive nature, by producing narcissistic or manic defenses which are essential transi-

tional aids to development. The thumb-sucking child with the fantasy that the thumb is the mother's nipple that he or she possesses and controls is temporarily successful in avoiding anxiety which otherwise could be overwhelming were the child to face the total separateness and uncontrollability of his or her primary object, the breast or mother. Similarly, when hypnotism is used to treat acute anxiety states, the hypnotist replaces some malfunctioning part of the mind of the patient, and actually fosters a state of projective identification between him/herself and the patient. This state, like all "transference cures," or hypnotism, may help stabilize a state of decompensation, breakdown, or instability (just as narcissistic or manic states can be stabilizers in normal development). However, this method of "curing" anxiety, be it in stages of development or in therapy, is basically fragile, and subsequent breakdown frequently occurs or treatment may need to be interminable. It is in effect a state of permanent infantile dependency on an object, a group, or some other external structure.

Freud's (1905) first statement on hypnosis was in "Three Essays on the Theory of Sexuality," in which he stated that the credulous submissiveness of the hypnotized subject "lies in the unconscious fixation of the subject's libido to the figure of the hypnotist, through the medium of the masochistic components of the sexual instinct" (p. 150, n.).

Ferenczi (1909), in "Introjection and Transference," stated the hypnotic state is an expression of the early child-parent relationship, with the subject being the small child and the hypnotist unconsciously regarded as either its mother or father. He felt that love and fear were the basic motivating factors in the compliance of the child.

Freud later (1921), in "Group Psychology and the Analysis of the Ego," compared hypnosis with being in love without sexual satisfaction. He felt the hypnotist represented the patient's ego ideal.

Jones's (1923) "The Nature of Auto-Suggestion" indicated that the subject projected his or her superego onto the hypnotist.

Paul Schilder (1922) wrote about the subject surrendering him/herself to the hypnotist because of the wish to share in the latter's "greatness." Schilder defined this greatness as resembling the power of a "magician" and "sorcerer." He described the subject as wishing to possess these powers after having projected magic qualities onto the hypnotist. He wrote also about the desire for omnipotence first projected onto another person and then absorbed into one's own personality by way of identification. Thus, although Schilder did not tease out the details of the unconscious fantasies of projective identification in the elaborate way Klein and her followers did, and did not appreciate the universality of the mechanism, he certainly arrived at the same basic idea.

Gill and Brenman (1958; Brenman, Gill, and Knight, 1952) have also written extensively on hypnotism, but like Freud, Ferenczi, Jones, and Schilder, they did not really investigate the part played by the hypnotist in the hypnotic state—the emphasis being largely on the patient's fantasies. In fact, there is no real differentiation between hypnosis and suggestion by any of these authors.

Stewart (1992) seems to be the only one who has considered the part the hypnotist plays in the state of hypnosis. One of his observations is that the hypnotic state can exist only as long as the hostile feelings of the subject toward the hypnotist are not made explicit. He summarized his views by saying that the hypnotic state represents a collusive manic denial of an omnipotent, controlling hostile attack on the hypnotist, together with the denial of anxieties of retaliation and guilt associated with it.

I believe that Stewart makes the same error I made initially when investigating the state of hypnosis, which is to attribute to it specific phenomena and dynamics. For example, in considering his initial point, I have seen numerous examples in which the patient remained in a deep trance despite expressing extremely hostile and paranoid fantasies about me. In fact, envy, which always contains hostility, is a frequent underlying motive of the hypnotic state. Since I believe that mutual projective iden-

tification is the central dynamic of the hypnotic state, then I would expect that *all* the phenomena which accompany this state can be present at different times.

Projective identification can be used in the service of love or hate, or even Bion's K (the epistemophilic instinct). It can be a defense against separation anxiety, loss, or merely separateness. It defends against all the pains and anxieties of the infantile and dependent state, whether these pains originate realistically from the outside, or in fantasy from the inside. So while I do not doubt that Stewart's ideas were valid for the cases he described, they are much too narrow to be used as a general theory, and while in some cases hypnosis represents mutual mania, in others it is a defense against persecutory anxiety. Still others would fit well into what Steiner (1993) might call a "pathological structure," i.e., a defensive organization which is somewhere in between the paranoid-schizoid organization and the depressive organization.

How do I view the value of hypnosis today in the light of my belief that it is a dyadic version of the mechanism of projective identification? As a research tool, it has some value, as one can investigate certain mental phenomena under laboratory conditions; but as always, one must beware of idealizing the process for this opens the door to what then becomes essentially magical beliefs, however scientifically they are disguised. We must be especially careful to set up good controls and to leave the evaluation of results to independent and uninvolved observers, as the unconscious meaning of hypnosis in particular, and its link to magical wishes and fantasies in us, may cause us unknowingly to distort our findings.

As a therapeutic tool, hypnosis occupies a complex position. Since I believe that hypnotism is identical with fostered projective identification, I believe it is parallel to any powerful defensive process and is similar in many ways to a religious conversion. Projective identification produces a confusion between self and object (often idealized) and removes in fantasy the disparities between infantile and adult qualities and capacities. Thus it

can be used as 1) defense against separation anxiety; 2) a method of omnipotent control of objects; 3) a defense against envy; 4) a defense against jealousy; 5) a defense against persecutory anxiety, both internal, as in hypochondriasis, and external, as in phobic and paranoid states.

Numbers 3 and 4 are also clearly defenses against oedipal conflicts and the concomitant pain of guilt, loss, and depression. These defensive maneuvers may diminish conscious anxiety and alter behavior, but of course character development is sacrificed. Anxieties are not worked through but suppressed and therefore liable to break through, and infantile misperceptions and delusions remain—in fact, are fostered. This process is parallel to the modification of anxiety produced by projective identification developmentally. However, the projective identification produced in the hypnotic state does differ from that occurring during normal development, as it has been fostered by the hypnotist who is reinforcing and colluding with the patient's unconscious omnipotent fantasies, and therefore the effects are given the additional charge and power of this duet. In addition, I believe this to be the essential difference between hypnosis and suggestion.

Suggestion is a state of mind produced by a subject who then invests the therapist with various fantasies which are projected into him or her, and responds to these fantasies as if they were reality. Moreover, these fantasies do not even need a living object, for they may be attached to the procedure being practiced, be it psychoanalysis, chiropractic, or acupuncture; to the building, whether a hospital or a place of worship; to a drug—the so-called placebo effect; to a pendulum, magnet, or needle that is twiddled or a joint that is cracked. The receptacles for these omnipotent fantasy expectations are endless.

The fantasies themselves are variations of omnipotence brought about by splitting and idealization, and produce awe, wonder, and worship on the one hand, which are the accompaniment of idealization; and fear and terror on the other hand, since the idealized object is very powerful and thus dangerous.

All of these responses may produce "healing" if the unconscious wish invested in the object is sufficiently strong.

Suggestion, then, is little different from transference as seen by Freud originally, which is also due to the fantasies the patient invests the therapist with; and in most therapies, use is made of suggestion knowingly or unknowingly for its unconscious effect. In contrast, during psychoanalysis, suggestion is analyzed and its unconscious meaning, which is always some need of the patient being satisfied delusionally, is made clear. Dissolution of suggestion, I believe, is synonymous with the depressive position of Klein (1935). It is a developmental position which is not easy to achieve. So-called "transference cure" is really cure by suggestion alone.

While Freud did equate suggestion with transference originally, he confused the picture somewhat by using the term suggestion, both for the suggestibility of the subject and for the suggestions or exhortations coming from the therapist.

Hypnotism, in contrast, is a fostering of and collusion with the patient's suggestibility by the hypnotist, who has fantasies similar to those of the subject, which he is enacting simultaneously. When the patient thinks unconsciously that the therapist is a god and reacts accordingly, that is suggestion. When the therapist agrees unconsciously with the patient that he is a god, that is hypnosis.

Under normal circumstances, if a child believes he or she is the most desired person in the life of one parent, this unconsciously means that the child is in a state of projective identification with the other parent. This fantasy, which is similar to an oedipal victory, will result in something like hypomania or some other grandiose condition, which, one hopes, will be dispelled by the reality confrontations of life and parents. However, if the parent does desire the child more than his or her mate and colludes with the child's fantasy consciously or unconsciously, this has an impact and a durability far greater than when the fantasy exists alone or is actively contradicted by the parent. This kind of collusion concretizes the fantasy and will produce

delusional states of grandiosity. A delusional duet of this nature is what I believe brought about the startling organic change in my ichthyotic case. I also suspect that delusional duets between parents and children, husbands and wives, patients and therapists, are far more common than is realized and that the hypnotic state is a crude and dramatic version of a process that is fairly common and frequently goes unnoticed because the "trance state" produced is so much more subtle.

I am not suggesting that therapy that depends to a large extent on suggestion or even "hypnosis" has no value, for while there may be relapse after symptom removal or the symptom may be converted, at times for complex reasons substantial therapeutic results occur, some of which I have outlined. Moreover, since psychoanalysis or even dynamic psychotherapy is available only to the fortunate few, hypnosis, suggestion, medication, behavior modification, religion, and all the therapies that depend on the modulation of anxiety will continue to be the treatments for the vast majority of patients. The modification of psychic structure by the modification of unconscious fantasy and anxieties, i.e., psychoanalytic change, is clearly a different order of change, however intimately mixed and confused the two processes frequently become.

Case Number 1

This patient came to me at the age of sixty-two for severe agoraphobia which had been present some thirty-five years. Her need for treatment had become acute following the death of her husband one month before. She was unable to go anywhere alone; her husband had paid all the bills, signed the checks, and even bought her clothing. She had been unable to travel except when accompanied by her husband or other close acquaintances. For the first year, she had to be accompanied to treatment. Her husband had left his estate in trust, which paid the patient a monthly stipend. She had two sons, who were both married, one living in Canada and the other in New York.

The patient's husband was an autocratic man whose own father and elder brother were killed when he was eleven years old, leaving him the virtual head of a family of four children and his mother, who took over the dead husband's small store. Even as a child, he carried the family money in a purse around his neck. He and my patient had an arranged marriage after he had married off his younger sister and brothers. My patient's marriage to this man, who literally ran everything, fitted her psychopathology admirably. Her function was confined to having children and supervising the kitchen.

This extreme dependency on the husband had been preceded by a similar total dependency on her mother who was also autocratic, dominating, and controlling. She virtually ran her only child's life, including arranging her marriage when the patient was about twenty-three. The patient had been brought up in Prague. She had been taken to and from school, never allowed out on her own, and never allowed to play with other children. She would sit in a chair in the corner while the mother baked and cooked and was instructed not to touch the walls of the room with her elbows or she would mark the paint, and she never did. She was told that she could not understand math, and so she didn't; that she could never dance, so she didn't. Once when attacked by another child in the park, she was admonished for raising her hand and was told that she must never strike back—and she never did again. At present, she was obese and had been so since she was a child of seven or eight. She ate what she was given, and what she was given was always too much.

The father was passive, a clerk, and the patient had little to do with or say to him. The mother treated the patient as a companion, discussed everything with her, including intimate details of her life with the father. He was consistently devalued, and apparently the parents' sexual relationship had ceased after producing this child. She was to be the mother's passport and ticket to wealth, survival, and freedom from the virtual ghetto they lived in. The patient was taught to sing and play the piano and was a good linguist. The mother's goal in life for her was to

make a good marriage and to produce children for a wealthy, elder, successful man—which she accomplished.

The patient's fantasies of being joined as an appendage to the mother, who did all her thinking for her, were paralleled by the mother's own need for an appendage who would give her the life that she had not been able to obtain for herself. The patient first became aware that the mother had something wrong with her on the night before her wedding, when the mother fainted and was seized with an attack of shivering and teeth-chattering as though she were severely ill.

Following the marriage, the husband had a serious row with the patient's mother: he had ejected her from the house because when he returned from work for an afternoon nap, he found the mother in his bed for *her* afternoon nap. They had an estranged relationship from that moment on. The mother became depressed when she found that she was not welcome in the patient's house. She developed a "brain tumor" which postoperatively resulted in her becoming somewhat paralyzed and having to be confined to bed in a nursing home for the remaining forty years of her life. She died at the age of ninety-three. The patient did not see her mother for the last twenty-odd years of her life. She had come to the United States and never went back to visit the mother (since she could not travel and her husband would not accompany her). She did see her mother just before her death; this was after the patient had had two years of psychoanalysis. She traveled alone to Israel on that occasion, and has done so at least six times since.

The patient's analysis focused on her fusion, first with her mother, and subsequently with her husband. Her agoraphobia began suddenly during her first pregnancy. The patient's mother-in-law wished to name the baby after her father, but the patient wanted to name it after her own grandfather. The mother-in-law cursed the baby in the patient's womb. This precipitated an acute attack of dizziness which persisted whenever the patient tried to go out alone. On analysis, the dizziness was connected to her feeling of hate toward the mother-in-law. This

was also a displacement from her mother (and later, her husband) for trying to control her life and even the life of her unborn child. Conflict between herself and mother or mother-in-law, or husband, was too frightening to think about and instead produced dizziness and dissociation. These phenomena were related to separation from her loved object, and occurred whenever she left home. They were relatively absent while she was at home, which seemed in fantasy to stand for being inside her object and thus in a conflict-free relationship, i.e., identified with and part of her object.

It became clear as the analysis progressed that the patient needed to be an appendage of mother and husband, and this was paralleled by the mother's need for an appendage child to supply everything she needed. This caused the subsequent collapse of the mother when the child got married and was pried away from her. The patient's husband continued the dynamic, for while he too was autocratic and ruled the patient, he hardly went anywhere without her. He had no friends, and apart from conducting his business, was a reclusive and depressed man. In this patient's analysis she attempted to convert me into a mother/husband who would be a controller and instructor who would tell her what to do and how to do it. The analysis also revealed her fantasies that I was totally dependent on patients (herself) and had no friends and family. At present the patient can travel by herself. She now shops for herself, writes checks, and even takes charge of some of the husband's business. At the age of sixty-nine, she is becoming an individual person for the first time in her life.

A dream late in her analysis illustrates the patient's dynamic fairly clearly.

Dream: The patient's cousin G (with whom the patient is totally identified and who is always referred to as "another me—maybe worse") was being physically assaulted and raped by Cossacks. The reason for the rape and assault was that G had a diamond in her brassiere. The diamond had been sewn in by G's

mother so that she would always have this precious thing to fall back on and support her in a time of need.

I interpreted that the diamond was the mother's brain which had been firmly sewn into the patient's heart, so that in times of need, she could fall back on her mother's mind and presence to look after and think for her. Having no brain of her own, she now became a victim, and everybody (the Cossacks) could use her and exploit her as she had no weapons to defend herself with. The patient accepted this interpretation with great emotionality and added, "You are saying that the Cossacks and my mother both raped me in their own way."

A dream six weeks later: She was supposed to go on a transport to Finland. Her mother was terrified that she would be "chupped."

The patient's associations. (1) Finland, a small country which stood up to and finally prevailed against Russia which wanted to engulf her and make her part of the Russian Empire. (2) "Chupped." In 1760 King Nicholas captured Jewish boys and inducted them into the army and converted them to Catholicism. They were lost to their families forever. (3) G was a cousin the patient identified with who went on a transport to England before the war. She served as a maid in a house which had a cook. This cook used to work for an analyst. G learned things from this cook, and when she told my patient's mother what the cook had taught her, the mother told my patient that these things were dangerous and could result in her getting lost.

The patient's internal mother struggles against the patient's (Finland) attempts to free herself from domination by her internal objects (mother and husband—Russia). She warns the patient she will be lost forever. However, it is clear that it is the sayings of the analyst-cook (from England, as my accent makes clear) which are feared by the mother, as they will lead to her getting "chupped" into my army and lost to her family forever. In other words, her internal mother fears that psychoanalysis

will liberate the patient from her domination. This "mother" projects her domination into the psychoanalytic process (the British analysts) and says that analysis is like King Nicholas and will capture her and convert her to a new religion.

A dream some weeks later: This was described as very terrifying. Her husband appeared, and he covered her up to protect her (she wept here). Then he gave her money as he always did when he was alive. Then he realized that the currency would not be honored in this country, and so he took it back, saying to the patient that she would soon join him and then could use the money.

So both mother and husband continue to exert their control over her, even from the grave, and fight against her liberation from them by the analysis. To give up these fantasies and accept responsibility for her life, limited though her future is, is still a terribly difficult step for her to take after all this time.

Case Number 2

This twenty-five-year-old male came to me complaining of depression, shyness, social anxieties, paranoid feelings in the street, fear of people looking at him and laughing at him, inability to study, work or concentrate, worries about being a homosexual, and about masturbatory episodes with other boys from the age of about thirteen. He had never had sexual intercourse with them or with women, but his fantasies were totally connected to having sex with women. He grew up in a culture where young boys were sexual objects of wealthy men. They were dancers, and when they were attractive, were frequently kept, used sexually, and given lavish presents. The men went out in the evening together while the women stayed home with each other. At the age of about twelve or thirteen, when my patient had a friend staying with him, he woke up and saw his father engaged in sex with his friend. The father also used to hold his friend's hand in public and had bought him many presents. The

patient's parents had been separated since the patient was about six or seven, after which time he was brought up by an aunt. He went to boarding school at age eleven and divided his free time between his parents. He describes his mother as spoiled and pampered; she would spend a lot of time in Paris and London buying clothing and going to the theater, and always had many maids. As an infant he was wet-nursed by a black servant, really a slave, who together with another aunt, looked after him. He has had lifelong dreams about older men having sex with boys.

At the beginning of his analysis, he had many anal omnipotent fantasies which he said had been present all his life. He remembered at the age of eleven writing an essay saying that the world's hunger could be cured by everybody becoming constipated. The constipation would fill people's stomachs, and therefore they would not feel any hunger: an omnipotent stool/food confusion. In the transference, the patient treated past interpretations as stool equivalents. He could not accept that the value of interpretation was largely based on the present understanding in the session. He kept records of interpretations and ruminated about them obsessively like old men reciting the Torah or the Bible to themselves or the Hare Krishna followers chanting mindlessly and continuously. He wanted to tape record sessions, and to recite them back to himself. These obsessions were sometimes defenses of a controlling nature against separation from his mother, standing for food, and sometimes they served as an identification with the mother (in the service of envy) who produced the food. In addition to serving as a defense against loss of the primary object, having feminine qualities made him in fantasy desirable to the rich father, who would, he hoped, pursue him and give him all he desired. Conversely, to identify with the father meant fighting and intrigue, which frightened him: he frequently mentioned that two of his uncles had been assassinated, and he suspected his father was the instigator. He had long periods of constipation during his analysis, particularly at holiday times when he felt small and abandoned by me. The trapped stools usually stood for food or

the nipple that he now controlled and possessed in fantasy. He engaged in diverse anal manipulations, would use suppositories, ointments, and often had pruritus and piles. Initially, the anus and stools represented the breast and milk directly, but later there were many fecal equivalents which he became addicted to. He had episodes of alcoholism and barbiturate abuse, cigarette smoking, junk food binges, and snuff using. These equivalents had the virtue of controllability, unlike his living objects—for example, his mother who was always going off and living her own life, and his aunt and black nurse who had both died of tuberculosis when he was about three.

He once dreamed about a tribe which actually does exist and which returns their dead to be buried in the ancestral grounds they had long ago left. The dead were left with "keepers" until the tribe could afford to transport the corpses back home for reburial. Sometimes the tribe could spend its whole life working to save enough money for this purpose. In the patient's dream, when the tribe came to dig up their dead, they found that the people who had taken the money were really gangsters, for they had not properly preserved the bodies, which had decomposed and washed out to sea.

This was really the story of my patient's life, which was being wasted by his attachments to dead things that would vanish and leave nothing useful behind. Following this dream was a period when the patient projected these aspects of himself into me, and I was fantasied as being as avidly fascinated by his products, dreams, material, and money as he was himself. There followed a mirror image of his idealization of anal products, which showed itself as scathing and contemptuous attacks on real breasts and real food, particularly on nourishing equivalents like learning and scholarly activities. Delinquent friends were admired, and diligent friends who became doctors and lawyers were scorned. He had many dreams which contained cruel and torturing attacks on breasts. These attacks were related to early envy and the unavailability and loss of his early objects.

There then gradually emerged a persistent and persecuting

fantasy of the patient's anus being a vagina. This was a concrete conviction he had, not just a fantasy, i.e., a true somatic delusion. He would feel that he was going to bleed and would frequently wear a sanitary napkin. He would often get himself examined by doctors who could not convince him that his anus was normal. He felt that either they had never seen a case like his before, and so could not recognize it, or that they did not want to tell him the truth for fear he would kill himself. He looked at his anus in a mirror frequently, often becoming sexually excited. He regretted that he could not put his own penis in it and have intercourse with himself. He seemed very much like a transsexual with a fixed body delusion, the delusion being confined to a part object.

He wondered if he could produce babies, and frequently fantasized himself doing so. He also identified with breasts and had a powerful preoccupation with having his penis sucked by men, women, and babies. He dreamed about babies sucking his penis, and on one occasion, they were trussed up—just as he himself had been swaddled as an infant. He had fantasies of having his semen bottled and sold to pilgrims on their way to Mecca to cure them of hunger and thirst. His associations were to milk bottles.

Although he enviously attacked the breasts, he also identified with them, and fantasized feeding everyone while simultaneously projecting his hated baby identity into those he fed. He also had bouts of flamboyant dressing at this time—"catching the eye like the Piccadilly tarts do," as he put it.

He dreamed on one occasion that he was eating bits of a statue of a woman, and mocking and laughing at the statue which was black like his wet nurse. He also dreamed of sucking his sister's lips, which went right inside his mouth. He then got an erection and ejaculated in front of royal men—father figures—who got very excited and wanted to suck his penis. So he devoured his sister, and his penis in fantasy became transformed into a nipple which men wanted to suck. Here again we see his fantasies and envy of his sister and mother, and his wish to be them. This fantasy was colluded with by the external reality of his father's

behavior, plus the overall cultural activities of using boys as women. He had a dream once of being a little boy in a nightshirt. He said, "He looked nice," and it reminded him of his mother in her nightdress. The next day when he pressed the bell to let himself into my office, he felt his rectum changed into a vagina.

The patient's envy of women, supported by his father's (and cultural) confusion and behavior, seems to have consolidated a somatic delusion which was, in fact, a psychotic fantasy. This delusion went away after about two years of analysis, but can occasionally flash back close to major separations, such as my vacation.

Case Number 3

This was the case of a thirty-four-year-old pathologist who suffered a schizo-affective breakdown. She had depressive and severe paranoid features, believing that she was being watched and laughed at by colleagues and that in the street people would stare at her and have mocking thoughts about her hair, face, and body. She felt they were saying that she was ugly and deformed. She believed they knew what she was thinking, particularly her shameful sexual thoughts and her preoccupation with men's penises. She felt God watched her and knew all her shameful thoughts and deeds. She had a voice in her head which was scornful, devaluating; it called her a "slut" and "whore," and said that she should be crucified, burned, and tortured, that death was too good for her.

Her external paranoia was precisely paralleled by her internal persecution. She had always been perfectionistic and obsessional about her work, and had already impressed her senior colleagues with its care and excellence. She had, in fact, produced several papers of importance. When she had been well, she took considerable pride in her promiscuity and felt she could get any man. Indeed, she had had considerable success, particularly

with married senior colleagues, for she was witty, seductive, and pretty in a country-girl, fresh way. This was in marked contrast to her unconscious feelings of worthlessness which broke through with her illness. Sin and God played a large part in her ruminations. Today (for this was many years ago), she would undoubtedly have been medicated, which would have been a pity, for she rapidly improved with analysis, particularly with the relief of anxiety which came from understanding the superego components of her persecution and its projected equivalents that led to her paranoia.

The analysis proceeded as might be anticipated, with transference manifestations of seduction, voyeurism, and cruel and harsh criticism. I became a handsome priest one day, and a lascivious fraud the next. Her most frequent attitude I described as "micro-pulping." She looked at me through a microscope to discern my failings, blackheads, and inadequacies, and then squashed me like a bug with a steam hammer, so that only a faint smear remained where once there was a human being. Cruelty does not quite describe it; vengeance from Jehovah would be more like it.

The one feature which was atypical was the extreme rapidity of her restoration to high quality functioning. What normally took months, took weeks, and what normally could be expected in years, took months. The factor which I believe was responsible for this emerged after some months' treatment and took both of us by surprise. The patient had heard my voice when she was in the waiting room (which was in my home) speaking, as she wrongly surmised, to my wife. The patient's fantasy was that I was obsequious and placatory, because I did not want to annoy my wife; otherwise, she would never have sex with me. It was clear that the patient's view of my sexual relationship was that it was carnal and hypocritical, as I interpreted, and this devalued view was a defense against the patient's envy and jealousy, particularly as I had not responded to her attempted seductions of me. Her most recent attempt had taken the form of her offering to increase her fees, which at the time she could not afford. I

pointed out her delusional overestimation of her stools (the fees), and the effects she fantasized they would have on me as mother in the transference. Her fantasied hope was that I would find them (the money) preferable to the father's penis. Taking the suggested raise would have confirmed her grandiose anal delusion of penis-stool confusion.

Following the analysis of this, she produced a memory of being awakened at night by her sister, who was six years her senior. The sister would take the patient's hand and lead her to the door of the parents' bedroom, where the sister would look through the keyhole, which the patient was too small to reach, to see, in the sister's words, "the dirty beasts doing it." "They're doing it, they're doing it, the dirty beasts are doing it," she would whisper to my patient in tones of glee and disgust. These episodes occurred several times a week, and on one occasion several times during the night, over a period of two to three years. My patient was three to five years old, and her sister was nine to eleven years old.

When I commented that her father sounded rather potent, she exclaimed in disgust, "He's an animal. He was always drunk, and he forced himself onto my mother. He would take me on his lap, slobbering, and I could feel his thing through his trousers." When her anger and disgust had cooled, I asked her if her sister put the lights on in the parents' bedroom. The patient exploded with anger and contempt. How could she? The parents would know, then, that the children were watching. "So your sister can see in the dark," I said. The silence that followed the implication that dawned on her was powerful and moving. I interpreted that the sister must have been deluded. The patient could only say that the sister was a CEO of a large public company.

An extraordinary sequel to this story was that the sister was admitted to a hospital three months after the episode I have described, with her first psychotic break. The sisters lived five hundred miles apart, and their contact was restricted to an occasional telephone call; so I think the sister's breakdown was coincidental, but it is difficult to know. The tragic outcome was

that the sister died of a perforated esophagus due to either tube feeding or eating glass or metal. The patient's recovery was rapid, her analysis taking some three years, and has been maintained until the present with no further treatment. I have seen her on half a dozen occasions since the termination of her treatment, spanning a period of some seventeen years. She married, has three children, lives in the third world, and has written several important papers on the mechanisms of viral replication. She told me the last time we spoke, "I'm still watching the dirty beasts doing it, but they're real now."

I believe her infantile, envious, voyeuristic attacks on the parental couple were given delusional force by the projections from a psychotic elder sister, and that when this factor could be analyzed, the patient's own personality, which was not basically psychotic, could maintain the difference between fantasy and reality.

Projective identification with the Mission doctor originally, and later with Charcot and Freud, was my personal history and experience, and my childhood heroes were always doctors, such as Ehrlich and Semmelweiss, and never sportsmen; my dreams were the operating theater, not the playing field. The Mission doctor cured my mother, who looked after and fed me, and in my fantasy, no doubt, he controlled and possessed her. When I saw them together, I must have possessed him by sight to take over his power and position. Later, becoming a hypnotist was a more sophisticated version of the same infantile fantasy.

Freud extrapolated from his analysis of his own dreams and fantasies a general theory called the oedipus complex and gave us all the courage and the example to extrapolate from our own dreams and fantasies. Mine are connected to earlier anxieties than Freud's and are related to wishes to become big through omnipotent fantasies, using projective identification and later hypnosis to implement these fantasies. I also have little doubt that my mother supported my fantasies enthusiastically—to have a "doctor-son" was even better than Oedipus. I also believe that this type of fantasy is common, perhaps, like the oedipus

complex, even universal. I think that the phenomenon of hypnotism is a temporary delusional state, but that it can have more permanent versions, even psychosis, when mutual projective identification occurs between any two people, particularly when one is in a position of power and authority, such as parent and child, doctor and patient, priest and disciple, political leader and followers, etc., etc. I believe that these delusional states are different from and less intractable than the psychosis which can occur without the assistance and support of these external hypnotists.

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A Perspective on Doing a Consultation and Making the Recommendation of Analysis to a Prospective Analysand

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A PERSPECTIVE ON DOING A CONSULTATION AND MAKING THE RECOMMENDATION OF ANALYSIS TO A PROSPECTIVE ANALYSAND

BY ARNOLD ROTHSTEIN, M.D.

This paper explores the premise that the analyst's optimistic attitude toward the efficacy of analysis significantly enhances the possibility of success in helping prospective analysands accept the recommendation of analysis. This enthusiastic attitude reflects the author's opinion that analysis is the optimal treatment, the best form of psychotherapy for most adults. From this perspective, all patients seen in consultation are regarded as analyzable; this attitude is maintained until a prospective analysand proves he/she is unanalyzable in a trial of analysis. Analytic data from six consultations conducted from this perspective are presented and discussed.

In psychoanalytic training we have all been taught to do a consultation in which a diagnosis is made and a judgment is rendered about a patient's suitability for analysis. We were taught from a perspective that asked, "Is this patient analyzable?" Following Stone (1954), we have learned to ask, "Is this patient analyzable with 'modifications'?" Another question that analysts are trained to consider in making assessments of analyzability is, "Is this prospective analysand analyzable only by an experienced graduate analyst rather than by a candidate analyst?" Finally, analytic candidates are trained to ask, "Might this prospective analysand be suitable for analysis after a preparatory psychotherapy?" Forty years ago, when Stone published his seminal paper, the collective wisdom was that such preparatory psychotherapy "contaminated" and interfered with the prospects of the

therapy evolving into an analysis with the preparing psychotherapist.

These questions and the conjectures, hypotheses, and ideals from which they derive equip the neophyte analyst with a number of premises and shape his/her attitudes as he/she enters the consultation experience. First is the idea that a judgment about suitability for analysis can be made in a consultation of one to six sessions with a patient in an interview type of engagement. This premise has persisted in spite of the fact that significant research has been reported to suggest it is fallacious. Bachrach's (1990) review of the research on analyzability clearly demonstrates that a judgment of analyzability and a related assessment of prognosis cannot be made with accuracy *until an analysis is completed.* Second is the notion that a prospective analysand should have certain aspects of character, thought of as capacities or ego strengths, manifest at the time of the consultation, in order to be suitable for a trial of analysis. This second premise derives, to a significant degree, from a deficit model of the development of psychopathology. This deficit model conceives of people as "defective" and "lacking" in the required aspects of character. Another analytic conception of character suggests that all aspects of an adult analysand's personality be understood as manifestations of a mind in conflict. Abrams's (1992) comments on what is required of a prospective analysand reflect what remains a majority point of view. He stated:

> The patient brings—among other things—psychological mindedness, a capacity for controlled regression, competent integrating and organizing functions, the potential to observe at a distance and experience with immediacy often at the same time, and a reasonably intact psychological foundation arising from a more or less successful oedipal-age organization. This grouping of aptitudes helps define the sources of problematic analyses . . . due to faulty ego equipment or limited developmental progression . . . (pp. 76-77).

Third, the majority of analysts are taught from a perspective

that conceives of analysis as indicated for a select suitable minority of those who seek analysts' help.

The decline in the number of such ideal potential analysands, even in the consultation rooms of respected established analysts, has contributed to the interest in questioning some of these pedagogic assumptions concerning assessment of prospective analysands.

My experience has led to different conclusions about doing a consultation and making the recommendation of analysis. It is important to emphasize that, given the current state of research methodology, my conclusions and the premises that underlie them are, like all such clinical dictums, no more than *opinions.*

I approach a consultation with an *optimistic attitude* that influences my capacity and success in helping prospective analysands begin and experience a fruitful analytic collaboration. This attitude is associated with three related hypotheses about the prospective analysand and our anticipated analytic collaboration. First, in my opinion, psychoanalysis is the *optimal* treatment, the best form of psychotherapy for most adults. Second, my *attitude* about patients, whom I see for the first time in a consultation, is that they are all potential analysands. I work to maintain that attitude throughout the consultation. I assume that their analyses will be successful. Third, I will accept another conclusion only after a prospective analysand proves to me that he/she is unanalyzable in a *trial analysis,* a trial that may last months to years. It is important to emphasize that it is difficult to answer with certainty the question, "How long should a trial of analysis continue before the analyst considers it a failure?" I suggest that the trial continue as long as the analyst believes there is progress. The fifth case reported in this paper did not demonstrate the kind of self-observing capacity reflective of genuine analytic work until the fourth year of our collaboration. In a related vein, it is noteworthy that failed analyses are not infrequently associated with therapeutic gains that are, in part, derived from unanalyzed transference gratifications. In a previous communication on the subject of analyzability (Rothstein, 1982) I noted,

> Analysts are left with the awareness that among a large group of subjects considered 'typical' narcissistic personality disorders, some will have optimal analytic experiences while others will accomplish much less. Paradoxically, it is worth emphasizing that an unanalysable narcissistic personality disorder may experience significant therapeutic gain from an incomplete analytic endeavour (p. 178).

In this paper I wish to emphasize that if any particularly positive, hopeful, negative, or pessimistic ideas about the patient, the diagnosis, or the prognosis occur to me during a consultation, I view it as possibly reflective of an emerging countertransference-transference engagement. Because I assume the patient is analyzable, I am more interested in understanding the patient's responses to me, to the consultation, and to the recommendation of analysis than I am in manifest aspects of his/her personality or presenting complaints. My attitude toward prospective analysands is quite different from the one described by Abrams. I do not expect the patients to bring much other than themselves to a *trial* of analysis, and I regard the trial as beginning with my first contact with the patient. In my experience many analysands who have successful analyses do not begin their analyses with the manifest capacities that Abrams believes are required of prospective analysands. Many successful analysands do not begin to experience the world in such an integrated fashion until they are well into the mid-phases of their analyses. The attainment of these capabilities and their relative stabilization is one of the goals of many analyses. Thinking of a patient as lacking in aptitudes, or as possessing faulty ego equipment, or as defective or arrested in development may represent a countertransference intellectualization in response to unpleasure evoked by the patient's personality, symptoms, or intense affects. Such a conceptualization about a prospective analysand can be productively thought of as an evoked or induced fantasy and responded to as data reflective of the beginning of the analysis.

It follows from the foregoing that if I find myself thinking

about differential diagnoses rather than considering a patient's sensitivity, I assume that I am responding to some transference trend that evokes unpleasure in me. Countertransference unpleasure associated with feelings of revulsion for a patient may be defended against by distancing oneself in the process of considering the prospective analysand's diagnosis. Conjectures about diagnoses that carry a negative valence, such as borderline, narcissistic, psychopathic or perverse, may signal such a countertransference trend.

It is worth remembering that most of the diagnoses that one might consider derive from the descriptive *psychiatric* perspective of DSM-III-R. It is clear that there are psychiatric diagnoses that are contraindications to a trial of analysis. The fifth case presented in this paper represents such a clinical exigency. However, from a *psychoanalytic* perspective, one of the important functions of diagnosis is to facilitate the analyst's task of helping a prospective analysand begin a trial of analysis. This point of view emphasizes that psychoanalytic diagnoses are no more than descriptive indicators of the data to be analyzed in both the transference and countertransference. From this pragmatic vantage point I employ three descriptive "diagnoses": I suggest that prospective analysands can be grouped descriptively as 1) *inhibited,*[1] 2) *enactment prone,* and 3) too disturbed and disturbing for me. The so-called "good cases" are more usually found among the first group of patients.

Before presenting clinical material shaped by my optimistic attitude, two cautionary notes are indicated. They are related to the subjective nature of the analytic enterprise: every analyst has his/her individual contraindications to beginning a trial of analysis, and every analyst will find patients who are too disturbed and disturbing to work with.

In agreement with Gedo (1981) I would not begin analysis

[1] Renik (1990) has implicitly approached this question of psychoanalytic "diagnoses" in his description of "*two complementary affect-defense configurations: inhibition in response to anxiety and enactment of wishful fantasy in response to depressive affect*" (p. 226).

with patients suffering with "the continuing influence of unalterable, but disavowed, delusional convictions" (p. 78). In addition, I would not begin a trial of analysis with an addict, with a patient suffering from a serious psychosomatic illness such as chronic ulcerative colitis, or with a patient who has made serious attempts at suicide. *I prefer not to work with such patients because my experience with them has taught me that the countertransference trends they evoke in me interfere significantly in my ability to maintain an analytic attitude suitable for successful analytic collaboration.*

During an extended consultation with a successful businessman who was addicted to cocaine, I was impressed with the serious impairment of judgment that accompanied the patient's intoxicated states. I could not be reasonably certain that he would not murder someone or get himself killed during the outbursts of anger that often accompanied his altered states of mind.

However, it is important to remember that other colleagues have worked successfully with such patients. Karush, et al. (1977) and Wilson (1990) have reported successful work with patients suffering from serious psychosomatic illnesses. I am emphasizing that uniquely personal factors can influence the prognosis of a trial of analysis. Stone (1954) stressed the same point when he stated that "the therapist's personal tendencies may profoundly influence the indications and prognosis" (p. 593).

In an earlier paper (Rothstein, 1990), I described the process of making the recommendation of analysis to two reluctant patients. In that communication I emphasized that "particularly in the introductory phase, it is the analyst's attitude toward the patient and his behavior and verbal associations rather than the frequency and/or the use of the couch that is the essential characteristic of the analytic method" (p. 153). In a related communication (Rothstein, 1992), I noted that "success is facilitated by a *flexible* attitude toward the structure of the analytic situation as well as toward the parameters of its technique. What is *essential* in analytic technique is the analyst's attitude. . . . Other features

of the analytic situation, such as frequency of sessions and use of the couch, though important, are not always and absolutely essential" (pp. 521-522).

At this point I will describe six experiences of recommending analysis. Three have worked out well. Of the remaining three, with one it is too early to tell if the trial will be successful, another seems to be working out well after three years of "preparatory" psychotherapy, while another patient is involved with reacting negatively to the recommendation for analysis while maintaining a tenuous, less intense involvement with me.

Case No. 1

This is an example of an "easy" case. In the first session, during the process of hearing the patient's story, and without forethought, we engaged the question of beginning a formal analysis.

Prof. A, a forty-eight-year-old successful college professor, sought help because of chronic dissatisfaction with his significant professional achievements, longstanding anxiety (fear of humiliation) associated with experiences of speaking in public, as well as stage fright associated with his hobby of singing in a chorus. Prof. A had five previous experiences of once- or twice-a-week psychotherapy over a thirty-year period. In our first session, after listening to this sophisticated New Yorker describe his life's journey, I spontaneously and incredulously asked, "How have you avoided having an analysis?"

It is important to emphasize that the optimism I am stressing in this paper shaped the content of my spontaneous utterance. Inevitably, my attitude about the efficacy of analysis exerted a shaping influence upon the prospective analysand's fantasies about analysis. These evolving fantasies undoubtedly influenced his motivation. The productive analysis of these fantasies is a characteristic of mid- and terminal-phase process. My confrontation concerning Prof. A's avoidance elicited a laugh and her-

alded the beginning of our understanding of the specific influences that had motivated him to avoid analysis. We agreed to begin an analysis. In the process of arranging hours, I mentioned that I did not think one could expect to get the job done working at a frequency of less than four times per week. We worked productively at a frequency of four times per week for fifteen months and have worked five times per week since that time.

Case No. 2

This case represents the somewhat more complicated problem of a patient seeking a consultation while engaged in a psychotherapy with which he was dissatisfied. Because his therapist was an analyst, I recommended that the patient attempt an analysis with that analyst. That did not work out, and he subsequently began an analysis with me.

Mr. D, a successful forty-nine-year-old banker, sought a consultation while in the midst of his second twice weekly psychotherapy. Six years ago he had entered psychotherapy with a man in another part of the country during the breakup of his first marriage. He remarried during the second year of that therapy and was transferred to New York by his bank four and one half years ago. He subsequently began psychotherapy in New York with a woman whom his therapist recommended. He sought my opinion about his dissatisfaction with his current therapy. He presented in significant distress, visibly upset at the prospect that his second marriage would fail. He felt there were personal issues that were intruding on his happiness and was pessimistic about the possibility of his therapist's providing sufficient help.

In our second session I pointed out that despite his concerns about his therapist, he had never had an experience with analysis, *the optimal method* of treatment for his problems. I noted that his therapist had a couch in her office, he was involved with her, and I suggested that his therapy might evolve into an analysis.

Four months later Mr. D called to tell me he had interrupted his therapy and requested that we begin an analysis. We began a trial of analysis, at a frequency of four times per week, which has worked well. Mr. D is currently in the second year of a very productive analysis.

Case No. 3

This was a situation similar to that in Case No. 2. Mr. X, a lawyer, sought a consultation four months after the termination of a seven-year analysis. After hearing Mr. X's story, my impression was that his analysis was prematurely interrupted, an interruption which I conjectured was in part evoked as a countertransference response to Mr. X's depressive affect and intransigent hostility. I felt it would be optimal if Mr. X could work these issues out with his first analyst.

With Mr. X's permission, I called his first analyst and shared my impression. The analyst responded that Mr. X was a "severe borderline." It seemed clear to me that the analyst had had enough of Mr. X's depressed, enraged longings and was glad to be rid of him. I am emphasizing that from my point of view on analyzability, it was not the patient's symptoms per se but the analyst's reaction to them that was determinative.

Some time later, Mr. X related to me that he had attempted unsuccessfully to resume his analysis and again requested he begin a second analysis with me. In spite of his wish to begin an analysis with me, I felt he was still too disturbingly involved with his first analyst for that to be a wise undertaking. I told Mr. X that because of his disturbed state it would be better that he wait a year before making the decision to begin a second analysis.

Mr. X began a second trial of analysis with me fifteen months later. He began the first session of his re-analysis stating, "For the last two years I felt I was slapped in the face by Dr. N [his first analyst] and angry. For the past two weeks I have been joyful and thought of kneeling next to you and stroking your

chin to supplicate you. I had a dream: I was lying with a man and stroking his penis until he ejaculated and then fucking a man in the ass. In the dream I had the sense, 'now I'm going to get mine,' as if I had been stroking Dr. N and now it's my turn." Somewhat later in the hour Mr. X remarked, "It's clear to me that I destroyed the analysis with Dr. N by establishing rigid stable patterns with him that put control on what I was feeling toward him." Later in the hour I suggested to him that he was worried that I would reject him as Dr. N had by thinking he was too sick for an analysis and that he was worried that I would be frightened by his anger and by his sexual longings for me. He began the second session by stating, "I have a profound sense that you are really disgusted with me 'cause I can't be analyzed." He began the fourth session with ten minutes of silence and then said, "I wish you'd say something." He paused and said, "I have a sense of being blocked." I suggested that he was afraid his anger would really hurt me. He responded, "Just your saying that is such a relief. I thought I'd like to spit on your floor." To my response, "Only on my floor?," Mr. X stated, "In your face; I'd like to knock you down and kick dirt all over you. I'd like to take a shotgun and point it in your face and pull the trigger and blow your brains all over the wall." I sighed and thought to myself, "and this is the first week of the analysis." Then I recalled earlier work with a latency boy who had shot me in the head with a rubber dart, and I said aloud to Mr. X about his wish to shoot me, "That sounds like great fun." Mr. X roared with laughter and remarked that he could not remember laughing with Dr. N. Later in the hour Mr. X[2] recalled his mother slapping him in the face in response to his complaining that neither of his parents did much for or with him. He remarked, "My anger seems so vitriolic and bottomless. I get a real sense of pleasure in being angry."

Cases No. 2 and No. 3 suggest that in spite of the difficulties

[2] I have reported aspects of mid-phase process of Mr. X's second analysis (Rothstein, 1991a, 1991b).

involved, whenever possible, I try to help analysands attempt to complete the work they are in the midst of before beginning a new trial of analysis with the consulting analyst. This recommendation helps emphasize to the patient that it is his/her analysis, rather than the consulting analyst's acquisition of analytic cases, that is important.

Case No. 4

This is an example of the common exigency experienced by the analyst when a prospective analysand confronts him/her with his/her "realistic" inability to schedule regular hours. The manner in which Dr. M presented his difficulties required some flexibility in devising a way to begin the necessary work, a flexibility that patients like Dr. M require and demand at the beginning of their analytic collaborations.

Dr. M, a chief resident in surgery, sought a consultation with me after being referred by a senior colleague to a contemporary of mine. My contemporary "diagnosed" Dr. M as "too disturbed and disturbing for him."

Dr. M had been informed by the senior consultant that, because of his self-destructive and self-defeating tendencies, analysis was indicated as a "life saving procedure." In spite of his past experiences of a failed analysis and of multiple failed psychotherapies, all with analysts we both knew were truly competent, Dr. M expressed his desire to begin an analysis with me. The only problem was that, because he was a surgical resident, he could not agree to regularly scheduled appointments. I agreed to schedule his four appointments weekly in response to the exigencies of our, but mostly his, schedule. After six months, a new job, and interpretations concerning his fantasy of being special to me by virtue of the nature of our scheduling procedure, he was able to schedule regular appointments.

Subsequent changes of schedule initiated by me have triggered anxiety, rage, depressive affect, and self-destructive en-

actments. These experiences have revolved around his sense of the loss of the narcissistically invented fantasy of being special to me.

In spite of a guarded prognosis, Dr. M and I continue to work productively in a disturbing analysis.

Case No. 5

This case illustrates the kind of patient for whom analysis is *not* the treatment of choice at the time of consultation. Her presenting complaints and the associated *psychiatric* diagnosis suggested that a more reality focused psychotherapy soon to be combined with medication was the indicated beginning treatment for her agitated depression. *However, I maintained an attitude that communicated that analysis was the optimal treatment to initiate at some future time in order to help protect the patient from a recurrence of her acute state.*

Dr. O, a twenty-eight-year-old pediatrician, sought help in an agitated state after being abruptly rejected by the first man she had been seriously involved with since college. This shy, self-effacing young woman was seriously depressed in our first session. Her appetite was poor, she was crying spontaneously, and was having trouble sleeping. She expressed profound pessimism about her ability to ever be truly successful in her work or in a relationship with a man.

Because of her acute state and the diagnostic consideration of a depression that might require medication, I suggested that she see me (sitting up) at a frequency of three times per week. During the first month of our work I mentioned to Dr. O that after she got over her acute (depressive) response, analysis was the optimal treatment to help her with her shyness, fear of humiliation, pessimism, and self-esteem problems.

However, after a month of psychotherapy her depression was getting worse. Referral to a psychopharmacologist and subsequent treatment with tricyclic antidepressants were effective in

alleviating her depression. Dr. O was treated with antidepressants for eight months, and we worked productively in a three-times-per-week psychotherapy for almost three years. During that time Dr. O attempted analysis. She found the experience of being a patient in psychotherapy embarrassing and the prospect of being an analysand even more humiliating. She lay on the couch rigidly, arms crossed with one foot on the floor. Because the experience of the couch was excruciatingly painful and because the prospect of being an analysand was so humiliating, we resumed the psychotherapy with its here and now extratransferential emphasis. Throughout this work she maintained a respectfully idealized view of me as the doctor who should have answers that would help her with her problems.

As we approached the end of the third year of her psychotherapy, Dr. O expressed her sense that she did not need any more treatment. Her wish to stop represented, in part, her response to her fantasy that being in analysis meant that she was a failure as a person, a failure she experienced as a profound humiliation. Her wish to stop was associated with a narcissistically invested fantasy that she could manage her own affairs. Such fantasies are commonly employed by young, ambitious, professionally successful prospective analysands, in resistance to the recommendation of a trial of analysis. Such patients need time to test the recommendation against their own capacities and the exigencies of their lives.

We agreed to stop meeting with the understanding that she could return if she felt it was necessary. Six months later, in response to a rejection by a man, Dr. O began an analysis at a frequency of four times per week. During this second trial of analysis, which is now approaching the end of its first year, Dr. O is more comfortable with the use of the couch. She misses an occasional session for work-related "realistic" reasons. She is aware that these "realistic" reasons are occasionally employed as enactment resistances. Although her prognosis is still in doubt, her trial of analysis is ongoing.

Case No. 6

This represents the type of patient for whom analysis is clearly the treatment of choice but who is unable to accept the recommendation at the time of the initial consultation. Nevertheless, it is important for the analyst to indicate and explain clearly, to such reluctant patients, that analysis is the optimal treatment for their current and lifelong difficulties. This patient and many other reluctant patients require time to assimilate the narcissistic injuries they experience in hearing the recommendation of a trial of analysis and in the prospect of relinquishing the gratifications they long for in anticipated enactments. Even though the recommendation is not immediately accepted, it can be employed as a referent in working with subsequent resistances.

Prof. R is a forty-year-old scholar of English literature and an aspiring playwright. He was referred by his best friend, an analyst, who described him as a talented narcissistic personality who has never allowed himself to have treatment.

In the first session he presented agitated and distraught at the prospect of divorce. Although he had not had sex with his wife in twelve years, he was burdened by the intense guilt he felt at the prospect of abandoning her. This prospect was more imminent because his daughter was about to leave for college and because he was involved in a passionate love affair with a much admired married writer. In addition Prof. R was preoccupied with the exciting fantasy of pursuing many love affairs with all the young women he felt his wife and marriage deprived him of.

Because Prof. R conceived of his difficulties as deriving from external circumstances and because he believed he could solve his problems by himself, it was clear that he would not accept the recommendation of analysis. Yet I felt analysis was the treatment of choice for his lifelong difficulties. I believed that Prof. R would have to fail repetitively before he could accept my recommendation and begin a trial of analysis.

I am emphasizing that despite an anticipated negative re-

sponse from a prospective analysand, the analyst should nevertheless make the recommendation of analysis as the optimal treatment. After making the recommendation, the analyst should work with the prospective analysand on the patient's terms. Because Prof. R had difficulty with the ideas of scheduled appointments and with paying for missed appointments, I agreed to see him on a catch-as-catch-can basis.

I have seen him once or twice a week, in response to the exigencies of his day-to-day pursuits of conquests and humiliations. It is my judgment that he will begin an analysis in two to three years.

In conclusion I reiterate the basic premise of this paper. The analyst's *belief* that analysis is the optimal treatment for most patients she/he sees in consultation is an important factor in her/his ability to help a prospective analysand collaborate in a trial of analysis. This belief is bolstered by an *attitude* toward the prospective collaborator that communicates optimism about the outcome of the trial. Prospective analysands are analyzable until they prove they are unanalyzable in a trial of analysis.

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Intuition and Consciousness

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INTUITION AND CONSCIOUSNESS

BY ALLAN D. ROSENBLATT, M.D. AND JAMES T. THICKSTUN, M.D.

Intuition represents an unconscious cognitive activity, the results of which become conscious at some point. Some recent nonpsychoanalytic explorations of cognition and consciousness are examined to illuminate our understanding of these processes and their relation to the psychoanalytic process. Our thesis is that intuition may be most usefully viewed as a form of unconscious pattern-matching cognition, which becomes conscious under certain conditions and which is only loosely related to primary process. A clinical example is given of the analyst's intuition to illustrate the initial ostensibly theory-free nature of the raw intuition and the subsequent theory-bound explorations of the intuitive conclusion. Implications for teaching and learning psychoanalysis are noted.

INTRODUCTION

Intuition, defined in Webster's Unabridged Dictionary as "knowledge obtained or the power of knowing, without recourse to inference or reasoning," refers to the more or less sudden and full-blown consciousness of a conclusion or judgment without awareness of previous cognitive steps. Although it is a common event in daily life and in psychoanalysis, oddly enough, it has hardly been explored in the psychoanalytic literature.[1]

[1] The only discussion of intuition per se that we have found is by Szalita-Pemow (1955), in relation to work with schizophrenics. She asserts that "the intuitive process" is essentially the same as other thinking processes, except that "it erupts into the conscious mind in a ready-to-use form" (p. 17). According to her, "all thought is produced by the process of dreaming" (p. 8) and depends primarily on visual images. These positions do not seem tenable in view of our current knowledge.

We examine here a number of questions regarding this process: 1. What is the nature of the unconscious cognitive activity that occurs? 2. What determines when consciousness supervenes? 3. What is its relation to primary and secondary process? 4. What is its role in the psychoanalytic process? Our thesis is that intuition may be most usefully viewed as a form of unconscious pattern-matching cognition, which becomes conscious under certain conditions and which can be only loosely correlated with primary process. This hypothesis has significant implications for the way psychoanalysis as a technique is learned and the way experienced experts practice it.

PATTERN MATCHING

By pattern, we mean some configuration or arrangement. It may be spatial, such as a face to be recognized, or a temporal sequence of acts or events, e.g., a behavioral pattern. Recent nonpsychoanalytic explorations of cognition and consciousness have focused on pattern matching as the basic element in cognition. We briefly review some of this work to demonstrate the convergence of several fields on this focal concept.

Gerald M. Edelman, a distinguished neuroscientist, in his book, *The Remembered Present* (1989), develops the thesis that consciousness is a result of the interaction and matchings between "value-category memory and ongoing . . . perceptual categorization" (p. 245). Value-category memory is the memory of a past pattern of shapes or sounds or events that is imbued with a "value" of being beneficial or inimical to the organism, i.e., an affectively suffused memory. Each perception is categorized or classed as an instance of some previously encountered pattern. The basic brain activity for Edelman, then, is categorization and recategorization or, in other words, pattern matching. He thus provides a neuroanatomical basis for the development of neuronal groups that generate and match patterns.

Israel Rosenfield, in his book *The Invention of Memory* (1988), building on Edelman's ideas, argues that memories, as well as

perceptions, are not locally stored, discrete "engrams" of information, but are recategorizations of previously encountered events. He points out that the critical relevance of context to perception demonstrates that "the brain does not sort information. . . . The brain must determine what combinations of stimuli are useful,[2] and to do this must create the categories, organization, and orderings of stimuli that are the information we perceive in the environment" (p. 66). In other words, information is not some external entity passively registered by the brain, but is the result of the brain's categorizing activity in processing incoming stimuli. Similarly, recollections "represent a categorization, a generalization . . . of past and present events colored by a common emotional reaction" (p. 83). He concludes, "There are no symbols in the brain; there are patterns of activity that acquire different meaning in different contexts" (p. 136). Again, we emphasize that the construction, recognition, and matching of patterns appear to be the brain's primary activity.

Turning now to another stream of research, workers in artificial intelligence (or AI) have begun to turn from the unpromising exploration of sequential rule-based systems to what is now called "connectionism," involving parallel distributed processing systems that deal with patterns. Caudill and Butler (1990) have reviewed recent work in the development of such systems and devices, termed artificial neural networks, modeled after the structure of the brain. They do not function in a digital and serial manner, as does the common digital computer, but in an analog manner with widely distributed parallel processes, and can perform "brain-like" functions that cannot be practically executed by digital computers.[3] The network responds globally

[2] This determination does not require a homunculus, but may be accomplished by means of competing neural networks, as noted in our subsequent discussion of them.

[3] Edelman, in his rejection of information-processing concepts, appears to consider only the digital computer model with linear processing, ignoring analog processing and neural net models. Similarly, he fails to see that his re-entrant models, themselves, represent a form of feedback.

to input, rather than locally with a previously programmed response. It is not *programmed* to respond in a predetermined way, but *learns* to respond. Memories are stored in such networks as a pattern of variable connection weights among simple processing elements, called "neurodes," analogous to neurones. Such networks can retrieve memory even when incomplete; they *generalize* from the specific information available and detect similarities in patterns.

Since our focus is on intuition, it is noteworthy that the authors say, regarding such neural networks:

> They operate from an *intuitive* understanding of the structure of the task they are performing—from a learned internal model of the process they are involved in—rather than from a set of facts or cognitive rules about the process. This type of model building is more reminiscent of *intuition* than of symbolic processing and is the natural domain of neural networks (Caudill and Butler, 1990, p. 26, italics added).

An internal model is, of course, a pattern, and the intuitive understanding comes from pattern matching. Such networks are self-organizing and "compete" for learning, depending upon the input, similar to Edelman's proposed function of the brain. Caudill and Butler point out a very significant implication when they note that this is "a mechanism that makes this scheme work without having to call upon some outside mediator to decide upon a winner arbitrarily. *The need for the homunculus has disappeared*" (pp. 88-89, italics added). Thus, the role of consciousness as a decision-maker is unnecessary. We will return to this point later.

The final line of investigation we cite is that of Howard Margolis in his book, *Patterns, Thinking, and Cognition* (1987). He assembles convincing arguments for his thesis that pattern recognition is the basic form of thought. From an evolutionary standpoint, he asserts that a cognitive process that produced quick recognition of foes and food supported survival. He proposes four basic processes of pattern-matching activity: "jump-

ing" (reaching a response without deliberation, as in "jumping to a conclusion"), "checking" (taking a closer look after jumping when a cue indicates the pattern does not quite fit), "priming" (facilitation of certain jumps, e.g., those known through experience to be productive), and "inhibiting" (inhibition of certain jumps, e.g., those that have proved dangerous). He considers reasoning to be an evolutionary late addition, "the specialized form of judgment that is built out of pattern recognition applied to forms of language" (p. 56).

Although to our knowledge the cognitive element of intuition is nowhere explicitly identified in the psychoanalytic literature,[4] it appears to have been related by implication to a kind of primary process manipulation of symbols (see Szalita-Pemow, 1955). As stated earlier, we believe that intuition reflects, instead, the operation of an unconscious pattern-matching activity, wherein a currently perceived pattern is matched to a stored pattern. The results of this activity may become conscious, depending on certain conditions, when a match is achieved. Patterns are likely stored in some sort of hierarchical ordering, so that some patterns are instances or parts of larger, more encompassing patterns, the larger patterns functioning as contexts for the smaller patterns. When a match is achieved, the new pattern that has been matched then usually becomes categorized as an instance or variation of the previously stored matching pattern.

It bears repeating that, by pattern, we do not mean merely a visual pattern. It may be auditory, a temporal sequence of behavior (as in a role), a pattern of symbols, etc. In the last analysis, the patterns that are matched are patterns of neural firings. Such a pattern may represent information about certain verbalizations or behaviors that have been categorized as signifying certain previously encountered motivations. When such a pattern is matched to a partial pattern of similar verbalizations or

[4] Freud (1933) mentions intuition only in passing, derisively classing it with revelation and divination as a bogus source of knowledge espoused by philosophers and opposed to scientific observation.

behaviors newly encountered, the newly encountered pattern becomes categorized as one of those which also signify the previously encountered motivations. As a result of such processing, the conscious intuition is experienced and then perhaps verbalized, for example, as in "He is clucking around like an overanxious mother hen."

PATTERN MATCHING: PRIMARY AND SECONDARY PROCESSES

The division of cognitive processes into "jumping" and "checking" may be compared to certain aspects of standard psychoanalytic theory, most notably the related paired concepts of primary and secondary processes and pleasure and reality principles. Jumping, which, according to Margolis (1987), entails "being cued . . . to whatever pattern we find first that satisfies the situation" (p. 40), implies a lack of discrimination and immediacy of action, reminiscent of primary process and the pleasure principle. In contrast, the aims of the reality principle and the secondary process are assumed, similar to checking, to bring to bear issues of adaptation on otherwise impulsive behavior.

The concepts of primary and secondary processes, originated by Freud in 1895 and more fully developed in 1900, referred to 1) the means of disposition or control of quantities of psychic energy in cognitive processes and 2) the existence of two distinct modes of thought. The energic concepts so long attached to these delineations are untenable and have been largely discarded. The formal characteristics of the primary process mode of thought are concreteness, the absence of negation or contradiction, timelessness, disregard of reality, condensation, displacement, and visual symbolism. Primary process is regarded as the more primitive mode of thought. However, Noy (1969) has cogently argued that while primary process may be the earlier mode to appear, "the processes remain the same, but their level of organization and performance changes, develops and im-

proves constantly, along with general cognitive development" (p. 158).

These ideas of two modes of cognition have been subjected to considerable criticism, with regard to inconsistencies and unclarities. For example, Gill (1967) has demonstrated that displacement and condensation, the presumed hallmarks of primary process, occur all along a continuum from the primary to the secondary process. Nonetheless, Holt (1976), while acknowledging that "the theory of the primary process is in sad disarray" (p. 301), maintains that "as a descriptive concept, it retains promise and usefulness" (p. 298). A model of cognition based primarily on pattern matching may, however, ultimately prove more useful and capable of integration with contemporary neuroscience.

It may be that what is called primary process represents a gross form of pattern matching, roughly equivalent to "jumping," where criteria for matching are relatively loose. Patterns, alone, in the absence of linguistic markers, may not permit the representation of the negative of the pattern or the representation of the past tense, so negative is then not differentiated from positive, nor past from present. Similarly, conditional propositions ("if . . . then" statements) are not capable of clear representation without linguistic symbols, so the absence of this kind of mentation in primary process thinking is compatible with a solely pattern-matching activity.

Checking, itself, seems to involve a form of pattern matching, albeit more narrowly focused and often constrained by the rules of linguistic symbolism. One might then consider secondary process to be related to checking and to represent the most refined form of pattern matching, where the patterns matched are patterns of linguistic symbols.

INTUITION AND CONSCIOUSNESS

We now turn to consideration of the role that consciousness plays in intuition. It is beyond the scope of this presentation to

review the whole subject of consciousness, and we will confine ourselves to considering briefly several notions about consciousness that seem relevant to our topic.

It should be noted that the role of consciousness in decision making has been a central issue in psychoanalysis. Aside from the thorny problem of psychic determinism versus free will and choice (see Groddeck, 1923; Knight, 1946), the implicit assumption in all insight-directed psychotherapies, including psychoanalysis, is that conscious understanding makes possible more adaptive decisions. Freud's original goal of making the unconscious conscious rested upon this premise. Yet, psychoanalytic theory recognizes that most decisions are made unconsciously.

One point should be made regarding functional explanations of consciousness. They "explain" consciousness by postulating a certain function or functions that it performs, rather than proposing a structure or mechanism to account for the phenomenon. In most, if not all, such explanations, the objection can be raised that the proposed function is not theoretically barred from occurring unconsciously. The implication of this objection is that, since the proposed function can be equally or even more efficiently performed unconsciously, then evolutionary pressures would not have resulted in its conscious function; therefore, the proposed function is not the *raison d'être* of consciousness.

Evolution and natural selection, however, do not guarantee unalloyed efficiency. If so, we might have wheels or tractor treads instead of legs. Natural selection pressures tend to produce improved overall adaptedness. However, a particular function that is not very efficient may "piggyback" along with another function that has great survival value and with which the inefficient function is genetically associated. Therefore an operation may require consciousness merely because we evolved that way, without regard to what is most efficient or possible.

An idea that has figured prominently in recent writings about consciousness and related issues, is that of *re-representation*. Simply put, in information-processing systems (which include the

brain) a message is sent more than once, usually to provide validation. Such re-sending may be involved in a repeated feedback loop with ongoing modification of the message.[5]

Edelman appears to employ this concept in his "re-entrant" systems to develop his neuroanatomical theory of consciousness. In his theory, consciousness is the re-representation of ongoing comparisons of incoming perceptions with stored memories and "values." The constantly varying matching between perceptions and memories are "replayed" to different parts of the brain, there to be further compared, and it is this replay that constitutes the phenomenon of consciousness.

Palombo and Winson both use re-representation ideas in their theories of dreaming. For Palombo (1978), the dream involves selected re-representation of waking experience for "comparison by superimposition" (p. 16) in order to transfer new information to permanent memory storage. The selected day residues of experience to be transferred to long-term memory are replayed, matching them with items already stored in memory to determine where they are to be stored. Winson theorizes that in dreaming (REM sleep), experience is re-represented, possibly as a form of rehearsal or maintaining skills. In this sense, such thought is truly Freud's "trial action."

David Olds (1992) suggests that the dream may be the first evolutionary instance of consciousness-like re-representation. He proposes that consciousness, itself, is part of a feedback system that allows a re-representation of multiple parallel-processed events in the brain in a linear-processed mode for the purpose of "proof-reading" (see footnote 3). Thoughts may be replayed to check for errors and behavioral sequences rehearsed to correct problems and maintain skills.

He cites the work of Libet, et al. (1983), who demonstrated that, when a subject was asked to "spontaneously" flex his fin-

[5] The concept of re-representation does not imply a homunculus as audience, viewing events, as lampooned by Dennett in his "Cartesian Theatre" (Dennett, 1991). The events are re-represented to another part (or parts) of the brain which has other functions, such as error-correcting, etc.

ger, certain "readiness potentials" were observed in the brain several hundred milliseconds before the subject reported conscious awareness of the intention to perform the act. Thus some decisions to act appear to be initiated unconsciously, subject to conscious "checking" and possible modification or veto of the action.

So, in the domain of action, consciousness appears to be the checking or modifying factor, rather than the initiating one. Similarly, it seems that, in the domain of intellectual discovery through intuitive pattern matching, consciousness has an analogous checking role.

What determines, then, when the intuitive judgment or pattern match becomes conscious? First of all, it is likely that only *some* successful matches of patterns become conscious while the vast majority remain unconscious, part of the constant stream of unconscious, though not necessarily repressed, information-processing activity. Only those matches that meet certain criteria enter consciousness.

We have speculated that conscious awareness may supervene when certain conditions are met, including the following: 1) the information that has been processed remains ambiguous; that is, there is unresolved competition for matching between two or more stored patterns; 2) the processed information activates certain motivational systems (e.g., sexual systems) with their associated affect, *and* the subsequent processing is not repressed; or 3) the pattern encountered is novel, i.e., significantly different from other stored patterns, evoking alerting or arousal activities (Rosenblatt and Thickstun, 1977).

Both ambiguity and novelty (in the first and third conditions) evoke arousal activities with associated affect, so one may consider that in all three conditions the mediating stimulus for consciousness is some form of affect[6] or, in our formulation of affect (1977), some form of appraisal which, if it became conscious, would be experienced as affect. We would venture that

[6] We are indebted to Dr. Owen Renik for this insight.

an unconscious pattern match becomes conscious as an "intuition" either when the new categorization arouses a sufficient level (or perhaps quality) of affect that is *not* repressed or when, as a result of the match, a larger pattern is created that is itself novel. Since most pattern matches result in neither of these events, they remain at an unconscious level.

This kind of unconscious cognition remains unconscious, not because of any repressive activity, but because it does not meet the criteria for consciousness. It is, if you will, preconscious cognition and is dynamic in the sense of being influenced by psychological factors, that is, the competition of processed information for conscious attention. That is not to say, however, that repression may not enter into the activity. If the affect aroused is of a nature that generates sufficient anxiety, the pattern match may be repressed and not achieve consciousness.

Many times, after a conscious intuition, one is able to call into consciousness the pattern matches that led to the final intuitive conclusion. Yet after other intuitions, one cannot consciously reconstruct this process. On these occasions, one of the subpatterns that has been matched may have evoked some repressive activity. It is also possible that those processes are incapable of becoming conscious. For example, one can recognize a familiar face without necessarily being able to reconstruct the process of such recognition.

There are those individuals, however, who rely largely on "intuition"—those with the well-known hysterical personality, for example. Their inability to reconstruct consciously the matches involved in an intuitive conclusion results not so much from a specific repression of content, but from the rejection, for various psychodynamic reasons, of the use of logical inference and verbal symbol manipulation in their cognitive style (see Shapiro, 1965). Thus the intuitive mode of thought may be used as a defense against more clearly addressing anxiety-provoking issues. It is possible, also, that the hysterical personality structure is biased to discriminate less sharply between differences. As a result, the threshold for the judgment of novelty is higher, and

consciousness is less likely to supervene during a series of pattern matches until a blatant novelty is encountered. The contrary is likely to be the case in the obsessional personality, where vigilance to detect differences as a defensive control activity is usually encountered. Thus the hysteric is more likely to experience large intuitive leaps, while the obsessional is aware of fractionated, easily recoverable deductions.

We do not intend to imply that intuition is somehow related to psychopathology. It occurs ubiquitously, both normally and across pathological boundaries. It may well be that especially creative and intuitive individuals have an enhanced ability, innate or acquired, to search across domains and match patterns not ordinarily included in the usual pattern-matching search.

A CLINICAL EXAMPLE

What about the use of intuition in psychoanalytic practice? To illustrate our thesis, the following clinical example is presented.

A thirty-four-year-old woman entered treatment because of difficulty in establishing an enduring relationship with a man. She vowed, on entering the analysis, never to allow herself to become emotionally involved with her analyst. Consequently, much of the analytic material centered around her fear of a state of helpless longing, explored in her external interactions with men and in the transference.

She would repeatedly declare that there was no point in wanting what she couldn't have, and she would challenge the analyst to demonstrate the usefulness of thinking otherwise. She would sarcastically dismiss most interpretations and chide the analyst for being unhelpful. The analyst viewed this behavior in the context of defense against dreaded transference attachment (wanting something she couldn't have), but was distressingly aware of a tendency to react defensively to her challenges, e.g., pointing out that she had distorted something he had said, that he had in fact not said that, but something different. She would

quickly and correctly point out with apparent relish the analyst's defensiveness, criticizing his technique and commenting on his flaws. On occasion, feeling frustrated and helpless, the analyst would become more silent than necessary, evoking a scolding from the patient, who would maintain that the analyst's task was to repeatedly engage her, even if she dismissed his interventions. She would feel guilty after her criticism, fearing that she had hurt the analyst's feelings.

As one would expect, the analyst, at appropriate times, tried to connect such behavior with some genetic material regarding the patient's interaction with her father, a bullying, domineering man with whom the patient fought intensely, especially in her adolescent years. Any such attempts were received with dismissive statements, such as, "I can't make any use of that, even though it sounds correct." Any suggestion that she had played some role other than that of innocent victim in the battles with her father was met by furious denial.

In one session, the patient told of an interpersonal encounter, wherein she was surprised and chagrined to find that the person had been made uncomfortable and had backed away from an interaction that the patient had consciously believed to be playful. The analyst became aware of a "flash" of understanding (one might say, "It dawned on him . . .") that the patient "played too rough." (At least, those words came to the analyst's mind to represent the intuitive gestalt or *pattern* that had occurred in nonverbal terms, including the ideas that the behavior had a positive object-seeking component, had an absence of conscious malice, invited a corresponding response from the other "player," etc.) Almost simultaneously "it dawned on him" that this description characterized his hitherto unconscious experience of the patient's interaction with him, i.e., the pattern of "playing too rough" was matched to the pattern of his experience of the transference/countertransference and the novelty of this match evoked its becoming conscious.

He then consciously wondered what his contribution had been in the light of this new perspective, and he associated to

childhood experiences when, thrown in with much older children, he reacted to their "playing too rough" with alternating verbal intellectual defensive weaponry and silent retreat. He then remembered that early in the analysis the patient, of small and wiry build, had commented that she had always felt "too boyish." On other occasions, she would indicate her envy of soft, feminine women who, in her view, were able to seduce and then exploit men in ways that she disdained. It became clearer then, from this supportive data (which may well have unconsciously figured in the achievement of the intuitive insight) that this transference/countertransference interaction reflected not only the patient's defense against positive involvement, but was itself a mode of relating and engagement, even if it was "too rough." Of course, it was apparent that the patient's earlier constant battling with her father was in part a provocative attempt to engage him in the only way that seemed to work at the time. The unconscious hostility that infused the behavior was certainly also appreciated by the analyst, in the "too rough" aspect of the interaction.

This example is not presented as an instance of therapeutic brilliance or unusual dynamic constellation. In fact, the dynamics of the case may be considered rather prosaic, and it may be argued that the analyst should have arrived at this "insight" earlier, had he not been blinded by his countertransference in the first place. It is only intended to convey how an analytic "intuition" occurs and what happens on experiencing it.

THEORY AND INTUITION

A most notable aspect of the immediate intuition is that, when it occurred, it did so in an ostensibly theory-free context. That is, the analyst did not wonder consciously what defense was represented by the analytic material being presented, etc. As a matter of fact, the intuition or insight was *outside* of the framework in which the analyst had been considering the transference/

countertransference interactions. All previous consideration had been in terms of defense by the patient against threatening positive feelings, with the analyst's countertransfence response to feeling disparaged and rejected by the patient's prickly "I don't need you for anything" attitude.

This is not to say that the intuition was totally unconstrained by theory. As analysts, we are all biased, at least unconsciously, to some extent in our attending to and selecting data that is presented. First, we screen our perceptions through our general psychoanalytic axioms, e.g., all behavior is determined, unconscious mentation is an important determinant in our behavior, people have a limited repertoire of reactions to other people and events, etc. Then we are biased by our theoretical preferences, the "school" to which we formally or half-heartedly or surreptitiously adhere. Finally, our idiosyncratic life experiences with resultant conflicts and ways of reacting are of singular influence in our perceptions, as this example demonstrates. However, these three types of "generic" biases, for the most part preconscious or unconscious, are different from a situation where the analyst starts with a conscious theoretical premise and attempts to infer or deduce a conclusion.

The second observation that can be made regarding this intuition is that it was quickly followed by just such conscious, theory-bound "checking" cognition, involving inference from certain theoretical assumptions. For example, is there some contribution of the analyst to a transference/countertransference interaction that fits this intuition? Is there some genetic component to the behavior of both patient and analyst that fits, etc.? The intuition itself may be elaborated within a variety of different psychoanalytic theoretical frameworks: standard ego psychology, using impulse and defense concepts, self psychology, using threatening fragmentation of self and selfobject concepts, object relations theory, using concepts of early object relations and introjects, etc. Had the analyst been of a different persuasion, say working within a framework of self psychology, he would likely have proceeded with different "checking" premises

after the initial intuition. For example, is the analyst serving some selfobject function that fits? Is there some failure of empathy that is provoking the patient's interaction, etc.?

These consciously directed checking activities would be classified as ratiocination or discursive reasoning. Yet they appear to be pattern matching, constrained to a narrow domain. For example, the checking of what the countertransference contribution of the analyst might be entails a conscious circumscribing of an area wherein a search may be made for a matching pattern. Thus conscious rational thought may be a form of pattern matching where the limits or parameters of the search are consciously demarcated.

INTUITION: LEARNING AND PRACTICING PSYCHOANALYSIS

The traditional view of learning a skill has been that a beginner starts with specific cases and abstracts increasingly sophisticated rules as he or she becomes more competent. Thus what makes an expert is simply a repertoire of rules combined with factual knowledge. AI researchers have assumed this model in developing the so-called "expert system" for computer applications to such skill domains as disease diagnosis.

Dreyfus (1987)[7] points out that this view goes back to Plato, who in the *Euthyphro* tells of a dialogue between Euthyphro, a religious prophet and expert on pious behavior, and Socrates. When Socrates presses Euthyphro to tell him the rules for recognizing piety, he "does just what every expert does when cornered by Socrates. He gives him examples from his field of expertise" (p. 19). Even though Euthyphro claims he knows how to distinguish pious from impious acts, he is unable to specify the rules from which he makes his judgments. Since rules are

[7] We are indebted to Dr. Roy D'Andrade for bringing this reference to our attention.

supposedly the basis of knowledge, "Socrates concluded that none of these experts knew anything and he didn't either" (p. 19).

Echoing the experience of Socrates in his search for rules of behavior, the results of such AI efforts to duplicate experts' performance by the step-wise application of rules have been disappointing. Rules were found to have multitudinous exceptions and irregular applications. In every instance, the computer programs based on rules and facts, while bettering the beginners efforts, could not equal the experienced expert.

According to Dreyfus, acquiring a skill moves in the opposite direction, starting with abstract rules and proceeding to particular cases. With increasing experience, rules are found to have exceptions and become subordinated to overall situational assessments. (One doesn't *always* interpret defense before impulse.) *Expert* know-how, then, is not based on procedural rules but "knowing what to do in a vast number of special cases" (p. 29). These special cases, we believe, constitute patterns that are stored unconsciously and are recognized by an unconscious process of intuitive pattern matching.

If the amassing of numbers of patterns that are usefully available makes the expert, then implications follow for the teaching and learning of psychoanalysis. The immersion in varied clinical situations and the exposure to multiple clinical vignettes takes on a greater importance in supplying those patterns for comprehension and storage. In many instances, however, as psychoanalytic training advances, theoretical courses multiply and clinical exposure becomes more limited to the three or four supervised analytic cases that the student treats. We might be well advised pedagogically to consider exposing our students to a greater number of clinical vignettes representing prototypical psychodynamic constellations.

It is our contention that the experienced "expert" psychoanalyst, in developing understanding, relies more on intuitive pattern matching from a vast storehouse of complex behavioral and relational patterns that reflect underlying dynamic constella-

tions, than on theory-based procedural rules. This intuitive insight is generally followed by more conscious evaluation, dependent on general "rules," as well as on the recognition of related insights. When intuition fails, the expert may consciously fall back on rules, temporarily, to organize the data.

It is likely that the inexperienced or anxious analyst will depend to a relatively great extent on attempts to understand the analytic data by consciously starting from theoretical assumptions and trying to infer conclusions. Such an approach inhibits the function of intuition by constraining the pattern-matching function to a relatively small number of patterns in a limited domain and interfering with other unconscious pattern matches from becoming conscious. It is this kind of constriction that Freud (1912) likely had in mind to avoid by advising the analyst to listen "with evenly-suspended attention" (p. 111). On the other hand, intuition without subsequent checking within some framework is more likely to lead to "wild" analysis. The ideal analytic attitude, then, is born of sufficient confidence to permit wide-ranging intuitive leaps and enough discipline to check conclusions rigorously against evidence.

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Dissolving the Myth of the Unified Self: The Fate of the Subject in Freudian Analysis

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DISSOLVING THE MYTH OF THE UNIFIED SELF: THE FATE OF THE SUBJECT IN FREUDIAN ANALYSIS

BY ERA A. LOEWENSTEIN, PH.D.

Employing Lacan's conception of desire, this paper explores the distinction between self *and subjectivity as it emerges in the psychoanalytic situation. Challenging the notion of the* self *as a singular, coherent, and bounded entity, I demonstrate, through a review of Dora's case, that the "Freudian subject" is a cast of characters, a loose net of contextual, contradictory, and shifting identifications enveloping not a discrete core, but its very absence.*

> Knowledge of men sometimes seems easier to those who allow themselves to be caught up in the snare of personal identity. But they thus shut the door on the knowledge of man.
>
> LÉVI-STRAUSS (1962, p. 249)

In contemporary Western culture *self* may indeed be described as the most commonly used signifier to represent a person's innermost nature. Our everyday language is imbued with references to the self. We often hear people saying: "I don't feel myself today," or "She didn't seem herself today." We speak of ourselves and others as possessing a low or high self-esteem, as

An earlier version of this paper was presented at the Spring Meeting of Division 39, American Psychological Association, Chicago, 1991. I would like to dedicate this article to the memory of Dr. Nathan Adler, a teacher, a mentor, and a friend whose wisdom and wit I greatly miss. Many thanks also to Dr. Max Loewenstein for his editorial help.

being or not being self-motivated or self-sufficient. We respect the self-made person and find ourselves concerned with the self-destructive one. Relying predominantly on spatial metaphor, our discourse construes the self as a cohesive essence enclosed within the boundaries of the individual. Our language reifies *self* as an enduring and bounded entity that can be distinguished from other selves and separated from its cultural and social context. As Taylor (1989) described it: we think we have a self, the way we think we have a head or a liver (p. 112).

Within Anglo-American post-Freudian psychoanalytic discourse, *self* has likewise emerged as a pivotal concept for understanding healthy as well as pathological development. Winnicott (1956), for example, distinguished between "true self" and "false self," viewing the "false self" as a protective but lifeless envelope shielding and holding a hidden authentic core. The false self, in Winnicott's opinion, develops in response to an environment that is less than good enough, one which does not enable the child to consolidate a stable ego. Introducing the notion of *identity*, Erikson (1950) similarly assumed the presence of a bounded self when he argued that normal adolescent development culminates with the consolidation of ego identity and the achievement of a new sense of enduring sameness and continuity (p. 261). The central position of the self in Kohut's theory can hardly be overemphasized. While viewing healthy development as leading to the formation of a cohesive, harmonious, and unified self, Kohut believed that all forms of psychopathology stem from environmental assaults on the child's innate thrust to consolidate a cohesive sense of self (1984, p. 53).

The formulations of Winnicott, Erikson, and Kohut resemble the popular views of self as a unique and bounded entity. Self, in this perspective, is construed as an immanent and positive essence. It is against this mythical construction of the self that a skeptic like Lévi-Strauss aimed his critique when he discerned the notion of a unified self as an illusion, an illusion which he believed is sustained by the demand of the social order rather

than by our apodictic experience. For Lévi-Strauss, the idea of a continuous and cohesive self is a projection of the external on the internal: that is, one self for one body. The ultimate goal of human sciences, in Lévi-Strauss's judgment, is, hence, "not to constitute, but to dissolve man" (1962, p. 247).

Freud's life project can be viewed as aiming to discredit the myth of the unified self, the self the human sciences have been promulgating since the beginning of the Enlightenment. Time after time Freud took it upon himself to demonstrate that the self is neither coherent nor unified. The idea that the subject who says "I" is not master in his or her house but is rather a feeble creature divided by contradictory wishes had, however, from its inception, a scandalous and subversive impact. The contention that the subject is divided and decentered from conscious awareness called into question the Enlightenment's spirit of optimism, challenging its most cherished beliefs in "reason," "truth," "free will," "responsibility," and "progress"—beliefs imposed to anchor and sanction "order" in a secular world. It would be correct, I believe, to maintain that most psychoanalytic revisions in the post-Freudian era, including ego psychology, Sartre's existential psychology, Kohut's self psychology, and control mastery have aimed at justifying and maintaining the fiction of the *self* that Freud had set out to challenge. In this paper I would like to examine the structure of subjectivity as it emerges from Dora's case study (Freud, 1905). Employing Lacan's contributions and ideas advanced by postmodernist thinkers, I would like to demonstrate that counter to the growing penchant to view the self as a singular, coherent, and integrated entity, Dora's analysis illustrates that the "Freudian subject," rather than a positive and coherent essence, is a loose net of contextual, contradictory, and shifting identifications enveloping not a discrete core, but its very absence.

Like all Freud's case histories, "Fragment of an Analysis of a Case of Hysteria," too, has educed a plethora of reinterpretations. In fact, Dora's case has ceased to be merely an account of one young woman's analysis and has become for many contem-

porary critics an emblem of the oppression of women in patriarchal society. Dora's aphonia, depression, fits of coughing, and suicidal gesture signify, for many feminists (e.g., Bernheimer, 1985; Gallop, 1985), symptoms not of one individual's pathology but rather symptoms of social malaise. Most recent reinterpretations of Dora's case history have thus focused on what is seen as Freud's phallocentric vision, drawing attention to his inability to recognize the importance of Dora's preoedipal ties to her mother or pointing to his failure to come to terms with his own femininity, that is, his orality and passivity (e.g., Sprengnether, 1985). Other readings (e.g., Marcus, 1985) have brought to our attention Freud's countertransferential reaction to his young and attractive patient. Hertz (1985), for example, posits that Dora's case history is a story of confused identifications. Through a textual analysis Hertz argues that Freud unconsciously identified with Dora's position; he, like Dora, felt vulnerable to the authority of his elders.

Literary and feminist commentators on Dora's case have enriched our thinking by demonstrating that each text bears the seeds of its own deconstruction. By indicating, for example, how Freud's patriarchal assumptions about the nature of female desire prevented his recognizing in time Dora's attraction to Frau K, these critics have shown that interpretations are always partial, myopic, and embedded within a particular cultural and political milieu. Reading the multiple rereadings of Dora's case, I am reminded of Lacan's (1974, p. 3) comment that it is impossible to tell the whole truth because the words that might allow one to do so are simply not there. Indeed, one cannot simply tell the whole truth. After my initial enthusiasm about discovering with the critics the multiple sub-narratives and side-plots in Dora's case history subsides, I am left with an uneasy thought: a thought that Dora's subjectivity has been reduced once again. If yesterday she was forced into the Procrustean bed of patriarchy, today she seems to be stuffed into the lean mold of feminism. Eager to uncover Freud's blind spots and to expose his masculine fallibility, recent critics, construing Dora alternately as vic-

tim or as heroine, have failed to recognize that Dora's case history offers us a far more innovative, complex, and subversive model of subjectivity.

THE SUBJECT OF DESIRE IN LACAN

Before delving into the subtleties of the case itself, it would be helpful first to explore the concept of desire, since desire, as I will shortly demonstrate, is the thread which strings together the multiple identifications comprising the "I." Desire, we may say, binds together the numerous identifications that form the cluster of our being. When speaking of desire, I refer to Lacan's conception of desire in its Hegelian sense. Lacan was influenced by Hegel (1807) through the teaching of the Hegelian interpreter, Alexandre Kojève, a Marxist philosopher whose lectures at the École des Hautes Études Lacan attended during the 1930's, along with a few other avant-garde Parisian intellectuals such as André Breton, Raymond Aron, and Georges Bataille (Macey, 1988, p. 96). While his French and Anglo-American contemporaries aspired to establish psychoanalysis under the aegis of the natural sciences, Lacan sought to bring psychoanalysis under the auspices of the humanities. Lacan was attracted to Hegel's philosophy for the very reason that it offered him the possibility of reformulating the Freudian wish in intersubjective and nonbiological terms. In Kojève's reading of Hegel, Lacan discovered a nonpositivistic framework in which to rethink the Freudian wish as well as the structure of subjectivity itself. What did Lacan find in Hegel and how did he integrate Hegel's conception of desire into his psychoanalytic thinking? Let us proceed with a summary of Hegel's formulation of human desire.

Meditating on Descartes's famous dictum, "I think, therefore I am," Hegel asks, "But what am I?" (Kojève, 1947, p. 33). The Cartesian reply, "I am a thinking being," did not satisfy Hegel. In Hegel's judgment, Descartes focused his attention solely on

the "think" and neglected the "I." Disappointed with Descartes's conclusion, Hegel set forth to explore the condition in which the "I" reveals itself (*op. cit*, p. 36). When contemplating the external world we forget ourselves, according to Hegel, and become absorbed in the object of our meditation. We lose ourselves in the object of our study. One is brought back to oneself only through desire. Only through what we lack and therefore want do we become aware of our being. Following Hegel, Kojève views desire as emerging from a sense of emptiness. While the act of thinking keeps the human in a passive quietude, desire disquiets, prodding one into action. Born of desire, action aims toward satisfying this emptiness, satisfaction that can be achieved only by "negation." The Hegelian desire can be fulfilled only by destruction, or by transformation of the desired object. To use Kojève's example: in order to satisfy hunger one must destroy or at least transform food (1947, p. 4). What distinguishes human desire from animal desire is that human desire is directed not toward a real or a "positive" entity that can be transformed and incorporated, but toward the desire of another human being. For Hegel, desire becomes human only if *one desires the desire of the other*, that is, if one wishes to be wanted, loved, or recognized by another human being. When it comes to the realm of love, for example, desire is human only if one desires not the body of the other but the other's desire. Similarly, desire directed toward a particular object, let us say gold, or toward an aim, such as becoming an artist, becomes human only if it is mediated by the desire of the Other whose desire is also directed toward the same object or aim.

In a nutshell Kojève posits that "it is human to desire what others desire, because they desire it" (p. 6). Human subjectivity comes into being only by risking one's life for the sake of satisfying one's desire, the desire to be recognized by another subject. This point in Hegel's dialectic is crucial for understanding the formation of Dora's subjectivity and therefore deserves further elaboration. It may also present a controversial juncture for

Anglo-American readers for whom the death drive seems foreign, if not implausible. Coming to our aid, Kojève explains this point clearly when he argues that to desire a desire entails wanting to substitute oneself for the value that is being desired by the Other. Without this substitution one would desire the value, the desired object, rather than the desire itself. In this way, to desire the desire of the Other is to want the other to consider my value as his or her own value.

Following Hegel, Lacan (1966a) maintained that the child acquires subjectivity through the Other. While we are born as Homo sapiens and have needs for food or shelter, we acquire our subjectivity and become human only through our desire to be recognized by another subject. In order to exist as a human, in order to acquire subjectivity, the child has to want to become the desire of the Other: first the desire of the mother and later of her substitutes. In the beginning the child does not merely wish for mother's proximity and her care, rather the child wishes to be *everything* for her. Speaking symbolically, we may say that unconsciously the child desires to be the complement of the mother, to become what she lacks and so desires, symbolically that is to say, her phallus. Identifying with the mother's desire, the child is not yet a subject per se. The child at this point is passive and subjugated, a lack or a nothing, having not yet occupied a place in a symbolic exchange.

If everything goes well, the Father, as metaphor for law and for prohibition of incest, intervenes at this point and renders this mother-child fusion impossible. Castrated, that is separated from the mother by the paternal interdiction, the child must renounce the omnipotent desire to become *everything* for the mother. In Lacan's opinion the resolution of the oedipus complex entails an important shift. The child moves from the realm of being the desire of the mother to having a limited desire that can be symbolized and expressed in language. By accepting this limitation—the fact that one cannot fulfill all that which the Other is missing—the child can accept his or her own lack and

limitation. The Lacanian desire, we must note, is markedly distinguished from a biological need. A need for food, warmth, or shelter can be quite easily satisfied. Desire, however, is insatiable. Desire can never be fulfilled because, in Lacan's view, we are inherently insufficient and lacking, and our access to the social order, to language and to the symbolic realm entails giving up the illusory sense of completeness and unity offered by the imaginary relationship to the mother.

A vignette may help anchor these concepts in the clinical experience. A talented and insightful graduate student in the humanities began to report in her psychotherapy sessions that she had begun writing poetry in an almost feverish manner. She was excited by this newly acquired passion that seemed to have seized her all of a sudden with an unusual intensity, and she explained it to herself and to me as a welcomed resurgence of a repressed childhood wish to become a famous poet. In a quite animated manner tinged with anxiety she ventured to entertain the thought that she may indeed be able to publish her newly crafted poems in a book. Within a couple of weeks her interest in poetry disappeared in the same mysterious way that it had emerged. There was no further mention of her newly acquired interest. She returned to work on her research and seemed content with it. It was only a few months later, while describing a much adored teacher in her department, that she surprised herself by recalling with some embarrassment that prior to becoming preoccupied with writing poetry, she had happened to overhear this teacher praising a female student for having published a poetry book. By writing poetry herself, my patient wished to be recognized and admired by her beloved teacher. By becoming a poet, she unconsciously attempted not just to become what she believed her teacher lacked and therefore desired, but also to annihilate her rival for her teacher's admiration and recapture her teacher's love and recognition. All this, of course, had been repressed until that moment, and so she was able to keep herself ignorant of the true motive behind her poetic aspirations.

DORA'S DESIRE AND THE DESIRE OF OTHERS

Turning back to Freud's case, I would like to examine how Dora's subjectivity was formed in relation to the desire of the Other and her wish to be recognized. Dora had been raised in a particularly skewed family constellation, and her subjectivity was thus formed not only in relation to the desire of her mother, father, and brother but also in relation to the desire of Herr and Frau K, the couple linked to Dora's family through disavowed adultery.

Dora's mother, we recall, was engaged in never-ending combat against invisible dirt. Incessantly, she cleaned her house, the household furniture, and utensils in a manner that made it almost impossible for anyone to use or, God forbid, enjoy them. Rogow (1978) who researched the life of Dora's brother, Otto Bauer, one of the most influential leaders of the Austrian Socialist Party between 1918 and 1934, reports that guests had to remove their shoes upon entering the Bauers' apartment, and adds that on Fridays and at other times of "thorough" cleaning the apartment had to be avoided altogether (p. 343). Mrs. Bauer's obsession and self-absorption did not leave much room for "normal maternal preoccupation," to use Winnicott's (1958) term. Dora's mother, it would seem, lacked a normal narcissistic investment in her daughter.

The extent to which Dora felt unrecognized by her mother is expressed in the manifest level of her first dream. In the dream a house is on fire. Her father awakens her and she dresses quickly. Her mother, however, wants to stop and save her jewel case, but her father says, "*I refuse to let myself and my two children be burnt for the sake of your jewel case*" (Freud, 1905, p. 64). The first surge of association Dora offers Freud quickly reveals that the dream was, not surprisingly, evoked by the day's residues. In the previous days, Dora relates to Freud, her parents had been engaged in a bitter dispute. By insisting on locking their dining room doors at night, her mother bars her brother's only escape

from his bedroom in case of fire. The jewel box, *Schmuckkästchen* in German, as Freud does not fail to recognize, refers through the adjective "*schmuck*," meaning "tidy," or "neat," not only to Dora's mother's passion for jewelry but also to her tormenting fervor for cleanliness. The lesson Dora derives from hearing her parents' altercation, regarding her mother's capacity for love or empathy, is no doubt profoundly disturbing.

The richness of Dora's case study, the sense that at times the text almost overflows with meanings, in contrast to its relative bareness when it comes to exploring the mother-daughter relationship is striking and confirms the observation that the realm of the preoedipal may well have been Freud's blind spot. From the meager information available I would like to propose that Dora's mother is able to accept her daughter only as her addendum. She, as Freud reported, "had no understanding of her children's more active interests" (p. 20). Dora is noticed, loved, or recognized as long as she complies with her mother's wishes, as long as she passively merges with her mother, partaking in her psychotic-like obsession. Either she joins or she is discarded. Dora, we are told, from an early age had chosen to withdraw completely from her mother's influence. She had identified and associated herself with her father. Dora, however, has to pay a psychological price for this choice. Identifying with men, she would search to love and possess a woman, like a man.

If Dora feels unrecognized by her mother, she feels betrayed by her father, whose desire for Frau K, Dora is convinced, prompts him to hand her over to Herr K in exchange for Herr K's tolerance of her father's affair with his wife. When she reproaches her father for his liaison with Frau K, when she objects to this exchange, pleading for recognition, asking her father to dismiss his mistress, her plea remains unheard. Dora's desire to remove the competitor for her father's affection remains unrecognized by her father, who replies that she must be grateful and ought not begrudge his friendship with Frau K, the woman who had saved his life. When Dora further explores this enigmatic message, she finds out, to her dismay, that when her father was

so unhappy that he resolved to put an end to his life, it was not the thought of her, his beloved daughter, that deterred him from his fateful plan. It was Frau K who, after following him into the woods, persuaded him to preserve his life for the sake of his family. It is Frau K and not herself, Dora is obliged to concede, who possesses the power to save her father's life, invigorate him, and restore his health and happiness.

Frau K, we are reminded by Freud, is not the first woman who competes with Dora for her father's desire. It was with her mother that Dora first had to struggle for her father's love. A close examination of the text reveals that in her struggle to be acknowledged by her father, Dora was obliged to come to terms with yet another female rival, with one who, while physically absent from the present cast of characters, makes her presence known to Dora through the physical scars she left on Dora's father. I am thinking of the woman from whom Dora's father contracted syphilis before his marriage to her mother. The fact that Dora does not in reality become the object of her father's desire is her good fortune. She does, however, unconsciously identify with the object of her father's desire, with Frau K, and most likely with the absent woman who caused her father to suffer from confusional attacks, paralysis, and other mental maladies associated with syphilis.

Lavishing on her attention and gifts, Herr K appears to offer Dora the recognition she craves. At first Dora may be gratified by the privileged position she occupies vis-à-vis Herr K's desire, but she is soon to discover its falsity. It is on that fateful day by the lake that Dora is finally confronted by the painful realization that Herr K's passionate declaration of love is nothing but a "generic" confession echoing an identical proposal made previously to his children's governess. As Freud correctly observes, what offends Dora is not so much that she is pursued by Herr K, but that he turns to her only when he gets nothing from his wife and nothing from the governess of his children. In her relation to her own governess, Dora's desire for recognition is similarly thwarted when she realizes that the governess's interest in and

affection for her are meant to capture her father's attention. The governess, we recall, is most obliging with Dora, treating her fondly and taking deep interest in her studies, as long as Dora's father is at home, but reacts to Dora with indifference when Dora's father is away on one of his trips.

Even with the prime object of her desire, Frau K, Dora cannot find the recognition she craves. Not that she does not enjoy unusual closeness with the mistress of her father. It was with Dora, we are told, that Frau K conferred about the hardship of her unhappy marriage with Herr K, and it was with Dora that she shared her bedroom when Dora visited the K's, while Herr K had to spend the night in other sleeping quarters. There was nothing, as Dora reveals to Freud, that she and Frau K did not discuss (Freud, 1905, p. 61). Soon, however, Dora finds the limits of this bond. She can enjoy special intimacy with Frau K as long as she leaves Frau K's liaison with her father undisturbed. Once Dora publicly accuses Herr K of pursuing her, she is quickly sacrificed by Frau K. Frau K we learn, discloses to her husband what only she knew from her friendly conversations with the young girl, that Dora secretly educated herself on sexual matters by reading Mantegazza's popular book on human reproduction. By divulging Dora's secret, the calculating Frau K supplies her husband with the ammunition he needs to rebuff Dora's accusation. The true motive behind Frau K's betrayal does not escape Dora's vigilant eye. She knows all too well that Frau K has sacrificed their intimacy not because she is concerned with her husband's reputation, but because she is eager to protect her own liaison with Dora's father.

Dora, it emerges, invariably feels betrayed and excluded from the circle of desires binding the significant others in her immediate circle. Whenever Dora gazes at the Other, she finds the Other's gaze averted toward another. The gaze of Dora's mother does not recognize Dora as a desiring being. Longing to be wanted and noticed, Dora turns to her father, whose gaze, she sees, beholds Frau K. Herr K's gaze is unreliable since it substitutes Dora for the governess of his children, or for any other

woman, treating them as interchangeable. Frau K's gaze, too, cannot be counted on, for, like Dora's governess's gaze, Frau K's gaze is meant not for her but for her father.

Throughout his work Lacan emphasizes the pivotal role of the mirror stage in the formation of the child's sense of unity. It is possible to argue, as Lacan did, that Dora's hysterical symptoms originated from an unresolved negotiation of the mirror stage. Lacan (1966b) convincingly argues that Dora failed to identify with her own body image. Having had an older brother, a year and half her senior, Dora, in Lacan's view, had identified her body image with her brother's. Through the phenomenon of transitivism, in which the child confuses her sense of self with another child's sense of self, Dora had identified herself as a male. This identification hindered Dora's gender identification and prevented her from accepting her own femininity. Lacan understands Dora's fascination with Frau K as Dora's attempt to redeem her alienated femininity. By identifying with Frau K, Dora unconsciously attempted to accept herself as a woman, that is, accept herself as an object of man's desire (Lacan, 1966b, pp. 67-68; Jalbert, 1983, pp. 323-324). While I find Lacan's analysis intriguing, I would like to suggest that matters are even more complex. Dora's identification with her brother is only one of many. At the time that Freud met Dora she may well have been searching for her alienated femininity in Frau K. Her subjectivity, however, can be understood only in relation to the entire network of desires in which, unbeknown to herself, she is so miserably ensnared.

DESIRE, IDENTIFICATION, AND THE FORMATION OF SELF

Dora's competitiveness and hostility toward men, toward her father, Herr K, and later her husband (see Deutsch, 1957), can be viewed as a derivative of her desire to be what her mother lacks. By identifying with her father, Dora unconsciously wishes

to be like her father, take on his attributes, negate him, that is to say, get rid of him and then occupy his place in her mother's desire. Dora's identification with her father represents, then, her attempt to be recognized by her mother. Dora's identification with her father, exemplified by her pursuit of knowledge, her hysterical cough, and the suicide note she leaves for her parents to find, can also be viewed as an attempt to become the complement of Frau K. By becoming like her father and taking on his symptoms, repeating, for example, his suicidal gesture, Dora unconsciously wishes to get rid of her father and take his place in Frau K's desire. She simultaneously wishes then to be like her father in order to be recognized by her mother and Frau K, and to be like Frau K so that she could be recognized by her father and Herr K. She wishes to negate her father and at the same time be like him.

The hysteric, Freud writes, in *The Interpretation of Dreams*, imitates or copies the other's symptoms or assimilates the other's traits through the process of identification. Analyzing the dream of the butcher's wife, also known as the dream of "the abandoned supper-party," Freud shows how his patient identified with her woman friend, of whom her husband constantly sang praises, in order to regain her position as the sole object of her husband's love (1900, pp. 148-151). In order to be recognized, Dora, like the butcher's wife and the graduate student in the earlier vignette, unconsciously identifies with what she believes the other wants. By forming an intimate liaison with Frau K, Dora wishes to possess the place Frau K occupies vis-à-vis her father's desire. By being like Frau K, Dora annihilates and negates her rival and assumes her place in her father's affection. Similarly, Dora's maternal preoccupation with the K's children, so pleasing to Herr K, who, we are told, was an affectionate and devoted father, earns Dora Herr K's approval. By devoting time to the K's children Dora puts herself in the place of Frau K. She annihilates and negates Frau K in an effort to win Herr K's admiration.

Lacan's formulation emphasizes Dora's preoedipal ties and

her identification with her brother and Frau K, while Freud's interpretation focuses on positive oedipal triangulation. My intention in this paper is not to embrace either line of interpretation, but to demonstrate how Dora's subjectivity comes into being through her attempt to fill her ontological void by becoming that which she unconsciously believes the other lacks and so desires. Subjectivity in this perspective is contextual and emerges like language and creativity from absence and desire. Dora's history, as I have demonstrated elsewhere (Loewenstein, 1992, 1993), cannot be reduced to a single narrative plot. Her subjectivity likewise cannot be reduced to a single *I*, whether it is a victim of patriarchal oppression or a heroine of feminist liberation. Freud's analysis, with all its pitfalls and limitations, still captures the multiplicity of Dora's "selves." Each of her several selves is composed of a cluster of identifications with one of the characters of her family drama. In claiming this, I obviously set myself apart from Kohut (1984), who maintained that a child fortunate enough to be raised in a human environment that is empathically attuned to the child's affective states and needs will "throughout his life experience himself as a cohesive, harmonious, firm unit in time and space connected with his past and pointing meaningfully into a creative-productive future. . ." (p. 52). If Kohut's work advocates the myth of the cohesive and harmonious self, Lacan's work allows us to distinguish *self* from subjectivity. Lacan's work allows us to see through the metaphor of the self as a unique, bounded substantive core within a biological body.

The psychoanalytic situation, with its emphasis on free association, creates a unique condition, one which permits the illusory bounded *self* to shed its masks and reveal its many facets. Enabling us momentarily to glimpse the fragmented and discontinuous aspect of subjectivity, the psychoanalytic encounter reveals, as Borch-Jacobsen (1988) aptly suggested, that the Freudian subject is best described as a *Dramatis Personae* (p. 9), as an amalgamation of an entire cast of characters. The metaphor of subjectivity as multiple psychic theaters has been astutely de-

veloped also by McDougall (1985), who suggests that psychoanalysis creates a stage for encountering the multiple casts of characters within the "*I*." Hermans, Kempen, and van Loon (1992), influenced by the work of the Russian literary critic Mikhail Bakhtin (1929), have similarly suggested a conceptualization of the self as a dialogical narrator. Hermans and his colleagues view the self as a dynamic field, consisting of multiple and relatively autonomous *I* positions (p. 28). Each *I* position voices an independent author narrating its experience of the world. The *I* fluctuates among diverse and often opposing positions. The *I* in one position relates to other *I's* in a dialogical manner. It may agree, disagree, understand, misunderstand, criticize, or ridicule the *I* in the other position. The metaphor of subjectivity as a dialogical narrator is a promising departure from rationalism. Approaching subjectivity from personality and social psychology perspectives, Hermans and his co-authors have failed, however, to account for the central role of desire in the creation of these *I* positions. A psychoanalytically informed theory of subjectivity must account for the role of desire in the formation of subjectivity. Postmodernism's tolerance for the discontinuous and diverse, and Lacan's insistence on the primal role of intersubjective desire in the formation of the *I* enables us to transcend the primacy of the bounded ego and the unified Kohutian self and to begin to examine alternative metaphors for subjectivity, metaphors which construe subjectivity not as a fixed enduring essence but as plural, contradictory, and provisional subjective positions fueled by absence and desire.

Before concluding, I would like to address, briefly, one other point. What are the clinical implications of this view? Do I mean to imply that our work aims at dissolving the patient's sense of being a coherent subject in the world, of having a unique identify or experiencing oneself as one? The answer to this question is, of course, a categorical No! The illusion of unity and identity, which we know as people and clinicians, and as Lévi-Strauss and Lacan do not neglect to remind us, is an absolute necessity for being in this world that is less than harmonious. When we en-

counter a patient who lacks this sense of subjective cohesion, we know we are dealing with a psychotic structure and our goal is to facilitate the process whereby the patient acquires the illusion of having a self that is coherent and relatively stable in space and time. At this point we find ourselves, once again, reminded of the dialectical and paradoxical nature of psychoanalytic thinking.

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ASCLEPIUS: MAGIC IN TRANSFERENCE TO PHYSICIANS

BY EUGENE HALPERT, M.D.

Transference to physicians contains a fantasy of the physician as omnipotent healer who can control life and death. While there may be many variations of the fantasy that reflect differences in individual psychological makeup and experience, the fantasy of a multipotentialed, bisexual figure who can magically control the forces of nature is probably an element in all transference wishes that occur in a therapeutic setting. Material from the myth of Asclepius, from a patient of Freud's, and from two of the author's patients will be examined to elucidate this transference fantasy.

It has long been known that the recognition and analysis of transferences to persons in the patient's life other than the analyst can be important in the uncovering of infantile conflict, fantasy, and memory. Analysis of transference to the analyst often leads to an understanding of some extra-analytic transferences, and vice versa. It is the purpose of this paper to explore the transferences of patients to physicians, since these relationships often embody, in a dramatic, accessible form, transference feelings and fantasies stirred by bodily illness or the fear of it. It is hoped that this exploration will help alert the analytic clinician to the transference fantasies and feelings that may be operative in any kind of therapeutic relationship. To this end, myths and rituals involved in the cult of Asclepius, the ancient Greek god of medicine, the history of a patient of Freud's, and the analysis of one of my patients will be explored. In addition, a vignette from the treatment of another patient will be reported.

THE MYTH OF ASCLEPIUS

The cult of Asclepius is thought to have begun in Thessaly. From there it spread throughout the ancient Greek world, its most well-known centers being at Epidaurus, Pergamum, the Island of Kos, and, after 420 B.C.E., the Acropolis in Athens. In 291 B.C.E. the god was brought to Rome when that city was struck by the plague. Exactly when the cult began and whether Asclepius was first seen as a gifted mortal, then became a hero, and then a demigod before being elevated to the status of god are matters of dispute among scholars. Kerenyi (1959) traced the roots as far back as 1500 B.C.E., and Martin (1987) noted that "outposts of his influence survived into the fifth century C.E. when most finally succumbed to Christianization" (p. 50).

By the fourth century C.E. over four hundred sanctuaries had been dedicated to Asclepius throughout the Hellenistic world. That the cult spread over such a wide geographic area and endured for so many centuries is indicative of the power of the myth of the physician god and how it must have resonated with the conscious and unconscious fantasies of millions of people. As E. and L. Edelstein (1945, Vol. 1) put it, "Asclepius, almost throughout antiquity, was the main representative of divine healing, a very important form of ancient medical treatment, and as such was never opposed by ancient physicians; moreover, the worship of Asclepius, beyond its medical significance, came to play such a role in the religious life of later centuries that in the final stage of paganism, of all the genuinely Greek gods, Asclepius was judged the foremost antagonist of Christ" (p. vii). We can get some sense of the intensity of feeling and the degree of healing power people invested Asclepius with from the words of Pindar (518?-ca. 438 B.C.E.):

> Such, as when erst his fostering care
> The hero Asclepius bred;
> Who first taught pain the writhing wretch to spare,
> Touch'd by whose healing hand the pale diseases fled (p. 272).

There are three events in the myth of this hero-god, who could teach pain to spare the writhing wretch, which are of special relevance to the topic of transference fantasies about physicians. These events are his birth, his raising the dead, and his own death and resurrection.

According to the oldest and most frequently told form of the myth, Asclepius was the son of the god Apollo and the nymph Coronis, who was unfaithful to Apollo while pregnant with Asclepius. As punishment for her infidelity, Apollo or his twin sister Artemis (there are two versions of the story) shot the pregnant Coronis with arrows and killed her. The dead Coronis was then placed on a funeral pyre. There are two famous ancient poetic versions of the story of Asclepius' birth. The older version is by Pindar:

> Now when by kindred hands the damsel lay
> Stretch'd on the pile sepulchral, and the flames
> Ran round; "Mine offspring thus to slay
> My soul shall ne'er endure," the god exclaims,
> "Nor leave its parent's pangs to share."
> Thus briefly, from the lifeless fair,
> Whom with one pace he reached (the pyre
> Self-opening to the saving sire),
> Away the struggling child he bare,
> And bade the Pelian Centaur sage
> Store the young mind with precepts rare
> Disease and mortal pain to suage (pp. 275-276).

The second recounting of his birth, written some five hundred years later by the Roman Ovid (43 B.C.E.-?17 C.E.), tells the same story.

While the myth and many of its details fit within the matrix outlined many years ago by Rank (1909) in his pioneering work, there are differences in the manifest content of the Asclepius birth myth and the birth myths that Rank analyzed. (The Edelsteins, in fact, state that the account of Asclepius' birth is "very singular and not paralleled in the birth saga in any other hero or

god" [1945, Vol. 2, p. 36].) Rank said that the myths of the births of heroes are distorted derivatives of the positive male oedipal conflict expressed as a family romance. He also emphasized the infantile narcissistic grandiosity and paranoid quality (father wishes to kill me) inherent in these myths. However, in the myth of the birth of Asclepius, the father is a savior as well as a killer. Apollo not only rescues the infant from the deadly consequences of his own rage, but gives birth to him symbolically. Apollo then entrusts the infant to Chiron, a centaur, who is to teach him the art of medicine. It might be argued that these features of the myth could still be encompassed by Rank's thesis; for example, the father's ambivalence, although manifestly portrayed in this myth, is displayed in a more disguised manner in the other myths in which the father is seen to be split into two—the father who wants to kill the child but entrusts the deed to another man who does not carry out the infanticide. Either he or someone else raises the boy. While this argument has its validity, it is not sufficient to explain the most striking feature of the Asclepius birth myth—that a live birth comes from a dead mother. As Kerenyi (1959) put it, "Birth in death: that is what is proclaimed in this mythologem" (p. xix). It is precisely this idea—the reversal of death and an implied method of doing it in a birth representing bisexual capacity—that I believe underlies the fantasy of the ideal physician.

The idea of a male as mother is more apparent in some other ancient Greek myths of miraculous births. For example, Dionysus' mother, Semele, died before he was born, or, according to another version, gave birth to him prematurely. The gestation was completed by his father Zeus who gave birth to him from his thigh. In the myth of Ariadne as she was worshipped on Cyprus, the goddess died in childbirth. In one of the rituals dedicated to this goddess, a young man would enact a couvade in giving birth to Ariadne's child.

Even if the myth of the birth of Asclepius is examined as a rescue fantasy, it is quite different from the rescue fantasies originally described by Freud (1900, 1910), Abraham (1922),

and Rank (1914). In those fantasies a young man rescues an important person, a disguised version of his father or mother. Freud (1910) said:

> In actual fact the 'rescue-*motif*' has a meaning and history of its own, and is an independent derivative of the mother-complex, or more accurately, of the parental complex. When a child hears that he *owes his life* to his parents, or that his mother *gave him life*, his feelings of tenderness unite with impulses which strive at power and independence, and they generate the wish to return this gift to the parents and to repay them with one of equal value. It is as though the boy's defiance were to make him say: 'I want nothing from my father; I will give him back all I have cost him.' He then forms the phantasy of *rescuing his father from danger and saving his life* (p. 172).

In the myth of Asclepius' birth it is, on the contrary, the father who rescued the son from the mother's dead and burning body. The first god of medicine, Apollo, reversed death through his feminine birth-giving capacities and passed this capacity on to his son, the future god of medicine. The idea of rescuing people from death and danger is central to the idea of the physician.

Some comments on the participants in the myth of Asclepius' birth are relevant. Apollo was the son of Zeus and was the sun god as well as the god of prophecy, music, medicine, and healing. Artemis, Apollo's twin sister, the killer of Asclepius' mother in some versions of the myth, was the virgin goddess of the forest and the hunt, and the helper of women in childbirth. She represents Apollo's feminine half as well as the life- or death-giving potential of her twin, the god of medicine. She, like her brother, is a bisexual figure. Chiron, the centaur, was considered the first physician and the inventor of herbal medicine. Like Apollo and Artemis, he was a being with more than one potential. In sum, then, the myth of the birth of Asclepius had, as one of its outstanding features, a birth that came from death. This was accomplished by a father with bisexual potential and abetted by an aunt who had similar bisexual potential. Chiron,

the creature who raised and taught the hero-god, also had more than one potential. The idea of bisexuality and multipotentiality is important to note because one element in the unconscious transference fantasy to physicians is that they are able to defeat illness and the threat of death, and to create life.

Examination of Asclepius' name and of further events in his life support the idea that life out of death, or the warding off of death, is central to the Greek image of the ideal physician. The ancients themselves commented on his name in this regard. Porphyry (232?-?304 C.E.) wrote, "Dried up means that which is too harsh. For skellein means to make harsh. Also the skeleton is that which is dried up through lack of flesh, and the name Asclepius comes from this word . . . together with the word for gentleness (Epios), that is, he who by the agency of the medical art does not permit dryness (death)" (Edelstein and Edelstein, Vol. 1, p. 124). The gentleness that was part of the picture of the ideal physician was emphasized not only in verbal descriptions but in the facial expression of his sculptural representations.

The most famous attribute of Asclepius was his ability to raise the dead. All the versions of the myth agree that Zeus killed him with a thunderbolt because he had raised the dead. However, different explanations are given for Zeus' rage. In one version it was because Asclepius raised the dead for money, that is, out of greed. More frequent among ancient explanations for Asclepius' punishment is that he had offended the laws of the Moerae (the Fates), which decreed that men must die. Zeus as the keeper of the natural order therefore had to destroy him. In other versions Asclepius' offense was that in giving men immortality, he had infringed upon the rights of other gods. Ovid, for example, had Hades complaining to Zeus that his power was being diminished: as a result of Asclepius' activity, fewer dead were coming to him. One way or another, the rule of the Olympians was being threatened; if men were immortal, they would no longer respect, obey, and worship the gods.

When Asclepius was slain by Zeus, who was his paternal grandfather, his father Apollo in a vengeful rage slew the

Cyclopes who had fashioned the thunderbolt Zeus had hurled at Asclepius. Simultaneously, he pleaded with Zeus to resurrect Asclepius. While Zeus punished Apollo for his crime, he did resurrect Asclepius. In some versions Asclepius was raised to the heavens as a star. While various vicissitudes of an oedipal struggle played out over three generations may be discerned in the myth, what I wish to call attention to is that the theme of death and resurrection runs through the myth of Asclepius from beginning to end. The essence of the fantasy of the perfect or divine physician is that he/she can defy death. It was this ability to thwart death that stirred the wishful fantasies of Asclepius' followers: through submission to this divine physician, they hoped to magically avoid death.

The early Christian proselytizers used the pagan belief in this myth to advance their attempts to gain acceptance of Christ. Justin the Apologist (ca. 100 C.E.) wrote, "And when we say also [that] . . . Jesus Christ our teacher . . . was crucified and died, and rose again and ascended to heaven, we propound nothing new and different from what you believe regarding those whom you esteem the sons of Jupiter . . . Asclepius, who, though he was a great healer, was struck by a thunderbolt and ascended to heaven" (Edelstein and Edelstein, 1945, Vol. 1, p. 177). The Christian version of the death and resurrection of a divine healer spoke to the same fears and wishes regarding death that the myth of Asclepius did.

Arlow (1961) noted, "The myth is a particular kind of communal experience. It is a special form of shared fantasy, and it serves to bring the individual into relationship with members of his cultural group on the basis of certain common needs" (p. 375). Following this line of thought, I will briefly describe some of the rites and healing methods practiced in the Asclepieia and the state of Greek medicine in antiquity in an attempt to understand the meaning of the myth to Asclepius' followers.

In Homeric times Greek physicians were generally itinerant craftsmen. Although they were respected, their therapeutic armamentarium was by modern standards almost nonexistent.

Life expectancy was short. Generally, a patient would seek treatment at one of the sanctuaries of Asclepius only after treatment by an ordinary doctor had failed. Unless one lived very close to an Asclepieia, a visit necessitated a long, tedious, costly journey. The god's chances of effecting a cure were improved by the fact that seriously ill or dying patients probably could not undertake the journey. Even if they could, they would not have been admitted to the sanctuary, since, as in all Greek temples, those near death were prohibited from entering lest they die and pollute the holiness of the shrine.

At an Asclepieia the pilgrims would bathe, make offerings, and then be led to the abaton, the place of incubation, where they lay on the floor to sleep and to dream. For it was through dreams that Asclepius healed. In these dreams (or in hypnagogic or hypnopompic experiences) the god himself or his representation as a snake or a dog was supposed to appear to the dreamer and either cure him/her directly by touching, kissing, or licking the affected body part or by telling the dreamer what regimen to follow in order to be cured. According to Martin (1987), "The therapeutae (the Asclepian priests) then would interpret and record the dream, which was the mystery of the cure" (p. 51).

This use of dreams must be understood in terms of the ancient Greek attitude toward dreams. The Greeks classified dreams as a subspecies of divination which, according to Martin, "was the most pervasive example of Hellenistic piety. Like philosophy, it assumed a finite and rational cosmos in which everything . . . was subject to the same sympathetic forces. Diviners revealed an order of things by claiming to 'read' or understand the sympathetic parallels within the cosmos" (pp. 40-41). Dreaming was one of the most ancient techniques of divination. The only complete work on dreams that has survived from antiquity is a work Freud (1900) discussed, the *Oneirocritica* of Artemidorus (second century C.E.). Martin (1987) stated, "Artemidorus' dream theory presupposed the threefold classification of

dreams common in antiquity: the . . . oracular dream, the non-predictive dream, and the oneiros or predictive dream. . . . He omitted the oracular dream from his considerations, as it belonged to the specialized practices of the so-called incubation cults and rarely occurred apart from their domain" (p. 49).

The myth, its accompanying rites, and dream interpretations were, of course, looked upon differently in antiquity from the way we view them now, but it is possible to extract from them something of value for understanding the transference fantasies of present-day patients to physicians. The longing for an omnipotent healer, which was as universal among frightened, ill patients in antiquity as it is among modern-day sufferers, was fostered by the shared beliefs of their fellow sufferers and the priests. They all believed that if they followed the rites, if they dreamed of the god as they were encouraged to do, and then carried out the suggestions that stemmed from the interpretation of the dreams, they could be cured of whatever ailed them. In short, the wish for a magical omnipotent healer and the hope of obtaining a cure for every conceivable physical ailment were ever present. In analysis (or in relation to an extra-analytic healer) this wish arises spontaneously. It expresses itself in dreams and in the total relationship to the analytic healer, but rather than being encouraged or supported, it becomes a subject for analysis, a point of possible entry into the unconscious infantile world of the patient.

Having reviewed the myth of Asclepius as well as some aspects of the cultural milieu of his cult, I will present some material dealing with more modern fantasies about physicians.

FREUD'S PATIENT: H.D.

H.D. (Hilda Doolittle), the American imagist poet and author, spent her adult life in Europe. She was treated by Freud for two and a half months in the spring of 1933 and for a little more

than a month in late 1934. Her dedication at the beginning of her *Tribute to Freud* (1956) reads as follows: "To Sigmund Freud, blameless physician." This is a direct reference to Freud as Asclepius. H.D. wrote in this memoir:

> It was Asclepius of the Greeks who was called the blameless physician. . . . This half-man, half-god (fate decreed) went a little too far when he actually began to raise the dead. . . . Our Professor stood this side of the portal. He did not pretend to bring back the dead who had already crossed the threshold. But he raised from dead hearts and stricken minds and maladjusted bodies a host of living children. . . . One of these children was called Mignon. Not my name certainly. It is true I was small for my age, mignonne; but I was not, they said, pretty. . ." (p. 101).

In other passages as well as in this one H.D. reveals a persistent transference fantasy of Freud as Asclepius, a physician who stood at the gate between life and death, who could prevent death and bring the dead back to life. I say persistent transference fantasy because these memoirs were written in the fall of 1944, some five years after Freud's death. That H.D. had such a fantasy is understandable. She had a lifelong preoccupation with the ancient classical world, particularly that of Greece. Swann (1962) noted, "H.D. has been called an inspired anachronism, a Greek reborn into modern times. No recent poet, perhaps, has been more indebted to Euripides, Sappho, Homer, . . . and other classical models" (p. 3). Swann noted further that of eighty-nine poems listed in her collected poems, "thirty-five have an unmistakable classical reference in their titles" (p. 3). Beyond this ready-made surface from which H.D. could choose a character from Greek mythology to personify her transference to Freud lay unconscious motivations for choosing Asclepius. H.D. had been concerned about death and dying since early childhood, and threads of this concern weave their way through her life, her work, and her memoirs. Take, for example, the following from the *Tribute*:

> Things happen that these people try to hide from us; a boy drowns in the river, a workman at the steel mill loses a limb, a foreigner or, as they say sometimes at the backdoor, 'a little stranger' has arrived somewhat prematurely somewhere. All these mysterious, apparently unrelated events, overheard hiding under the kitchen table, or gathered or inferred, whispering with other inarticulate but nonetheless intuitively gifted fellow-whisperers of one's own age . . . have to do with, or in some ways suggest, a doctor. . . . A doctor has a bag with strange things in it, steel and knives and scissors. Our father is not a doctor but he has a doctor's picture . . . in his study. He is quiet and strangely tender when we are ill. He likes to tell people he had hesitated for a long time before deciding on his profession, that doctors have always said that he should have been one of them. (p. 26).

In these few sentences H.D. outlined childhood fears and concerns about death, injury, and loss of body parts as well as curiosity about sex and birth. She associated these concerns with doctors who, in her mind, held sway over life, death, and injury. Doctors in turn were associated with her father, a mathematician, astronomer, and Ph.D. doctor. She wished for some interest and tenderness from her father, who related to his children in an abstract, intellectualized way when he related to them at all. According to Swann (1962), William Carlos Williams, an occasional dinner guest at the Doolittles, said that Dr. Doolittle was a "tall, gaunt man who seldom even at table focused on anything nearer, literally, than the moon" (p. 14).

H.D. felt isolated from her mother as well. She stayed as close as possible to the brother she felt was her mother's favorite so that she might feel close to her mother. That male and female, mother and father, were fused in her mind is indicated by a few lines from one of her poems.

> what is this mother-father
> to tear at our entrails?
> what is this unsatisfied duality
> which you can not satisfy? (1956, p. xii).

Separation and loss through death were themes in her life. Although she had five male siblings, she was the only surviving female; two sisters had died in infancy. Her first child was stillborn, a favorite brother was killed in World War I, and her father died shortly thereafter. She herself nearly died of bilateral pneumonia while pregnant. She had not only feared for her own life but for that of the unborn baby. During the time she saw Freud he was seventy-seven and had been ill with recurrent cancer for ten years. She knew of his illness even before she saw him. References to death, dying, and resurrection abound in the *Tribute* as well as in her other writings. For example, in the *Tribute* she wrote, "Is it possible that I (leaping over every sort of intellectual impediment and obstacle) not only wished, but *knew*, the Professor would be born again?" (p. 39).

H.D. also wrote about her fantasy of giving her life for Freud's, as Alcestis did for her husband in Euripides' play: ". . . the play is going on now—at any rate we are acting it, the old Professor and I. He is Hercules struggling with Death and he is the beloved, about to die. Moreover he himself, in his own character, has made the dead live, has summoned a host of dead and dying children from the living tomb" (p. 74). Faced with the prospect of Freud's death and, in her mind, of her own, she insisted to herself in fantasy that Freud, like Asclepius or Christ, would be reborn and would resurrect others. She simultaneously imagined him to be the male hero, Hercules, and the female heroine, Alcestis. As Hercules, Freud would successfully wrestle with Death and bring H.D. back to life. As Alcestis, Freud would be the female heroine, "the beloved, about to die," who comes back to life.

In summary, then, in H.D.'s transference to Freud the physician, Freud embodied both male and female principles and, like the prototypical physician of her beloved Greece, Asclepius, he could magically make the dead live and summon people, particularly children, from the grave. Her wish to summon children from the grave probably refers to her sisters who died in infancy as well as to her stillborn child.

CASE EXAMPLES

It is not necessary for a person to have ever heard of Asclepius to form a transference fantasy about a physician that embodies the elements outlined in the review of H.D.'s story. While the most detailed material I will present is from the analysis of a patient who knew a great deal about Asclepius, a vignette from a patient who never mentioned him will illustrate that the fantasies contain essentially the same elements.

Case No. 1

A single young woman with a widespread knowledge of mythology had been in analysis for about one year when she began to have mild spotting between her periods. This woman, who was approaching her thirtieth birthday, had come for treatment because certain characterological symptoms had prevented her from reaching her goals of love, marriage, and motherhood. The approach of this birthday was fraught with particularly intense feelings as she wondered whether she would ever form a loving relationship and get married before she was too old to have children. Up to this point in treatment, derivatives of her wish to have a child by me had been particularly prominent. They became even more prominent as she approached and passed the ninth month of treatment and again, a few months later, as her dread thirtieth birthday drew near.

In the session in which she first mentioned her spotting, she spoke of being jealous of two slightly younger friends who were both pregnant with their second child. She wondered, "Will I ever feel life in me? Will I ever give birth? Or will I just get old and go to my grave childless? I bet you had children when you were young too, I mean that your wife had them." A few minutes later she mentioned that she was spotting although she was in the middle of her menstrual cycle. She went on talking without any further direct reference to the spotting or any disguised

reference to it that I could recognize. I then said that it was curious she had made no further mention of her spotting, since it was an unusual occurrence which I imagined she must be worried about, especially since she had mentioned it after talking about her fear of going to her grave childless. She replied, "I'm more than worried, I'm terrified. I've never spotted before, and the first thing I think of is cancer. I don't want to talk about it. It scares me too much. I thought of making an appointment with my doctor, but I think maybe it will stop. Maybe it's nothing. Maybe it's just caused psychologically by all these feelings and thoughts I've been having about pregnancies and babies and you. I hoped that you would make it go away either by making an interpretation or by ignoring it. Somehow, I felt that if you didn't say anything about it, then it would mean that it wasn't significant, that it wasn't cancer." I commented that she was so scared that she wanted to believe I was all-powerful so that one way or another I would protect her from its being cancer or would cure her. She wept as she replied, "If it's cancer, I have death in me rather than life. They'll take my womb out. I'll not only never have a child but I'll die. I know that it doesn't have to be cancer but that seems to be the only thing that I think about. Yes, I want you to say something that will make it go away, make it something else. As if you could say abracadabra and make it go away."

The next session she reported that she had continued to have some mild spotting and had called her gynecologist. She had arranged for an appointment with him to follow her next session. That night, the eve of her appointment with the gynecologist, she dreamed:

> I was walking to the doctor's office on my way to my appointment with him. All of a sudden I heard what sounded like a dog panting behind me. You know how dogs make me uneasy. Yet somehow I wasn't uneasy in the dream. When I turned around, a long-haired dog, I don't know what kind, was there. This is the embarrassing part. He began sniffing at me [long

pause] between my legs. Then he put his head under my skirt and began licking.

Her first associations had to do with her anxiety about her visit to the doctor after this session. He was an excellent physician: he had saved the life of a friend who had nearly bled to death from a ruptured fibroid. The two pregnant friends she had been talking about were also his patients. One of the two had had difficulty conceiving the first time, and it was due to this doctor's skill that she finally succeeded. The friend called him a miracle worker. The patient said that she wished he was indeed a miracle worker who would save her from bleeding and possible death, as well as preserve her capacity to bear children. She commented that she actually did not know whether she was going to see this doctor or his female partner. The female doctor, whom the patient had seen before, also enjoyed an excellent reputation.

At this point about two thirds of the session had gone by, and I commented that she had not said anything about the dog. She said she felt embarrassed and was aware that she was avoiding talking about the dog. Her first thoughts were that when she said she couldn't recognize what kind of dog it was, she meant what sex it was. It could have been either male or female. As with the doctor, she did not know which she was going to see, the male or the female. The idea of the doctor as a dog led her to Asclepius. She noted, "Asclepius often appeared as a dog, and healing dogs were kept in his temples. If they licked the injured or sick part of the person, it was supposed to be healed. I must be even more scared than I think, to be reduced to the level of wanting to be magically healed with a lick. Have I ever told you that when I was little, whenever I got hurt I would run to my mother or father. They would kiss me where I hurt to make it better. That was our little ritual. Even when I was really sick and they would take me to the doctor, they would kiss me and hug me and rub me to make me feel better."

Before I proceed with the patient's story, some comments on her associations to Asclepius via the dog are relevant. The dog and the snake were both theriomorphic forms of the god. As the patient noted, his devotees believed that to be licked on the afflicted body part was a method of cure. Snakes as well as dogs were kept in the temple. While sacred snakes could be found in the temples of other gods, dogs seem to have been unique to Asclepius. According to Kerenyi (1959), "There is a striking equivalence of dog and snake in Greek mythology of the underworld; their forms merge and their meanings as well. 'Dogs,' says an ancient exegete, 'are also snakes.' The equation can only be taken to mean that both animals may express the same psychic content" (p. 32). Among the ancient Greeks (and among the cultures of pre-Columbian Mesoamerica) the snake was seen as a symbol of regeneration and rebirth: from the observation that snakes shed their skins came the idea that they were being reborn. The idea of the regenerative power of the snake may contribute to its image as a phallic symbol, as well as to the Greeks' equating the dog with the snake. The image of a dog is often evoked in the context of a fear of dying, or of actual death, as a representation of the mother (Halpert, 1980).

When my patient associated to Asclepius, I was surprised. While I had listened to her dream, my own thoughts had been that the dog was a representation of me. Her session occurred when she was on her way to the doctor, I sat behind her, and patients on occasion had referred in dreams to my baldness by its opposite, hairiness. In the context of her coming visit to the doctor and her concern about it, and because she was working productively, I did not intrude with any of my own ideas. The possibility that her interpretation of her spotting as a sign of cancer reflected her fear of punishment for incestuous wishes was for the moment outweighed by the more immediate concern of working with her fear and her denial so that she would take appropriate action and go to the doctor.

As it turned out, the cause of the spotting was a benign cervical erosion. About two weeks later she returned to the dream.

As she came into my office that morning, she noticed a woman walking a dog across the street; it was the dog she had seen in her dream. She flushed and said, "I think that dream must have had something to do with you as well as with the other doctor. Who am I kidding? I'm sure I've known that all along. It was just too much to tell you at the time. When you told me that I hadn't said anything about the dog, I thought to myself why are you always so goddamned nosey. As soon as I thought that, I realized that you were the dog. But how could I say that then? It is almost too embarrassing now."

Over the next several sessions we were able to piece together her wish for the gynecologist to be like me and for me to be like that doctor. She endowed us both with the magical curative powers of Asclepius. She wanted both of us to keep her from dying and wanted me to look up her vagina, as she knew the gynecologist would, tell her what was wrong, and heal it with a kiss. Her transference fantasies to both me and the gynecologist derived from the multiple unconscious meanings of the kisses from both her parents when she was ill or hurt as a child. These meanings, which became ever more clear, revolved around her own bisexual fantasies, her incestuous impregnation fantasies, her wish to excite me, her castration fantasies, and her wish for a phallus.

Case No. 2

The patient was a middle-aged man in psychotherapy who was preoccupied with the fear of having a heart attack and dying. Several months after he began his therapy with me, his doctor had a heart attack. The patient came to a session the day after he had heard this news and looked shaken. He told me, "X has just had a massive coronary. They say they don't even know whether he is going to make it. I can't believe that he could die. I can't believe that he could get sick." When I asked him about this belief, he laughed and said, "I know it's possible for a doctor

to get sick and die, yet somehow I don't believe it. Somehow I think of them as being immune. Maybe it's because I've seen X pull my uncle from the brink of death and have heard similar stories from friends who also go to him. That's why I chose him as my doctor. Maybe it's because, if he can have a heart attack, then he really doesn't know all the answers and I could have one too. Maybe it has to do with all these feelings about my father that we've been talking about." This referred to his increasing awareness of his long-repressed murderous feelings toward his father. I said that he seemed to need to elevate X and doctors in general to a position of immortality out of fear that if X could die, his father could die, and he could die. He responded, "I don't think doctors are Jesus Christ or God. You think I'm waiting around for the resurrection?" I said, "I think you don't even want to get to the point where you would have to be resurrected." He laughed and said, "Well, Doc, you're right about that. I don't want to die. Maybe there is something to the idea that I want to hedge my bets, that just in case I was dying I'd want X there, or somebody to pull me back. Have you taken any good CPR courses lately, Doc?"

His alarm at his doctor's illness was also related to his fear of his own parricidal wishes. The doctor who, he believed, had all the answers was a representation of his dominating, controlling father who behaved as if he had all the answers and the patient knew nothing. The patient had felt this as a child and as an adult. It was only since he had been in treatment that he had become aware of his hatred of his father and its relationship to his fear of dying from a heart attack. The idealization of the physician and the wish for him to be omnipotent served as a defense against his aggression toward his father. In his fantasy, if the physician is invulnerable, then the patient could never be responsible for killing him. The idea of an invulnerable physician helped to relieve him of the guilt for his intense parricidal wishes. The image of the caring, omnipotent physician thus served, through reaction formation and denial, to defend against conflictual aggressive drive derivatives in this case. It

would seem to be the case generally. Asclepius' father, Apollo, nearly murdered him, and did murder his mother before he rescued Asclepius. Seeing the snake, one theriomorphic form of the god, only as an agent of healing and regeneration serves also to deny the fact that some snakes can and do kill, and that the paternal phallus which it can unconsciously represent is often given destructive as well as creative powers.

DISCUSSION

For millenia, physicians have held a special place both in society and in individuals' thoughts and feelings. In antiquity and in more primitive societies even to this day, the wish for cure of pain, illness, and injury was and is expressed as conscious magical expectations. These expectations occur in the context of the cultural beliefs about and shared fantasies of the causes of illness, pain, and death. Today in the minds of even the most educated, sophisticated people, the figure of the physician is often consciously or unconsciously imbued with magical powers. If one stops to reflect on why this should be, several things suggest themselves. First, any serious injury or illness causes some threat of helplessness. The psychological consequences of this vary from individual to individual, depending on the structure of the ego and the intrapsychic meanings of helplessness and of the particular illness to the afflicted person. Whatever the variations, though, all of us experience some wish for mastery or for a person who can master these things for us. It is not surprising that there is regression at times of physical illness, or the threat of it; thus, a person like my first patient fantasized being cured by both her gynecologist and her analyst with a kiss on her genitals, just as she had felt healed by her parents' magical kisses in childhood. Regression of various kinds—ego, superego, narcissistic—during physical illness is an everyday phenomenon. This is true even when the illness is not of a serious nature. Freud (1914) noted, "It is universally known, and we

take it as a matter of course, that a person who is tormented by organic pain and discomfort gives up his interest in the things of the external world, in so far as they do not concern his suffering" (p. 82).

It is this narcissistic threat to and regression of the ego which is most basic to an individual's unconsciously transferring to the physician the magical powers that were invested in parents in early childhood. Every physical symptom or illness, from the mildest to the most severe, may in the unconscious fantasy world of any individual, be interpreted as a harbinger of death. Even people who are not hypochondriacs, when experiencing some illness or pain that they know poses no threat to life, will make comments like "I feel like I'm dead" or "I feel like I'm dying." These comments may be taken as derivative manifestations of the ego's alertness to any threat to the body as a threat to the ego itself. As Freud (1923) noted, the ego is first and foremost a body ego.

Freud wrote extensively about death. In *Inhibitions, Symptoms and Anxiety* (1926), he stated:

> But nothing resembling death can ever have been experienced; or if it has, as in fainting, it has left no observable traces behind. I am therefore inclined to adhere to the view that the fear of death should be regarded as analogous to the fear of castration and that the situation to which the ego is reacting is one of being abandoned by the protecting super-ego—the powers of destiny—so that it no longer has any safeguard against all the dangers that surround it (p. 130).

What I believe Freud meant is that since we can only fantasize about what it is like to die, to be dead, the fantasies have to be based on known dangers, the dangers of loss, separation, and castration. When Freud spoke of the fear of death in terms of abandonment by the protecting superego, he was speaking of abandonment by the incorporated maternal and paternal object representations which form a core part of the superego. Therefore, in unconscious fantasy death poses the threat of the entire

hierarchy of dangers outlined by Freud: the loss of the object, the loss of the object's love, castration, and the loss of superego approval. It is small wonder, then, that anxiety and regression to infantile modes of mental functioning occur when physical symptoms appear. It is also small wonder that our mental representation of the person we turn to in the face of the threat of death, the physician, will involve the transference of all the powers of the childhood objects we dreaded losing in death.

In considering the threat of loss posed by death, and the myth of Asclepius being resurrected and raised to heaven, it is interesting to note that Pollack (1975) traced the origin of the concept of heaven to the wish for a regressive symbiotic reunion with the archaic mother as a defense against object loss. The image of the ideal omnipotent physician may also represent, as it did most clearly with my second patient, a defense against both the patient's aggression, which is aroused by the threat of injury and loss, and the physician's unconsciously feared aggression. (Apollo murdered Asclepius' mother and nearly murdered him.)

Freud (1913), in speaking of the human response to the threat of death, wrote,

> The Moerae [the Fates] were created as a result of the discovery that warned man that he too is a part of nature and subject to the immutable law of death. Something in man was bound to struggle against this subjection, for it is only with extreme unwillingness that he gives up his claim to an exceptional position. Man, as we know, makes use of his imaginative activity in order to satisfy the wishes that reality does not satisfy (p. 299).

In creating the image of the ideal physician, Asclepius, the people of classical antiquity were exercising the imaginative activity that Freud spoke of, to deal with the anxiety aroused by the "subjection to the immutable law of death." They created a shared transference figure who was born out of death, learned through the perfecting of his healing craft to bring others back

from the dead, and was finally brought back from death himself. Like Christ, who took over Asclepius' devotees, he offered the promise of the defeat of illness and death.

While in many ways the people of modern-day industrialized society share cultures and beliefs far different from those of the ancient Greeks, Romans, and other peoples who believed in Asclepius, there are nonetheless commonalities in the realm of ego functioning and unconscious fantasy formation. In the face of pain, illness, or death, it would seem that the ego activities of humankind have much in common, whether in the ancient world or in the present. Thus H.D. and my first patient could actually reach out specifically to the image of the ancient Greek god of medicine, Asclepius, to express transference fantasies about the analyst as physician. Most patients will not use the image of Asclepius, but will nonetheless express some of the same underlying components of the transference fantasy when confronted with questions of physical illness and death.

The study of the details of the myth of Asclepius, of the life and memoir of H.D., and of patients points to a common fantasy of the physician having the power to heal all hurts and to control the question of life and death. Physicians are seen as parents are in the earliest stages of development—as having everything, including the attributes and potential of both sexes. While there may be many variations of the fantasy reflecting variations in individual psychological makeup and experience, the fantasy of a multipotentialed, bisexual, omnipotent figure who can magically control the forces of nature is probably an element in all transference wishes for cure, including those that occur in analysis.

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CONFLICT AND DEFICIT

BOOK REVIEW ESSAY ON *CONFLICT AND COMPROMISE: THERAPEUTIC IMPLICATIONS*[1]

BY MERTON M. GILL, M.D.

Because of its combination of theoretical and clinical material and its detailed and frank confrontation of opposing views, the recent publication of the volume *Conflict and Compromise*, which I believe would be more correctly entitled *Conflict and Deficit*, provides an opportunity for a discussion of a major current issue in psychoanalysis. The principal, and indeed, only protagonist of the deficit argument is Paul Ornstein, while all the other participants, nine in all, uphold the conflict position with greater or lesser exclusiveness.

Part I: Theory

One of the leading misunderstandings in the debate is that Ornstein is considered to be rejecting the concept of conflict, when in fact he is not. It would be an error, however, to say simply that he wishes deficit to be accorded equal stature with conflict, for he accords conflict a role secondary to deficit. In so doing, he is in fact following a primary line of Kohutian self psychological thought. Indeed, the conflict between that self psychology and what I will call mainstream analysis, as a neutral term, is clearly a major background to this volume.

Manifestly, the dispute is about the theory of neurosogenesis, or

[1] *Conflict and Compromise: Therapeutic Implications* edited by Scott Dowling, M.D.; Madison, CT: International Universities Press, Inc., 1991. This book was published as a monograph in the Workshop Series of the American Psychoanalytic Association. The Workshop for Mental Health Professionals, from which the monographs derive, addresses subjects that are of current concern to psychoanalysts and are considered to be of interest to the mental health community at large.

Unless otherwise noted, all page numbers cited refer to the volume under review.

in a more familiar idiom about the relationship between the intrapsychic and the interpersonal, or more generally, in my opinion, about the relative roles of the intrapsychic, whether innate or secondarily internalized, and the environment.

Ornstein argues that Arlow is in fact proposing a change in Freud's theory of neurosogenesis, although Arlow does not seem to recognize that. Ornstein draws this conclusion from Arlow's definition of trauma (another way in which the subject matter of this book could be described is in terms of the relationship between trauma and drive) as "a special vicissitude of development, seen in the context of continuing intrapsychic conflict" (p. 7).

Such a definition prejudges the issue, since it declares intrapsychic conflict to be the context within which all development takes place. The use of the idea of development is in fact a disguised reference to deficit, inasmuch as deficit, in the context of those who argue for it as a phenomenon distinct from and perhaps even prior to conflict, is the intrapsychic consequence of trauma.

That development does indeed pertain to deficit in this material may be seen in Boesky's references to Anna Freud as an authority who, he alleges, agrees with his position. His citation from Anna Freud (1974) is important enough in the argument to be quoted in full:

> It would be convenient to take the point of view that success or failure on the developmental lines primarily shapes the personalities which secondarily become involved in internal conflict [this is Ornstein's position]. But any statement of this kind would be a gross falsification *once the infant ceases to be an undifferentiated, unstructured being*. It would ignore the temporal relations between the two processes which occur simultaneously, not subsequent to each other. Progress on the [developmental] lines is interfered with constantly by conflict, repression, and consequent regression, while the conflicts themselves and quite especially the methods available for their solution are wholly dependent on the shape and the level of personal development [read psychic structure] which had been reached. However different in origin the two types of psychopathology are, in the clinical picture they are totally intertwined, a fact which accounts for their usually being treated as one (italics added, pp. 181-182; in A. Freud, 1974, pp. 70-71).

I have emphasized the clause, "once the infant ceases to be an undifferentiated, unstructured being," because the crux of the ar-

gument may lie there. Is there ever a time when the infant has no structure? And may it not be that in this early time trauma plays a role leading to deficit, or at least to alteration from normal or desirable structure?

Robert Tyson argues in this volume that the "appearance of psychic conflict is something of a developmental achievement when the necessary components have become available" (p. 33). He suggests that the infant "is not capable of beginning to experience conflict until early in the second year of life" (p. 34). May it not be that defects in psychic structure can therefore occur in the first year of life? Can these not be, in the language of self psychology, the result of failure of the selfobjects, or in more usual language, of deprivation, or, even in the language of this monograph, of trauma?

Actually, Anna Freud's statement seems to me to contradict her view that there is an innate enmity between drive and ego (1936). The issue is clearly related to different views of whether or not the infant is a structured human being from the beginning. Surely, it is generally agreed that the drives are present from the beginning, although for example, Loewald (1978) and Kernberg (1988) argue that they are secondarily formed. Furthermore, is current research on infancy not also demonstrating that the infant's traffic with the environment is present from the beginning? Again I suggest that the truly underlying theme in the dispute between concepts of conflict and deficit is that of the relative roles of drive and experience.

Boesky echoes Anna Freud's view when he says that the "developmental structures in the preverbal phase to which Ornstein is alluding represent the primitive psychological substrate and therefore are in a very different frame of reference [than in the structural model]" (pp. 182-183), but nowhere that I can find does Ornstein say that his view of deficit essentially relates to preverbal life. In fact it is clear that Ornstein finds deficit in all less than optimal functioning.

Arlow cites Anna Freud too, but this citation seems even more clearly to agree with Ornstein. She writes (1974): "We can . . . differentiate between two types of infantile psychopathology. The one based on conflict is responsible for anxiety states and the . . . infantile neuroses; the one based on developmental defects [deficit?],

for the psychosomatic symptomatology, the backwardness, the atypical and borderline states" (p. 70). And further: "Where deprivation and frustration [trauma, failure of selfobjects?] are excessive, this leads not to symptom formation, but to developmental setbacks [deficit?!]. It is only in the later course of differentiation and structuralization that the resultant deviations from normal growth become involved in phase-adequate internal conflicts as they are known to us" (p. 71).

That the issue of the relative roles of drive and experience underlies Arlow's argument becomes apparent when he writes, soon after citing Anna Freud: "For the most part, proponents of this approach [how 'the deficit concept has been applied'; the 'claim that . . . there is failure to establish clear boundaries between the self and the object'] impute the origin of deficits to inadequate or unempathic mothering and tend to trace the traumatic factors to the preverbal period of life" (p. 8).

In my view this is the familiar charge that self psychologists attach too much importance to experience and empathy. The relating of the charge to the preverbal period is a red herring, as I believe I can demonstrate when I come to discussing the disputed interpretations of the clinical material in the volume.

But first, I continue the theme of the relative roles of drive and experience.

The blurring and minimization of the role of experience may be seen in Boesky's comments too. In his initial presentation Boesky says that modern structural theory includes four components, namely, "drive derivatives, unpleasant affects . . . , defenses, and superego aspects." But then, almost as an afterthought, he says that these must be linked "to the cardinal danger situations of childhood" (p. 16), which of course is the experiential factor. But in his rebuttal to Ornstein he says that the "methodology . . . for validation in the structural model is predicated on the . . . interrelatedness of the drives . . . the defenses, . . . the pleasure principle, the affects, and the superego. . . . Everything that happens in the mind affects everything else in the mind" (p. 181). "In the mind": experience has disappeared from the formulation!

Boesky is thoroughly aware of the importance of experience. He refers to it primarily as "object relations." He says that since *Inhibitions, Symptoms and Anxiety* (Freud, 1926), structural theory has

been an object relations theory (p. 17). He says that "with his [Freud's] description of the cardinal dangers of childhood he welded structural theory to object relations" (p. 17). Pace Boesky, the seam is not very tight! Boesky even seems to ascribe the origin of affect to experience. He writes that "Freud described the origin of these affects as lying in the unspeakable horrors which haunt the childhood of mankind" (p. 17). Of course I know that he agrees with Freud that affect is a drive derivative. I am only trying to show how leaky indeed is the seam. Boesky admits that "the structural model has had little to offer about the interaction of the analyst and patient" (p. 188), but it is not clear whether he means this in principle or whether he means only that adherents of the structural model have failed to take this factor adequately into account.

When Boesky first lists the ways in which analysis has changed (pp. 25-26), he does not list recognition of the importance of object relations, but later on the same page he does include object relations in listing phenomena of which our understanding has substantially altered. And indeed when he comes to discuss object relations as such, he says that "the object relationship is never a separate component of a compromise formation; it is part of every single one of the components of conflict which comprise the compromise formation" (p. 28). He states, "Nor have those who advocate the use of structural theory ever forgotten about the critical importance of object relations" (p. 27). Ornstein is handicapped in emphasizing the role of object relations because he is an advocate of self psychology, and, lest they be branded as interpersonalists, many self psychologists shy away from recognizing the centrality of object relations in self psychology practice, as well as in theory. I should note that many analysts distinguish between object relations and interpersonal relations, considering the former to be the intrapsychic experience of the latter as externally observed in "social psychology."

Boesky is well aware that the issue is one of the role of experience. He writes: "Ornstein wished that the authors would have said more about how reality becomes etiologically significant in pathogenesis. . . . So do I, but that, alas, has been the quest of every psychoanalyst since Freud. It is puzzling that our inability to give the final answer to this question suggests to him that highly important events in the life of the child 'no longer count' [for proponents

of conflict against deficit]" (p. 187). Boesky's citation is tendentious. What Ornstein actually wrote is this: "Boesky did list reality as one of the components of conflict as well as compromise, but without explaining how it becomes an etiologically significant part of psychopathology. Do such expectable life-events as the birth or death of a sibling, or loss of a parent no longer count as potentially traumatic? Should these be considered simply as 'special vicissitude[s] of development in the context of continuing intrapsychic conflict' "? (p. 162). I too referred to this definition of trauma by Arlow (p. 7). Of course Ornstein knows that Boesky knows that such events are potentially traumatic and that he deals with them exhaustively in his practice. But Ornstein is asking about their role in *theory*. Boesky says we cannot give a "*final answer*" to that question. Even if not final, does Ornstein's view of deficit provide nothing toward an answer to that question?

Mayer writes later in the volume that she interprets Ornstein as correctly saying that "our theory of technique has given short shrift to these aspects of the analytic engagement as well as to how complex they are" (p. 204). I will later question whether this is simply a matter of the theory of technique.

Boesky says that another question Ornstein asks is more interesting than the one about how reality becomes etiologically significant in pathogenesis. I would have thought this latter is truly an interesting question. Tyson says that Ornstein "has greatly broadened the scope of the discussion beyond the original charge" (p. 194). That was presumably to discuss conflict and compromise. But, as Tyson acknowledges, to invite Ornstein, a prominent self psychologist, to discuss the issues from his point of view inevitably meant that Ornstein would have to discuss the relationship of conflict and deficit.

Boesky says he would prefer to state the question of how reality is etiologically significant in pathogenesis by saying that "the problem is how to better understand the differences and similarities between normal and pathological development" (p. 187). But I believe, as I suggested in discussing Anna Freud's views, that to frame the question in terms of development obscures the underlying issue of the relationship between drive and reality (experience).

The second question which Ornstein asks and which Boesky finds more interesting is about the "mode of therapeutic action and

[specifically] the relation between insight and relational factors" (p. 187). Here again "relational factors" surely refers to experience, and as I have suggested, for Ornstein experience in turn implies reality, which implies potential trauma, which implies potential deficit. Indeed, to place the problem in terms of the therapeutic relation is an implicit recognition that we are not dealing simply with the preverbal period of an infant but with a general question about psychological functioning, with the more specific issue being the role of reality.

There is much discussion in the volume of the several authors' understanding of the position of the concept of conflict in theory. All the authors except Ornstein explicitly regard it as an aspect of structural theory. By the latter, of course, they mean the Freudian theory of id, ego, and superego. It is interesting, by the way, and I think correct, that Boesky suggests that the term "ego psychology" is a metonym for the tripartite structural theory, a part standing for the whole.

One way to characterize the central issue of the monograph is how to place object relations in the structural theory. Boesky is clear on the point: "An object relationship cannot and should not be tacked on to *id*, *ego*, and *superego* as a fourth dimension of compromise formation, because the terms represent very different frames of reference" (p. 27). All the authors except Ornstein write as though the concept of deficit violates the structural theory, that is, is somehow incompatible with it.

That would seem to be true if one argues that psychoanalysis is solely an intrapsychic theory. How then shall we integrate the interpersonal or, more generally, experience with the structural model? A major issue in much contemporary theory in psychoanalysis, as Boesky said, is how to conceptualize the role of experience in our model of the human psyche. Mayer's effort, which I mentioned, to relegate the problem to one of technique rather than basic theory, is simply to sweep it under the rug.

A frequent way the problem is expressed is in terms of the relationship between the intrapsychic and the interpersonal. As I said above, the term interpersonal has unfortunately developed the apparently ineradicable connotation that it refers to experience as viewed from outside the psyche. As the self psychologists usually put it, and indeed Ornstein does so in this volume, the interper-

sonal is a matter of social psychology rather than psychoanalysis, because psychoanalysis is concerned only with the intrapsychic. In other words, the interpersonal becomes psychoanalytically meaningful only as it is experienced in the psyche, that is, in psychic reality.

So the problem that is being struggled with is the relationship between psychic and external, or as Freud often put it, material (*materiellen*) reality. Strachey (1966, p. 373, n. 1) notes that this central distinction first appeared as far back as the *Project*, in which Freud (1895) wrote about "indications of reality—but of thought-reality not of external reality" (p. 373). Freud used as equivalents the terms external, factual, and material reality, counterposed to thought or psychic reality.

Psychoanalytic consideration of the role of external reality has been discussed under various headings which have yet to be integrated with one another. A major chapter in the psychoanalytic theory of external reality is dealt with under the rubric of adaptation. Hartmann's magnum opus was on ego psychology and the problem of adaptation (1939). He also wrote in greater detail on the reality principle (1956).

Epistemology has become an issue much discussed in current analytic theory in connection with the idea of psychoanalysis as a hermeneutic science as well as the proposal of a constructivist model (Hoffman, 1991a) as against a positivist model. Mainstream psychoanalysis assumes a positivist model. Hartmann, for example, accepted a positivist model. He did not even raise any explicit question about the issue, although his writing on the reality principle made much of the concept of the social determination of what one considers reality to be and in writing of how the process of analysis corrects "distortions," while he did not surround the word distortion by quotation marks, he did put them around the word "objective" (1956, p. 265).

The issue has also found its way into the metapsychological points of view. In 1959 David Rapaport and I proposed adding adaptive and genetic aspects to the usual structural, dynamic, and economic viewpoints. We stated: "*The adaptive point of view demands that the psycho-analytic explanation of any psychological phenomenon include propositions concerning its relationship to the environment*" (p. 159). Our proposal was quickly adopted by mainstream psychoanalysis

and is still generally accepted, although Glover (1961) and Schafer (1970) raised objections. They said that adaptive and genetic considerations could be expressed in the three already existing points of view: the structural, dynamic, and economic. In effect, they were maintaining the view that psychoanalysis proper is purely intrapsychic. I later wrote a critique of Freudian metapsychology (Gill, 1976).

A major clarification of the controversy lies in the difference between the description of reality as it appears to an external observer and how it is experienced by the subject. Freud (1916-1917) said that "*in the world of the neuroses it is psychical reality which is the decisive kind*" (p. 368, emphasis in the original). In mainstream analysis that formula has been altered to read: In the world of psychoanalysis, it sometimes seems as though psychical reality is the *only* kind.

That latter formula would seem to be consistent with a constructivist view of reality, but it is not. It is consistent only with radical constructivism (Benjamin, 1991; reply to her by Hoffman, 1991b; Bernstein, 1983), according to which we cannot assume an external reality. Ordinary constructivisim holds only that we can never know reality except as it is mediated by our own beings; and since we differ from one another in one manner or another and one degree or another, our views of reality differ in one respect or another. Hence, although we can reach consensual agreement in our view of reality, we must always allow for the plausibility and usefulness of other views of that reality. As the issue is often expressed, the criterion of validity of a particular view of reality is not correspondence with an unknowable reality as such but only of comprehensiveness and consistency. To these must be added that external facts are not contravened. If the patient's parents have been divorced, that is an external fact. What it means to the child (and others) are constructions. It is only in radical constructivism that "anything goes," that is, that any version of reality is as good as any other.

In the present context, the issue appears in terms of what constitutes a "trauma." In the view in which only psychic reality matters, a trauma can never be described in external terms but only in terms of psychic reality. A trauma to one person may be a boon to another.

But this abstract principle falters when certain situations come

into consideration. Arlow says, for example: "What is traumatic is not inherent in the nature of the experience, except perhaps in the most extreme forms of abuse" (p. 6), but who is to determine what is extreme abuse? Arlow says, quite correctly, "In psychoanalysis trauma is a retrospective concept. Looking backwards, when the analytic evidence indicates that a particular event, situation, happening, or relationship had an adverse or noxious effect upon the individual's development, only then do we invoke the concept of trauma" (p. 6). But does not the same reasoning apply to deficit? The difference is only that the word trauma emphasizes the external event, whereas the word deficit emphasizes the intrapsychic effect of the event. The argument arises from the fact that mainstream analysts do not recognize that when interpersonalists, object relationists, and self psychologists speak of deficit, they usually *do* mean the intrapsychic result of the event. And of course they attribute relatively more importance to events than do mainstream analysts. Furthermore, mainstream analysts mistakenly consider that in their emphasis on the event—as it is intrapsychically experienced—these other psychoanalysts are necessarily denying or at least inappropriately minimizing the role of drive. Once again, I say the struggle is really about the relative importance of event or drive.

Mainstream analysts, as in this monograph under review, use different words than deficit to convey the same idea. They are willing to speak of ego weakness, even of Freud's concept of congenital ego vulnerabilities, but they do not recognize the equivalence of such concepts to the concept of deficit.

Why not? There are reasons in addition to their conviction that drives are not being recognized. An important one is that the idea of deficit connotes to many—and it cannot be denied that it is sometimes so dealt with by some self psychologists—an absence of something, a hole in the psyche. The notion of a hole in the psyche, of course, makes no sense. Psychic structure may be other than desirable, but it cannot be absent. Perhaps it is the idea that something can be absent from structure which plays a role in mainstream analysts' believing that the concept of deficit is incompatible with structural theory.

The idea of a hole in the psyche can exert a pernicious effect on both theory and practice, because a manifest subjective sense of

deficit or absence on the part of the analysand may be accepted by the analyst without further investigation. To the mainstream analyst, a manifest subjective sense of deficit is simply a point of origin for the further investigation and analysis of this sense of deficit. The point has been made a number of times in our literature. Kohut provides some basis for this criticism of self psychology in his concepts of "self state dreams" (1977) and "empty depression," even in the concept of fragmentation. Unfortunately, these terms—certainly the last two—are sometimes not dealt with by self psychologists as metaphors, which is all that they are. So again we have the familiar charge against self psychologists. Not only do they allegedly deny drive—and mainstream analysts find, of course, that the analysis of these metaphors leads to drive issues—but they allegedly accept the superficial manifest conscious instead of probing for the underlying hidden unconscious.

Yet another connotation of deficit accounts for its rejection by mainstream analysts, and that is the implication that a deficit calls for remedial activity on the analyst's part, to make up for what is missing. That, of course, lands us squarely into the issue of activity on the analyst's part, something which is forbidden by the whole system of conceptualization which may be summarized under the concept of neutrality. The way that problem often appears, as it does in this monograph, is under the concept of "corrective emotional experience."

Here the solid ranks against the concept of deficit begin to waver. In our literature more generally, and in this monograph too, corrective emotional experience—shorn of Alexander's use of the concept to urge role playing by the analyst—finds growing acceptance. Boesky writes: "My prediction is that as we refine our criteria of evidence and learn more about the interrelation between insight and relational factors we will discover that the sharp distinction between these two categories masks the complexity of the manner in which they are interrelated" (p. 187). And, "In my opinion the profound importance of the interaction between the patient and analyst is indisputable" (p. 187). By the way, in my opinion Boesky errs when he says that "Freud insisted on the importance of relational matters when he quarantined the unobjectionable positive transference to protect it from being analyzed away too soon" (p. 187). Freud did indeed insist on the importance of the unobjec-

tionable positive transference, but rather than being concerned about its being analyzed away *too soon*, he never suggested it be analyzed away at all (Gill, 1982; Kanzer, 1980; Stein, 1981) except in the very general sense that he argued for the impossible, namely, that transference should be totally "resolved."

Part II: Clinical Material

The ideas about theory and the theory of technique which I dealt with in Part I can be clearly exemplified in the clinical material presented in the volume and the controversies about its understanding in which the authors engage.

Boesky offers a nice example of the patient's effort to engage the analyst in an interaction which he was able to detect and refrain from. "A woman in analysis was embarrassed to describe her wish to have her husband 'do a certain sexual thing to her.' . . . [She] demanded that I should say something more. . . . All that she wanted was that I should just talk to her. Obviously she did not mean that literally since I was indeed speaking to her. At about this time she blurted out that she wanted her husband to perform cunnilingus. . . . [H]er enactment with me expressed the defensively altered forbidden wish to make me also use my tongue on her by forcing me to talk" (p. 21).

By the way, it might be argued that this example refutes my contention that there is unceasing interaction in the analytic situation (Gill, 1991). I would counter that the analyst's refusal to talk—that is, in the way that the patient wanted him to—was an action. More generally, granted the context of the analytic situation, the analyst's silence is as much an interaction as his or her speech. Of course, his or her silence may mean no more than: "Go ahead. I'm listening. . . ." Lipton (1977) has argued that the only justifiable reason for the analyst to be silent is that he or she is listening. If the analyst is silent for some other reason, it represents an attempt to influence the patient by manipulation without disclosing what the analyst wants.

Mayer presents a case which provides an interesting illustration of how an apparently very well-conducted analysis may betray the analyst's bias toward the greater importance of drive over experience. She describes a woman with a negative oedipal fantasy who

became depressed when she became pregnant. Mayer's explanation is, among other issues of course, that the patient felt she was pregnant by the wrong person, since it was her mother by whom she wanted to have a baby. Mayer writes: "It is when reality challenges or conforms to crucial unconscious *fantasies* that it takes on special significance in reorganizing intrapsychic equilibrium" (pp. 61-62). A major issue in the analysis was indeed the patient's wish for intimacy with her female analyst. But we are also told that when the patient was five, her mother spent a year in a tuberculosis sanitarium, during which the patient saw her rarely. She recalled how sad and lonely the year had felt. Is it not possible that this reality event calls for more prominence in the understanding of the case, in addition to that accorded the negative oedipal fantasy? I am not arguing against the validity of Mayer's formulation, but I am suggesting that this may be an example of how theory determines the analyst's relative weighting of drive and reality in explaining a case.

I can make a similar point, and indeed Mayer herself does so, with regard to the relative roles of reconstruction of the past and work in the here-and-now transference. Mayer raises the point by asking why an analysis takes so long. She tells us that "the last three years of [this four-year] analysis added remarkably little to what I had felt able intellectually to formulate . . . quite early in the analysis. . . . It [analysis] takes a long time because gaining a lively experience of what those formulations really mean in an immediate and day-to-day way happens very gradually and, most of the time, not very dramatically" (pp. 56-57). Even this formulation fails at first to make explicit that it was a *transference* interaction which made the formulation come to life. Heralded by a slip and an event in the patient's outside life which involved the analyst apparently in a peripheral way, the patient's jealousy and bitterness first became explicit in the transference. It had been hidden by an enactment of the transference by way of the outside relationship.

So I can ask, is it possible that a conviction of the centrality of a continuing transference/countertransference interaction might have led to this insight sooner? And, to return to the previous point, is it possible that a greater openness to deficit as compared to drive might have meant that the understandings of the case would have included important insights beyond those which were clear after only one year?

For example, after the hidden transference came to light, Mayer writes that "I was reminded of my earliest meetings with Annette and what had happened with her complaints about her husband. Annette's sense of injury had been powerful but no complaint, once explicit, quite stood up to scrutiny" (p. 59). What if the analyst had sought to find out how this line of investigation was experienced by the patient? Might the patient not have felt abashed, even attacked, and might the long honeymoon Mayer describes have ended sooner? I know how arrogant this second-guessing of an analyst may sound to the reader, but I remind him/her that Freud (1937) said the only way to shorten analysis is to do it better.

Mayer, in my opinion, correctly, albeit gently, criticizes Brenner for writing, " 'In a therapeutic setting, transference is analyzed *rather than* reacted to in any other way. . . . Only in psychoanalytic therapy [note how the use of this phrase rather than simply psychoanalysis implies that psychoanalytic technique can be done in other than psychoanalysis proper; I elaborate the point in another place (Gill, 1984)] does the object of transference *limit* her or his reaction to analyzing it . . .' " (Mayer, p. 200, italics added; Brenner, p. 102). Mayer continues: "I would alter those sentences slightly. [!] For me, psychoanalytic therapy is not precisely defined by the fact that the analyst/therapist [again broadening the context in which one can speak of psychoanalytic technique] *limits* his or her engagement with transference to analyzing it. Partly, I don't actually find that such limitation turns out to be possible, even with the most stringent attention to how I interact with my patients and the most careful efforts to maintain 'analyzing' as my top priority with patients. But more to the point, I hear it as a misemphasis in *defining* what for me makes therapeutic work analytic" (pp. 200-201). Mayer goes on to make the same points about technique that I (Gill, 1979) and a number of others—for example, Ferenczi (1955), Racker (1968), and Natterson (1991)—have been arguing for years. Brenner's position is a loud echo of Eissler's (1953) position, presumably abandoned by many, if not most, even mainstream psychoanalysts, that in true psychoanalysis "parameters" must ultimately be reduced to zero.

Mayer goes on to say, however, that she does not agree with Ornstein's contention that she has abandoned the "particular conflict and compromise theory which most of us have enunciated in

these papers" (p. 201). No, she has not abandoned it, but she has added the validity of the idea of deficit in her "emphasis on the relational elements of the transference" and this emphasis is indeed not "really an outcome of our [most of the participants'] conflict model . . ." (p. 202).

But Mayer relents: "Having said all that. . . . I think it is important to recognize that what I have called a straw man in Dr. Ornstein's critique has not been as absent from . . . *formal theory* and therefore clinical practice as we might like to think" (p. 203, italics added). Mayer goes on to describe the issue as one of *technique* and argues, correctly and insightfully in my view, that "many things which analysts have subsumed in vague terms like *tact* and *timing* should not remain so vague or so extraneous to our formal theory of technique" (p. 204). Again she refers to "formal theory," but now to theory of technique. My argument is that she has in effect admitted without realizing it that formal theory, from which, after all, the theory of technique flows, should include the phenomena which Ornstein refers to as deficit. Finally, Mayer says, "Deficits are a reality . . . [which] become . . . embroiled in . . . structural conflict, from very early on [again a hint that there may be prestructural deficit]" (p. 204). Ornstein does not dispute the embroilment of deficit in conflict, but his argument is unacceptable to most because he not only questions the time-honored relative weighting of drive and experience in traditional psychoanalytic theory but also adds the actually separate argument that there is an important sense in which experience is superordinate to drive. That latter argument is obscured by the fact that the superordinacy is ascribed to the self, not to experience. I take no position on that latter point in this essay. One reason is that I do not want to obscure my main argument here.

Kafka's first illustration enables me to point to a fairly subtle example of the difference between his technique and the technique which flows from seeing the transference as codetermined. He makes concessions to what is ordinarily considered strictly correct technique because of what he calls his patient's "mistaken prejudgments" with regard to such matters as fees for missed appointments and flexibility in changing appointments. Most pointedly in this regard he says that "she insisted on relating to me according to the view that I am a domineering, demanding person, despite the ab-

sence of supporting evidence to that effect" (p. 71). In other words, he implies that her view was made of whole cloth. It happened that the patient was sufficiently convinced that her "experience of the treatment was incorrect" (p. 71) and she entered analysis. My view is that it is an error to say that she had no evidence to support her "incorrect" prejudgments. The extrinsic rituals of the analytic situation—granted that the patient was only gradually eased into analysis—the couch, the frequency, the anonymity—were selectively (Hoffman, 1983), even plausibly (Gill, 1982) taken by the patient to validate her preconceptions. For me "selective" and "plausible" rather than "incorrect" are more than the substitution of mollifying terms to pacify the patient. They betoken both a significantly different theory as well as atmosphere.

One might say that one cannot quarrel with success, and Kafka's technique was apparently finally successful. I would still maintain that the difference I am suggesting might in some cases make the difference between success and failure.

Ornstein comes close to making the same point about Kafka's work that I have, but he too speaks of the patient's views as "distortions." He criticizes Kafka for "directly correcting the distortions" rather than exploring the patient's feelings (p. 144). He suggests that Kafka's approach might result in iatrogenically provoked intensification" (p. 144) of the patient's resistances. Boesky, usually a very careful disputant, distorts Ornstein's remarks and alleges him to have said that "Kafka showed no interest in the patient's subjective experience of him" (p. 184) and that "Ornstein believes that most of the resistances described by Kafka were iatrogenic" (p. 185). Ornstein said neither of these things. (Kafka later quotes him correctly about the intensification of a resistance [p. 207].) I am sure Boesky's distortions were not deliberate. They attest, rather, to the heat of this discussion.

Kafka becomes quite openly exercised. He quotes Ornstein as saying that "it is important to focus 'primarily on the patient's inner experience' " (p. 207). What Ornstein actually said was that "Kafka . . . does not *directly* pursue his patient's subjective experience of him" (p. 143, italics added). Ornstein would have been less subject to misunderstanding if he had said that Kafka did not pursue the manner in which his behavior was selectively and plausibly interpreted by the patient as supporting his contentions. Kafka later

quotes him correctly. Here is an example of how, at least as his account is presented in this volume, Kafka failed to *directly* pursue the patient's experience of him. It relates to the issue of homosexuality in Kafka's second patient. Kafka says this: ". . . after a party at which a woman seemed attracted to him, the patient dreamed he was a space explorer, far removed from earth. I suggested the interpretation that he seemed to remove himself from human contact in the dream. This was followed by the patient's picking up a homosexual partner for a sexual fling, which I again interpreted as an effort to present himself as independent in the sense of not needing others" (p. 74). The interpretation seems odd to me. Might not picking up a partner imply that the patient *does* need others? Might not his action have been designed to show that he did not need the *analyst*? Again I am aware of the dangers of second guessing a clinical report, and, of course, the interpretation I suggest may well be wrong, but is it not a necessary part of our discussions to indicate how we might have done differently in a clinical situation? Is it then also possible that the patient was stung by the analyst's interpretation and was moved to show the analyst he did need others but not the *analyst*? I know the rejoinder may be "Yes, that is a possible interpretation but many interpretations are possible." My point is not that it is a possible interpretation but that it is a different kind of interpretation—one in which the analyst seeks to know how the patient may have responded to an interpretation as a suggestion with transference significance (Gill, 1991) as well as a proposal about the dynamics of the neurosis.

Actually Kafka went further with his interpretation of this episode. As Ornstein also notes, Kafka said "Perhaps, I ventured, he had never surmounted his disappointment and anger at his mother, who, he might well have thought, had betrayed and abandoned him when he reached adolescence" (p. 74).

Ornstein says that Kafka told us that the patient was emotionally uninvolved and asks whether the patient might not have had this same perception of his own experience in the analysis and expressed it in his dream (p. 145). That is a good question, but an interactional model would ask another question: Did the patient experience the analyst as aloof—plausibly, I would say, given the traditional analytic stance—and might this not have been expressed in his continuing his own aloof behavior? Ornstein's suggestion is

an example of what Kohut (1977) described as a self-state dream interpretation, objected to by many mainstream analysts because it is based solely on manifest content. But Kafka seems to be using the manifest content similarly.

Ornstein correctly points out that Kafka responded to the situation with a genetic interpretation about what the patient had missed from his mother. I (Gill, 1982) have suggested that a genetic interpretation is often a flight from the transference, or at least is often less effective in a particular situation than a transference interpretation. Ornstein's interest is in showing what the patient missed from his mother to buttress his view of the importance of deficit. In fact, the patient may well have missed his mother long before he was sent away to boarding school. Kafka emphasizes that as a trauma, but he also tells us that the mother was a painter who spent most of her days at her studio where she could not be interrupted (p. 73).

Kafka asks how Ornstein could know "from a selected, disguised description of part of what took place in the early months of a treatment, used to illustrate a particular point, that the treatment was unsuccessful" (p. 208). But that is not what Ornstein said. And Kafka did say, with regard to his interpretations which Ornstein criticized, "This line of interpretation seemed to have no effect" (p. 74); then Kafka makes a transference interpretation of the kind Ornstein asks for; and, as Kafka reports, "this seemed more meaningful to him" (p. 74).

Kafka writes: "I want to reassure Dr. Ornstein that he need have no fear that I failed the man who took refuge in a homosexual adventure, by neglecting to discuss with him the many reasons he had for doing so" (p. 209), and he proceeds to detail some of the dynamics which were uncovered. But Ornstein was speaking only of how Kafka dealt with the specific sequence described of an experience, a dream, its interpretation, a behavior apparently in response to the interpretation, and the interpretation of the behavior. In a second instance of the patient's homosexual exposure, Kafka does indeed tell us this was a transference response to the analyst's announcement of a vacation.

Kafka complains that Ornstein is overlooking that his presentation was designed to illustrate a particular point, namely, that he wanted to describe "one way of dealing with a particular problem

presented by some patients . . . who had little understanding that they had psychological problems, and little interest in talking about themselves" (p. 207). I believe that Ornstein was attempting to show that Kafka could have accomplished this goal even more successfully had he followed a different technique. In fact, Ornstein does say, "Regarding his immediate goal of engaging his two reluctant patients in analysis, Kafka succeeded" (p. 142). Kafka mentions but does not highlight the fact that both of the patients he describes were not at first in full-scale analysis. For me, that demonstrates yet again that analytic technique, especially as improved in line with Ornstein's criticisms, can be used in less than full-scale analysis (Gill, 1984).

Kafka actually does call for taking experience seriously in pathogenesis and indeed in human functioning generally: ". . . the influence of the individual's context, and especially of the interrelationship with objects, the influence of experience, is profound" (p. 206). He says his "technical approach [helps the patient to] consider how . . . the interrelations of the internal context of mental conditions and the external context of his relationship to his world . . . influenced his theories . . . his modes of dealing with his inner aims . . . his adaptation" (p. 206). Again, as does Mayer, he speaks of his "technical approach" but I say it does not occupy an adequate role in his "formal theory" of the psyche.

In the interest of collegiality, I suppose, Kafka says, "There are kernels of truth in Dr. Ornstein's discussion," but these turn out to be as nonspecific as "it is worthwhile to hear a variety of views" (p. 212). What he feels more strongly is that "[Ornstein] did not listen to what I said" (p. 207) and that Ornstein numbers himself among "those presenters of a putatively remarkable, new, fundamentally different paradigm" (p. 212). I suggest that the tone is inappropriate, but it does show that feelings run high here. In my opinion, Ornstein has listened to Kafka more than Kafka has listened to Ornstein.

Actually, Kafka says: "I do not think the concept of deficit is erroneous. I have a concept of deficit, and once wrote about cognitive problems and their influence in a patient's development and on his analysis" (p. 210). The reference Kafka gives is to his paper (1984) in *The Psychoanalytic Quarterly*, "Cognitive Difficulties in Psychoanalysis." It is indeed about a patient with a cognitive deficit, but

Ornstein is talking about an affective, interpersonal deficit in object relations, not a cognitive deficit.

Willick comes closest of the authors to agreeing with Ornstein. One of the outstanding features of the analysis he describes is that because he felt the patient could not start the sessions on her own, he did so. But in doing so, he did indeed recognize her deficit in object relations and responded to it in his behavior rather than adopting the "correct" stance of the silent analyst. It is not clear how thoroughly he analyzed this interaction. He recognizes deficit but believes that those who do tend to attribute it to the earliest years of life and to inadequate mothering. He fears that someone who adopts this point of view will not see how the deficit is involved with conflict and therefore will fail to analyze the problem adequately. He argues that it is very difficult to differentiate between conflict and deficit in clinical work (p. 93), yet he describes in detail his patient's inability to maintain an image of him when away from him, and he ascribes the problem to her fantasies about being adopted. He says these fantasies "are derived primarily from experiences and conflicts which took place with the adoptive parents" (p. 89). Finally, he asks, "What kind of mother left Carol with such uncertainty about her basic security?" (*ibid.*).

But he rejects Ornstein's contention that he is not really being true to his model of conflict. He prefers to speak of ego defect, but he does speak of deficit as well. He says that "it is important to understand that such deficits are intimately related to and intertwined with psychic conflict" (p. 93). Does he think Ornstein would disagree with this? What he is really objecting to is Ornstein's view that conflict can be based on deficit as well as vice versa. Ornstein says that conflict can be "secondary."

Another way in which Willick can continue to maintain that he disagrees with Ornstein, even though he actually agrees with him in large measure, is to offer a definition of drive which subsumes Ornstein's selfobject concepts. As I said, it is self psychology's altered position on drive which underlies much of the dispute in the book. Willick writes: "My use of the concepts of sexual and aggressive drives is much broader than Dr. Ornstein seems to believe. I include under the heading of sexual drives all those longings to be loved, to be loved exclusively with no rival, to be special, and to be on the mind of the loved object incessantly. I also include wishes to

be admired, praised, adored, respected, and understood . . . all the aspects of [my patient's] aggressive drive as well, those feelings of rage, envy, murderous intent, rivalry, and competitiveness. . . . I find nothing in the language that I used to describe Carol's thoughts and behavior that cannot be explained within the drive-defense, compromise formation model, provided that the model includes the sexual and aggressive drive derivatives in their broadest sense" (pp. 216-217). And, as if this is not enough, "that broad sense includes all the aspects of narcissistic vulnerabilities, narcissistic defenses, and narcissistic fantasies which accompany the development of object relations throughout childhood and adolescence"! (p. 217). With that description of drive, Ornstein could join the drive-defense, compromise formation club too, although he might still be blackballed for ascribing superordinacy to the self, actually a concept related to his view of the primacy of deficit resulting from inadequate mothering.

A final point of confusion is the question of what kinds of disorder require the use of a concept of deficit. Willick titles his paper "Working with Conflict and Deficit in Borderline and Narcissistic Patients." Where other authors also concede a point to Ornstein, it is in regard to such pathology rather than to the ordinary "oedipal neuroses" considered the best kind in terms of analyzability. Ornstein is not confining his contentions to narcissistic personality disorder, nor would I. The confusion arises from the history of Kohut's development of self psychology. At first he argued for his point of view only in relation to so-called narcissistic personality disorders. But the self psychology point of view is now considered to apply to all development, whether normal or pathological. The idea expressed by a number of the authors that Ornstein is referring only to deficit arising in the first few months of life is wrong. Again, Ornstein is open to such a misunderstanding not only because originally selfobject deficit was described primarily in terms of archaic selfobjects but mainly because Ornstein should, in my opinion, be expressing his point not merely in terms of deficit but in terms of object relations and the relative roles of drive and experience in psychic life.

Finally, the issue is indeed one of basic theory, not just technique. Ornstein recognizes this. He writes: "Modifications [in technique] were indeed introduced but these were essentially relegated to a

mere 'technical necessity' in the particular instance, without a correlated attempt at generalization and change in theory as a result" (p. 154).

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BOOK REVIEWS

MAPPING THE MIND. THE INTERSECTION OF PSYCHOANALYSIS AND NEUROSCIENCE. By Fred M. Levin. Hillsdale, NJ/London: The Analytic Press, 1991. 264 pp.

In *Mapping the Mind*, Fred Levin invites the interested and steadfast reader on an unabashedly speculative journey to the interface of psychoanalysis and related disciplines—not only neuroscience, but also cognitive psychology, infant observational research, learning theory, etc. Wielding his voluminous fund of knowledge, he gradually fashions a developmental perspective that draws on selected psychoanalytic principles (weighted especially toward self psychology), specific features of neuroanatomic growth in early childhood and throughout the life cycle, learning theory, new information about the function of neural structures, and specific theories of infant development. In this process, he establishes correlations between brain development and core sense of self, between the (presumed) special effectiveness of metaphor in interpretation and the bridging of hierarchically organized memory systems, between information-processing theory and REM cycles, between REM and nonREM cycles and transference/nontransference states, between therapeutic action and hemispheric integration, and so on. These bold, provocative, and stimulating ideas are presented with varying types and depths of scientific support; some are from primary sources but others are clearly filtered through theory.

Altogether, Levin's energy and enthusiasm, his creative leaps and original correlations, seem to cut through concerns about level of abstraction, autonomous scientific disciplines, indeed the fundamental question of how he thinks about the relationship of psychological experience to brain events. This may reduce the appeal of this book for some sophisticated readers, since Levin is outspoken in his wish to draw analogies and thereby assert connections between neural structure and function and human psychology as he understands it, with little deference paid to philosophical refinements.

On the other hand, a reader only moderately familiar with neuroscience research and little versed in philosophy of science controversies may be awed by this tour de force, wherein Levin not

only attempts to integrate the exploding field of neuroscience with psychoanalytic principles but also includes literature from a vast array of related disciplines. At times this reader felt numbed by the kaleidoscopic effect of correlations between scientific perspectives that are addressing very different levels of inquiry and abstraction, while the author is examining topics that, within the single discipline of psychoanalysis, generate considerable controversy. For example, he devotes several chapters to the importance of nonverbal communication in the transference relationship, first presenting theory and research findings from sciences which examine different aspects of language and communication, then postulating—on the basis of an information-processing theory of REM and non-REM cycling—an analogous process in the production of transference and nontransference states, and then presenting a clinical example which is introduced by a reference to brain localization of prosody and its importance in early (preverbal) communication of affect. To this reader, the clinical example, colored as it is by Levin's favored psychoanalytic bias, gains little from this adventurous, interesting, and admittedly speculative theorizing, but rather touches on issues within our own discipline that productively occupy contemporary psychoanalysts—e.g., re-examinations of dichotomous notions of action versus words, the nature and origins of preverbal memory and its "capture" in psychoanalytic treatment, interactive versus intrapsychic interpretation, the overarching notions of enactment, and actualization in the transference, to name a few.

Moreover, the notion that psychoanalysis needs to mature as a scientific discipline, in order to "continue to command the respect of the scientific world" (p. 186) appears to be gaining momentum from various quarters. Some would argue that what is needed is not so much an attempt to "relate exactly" the psychological and the biological (indeed, that this is not possible—as per Edelson[1]), but is rather the evolution of a research methodology aimed at testing the hypotheses *within* the science of psychoanalysis itself. Certainly, there are others who envision our scientific development as dependent on precisely the kind of interdisciplinary integration that is Levin's forte.

[1] Edelson, M. (1986): The convergence of psychoanalysis and neuroscience: illusion and reality. *Contemp. Psychoanal.*, 22:479-519.

While Levin is appropriately modest in his assessment of his attempts to "stretch our knowledge" and establish correlations with neuroscience, his speculations are fascinating and, I think, most successfully focused on issues that bear on *changes* in mental functioning—for example, the well-characterized changes of cognitive capacities during childhood development, or the changes observed in successful treatment. In the former, "brain" seems most clearly to have an impact on "mind" while the opposite seems to operate in the latter, although, of course, the reverse applies to both. Research on cognitive development and patterns of brain growth provide a thought-provoking backdrop for psychoanalytic theories of development, and have already been usefully applied to reassessments of postulated origins of psychopathology (see for example, Westen,[2] Cooper,[3] Weil,[4] etc.) and clinical reconstructions.

Levin's effort, like many far less ambitious attempts to reconcile psychoanalytic thinking with observable phenomena, is subject to the criticism that it is "not psychoanalytic." This kind of insular thinking may be the negative counterpart of Levin's freewheeling exploration, but, I think, it is ultimately more damaging to our field. Dialogue and interdisciplinary research enrich psychoanalysis and relate us to the natural and social sciences, which we can hardly afford to disdain. Levin's bold intellectual journey documents an ongoing dialogue, and I applaud him for it; pragmatic considerations regarding who will do the research and who will support it, financially and academically, are understandably not included here. Unfortunately, those concerns impinge even less on the average practicing psychoanalyst[5] and ultimately consign such adventures to the periphery of our field.

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[2] Westen, D. (1990): Towards a revised theory of borderline object relations: contributions of empirical research. *Int. J. Psychoanal.*, 71:661-693.

[3] Cooper, A. M. (1993): Paranoia: a part of most analyses. *J. Amer. Psychoanal. Assn.*, 41:423-442.

[4] Weil, A. P. (1985): Thoughts about early pathology. *J. Amer. Psychoanal. Assn.*, 33:335-352.

[5] Reiser, M. (1993): Unpublished address to the Faculty of the New York Psychoanalytic Institute: Psychoanalytic Research: Its Place in the Psychoanalytic Curriculum. June 3.

MEMORY'S VOICE. DECIPHERING THE BRAIN-MIND CODE. By Daniel L. Alkon, M.D. New York: HarperCollins Publishers, 1992. 285 pp.

Whether one dates the origins of psychoanalysis to the publication of *On Aphasia* (1891), to the writing of the *Project* (1895), or to the writing of *The Interpretation of Dreams* (1899), the present decade marks our centennial. It also happens to have been declared "The Decade of the Brain" by the neurobiological community. Despite shared roots in nineteenth century philosophy and medicine, the two disciplines have pursued separate courses of development since. Thus, the decade of the 1890's was also the decade of Ramón y Cajal and the establishment of the neuron doctrine. Freud was an early adherent to what was, at the time, a hotly disputed *hypothesis.*[1] His attempt, in the *Project*, to construct a neurological model of mental functioning depended heavily on the concept of structurally independent neurons which were connected to one another at "contact barriers." It was not until the first decade of the next century that Sherrington proposed the name "synapse" for these *hypothesized* structures. By then Freud seems to have come to the conclusion that the data available to him would not support a workable neurobiological model of the mind. Psychoanalysis had become a separate discipline, and the problem of the relation of the phenomena it studied to the underlying workings of the nervous system seemed, with passage of time, to be less and less pertinent. Alkon, if nothing else, provides us with the opportunity to assess the relevance, for our field, of some of the dramatic developments in neurobiology since Freud turned to a purely mentalistic metaphor in his effort to explain human psychology. Not the least of the questions which will arise in the mind of the reader of this volume will be: To what extent, and in what areas, would Freud's conceptualizations have been affected had he been in possession of the sort of information Alkon reviews? A related question is: To what extent are the findings of modern neurobiology relevant to the theory and practice of psychoanalysis?

[1] Actual demonstration of structurally discrete neurons in apposition to other discrete neurons did not happen until the 1950's, with the advent of the electron microscope.

Regrettably, from these standpoints, the areas in which the author provides new information seem to have limited applicability to the day-to-day practice of psychoanalysis. His life's work appears to have been devoted to the understanding of how neuronal bodies, and complex neuronal systems, are modified by the stimulus ambience in which they are placed. There appears to be little doubt that modification does occur—that neurons are modified by experience. "Memories" are, in fact, encoded on cellular membranes in the form of alterations in ion channels. There are, in addition, changes within the cell cytoplasm which affect the expression of both DNA and RNA. The description of his and others' work with regard to these revolutionary discoveries constitutes one thematic thread in the book. It is a fascinating story that cannot help but grip the reader's attention.

It is also a very human story, one in which the foibles and idiosyncracies of investigators, including the author, are described in some detail. What is lacking is a coherent hypothesis that deals with how these events at the neuronal level are expressed at the complex systemic level on which psychoanalysis (or, for that matter, any other psychology) operates. Alkon does recognize that his science is not much better prepared to address the phenomena with which clinicians must deal than were his scientific ancestors a century ago. Regrettably, he invokes a Pavlovian model to bridge the chasm between his work and the problems of the clinic. Descriptions of his science are intertwined with accounts of highly complex human dilemmas. In recounting the latter, he tends to reduce the origins of the clinical problem to a single overriding source of malevolent influence.

Fathers, in particular, have a very bad press in these histories. They are perceived as the *deus ex machina* not only for Alkon himself, but also for Helmholtz, whom he regards as his intellectual ideal, and for the patient Michelle, a childhood friend, who became psychotic in middle adulthood, and to whom he dedicates this book. It goes without saying that he is much less precise in his formulations with regard to these disparate outcomes than he is with regard to the events which determine whether the snail *Hermissenda* will learn to withdraw its foot in response to a puff of air. He is persuaded, however, that there is a connection—as, I must confess, is this reviewer.

A Pavlovian conditioning model such as Alkon invokes simply

does not have the explanatory power he demands of it. Pavlov himself, after all, was unable to account for why some of his animals fought his apparatus and refused to be conditioned. He concluded that they suffered from yet another neurosis—a neurotic insistence that they not be subjected to his experimental interests. Notably absent from Alkon's accounts of the origins of psychopathology is any consideration of such staple concerns of the practicing psychoanalyst as a developmental process that includes critical periods of maturation and the availability, in the "average expectable environment," of age-appropriate input. He seems, rather, to envision the childhood experience as though it were linear and continuous—i.e., lacking all relatively abrupt, newly emerging potentialities. For example, he makes no mention of the fact established by Flechsig in the 1880's, that during the period of brain maturation, myelin deposition in various areas follows a predictable time sequence. This is a neurobiological fact which dictates that maturational readiness to respond to particular forms of sensory input and, as a consequence, the potentialities to form memories based on particular modes of input, emerge over time. Neither does he mention Piaget, Erikson, Spitz, or Mahler, all of whom have dealt with such emergences as they are seen in the maturing child. Needless to say, the issue of libidinal development is notable only by its absence. He seems not to consider that the quality of memories may depend both on the *context* and on the *state of maturational readiness* at the time the developing individual is exposed to the remembered events.

While this volume is by and large well enough written, there are passages which one could hope would be clarified were it to go into a second edition. After several readings, I continue to be unable to follow his characterization of Johannes Müller (p. 48). As an analyst, I regret his omission of Brücke's name from the list of Müller's students. He, after all, joined Helmholtz, Du Bois-Reymond, and Bernstein in the *Brüderschaft* oath to defy their mentor's vitalism, and to maintain the principle that there must be a physical cause for all observable events. It was Brücke, of course, who imparted this commitment to Freud. Finally, I would point out that Flourens (p. 47) was not an Italian. He was born and bred in France and spent virtually his entire career at the Jardin des Plantes in Paris.

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THE REDISCOVERY OF THE MIND. By John R. Searle. Cambridge, MA/London: MIT Press, 1992. 261 pp.

This is a book by the noted philosopher of mind about vexing problems in the philosophy of mind. So why should psychoanalysts be interested? The short answer is that problems in the philosophy of mind are no less our problems; notwithstanding great methodological differences in the two disciplines, there is a considerable overlap in content. A somewhat longer answer concerns Searle's particular "rediscovery" of the mind (and the mental). Searle's conceptualizations, unlike those of many of his contemporaries,[1] can encompass, rather than exclude, basic psychoanalytic ideas.

John Searle indeed takes up several matters which should be of vital interest to psychoanalysts. 1. How can consciousness be known? (Usually this epistemic question devolves to another: namely, how can consciousness be explained from a "scientific-objective" third-person view? Searle, however, does not leave it there.) 2. What is the ontological nature of consciousness; in other words, what is it? 3. How does consciousness arise? 4. What is the role of consciousness in the mental? All of these questions (not surprisingly to psychonanalysts) lead to considerations of the unconscious, particularly in relation to consciousness.

Let me take up first what are (at least in this analyst's view) some points Professor Searle makes which are highly compatible with the best of psychoanalytic clinical theory and metapsychology:

1. "Mental phenomena are caused by neurophysiological processes in the brain and are themselves features of the brain" (p. 1). This simple statement of "biological naturalism" declares Searle's intent to provide a nondualistic account, and sets the stage for a cogent attack on functionalism generally (including behaviorism in its various forms) and cognitive computationalism (i.e., the brain is like a computer, and the mind its software) in particular. I am not unaware that some analysts are comfortable with computer-artificial intelligence models, while others, including some "neo-structuralists," will not concern themselves with whatever structure underlies mental function. Other psychoanalytic theorists claim we have no choice but to be content with functional explanations of

[1] E.g., Dennett, D. (1991): *Consciousness Explained.* Boston: Little, Brown.

consciousness and unconsciousness and their interrelations. I take this to reflect a pessimistic assessment of the practical state of affairs regarding even future conceptual bridges between mind and brain rather than any argument in principle for functionalism's sufficiency.

2. There can be no study of the mind and what is mental without studying consciousness (and by implication its relation to unconscious processes). Searle does not finesse this matter; in fact the ontology (the *is-ness*) of consciousness is for him *essentially and irreducibly a first person subjective ontology* (pp. 93-105). This means that, for Searle, how we subjectively experience our perceptions, beliefs, desires, pains, the so called *qualia* of consciousness, must not be explained away. With regard to the epistemic issue, i.e., knowing consciousness, no less, the same position is compelling: even if one could objectively know and specify every neurophysiologic aspect of one's pain, for example, one would not have a very satisfactory knowledge of pain without having had (and therefore known) the subjective experience of pain.

3. Regarding the unconscious, Searle has a great deal to say. Chapter 7, "The Unconscious and Its Relation to Consciousness," is devoted entirely to the topic, and much here is not particularly problematic for psychoanalysis. In Searle's view, for example, consciousness, consisting of conscious mental states, is not only first person and subjective, but necessarily *about* something. This *aboutness* is called intentionality. He goes on to characterize the unconscious in the following way: ". . . the ontology of the unconscious is strictly the ontology of a neurophysiology capable of generating the conscious" (p. 172). Although psychoanalysts must surely take issue with the word "strictly" in the above, this dispositional account of the unconscious (i.e., the unconscious is that collection of neurophysiological processes disposed to causing what was merely potentially conscious to be conscious) is quite consistent with, although in no way a sufficient or complete account of, our notions of repression. What has been repressed (or never conscious in the case of primal repression) is *disposed* to become conscious or at least exert an active influence on what does. Indeed, Searle seems to have little problem with what he terms "Freudian cases . . . of repressed consciousness . . . always bubbling to the surface, though often in disguised form" (p. 172-173).

But now, while still on the topic of the relation of the unconscious to consciousness, I must point out an area of significant disagreement between Searle's view and what is compatible with psychoanalysis. Correctly, Searle ascribes to Freud a position that he himself finds incoherent: namely, that unconscious mental states exist as not merely dispositional, but mental, subjective, and *intentional* even while unconscious. Indeed, it is hard to imagine a psychoanalyst who would disagree with Freud here; the assumption of unconscious contents and processes *about* subjectively meaningful matters is perhaps the central assumption of psychoanalysis.

The crux of the disagreement might turn on the understanding of "mental." Thus, whereas Searle sees "true ascriptions of unconscious mental life as corresponding to an objective neurophysiological ontology, but described in terms of its capacity to cause conscious subjective mental phenomena . . ." (p. 168), he is troubled by his understanding that for Freud, "Their ontology is that of the mental, even when they are unconscious" (p. 168). But, is this really an ontologic problem Searle is having with Freud? This seems unlikely, given Searle's own description of the ontology of the mental, whereby mental phenomena are "caused by neurophysiological processes in the brain and are themselves features of the brain" (p. 1). In other words, if these are really the ontologic criteria for being mental, how does the psychoanalytic unconscious fail to meet them? What I believe Searle does, however, at least here, *is to require consciousness as a necessary feature of the mental.* Although I do think there exists unconscious mental life that is essentially subjective, first person, and intentional, if consciousness is an ontologic criterion for being mental, by definition nothing unconscious can be mental. Suffice it to say, Searle and psychoanalysts must remain in disagreement here; but each has an obligation—psychoanalysts to provide evidence for a subjective, intentional unconscious and Searle to justify restricting what is mental to what is conscious.

Interestingly, Searle does find a place for repression: "*The ontology of the unconscious consists in objective features of the brain capable of causing subjective conscious thoughts.* . . . But the existence of these causal features is consistent with the fact that in any given case their causal powers may be blocked by some other interfering causes, such as psychological repression . . ." (p. 160). But here, as with his ease with repressed desires, beliefs, etc., "bubbling to the surface,

though often in disguised form," the psychoanalytic position can gain some hold. How would Searle account for the "psychological repression" or the "disguising"? Wouldn't some truly mental, intentional, subjective assessment be required, even though unconscious, to recognize that some sort of repression or disguise or defense is warranted? And what about those transforming processes, not accessible to consciousness, yet effecting the repression or disguise; wouldn't these too best be considered mental, intentional, and subjective? (Clearly, all compromise-forming processes would fall into this class.)

Related to this matter, Searle holds that associations themselves need not have any underlying "mental" process. He makes a distinction between rule-following processes, which are mental (and indeed intentional), and associations such as those via resemblance (and presumably other associationalist/primary process principles: contiguity in time or space, part for whole, etc.), "which need not have any mental content at all in addition to that of the relata . . ." (p. 240). He likens the ascribing of mental content to such associational processes to considering the nonconscious brain processes causing visual experience to be mental; in both cases for Searle this is plain wrong. Such nonconscious visual processing and associational phenomena have only "as-if" intentionality, inferred and posited.

My own opinion is that there is room between the brute and fixed "association patterns" of visual processing on one hand, and the clearly mentally mediated rule-following on the other; and that the nonfixed, idiosyncratic, unpredictable, externally and *internally* context-dependent, seemingly not only intentional but motivated associations with which psychoanalysts contend, occupy some of that room. However, Searle's position, even were it less elegantly set forth, raises just the sort of doubt which psychoanalytic theorists ought to take seriously. (Taking this sort of doubt seriously will, of course, require more than just statements of opinion to the contrary.)

A further problem Searle raises, as much for cognitive psychologists and cognitive scientists as for psychoanalytic theorists, involves his challenge to the almost ubiquitous assumption of various unconscious mental representations. Here, too, it will not suffice for

any of us to merely answer, " 'What else could it be?' 'How else could it work?' " (p. 246).

I have one final point. In explaining how consciousness can be an "emergent" property of brain processes/neurons, and yet be caused by and consist of no more than those brain features, Searle proposes an analogy with H_2O molecules and liquidity, an emergent property of these same molecules. Although I understand the work his analogy is doing, I feel it is too restrictive and serves to gloss over a gap in our understanding of consciousness. The trouble is not ontologic—Searle's own "biological naturalism" provides for a very reasonable gap-free ontology. But I do see an epistemological gap of sorts. How can we understand *that* consciousness arises from various collections of neurons under various conditions? How can we understand *how*? Unlike H_2O molecules, which must in any aggregate state be considered either a fluid or a solid, countless collections of neurons never give rise to consciousness. Now I am not expecting Professor Searle to answer these questions directly; but I do wonder if in propounding so forcefully the essential, irreducible, first person, subjective nature of consciousness, he doesn't lull us into believing we have a more inclusive epistemic grasp on the ontology of consciousness than we do. Is there not a model whereby bridges between third person neurophysiologic understanding and first person subjective experience of consciousness could be better facilitated? My own guess (and I say this with apologies for being no sort of philosopher) is that some special breed of emergent property is operative here, one that involves evolution and transformation. Thus consciousness evolved and arises transformed out of specific configurations under particular conditions of the very neurons which comprise consciousness; much as the animate nature of life forms evolved, transformed from the self-same organic compounds of which it wholly consists.

Searle's book neglects these "principles of transformation" on two different levels. With respect to the unconscious, he does not regard as mental those unconscious transformational processes involved in forming the manifest disguises which accompany repression. Nor do the unconscious processes involved in recognizing the need for repression fit comfortably for Searle as mental. It is also unlikely that he would characterize as mental any of those trans-

formations instrumental in forming every sort of compromise formation. Yet would he be happy with what seems the not very plausible alternative—hard wiring? At a different level of theorizing, with regard to the emergent property status of consciousness, could a transformational model prove more useful?

Notwithstanding these criticisms, I remain enthusiastically positive about this book. *The Rediscovery of the Mind* is written with extreme clarity and straightforwardness. John Searle thereby gives those analysts willing to consider his challenges real hope for grounding a science of the mind in which psychoanalysis can take part. In Searle's brand of philosophy of mind, better understanding of how the mind works can neglect neither neurophysiologic links, nor the mind in its intrinsic subjectivity. We as psychoanalysts can ill afford to neglect the basic philosophical issues Searle sets forth.

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OVERCOMING THE ODDS. HIGH RISK CHILDREN FROM BIRTH TO ADULTHOOD. By Emmy E. Werner and Ruth S. Smith. Ithaca/London: Cornell University Press, 1992. 280 pp.

This book describes a careful study of the long-term consequences of biological and psychosocial conditions in the first two years of life on later adaptation. The subjects were born in 1955 on Kauai, a Hawaiian island with a low mobile population descended from mainly Asian, Portuguese, and Philippine immigrants. Satisfactory intermarriage, good health care, and community responsibility made for a dependable sample to work with. The subjects were studied at intervals from birth to age 31-32. By the end of that time, most were in full-time employment, were satisfied with their work, and had reached an occupational level above that of their parents. More women than men relied on people for their emotional support, and more men than women were concerned with their careers. They were considered to be "ordinary people" who lived "ordinary lives."

One-third of the 505 subjects available at age 31-32 had been classified in early childhood as being "high risk." Their status in later childhood and adolescence has been told in detail in three previous books. Over the years two thirds of them developed serious learning problems, conduct disorders, delinquencies, and/or

teenage pregnancies. The authors then sought to determine what factors made for successful adaptation among the one-third of high risk subjects (72 at age 18 and 63 at age 31-32), who developed into "competent, confident, and caring young adults." They are described as "resilient." They overcame the odds. The authors' task was to assess their transition to the world of work, marriage, and parenthood.

The research began with setting, for each infant, a stress score based upon his or her having experienced moderate to severe pre/perinatal stress, and at least four psychosocial stresses, such as poverty, parents with little formal education, and disorganized families, within their first two years. When the children were ages 1 and 2, pediatric and developmental assessments were made of their families' socioeconomic status, of the emotional support they received, and of each mother's parental skills. Inquiry was made about any stressful events that had occurred so far in the child's life. Fathers' attitudes appear only in several individual histories. Additional information about the family was sought from social service and public health records. This cluster of data accumulated for the subjects' first two years provided the base for their classification as being at high or low risk.

Follow-up studies were carried out when the subjects were ages 10, 18, and 31-32: assessments were made of their socioeconomic status, of the educational stimulation and emotional support they received, and, at age 18, of their perspectives about themselves and others and the quality of family life they experienced in adolescence. For the years in between (ages 2 to 10, 10 to 18, 18 to 31-32) information was drawn from medical, educational, and court records, inspection by public health nurses of the quality of family life, and the subjects' self-assessments, career choices, and employment histories. Semi-structured interviews, group tests, and questionnaires provided the bulk of information gathered independently of the community records. Additional contributions were made by parents, teachers, social workers, psychologists, pediatricians, public health nurses, and, later, court and military personnel. Finally, specialists from appropriate fields reviewed all the data. Individual interviews and personality tests were carried out only for those in the high risk group who had had chronic mental health problems, repeated delinquencies, and teenage pregnancies. Thus

the results of the study are based mainly on group data, drawn from a very large number of interrelated variables over a more than 30-year period. This is an unusual volume of information, tightly organized and clearly presented in the text and in appendices. It also contains a thoughtful review of related research.

At age 18, 42 girls and 30 boys in the high risk group functioned well in school and socially, and had realistic expectations for themselves. The promising development of these "resilient" subjects is attributed to a number of protective factors: no prolonged separations from the mother in their first year, no siblings following them for at least their first two years, the absence of problems in their first two years of life, positive educational experience, the richness of attention they received during their first years, parents who were good models of identification, intelligent, caring teachers, and household structures and rules. All of these reinforce psychoanalytic understanding of the needs of infants and young children for emotional, cognitive, and social experiences that can provide for normal ego and superego development. In contrast, the kinds of stress that affected adaptation negatively were mainly poverty, family instability, behavior disorders in childhood, and other cumulative familial or social stresses. Boys were found more vulnerable in their first decade, girls in their second decade. For clinicians it is striking to read that the most common childhood stressor with long-term consequences was the birth of a younger sibling before the second birthday of the index child.

Among the subjects in the whole sample with serious problems at 18, about half had stable lives at 31-32. This is explained in part by the support systems available to them from satisfying relationships with siblings, marriage, enjoyment of parenthood, religious affiliation, employment, and military service. The authors see the latter recoveries as an indication that maladaptive functioning was not necessarily continuous from youth to adulthood. On the other hand, they report that 15 percent of the high risk subjects who had not developed problems earlier had serious problems at 31-32. No specific reasons for this are cited. It may well be that clinical examinations of the subjects' defensive structures and compromise formations that appear during childhood or adolescence, and that do or do not have continuity, might reveal problems that were ob-

scured in their beginnings or at later intervals. Probably, only intensive studies of an individual's way of life can bring to light hidden predilections for or safety from disorders that escape scrutiny in broad sociological counts. Psychodynamic factors were outside the scope of the Werner-Smith research. Indirectly, however, it suggests that it could be valuable to study the fluctuations, from infancy to adulthood, of observable and/or consciously known clinical disorders.

It is not surprising to learn that at age 18 the majority of high risk subjects with mental health problems were of low socioeconomic status from early childhood and had had problems in school at age 10. Other early "predictors" of mental health problems were, for boys, high perinatal stress, high activity level, distressing habits at age 1, low levels of maternal education, and family instability; for girls, congenital defect, low physical development at age 2, and learning disability. Several of these gender differences suggest a higher societal expectation for boys than for girls. They cannot be evaluated without information about differing parental and social attitudes toward boys and girls. The authors correctly emphasize the cumulative effects of biological predisposition, caregiving deficits, and poverty on the maladaptation of the high risk subjects.

According to the subjects' responses to tests and questionnaires, successful adaptation, generally positive relationships, a capacity for intimacy, satisfaction in work, and goals such as having a good job or a good life were found to be essential criteria for their having overcome the odds with which they were confronted in early life. To a large extent these criteria reflect the authors' main emphasis on the presence or absence of "stressful life events" (which are cited in extensive detail) among the high risk subjects. From the several brief individual histories, it appears that the homogeneous working class population of Kauai placed a particularly high premium on stability and family cohesion. Moderate wishes were expressed, in some cases, for upward mobility. Eighty-eight percent of the men and 80 percent of the women in the original cohort had schooling beyond high school, a much higher percentage than occurred in the United States in the same years, but only 9 and 12 percent, respectively, went on to graduate or professional school. Although it might be asking too much to expect people from working class

families, most of whose forebears were immigrants, to strive for higher education or vocational advancement, the fact remains that few in the resilient group had career prospects at age 31-32. These few were, among the men, a textile designer, a minister, an engineer, an officer in the United States Army, and an entrepreneur. Among the women there was a poet-in-residence in a school, a paralegal president in a business, a sergeant in the United States Air Force, a tour president, and a writer of children's books. With mainly these exceptions, the picture of the resilient subjects contains no signs of aims toward work that involved a larger social concern, industrial or technological skills, or creative endeavors. Thus the level of successful adaptation in the resilient group may be considered modest. It was based, for the most part, on (reported) satisfactory personal social relationships, self-assessment, and gainful employment, and on an absence of overt or expressed psychological or social problems. From a broad sociological point of view their overcoming the odds is impressive. Yet without knowledge of their individual capacities to deal with frustrations and gratifications, their normal developmental or neurotic conflicts, mild or serious, one cannot reliably appraise the level of individual adaptation or mental health achieved by either the low or the high risk subjects. Actually, the authors state that 10 percent (exact numbers are not available) of the low risk subjects had serious problems at age 31-32. The source of this datum is not found in the text or the tables, perhaps because the authors' principal focus was on the outcomes of the high risk subjects. The missing explanation might have thrown light on the events that made for the failures as against the successes of the resilient group.

Clinically and theoretically, events from birth to two years, taken as a whole, provide a sound base for the study of long-term effects of early stress. A better base for the assignment of the subjects to high or low risk groups might have been yielded by distinguishing, separately, the outcomes of subjects who had endured pre/perinatal stress, those with congenital defects, and those who experienced cumulative stresses in their first two years. The first two factors are of a different order from the third. Combination of the three precluded a measure of the relative weights of each. The division, in a sample of limited size, might not have yielded findings of statistical significance, but it might have contributed finer clues to the deter-

minants and the long-term effects of high risk. The other criterion for high risk, at least four psychosocial stresses in the first two years, may have obscured instances in which only one or two severe stresses can have been equal to or more harmful than the four used as part of the base for assignment to high risk. Similarly, there can have been instances in which severe psychosocial stresses or traumas experienced in early childhood years after age two disposed a subject to be high risk.

Werner and Smith present a succinct account of conditions that make for social adaptation or its failure. The comprehensiveness of this sociological study provides a model for study of the smaller and larger details of everyday events and behaviors that fashion a life. It makes a strong argument for the values of protective factors such as family cohesion, good schooling, steady employment, marriage and parenthood, and other group affiliations. With the strengths that the resilient subjects acquired, they were able to keep in step with the demands of reality. Early in life their gratifications were found largely in their family structures and in their capacity to work in school; later, in the kinds of work they found suitable. About work Freud wrote: "No other technique for the conduct of life attaches the individual so firmly to reality as laying emphasis on work; for his work at least gives him a secure place in a portion of reality, in the human community." Work, he said further, makes possible the displacement of a large amount of instinctual drive derivatives to professional work and to the human relations connected with it: ". . . it lends it a value by no means second to what it enjoys as something indispensible to the preservation and justification of existence in society."[1]

This fine account of the general course of the lives of high risk subjects who made adequate social adaptations tells the factors that enabled them to win a battle that so many in their socioeconomic strata lose. If our interest extends beyond their earning a living and having satisfying social relationships in their homes and communities, we may still wonder about the extent to which the potentials of the resilient group for higher aims were lost early in their lives.

SYLVIA BRODY (NEW YORK)

[1] Freud, S. (1930): Civilization and its discontents. *S.E.*, 21:80, n.

PERSONALITY DISORDERS. NEW PERSPECTIVES ON DIAGNOSTIC VALIDITY. Edited by John M. Oldham, M.D. Washington, DC/ London: American Psychiatric Press, Inc., 1991. 197 pp.

This multiauthored book edited by Oldham, Professor of Psychiatry at Columbia University, focuses on the validity of personality disorders as defined by DSM-III and DSM-III-R. Personality disorders have been particularly difficult to categorize because of the lack of sharp boundaries distinguishing them from each other and from normally distributed personality traits. It has been a challenge in the study of these conditions to establish diagnoses that are useful for both practice and research, and to distinguish patients with a constellation of psychopathologies that differ meaningfully from those of other patients. This timely and scholarly volume focuses on that challenge.

The chapters in this book have been written primarily by academic psychiatrists and psychologists, including some psychoanalysts, and cover a broad range of topics. These include the concept of construct validity; methodologies for evaluating validity (including use of longitudinal data, biological markers, response to pharmacologic intervention, and a complex long-term inpatient assessment by multiple experts); the diagnostic validity of specific personality disorders; and the implications of high comorbidity between depression and Axis II disorders, and among the Axis II disorders. The editor highlights the common themes and dilemmas in a brief, thoughtful introduction.

Historically, the personality disorders, previously termed character disorders, were categorized in DSM-I and II according to clinical observations based largely on psychoanalytic theory. DSM-III and III-R moved away from such a theory-based model to substitute a "descriptive" approach using "easily identifiable behavioral signs or symptoms" as the basis of diagnosis (DSM-III-R, p. xxiii). While the system has been useful for Axis I disorders, the diagnostic criteria for personality disorders require more observer inference than such readily confirmed signs or symptoms as cognitive, mood, or psychomotor disturbances.

In practice, as W. John Livesly and Douglas N. Jackson describe in a chapter entitled "Construct Validity and Classification of Personality Disorders," the personality disorders defined in DSM-III

and III-R are constructs derived from the general clinical knowledge and theory of many experts, and consist of a cluster of traits. As these authors note, the characterization of these disorders involves specifying the traits comprising each disorder and defining those traits in terms of theory and prototypical behaviors. This clear and interesting chapter provides a useful overview of the concepts of diagnostic validity.

In Chapter 6, "Is Narcissistic Personality Disorder a Valid Diagnosis?," John G. Gunderson and Elsa Ronningstam describe a diagnostic interview tool they devised and its ability to identify patients with NPD and distinguish them from patients with related personality disorders and other psychiatric disturbances. Among distinguishing traits for NPD, these investigators found that the most pathognomonic was grandiose self-experience. In Chapter 7, "Diagnostic Efficiency of DSM-III Borderline Personality Disorder and Schizotypal Disorder," Thomas H. McGlashan and Wayne S. Fenton discuss the interesting observation that, while severe or prototypic BPD occurred frequently, severe or prototypic schizotypals were rarely seen. They speculate that severe schizotypal disorder may result in a change of diagnosis to schizophrenia or schizoaffective disorder, while BPD is an independent disorder in which severity does not result in a diagnostic change. In contrast, Widiger, et al., in Chapter 9 ("Comorbidity Among Axis II Disorders"), propose that BPD may be "a nonspecific diagnosis indicating a level of pathology or general neuroticism" (p. 175).

A recurring topic discussed in several chapters concerns the relative merits for classification of a categorical model (i.e., discrete categories of psychopathological entities, such as the personality disorders currently specified) versus a dimensional model (a model in which individual traits are scored and a superordinate dimensional score determines diagnosis). As discussed in Chapter 8 by Bruce Pfohl, et al. ("Axis I and Axis II Comorbidity Findings: Implications for Validity") and in Chapter 9 by Widiger, et al., Axis II disorders have a high rate of comorbidity, both with other Axis II disorders and with Axis I disorders. As a consequence, several authors favor some form of dimensional model to supplement or replace the existing categorical model. Widiger, et al., in particular, strongly argue for the usefulness of a dimensional model and compare the merits of various specific models that have been proposed.

Dimensional systems offer certain advantages, particularly for personality disorders, whose defining features occur along a continuum from normality to severe pathology without clearcut boundaries. In its emphasis on traits, DSM-III-R has incorporated prototypal and dimensional features not seen in the earlier DSM-III. As a categorical system, however, DSM-III-R (like the earlier DSM versions) provides no method for rating key personality variables, such as psychological mindedness, quality of object relations, flexibility of defenses, affect modulation, and impulse control, which could be more effectively assessed dimensionally.[1] The clinical relevance of such information is obvious to clinicians, and its addition to a system that currently classifies disorders on the basis of overt behaviors or defensive styles would be significant. Analysts routinely use a dimensional model, for example, in assessing ego capacities of patients being considered for analysis.

Chapter 4, "Biologic Validators of Personality Disorders" by Richard J. Kavoussi and Larry J. Siever, uses a dimensional model to correlate spectra of personality psychopathology (in this case cognitive disturbance, affective regulation, impulse control, and anxiety/social inhibition) with neurotransmitter systems. The authors speculate that the Axis II disorders may be "prototypes or a form fruste of particular Axis I disorders on a spectrum of psychopathology with similar underlying biologic substrates and genetic antecedents but with differing degrees of phenomenologic expression due to environmental or developmental factors" (pp. 74-75). It seems to this reviewer that a model of this type offers promise for conceptualizing all behavior, from so-called normal to the most seriously disturbed, along a true biopsychosocial continuum.

Although the methodology and clinical perspectives employed in this volume differ from those of psychoanalysts, the questions raised are nevertheless important to all clinicians and clinical researchers. A substantial portion of patients currently being treated with psychoanalysis or long-term psychoanalytically oriented psychotherapy have Axis II disorders or many features of these disorders. As psychoanalytic clinicians, we have meaningful information about these patients, and should be searching for ways to incorpo-

[1] Frances, A. (1982): Categorical and dimensional systems of personality diagnosis: a comparison. *Comprehensive Psychiat.*, 23:516-527.

rate psychodynamic clinical findings into the knowledge accumulating about these disorders. We should also be developing a conceptual framework to integrate information gathered from psychopharmacologic, genetic, epidemiologic, neuroimaging, and other sources into our own theory and practice. This illuminating book makes a valuable contribution toward advancing understanding an important field.

INGRID B. PISETSKY (DURHAM, NC)

IN THE NAME OF LOVE. WOMEN, MASOCHISM, AND THE GOTHIC. By Michelle A. Massé. Ithaca/London: Cornell University Press, 1992. 301 pp.

In the genre of the Gothic novel, the heroines are submitted repeatedly to being humiliated, dominated, terrorized, or beaten—all "in the name of love." Michelle Massé, Associate Professor of English at Louisiana State University, has used the Gothic novel for a study of masochism in women from feminist and psychoanalytic perspectives. Her sources range from *Jane Eyre* to *Rebecca*, *The Yellow Wallpaper*, *The Story of O*, and more contemporary and lesser known works of fiction.

In the prototypical plot of the romantic Gothic, a young girl, trapped in an isolated setting such as an English country estate, uncovers a sinister secret. As the story unfolds, she is mistreated and abused by a bad man (who may turn out to be a good man) and is saved by a good man, whom she marries in the end. Massé sees these stories as representations of the beating fantasies articulated by Freud in " 'A Child is Being Beaten.' " The parallels are convincing: heroine and reader of the Gothic novel are compulsive voyeurs of scenes in which children or girls are beaten or humiliated by parental figures. As a patient who obsessively enacts a beating fantasy, the Gothic heroine seems frozen in time, drawn repeatedly to experience pain and pleasure simultaneously. We watch the submissive heroine in Du Maurier's *Rebecca*, for instance, humiliated in front of servants by her mysterious husband and yet drawn inevitably to unearth his secrets.

Like Freud, Massé sees the beating fantasy as central to masochism. Her interpretation of the beating fantasy and how it might inform us about masochism in women, however, diverges from

Freud's explanation of a guilt-ridden regression from oedipal conflict to anal-sadistic expressions. Massé's central thesis is that the beating fantasy is a response to and repetition of a culturally induced trauma experienced by girls in Western society, a mirroring of gender-related patterns of submission and dominance which girls absorb in the process of socialization. Society dictates that women must strip themselves of autonomy and subjectivity in order to be loved. For Massé, a crucial determinant of masochism is the trauma of loss of agency and identity; it is this loss, and its repetition, which create the sense of horror in the Gothic novel. Here Massé evokes Freud's explanation of the sense of the uncanny as reflecting the return of the repressed and the compulsion to repeat. While Massé thus focuses on external and social traumata as causes of masochism, she nevertheless describes the intrapsychic processes of internalization, repression, and eroticization in her discussion of its formation. Basically, however, she has little sympathy for an intrapsychic focus.

Like other feminist writers, Massé takes Freud and psychoanalysis to task for overvaluing the father's role in the psychology of the girl and for overemphasizing the idea of the beating fantasy as a mental product. In so doing, Freud, she asserts, negates and replicates society's patriarchal patterns: ". . . Freud's discussion of the beating fantasy in girls recreates the fantasy's own hermetic enclosure while erasing hierarchy. . . . And, because there never was a problem, her distanced, rapt observation of 'a child is being beaten' remains her futile attempt to escape the heterosexual dynamics of sadomasochism" (p. 72).

Massé lays out her thesis in the first three chapters of the book. Here she argues that masochism is a basic coping strategy for the oppressed. A masochistic identity is a forged negative identity with hidden, internal sources of control. In an interesting discussion of the dynamics of power and the meaning of the "gaze," she points out that to stare is the domain of the dominant, yet the secret gaze of the subordinate becomes a potential means of identifying and appropriating patterns of domination.

In the remaining chapters, Massé elaborates her ideas in detail. She takes up Pauline Réage's *The Story of O*, in which the woman "O" yields herself totally to her male abusers, whom she loves and exalts. Overlaying the book is a veneer of religiosity which Massé

feels mirrors how large cultural institutions, including psychoanalysis, support women's subjugation. This support, she points out, is repeated by the rapturous critics of the novel, whose metaphysical interpretations gild its blatant pornography. In Daphne Du Maurier's *Rebecca*, as in *The Story of O*, the beating fantasy is compulsively repeated. The protagonist in *Rebecca* moves from passive spectator to beaten to active spectator and finally to dominance over an infantilized husband.

In perhaps the most interesting chapter, Massé examines Charlotte Brontë's *Jane Eyre*. In this novel, Massé sees a break from the repetition compulsion in a strong, clear-eyed heroine who sees and names victimization, knows she must suffer, but refuses to embrace an identity of victim or the tempting satisfactions of victimizer. While Jane "becomes tempted" by Gothic romance, she does not "confuse love with dominance."

Finally, in a chapter called "Resisting the Gothic," Massé discusses predominantly modern fiction, by authors such as Margaret Atwood and Isak Dinesen, in which three possibilities for women's avoiding masochistic solutions are presented: aggression against the dominating male, self-conscious subversion, or a utopian vision of changed gender roles, all of which are accomplished through communication with and helping other women. "All refuse the eroticization of pain that perpetuates the beating fantasy, recognize their accord with other women, and identify the systemic nature of the forces that seek to confine them . . ." (p. 272).

For the psychoanalyst, there are several problems in Massé's book. First, and least important, much of the fiction which she treats, except for the classic novels, may be unfamiliar. This, coupled with Massé's saturated prose, makes for some difficult reading.

Second, Massé takes no prisoners in her attack on Freud's and current psychoanalytic views of masochism. While she cites modern psychoanalytic writers such as Stoller or Person, she nevertheless condemns psychoanalysis for ideas it no longer holds, as, for example, the view that masochism is a natural female instinct. Massé emphasizes the influences of environmental trauma, the ego's adaptations in maintaining the love of the object, and the self-cohesive functions of masochism; these ideas all are central to modern psychoanalytic understandings as well. Moreover, while Massé does acknowledge in the last chapter the complexity of the phe-

nomena she addresses in her questions of how inter- and intrapsychic interact and about the nature of causality, her one-sided, polemic focus throughout the book overrides this understanding.

Third, Massé's use of fiction as data is problematic. At times the fictional heroines are treated as clinical cases. For example, Jane Eyre is used to prove that unhappy childhoods make for better adaptations to reality. At the same time, Massé often dismisses psychoanalysts' clinical data as unrepresentative.

Yet, for all this, the book is interesting and provocative. That Gothic fiction is by and large written by women, about women, and for women must mean that its appeal tells us something important about the psychology of women. Perhaps this account tells us more about the psychology of women and less about that complex and problematic subject of masochism, whose very definition has confounded psychoanalysis from the beginning.

NANCY KULISH (BIRMINGHAM, MI)

FREUD, PROUST, PERVERSION AND LOVE. By Hendrika C. Halberstadt-Freud. Amsterdam/Berwyn, PA: Swets & Zeitlinger, 1991. 218 pp.

Proust's great novel is called *Remembrance of Things Past* in English. The original French title, *À la recherche du temps perdu* could be translated as *In Search of Lost Time*. This translation would make it clear that the book is an answer to Proust's parents' complaints that he wasted his life. Rather than devoting himself to some useful profession, as did his father and brother who were both physicians, Proust became a socialite, aesthete, invalid, and raconteur who also wrote.[1] Only after the death of his mother did he devote himself to writing full time, slowly and painfully producing his gigantic novel built on the experiences of his lonely illness and the empty pleasures of society.[2] Proust's great book answers his parents' objection to their son's way of life by using his experience of society life to reach a deep understanding of human motivation.

Proust believed that love is longing, only sustainable when un-

[1] Painter, G. (1959): *Marcel Proust*. New York: Vintage, 1978.
[2] Hayman, R. (1990): *Proust*. New York: Harper.

fulfilled, only pleasurable insofar as one is able to enjoy pain. He believed that satiety can only produce dullness and boredom. Envy and jealousy prevent the dullness and boredom of satiety. Thus, he understood pleasure in inflicting and suffering pain as the inescapable dynamic of human existence. Sadomasochistic reversals of social status in which humiliation accompanies physical pain are the prototype of erotic excitement for Proust.

Above all, Proust saw and delineated in exquisitely fine detail the parallels between the psychological and the social, uniting in the form of fiction what has been divided, to the mutual loss of the sciences of psychology and sociology. He understood society as organized pleasure attained by inflicting pain. Like love, he thought, a party can give pleasure only as the participants are aware that they might have been excluded, that they are privileged to be invited. Part of the pleasure in belonging to a social circle is the pleasure of excluding others. In an ironic turn, worthy of Proust himself, it is only now, over half a century after he finished his great psychological novel, that psychoanalysts have attained a view of perversions that can intersect with his.

Halberstadt-Freud sets out to show that perversion is a defense against separation anxiety, dissolution of identity, overwhelming aggression, narcissistic anxiety, and fear of women. She includes the sadomasochism of everyday life in the perversions, thus widening her field of interest. She attributes the origin of perversion to the seductive mother. Halberstadt-Freud appears to have overlooked Socarides's conclusions about the preoedipal origins and the role of early and ongoing disturbed relationships with the mother in generating the perversion.[3] She believes that such a mother encourages the oedipal boy to develop the fantasy that she values him more than she does the father. The little boy responds by failing to accept the limits of reality, denying the value the mother attaches to the father's sexual potency and his power over the family. The situation can come about even in the presence of a patriarchal family when the mother conveys to the child that the father's authority is not real, not fair, or not what she believes in. This

[3] Socarides, C. W. (1988): *The Preoedipal Origin and Psychoanalytic Therapy of Sexual Perversions*. Madison, CT: Int. Univ. Press.

emboldens the child to defy authority by actually indulging in the forbidden pleasures which the neurotic might not even allow herself or himself consciously to dream of.

But how does this square with the observation that the person who develops a perversion is often the fearful adult who was a timid, over-compliant child? Suppression of anger and jealousy in the compliant child leads to splitting off of these feelings and channeling them into masturbation fantasies which become the basis for perverse enactments.

Halberstadt-Freud gives us a remarkable account of the similarities between Freud's thought and Proust's. She points out that Freud and Proust both depicted perversion as what Stoller[4] would later call the erotic form of hatred. She draws a parallel between Proust's "involuntary memory" and Freud's "primary process." Both are timeless; both use condensation, displacement, and imagery. Similarly, Proust's "voluntary memory" is like Freud's "secondary process." Both use the laws of time, logic, and reality. Like Freud, Proust discovered that love is transference. Also like Freud, Proust viewed the state between waking and sleep as the dream state and as the access to the unconscious as well as to the thoughts and feelings of childhood. Both believed that jealousy is a necessary condition of love.

Halberstadt-Freud believes that Proust differed from Freud in a way in which she also differs from Freud: Freud paid relatively little attention to the role of the mother and never fully elucidated the genesis of the perversions. Actually, Freud's discussion of Leonardo does suggest that early oral seduction and sudden loss of the beloved mother may inhibit the capacity for heterosexual love. In Freud's view, however, Leonardo did not suffer from perversion, but managed a sublimation of heterosexual desire which may have allowed him the overt expression of homosexual wishes. Freud does not reconstruct a particular type of mother or style of mothering to be associated with sexual perversion. Both Proust and Halberstadt-Freud emphasize the role of the mother and her child-rearing practices in fostering the perversions.

Freud's earliest idea about perversion was that it was the fossilized version of the partial drive of the infant and young child.

[4] Stoller, R. (1975): *Perversion. The Erotic Form of Hatred.* New York: Pantheon.

Perversion is the gratification of pregenital wishes, as in sadism, voyeurism, and exhibitionism. According to Halberstadt-Freud, his later view that the fetishist disavows the difference between the sexes is the key to all perversions. The manipulation of the object is the inevitable outcome of the child's having been used to satisfy the need of the mother rather than allowed to express and satisfy his own needs.

Halberstadt-Freud gives a series of vignettes from her own practice to show that patients with perversions are analyzable and to argue that deeper understanding of perversions can be derived from treating perverse patients with analysis. Among these are the following. A male cross-dresser feels relaxed and like himself only when in the guise of a woman. He comes to Halberstadt-Freud's office in drag. She feels no "real contact" with him. The treatment ends. A woman patient plays a game of tying her male lover to the bed and beating him to orgasm; he does the same for her. She gets no pleasure from intercourse. A supervisor advises Halberstadt-Freud not to continue the treatment because perversion is too gratifying to be dislodged by psychoanalysis. Halberstadt-Freud regrets taking the advice because she now believes that people with perversions have frustrated infantile needs which can be analyzed.

A male homosexual who engages in much teasing and rivalry with his partner develops a heterosexual transference to Halberstadt-Freud, gets married, and chooses a career he likes better than the one chosen for him by his step-parents. He had lost his own parents and had been shifted from one foster home to another before being adopted by a mother who, he believed, never loved him as much as she did her own daughter. The analysis was not complete, as he was never able to express anger toward his analyst.

A married woman enjoys her fantasies of having submissive lovers more than she does having intercourse with her husband. A married man has himself beaten and stepped on by his wife, but is afraid to attempt intercourse lest he be impotent. A homosexual man only enjoys anal intercourse after being beaten by an anonymous partner. He links this to his experience of being seduced in a humiliating way by his mother. For all of these patients, Halberstadt-Freud believes that the crucial dynamic of perversion is defying the parent in order to escape the symbiotic fantasy, forge a separate identity, and maintain it.

Proust's famous scene of the "goodnight kiss" illustrates a similar theory of the genesis of perversion. According to Halberstadt-Freud, Proust has encapsulated his theory of the genesis of perversion in the screen memory of the goodnight kiss. The mother indulges her child in a bedtime ritual in order to keep him close to her. The father wants him to be more manly, which to the father means more self-reliant. The mother needs her child as an ally against the father, as a substitute for him when he is away, and as a validator of her role in life. The child, in turn, sees his mother as all good and those who keep her from him as all bad. When the father refuses to allow the ritual one evening, the narrator suffers until the father realizes how terrible he feels and orders the mother to spend the night with him. He is to be allowed what he wants as long as he is sick and helpless. His fate is sealed.

Another scene of central significance in Proust's *Remembrance of Things Past* is the lesbian love scene. In it, cruelty is linked to the need for repudiation of the parent as the primary love object. Mlle. Vinteuil has been brought up by an overly solicitous father who wants her to be a dainty, feminine child instead of the sturdy mannish one she really is. She cannot love as a woman without giving in to the coercion of his idealized picture of her. The lover who helps her to deny the father by spitting on his portrait allows her to experience sexual pleasure of her own. The implication for Proust is that effeminate boys are equally misunderstood and pushed toward a masculinity unnatural to them.

Sadism is an attempt at liberation, but in Freud's view, the sense of guilt transforms it into masochism. Primary masochism, according to Halberstadt-Freud, was alluded to but never fully understood by Freud. The original dependence of the infant on the parent, with the consequent need to protect the parent even at the cost of pain and suffering to oneself, is what she posits as the origin of primary masochism. Primary masochism is then fostered throughout childhood and adolescence by the binding overprotection of the family. Pubertal sexual fantasies are colored by the idea that love and pleasure are a revolt against one's parents. The split-off hatred toward the beloved parents results in the paradoxical hyperesthetic traits of perversion. Proust believed that it is just these traits that are enacted in society: in the drawing room, domineering women are worshipped by frightened men; aristocrats hire servants to beat

them; aesthetes torture rats for pleasure. Like perversion and social life, love is a revenant of that primary masochism which haunts everyone.

This observation leads Halberstadt-Freud to underline a clinical observation: perversion is not merely the enactment of a particular sexual scenario; perversion is also the defensive use of the perverse scenario in any situation which threatens psychological disaster. This generalizes erotic moment into character. Halberstadt-Freud seems to have missed Arlow's observation and elaboration of this same point.[5]

Thus, Halberstadt-Freud concludes, the fascination of Proust's story lies in its evocation of the universal struggle of the growing child to free him/herself from the primary tie cherished from infancy. Freud and Proust both knew that the sufferer with a perversion is not so different from the lover and neither is he or she different from the artist. All long for what is not possible to attain.

Hate and love, sadism and masochism, go hand in hand in Halberstadt-Freud's conception. Perversion results from childhood events which the child experiences as cruel even when the parents inflicting the pain do not intend harm. While Proust introduced perversion in the context of a lesbian love, Halberstadt-Freud tells us that her theoretical understanding does not encompass female perversions, a topic on which she believes that more research is needed. I believe that some research is available and could have enriched her book.[6] Yet when she presents clinical vignettes of six patients with perversions, four are men and two women. She follows what used to be the general pattern of using clinical material from women and making theoretical and developmental statements in which maleness is normative. Yet she triumphs over both the assumption that maleness is normative and over the once prevalent belief that perversion is not treatable because it is too plea-

[5] Arlow, J. A. (1971): Character perversion. In *Currents in Psychoanalysis*, ed. I. M. Marcus. New York: Int. Univ. Press, pp. 317-336.

[6] See Grunberger, B. (1966): Some reflections on the Rat Man. *Int. J. Psychoanal.*, 47:161-168.

Richards, A. K. (1989): A romance with pain: a telephone perversion in a woman? *Int. J. Psychoanal.*, 70:153-164.

Zavitzianos, G. (1971): Fetishism and exhibitionism in the female and their relationship to psychopathy and kleptomania. *Int. J. Psychoanal.*, 52:297-305.

surable. Her point of view is ultimately that perversion is treatable precisely because it is excruciating and that the etiology of perversion is far more complex than was thought in the days when male fear of "female castration"[7] was thought to be the dread against which perversion was the defense. For me, this book is very important because it gives clinical material from the actual treatment of patients with perversions and presents them in a light sympathetic enough to encourage other analysts to attempt to do the same thing.

ARLENE KRAMER RICHARDS (NEW YORK)

THE FLIGHT OF THE MIND. VIRGINIA WOOLF'S ART AND MANIC-DEPRESSIVE ILLNESS. By Thomas C. Caramagno. Berkeley/Oxford: University of California Press, 1992. 362 pp.

It was only a matter of time until the polarization between the psychoanalytic and the biological so characteristic of contemporary psychiatry would spread to the fields of literary criticism and psychobiography. Within academia, legions of semioticians in recent years have embraced Lacanian psychoanalysis and Saussurean linguistics as the royal roads to the literary text. With the appearance of this new volume by Thomas Caramagno, we now have a psychobiographer who suggests that impaired interhemispheric relations may be the neurophysiological basis for Lacan's observation that writers' texts subvert their own apparent meaning. More specifically, Caramagno asserts that psychoanalytic attempts to understand Virginia Woolf and her art have been seriously misguided because they have failed to take into account the biological basis of her manic-depressive illness.

While a departure from the excesses of Lacan may be welcome to some readers, the author's approach has its own unique limitations. Caramagno begins his book with a polemical tone. He takes psychoanalytic biographers of Woolf to task for overemphasizing the pathogenic influence of her childhood traumata, such as her mother's untimely death and her sexual abuse at the hands of her half-brothers. He accuses his predecessors of blaming the victim for her

[7] Bak, R C. (1953). Fetishism. *J. Amer. Psychoanal Assn.*, 1:285-298.

illness. He is particularly critical of Alma Bond's[1] attempt to understand the psychological contributions to Woolf's suicide. Caramagno suggests that the search for meaning in her suicide is merely a reflection of our own need for narrative unity and that it is more likely that Woolf died "for nothing more meaningful than the fact that the biochemistry of aging bodies changes and intensifies depression. Or perhaps it was season. There is a striking peak incidence of suicide in May, a rise that begins in March . . . , as do the rates of hospital admissions for depression; affective disorders are intimately connected to the body's circadian and seasonal rhythms. So perhaps Woolf died because age and winter combined to exacerbate depression" (pp. 61-62).

To be sure, applied psychoanalysis is fraught with a set of thorny methodological pitfalls. Any psychoanalytic biographer steps out on a speculative limb from time to time and probably deserves a modicum of criticism for basing hypotheses on somewhat questionable evidence. However, the biological reductionism that Caramagno puts in the place of applied psychoanalytic thinking is equally problematic. He seems to believe that the presence of biochemical and neurophysiological factors eliminates psychoanalytic meaning and complexity from the playing field. Two patients with bipolar illness may be equally depressed, but one may commit suicide while the other does not. The reasons for the differences reflect the convergence of psychological and biological forces. The situation is one of "both/and," not "either/or."

Another difficulty arises in the author's appropriation of the term countertransference to describe the biographer's relationship to his or her subject. Although he criticizes, with some justification, the tendency of some psychobiographers to read their own conflicts into the author's text, he does not seem to understand that one cannot escape the introduction of one's subjectivity into the interpretive endeavor. Indeed, his emphasis on the biological underpinnings of Woolf's life and art is itself a "countertransference" to the writer and her text based on his own preferred view of illness and creativity.

Caramagno's approach to Woolf's life is mirrored by his attempts

[1] Bond, A. H. (1989): *Who Killed Virginia Woolf? A Psychobiography*. New York: Human Sciences Press. Reviewed in this *Quarterly*, 1993, 62:153-158.

to make sense of her literary contributions. In his commentary on Woolf's first novel, *The Voyage Out*, he appears to argue for a phenomenological perspective: "We must prepare ourselves for the possibility that the text means what it says—that consciousness is a puzzle without resolution" (p. 171). He questions the castration imagery which others have noted in the scene in which Terence kisses Rachel and she sees an old woman slicing a man's head off with a knife: "The kiss's meaning is a florid unmeaning" (p. 179), Caramagno asserts.

To the author's credit, he does acknowledge the usefulness of certain psychoanalytic constructs. In his discussion of Mrs. Ramsay in *To the Lighthouse*, he makes effective use of Winnicott's notion of transitional space. The objectification of the self described by Christopher Bollas is incorporated into Caramagno's analysis of *Mrs. Dalloway*. As the book approaches its endpoint, the author seems to grow more conciliatory in his tone. In the Epilogue, Caramagno makes a point with which few of us would quarrel: "We have a uniquely human need for meaning, and we often benefit personally and psychologically from introspective insight, but ignoring biochemistry does not liberate psychoanalysis" (p. 302).

Virginia Woolf is a literary figure who is endlessly fascinating to admirers of her work. Including the compelling evidence for manic-depressive illness in a psychobiographical study of her is of unquestionable importance. However, as is often the case with a purely descriptive or biological approach to a psychiatric patient, Virginia Woolf *the person* gets lost in the emphasis on genetic pedigrees, symptom profiles, and cognitive features of affective disorders (all of which the author presents with considerable scholarship and attention to detail). Caramagno would have succeeded to a far greater extent if he had striven for the balance between mind and brain which he himself extols in his Epilogue.

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ABSTRACTS

The Dutch Annual of Psychoanalysis. I, 1993.

Abstracted by Jonathan Dunn.

The Psychoanalytic Society and the Analyst, with Special Reference to the History of the Dutch Psychoanalytical Society 1917-1947. Han Groen-Prakken. Pp. 13-37.

The problems in the development of the Dutch Psychoanalytical Society were the same problems inherent in all psychoanalytic organizations starting with Freud. Scientific controversies often mask the psychopathology and personal incompatibilities that more profoundly "split" psychoanalytic groups and institutes: conflicts related to envy, idealization, competition, power, etc. Groen-Prakken's chronicle highlights the Freud-Jung schism because many of the Dutch psychoanalytic pioneers were analyzed and trained by Jung. She also discusses the anti-Semitic attitudes of the early Dutch psychoanalysts toward their European counterparts who immigrated to the Netherlands during the Nazi regime; these more experienced analysts had a disorganizing effect on the smaller, less sophisticated, and perhaps more insecure Dutch group. Where the three main founding factions of psychoanalysis in Holland ("straight Freudians," university-affiliated psychiatrists who were seeking nonbiological theories of mental illness, and the Jungian-oriented group) stood on the issue of lay analysis, and how they dealt with this controversy, is also reviewed.

On the Secret Fantasy of Being an Exception. Antonie Ladan. Pp. 81-99.

Analysands whose conflicts are dominated by unconscious fantasies of being a superior exception present particular technical difficulties. These patients disavow transference wishes and distort their sense of time because they cannot tolerate dependence, longing, or vulnerability to frustration, aging, and death. The sense of exceptionality must be kept secret, lest the illusions fueling this conviction become apparent. The author links this phenomenon to an unloving childhood: adopting a pseudoadult identity, which rigidly stresses omnipotent control and autonomy, blocks out feelings of worthlessness and rage. Ladan discusses how the secret of exceptionality constitutes a central oedipal masturbation fantasy while defending against guilt and shame. She suggests that to help analysands gain a right to their emotional life, it may be necessary for the analyst to spell out the deprivations they have suffered. Finally, Ladan notes some typical countertransference-based collusions with the defense structure of exceptionality.

Along and Across the Boundaries of the Delusions of Grandeur. Jacob Spanjaard. Pp. 129-141.

The author maintains that successful treatment requires a sufficient analysis of delusions of grandeur. This narcissistic phenomenon intertwines with all symptoms, defenses, and mental structures. In health, delusions of grandeur help us cope with our vulnerability to frightening realities, such as death or other malevolent external

forces that we cannot control. Moreover, idealizing our productions is necessary to succeed in our creative pursuits. Grandiosity lurks behind consciously and rationally stated ideals, for in the unconscious such ideals are considered fully realized. Spanjaard notes typical countertransference-based reluctances to address the patient's delusions of grandeur. He argues that delusions of grandeur are best analyzed when they appear in the transference, and that the analyst's suggestive influence may also play a vital role in helping the patient resolve the self-defeating effects of these delusions.

A Modern Oedipus. Antonius Stufkens. Pp. 143-159.

Stufkens reviews the Oedipus myth from a number of perspectives. He stresses preoedipal and narcissistic elements; Oedipus' arrogance, manipulativeness, and impulsivity reflect his need to omnipotently deny generational and sexual boundaries. The author traces such character pathology to Oedipus' abandonment and bodily mutilation as an infant. Oedipus' encounter with the Sphinx represents the male child's struggle to individuate from his primal union with the fantasied bisexual mother, as well as his quest for self-definition and for comprehension of the primal scene. Oedipus' eventual dethronement symbolizes the necessity for the narcissistic "king-boy" to accept his childhood oedipal position—the everyman task that every man must to some extent confront. Stufkens stresses the importance of integrating preoedipal and oedipal developmental issues and conflicts into a common matrix out of which mental life can be understood.

Do Girls Change Their Object? Hendrika Halberstadt-Freud. Pp. 169-190.

Halberstadt-Freud argues that healthy female development involves resolving an ambivalent tie to the sadomasochistically tinged fantasy of the phallic mother; feminine development does not involve any change from the maternal object itself. Femaleness is rooted in a primary feminine identification. Unlike the boy, whose movement away from mother represents his *not* being like her, the girl's pursuit for autonomy invariably intensifies her identification with her mother and provokes a conflict between her murderous impulses and her primal wishes for "symbiotic illusion." Halberstadt-Freud discusses how biological realities, social norms, transgenerational influences, and maternal and paternal response influence the girl's fantasies about her sexuality, her sense of self, and her maternal relationship. She also addresses how menstruation, adolescence, the relationship with the father, childbirth, and motherhood bear on the girl's separation-individuation process from the preoedipal mother.

On Shame and Humiliation. Some Notes on Early Development and Pathology. Herman Sarphatie. Pp. 191-204.

Sarphatie differentiates the phenomenology and function of shame from shyness, humiliation, humiliation fury, and narcissistic rage. Each of these affective experiences plays a particular role in psychological development, internal regulation, social customs, moral values, ego ideals, and psychopathology, particularly the narcissistic disorders. Shame emerges from the act of giving up self-determination and power. While shame always carries a sense of exposure, the external other's attitude

must be accepted by the shamed one; in this sense, the shame experience always involves self-rejection. Sarphatie posits the beginning of shame around two years of age, when subordination to authority and an experience of negative self-evaluation can be mentally symbolized. He discusses the parents' impact on the development of the child's healthy and pathological shame in terms of ego flexibility and ego inhibition. He finally notes the importance of addressing the analysand's shame in treatment.

Mirrors and Shadows of the Analyst. Jan Groen. Pp. 205-222.

Analysts' narcissistic problems---their need to use the analysand to shore up their self-esteem and maintain an illusory grandiosity—negatively affect the analytic process. The analyst may turn the adoring analysand into an idealized transference object. Concomitantly, the analyst may be unable to accept the loss of individuality produced by the analysand's demanding only to be mirrored. In both situations, analysts defensively impose a role on the analysand, rather than opening themselves up in a role-responsive manner. Along these same lines, analysts may try to duplicate themselves through the analysand, or may turn the analysand into an idealized sexual partner with attributes they would like to appropriate for themselves. The analyst's unconscious envy, revenge, and acts of thievery embedded in these countertransference dynamics may cast a persecutory shadow on the treatment. Groen compares generative empathy, in which the identification with the analysand is temporary and a sense of separateness is always maintained, with pseudoempathy, which involves a protracted merging and a "theft of emotions."

Growing, Mourning and Affective Dissonance in the Process of Psychoanalytical Therapies. Frans De Jonghe. Pp. 223-235.

De Jonghe links the process of mourning to the mutative aspects of interpretation and support in psychoanalytic treatment. Interpretation and support are effective insofar as they induce in the patient a dissonant experience of the analyst as simultaneously both transference object and new object. This affective dissonance confronts patients with what they once had but now desire. A mourning process is thereby effected, in which patients gain psychic growth through relinquishing the illusions they employ to temper their painful sense of wanting due to loss. De Jonghe describes other ways in which interpretation inherently creates an experience of loss in the patient. He argues that therapeutic change may come solely from the patient's experiencing the contrast between the therapist as new object and as transference object, without any cognitive elaboration of this contrast (the therapist supports the patient in this experience but does not have to interpret it). The author also notes clinical problems that result when unfulfilled desire is due more to chronic deprivation than to traumatic loss. Therapy stalls when the new experience with the therapist is either too similar or too unlike the patient's past, because in these cases affective dissonance cannot be felt.

On Having and Giving Value. Nikolaas Treurniet. Pp. 239-260.

Valuing implies both an estimation and a feeling; the act of giving value personalizes one's world. Loving, taking pleasure in, choosing, and giving meaning to are

part of, but not synonymous with, valuing. The baby must feel itself valuable to its human environment in order to create value for itself as an adult. The child's aggression, rather than being an innate drive, is often an attempt to preserve a sense of value. Theoretical labels are frequently used to devalue and pathologize the child's experience: for instance, the term "childhood omnipotence" may damagingly impose an adult standard on the child's healthy exuberance. Concomitantly, Treurniet argues that the personal agency and subjectivity inherent in the individual's valuing activity is lost in metapsychological concepts that reify mental phenomena. The analyst inevitably conveys his personal values to the patient, and his neutrality must always communicate an affirmative value with respect to the patient's whole inner life: the greatest potential of psychoanalysis is to help the patient create value in his or her life.

This analytic task is parallel to the functional value of civilization, namely, that it provides its members with the freedom to create value through culture. Society's ideologies and denial systems are unmasked by such individual freedom. Exposing the illusory quality of the community's ideals in this way may cause insecurity and disorganization, and to regain equilibrium and security, society's attention to the external world may constrict in a self-serving and/or dishonest manner. But, like the "holding" function of the analyst, a society that provides safety to its citizens through democracy and a free press can withstand such an open investigation of its values. Treurniet's critique also includes the misuse of technology, the "New Left" of the 1960's, and the political process and the media in America.

POLITICAL SCIENCE

Abstracted by Michael J. Bader.

In the following two articles, Michael Rogin brings his expertise as a political scientist to bear on an analysis of how social conflicts can be translated symbolically in a way that draws upon prevailing intrapsychic dynamics. Rogin is interested in political repression and its use of anxiety and conflict in the individual. Two films are examined from this point of view.

Black Face, White Noise: The Jewish Jazz Singer Finds His Voice. Michael Rogin. **Critical Inquiry.** XVIII, 1992. Pp. 417-454.

Rogin considers the first feature-length talking movie, *The Jazz Singer*, made in 1927, starring Al Jolson. *The Jazz Singer* marked the death of silent films while telling a story about familial and cultural parricide. The central character, Jack Robin (a.k.a. Jackie Rabinowitz), kills his oedipal father *and* the silent movie era through his devotion to singing jazz, a symbol of generational revolt in the 1920's. Like the Jewish moviemakers who built Hollywood, the main character revolts against his failed immigrant father by pursuing upward mobility and the love of a "shiksa." The movie struggles to depict the guilt involved in rebellious assimilation, as well as the costs to the family and the immigrant community. Rogin argues that the movie transposes the social pressures of anti-Semitism into a purely intrafamilial father-son conflict, concealing social reality.

At a time when black performers were banned from starring roles on stage or film, the black voice was "ventriloquized" through the use of blackface. By the early twentieth century, Jews had almost entirely taken over blackface entertainment. Rogin sees blackface as a mask used by Jewish entertainers in their struggles to assimilate. He argues that *The Jazz Singer* emasculated revolutionary black modern music in the name of paying it homage. Blackface resurrected the plantation myth of the childlike Negro and domesticated the improvisational energy of authentic black music.

JFK: The Movie. Michael Rogin. **American Historical Review.** XCVII, 1992. Pp. 500-505.

Contributing to a special issue devoted to commentaries on Oliver Stone's controversial movie *JFK*, Rogin argues that Stone's narrative exploits and expresses underlying homosexual anxieties. Rogin shows that the homosexual subplot involving Clay Shaw, David Ferrie, and Willie O'Keefe actually fuels the entire story and is not separable from the political conspiracy narrative. Through a textual analysis of several scenes and published interviews with Stone himself, Rogin attempts to show that the paranoid content of the film is related to homosexual anxieties.

Canadian Journal of Psychoanalysis/Revue Canadienne de Psychanalyse. I, Number 1, 1993.

Abstracted by Marc-André Bouchard.

Introduction. Eva P. Lester. Pp. 1-4.

In 1954 the first and last issue of the *Canadian Psychoanalytic Review/Revue Canadienne de Psychanalyse* was published. The Canadian Psychoanalytic Society was then a provisional society of the International Psychoanalytical Association, with a membership of seven and the stated purpose of "forming a new society to promote psychoanalysis in Canada." In the mid-eighties, a few members, led by W. Clifford Scott and Paul Lefebvre, met to reactivate the project of a Canadian psychoanalytic publication. Now a mature society numbering several hundred members and four active branches of its national institute, the Canadian Psychoanalytic Society voted to proceed with the present new publication of the *Journal/Revue*. The new journal is bilingual and open to contributions from Canadian authors, as well as from all other psychoanalytic constitutiencies. The Editor, Eva Lester, conceives the journal as "a medium for diverse psychoanalytic voices not often found in one publication. The very nature of our Society with its two linguistic traditions and its reflection of the psychoanalytic streams in Continental Europe, Great Britain, and the Americas, supports this vision."

Contemporary Considerations Influencing Psychoanalytic Interventions. Douglas H. Frayn. Pp. 7-25.

Interpretation of unconscious transference impulses and libidinal repression remains the cornerstone of classical psychoanalytic interpretation. According to Frayn,

there is increasing support for a preinterpretive phase, and preference given to nontransference interpretations prior to an adequate development of the narcissistic patient's self-reflective capacity. By contrast, early interpretations of drive/conflict elements within regressive transferences, rather than leading to introspection, have been noted frequently to lead to "defensive unrelatedness" between analyst and analysand. For self psychologists, pathological narcissistic deficits are based on thwarted development and require involvement, affirmation, validation, and idealization by the selfobject (analyst). Some analysts feel it necessary to extend empathic listening to include a complementary, sympathetic, "proud parent" stance. Frayn believes these often appear as transference-gratifying, re-educational psychotherapeutic interventions. The analyst should not attempt to approximate the infant-caregiver, except to sustain and acknowledge the selfobject fantasy within the patient. Analytic intervention should help the patient express her or his troubled intrasubjective world symbolically through words rather than through symptomatic behavior. Analysts of any orientation could benefit from the appreciation and therapeutic use of the processes of empathy, intuition, projective identification, and externalization which seem to be involved in the creation of the various intersubjective regression phenomena. If interpretation brings about insight through structural changes, other dynamic reorganizations and significant ego integrations take place via affect clarification, abreaction, affirmation, suggestion, and reassurance. Empathic statements, including validation, sympathy, compassion, even praise, may be internalized as self-confirmatory reactions. More than just temporary auxiliary ego support, these interactions can encourage the progression of object constancy and self-soothing. The expanded role of subjectivism—within both the patient and analyst—is stressed. Identification and exploration of shared analytic phenomena facilitate conscious reconstructions rather than repetitious living out of regressive transferences.

Intergenerational Grief—Who's Mourning Whom? Louis A. Demers. Pp. 27-40.

In this fascinating paper, the avatars and vicissitudes of mourning and intergenerational grief in the psychosomatic variant of the narcissistic personality disorder are examined. A patient, unaware that he is struggling with unconsciously transmitted grief, may be under the influence of a cryptic mourning process and may develop a vulnerability to psychosomatic disorders. The cryptic mourning process, initially bound by psychic activity in the first generation, becomes somatized within successive generations.

Patients in the psychosomatic variant of the narcissistic personality disorder share the usual characteristics of the narcissistic personality, with the following added features: (1) a particular factual thinking mode; (2) a disaffected manner in dealing with emotions; (3) a deficiency in their symbolizing and fantasizing functions. Specific mediators for somatic vulnerability include the impoverishment of the capacity to symbolize and elaborate fantasies and dreams. The author here suggests consideration of one additional, nonspecific factor in the etiology of somatic vulnerability: cryptic mourning.

To conceive of introjection as the universal response to object loss helps to explain a wide variety of pathological grief reactions, including the important distinction

between introjection and incorporation. Introjection is a psychic process that, while temporarily aiming to preserve the object, ultimately aims to give it up. Introjection refers to form; incorporation, on the other hand, refers to the content of a fantasy—a cadaver maintained "dead-alive" and never relinquished. In faulty mourning, incorporation will take the place of introjection, a substitution reflecting the inner struggle of the ego both to escape and to master the pain of loss; but in healthy mourning there is a often a residue of introjection concurrent with a parallel series of partial detachments from the introject.

Wholesale fantasmal incorporations lead to wholesale identifications in which the mourner attempts to retain or identify *in toto* with the lost object. This situation demands a new distinction between the inside and the outside and between the different parts of the ego. Normal grief seeks to restore these limits; otherwise, deviant topographical resolutions ensue.

Investigating the various topographical locations of the lost object, the author proposes, with the help of Guillaumin, four clinical categories. First, *utopian mourning*, a protective idealization with the purpose of creating a quasi-ideal status for the lost object. Second, *ectopic mourning*, in which traces of the lost object are masked and processed through projective substitution, rendering a child a "cryptophore." Abraham and Torok's theoretical and clinical description of the process of "endocryptic identification" is used to describe the way a child absorbs unending parental grief. Through an occult incorporative process, the child becomes host to the unmourned deceased, the latter having a parasitical relationship to the child. Basically, "cryptophores," constantly struggling with a "ghost effect," are the unconscious carriers of the crypts of their parents, trapped in borrowed guilt to pay a debt not discharged by the preceding generation. Third, *nontopographical mourning* is characteristic of melancholic outcomes, through a sort of invasion of the ego by the lost object, implying the impossibility of containing or elaborating it. Fourth, *paratopographical mourning* uses partial objects in an obsessional or fetishistic manner, clinging to them in order to keep the object alive metonymically, thus avoiding an insufferable narcissistic wound.

Three clinical vignettes of cases of *ectopic mourning* are presented, along with an illustration from Richard Lortz's book *Bereavements*, showing that a psychosomatic destiny comes into play very early in one's life, sometimes even before birth.

On Lying. François Sirois. Pp. 41-60.

In trying to understand the analysand, the analyst is confronted on a daily basis with lying, more through force of resistance to hidden truth than through malice on the part of the speaker. The opinions of Aristotle, Plato, Augustine, Thomas Aquinas, and Rousseau are called to mind. Lying is often seen as a fiction wherein the subject abuses him or herself. But the psychological aspect concerns not only the lies one tells oneself, it may also involve a refusal of the truth, a refusal to know, or a mode of relating where the prime intention is to deceive. Four kinds of lies are described. The plain lie is a mild, furtive lie by someone who normally does not lie. It appears in neurotic patients, a symptom of transference following activation of a source of conflict during treatment. The outrageous lie is pernicious, a sign of character disturbance, associated with psychopathic characteristics. O'Shaughnessy

describes the case of an aggressive liar who seeks omnipotent control over the object through identification with a nonreliable object. Bollas describes a mystifying liar, who uses the analyst as a public for his lie, the better to captivate the analyst, to create a fantastic object that will satisfy the desires of the subject. The fantasy lie has been described by Deutsch as daydreaming communicated as reality. It is a fiction about oneself (*pseudologia fantastica*), the lie of the dreamer introverted into fantasy. The intent to deceive is aimed first at oneself, but also at the other, who, it is hoped, will also believe, rather than spoil things by doubting. Finally, the white lie is used to hide a part of oneself from the gaze of the other, to hide the thoughts, mood, body, and emotional state of the subject, to prevent intrusion of the other into the private sphere. Here, suppression and reserve are the issue, rather than fabulation. On a more psychoanalytic level, lying may be defined simply as a symptom, a compromise in the face of opposing forces. As a process, lying is linked to repression and defense mechanisms, especially denial, negation, and disavowal. As a product, lying is linked with fantasy, the desire to deceive, and illusion.

Between Earth and Heaven: A Few Remarks on Use of the Couch in the Analytic Setting. Domenico Arturo Nesci. Pp. 61-72.

The analysand stretches out on the couch, no longer upright. The analyst is seated comfortably behind the couch, listening with evenly hovering attention while maintaining a more direct contact with the ground and reality. The place of analysis and the scheduled sessions thus become the theater of a new version of an eternal mythic motif. In this setting, it is ethnopsychoanalysis that informs us. According to Frazer, "divine monarchs and priests" and "young pubescent girls" were subject to similar rules in different cultures: they were forbidden to touch the ground or to cast eyes on the sun. There is an evocative correlation between the suspended, isolated position of such figures and that of analysands, who are asked to raise their feet from the floor and, one might say, to place themselves between heaven and earth. This, in the interest of facilitating the departure from the mundane space/time of consciousness and encouraging abandonment of "earthbound judgment." The couch becomes the means of putting the fundamental rule of analysis into practice. The phenomenon of the margin is of interest in understanding the psychoanalytic setting as a space of change. Using the studies of Vernant, then of Freud and Chasseguet-Smirgel, the author proposes that the analyst and the analysand merge and are confused in the suspended time of analytic rite, and then separate in the hope that the analyzed parts will find different configurations more adapted to reality. The couch gives form to the neutral zone which separates natural science from social science, scientific research from therapy, the contractual relationship from the relationship of transference; this prevents the analyst's office from becoming the monster factory exemplified by H. G. Well's celebrated story, "The Island of Dr. Moreau." The couch represents the limit of the analytic operation, the border between the analyst and the analysand, the asymmetry of the relationship, the terminability of analysis, the reversibility of regression. It becomes the concrete metaphor defining the horizon of meaning, the imaginary line between heaven and earth, allowing our creative "impossible profession" (Freud) to exist.

The Story of I: Perspectives on Women's Subjectivity. Jessica Benjamin. Pp. 79-95.

This paper considers aspects of maternal and paternal identifications as they figure in women's development. "The Story of I" is, of course, a play on *The Story of O.*, meant to evoke concern for women's subjectivity, for their being sexual subjects rather than objects. Benjamin makes a double-edged point: (a) that the categorical distinction between phallic father and containing mother offers a useful metaphor for identifications; (b) but that these pairings should be transcended and reconciled in certain categories, dissolved in or destabilized by others. Benjamin reminds us of Fast's theory of gender differentiation and its reinterpretation of the idea of bisexuality to mean the position of identifying with both parents. Ideally, children of both sexes continue to identify with both parents; the rapprochement father is a kind of paradigm of *identificatory love*. The more "outside" object at this time is the father. The boy toddler's homoerotic love affair is with the father as representing the world. This love serves as the boy's vehicle for establishing masculine identity and confirms his sense of himself as subject of desire. Girls seek what toddler boys recognize in their fathers and wish, through identification, to affirm in themselves: recognition of their own desire. The process of identification can be successful only if it is reciprocal, when the father identifies with the child and says, "You can be like me," or when the validating mother says, "You are just like your Dad." If, however, the tension of separating from the mother is too difficult, the two parents begin to be formulated as a gender split: mother represents attachment and father the recognition of independence, but mother is too close and father too far away.

The origins of this idealization have been obscured insofar as psychoanalysts assumed that unattainable longings for the idealized father expressed in the transference of women patients were oedipal, heterosexual in character. The longing to identify with the idealized father of separation in order to be empowered, to separate from mother, and to feel excited, appeared in the guise of penis envy. This was interpreted as resistance to oedipal feelings, a possibility among several, or it was conflated with oedipal wishes. Similarly, the idealized father transference of male patients, or the urge to submit to father in order to incorporate the phallus, was understood as a negative oedipal stance, rather than an expression of their longing to recognize themselves in and be recognized by the early dyadic father. In short, the importance of identificatory love in emotional life, its persistence in tandem or in oscillation with object love, was missed.

Eating Disorders and Femininity: Some Reflections on Adult Cases that Presented an Eating Disorder during Adolescence. Janine Chasseguet-Smirgel. Pp. 101-122.

The study of philosophy and religion confronts us with the body-soul duality, the body considered as an instrument of the devil destined to overpower the human soul, a filthy coating we must rid ourselves of. The body has needs and desires that persecute the psyche. It changes, declines, dies, and rots, while the psychic self (the "soul" in its metaphysical version) is limitless, glorious, and eternal. Selvini-Palazzoli was the first to demonstrate that in anorexia it is not food the patient fears, but the

body. Bulimia represents the same effort to control the body, the same desperate attempt to be in charge. *Tota mulier in utero*. This misogynous adage, motivated by masculine envy and fear of the creative maternal, corresponds to the internal self-image of certain female adolescents, against which they rebel.

The author examines the unconscious relationship between excreta and food, between eating disorders and autoerotic deviations, in her patients. She suggests that eating disorders are manifested as a means to attain self-sufficiency; such patients attempt on an unconscious fantasy level to function in an autarchical manner, to be independent of whatever comes from the external world. In bulimia, as in anorexia, the object is not food; the object is the body itself, confounded with the body of the mother. The issue is, above all, one of taking charge, of distending the body, making it swallow anything, in any order. The anal signification of this behavior is often evident. It is possible to link the excremental bulimic world to the negative nature of the precocious infantile autoeroticism of these patients (anal masturbation and its derivatives). In the same vein, in bulimia there exists an autarchical fantasy in which the subject eats her own feces. The equation between feces and food, between the subject's buttocks and the mother's, as well as the mother's breasts, indicates the various characteristics common to bulimic patients: autarchical illusion and pseudoindependence; kleptomania; the food-feces equivalence; active sexual behavior marked by fear of maternal intrusion and control, the sexual partner being insufficiently differentiated from the mother.

These activities conceal unavowed passive desires experienced as shameful and dangerous: sometimes manifest homosexuality, which aids in disengaging from the maternal feminine through projection of the ideal self onto another woman; penis envy, the desire to acquire the member lacking in the mother, in order to become differentiated; the violent, quasi-incestuous father, insufficiently differentiated from the maternal imago, and encouraging pregenital regression; and the appearance of perverse behaviors without stable organization. Despite struggles for autonomy, the patient does not abandon the desire to merge with the primary object, to repair the precociously experienced discontinuity. Several clinical cases serve as examples. Chasseguet-Smirgel concludes by emphasizing that these hypotheses are far from being applicable to all women. The construction of a positive autoeroticism makes it possible to avoid the dramas to which eating disorders bear witness.

The Role of Fantasy in Shaping and Tracking Female Gender Choice and Sexual Experience: To Make Love or To Make Believe? That Is the Question. Estelle Shane and Morton Shane. Pp. 127-143.

This paper discusses the place of *conscious* fantasy in the sexual life of women. In certain psychoanalytic, lay, and literary sources, fantasy is thought to enhance sexual experience. In contrast, the authors have observed that conscious fantasy appears often to serve as needed protection against full, intersubjective, sensual-sexual sharing with another, a protection that in itself provides the conditions necessary for sexual satisfaction. For Freud, fantasy takes the place of actual experience; for Klein, *phantasy* invariably accompanies it. This crucial distinction has been blurred over the course of the time, particularly in the area of sexuality where fantasy plays a central role. The predominant point of view of those who have written about this topic (e.g.,

Kernberg, Stoller, Hollander) is that there need be no concern that conscious fantasy interferes with mutuality. But clinical experience has led the Shanes to conclude that private fantasy and shared fantasy can both serve to dilute intimacy and to protect against the fullness and immediacy of sensual-sexual sharing.

Contemporary Psychoanalysis. XXVIII, 1992.

Abstracted by J. Alfred LeBlanc.

The Opposing Currents Technique for Eating Disorders and Other False Self Problems. Steven Stern. Pp. 594-615.

Stern describes his adaptation of an interpersonal technique to the treatment of a particular subgroup of psychoanalytic patients—those who because of false self character defenses are highly resistant to the direct discussion of the transference or of the therapeutic relationship. These patients, e.g., the eating-disordered previously described by Hilde Bruch, are often hypervigilant about whose interests are being served in the treatment. Bruch emphasized mirroring the patient's own self-exploration and self-definition to counteract the suspicion of control by the therapist. Many of the patients described depend heavily on defenses of denial, disavowal, and dissociation to maintain a split between a traumatized self and the "false self" evolved for security relations with necessary others. A manifestation of this split in the transference is the patient's disavowal of affective wishes and needs with the therapist. This results in a restricted awareness of the transference process.

To counteract this restrictive influence, Stern advocates the use of a Sullivanian technique which clearly identifies the influences of "the other people in the room," and in a back-and-forth movement gradually differentiates the patient's actual experiences and wishes from the influence of those "other people." This has been referred to as a "widening and balancing" or "managing opposing currents" technique. The result is that disavowed affects, needs, and developmental goals previously unacceptable can, through this facilitating and "holding" method, be finally integrated. Stern refers here to character pathology subsumed under Winnicott's "false self" organization, Kohut's "vertical split," and Stolorow, Brandchaft, and Atwood's "fundamental psychic conflict." He emphasizes that the "opposing currents" method requires holding in mind simultaneously both of the patient's dominant motivations—the underlying repressed needs, and the "other-person" directed repudiation or disavowal of those needs—which structure the false self. Stern, in a discussion of a twenty-six-year-old woman's anorexic and character pathology and treatment, underscores his opposing currents technique as crucial to her emergence and recovery. His empathic recognition of the patient's defensive need for control *and* for primary nurturance and connectedness is emphasized, as are safety needs and the search for mastery. Following Weiss and Sampson, Stern views re-enactments *primarily* as problem-solving attempts, not as compulsive acts under the aegis of the pleasure principle, nor as efforts to re-create the interpersonally familiar, as in Mitchell's view. Stern omits reference to the reality principle and to prior contributions on mastery, including Freud's. Nor does he address himself to qualities of pleasure that may fuel the satisfaction achieved through mastery, except to emphasize the sense of safety the patient achieves in the analysis.

From this perspective of safety, or of control-mastery theory, Stern indicates that interpretations are to be utilized only when facilitating, or deepening, the analytic process. He stresses that not all interpretation is useful, and one wonders if he is referring to "wild analysis," in which issues of resistance, defense analysis, and timing of interpretation are eschewed. But his digression from Gill's recommendation—to aggressively interpret the transference where there is clear resistance to awareness of the transference and to utilize instead this opposing currents technique—appears constructive. Moving away from generalization to specific application, Stern offers a clearer understanding of the quality and character of the underlying resistances and transference experiences of this group of patients.

Vincent's Suicide: A Psychic Autopsy. W. W. Meissner. Pp. 673-694.

Meissner addresses the enigma of suicide through a detailed study of van Gogh's life and letters, and through the observations of other authors, such as Gedo, Heiman, Menninger, Nagera, and Poznanski, which are relevant to van Gogh's experience. While acknowledging the basic Freudian mechanism of murderous impulses turned against the self, he greatly enhances our understanding of the various yet interactive forces which tend to make the suicidal act compelling. And he describes three suicidal elements, "heightened inimicality, increased emotional perturbation and hopeless constriction," which in conjunction embody the suicidal state. He notes that the organization of pathogenic introjects is central to understanding the dynamics of suicide. He quotes Buie: "Suicide is a phenomenon of disturbed internalization, an effort to cope with hostile introjects and to cope with the absence of those comforting inner presences necessary for stability and mental quiet."

The historical life data he presents are clearly illustrative of these disturbed internalizations. Meissner explores van Gogh's symbiosis with his brother Theo and his inability to enlist anyone but Theo as a secret sharer. In his one close artistic relation with Gauguin, he contrived to have himself rejected and despised. We learn that van Gogh was "a replacement child" born a year to the day after the first Vincent. The influence of his mourning mother, the austerity of the parsonage, and the ever-haunting presence of the grave of his brother (the primary object of his mother's affection) gave him the sense that it was better to be dead than alive. Being a replacement child, an inevitable disappointment to his parents, was the central pathogenic introject van Gogh repeatedly attempted to overcome. Another unconscious introject was his identification with Christ. In his *Pietà* we can discern multiple interwoven dynamic factors: the suffering, persecuted son (with Vincent's features), the mourning mother who receives him (a wish fulfillment and final acceptance through death?), and the surpassing of the dead brother and minister father.

In a discussion of the final paintings, *Crows over the Wheat Field* and *La Berceuse*, Meissner depicts the convergence of the trio of suicidal elements. The heightened inimicality is evident in the rupture with Theo, his last link. As van Gogh's emotional perturbation and hopelessness increased, so did his conviction of real abandonment: the religious fantasy of death and resurrection beckoned.

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