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PSYCHOANALYTIC TECHNIQUE AND THE INTERACTIVE MATRIX

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In this paper the concept of an "interactive matrix" is introduced. The interactive matrix is shaped, from moment to moment in every treatment, by the personal characteristics of the analysand and of the analyst. These include the beliefs, commitments, hopes, fears, needs, and wishes of both participants. It is only within the context of the interactive matrix that the events of an analysis acquire their meaning. The implications of this perspective for analytic technique are explored and illustrated with a clinical example.

For some time now, the practice of clinical psychoanalysis has been going through a profound transformation. Clinicians and theorists of all persuasions are turning away from the one-person model of the analyst as a detached observer listening with evenly hovering attention to a freely associating patient. Instead, there is a growing consensus that the analytic dyad consists of two people in a complex interaction, each participant bringing a unique personality to the project. My purpose in this paper will be to develop the implications of this clinical sensibility, focusing especially on our technique. In doing so, I will be questioning not only the particular methodological prescriptions that together make up so-called "standard psychoanalytic technique," but—more broadly and more radically—I will be questioning the possibility of having any "received" technique at all.

Consider the roots of our clinical method. When Freud wrote about technique, he described what he had personally found effective; his recommendations were generalizations from his

experience as an analyst. At times the papers on technique read like cautionary tales. "Don't do this," Freud tells us, "because if you do you will have more trouble than you bargained for." The analyst should remain anonymous, for example, because self-revelation makes it difficult to overcome deep resistances, makes some patients insatiable about knowing more, and makes resolution of the transference highly problematic (1912b, p. 118). Evidently, these problems cropped up when Freud experimented with telling patients about himself, and he is passing on his experience in the hope that doing so will help novice analysts avoid temptation. Similar concerns underlie his advocacy of other technical principles. But, since most of them were in place by 1915 or so, the experience on which they were based is limited compared to our own. Freud's generalizations may have been valid at the time and in the place they were made, or they may not have been. They may travel well across oceans and decades to contemporary practice in other places, or they may not.

Freud sometimes expressed caution about technical generalities. In his "Recommendations to Physicians Practising Psycho-Analysis" he wrote:

> . . . this technique is the only one suited to my individuality; I do not venture to deny that a physician quite differently constituted might find himself driven to adopt a different attitude to his patients and to the task before him (1912b, p. 111).

Significantly and unfortunately, however, Freud rarely told us what it was about himself that shaped his technique. It would have been helpful if he had done so, and it would certainly have gotten psychoanalytic discourse about clinical method off on quite another foot. But, as is well documented, Freud was wary about the general public learning very much about analytic technique, much less about analysts' personal reasons for doing what they do. This caution was reasonable in light of the wide-

spread skepticism about what goes on in the consulting room. Public reaction to what is perhaps his best known confession—the acknowledgment that he preferred the couch because he disliked being stared at—has typically been less than generous.

Despite Freud's own awareness (at least occasionally) of how much his personality influenced his method, somewhere in the history of psychoanalysis his generalizations from limited experience got elevated into universal, even a priori, rules of procedure. In some cases (like self-revelation) Freud's hunch became a rule that putatively defines psychoanalysis as a treatment modality and that distinguishes it from other psychotherapies. This happened despite the publication of other analysts' clinical experiences that differed strikingly from Freud's. Sandor Ferenczi—widely acknowledged as the leading clinician of his day—experimented with self-disclosure and reported dramatically different results. But despite the conflicting data Freud's preferences became unquestioned imperatives, and open discussion of interesting and crucial matters of technique was stifled.

I will illustrate some of the problems that accompany this legacy by describing a recent experience that I had doing supervision. Martha, a forty-five-year-old accountant, has been in treatment for two and a half years with a male analyst a few years younger than she. The analysis has frequently been abrasive, due largely to Martha's conviction that she will feel humiliated and degraded should she experience her analyst as interesting in any way, shape, or form. There has been a good deal of professional competitiveness (Martha has friends who are therapists, and they provide her with a vast armamentarium of interpretations that have not occurred to her analyst) as well as a sexualized contentiousness aimed at denying her analyst's appeal. My sense, supervising the case, has been that Martha would feel mortified if confronted with her own desire. This is significantly exacerbated because she has been frustrated in her efforts to find a romantic relationship, her analyst is an appealing man, and he is even younger than she is. Her demeanor in the analysis, similar to her characterological style in the rest of

her life, is to induce the dreaded feeling of mortification preemptively in the other.

The moment I will describe occurred at a time in the treatment when things were changing rapidly. Largely as a result of the analyst's patience with Martha, his willingness to stick with her through difficult times, and his ability to examine some quite aversive countertransference reactions, Martha has been able to experience a range of new feelings toward him. She is moving toward a powerfully felt erotic transference, by which I mean that she is developing a crush on him.

In the midst of this, the patient arrives for a session two or three minutes late. Because the analyst's office is in his suburban home, however, it is not clear whether he was actually in the office waiting for her or whether he was late himself. Martha mentions the late start to the analyst, implying (at least to his ear) that the sessions should be extended to make up for it. The analyst responds by reminding her that it is she who was late, adding (a bit defensively, I thought) that they will be stopping on time. There is some discussion about which of the two was late. This ends inconclusively, and Martha goes on to talk about other things.

As the session comes to an end, it occurs to the analyst that a charged issue has been overlooked. He brings up the unfinished business from the beginning of the session, wondering whether Martha has any feelings about his decision not to make up the time. Martha responds angrily, and perhaps more emotionally than is usual for her. She says that she had been upset earlier, but that she had gotten over it and was glad to do so. Wanting the analyst to extend sessions isn't just an issue for today, she says; she *always* wants that from him. He should offer to go overtime frequently, not just when a session starts late. This would be the evidence she so badly needs that the analyst loves her.

As the time comes to leave, Martha tells the analyst that she is feeling lousy. She had been hurt at the beginning of the session, but she had gotten over it. Now, thanks to the analyst's inter-

vention, she is depressed again. She leaves looking visibly upset. The analyst, for his part, feels guilty that he has hurt her. His guilt is focused not just on having made her feel bad, but is more specifically a reaction to having confronted her with his own desirability and with her passion for him.

Martha begins the next session by saying that she had taken a wrong turn while driving to the session, and that she was sure she would be late. She had thought about it, and realized that actually she didn't want to come at all, although despite the mistake she did arrive on time. The analyst—feeling somewhat guilty that this normally competent woman had become regressively confused as a result of his heavy-handedness at the end of the previous session—quickly connected Martha's wrong turn to her feeling of humiliation as she had left. Making this interpretation, he added that he was sorry that he had hurt her.

When he reported apologizing to the patient in our next supervision, the analyst prefaced his account by saying, "Of course you'll think that I shouldn't have said this, but. . . ." For my part, I was somewhat chagrined by that remark, largely because he was correct. I tend—with the appropriate caveats about special circumstances that accompany all rules of analytic technique—to believe that we should not apologize to our patients. In thinking through the issue, my first concern with apologizing, as with many other interventions, has to do with not infringing, any more than necessary, on the patient's autonomy, on his or her freedom to react to me as spontaneously as possible. On several counts, I find, apologies limit spontaneity. For one thing, I think that often they serve as a kind of undoing; as interpersonal events, they pull for reassurance or even for concern that the perpetrator of the offense should not feel too bad about the damage that has been caused. More generally, conventional interventions tend to evoke conventional responses. "I'm sorry for that" is a conventional comment par excellence. The conventional response is to dismiss the matter with a shrug and a "that's all right"; it is what I would expect most patients to do. On two

counts, then, apologies compel (or at least invite) a particular response, whereas silence leaves the field more open to whatever comes next from the patient.

I am in fairly good theoretical company when I say this; Sullivan (1953) referred to at least some apologies as "propitiatory gestures" (p. 200). So at this point it would be relatively easy to turn a set of observations into a technical prescription. But before I go too far overboard about the wisdom and the universal applicability of my thoughts about apologies, I need to indulge in a bit of self-revelation. First, I frequently notice that when I have felt slighted or angered, an apology is the last thing I want. I would rather be left alone with my feelings, to be angry or whatever else I am, at least for a while. Opportunities for self-righteousness come along rarely enough that they deserve to be savored when they do arise. Second, at least some of the time I sense that when I am apologizing to somebody else, it is precisely because I am looking for forgiveness, not so much because I am empathically concerned with the other person's feelings. So on both sides, I am quick to notice the ways in which apologies are designed to influence the behavior of the other.

Apparently, then, my analytic conclusion that apologizing limits the patient's autonomy does not spring from an emotional vacuum; it is hardly a pristine logical deduction from detached observation. Rather, it is a sensibility shaped by personal predilection, even by personal idiosyncrasy. Do I want to promote universal rules of technique on the basis of my own quirks? Do I even want to indoctrinate my supervisee into a way of working with no more solid foundation than this?

If I had not gotten into these personal musings, I would have stuck with the idea that my supervisee had done something wrong. What occurred to me at first was something along the lines of "apologies are not analytic," and I could imagine saying a more or less polite version of that. But instead I decided to ask my supervisee what his own feelings about apologies were. Quickly and adamantly, he told me how important to him they can be. In fact, he said, he often finds himself in situations

where he feels he cannot continue with whatever he is doing until he receives an apology. If he is sure he has been seriously wronged, he feels that the person who has wronged him is so out of step with his state of mind that only his or her recognition of the fact will heal the breach. Neither closeness nor collaboration with this other person is possible in the absence of such recognition.

I have heard such sentiments expressed before, both in and outside my office. This time, however, I heard them differently. My supervisee was sure I would think he should not have apologized. He is right, although with some reflection it is more accurate to say that I think *I* should not have apologized, in light of my personal feelings and the derivative theoretical commitments. But what about *him*, with his own personal and professional stake in the issue? Could he—or should he—learn to do what I do naturally?

Historically, this has in fact been the essence of psychoanalytic training. Consider one striking example among many of the way personal preference has been elevated into universal technique. For the American ego psychologists, the timing of interpretations is delicate and intricate. We must begin at the surface and proceed carefully through the topographic levels, arriving at the depths only when they have been delicately and cautiously exposed. First interpret resistance, then transference, then impulse, they say—or, in Fenichel's terms, we should interpret "what is already in the preconscious—and just a *little bit more*" (1941, p. 53). If we do not do this, the ego psychologists are sure, we will lose the potential insight, and perhaps even lose the patient. But in contrast, Kleinian analysts insist that unless we plunge immediately into the heart of darkness, getting at the deepest level of the patient's desires and fears, we will frighten the patient and compromise our analytic potential. The analyst's very caution in the face of the patient's greed, hatred, and paranoid anxiety is contagious (see Segal, 1967). If we cannot confront what is most terrifying and most painful, how can we expect our patients to do so?

Adherents of both schools claim to have evidence that their particular point of view is correct *because it works*. Note the similarity of this line of argument to Freud's in the papers on technique. Debates like this—in the absence of anything remotely like a clinical trial that would provide evidence of the relative efficacy of different technical approaches—are rampant in psychoanalysis. It is hard to escape the conclusion that adherents of each school are describing what works for them, and perhaps even inadvertently saying something about what attracted them to the school in the first place.

Not being immune to traditional values, I found it tempting to argue things out with my supervisee on theoretical grounds. It would go roughly like this: I would point out the importance of autonomy, its relationship to the technical principle of free association; perhaps I might invoke a modified version of the rule of abstinence. He would respond by invoking the priority of narcissistic equilibrium. Autonomy, he would say, depends upon the experience of an intact self; until he heals the wound he has inflicted, the patient is going to flail around in a desperate attempt to restore her self-esteem. To which I might respond that the sense of fragmentation itself is secondary to the patient's perceived need to squelch her rage, a reasonable need in light of the analyst's overt countertransference reaction—his masochistic and self-abnegating apology.

The argument might go on for quite some time, and as I play it out in my mind, it seems increasingly pointless. There is no way of adjudicating, or even of joining, one person's conviction about the priority of autonomy and another's conviction about the priority of narcissistic equilibrium. They are simply two paths that may lead to understanding a moment in an analysis; neither is anything remotely like a royal road. The theoretical arguments are equally sound—and equally flawed—on both sides. When all is said and done, I cannot imagine a person embracing one over the other on purely intellectual (or even on purely rational) grounds.

This does not mean that there was no rational basis for dis-

cussion between my supervisee and me. I did feel that he had acted reflexively with his patient, that his response to Martha was short-circuited by his guilt and anxiety. What we talked about, including the focus on what each of us feels about apologies, provided a new context for understanding what happened in that analytic moment and a new way of thinking about his participation. But even with our deepened understanding of the interaction, I do not assume that my supervisee will or should change his mind about what to do. I can imagine, in fact, that some day he will supervise someone who reflexively, guiltily, and anxiously fails to apologize to a patient. Just as my personal preference allowed me to notice something that was going on, sensitized me to an alternative, and provided a platform for a new and more rational way of thinking about what went on, so will his. But the rationality lies in our discourse; it is not inherent in any particular technical principle.

Notice that to this point I have developed the idea of the difficulty of deciding in advance whether to apologize to a patient without having said anything about what the patient brings to the interaction. Clearly, though, patients are as different from each other in this respect as analysts are. There are patients who want or even require apologies as healing gestures and signs of concern and respect, and there are patients who resent them as condescending and controlling intrusions. It does an injustice to the complexity of our work to say that these are simply analyzable wishes; in my experience they are not necessarily resolvable—at any given moment, at least—by interpretation. It is something of an analytic conceit, or perhaps the prerogative of a supervisor or consultant, to say with any certainty that a patient's reaction could have been modified if only the analyst had intervened correctly. The patient who requires an apology, for example, may not be able to analyze that need until and unless the analyst offers something that makes it possible to do so.

In addition to specific feelings about apologies, both analysts and patients have personal reactions to the analyst's relationship

to the canons of classical technique. Whether Freud ever followed them himself, and whether or not they have become obsolete in the eighty years since he invented them, we each have what amounts to an internal object relationship with his method. For long periods in the career of most analysts, these rules of procedure stand as our collective professional ego ideal. Some of us quiver at the prospect of modifying long-sanctioned practices, feeling guilty and ashamed when we do something that is at odds with received procedure. Others of us welcome the opportunity to break rules, perhaps even feeling a secret thrill at the defiance of our teachers and their orthodoxy. The analyst's feelings about this shape his or her feelings about particular interactions throughout every treatment.

Patients sense and react to their analyst's inner relationship to the received method. Most patients are well aware of one or another version of the analytic frame. Even those who are not are likely, sooner or later, to know something about the analyst's investment in his or her role as a analyst. Some patients welcome the idea or even insist that the analyst tailor technique to suit their needs; others feel safer when the analyst sticks firmly to established ways of doing things that reflect long-standing personal values and choices. I have worked with people who get into a competitive struggle with the analytic technique, which becomes a kind of personal rival. They have told me that I must care more about my role, or about the rules I am supposed to follow, than I do about them. It is as if my relationship to Freud matters more to me than they do. For such patients, bending the rules is a gesture of loving concern and invites collaboration. But for others, the same kind of flexibility is a threat—perhaps it makes them feel too powerful in their competitiveness or even in their sadism.

So we are left with analytic dyads that are vastly different in their attitudes (whether patient and analyst have similar or different feelings) on any particular issue. With this in mind, I would like to introduce a concept that I will call the *interactive matrix*. The interactive matrix is a construct that can help us

characterize the make-up of a particular dyad. We can use it to specify the beliefs, values, commitments, hopes, needs, fears, wishes, and so on that both analyst and patient bring to any particular moment in the treatment. These ideas and feelings, in turn, become important determinants of the meanings with which each participant invests the events of the analysis.

The interactive matrix is a third step in the evolution of our thinking about method. First there was Freud, who taught—despite his occasional warnings to the contrary—that certain rules of technique can be applied across the board to all analyzable patients. The fundamental rule and the rule of abstinence set the frame within which an analytic process can get going. For classical analysts, these rules can and must be specified in advance; they become conditions of the treatment. The basic rules generate derivative rules: the rule of anonymity, the principle of neutrality with its imperative to avoid giving advice or encouragement, and rules against making any kind of small talk are all cases in point. Psychoanalysis is by definition treatment conducted according to these rules, with a properly selected patient.

The second step came with the realization, by analysts of many different theoretical persuasions, that numbers of patients who could participate in an analysis in the sense that they could work with their transferences and their resistances were not capable of tolerating the austerity of standard technique. Early on, this was discussed in terms of some patients' need for a more actively established alliance with the analyst, an alliance that was explicitly viewed as a departure from the older rule of technical neutrality (Greenson, 1967). Recently, this approach has broadened considerably. Technique, it is argued, must be tailored to the capacities of the individual patient. We cannot say in advance how active the analyst ought to be, how warm or supportive, what the correct timing of interpretations is.

There is considerable overlap between this approach and the one I am advocating, because both allow for considerable technical flexibility. But there is a substantial difference, because in this second-stage method, the variations depend exclusively

upon the needs of the patient. This is usually couched in terms of developmental level and/or nature or severity of psychopathology. The empathic analyst, observing his or her patient with no methodological axe to grind, determines what the patient can use. Drawing from an enlarged bag of technical tricks, the analyst intervenes correctly, and the treatment stays on track.

I want to be clear that I admire and use a great deal of what has come out of this second-stage approach (see, for example, Pine, 1985). But I also want to point out that it takes little account of the interaction between patient and analyst, because all variations in technique are attributed to the needs of the patient. The analyst remains a detached, although empathic observer of the patient's process. Despite Freud's warning that his technical recommendations are "suited to my individuality," even in second-stage thinking no consideration is given to the analyst's need to establish an atmosphere within which he or she can think and respond freely and creatively. Thus, the particular analyst's hopes, fears, and beliefs are not taken into account as legitimate determinants of technical choices.

Recently, a number of authors have addressed the nature of the psychoanalytic process in a way that highlights the individuality of the analyst as a force in shaping the experience of both participants in treatment. Changing views of the ubiquity of countertransference and its influence on the relationship between analyst and analysand (Jacobs, 1991), the role of mutual enactments as determinants of the course of every analysis (Chused, 1991; McLaughlin, 1991), and the analyst's personal contribution to the patient's transference experience (Boesky, 1990; Gill, 1982) each sensitize us to the inherently interactive nature of the psychoanalytic situation. But, in one of those dialectical swings in the relationship between theory and practice that characterize the evolution of psychoanalysis, at this point in our history, technique lags behind conceptualization. The implications of an interactive model of the psychoanalytic process have not yet been fully integrated into our thinking about method.

Third-stage approaches to technique—embodied in the concept of an interactive matrix—grow out of our evolving understanding of the psychoanalytic process. Thus, the third stage represents a far more radical break with tradition than the second, because its approach to technique reflects the belief that everything that happens in an analysis reflects the personal contribution of each participant. There is no such thing as a "simply" analyzable patient in this model, one who will respond to standard technique by free associating with unconscious resistances providing the only roadblocks. Neither is there an "average expectable" analyst, capable of following prescribed rules without intrusions from his or her own personality (see Hoffman's [1992] critique of "technical rationality"). Instead, we have to consider the genuine differences in sensibility that characterize, for example, my supervisee and me around our feelings about apologies. The concept of an interactive matrix is necessary if we take seriously the idea that there are always two people in the consulting room.

In developing the concept of the interactive matrix, I have been influenced by the philosopher Ludwig Wittgenstein (1953), who wrote about the way languages work. The meaning of a word, Wittgenstein wrote, can be known only when we understand the broad context within which it is used. We cannot know what the word "means" to a person speaking it unless we know its function, unless we know what the speaker is trying to do with it. And we can never learn this by focusing exclusively on the word itself, we must look at its use within the overall structure of the language. Like Wittgenstein, I think of this idea in terms of the rules of games. There are games—football comes to mind—that sanction certain actions that in other contexts are considered criminal. Tackling somebody who is trying to get someplace quickly is an act of random violence on the street; in the stadium it can be a game-saving act of heroism. What the act means—what it *is*, really—depends upon the circumstances within which it occurs. We can say very little about one person tackling another unless we know what game they are playing.

Applying Wittgenstein's analysis to clinical process we can say that the interactive matrix establishes the rules of the analytic game in each individual treatment situation, and provides the context within which specific exchanges—including technical interventions—acquire their meaning. Saying this goes beyond maintaining simply that something does or does not work, and it implies much more than saying that different patients require different interventions. Rather, it asserts that we cannot even describe an intervention meaningfully without understanding the interactive matrix within which it is made.

Consider my opening clinical example: Should the analyst apologize or not? The concept of an interactive matrix exposes this as what the philosophers call a "poorly formed" question. The problem, I want to stress, is not that some patients—and some analysts—need, want, or can use apologies while others cannot. Rather, the problem is that we cannot know what an apology *means*, or even what an apology *is*, outside of the particular rules that get established within each individual interactive matrix. Is an apology an empathic act of kindness or a sadistic act of control? That is certainly something we would want to know *before* we start encouraging or prohibiting the act. But it is not something we *can* know before we ask the analyst and the patient involved, and before we know what, if any, understanding they have arrived at (generally tacitly and often unconsciously) together. As things developed between my supervisee and me, it became clear that as people and as analysts he and I are just too different for me to assume that what works for me will work for him. If I had just gone ahead and told him not to apologize, it would have been tantamount to saying that he ought to wound his patient. Especially if the differences in our feelings about apologies had not been made explicit, this would have set up a conflict that would make both learning and doing treatment extremely difficult.

What is true in supervision is also true in analysis: around any given issue at any given time, patient and analyst may have quite similar or quite different feelings. In Wittgenstein's terms, they

may or may not be playing the same game. When they are—when their sensibilities about things are roughly the same—we can characterize the analytic dyad as "concordant." When, as will inevitably happen, the two have feelings that are at odds with each other, we can refer to the dyad as "discordant." It is helpful to think of concordance and discordance around some issues that are discrete and involve specific behaviors, while other issues run pervasively through the analytic process. If, when, and how one should apologize would be an example of the former. Others of this type involve "frame" issues—fees, length and flexibility of sessions, cancellation policies, and the like. There are questions of social tact that can become important—whether the analyst says "happy birthday" or "Merry Christmas," whether the analyst is willing to shake the patient's hand before vacation or respond conventionally to comments about recent events in the news, and so on.

Beyond these discrete and easily identifiable issues, concordant and discordant feelings and attitudes run through the background of all analyses, shaping their ambience in ways that can be difficult to pinpoint. For example, both participants have expectations—largely unconscious—about the latitude of transference play that will be encouraged or tolerated. That is, both have ideas about how close to some consensual "reality" the patient's sense of the analyst ought to be. Again, patients and analysts bring to the consulting room their own feelings of comfort and discomfort with levels of affect and activity, and with a "permissible" emotional range. The match between the two will be more or less harmonious in these and many other areas.

Paradoxically, periods of concordance in the analytic dyad can mask the importance or even the existence of an interactive matrix, because during these periods the acts of both analyst and patient flow smoothly. Martha and her analyst, for example, were in accord about the meaning of apologies. The apology was tendered and accepted, and the two went on to other things. Because the moment passed so smoothly, the exchange would have escaped notice entirely if the analyst and I had not gotten

involved in discussing it in supervision. Historically, this kind of smooth exchange has contributed to the difficulty of discussing technique in any vital way. At moments of great concordance, it can be difficult even to notice that something *happened* between patient and analyst, much less that there was an important interaction that would shape the atmosphere in the room for some time to come. There are many such noninterpretive moments in every analysis; they may be verbal or nonverbal, they will rarely be commented on in the analysis, and they are almost never reported when cases are presented to outsiders. Consider not only the apology given and received but the analyst's smile of greeting at the door, the handshake before vacation, the good wishes before a stressful challenge in the patient's life, even the shared appreciation of a creatively elaborated transference fantasy. When meaning is shared, things go so smoothly that the interactions can seem like non-events.

Despite rarely being noticed, such moments are crucial ingredients in any analysis. No analysis can get going or last for long unless there is considerable concordance between the sensibilities of patient and analyst. This is a significant determinant of "analytic fit" and becomes one of the important underpinnings of the working alliance, or what Freud called the "unobjectionable positive transference" (1912a, p. 105). Thinking of this in terms of an interactive matrix adds to these more traditional formulations the idea that both the analyst and the patient make a personal contribution to the mix. The contributions of both precede the relationship, are neither transferential nor countertransferential in any traditional sense, and contribute decisively to the eventual shape of the relationship, including both the eventual transference and the countertransference.

But like all intense relationships, every analysis is always teetering on the brink of discordance. The analyst may fail to apologize when the patient requires it, or the analyst may surprise the patient by extending a hand when the patient expects or wants greater reserve. The patient may insist on experiencing the analyst in a way that the analyst considers far-fetched or too

close to home, or the patient may want to stay on the consensually validatable surface while the analyst pushes for expression of a deeper, more fantastically elaborated transference experience. Just as moments of concordance mask the occurrence of interactions and even of events, moments of discordance highlight them. There is no doubt during such moments that something is happening. They are definable points in an analysis, characterized by tense feelings that are palpable to both participants.

These tense feelings are comparable to but different from the tension that arose in working with my supervisee. Discordant moments in analysis are rarely experienced as conceptual disagreements, nor are they usually as accessible to consciousness as they are in supervision. But they are uncomfortable to both participants, giving rise to the feeling that something must be done. The tension requires resolution. In supervision, this can sometimes be done by openly addressing the area of disagreement, as my supervisee and I did. In analysis, the resolution of discordance typically leads to more or less subtle forms of negotiation between patient and analyst. Clinicians writing from a range of theoretical perspectives report that over time they notice differences in the way they feel, think, talk, and act with different patients (Goldberg, 1987; Pizer, 1992; Russell, 1986). Most typically, these shifts occur unconsciously, and while some can be attributed to the effects of countertransference, not all can. Those that cannot reflect a kind of mutual adjustment that follows the negotiation of discord within the analytic dyad.

The concept of negotiation covers a variety of exchanges that occur in every analysis, that share some characteristics, but that are also significantly different. Looking at negotiation in terms of the interactive matrix casts light on the different kinds of negotiation that go on in every analysis. Most obviously, both participants are fully aware of some of their negotiations, while others are deeply unconscious. Often, conscious negotiations are focused on the analytic frame—scheduling, cancellation policies, fees, and so on. Discussions of these issues can be explicit

and—I suspect more frequently than is reported in the literature or even informally—some compromise is reached. Because analyses last years instead of months or weeks, because many jobs require frequent travel, because analytic fees have increased way beyond what our professional forebears could possibly have imagined, there is more inherent tension today between analyst and analysand around the conditions of treatment than there was in the past. Treatment is impossible if there is too much discord around the frame. The complexity of life in our time and place, and the realities of psychoanalytic practice, would require negotiation even if nothing else did.

There are many other dimensions of the analytic relationship, however, around which the dyad can become discordant but which are not, and probably cannot be, talked about directly by the two participants. I have already mentioned some pervasive yet rarely explicit characteristics of patient and analyst that shape the quality of their interactions. Examples include the degree of emotional closeness that is comfortable; the level of affective intensity and expressiveness that is desired and feared; the latitude of transference—and countertransference—play that is needed and/or tolerable. These can be grouped under the general heading of what each participant wants or needs the other to be and what each feels he or she comfortably can be. Pizer (1992) has elegantly described how he and his patient accommodated to each other, subtly, spontaneously, and over a long period of time, in a way that made an analytic process possible. Negotiation around such issues—typically unconscious—runs through the fabric of every analysis.

Thinking in terms of the negotiation of discord within an interactive matrix does not simply address previously unattended aspects of the analytic process. It also casts light on what actually goes on when an analyst employs standard technique and a classical model of transference analysis. Return to the example of my supervisee and his patient, Martha. Let us say that in the situation I described the analyst had relied upon the accepted psychoanalytic procedure of "not apologizing," which

he might explain as an application of the principle of neutrality and the rule of abstinence. Let us say, further, that Martha expected or needed an apology. She would react to the analyst's behavior in her own idiosyncratic way. Then, having applied proper technique with an analyzable patient, the analyst would move to the next step, interpreting the patient's reactions as manifestations of an endogenously determined transference, perhaps as the residue of infantile responses to perceived slights or frustrations. Martha's reaction to the absence of an apology would be the focus of the work. The analyst's failure to apologize would be a serendipitous trigger of her reaction, like the day residue around which wishes get organized into a dream.

This seems reasonable, but consider what happens when we view the transaction through the lens of the interactive matrix. If analyst and patient were concordant around the issue of apologies, *there would have been nothing to interpret in this situation*. If the analyst had apologized, he could never have interpreted the patient's need for an apology, because he would never have noticed the need in the first place. Let me make clear that both the need to interpret and the possibility of interpreting grow out of the discordance and not out of some presumptively neurotic need of the patient's. That is, it emerges from the interaction between two particular people and *not* simply out of the patient's reaction to the analyst's technique.

Consider what would have happened if Martha shared my distaste for apologies. Under these circumstances, if her analyst had not apologized, the two would continue with whatever they were working on; there would be no disruption and no cause for comment about what was happening between the two of them. But an interpretation would be possible and perhaps necessary if the analyst had in fact apologized. Perhaps upon hearing the apology and resenting its intrusiveness, Martha would bristle more or less openly. Noticing this discordant moment, the analyst would wonder what had caused it. He would focus on what he had just said, raising questions about Martha's feelings about apologies. Addressing her annoyance, he might question why it

is that she does not expect or want acknowledgment and even reparation for the narcissistic injury he has caused. This is an interesting and potentially revealing line of inquiry, but, to reiterate, it could not be raised by an analyst who had not offered the apology in the first place.

If we generalize this line of thinking, its implications are provocative. It appears that the act of interpretation itself requires some degree of discordance in the analytic dyad. Despite the importance of moments of concordance in carrying the work of analysis, it is difficult to interpret during them. The need to interpret and the act of interpretation itself grow out of moments of personal discordance between analyst and analysand. The discordance may be around specific behaviors, like apologizing, it may be about ways the patient is experiencing the analyst in the transference, or it may be around different ways the two participants are experiencing the patient's life historical narrative.

Looking at things this way, interpretation emerges as *one form of negotiation*. In a classical sort of interpretation the analyst is saying: "Perhaps it will be helpful to see your ideas and feelings as the products of wishful thinking, or as the residue of some old relational experience. If we put them in that context, we will be able to appreciate more about what formed you into the kind of person you are, and also bridge a gulf between us that has developed recently." Successful interpretations not only facilitate the patient's awareness of previously rejected thoughts and feelings, they also heal and deepen the analytic relationship. This function of interpretations can be seen only in the light of an interactive model of the analytic process.

When the patient disagrees with what the analyst has said, the similarity of an interpretation to a negotiating position becomes clearer. In response to a transference interpretation the patient may say "I am only feeling this because you did that," or something along those lines. When the negotiation is going well, this will lead to a revised interpretation, to a further response by the patient, and so on. Occasionally, it will also lead, always subtly

and typically unconsciously, to a change in the analyst's behavior. *The process ends when a new feeling of concordance has been established.* This way of understanding the interpretive process stresses the significance of *personal* discordance; neither the idea that an interpretation is needed nor the content of the interpretation itself can be deduced from a priori theoretical principles.

I want to conclude by making one aspect of my argument especially clear. I am not suggesting in some prescriptive way that the analyst ought to consider the interactive matrix in formulating an intervention. Rather, I am saying that the interactive matrix exists; it is a simple matter of fact. Accordingly, every event of an analysis becomes what it is and acquires its meaning within the context of the interactive matrix, whether the analyst thinks so or not. This includes everything that the analyst does, from setting the frame, to building a working alliance, to delivering an interpretation. I believe that only by holding tenaciously to this interactive model can we study the analytic process in a way that is true to how each of us, as practicing clinicians, lives it. Our appreciation of what we actually do with and for our patients can only benefit from our recognition that, in the final analysis, the interactive matrix—not the psychoanalytic textbook—is the crucible within which technical procedures are forged.

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The Couch as Defense and as Potential for Enactment

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THE COUCH AS DEFENSE AND AS POTENTIAL FOR ENACTMENT

BY MARIANNE GOLDBERGER, M.D.

Use of the couch in psychoanalysis is almost universal because of its many advantages. This paper focuses on situations in which the use of the couch is not *beneficial, involving problems of the patient or of the analyst. Interferences with the usefulness of the couch are illustrated by means of vignettes from the analysis of four patients which demonstrate the isolating potential of the couch and the reasons why this may make the couch appeal to some patients and repel others. The distancing potential of the couch may sometimes appeal to analysts, particularly when the face-to-face arrangement is troublesome. The use of the couch for the enactment of conflict is discussed, as are analytic attitudes toward the use or non-use of the couch.*

The advantages of using the couch in analytic treatment—advantages for both patient and analyst—have been found to be so important that its use is almost universal. This paper deals with analytic situations in which the use of the couch may not be beneficial. First, I shall discuss patients' problems which lead them to use the couch for purposes of defense (that is, to isolate themselves from particular feelings and thoughts) and problems which present them with difficulty in using the couch. Then I shall discuss analysts' problems in having their patients use the couch. Some analysts feel that the couch distances a patient, but

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a larger group is comprised of those who prefer to have patients use the couch, and this sometimes leads them to be persuasive rather than analytic in dealing with the issue. Clinical vignettes will illustrate the situations just described.

My first lessons about the potential of the couch to isolate the experience of feelings were provided by an analytic patient who returned for more treatment two years after what had been an unusually helpful, deeply meaningful five-year analysis, five times a week on the couch. Sitting face to face upon her return, she said that both her personal and her professional life continued to go very well, but there was one area that had not been dealt with satisfactorily in the analysis. She emphasized that she would have to talk about this sitting up, at least for some time, because that was the only way she would experience the intense feelings of shame that had prevented her from working on this adequately before. She confessed that she used to "dive onto the couch," especially on those days when she anticipated that she might talk about something shameful. Once safe on the couch, she felt she could talk about everything. She had now decided that she would be able to analyze fully what was troubling her only if she had to look at me. The problem had to do with a kind of masturbation which brought extreme shame when she spoke about it.

It is important to mention that this patient had talked vividly and in detail about sexual matters, including masturbation, during her analysis. She was returning now because, contrary to her strong hope when we terminated, she had not been able to stop the particular kind of masturbation that was so disturbing to her.

This second period of analysis lasted about two years. After several months of sitting up, the patient felt she had dealt sufficiently with the shame issue, and she wished to resume using the couch because, on the basis of her previous experience, she knew its advantages would now outweigh its disadvantages.

When the "shameful subject" had come up during the latter part of the earlier analysis, it had always been in an atmosphere

of duress. She felt that she "must" talk about it and forced herself to do so. Because of the intensity of this coercive tone, I had thought that we needed to understand the enactment of being forced to do something before we would get very far with the meanings of the bodily experiences and the accompanying fantasies. The repetition involved her recumbent position during the numerous childhood enemas administered by her mother. During those enemas not a word was spoken, and they never looked each other in the face. We frequently spoke about her wish that I extract her thoughts from her. She wanted to make it clear that she was well aware of how "bad" she was for wanting to masturbate. This meant to me that forceful defenses were always present in this area, and because she maintained such defenses, the process of experiencing and observing her feelings and fantasies could not be integrated.

In her decision to return to talk with me face to face so that she could fully experience her shame, she was bringing the enactment to a level where we could begin analytic work with it. She was gradually better able to tolerate her painful feelings of shame and could therefore begin to describe more details. However, she was not yet aware that her desire to face me would guarantee that the subject remained in the context of shame, and for this reason it also fulfilled a defensive function. This defense turned out to be necessary to prevent feelings of excitement. After all, she had returned to analysis with the goal of ridding herself of this activity and making sure it would never happen again. The atmosphere of self-blame still surrounded the emergence of more particulars—"you see how terrible I am, but at least I know I'm terrible"—so that the whole complex was partly sealed off as an organized entity. Only with the persistent analysis of the need for this tone of shameful confession in order not to acknowledge her forbidden impulses could there be any change. When she no longer had to disown her pleasurable physical sensations as well as her accompanying rage, she was able to resume using the couch.

This patient had used the couch to isolate intense feelings of

shame connected with certain masturbation activities and fantasies. While on the couch she became able to talk about almost "everything," in time fully connected with a wide range of feelings. However, in talking about one area, she had become aware that she avoided the most intense shame by virtue of being on the couch. She had talked about the conflicts in question and *had* felt shame, but knew that some detachment remained as long as she did not have to look at me.

A colleague consulted me about the analysis of a patient in whom the defensive function of the couch in certain areas did not become clear until near the end of a six-year analysis. Issues over the couch had actually been present at the beginning of the analysis, but had escaped the notice of both analyst and patient.

Conflict over use of the couch became manifest during the middle of the analysis when the patient decided to sit up for several weeks and cut down the number of sessions to one or two per week. The conflict had been primarily over submission: the whole setup of the four-times-per-week schedule and the use of the couch *now* seemed to her to have been rules imposed on her as conditions of treatment. She looked back at her initial compliance as a "willingness to give up my autonomy," although she had been quite unaware of it at the time. Now she struggled over whether or not to remain in treatment, sounding as if determined to stop. During the period of sitting up and having fewer sessions, she wanted to be able to choose analytic treatment as an active participant. Once she felt that this relative autonomy had been achieved, she spontaneously returned to intensive treatment, and to the couch. The analyst thought her conflicts over submission had been partly resolved at this time, and even more important, these issues now remained accessible to the analytic work.

After about five and a half years, the decision to terminate was made because the patient felt that she had attained most of her goals. Some time before the planned termination date, the patient mentioned that she would like to sit in the chair, face to

face, before the analysis stopped, because, she said, "You're not a complete human being to me." She did not elaborate further. The subject of sitting up was not mentioned again for about two months. The patient talked a great deal about losses in various parts of her life, most particularly the painful feelings of loss about the recent breakup (mutually agreed upon) of an intense love affair with a man named Bill. The coincidence of breaking off the relationship with Bill at the same time as her decision to terminate her analysis had been explored more than once, but she had not seen much connection between them. She had been speaking about Bill when she remembered having had a "bad" dream:

> I'm in a barren town and it's morning. I'm hungry and in need of coffee. I find a place that looks like a cafe or maybe a dental office. There's one dental chair. The dentist is working on a man and I watch. He's working without a mask or gloves. The doctor asks the patient in the dental chair, 'How's your boyfriend?' He asks about AIDS but is reassured. There's no real reason for reassurance—he's much too casual about it. All the others sitting in the cafe were being served but me. I got up and left. I didn't know where to go. It was a very barren, depressed place. I was alone, lonely. What was I doing there? I was very much alone.

Her associations went to Bill and the fact that her love for him had stopped being "valid." She was impressed with the strength of the bleak feeling in the dream; it made her think of her recent losses. Ending the analysis did not seem like a loss but a gain. Thinking about Bill, she realized that if he took the initiative she "would still take him back." The analyst noted her sense of passivity regarding that, and she responded, "I love him very much and would do as he wanted." While musing over her tendency to be compliant with certain men in her life, she recalled that she had never pursued her idea about sitting up before the end of the analysis. She was doing what she thought the analyst wanted regarding sitting up. Then she said it was

really more than that. His silence about the couch had made her conclude that he had "dismissed" the idea, because that was not the way things are supposed to be done in analysis.

Thinking that a dentist's chair can accommodate a patient's sitting up or lying down, the analyst mentioned that the dream suggested a concern about the rules, and the patient immediately responded by saying that the dentist wasn't being safe—that is, he was breaking the rules. She added, "I play by the rules." She then realized that she had just assumed that the analyst shared her own disapproval of sitting up. It became clear to her that while wanting to sit up, she also had considerable fear of doing so, and that picturing her analyst as a "disapprover" was a way of stopping herself from talking about it. "Sitting face to face is a confrontation; you'll see something I don't want you to see. You don't know my face, my eyes. It's kind of private."

She went on to say that the couch permitted her a certain privacy, which she likes. She now wanted to live life on her own. Her associations went to her recent feeling of not wanting to "be entered" sexually and not wanting to "deal with the penis at all." A little later, she said, "I don't look in your eyes, you don't look in mine. I don't enter you, nor you me. I used to like to be entered." (This last was accompanied by sadness.) As termination approached, she became more aware of wanting to keep some part of herself private, not intruded upon, and being on the couch allowed her to have that. Sitting up she would feel more open, vulnerable to complete penetration. At the same time she also wanted very much to sit up so that *she* could see the analyst, could have more time to look at him, and could see him as a real, whole person.

The following week she sat up and then said that she had "the worst nightmare I've ever had":

> I'm with three brothers visiting my mother in a nursing home. I don't see her but I know she's there. It's like a homeless shelter. The beds are stacked up. My brothers are cutting mother up into pieces, doing it coldly. I tell them they're gonna

get caught. Then I'm at a lectern. My brothers are in the audience.

The patient's associations went to her relationship with Bill. She said that she "became" her mother in the relationship with him. After some elaboration of the ways she felt she was just like her mother, she talked about the sense of strength and activity that she had gained from the analysis. "Finishing analysis is like killing my mother." As she spoke of her increased comfort in being active and assertive, she understood that she was equating her activity with being a murderer.

Using only those aspects of this rich material that pertain to the couch as a defense, we can see the following sequence. Two months earlier the patient had proposed the idea of sitting up at the end of her analysis, and then used the fantasy of her analyst's disapproval to inhibit revealing thoughts and wishes that would make her anxious. The "rule" of the couch served to defend against talking about her impulse to look at and penetrate the analyst, as well as her reluctance to have him know everything about her. Paradoxically, in regard to the latter, she could remain a "good" analytic patient by staying on the couch, hiding her secret "bad" patient self.

Undertaking the action of sitting up, as compared to only talking about it, seems to have allowed this patient to experience more deeply thoughts and feelings connected to her subtle but major conflicts surrounding autonomy and compliance. Actually, the period of sitting up during the middle of her analysis had enabled her, *for the first time*, to become aware of her conflicts about compliance. Focusing on what was making it difficult for the patient to use the couch *at that time* might have resulted in a greater awareness of conflicts over authority. But, if the analyst had pursued the couch issue more—that is, in some way influenced the patient to use the couch—then it might have been harder to tell whether the source of the conflict was the patient or the analyst. The patient's affectively crucial conflict at that time focused on whether or not she really wanted analysis,

not the couch per se, and it did become clear to her that this was *her* internal conflict of which she had previously been unaware.

During termination, sitting up also facilitated more self-awareness. Witness her nightmare when she sat up: with more analysis of her defenses, her impulses, accompanied by anxiety, came increasingly into her awareness. Since our emotions are pervasively moored in our physical selves, many individuals are able to become fully aware of affects connected with their thoughts only after enactment in physical behavior. This patient needed to experience her autonomy-submission conflicts in the language of the physical action of sitting up before she could begin to find words to express them. The issue of physical action in analysis will be taken up in the discussion section of this paper.

The case of Mr. G demonstrates how the couch can be an issue for both patient and analyst. Mr. G suffered from anxiety, depression, and lack of professional achievement when he sought treatment in his late twenties. He was convinced that only intensive treatment would be helpful, but he was very reluctant to use the couch. His dread of the couch was significantly determined by conflicts about his relationship with his father, a mental health professional, who had alternated between being coolly withdrawn and being relentlessly intrusive into his mind. Mr. G described his father as asking him about everything that was on his mind, acting as if he already knew what was there, and telling him what it all meant. Initially, we arranged to meet five times a week sitting up, with the understanding that we would talk about his fear of the couch and that he might eventually decide to use it. We both realized that his inability to use the couch was the result of problems that had brought him to treatment in the first place.

Mr. G's approach to the therapeutic work was that of a harsh taskmaster toward both of us. He derided himself sarcastically for being afraid to use the couch, and derided me more politely

for not telling him how to overcome his fear. One major concern about the couch was that he would not know whether I was paying attention; for all he knew, I might sit there doing my correspondence. He also had an aversion to being watched. After a few months he decided to try lying down with the proviso that this would not commit him to it forever. He was extremely self-conscious and uncomfortable on the couch, and it was clearly harder for him to talk than before. He hated the fact that I could now observe him without his being able to watch me. After about two weeks he turned around to look at me in the middle of an hour and found me leaning back in my chair with what he called "a far-away look." Instantly angry, he sat up and told me that I had completely confirmed his fear of my not paying attention, and what was worse, I had done so after he had already explicitly told me that this was his concern.

He went to the chair and considered leaving analysis. Although he was enraged about what had happened, he was also reluctant to give up on treatment because he had already "failed" in several previous attempts with other therapists and analysts. After a few weeks he decided to remain, but for a long time he felt free of his self-imposed obligation to try to use the couch.

We spent the next four years sitting face to face, with this extremely observant man hardly ever taking his eyes off me, particularly my face. He was acutely aware of every nuance of my facial expression and of everything that was discernible about my surface behavior. Here was an instance in which I was tempted to encourage the patient to use the couch for my own benefit. For many months I thought that I might not be able to give him my optimal analytic attention since part of my awareness was involved with what was happening on my surface. I could not "rest my face," as Greenacre put it so well (1954, p. 680). But after a time, and with ongoing self-analytic work, I found myself increasingly comfortable with what I thought of as a "sitting-up analysis." I learned in practice what I had known

theoretically—namely, that what defines analytic work is not the use of the couch but the consistent attempt to understand an individual's conflicts in every detail.

This patient's conflicts about his father prevented him from using the couch. In fact, he would not have been able to make use of the psychoanalytic method if using the couch had been a precondition. However, major work was accomplished in the analysis of transference although we were looking at each other. Furthermore, sitting up did not prevent his elaboration of many detailed fantasies about me, just as rich and just as deeply felt as those developed by patients who do use the couch.

Discussions with analysts from various institutes have made me aware that insistence on the use of the couch sometimes has more to do with the interest of the analyst than that of the patient. One example comes from the analysis of a young woman who had been sexually abused in childhood by her uncle and grandfather. She was strongly motivated to have analysis, but was much too anxious to be able to use the couch at first. Her analyst explored her fears but to no avail for many weeks. The patient then stopped any mention of the couch, but continued to be very involved and productive in a sitting-up analysis.

The analyst had begun to feel that he "had to bring up the couch" when he discussed the situation with me. Because I could not find derivatives of the couch issue in the patient's material at this time, I inquired about the source of the idea that he "must" bring up the couch. He said that during his analytic training, supervisors and instructors of case seminars had repeatedly indicated that the analyst *must* keep discussing why a patient was not using the couch and should not "allow" the patient to avoid this issue.

In this patient it seemed clear that her unwillingness to use the couch was a symptom of her inner conflicts, just as it was with my patient, Mr. G. I reminded my colleague that he would not keep focusing on other symptoms *as such* with a patient, but would expect to understand them eventually through the usual

method—that is, with the patient trying to say everything on her mind as freely as possible. Why, then, should he deal differently with her symptom of not using the couch? If an analyst feels compelled to keep bringing up a particular symptom (in this case, not using the couch), it is likely to reflect something important about the analyst.

DISCUSSION

This section will survey the literature dealing with the couch, will describe analytic attitudes toward the use or non-use of the couch, and will discuss the potential use of the couch for the enactment of conflict.

First, let me repeat that the reason for using the couch in psychoanalysis is to provide a place where a patient can express the fullest range of thoughts and feelings. As an analytic patient experiences her or his impulses more vividly and intensely, the physical immobilization of the couch usually provides a place of greater safety for the attempt to express "everything" out loud. However, there are exceptions to this generalization. For patients who are utterly unable to feel safe on the couch, its use has no benefit unless and until they can begin to feel different through analytic work. If it is the analyst who needs the feeling of safety by having the patient use the couch, then it is she or he for whom self-analytic work is indicated.

The literature relevant to this essay is rather sparse, perhaps because in a four- or five-times-a-week analysis the use of the couch is taken for granted whenever the indication for analysis is clear. On the other hand, many interesting papers have dealt with a variety of therapies which are not strictly relevant to the issues in this paper. For example, some papers discuss the use of the couch in once- or twice-weekly psychotherapy or in treatment with psychotic patients. Harold Stern wrote a book, *The Couch, Its Use and Meaning in Psychotherapy*, which includes just about everything written on the subject up to 1978 but not specifically from the vantage point of this essay.

Freud's frankness about his dual motives for insisting on the couch is well known: "I cannot put up with being stared at by other people for eight hours a day (or more)" (1913, p. 134). His other motive was to prevent his facial expressions from influencing his patients. He wanted the patient's transference to develop independently so that it could be better defined as resistance.

Freud recognized that patients might use the couch for resistance. In his 1913 paper on technique he described patients who "contrive" to say a few sentences before or after the actual "session"—that is, when they are off the couch:

> In this way they divide the treatment in their own view into an official portion, in which they mostly behave in a *very inhibited manner*, and an informal 'friendly' portion, in which they speak really freely and say all sorts of things which they themselves do not regard as being part of the treatment (p. 139, italics added).

Here Freud made explicit reference to the use of the couch as defense. He then made his technical approach perfectly clear:

> The doctor does not accept this division for long. He takes note of what is said before or after the session and he brings it forward at the first opportunity, thus pulling down the partition which the patient has tried to erect (*ibid.*).

Several authors who discuss the couch point to its possible use in the service of defense.

Fenichel (1953), listing the manifold expressions of resistance, mentioned a patient whose "specific attitudes of resistance have enabled him to keep this new knowledge quite separate from his real life. It is as if he had said to himself: 'This is all valid only as long as I lie on this couch; the moment I get up, it doesn't count.' " (p. 325).

Lewin (1954) discussed the frequency with which patients equate the analytic work with being in bed, and the conflicts that may ensue from such a parallel. He suggested that because the

recumbent posture resembles being in bed, a patient may make a split between what he says while on the couch and what is "true" the rest of the time (p. 507).

Lewin also drew attention to the widely ranging fluctuations in patients' degrees of wakefulness on the couch, from the one extreme of going to sleep to the other extreme of strong vigilance (p. 508). He said that most analyzable patients are usually in the intermediate range, and that this model is useful for understanding analytic patients' very difficult task of being neither too vigilant nor too much asleep. His view clarifies why an "id interpretation" will produce a shift toward vigilance—that is, alerting the defenses—whereas a "defense interpretation" tells patients they are being extremely vigilant and they may then shift toward the less vigilant side. Extreme loss of vigilance—that is, falling asleep—usually represents a form of defense.

Greenacre (1959) took up the subject of the couch in her paper, "Certain Technical Problems in the Transference Relationship." While she found use of the couch an asset overall, she emphasized the importance of not separating what is talked about when the patient is sitting up. "Everything that happens or is spoken between analyst and analysand is really a part of the analysis and may ultimately assert itself as such" (p. 496). She went on to state, "If I think a patient is saying in one way or another that he would like to sit up, I may simply ask him if he would prefer to sit up, but I leave the decision up to him" (pp. 496-497). She also described the many different meanings which the change from recumbent to sitting posture can have for different patients, and stated that she treats such a change "like any other symptomatic transference act" (p. 497).

Macalpine (1950) stressed the wide variety of patients' reactions to the use of the couch: ". . . it is well established in the literature that it is far from being the rule that the analytic couch allays anxieties, nor is the analytic situation always felt as a place of security . . ." (p. 523).

Because of his changed conception of transference and its analysis, Gill (1984) recognized that "while the couch is ordinar-

ily considered to be conducive to regression it may enable an isolation from the relationship which has a contrary effect. No universal meaning of any aspect of the analytic setting may be taken for granted" (p. 174). Gill also stressed the importance of each individual analyst's experience of the analytic setting: "Some analysts feel themselves isolated from a patient on the couch . . ." (pp. 174-175).

Questions about the couch are most likely to appear in connection with discussions about analyzability; when a patient's problems might preclude undertaking an unmodified analysis, recommendation for "intensive treatment" may be made, but with the understanding that the patient may not benefit from using the couch. A number of papers dealing with the couch consist of case studies in which patients had difficulties using the couch (McAloon, 1987; Myers, 1987; L. Reiser, 1986; Weissman, 1977). Myers presented case material from three analyses in which dramatic, unexpected movements by patients on the couch dominated the analytic hours for long periods of time. He was candid about his reactions: "I felt 'forced' into action, and here I specifically mean forced into speaking to him, and angry at having to do so 'against my will' " (p. 647). He emphasized the importance of self-analysis at such times.

Comments on the use of the couch are also found in books dealing with principles of psychoanalysis and psychotherapy. Such allusions to the couch are usually brief, indicating the author's general attitude.[1] Most of them recommend an attitude more flexible than Freud's strong advocacy. In contrast, Brenner's 1976 text on psychoanalytic technique presented the couch issue in detail, and is therefore specifically discussed below.

Most analysts support the notion that if an analytic patient does not wish to use the couch, one should maintain an analytic attitude—that is, one should try to understand the underlying

[1] Examples include Blanck and Blanck (1974), Fromm-Reichmann (1950), Greenson (1967), Guntrip (1971), Horney (1952), Kubie (1950), Salzman and Masserman (1962), J. Sandler (1988), Saul (1958), Sharpe (1930), Wolman (1967).

conflict rather than urge the use of the couch. On the other hand, these same analysts probably share Brenner's view that "Analysis is not possible if a patient does not use the couch, things being as they are in present-day analytic practice" (1976, p. 182). Brenner reasoned that if a person is to have an analytic treatment, it is greatly to her or his advantage to use the couch and face away from the analyst. He cites the facilitation of saying freely whatever comes to mind with as little interference as possible from external stimuli, and he comments that when facing the analyst a patient is necessarily influenced by the analyst's facial expressions and physical gestures (p. 183). Therefore, if a patient will not use the couch, despite the analyst's statement at the outset that it is to the patient's advantage to do so, it follows that the avoidance of the couch must be a symptom of psychic conflict (p. 184).

In such a situation Brenner advises that, "like other symptoms it should be analyzed in the usual way" and that "one can say quite correctly that analysis can be carried on face to face under those circumstances" (p. 184). But Brenner and many other analysts believe that only a limited amount of analysis can take place with the patient sitting face to face. Stated simply, one cannot be analyzed if one never uses the couch. However, if we allow that "some" analysis can be carried on face to face, then we are in a theoretical quandary: what are the criteria by which to decide how much use of the couch makes the treatment "analysis"? Here Brenner's own advice (1969) regarding the analysis of phobias comes to our aid. He suggested that we discard Freud's 1919 dictum that at some point in the analysis of every phobic patient one must persuade her or him to confront the phobic situation. Brenner based his opinion on repeated demonstrations of clinical work with patients—namely, that analysis of patients' conflicts results in their "resuming activities previously avoided because of the anxiety" (p. 349). He also stated that the use of the analyst's personal influence over a patient, in this instance to discard a symptom, is not a useful analytic approach. If this view is applied to a patient whose fears make her

or him avoid the couch, one would analyze "in the usual way" even if the patient were never able to use the couch. Such a patient might terminate an analysis with some conflicts incompletely analyzed—a finding which is not rare even in satisfactory analyses—though the process is still recognized as analysis.

Finally, a discussion of the use of the couch should also consider how it intersects with the role of enactment in the psychoanalytic process. The numerous recent papers on enactments during analysis have underscored the counterpoint between behavioral and verbal expression (see Roughton's recent discussion, 1993). These two modes of expression are closely entwined when the couch is part of an enactment of conflict. The patient who is relatively immobile on the couch and communicating verbally may be contrasted with the patient who sits up and communicates through action as well. Of course, this simplification fails to mention that thoughts and verbal expressions are themselves actions.[2] The complicated, unresolved questions in a psychoanalytic theory of action are only touched on in this discussion. Even so, most analysts probably agree that limiting our analytic understanding to only that which can be put into words would limit a patient's ability to make the fullest and deepest connections between affects and ideas.

The increasingly rich literature about enactment has emphasized that important experiences and fantasies, and the feelings which accompany them, are not necessarily represented verbally. This can be true even for experiences from the time *after* the acquisition of language. Anne-Marie Sandler (1975) has stressed that modes of unconscious childhood cognition "persist in the present and . . . are still utilized in the present" (p. 376). I believe that such nonverbal experiences and fantasies may be initially available only through enactments. Our emotions and thoughts are inextricably embedded in our bodies, so that our actions may connect with meanings and memories from all lev-

[2] The interesting area of "action-thoughts," as studied by Busch (1989), is not taken up in this paper.

els of mental functioning. For example, since primitive forms of thinking are readily observed in dreams, it is not surprising that defensive activity in dreams is often found to be depicted by *physical action* (Goldberger, 1989). Children's play often uses action to depict experiences and feelings which are not yet represented verbally.

This brings us back to the couch. If the issue of remaining on the couch per se is made the main focus of analyzing, then the conflicts being enacted by changes in posture may not become fully understood. Analysts need to be alert to the possibility that their strong preference that the patient use the couch may interfere with perceiving the subtle ways in which the couch abets their own avoidance of and defense against strong affects in the transference.

I have become increasingly convinced that we should not encourage the converting of enactments into verbal expression prematurely, before they can be analytically useful—that is, before verbal connections for the actions are *preconsciously* available. Perhaps this applies especially to the use of the couch, since the fantasied authority of the analyst, or of "analysis" as an ideal, is often significantly involved. This means the analyst should not reach for "meanings" of actions before a patient is able to observe the surface phenomena. If the analyst interprets material that is still *unconscious*, the patient's understanding is likely to remain intellectual at best; at worst, the patient will try to inhibit that particular action. We are all familiar with a patient reacting as if criticized when mention is made of some behavior of which he or she was completely unaware. Today's analytically sophisticated patients are often only too ready to assign meaning to their actions long before they have affectively meaningful data to support their conclusions, especially if they assume they have somehow done something "wrong." I believe the analyst can often be most helpful by viewing enactments as latent information *not to be put into words too soon*, although the goal of *eventual* verbalization remains in place.

The inconstant use of the couch is often seen with analytic

patients who are involved in stormy and intense transference reactions for a time, and whose communications then spread from words alone to various kinds of action. In such a situation, one frequently hears comments from colleagues that the patient has lost the "as if" quality of the transference, implying that it would be preferable for the patient to maintain the "as if" quality. Actually, if a patient preserved this awareness *all the time*, a deep, affectively integrated analysis would probably not be possible. It seems to me that profound changes are possible only if the patient *does* lose the "as if" quality of the transference long enough to acquire a sense of emotional conviction. And it is precisely at those times when the "as if" quality is minimal that a patient is action-prone and is therefore likely to engage in some kind of face-to-face interaction with the analyst.

The issue of keeping enough awareness of the "as if" quality of the transference brings to mind those patients with greater ego defects for whom this awareness is frequently fragile. In those instances the technical considerations are often very different; the analytic situation that I have been describing applies to patients in the neurotic range of functioning. My implying the presence of an ego restriction if a patient must always maintain an awareness of the "as if" quality of the transference—what Lewin might call hypervigilant—is not to be misunderstood as *advocating* the use of action instead of words, or advocating joint enactments of analyst and patient.

In conclusion, I want to add that my suggestion that a psychoanalytic treatment can take place without using the couch could be misread to imply that there are no "fundamentals" in psychoanalysis, or that any treatment emphasizing freedom of verbal expression can be considered analysis. On the contrary, this essay represents my thinking about the couch as defense *in the setting of an intensive analytic treatment*, four or five times a week. As has already been said, the couch is intended to facilitate freedom of verbal expression, and in my view it is the latter that is fundamental to the analytic method; the couch does not in itself define psychoanalysis.

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New Findings on the Neurological Organization of Dreaming: Implications for Psychoanalysis

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NEW FINDINGS ON THE NEUROLOGICAL ORGANIZATION OF DREAMING: IMPLICATIONS FOR PSYCHOANALYSIS

BY MARK SOLMS

A recent clinico-anatomical study of the dreams of 332 neurological and neurosurgical patients suggests that the essential psychological processes of dreaming are mediated by higher forebrain structures (inferior parietal and mediobasal frontal lobes in particular) rather than the primitive brainstem nuclei which regulate REM sleep. The fundamental neuropsychological mechanisms involved in dreaming appear to be (1) inhibitory mental control, (2) spatial thought, and (3) quasi-spatial (symbolic) operations. The essential factor in REM sleep, by contrast, is basic arousal. These neuropsychological findings call into question prevailing theories (based on physiological evidence) of the relationship between dreaming and REM sleep. Dreams and REM appear to unfold over different anatomical structures, and they involve different psychological mechanisms. The implications of these findings for psychoanalysis are discussed in this paper.

INTRODUCTION

In this article I wish to draw attention to some results of a recent neuropsychological investigation into the cerebral organization of dreaming (Solms, 1991, 1995). The aims of the original re-

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This paper is based on a paper that was read at a meeting of the New York Psychoanalytic Society, 14 April 1992. Other papers on aspects of this research were read before a meeting of the Section of Neurological Sciences at the Royal London Hospital (31 January 1992), a seminar at the New York Academy of Medicine sponsored by the Psychoanalytic Research and Development Fund (11 April 1992), and a Wednesday Meeting at the Anna Freud Centre, London (27 January 1993). The proceedings of the last-mentioned meeting were summarized in Solms (1993).

search were (1) to establish whether bedside evaluation of changes in dreaming might be of any diagnostic or localizing value in the clinical neurological situation, and (2) to discover what brain structures—and what brain functions—are implicated in the normal process of dreaming. These are purely neuropsychological aims, and this research was instigated for a purely neuropsychological reason, namely the lack of any systematic clinico-anatomical study of dreams (as opposed to REM) in the existing literature.[1] In conducting this research I was aware that the findings might also be of interest to psychoanalysis, due to the special place which dreams occupy in the history and theory of that discipline. However, it is important to stress that *this study was not intended to test any theory of dreams, psychoanalytic or otherwise*; it aimed only to address the two issues mentioned above. I emphasize this point at the outset because it determined the methodology that was applied and the questions that were addressed. Psychoanalytic or neurophysiological (as opposed to neuropsychological and clinico-anatomical) techniques were not applied in this study. This constrains inferences from my data beyond neuropsychology, to these related fields. Nevertheless, some findings turned out to have obvious implications for psychoanalysis (and for sleep physiology), and that is why I am drawing attention to them here. I report them in the hope that they will stimulate further research in these related fields.

It is perhaps surprising to learn that the neuropsychological organization of dreaming has received scant scientific attention. This is part of a general (but not exclusive) tendency in modern neuropsychology, namely, a tendency to study only those functions and behaviors which readily lend themselves to quantification and to experimental investigation. This tendency recently prompted Sacks (1984, p. 164) to write, in a very apt turn of

[1] There have been scattered publications (especially in the older neurological literature) reporting isolated clinico-anatomical correlations (primarily in single cases), but no systematic studies have been reported. The existing literature is summarized below.

phrase, that "neuropsychology is admirable, but it excludes the *psyche*." There is of course no good scientific reason to avoid the subject of dreams, or any other aspect of subjective mental life, in neuropsychology. My own interest in the subject started from the observation that certain neurological and neurosurgical patients complained of specific changes in their dreaming, the onset of which they dated to the beginning of their illnesses. This was a simple clinical observation, as deserving of attention as any other; there was no a priori reason to doubt these reports. The scientific task was to discover whether the patients' descriptions displayed any degree of uniformity, and whether typical subjective changes tended to co-occur with particular pathological-anatomical and clinical presentations. Unless dreaming turned out to be arranged in a fundamentally different way to other psychological functions, there was every reason to expect that it would be possible to establish a taxonomy of changes in dreaming with focal neuropathological significance. Likewise, on the basis of experience with other mental processes, it was reasonable to expect that the pattern of these changes would cast light on the neural organization of the normal dream process.

A possible objection arises at this point, namely that scientists have in fact long been interested in the neurological organization of dreams. REM sleep was discovered in the mid-1950's by Aserinsky and Kleitman (1953, 1955); the observation that REM regularly co-occurs with dream was established shortly thereafter (Dement and Kleitman, 1957a, 1957b); and the intimate network of structures and mechanisms that comprise the anatomical and physiological substrata of REM have since been reliably identified and localized in the activatory core of the brain (by Jouvet, Sakai, Hobson, etc.). These facts are undoubtedly true, but a fundamental conceptual distinction must be drawn between REM sleep and dreaming. REM sleep is a physiological state, defined by entirely physiological criteria (eye movement, muscle tone, EEG profile, etc.). This physiological state has a high statistical correlation with the psychological phe-

nomenon of dreaming,[2] that is, *the two phenomena tend to co-occur*, but this does not mean that *they are one and the same thing*. To treat the two states as synonymous would be to commit both a logical and an empirical error (Labruzza, 1978; Vogel, 1978; Wasserman, 1984). The principal observation that I wish to report in this article pertains to just this issue: the results I report below suggest that *the essential psychological mechanisms of dreaming might not be regulated by the deep brainstem structures which are known to regulate the physiological mechanisms of REM sleep*.

This issue is important for psychoanalysis because the view that REM sleep is synonymous with dreaming has in recent years undermined Freud's (1900) classical theory; that is, the scientific community at large has rejected Freud's psychological conception of dreams in favor of a variety of physiological theories. I will quote just one representative example of this trend:

> The primary motivating force for dreaming is not psychological but physiological since the time of occurrence and duration of dreaming sleep [i.e., REM sleep] are quite constant, suggesting a preprogrammed, neurally determined genesis. In fact, the neural mechanisms involved can now be precisely specified. This conclusion does not, of course, mean that dreams are not also psychological events. . . . But it does imply that the process is much more basic than the psychodynamically determined, evanescent, "guardian of sleep" process that Freud had imagined (Hobson and McCarley, 1977, p. 1346).

I quote this example because Hobson and McCarley's critique of the classical theory has been particularly influential (see also McCarley and Hobson, 1977; Hobson, 1988).

[2] I am excluding from consideration the fact that an ongoing thought process can be demonstrated during all sleep stages. The word "dreaming" is used here in the everyday sense, to refer to a hallucinatory, self-involving narrative. Likewise, in the investigations and literature discussed below, the term corresponds to a subjective state which patients themselves described as "dream."

METHOD

The reader is referred to the original neuropsychological study cited above for a fuller account of the methods employed in this research. Only the essential facts are mentioned here. Over a period of four years, the dreams of 332 neurological and neurosurgical patients, with a wide variety of lesions in different parts of the brain, were studied, together with 29 controls with nervous system pathology (or suspected pathology) which spared the brain itself. Changes in dreaming were characterized by means of a simple clinical interview. Patients were classified according to, among other things, the presence or absence of dreams, the quality of sleep, the vivacity of dream imagery, the affective tone of dreams, dream frequency, and so on. The interview was conducted in a flexible manner and adapted to the individual circumstances of this seriously ill population. Clinical status was characterized by routine neurological and neuropsychological work-up, and classified in accordance with standard nosological criteria. Lesion site and type were similarly determined by standard clinical techniques—CT and MRI imaging (with template projection), cerebral angiography, surgical observation, biopsy, etc.—and they were classified according to conventional anatomical and pathological categories.

Typical patterns of change in dreaming were identified, and were correlated with associated clinical symptoms and signs, and with the site and type of neurological pathology. Appropriate descriptive and inferential statistical techniques were utilized in the analysis of the data. The nature of the underlying neuropsychological deficits associated with the changes in dreaming were determined by the method of syndrome analysis (Luria, 1973, 1980; Luria and Majovski, 1977; Walsh, 1987).

RESULTS (AND SURVEY OF THE LITERATURE)

I do not intend to report all the details of my findings here. I shall summarize only the most essential results, with special ref-

erence to those which have implications for psychoanalysis. The relevant cases can be grouped under seven headings.

Group A. Preservation of Dreaming with Brainstem-Core Lesions

My series included 61 patients with damage to the brainstem (broadly defined). Twenty-two of these patients had lesions which implicated the anatomical region considered critical to the regulation of REM sleep (i.e., the brainstem-core, which is marked by the letter A in the diagram, p. 62). The only clinical neuropsychological feature that distinguished statistically between patients with and without damage to this region was hypo-arousal. Eighteen of the 22 patients reported preservation of dreaming. Only four of them reported cessation of dreaming. The latter four cases all suffered significant hydrocephalus (which is a common complication of pathology in this area). This necessarily meant that the zone of dysfunction was not confined to the region of the primary lesion. In order to distinguish the effects of the primary (brainstem) lesion from those of secondary (forebrain) hydrocephalus, the dreams of five hydrocephalic patients (three of whom had definite brainstem-core pathology) were studied before and after ventriculo-peritoneal shunting (which reverses the hydrocephalus and thereby isolates the effects of the brainstem lesion). In all five patients dreaming returned within four weeks of the surgical (shunting) procedure.

The lack of relationship between deep brainstem lesions and cessation of dreaming was an unexpected finding, for it seemed to contradict the one clinico-anatomical correlation that *had* been firmly established in relation to dreaming. However, a survey of the relevant literature revealed that *it has in fact never been demonstrated that brainstem-core lesions—or cessation of REM sleep—is accompanied by cessation of dreaming*. In the very extensive literature that has accumulated around the phenomenon of REM, it was possible to trace only one report, of a single case, in

which loss of REM with a brainstem lesion was accompanied by cessation of dreaming (Feldman, 1971). Surprisingly, other investigators of such cases seem not to have asked their patients about changes in their dreams (Adey, et al., 1968; Chase, et al., 1968; Guilleminault, et al., 1973; Freemon, et al., 1974; Markand and Dyken, 1976; Cummings and Greenberg, 1977; Osorio and Daroff, 1980; Lavie, et al., 1984).[3] Schanfald, et al. (1985) reported one further brainstem case, but without demonstrating absence of REM.

Groups B & C. Cessation of Dreaming with Inferior Parietal and Deep Bifrontal Lesions

One hundred and twelve of my 332 patients reported global cessation of dreaming at first assessment (most of these patients recovered within a year). Sixty-four of them had focal lesions (the damage was diffuse in 48). The focal cases fell into *two groups*. In the *first* group, 47 cases had definite parietal lobe involvement, and 8 cases had probable parietal lobe involvement (i.e., space-occupying lesions in close proximity to the parietal lobes). The critical site of lesion appeared to be the inferior parietal lobule of either hemisphere (the region marked by the letter B on the diagram). This site of lesion discriminated

[3] This statement requires qualification. None of these investigators asked the patients whether or not they still dreamed *in general*, but one author (Lavie, et al., 1984, p. 118) described one patient with a localized pontine lesion who awoke spontaneously during REM sleep on one occasion in a sleep laboratory, and "could not recall any dreams" *on that one occasion*. Also, Osorio and Daroff (1980) mentioned, in an oblique turn of phrase, that the absence of REM sleep in two patients with spinocerebellar degeneration whom they studied in a sleep laboratory over three consecutive nights, "included all the concomitant phenomena" (p. 278). This could mean that their two patients reported no dreams *on the three consecutive nights in question*. These do not constitute instances of cessation of dreaming. Schanfald, et al. (1985), who conducted REM studies over (a maximum of) five sleep-laboratory nights on two patients described as cases of "absence of dream recall," admitted that "such absence of recall [i.e., in the time-limited, sleep-laboratory context] has also been observed in subjects without apparent brain damage" (p. 246).

very significantly between dreaming and non-dreaming patients ($p = 0.0003$, $F = 13.68$). The non-dreamers were distinguished from the dreaming patients by three symptoms: left-right disorientation, finger agnosia and short-term (immediate) visual memory deficit. Long-term (recent and remote) memory disturbance did not distinguish between them. In the *second* group, eight cases had definite bilateral frontal lobe involvement, and one case had probable bilateral frontal lobe involvement (i.e., a unilateral frontal lesion with mass effect). The critical site of lesion was the white matter surrounding the anterior horns of the frontal ventricles (letter C on the diagram; $p < 0.05$, $F = 5.19$). No other sites of lesion discriminated statistically between dreamers and non-dreamers. These cases were distinguished from the dreaming cases by three symptoms: disinhibition, adynamia, and perseveration. The subjective loss of dreaming was again not associated with amnesia. One control patient reported global cessation of dreaming; this was a (highly suggestible) case of hysterical quadriplegia. Interestingly, the cases in both Groups B and C could be distinguished from dreaming patients in terms of the subjective quality of their sleep; that is, the non-dreaming patients reported significantly disturbed sleep (see Table 1, p. 63).

The fact that a higher cortical lesion, rather than a deep brainstem one, correlated with cessation of dreaming was another unexpected finding. However (in contrast to the lack of evidence linking cessation of dreaming with brainstem lesions and/or cessation of REM sleep), a comprehensive search of the literature strongly confirmed the link between cessation of dreaming and higher cortical lesions. In regard to the *parietal* lobes (Group B) it was possible to trace 38 cases similar to my own in the world literature (Wilbrand, 1887, 1892; Müller, 1892; Grünstein, 1924; Lyman, et al., 1938; Humphrey and Zangwill, 1951; Gloning and Sternbach, 1953; Boyle and Nielsen, 1954; Nielsen, 1955; Ritchie, 1959; Farrell, 1969; Moss, 1972; Epstein, 1979; Basso, et al., 1980; Epstein and Simmons, 1983; Peña-Casanova, et al., 1985; Habib and Sirigu,

1987; Neal, 1988; Farah, et al., 1988). In regard to the *frontal* region (Group C) it was possible to trace reports of eight such cases in the neurological literature (Piehler, 1950; Gloning and Sternbach, 1953; Schindler, 1953), as well as a number of reports in the psychiatric literature, of large series of cases with cessation of dreaming following prefrontal leucotomy (Frank, 1946, 1950; Piehler, 1950; Partridge, 1950; Slater [Humphrey and Zangwill, 1951]; Schindler, 1953; Jus, et al. 1973; Freeman [Jus, et al., 1973]).

Group D. Non-Visual Dreaming with Medial Occipito-Temporal Lesions

Two patients in my series reported circumscribed loss of visual dream imagery with preservation of dreaming itself (they dreamed, as they said, in "sensations" or "words" rather than in "pictures"). The lesion involved the medial occipito-temporal area in both cases (which is marked by the letter D on the diagram).[4] These patients both suffered deficits of waking visual imagery and of short-term (immediate) visual memory. No control patients reported this phenomenon. The quality and extent of the waking imagery defect (in my cases and those reported in the literature) directly paralleled that of the dream imagery (e.g., loss of color imagery was accompanied by achromatic dreams).

I have traced published reports of 12 previous cases with this striking symptom (Charcot, 1883; Grünstein, 1924; Adler, 1944, 1950; Brain, 1950, 1954; Gloning and Sternbach, 1953; Macrae and Trolle, 1956; Tzavaras, 1967; Efron, 1968; Benson and Greenberg, 1969; Brown, 1972; Kerr, et al., 1978; Botez, et al., 1985; Sacks, 1985; Sacks and Wasserman, 1987).[5]

[4] Due to the small number of cases in this group, the localizing significance of the lesion site marked by the letter D could only be established by combining my own cases with those reported in the existing literature (see below).

[5] It is of historical interest to note that Freud examined Charcot's (1883) patient

Group E. Inability To Distinguish Dream from Reality with Anterior Limbic Lesions

Nine cases in my series displayed loss of the ability to distinguish dreams from reality. These patients were unable to determine whether dream events had actually happened or not. Most of them reported, in addition, *increased frequency of dreaming*. Some experienced *almost continuous dreaming*. One described *continuity of the same dream across intervening periods of wakefulness*. The lesion in these cases invariably compromised anterior limbic structures (marked by the letter E on the diagram). The patients in this group suffered from a wide range of associated deficits: hallucinations, delusions, confusions between thought and reality, confabulatory amnesia, reduplicative paramnesia, disorientation, anosognosia, and hemispatial neglect. No control patients reported this dream phenomenon.

It was possible to trace reports of 11 similar cases in the literature (Grünstein, 1924; Gloning and Sternbach, 1953; Whitty and Lewin, 1957; Lugaressi, et al., 1986; Berti, et al., 1990). There was a degree of variability in these cases: in some cases the emphasis fell upon increased frequency or vivacity of dreaming; in other cases confusion between dreams and reality was the outstanding feature.

Group F. Recurring Stereotypical Nightmares with Complex-Partial ("Temporal Lobe") Epilepsy

Nine patients in the series reported recurring nightmares with stereotypical content. These nightmares were seizure equivalents; successful surgical or pharmacological treatment of the seizure disorder resulted in a disappearance of the recurring nightmares. Surface electrode EEG recordings and the phenomenology of the seizures suggested involvement of temporal-

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in 1885-1886 (see Schilder, 1931). He also translated into German Charcot's report of this case (Freud, 1886).

limbic structures in these cases (the approximate region is marked by the letter F on the diagram). All but one of these cases suffered, in addition to complex-partial epilepsy, some form of affective disturbance. No control patients reported this phenomenon.

Unlike the other phenomena described above, this symptom is relatively well established in clinical neurology. Cases have been reported since the turn of the century. De Sanctis (1896) is usually credited with the first description. Freud (1900) cites an article by Thomayer (1897). I have been able to trace later reports by Kardiner (1932), Penfield (1938), Penfield and Erickson (1941), Rodin, et al. (1955), Ostow (1954), Epstein and Ervin (1956), Epstein (1964, 1967, 1979), Epstein and Hill (1966), Snyder (1958) and Boller, et al. (1975).

Group G. Completely Normal (Unchanged) Dreaming with Dorsolateral Frontal Lesions

Twenty-four patients in the series reported completely normal dreaming despite definite (and sometimes severe) changes in other aspects of their mental functioning. The lesion was focal in 16 cases. Among these 16 cases, 12 had dorsolateral frontal-lobe convexity lesions (see the region marked by the letter G on the diagram). The lesion was restricted to the left cerebral hemisphere in 12 cases. Nonfluent aphasia and other higher motor deficits were over-represented in this group, but these symptoms did not reach statistical significance. Ten of the 26 control subjects reported completely normal (unchanged) dreaming.

DISCUSSION

I am going to concentrate my discussion on Groups B and C—that is, on the patients who reported *global cessation* of dreaming. If one compares the anatomical location of the le-

sions in these groups (letters B and C on the diagram) with the location of the structures that regulate REM sleep (letter A), the lack of overlap between the region that is critical for REM sleep and those that are critical for dreaming, is obvious. The region that controls REM sleep is embedded deep within the phylogenetically primitive brainstem, whereas those that are critical for dreaming are located within the cerebrum proper, in some of the most highly developed parts of the hemispheres.

The following three findings have a bearing on the issue of the relationship between REM sleep and dreaming. First, my series of 332 patients did not include a single case with a lesion restricted to zone A that resulted in cessation of dreaming, although it included 18 cases where the damage was localized to precisely this zone. Second, the series included 4 cases with global cessation of dreaming where the patient had a mass lesion within zone A combined with secondary hydrocephalus (which resulted in simultaneous disturbance of zones B and C). Since hydrocephalus is a treatable condition, these patients provided an ideal experimental group, to determine whether cessation of dreaming is attributable to pathology in the primitive structures of zone A or the higher cortical centers of zones B and C. In all of these cases, within four weeks of the surgical reversal of the hydrocephalus (that is, of the dysfunction in zones B and C), the subjective experience of dreaming returned (despite the continued presence of the primary pathology in zone A). Third, it was possible to demonstrate significant disruption of zones B and C in every focal case of global cessation of dreaming.

The above findings cast considerable doubt on the conventional theory of REM sleep in relation to dreaming. They are also consistent with the observations of other investigators, as reported in the available literature. The body of clinicoanatomical evidence strongly supports the view that forebrain structures are essential for dreaming whereas brainstem structures are not. However, only incidental physiological data pertinent to this question are available. In the existing clinicoanatomical literature, apart from my own observations, it was

possible to trace 46 individual case studies (and a number of group studies) reporting global cessation of dreaming with forebrain lesions in association with various disturbances of higher mental functions (see above). By contrast, it was possible to trace only two case reports of loss of dreaming following brainstem lesions (Feldman, 1971; Schanfald, et al., 1985). Moreover, as far as the available physiological evidence is concerned, *every published sleep-laboratory study of patients reporting global cessation of dreaming following forebrain lesions has established that normal REM sleep is preserved in these (non-dreaming) cases* (Benson and Greenberg, 1969 [cf. Efron, 1968, and Brown, 1972]; Jus, et al., 1973; Kerr, et al., 1978; Michel and Sieroff, 1981).[6] By contrast, *cessation of dreaming has only once been observed in a case with established loss of REM* (Feldman, 1971). Taken together, these findings cast serious doubt on the theory that core brainstem structures critically regulate the dream process, and they contradict any theory which postulates an exclusive causal link between deep brainstem mechanisms and dreaming. However, in the absence of more comprehensive physiological data (i.e., correlative neuropsychological and sleep studies of dreaming and non-dreaming patients), the available evidence does not yet *exclude* the possibility that REM is necessary for dream.

At this point I must digress in order to discuss another interesting finding. It might be expected that if someone no longer experiences dreams, then that person would sleep more soundly than before—that is, that she or he would experience sleep unadulterated by dreams. Freud's theory, on the other hand, predicts the counterintuitive opposite: if dreams are the *guardians* of sleep, then patients no longer capable of dreaming should sleep *less* soundly than before; dreamless sleep should, paradoxically, be *more* disrupted than dreaming sleep. My results support the latter contention (see Table 1). However, this conclusion must be regarded as tentative. It is based on the patients'

[6] These studies have also confirmed the subjective absence of dreams in forebrain cases (both parietal and frontal) by means of REM-sleep awakenings.

subjective assessments of the quality of their sleep—a physiological state—and physiological (sleep-laboratory) confirmation is therefore necessary. What should be stressed here, however, is that the very existence of a group of patients who experience a loss of conscious dreaming opens new paths to the scientific investigation of the function of dreams. Previous experimental investigations into this question have traditionally relied upon REM-deprivation paradigms. However, REM deprivation is not synonymous with *dream* deprivation. Also, it is difficult to distinguish the effects of REM deprivation from those of sleep deprivation.

I shall now briefly discuss the *psychological* aspects of my study. What psychological changes does one observe in association with the dream disorders described above, following damage to the various structures marked in the diagram? Damage to zone A frequently leads to a total loss of consciousness, but in less severe cases there are signs of obtunded consciousness, drowsiness, and the like. The fundamental psychological disturbance in patients with disruption of these structures appears to be one of *basic arousal and activation*. This factor is also assumed to be critical to REM.

Lesions in zones B and C lead to completely different disturbances. The symptoms that arise with loss of dreaming following damage to zone B in left-hemispheric cases form part of the so-called Gerstmann syndrome. The fundamental disturbance underlying this loose syndrome, according to the investigations of Luria (1973; 1980), is that of quasi-spatial (symbolic) synthesis.[7] Patients with damage to this region lose their ability to

[7] The abstract, integrative functions of the inferior parietal region (tertiary cortex) may be contrasted with the concrete, sensorimotor functions of primary and secondary cortex. It is interesting to note in this regard that all patients in the present study with sensorimotor symptoms arising from focal damage to primary and secondary cortical zones (excluding zone D [secondary visual cortex]; see text) *did not experience analogous sensorimotor symptoms in their dreams*. Thus, for example, cortically blind patients could see normally in their dreams, motor aphasics could speak normally, and hemiplegic patients experienced normal movement. Apart from the

understand and use the basic symbolic systems of their culture: reading and writing; mathematical signs and operations; the nominal function of speech; the logic of grammar and syntax; the spatial-orientational abstractions of left and right, north, south, east, and west; symbolic gestures, and so on. This factor breaks down simultaneously with the ability to generate dreams. *This finding points to a fundamental symbolic factor in dreams. Moreover, it demonstrates that this factor is essential to the entire dream process, for without it, dreaming is impossible.* Damage to zone B in right-hemispheric cases leads to complex disturbances of concrete spatial thought, both in relation to one's own body and to the external object world. *This points to an equally basic spatial factor in dreams*; but we have always known from our conscious experience that space is an important quality of dreaming thought.

Damage to zone C, on the other hand, leads to marked changes in the personality of the patient (this is the precise region that used to be targeted in prefrontal leucotomy; cf. the literature cited above). The neuropsychological changes which discriminated the non-dreamers in this group related to *affect regulation, inhibition, and impulse control.* These patients were strikingly disinhibited, impulsive, distractible, and perseverative. This suggests that dreams do not express simple activation of the sleeping brain (cf. Hobson, 1988, pp. 203-222), for dreams are *impossible to produce without specific influences from some of its highest inhibitory mechanisms.*

Considered together, the following three factors emerge from these results as being essential to the conscious experience of dreams: (1) *symbolic operations*, (2) *spatial thought*, (3) *inhibitory mental control.* These are far from the basic *arousal* factor that seems to be fundamental to REM-sleep.

In the space remaining, I wish to comment on the other four

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wish-fulfilling aspect of these phenomena, they demonstrate that dreaming involves a complex representational process, and not a simple or direct activation process (contra Hobson, 1988, p. 205).

groups of patients mentioned above: those who experienced non-visual dreams, those who experienced recurring nightmares, those who could not distinguish between dream and reality, and those whose dreams were completely unaffected by their neurological disease. I will start with the last group: the *normal* dreamers. Despite the total sparing of their dreams, these patients suffered severe deficits in other aspects of mental functioning. The region of the brain that was involved here (zone G) is traditionally considered to be part of the motor system; in fact, it is thought to be the highest executive end of the motor system, essential for the planning, regulation, and verification of all voluntary activity. Patients with damage to this part of the brain are unable to translate their intentions into motor actions; they get the order mixed up, they constantly repeat the same action, or they find that although they know what they want to do, they cannot bring themselves to actually do it; they cannot subordinate their actions to their original verbal intentions. In other cases, the intentions themselves are affected; they are unable to formulate plans, there is a breakdown of all purposive activity, and their thoughts become as erratic as their actions. In some essential respects *these patients think and behave in their waking life as we do in our dreams*. The significance of this group of patients (whose dreams were entirely unaffected despite substantial lesions in this area) is the following: they suggest that it is perhaps not only the primary musculo-skeletal system that is deactivated in dreams, but also *the entire motor system, including its highest psychological components which control goal-directed thought and voluntary action*.

Taken together with the earlier findings, the following general picture emerges. Those parts of the brain which are *most* essential to the dream process (which, when damaged, produce a total *cessation* of dreaming) are responsible for *symbolic operations, spatial thought, and impulse control*. On the other hand, the part of the brain that is *least* essential to the dream process (which, when damaged, has *no effect* on dreaming) is responsible for *goal-directed thought and action*.

Now the other three groups may be considered briefly. First: the patients who reported non-visual dreams (zone D) suffered an associated symptom known as irreminiscence; they were unable to generate visual mental images in general. Here the fundamental deficit seems to be one of *visual representation* as a whole. In all other respects, these patients continued to experience normal dreams. The integrity of these other aspects of dreaming suggests that *visual representation (and this cortical region) should be placed at the terminal end of the dream process.* This may be considered as neuropsychological support for the theory of topographical regression in dreams.

Second: the patients who were unable to distinguish dreams from reality suffered similar confusions in waking mentation; they hallucinated, misrecognized people and places, mistook their thoughts for actual experiences, and so on. What these symptoms have in common is the factor of *reality testing.* This clinical phenomenon is, therefore, not so much a disturbance of dream as it is a disturbance of that factor which, in waking mental life, suppresses or inhibits dreams or dream-like mentation. This would explain why these patients also experienced *increased frequency* of dreaming. Cases of *continuous dreaming* seem to confirm the existence of an ongoing thought process during sleep (which is normally inhibited and preconscious).

Third: in the patients who suffered recurring nightmares, there were no impressive mental changes other than psychical seizures. The seizures themselves, therefore, are the common underlying factor. A seizure is nothing other than a pathological activation and discharge process. Again, this points to an arousal factor in dreams, which evokes the basic activation factor that is presumed to underlie REM-sleep regulation. This connection between the two phenomena (epilepsy and REM sleep) might provide a clue to the empirical link between REM sleep and dreaming. The fact that REM and dreaming are indeed linked in some significant way cannot be denied—although they appear to have different neurological organizations—and this link requires explanation.

To this end, I shall now *summarize* my findings and describe the model of the dream process as a whole that emerges. It was well established before I undertook this study that REM activation almost invariably co-occurs with dream. This fact stands; but now we may suggest in addition that although REM activation *co-occurs* with dream, it *stands outside*, as it were, the dream process itself. Dreaming can apparently occur without the preservation of REM-regulating structures and, conversely, dreaming can cease despite the definite preservation of REM. It therefore seems reasonable to formulate the following hypothesis: *the structures which regulate sleep are neither necessary nor sufficient for dreaming*. A critical test of this hypothesis requires physiological investigations which transcend the stated aims and methods of the present research.

We have identified *another* arousal phenomenon, namely, nocturnal seizure activity, which also co-occurs with dream. Taken together with the observation that dreams appear to protect sleep, a further hypothesis seems justified: *anything which disturbs sleep can give rise to a dream*. REM activation is but one such phenomenon (albeit a regular and a common one), nocturnal epileptic activation is another such phenomenon (albeit a pathological one), and there may be many more. But such phenomena act merely as *triggers* of the dream process; *the psychological work of the dream itself occurs over fundamentally different structures*.

In waking mental life, in the normal course of events, any arousing stimulus proceeds in the direction of an efferent response; that is, toward the *motor* systems. During *sleep*, however, these systems seem to be inhibited. Thus there are two possibilities for an activation process (principally but not exclusively arising from reticulate and limbic regions) which occurs during sleep: either (1) it can overwhelm the inhibited motor systems and proceed toward goal-directed activity, thus disturbing sleep, or (2) it can be deflected toward the perceptual systems and proceed toward hallucination. The control mechanism, it would appear, is critically mediated by mediobasal frontal and anterior limbic structures (zones C and E in the diagram). These regions

are essential for affect regulation, impulse control, and reality testing; they act as a form of "censorship." If they are damaged, the motor system is not inhibited during sleep, dreaming is impossible, and sleep is disturbed. If these functions are overwhelmed by an excessively powerful stimulus (such as occurs with a nocturnal seizure), anxiety ensues, dreaming breaks down, and again, sleep is disturbed. (It is at this point that the phenomenon of recurring nightmare must be located.) If, however, the mediobasal frontal-limbic region is functioning normally, the arousal process is deflected toward the perceptual systems, where it is worked over by specific representational mechanisms which are critical to symbolic and spatial thought. This is the normal situation in dreams; under the inhibitory and regulatory control of mediobasal frontal-limbic mechanisms (zones C and E) an efferent activatory process shifts retrogressively to the posterior, perceptual systems of the parieto-occipital region (zones B and D), and therefore lacks any contribution from the motor regions (zone G) which normally imbue waking mental life with its characteristic coherence, structure, and purpose. These appear to be the essential ingredients of dreaming from the neuropsychological point of view.

In *conclusion*: the results of this study suggest that, in dreams, the primary "scene of action" of mental life shifts retrogressively, under the regulatory control of mediobasal frontal and anterior limbic systems, away from the dorsolateral frontal region (which is, as it were, the executive focus of normal waking cognition) toward the parieto-occipital (perceptual-mnestic) systems. Nocturnal mentation is thus deprived of the characteristic goal-directedness of waking mental life, and the activating impulse is worked over symbolically in visuo-spatial consciousness. I hope that it is obvious from all that I have said that the results of this study, the first systematic investigation of the clinical neuropsychology of dreaming, provide striking confirmation of the classical theory of dreams that was introduced by Freud almost one hundred years ago.

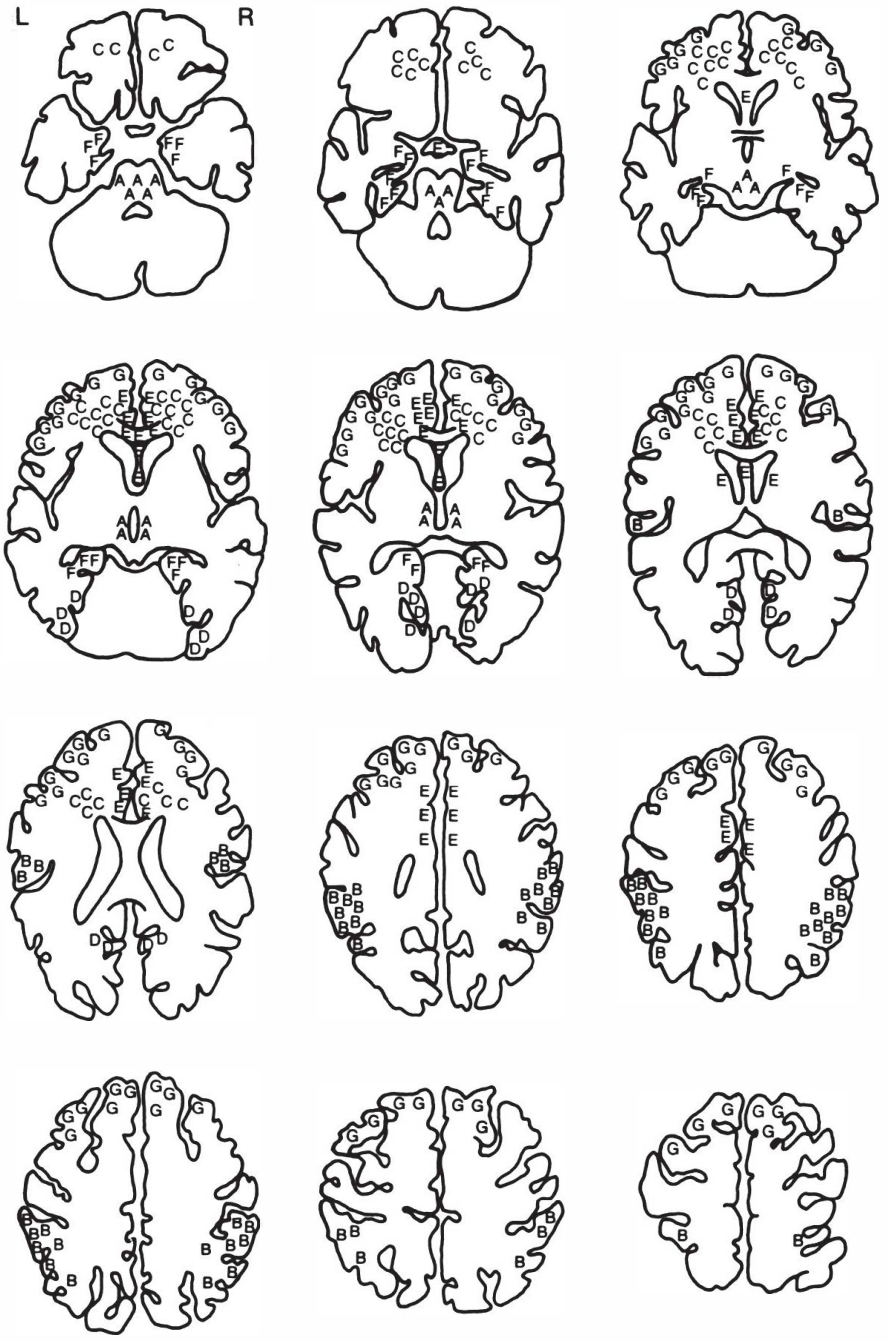

Diagram. Serial sections through the human brain at planes and intervals corresponding roughly to typical CT images (after Damasio and Damasio, 1989). The letters A-G correspond to the seven groups of patients discussed in the text.

TABLE 1
Quality of Sleep in Cases with and without Global Cessation of Dreaming.

	SLEEP	
DREAMS	(DISRUPTED)	(NOT DISRUPTED)
Absent	49	52
Present	59	127

Excludes "unsure" responses. $X^2 = 7.87$; $p < 0.01$.

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Toward an Understanding of Unmentalized Experience

Judith L. Mitrani

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TOWARD AN UNDERSTANDING OF UNMENTALIZED EXPERIENCE

BY JUDITH L. MITRANI, PH.D.

The term unmentalized experience *is defined, elaborated, explicated, and illustrated with clinical examples from the analysis of adult patients. The origins of the author's conceptualization of the term are traced from Freud's early notion of the "anxiety equivalent" through the work of present-day object relations theorists. A model for the somatic recording of early pre- and postnatal experience is derived from Stern's research in the field of infant development, and some implications for treatment are noted.*

> Without sensibility no object would be given to us, without understanding no object would be thought. Thoughts without content are empty, intuitions without concepts are blind.
>
> KANT

INTRODUCTION

In an earlier paper (Mitrani, 1992) I addressed some of the clinical issues involved in the psychoanalytic treatment of certain

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patients who, while under threat of being overwhelmed by organismic panic (Grotstein, 1984) or of being engulfed in a "black hole" of despair (Tustin, 1972), protect themselves against the terrifying awareness of early experiences of bodily separateness and loss which have yet to be mitigated through a process of human interaction. Since earliest infancy the awareness of these experiences in their raw primordial form has been kept at bay through the deployment of certain encapsulating forces akin to those utilized by autistic children, as described over the past three decades by Bick (1968), Meltzer, et al. (1975), and Tustin (1969, 1972, 1980, 1981, 1984a, 1990, 1991). In my earlier paper I emphasized the survival function of those autosensual maneuvers which form psychobiological containers for *unmentalized experience.*

At that time it was called to my attention by certain readers that the term unmentalized experience required some explication as to its source and meaning. This paper therefore aims toward a definition of this concept in order to enhance its usefulness for the purpose of scientific discourse while at the same time attempting to facilitate its use as a model for understanding yet another dimension of human functioning.

First, I will give a brief working definition of the term unmentalized experience, after which I will trace the predecessors of the concept from Freud through the present-day object relations theorists. I will also show how such ideas, derived from clinical experience, may be further enhanced by mingling them with those derived from modern fetal and infant observational research. From time to time I will return to the clinical arena in order to illustrate certain aspects of unmentalized experience and the transformation of these through the analytic process. As I intend to address several divergent theoretical schools of thought in psychoanalysis in order to accomplish my task, I will attempt to transcend the language barrier which exists between, and even within, theoretical orientations by providing numerous footnotes to be used by the reader as necessary.

WORKING DEFINITION OF UNMENTALIZED EXPERIENCE

In this paper the term unmentalized experience denotes elemental sense data, internal or external, which have failed to be transformed into symbols (mental representations, organized and integrated) or into signal affects (anxiety which serves as a signal of impending danger, requiring thoughtful action), but which are instead perceived as concrete objects in the psyche or as bodily states which are reacted to in corporeal fashion (e.g., somatic symptoms or actions). Such experiences are merely "accretions of stimuli" which can neither be used as food for thought nor stored in the form of memories. These experiences, which have not been kept in mind, cannot be repressed. Instead, they are isolated as if in quarantine, where they remain highly immutable. These unmentalized experiences therefore represent one of the most challenging aspects of our work.

I believe Freud's notion of the "anxiety equivalent" (1895, p. 94) in "actual neurosis" was the first attempt to characterize this phenomenon in psychoanalysis. A brief review of Freud's thinking in this area will provide the necessary background for what is to follow.

THE ANXIETY EQUIVALENT

In 1894 Freud wrote to Fliess:

> There is a kind of *conversion* in anxiety neurosis just as there is in hysteria . . .; but in hysteria it is *psychical* excitation that takes a wrong path exclusively into the somatic field, whereas here [in anxiety neurosis] it is a *physical* tension, which cannot enter the psychical field and therefore remains on the physical path (1892-1899, p. 195).

Here, Freud seems to be suggesting that in the case of the individual suffering from anxiety neurosis, there may exist a phys-

ical tension which may somehow be present without a psychical concomitant.

In his model of conversion hysteria, Freud (Breuer and Freud, 1893-1895) had proposed that his patients had maintained psychic health until a point at which an event, idea, or sensation awakened in the ego such painful feelings that the individual was compelled to "forget" for want of alternate capabilities with respect to resolving internal contradictions. In this second model, however, Freud understood somatic symptom formation as an organic "anxiety equivalent" (1895a, p. 194). He observed that disturbances of "bodily functions—such as respiration" (p. 94) often accompany, mask, or even substitute altogether for anxiety, and in contrast to the anxiety of the hysteric, the analysis of such anxiety fails to uncover a repressed idea. Here, *in the case of the anxiety neurosis, or "actual" neurosis, the somatic symptom results from physical sensations which have been denied access to the psychic apparatus—sensory experiences which have failed to be mentalized*—whereas in hysterical conversion, psychic stimulation induced by conflict is repressed, i.e., banished to expression in a physical organic symptom.

In either case, Freud cited "a *psychical insufficiency, as a consequence of which abnormal somatic processes arise.*" He suggested that in both, "instead of a psychical working-over of the excitation, a deflection of it occurs into the somatic field" (1895a, p. 115). The distinction Freud makes here is of paramount importance, in that hysterical conversion is seen by him as a subtype of repression in which the organic symptom is a physical representation of a psychic transformation, while *the organic symptom of anxiety neurosis is understood as a direct expression of unmentalized somato-sensory excitation.*

In further distinguishing between hysterical conversion and the actual neuroses or anxiety equivalent, Freud described the bodily symptoms of the former as representations of psychic or mental experience which might be interpreted as stemming from an unconscious conflict between the instinctual needs and the ego's defenses. In other words, the conversion symptom

constituted a compromise with the characteristics of a symbol standing for an idea. However, the symptom of actual neuroses was thought to be the equivalent of a psychic state of an undifferentiated or primitive anxiety—not the representative or physical expression of a psychical activity which has gone awry, but an indication that a psychic activity has failed to occur.

It might be said that the conversion symptom is a substitution of a bodily symptom for a conscious action which represents an unconscious desire to act upon an idea, while the organic symptom of the anxiety neurosis indicates a lack of mentation of a sensory experience, the idea of the action never having been formed. From this, one might conclude that there is a relationship between conversion and repression, while relating anxiety equivalents to the more primitive varieties of projection or, more precisely, to the use of *projective identification for the purpose of communication* (Bion, 1959, 1967). I wish to emphasize that the distinction between these two models of somatization lies in the observation that in hysteria the excess of excitation is psychical in its origin. That is, the excitation is provoked by conflicting ideas. But in anxiety neurosis, the excitation is purely somatosensual, physical in its origin and as yet untransformed in the mental sphere.

In light of these findings, Freud (1916-1917) concluded:

> The problems of the 'actual' neuroses . . . offer psycho-analysis no points of attack. It can do little towards throwing light on them and must leave the task to biologico-medical research (p. 389).

It seems Freud relegated those neuroses of a somatic nature—neuroses which were devoid of psychical content—to the background of psychoanalysis. In short, such patients were assumed at one time to be unanalyzable. Fortunately, the pioneer work of Melanie Klein, as well as the extensions of her work by both the Kleinian and the Independent schools to the present day, has amplified our understanding of such primitive states. This understanding has led to a refinement in technique which has

facilitated access to those patients previously thought to be unanalyzable. Such access becomes possible through a process of analysis in which countertransference can be understood as (at least in part) an indication that a communication of a sensory experience has taken place, requiring transformation in the mentality of the analyst. Throughout this paper, I will examine some of the pivotal ideas of the British school as they apply to the concept of unmentalized experience.

EXPERIENCES WHICH REMAIN UNMENTALIZED

In order to begin to render the concept of unmentalized experience meaningful, it may be important to delineate those experiences which are most likely to remain unmentalized and how this might occur. I will therefore attempt to describe some of the elemental happenings in the life of the fetus and of the neonate which are sometimes kept out of the mental sphere due to a "coincidence of vulnerability" in both infant and mother, with unfortunate consequences for the development of mental structure. Here, I shall once again return to the work of Freud on the anxiety equivalent in actual neurosis.

Freud (1926) noted that anxiety, as well as other affective states, is a precipitate of "primaeval traumatic experiences, and when a similar situation occurs" (p. 93), anxiety is revived, expressing itself in a form determined by the experience which provoked it originally. He suggested that "in man, birth provides the prototypic experience," and he viewed "anxiety-states as a reproduction of the trauma of birth" (p. 133), drawing attention to those physical sensations which frequently accompany such affective states (p. 132).

Freud then proposed that those

> innervations involved in the original state of anxiety probably had a meaning and purpose. . . . at birth it is probable that the innervation, in being directed to the respiratory organs, is pre-

> paring the way for the activity of the lungs, and, in accelerating the heartbeat, is helping to keep the blood free of toxic substances (p. 134).

He also said that "the baby will repeat its affect of anxiety in every situation which recalls the event of birth" (p. 135) and concluded that what is recalled and what it represents is "separation from the mother" (p. 137), which is regarded as catastrophic. Here, Freud seems to imply that the purpose of the sensations which accompany the original as well as subsequent states of anxiety is to rid the self of the primal experience of separation, which is felt to be deadly toxic.

It has recently been brought to my attention (Osterweil, 1990) that the presence of toxins in the prenatal environment might threaten the fetus with actual physical destruction; that the mother's emotional states might affect her physical chemistry and may sometimes be at the root of spontaneous abortions in early pregnancy; and that biochemical intrauterine alterations may cause fetal distress and even premature labor in the last stage of pregnancy. Although such perils experienced in utero may be overcome on a physiological level with the aid of modern medical procedures, such early trauma may leave behind emotional scars, perhaps in the form of a felt threat of "discontinuity of being" (Winnicott, 1960a).

Recent prenatal and perinatal research (Mancia, 1981; Osterweil, 1990; Piontelli, 1985, 1987, 1988, 1992) seems to confirm what Freud (1926) intuited years before when he stated:

> There is much more continuity between intra-uterine life and earliest infancy than the impressive caesura of the act of birth would have us believe. What happens is that the child's biological situation as a foetus is replaced for it by a psychical object-relation to its mother (p. 138).

What Freud implied then, and what we can be more certain of now, is that the infant's immediate postnatal relationship with the breast-mother is not only the "prototype of the expression of

sexual satisfaction in later life"[1] (Freud, 1905, p. 182), but that it is a continuation and a transformation of the sensory *feeling* of being inside the mother's body.

For some babies, this is a tangible feeling of being held safely and securely within the mother's womb, which is, after birth, transformed into the feeling of being held in the postnatal womb of the mother's mind as well as in her arms. However, for some less fortunate neonates, there may be instead a sensory experience of a prenatal disturbance which is tantamount to a catastrophic psychological birth (Tustin, 1983), one which may remain untransformed by the mind of the mother. It is therefore likely to elicit the most primitive forms of anxiety, which are indistinguishable from the physiological sensations of unbearably painful irritation, mutilation, burning, or tearing of the body. These experiences, if they should continue unabated, may produce an endless bodily agony of spilling, falling, dissolving, and evaporating into nothingness. This felt experience constitutes a "nameless dread" (Bion, 1967) which provokes "unthinkable anxieties" (Winnicott, 1960a) and which truly threatens the infant's sense of "going-on-being" (*ibid.*) and the "rhythm of safety" (Tustin, 1986) necessary for the establishment of normal object relations. Since such catastrophes are experienced by a "body-ego" (Freud, 1923a) or a "felt-self" (Tischler, 1979), which as yet cannot tolerate the awareness of such physical discontinuity, that awareness (or even the capacity for awareness) is felt as a toxin which is expelled or perhaps withdrawn from (Grotstein, 1991).

For example, Robert (who had come to analysis after numerous hospitalizations and suicide attempts) told me of a visual handicap from which he had suffered all of this life. "I have this one eye which needs correction. I have no depth perception in that eye. Through it I see the world in only two dimensions.

[1] Gooch (1985) wrote an extensive thesis on the subject of the mother-infant nursing relationship as a prototype for sexual satisfaction in adult couples. She suggested that failures and frustrations experienced in this early nipple-mouth connection replicate themselves in a variety of sexual dysfunctions in adulthood.

Many doctors have tried to correct it, but it can't be fixed. Although, I think I like it that way. I see the world the way I like it best. They call it a lazy eye. One time in the emergency room a doctor told me that I must have had a traumatic birth. He said that this eye problem is typical of this."

Over time we came to understand the lazy "I" as a somatic *presentation* of an unborn-he who could not bear changes in light, temperature, or textures and so could not be *fixed by* the analysis but could only be *fixed onto* it. He could not bear the end of the hour, as it felt to him that I was peeling him off the placental walls next to the couch, which he often stroked during episodes of mute anguish (Osterweil, 1990; Paul, 1983). His "adhesive" way of using me in the sessions (and between times on the telephone) and his experience of being torn away from me over and over again with each separation were "felt" by my patient and "suffered" by me for many months. During holidays and sometimes even over weekends Robert would engage in behavior that would result in his being put on "hold" in the hospital. He would often describe in great detail and with much emotion previous episodes in the hospital when he was actually placed in four-point restraints in a padded room. On one occasion when he overdosed on a mixture of substances, not only was he hospitalized but he also required renal dialysis. In a very dramatic way, Robert brought home to me his felt need, not just for the womb, but for the umbilical cord and its vital functions as well.

It seems to me, although I had no evidence of this at the time, that he experienced all endings as re-enactments of his birth, the sense of which I gradually attempted to communicate to him as we struggled along painfully together. We finally came to discover that his actual birth had been premature (by one month), brutal (his father delivering him under primitive conditions where there was no medical assistance available), and dangerously complicated by placenta previa. The patient's recollections of this event seemed indeed to be "body memories" which were

both encapsulated and expressed in behavior, character, and physiological anomaly.

With the above in mind, I will now backtrack to discuss the specific factors identified by Freud (Breuer and Freud, 1893-1895) as those which prevent physical excitation from being worked over in the psychical field and which precipitate the formation of the anxiety equivalent, which is a sign of unmentalized experience. Freud listed these etiological factors as: (1) sexual abstinence, (2) coitus interruptus, and (3) deflection of psychical interest from sexuality. If, in light of our present-day understanding, we were to substitute for these three: (1) the subjective experience of privation, externally or internally imposed, (2) premature disillusionment with, and (3) schizoid withdrawal from the primary object (the holding and containing breast-mother of earliest infancy), it might be possible to flesh out Freud's original model of anxiety neurosis.

An updated version might read: *somato-sensual excitation,* arising from a *premature awareness of bodily separateness* from the *primary caretaker* (who is at first experienced as a part of the self)[2] may result in a *felt experience of primordial terror* which must be *deflected from the psychic or mental apparatus* in the event of *psychical insufficiency* (the lack of an external or internal containing object). Subsequently, this experience which remains *unmentalized* finds aberrant means of both containment and expression in its "equivalent" (e.g., autosensual encapsulation, somatic symptoms, hyperactivity), which serves to keep the "felt-self" free of toxic substances (e.g., awareness of the absence of the good object, which is *felt* as a toxic substance or as a treacherous void).

Because it may seem that at this point we have entered into the internal world of objects and fantasy, I will continue my discussion with these familiar concepts, perhaps adding some

[2] This concept was addressed by a number of authors: e.g., the "subjective mother" of Winnicott (1962); the "background object of primary identification" and the "sensory floor," terms coined by Grotstein (1980); the "archaic selfobject" of Kohut (1971).

new variations on several old themes. It is my intention to make clear distinctions between mental states and what Bion (1962) referred to as the protomental.

THE CONCEPT OF FANTASY

Derived from the work of Melanie Klein (1932) and of others of the Kleinian group in London (Heimann, 1952; Isaacs, 1952), the concept of unconscious fantasy has amplified Freud's earlier notion of the term. For some time, it has been a widely held belief that fantasies are processes active in the infant long before they can be represented in a symbolic or verbal manner. The earliest "phantasies" are presented in a "somato-sensual" mode (Isaacs, 1952, p. 74) as bodily sensations and then as motor action.

The infant (in a position of maximal vulnerability and minimal motoric and verbal capability) employs fantasy as a means of defense, for inhibition and control of instinctual urges, for expression of wishes and desires and their fulfillment. The omnipotent character of these fantasies is directly proportionate to the degree to which vulnerability is experienced by the infant. As primitive anxieties increase, so the fantasies which constitute the prehistoric self-survival tactics of infancy proliferate, employing the senses, the viscera, and the bodily organs in the service of expression.

The form taken by these primitive fantasies in infancy is in part determined by the mother whose own unconscious fantasies, projected into the infant at or even before birth, intermingle with innate infantile "preconceptions" to provide the primordial basis of the infant's own fantasies. The mother's fantasies, in a sense, provide the alphabet from which the infant begins to spell out the meaning of its life experiences: its earliest sensory and affective states. The form or shape of mother's fantasies about her own and her baby's emotional states are, in a sense, passed on through the placenta and in her milk

(Brazelton and Cramer, 1990; Mancia, 1981; J. Mitrani, 1987; Piontelli, 1985).

Although Isaacs (1952) considered the expression of infantile fantasies to take place initially on a bodily level,

> since the infant has so few resources at its command for expressing love or hate—his profound and overwhelming wishes and emotions (p. 95),

she maintained that the first fantasies are represented in the mental sphere. She proposed that the infant's earliest affective encounters are not merely bodily happenings but are also experienced in mental processes, namely, as fantasies represented nonverbally and nonsymbolically, ostensibly in the form of images or pictographs. She also stated:

> Perhaps the most convincing evidence of the activity of phantasy without words is that of hysterical conversion symptoms (p. 90).

Here she drew our attention to the possibility that in conversion, the individual returns to the use of a

> primitive, pre-verbal language, and makes use of sensations . . . and visceral processes to express . . . phantasies. . . . Each detail of the symptom turns out to have a specific meaning, i.e., to express a specific phantasy; and the various shifts of form and intensity and the bodily part affected reflect changes in phantasy, occurring in response to outer events or to inner pressures (p. 90).

This view of fantasy, which Isaacs exemplified with hysterical conversion, does not really seem to explain Freud's second area of somatic disturbance—the anxiety equivalent of anxiety neurosis—which I believe to be associated with a protomental area of experience and its concomitant realm of protofantasies.[3] The

[3] What I am referring to here is an area of experience and fantasy involving the prenatal, perinatal, and immediate postnatal existence of the fetus/infant; that area which Winnicott (1949) designated as the realm of the "psyche-soma," in which

notion that an individual's earliest experiences, both pre- and postnatal, contribute to the emergence of somato-sensual protofantasies (which are at first recorded as body memories) and the idea that these protofantasies are both presented and expressed primarily on a protomental level may fill this gap left by Isaacs in our understanding of such primitive states of being.

A model for the establishment of body memories (which may be thought of as the prototype of later memories recorded in the mind, just as protofantasies recorded somatically may be thought of as the forerunners of their later mental counterparts) might be extrapolated from the work of Stern (1985), stemming from current infant observational research. I will attempt to formulate one such model in another section of this paper. However, I would first like to briefly clarify my substitution above of the term *presentation* for the term *representation,* which Isaacs uses in her discussion of fantasy.

PRESENTATION VERSUS REPRESENTATION

The earliest fantasies, as I will attempt to point out throughout this paper, are at first not represented in the mental realm. That is, primary fantasies, or what Bion called protofantasies, arise from central and peripheral neural perceptions of emotional experiences with objects which are presented (e.g., sensual experiences at the breast or even before that, in utero) and these fantasies are concretely recorded (presented, rather than represented) as body memories, later to be presented for expression through the visceral organs and the muscular system of the neonate. Such experiences, although presented in a somatic mode as body memories, may not have attained mental representation. This area of protofantasy, associated with such early experiences, precedes those fantasies which Isaacs referred to as

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experiences are recorded somatically, an area that was later elaborated upon in an "imaginative conjecture" by Bion (1970).

mental events; i.e., fantasy associated with an experience which is re-presented from the somatic to the psychic or mental realm with the aid of a containing object. The distinctions made here—between *fantasy* proper and *protofantasy* and between *presentation* and *representation*—are analogous to the distinctions Freud made between *hysterical conversion* and *anxiety equivalent.*

INNATE FORMS

It has been suggested (Tustin, 1987) that any attempt to differentiate between the earliest protofantasies and later fantasies in the mind is somewhat complicated by the use of the term fantasy in describing both, because this term can easily be misinterpreted as synonymous with sophisticated mentational processes. Tustin prefers using the term *innate forms*[4] which she defines as biological reactions or physiological reflexes with psychic overtones.[5]

Perhaps this distinction between the protofantasy and the unconscious fantasy will become increasingly relevant to the reader if we consider how it affects our approach to the treatment of patients. Until recently, traditional psychoanalytic approaches to treatment have been aimed toward seeking out conflicts and fantasies *within the mind* that seem to exert their pathological effects upon our analysands as manifested in their intra- and interpersonal relationships, in their capacity to work and play, and in their state of physical health. The introduction of the notion of unmentalized experience implies an approach in which the analyst attempts to shift somato-sensory or body

[4] The innate form which Tustin conceptualized as a *biological predisposition with psychic overtones* seems to be closer in meaning to Bion's "preconception."

[5] I have elsewhere suggested (Mitrani, 1993a) that in psychosomatic patients, these have remained untransformed by reciprocal interactions with an attentive, thinking mother and have found expression in psychosomatic symptoms which block further development and transformation into symbols. In such cases, the patient is transfixed on this pathological psychosomatic level and mentation is obviated.

memories and protofantasies from the body into the mind—from the realm of action and bodily events to that of logical verbal expression—where these may be represented symbolically for the first time, finally to be introduced into the orbit of self-reflection. The aim of psychoanalysis here is to build psychic structure, to further develop a mind ego from an original body ego (Freud, 1923a). I believe that one key to accomplishing this aim lies in Bion's theory of functions and his concept of *container-contained.*

BION'S THEORY OF FUNCTIONS

Bion (1957, 1967) traced the origins of the "psychotic part of the personality" to the baby's experience of the mother's inability to provide an adequate "container" for its fears of impending doom. Bion delineated a model in which the capacity of the mother to receive the baby's anxiety, unwanted parts of the self, of the senses, and of the mental apparatus, which are felt to pose a threat to the child's existence; her ability to transform raw sensory data ("beta elements"), through her "alpha function,"[6] into the stuff of which dreams, thoughts, and memories are made ("alpha elements"); and her knack for returning them to the baby (sufficiently detoxified for the baby's underdeveloped system to be able to tolerate) in an unimposing manner, all coalesce to make up an adequate container or containing object.

[6] The receptive capacity of the mother which Bion called reverie is that quality of the primary object which performs alpha function (the transformational operation of the mind). The mother's alpha function operates as a semipermeable membrane which processes the infant's beta elements (its raw sensory perceptions of emotional experiences), detoxifying them, imbuing them with meaning, and returning to the baby the purified and digestible alpha elements which cohere to make up a contact barrier (Freud, 1895b; Bion, 1962) or alpha membrane (Meltzer, 1978, p. 79) essential to the development of a mind for thinking thoughts; a mind with the capacity to separate conscious from unconscious, internal from external, fantasy from reality, wakefulness from sleep and dreams, with fluid communication between these dualities.

The mother as container operates in a state of "reverie" (or receptive attentiveness) which must be adequate relative to the constitutional vulnerability of the individual infant.

Bion (1963) reminded us that at first, "The infant depends on mother to act as its alpha-function" (p. 27).

> The infant, filled with painful lumps of faeces, guilt, fears of impending death, chunks of greed, meanness, and urine, evacuates these bad objects into the breast that is not there. As it does so, the good object turns the no-breast (mouth) into a breast, and the faeces and urine into milk, and the fear of impending death and anxiety into vitality and confidence, the greed and meanness into feelings of love and generosity and the infant sucks its bad property, now translated into goodness, back again (p. 31).

Bion proposed that the development of an apparatus for thinking depended upon the "successful introjection of the good breast that is originally responsible for the performance of alpha-function" (p. 32).

It seems that the baby must first have an experience of being introjected by the mother before it can introject the mother as an object with the capacity for alpha function. It might be that this is especially crucial after the experience of being projected out of the mother in the process of birth, an experience which has the potential to provoke the most terrifying anxieties. This notion would surely be in keeping with Bion's—that the infant's experience of the container precedes its own development of alpha function.

Grotstein (1992), paraphrasing Fairbairn (1952), made an important clarification. That is, that the baby's experience of being introjected by the mother and its introjection of the mother as a containing object are processes which actually occur simultaneously rather than in sequence. As Grotstein expressed it, "The infant introjects the introjecting mother in the act of introjecting and thus has the object inside in whom he is inside."

Owing to Bion's work, we now understand that in order for

the normal processes of projective and introjective identification to proceed in a healthful manner, without mutating into pathological autistic maneuvers or hyperbolic disintegration of the self, the holding mother of infancy (Winnicott, 1941) must also exhibit containing[7] properties. The metabolic processing of the baby's raw sensory experience (which is initially devoid of meaning) through the mother's mental function leads to increasing development of symbol formation and a decrease in mindless action and somatization in reaction to intense affective states. Normal projective identification and subsequent introjective identification with a containing object leads to a decrease in the tendency to concretize emotional experience and to an increase in the development of abstract and creative thinking, replacing action symptoms, related to painfully unbearable emotional states, with increasing tolerance of psychic pain and mental transformations.

The overanxious mother may be impaired in her capacity for reverie. If she cannot receive her baby's communications, she may be internalized[8] as an obstructive object which is unwilling

[7] The properties necessary for adequate containment are the capacities to receive and take in projected parts and feelings of the infant; to experience the full effect of these on the psyche-soma and to bear those effects; and to think about and understand these projections, gradually returning them to the infant in due time and in decontaminated form. This assumes a mother who has her own boundaries, internal space, a capacity to bear pain, to contemplate, to think, and to reflect back. A mother who is herself separate, intact, receptive, capable of reverie, and appropriately giving is suitable for introjection as a good containing object. Indentification with and assimilation of such an object leads to the development of a capacity to make meaning (alpha function), increased mental space, and the development of a mind which can think for itself. Bion coined the term reverie for the attentive, receptive, introjective, and experiencing aspect of the container, and I believe that this function of the maternal environment is analogous to the mental/emotional aspect of what Winnicott (1941) referred to as holding.

[8] In such situations, incorporation rather than introjective identification and assimilation occurs, and the object is not integrated into the personality, there to be mitigated or modified by other experiences/objects. As a foreign body or "undigested fact" (Bion, 1962, p. 7), it is often projected either onto external objects in the

or unable to contain. If she cannot digest that which she receives but is instead felt to add her own anxieties to those already overwhelming the infant (i.e., using the infant as a container for her own "unthinkable dreads"), what she hurriedly gives back to the baby will be suitable only for some hyperbolic form of discharge. Consequently, the baby will develop a precocious mind as an instrument for evacuating or encapsulating experience rather than as an instrument for thinking thoughts.

Federn's (1952) work preceded Bion's thinking when he suggested that whether physical or mental, the experience of pain is relegated to the domain of the ego, and he distinguished between *suffering* and *feeling pain*. He suggested that suffering is the expression of an active function on the part of the ego, during the course of which the pain-inducing event (frustration with or loss of the object) is taken within the boundaries of the ego and the full intensity of the event is appreciated, consumed, and digested, thus undergoing transformation by the ego and, in turn, transforming the ego. Feeling pain is, on the other hand, a process in which the pain-inducing event cannot be endured and worked through within the bounds of the ego. The pain is not contained within the ego but merely touches upon the border of the ego, affecting it painfully, and with every recurrence, it meets the ego boundary with the same intensity and with traumatic effect. Therefore, such pain poses a threat to the ego's integrity and must be warded off. Such painful experiences are not taken within the bounds of the ego, there to be subjected to a process of mentation, but instead remain unmentalized in the form of body memories.

Federn attributed this inability of the ego to suffer pain to a primary failure of the ego resulting from a lack of narcissistic cathexis of the ego boundary.[9] The capacity for suffering pain

present in an attempt at containment and modification, or it can be encapsulated internally, later to become the core of a pathological organization.

[9] James (1986), utilizing the work of Winnicott in his paper on premature ego

seems to be related to thinking. This distinction between suffering and feeling pain was later made by Bion (1965), without reference to this work of Federn, who seemed to be articulating what Bick (1968) would later term the *psychic skin* and what Meltzer (1986) would later call the *alpha-membrane*.

In the case of a weak ego boundary, it would seem that the baby's painful experience has touched the mother, but has not been introjected by the mother, who, it seems cannot bear to suffer her baby and who is therefore unable to mitigate its experience. The possibility that this environmental factor not only applies to postnatal life but also to prenatal development is addressed in perinatal research (Mancia, 1981).

The body ego (Freud, 1923a), which I am here equating with the protomental apparatus (Bion, 1962), does not create mental representations of experiences, but instead perceives these experiences as bodily states to which it reacts with bodily states and actions on a visceral or motoric level. These reactions are manifestations of protofantasies which are presented in a somato-sensual mode: as bodily sensations (sense impressions) or as sensory experiences devoid of meaning in the symbolic sense of the word.

It will be recalled that Freud (Breuer and Freud, 1893-1895) referred to these sense impressions as somato-sexual excitations which are felt to be physical in origin and untransformed in the mental sphere. Bion called these sense impressions of emotional experiences (which are not transformed in the mental sphere) beta elements. Bion also noted that these beta elements are not appropriate for thinking, dreaming, remembering, or exercising intellectual functions usually related to the mental apparatus. He posited, after Kant, that these are experienced instead as "things-in-themselves" which are generally evacuated (Bion, 1962).

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development, clarified that the baby's ego boundary is originally cathected by the "ordinary devoted mother" in a state of near-total preoccupation with her infant. Lacking the auxiliary ego function of the mother, the baby develops its own ego prematurely and defensively.

Bion's theory describes alpha function as that function of the personality which works over these beta elements, transforming them into alpha elements which have been given meaning and so are able to reside within the mental sphere. These are utilized in the formation of dream thoughts, unconscious waking thought processes, and dreams themselves, and are stored as memories in the mind. Alpha function may be said to be that function of the maternal object which provides the infant, and perhaps even the fetus (Mancia, 1981), with the experience of a psychic skin.

THE FUNCTION OF THE SKIN

The contribution of Bick (1968) seems to articulate the first element essential to the elaboration of a model for the development of mental structure and the subsequent mentalization of experience. In her work with both autistic children and normal infants, Bick noticed certain behaviors which led her to believe that these individuals experienced the absence of suitable boundaries capable of holding together mental contents not yet differentiated from bodily contents.

Bick proposed the notion of a psychic skin (perhaps similar to the concept of ego boundary in the primitive body ego), which ideally serves, in its function, to passively bind together the parts of the nascent self. She described this psychic skin as a projection of or as corresponding to the bodily skin, and posited that it is "dependent initially on the introjection of an external object, experienced as capable of fulfilling this function" (p. 484). I believe that the external object here is a complex, undifferentiated object composed of experiences of continuous interaction between a physically and emotionally holding and containing mother and the surface of the infant's body as a sensory or sensual organ. This complex notion appears to be one Freud himself struggled with, as evidenced by his statement that the

> ego is first and foremost a bodily ego; it is not merely a surface entity, but is itself the projection of a surface (1923a, p. 26).

Bick (1968) hypothesized:

> Later, identification with this function of the object supersedes the unintegrated state and gives rise to the fantasy of internal and external space (p. 484).

She posited this as an essential basis for normal adaptive splitting, which allows for the idealization of the self and object as described by Klein. Bick warned:

> Until the containing functions have been introjected, the concept of a space within the self cannot arise. . . . construction of an [internal] object . . . is therefore impaired. In its absence, the function of projective identification will necessarily continue unabated (p. 484).

Bick was the first Kleinian to make the crucial distinction between *unintegration*, as a helpless, passive state of maximal dependency, and the active, defensive maneuvers of splitting or *disintegration* in the name of growth (although Winnicott had addressed these issues at length some ten years earlier). She associated the former with annihilation anxiety and, I believe, particularly with the fear of not going-on-being (Winnicott, 1958), while she related the latter to persecutory and depressive anxieties.

> The need for a containing object would seem, in the infantile unintegrated state, to produce a frantic search for an object—a light, a voice, a smell, or other sensual object—which can hold the attention and thereby be experienced, momentarily at least, as holding the parts of the personality together. The optimal object is the nipple in the mouth, together with the holding and talking and familiar smelling mother. . . . experienced concretely as a skin. . . . Disturbance in the primal skin function can lead to development of a "second-skin" formation

> through which dependence on the object is replaced by a pseudo-independence . . . (Bick, 1968, p. 484).

In a paper elaborating on Bick's concept of the second skin, Symington (1985) discussed the survival function of omnipotent fantasies. She described one such fantasy as a tightening or constricting of the smooth muscles of certain internal organs. Such internal constriction, possibly resulting in spasm, provides a continuous skin, without gaps through which the self risks "spilling out into space . . . never being found and held again" (p. 481). Symington's many examples from infant observations, as well as her observations of adult patients in the analytic setting, give credibility to her conclusion that the fear of unintegration, "that very early unheld precariousness" (p. 486), is at the root of our fears of dependency and is the prime mover of second-skin development, which is the prototype for later, more sophisticated omnipotent character defenses. Hyperactivity in children, compulsive physical action, and speech used as a vehicle for action (seen in adults as well) have also been cited in the literature as other types of second-skin formation.

Anzieu (1985, 1990) and other workers in France have delineated an entire category of second-skin phenomena. They have used the term "psychic envelopes" to talk about such protections which are constructed out of sensations of sound, touch, smell, sight, etc., while Paul (1990) has described the phenomenon of mental pressure which also seems to provide a womb-like protection against unmentalized experiences which are throwbacks to the experience of birth.

The most exhaustive study of unmentalized experiences and of the sensation-dominated protections erected in avoidance of the repetition of the unbearable feeling of these is to be found in the work of Frances Tustin (1987, 1990) on autistic states in both children and adults. In one paper (1983), she extended Klein's (1930) ideas on symbol formation and ego development, drawing our attention to the severity of the consequences of a

failure in the expansion of symbolic functioning beyond that of symbolic equation (Segal, 1957).

THE FORMATION OF SYMBOLS

The development of the capacity for symbol formation is a necessary prerequisite for progression from evacuation to mentation—from the physical or somatic reaction to the psychic action. The development of the psychic structures, which are essential for effective handling of painful experiences inherent in living, is partially dependent upon this capacity for symbolic functioning. The earliest symbols (or, more accurately, protosymbols), based on sensual and perceptual input, are at best "symbolic equations" (Segal, 1957) and, as these are undifferentiated from the object symbolized, they can hardly be called symbols or representations. The transformation of concrete protosymbols into psychic representations of the original object depends upon the introjection of a container which can deal with anxiety arising in relation to objects in order for substitutions to be effected (Bion, 1962).

Deficiencies in the earliest maternal environment abandon the infant to experiencing the most severe varieties of anxiety—those of unintegration (Bick, 1968; Winnicott, 1958), of liquefaction and evaporation, of nonbeing and total loss. One of the many reactions provoked by prolonged exposure to such anxieties is a precocious "over activity of mental functioning" (Winnicott, 1949, p. 246) or "premature ego-development" (Klein, 1930, p. 244).

In her paper, "On the Importance of Symbol Formation in the Development of the Ego," Klein (1930) appears to address the notion of overactivity of mental functioning with her concept of precocious ego development, although it would seem that this is somewhat of a misnomer. What she described might be better termed precocious pseudo-ego-development. Klein further characterized this precocious development as premature

empathy for or premature identification with the object. This consisted in early genitality or the premature onset of the depressive position with its incumbent anxieties related to true guilt, remorse, and the need or desire to make reparation, all felt toward an ambivalently loved object. Since the newborn is, in all likelihood, inadequately prepared to deal with such complex anxieties, which require the aid and support of previously established internal containing objects, further moves toward development become inhibited, and the infant may, of necessity, retreat in varying degrees into an autosensual world.

For example, one patient who had been raised by a severely disturbed mother (who, as the patient was told, closed the door to her newborn infant's room when she heard her cries because she did not know what to do for her) re-experienced, in the analysis, a time in early infancy when, while lying in her crib, she attempted to make meaning of her mother's failure to attend to her. Had she cried too loud or not loud enough? Was the pitch too high or too low? Should she continue to cry out or should she stop, and if so, for how long? Is mother ill or asleep, or had she left forever? Is mother dead and am I? This patient was not able to be a baby-at-one-with-her-mother and so was pushed to develop her mind in the service of avoiding experiences of loss; she developed as well a rather precocious concern for her caretaking object. She would often become terrified when, in this avoidant state, she could not "feel her self."

This patient's ruminations were not thoughts connected to experiences, but rather an agglomeration of words which provided a cocoon of sensation, within which she could wrap her fragile self for protection. Indeed, when I was able to communicate this to the patient, she recalled that she had once been told by a family member that on the day she was brought home from the hospital, she was left wrapped in a blanket in the middle of mother's bed where no one was permitted to enter to offer comfort when she cried, since mother believed that this treatment would "toughen her up" and diminish her dependency upon her caretakers. With such patients, if we attend to

the content of their communications, we run the risk of colluding with their attempts to "toughen up" and to protect themselves against (while failing to help them to contain) these early experiences of loss. Such toughening leaves little room for a self, which gradually becomes compressed and out of reach of feeling.

Often, at the end of the week, this patient would launch a barrage of words at me, allowing me seemingly little space for interpretation should I be able to gather my thoughts together long enough to formulate one. I found that when I could interpret the content of these utterances, my interventions would have little or no effect upon this patient. However, I was finally able to understand and to point out to her the function of her speech: it was a means by which she protected herself from experiencing the terror and bodily pain of being left by me over the weekend break, which felt like a door closing, leaving her "hard and all sandpaper." I also pointed out the way my interpretations and her lack of response to them kept us in a static place, so that it felt to her that I could not leave her. She was then quite moved, and the subject of the weekend separation was opened up, along with all of the painful experiences of past abandonments. When I began to *suffer* these painful states, she became more able to think about them.

Klein (1946) pointed out that the introjection of the good object, necessary for tolerance of anxiety, may be impeded not only when there is an excess of envy toward it but also when "the ego is compulsively subordinated to [its] preservation" (p. 9, n.). Thus, in the case of premature concern for the welfare of the object, or what Klein called premature empathy toward the breast, fantasy life may be truncated and restricted to expression in the visceral and muscular spheres, and the process of symbol formation may be brought to a halt. In order for substitutions, displacements, and equations to be effected, the individual must be able to tolerate anxiety. Intolerance results in a retreat to prenatal existence and absolute identification with the object, which perpetuates a vicious cycle: the confusion between self

and object extends to a confusion of ego with the object and consequently to a confusion of the symbol with the object symbolized.

Anxiety-provoking experiences which cannot be worked over through contact with the mother (and, through extension and symbolization, in the outside world) will remain at a concrete level, unmentalized and perhaps finding expression in the realm of mindless action or somatization. In extreme forms, this dilemma can be observed in the so-called alexythymic individual who lacks words for feelings or affective states and expresses these states somatically. The question may here arise in relation to the notion of unmentalized experience: if such experiences are foreclosed from the mental sphere, how and where are they stored and what is the process by which they are recalled? An attempt to answer this question may be taken as the focus of the following sections.

MEMORIES IN FEELINGS

Matte-Blanco (1988), in a discussion of the impact of traumatic early experiences upon the analytic process, highlighted the difficulty, if not the impossibility, inherent in the process of recovering clear memories of these events. He has unearthed a 1957 quotation from Klein in which she offered a solution to the problem:

> All this is felt by the infant in much more primitive ways than language can express. When these pre-verbal emotions and phantasies are revived in the transference situation, they appear as 'memories in feelings', as I would call them, and are reconstructed and put into words with the help of the analyst. In the same way, words have to be used when we are reconstructing and describing other phenomena belonging to the early stages of development. In fact we cannot translate the language of the unconscious into consciousness without lending it words from our conscious realm (p. 5, n.).

Perhaps, when we encounter such memories in feelings with our patients, we may not merely be encountering unconscious experience but unmentalized experience; not repressed memories but body memories which have been entrapped in the realm of the unthought.

It is interesting to note that in that same work Matte-Blanco reported that, in his experience

> the expression of these 'memories in feelings' is fundamental in the treatment of some cases. Without them, these patients could not be cured. . . . [In some cases] no increase in memories *of the happenings* was obtained. The feelings, instead, were abundantly and repeatedly discharged over a long time. I feel that this repeated expression of most varied feelings connected with episodes and persons concerned, now made towards a basically respectful and tolerant analyst who tries to understand the meaning of the emotional expression and its connections with the details of early experiences and actual relationships, is the real healing factor (p. 163).

Matte-Blanco's conceptualization of technique in working with such memories in feelings bears a striking resemblance to those expressed by Balint (1952) and more recently by Stewart (1989) and others of the Independent group in London with regard to the "technique at the basic fault." These workers have noted that there are times in the analysis of certain patients when words do not carry the ordinary meaning for the patient which they would during other phases of the analytic dialogue. These interludes in analysis, which may be quite brief or which may last for a prolonged period of time, must be borne by the analyst, who must be able to experience, in the countertransference, the full impact of that which the patient cannot bear to experience *prior to the formulation and delivery of an interpretation.* This period of interpretive inactivity could be likened to a period of mental gestation in the mind of the analyst which is an essential feature of the analyst's reverie. It is related to the notion of negative capability often referred to by Bion, which may

also be considered analogous to the primary maternal preoccupation that Winnicott (1956) thought essential to normal development of the baby. Indeed, these factors are now noted by some to be essential to healthy development even before birth (Mancia, 1981).

PERINATAL RESEARCH

In Mancia's paper on the mental life of the fetus (1981), empirical data from embryological and perinatal research regarding the motor functions, the sensory abilities, and the appearance of REM or active sleep in the fetus (which can be observed between twenty-eight and thirty weeks of gestation) is integrated with the work of Bick (1968) and Bion (1962). In formulating his hypothesis, Mancia drew an analogy between this "prenatal psychic nucleus," which is based upon unconscious fantasy elements transmitted by the extrauterine objects through the intrauterine container (the original holding environment), and Bion's (1962) "pre-conceptions." He also discussed the role of REM sleep in the prenatal development of

> the psychological function of the [psychic] 'skin' which . . . may be able to contain the Self of the child and to protect it from disintegrating under the pressure of impulses which come into play at the moment of birth (Mancia, 1981, p. 355).

Mancia suggested that this prenatal foundation of the psychic skin favors the inception of the container-contained relationship, which is indispensable for the development of an apparatus for thinking (Bion, 1962). His interesting conjectures, which are based upon nonpsychoanalytic data, broaden this perspective just as they deepen our understanding of the impact of the earliest experiences upon mental development of the individual. Most significant are his reports of findings, in observation of both fetuses and prematurely born infants, that the disruption of the maternal environment (whether physical or emotional) results in a reduction of active (REM) sleep and an increase in

motor activity which Mancia noted as an indication of the evacuation of beta elements rather than their transformation into alpha elements which would coincide theoretically with REM sleep.

As I stated earlier, a developmental model, which might be constructed in order to further clarify the reader's understanding of the formation of beta elements, can be derived from the work of Stern (1985). I will attempt to construct such a model, suggesting the process through which such undigested facts (Bion, 1962) or unmentalized experiences might be stored and recalled.

THE EMERGENT SELF AND THE CORE SELF

According to recent infant observational studies, the basis for mental development seems to be determined during the first months of life by the earliest organizations of subjective experience of self and other. In Stern's (1985) model of development for the first year of life, he identified four "senses of self" which contribute to the formation of an integrated pattern of object relatedness that is sustained throughout the life cycle. Each sense of self provides a precursor to what subsequently develops. He suggested that the first to develop is the "emergent" sense of self. This sense of self is both composed of the experience of the process of "emergent organization" and is the product of that organization of experience. The experience central to the development of this first sense of self is that of the body "coming into being" and the process of organization of sensory experiences through "amodal perception,"[10] "vitality affects,"[11]

[10] According to present-day research in infant development, newborns are thought to have an innate capacity to take information received in one sensory modality and translate it into any other sensory modality. The resulting perception exists in some supramodal form (wherein the breast that is seen, the breast that is smelled, the breast that is tasted, and the breast that is touched are linked together) and is encoded in what Stern referred to as an amodal representation which can be recognized in any of its sensory modalities.

[11] According to Stern, vitality affects are formations of feelings or somato-sensory experiences, i.e., waves or rushes of feeling, perhaps laid down as a pattern of neural

and the processes of assimilation and accommodation. Thus, an experience can form an "activation contour."[12] Unlike "categorical affects,"[13] there are an infinite number of possible activation contours. A single activation contour might be made up of many vitality affects which derive from a particular amodally perceived experience. Perhaps a primitive aspect of each adult individual's psyche-soma, as in the case of the newborn infant, remains endowed with a pattern detector which maintains the capacity for identifying such contours throughout life. If this were so, then extremely diverse events could thus be yoked or linked together should they happen to share the same pattern of vitality affects or activation contours.

Stern (1985, p. 58) quoted Defoe, speaking through his literary heroine, Moll Flanders, who said, while incarcerated for her crimes: "I had . . . no thought of heaven or hell, at least that went any farther than a bare flying touch. . . ." It seems that the activation contour of her present situation (imprisonment) resonated with an activation contour of a particular sensation (a fleeting touch) which she had previously had no thought of (no ideational content) and that these evoked the same vitality affect experience. Indeed, Stern reminded us of neonatal studies which demonstrate that "not all affective life is the handmaiden of cognition" (1985, p. 66).

To illustrate this notion, I will present a clinical example. The patient R, in her third year of analysis, returned from the spring break to tell me that she had missed coming more than she had imagined possible. She had attended a concert of classical music

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firing in a particular area of the nervous system. Vitality affects, unlike categorical affects (e.g., sadness, happiness, anger), have no symbolic content. Abstract dance and music are examples par excellence of the expressiveness of vitality affects, which do not resort to plot or categorical affect signals.

[12] An activation contour is an engrammatic pattern which is registered at the somatic or physiological level—at the level of brain, not at the level of mind.

[13] Categorical affects are those having a distinct quality of feeling. They have evolved as social signals which are commonly understood by all humans through facial expression, intensity, urgency, and hedonic tone (the quality of pleasure-unpleasure). These are discrete affects, such as sadness, happiness, fear, anger, disgust, surprise, interest, shame, or any combination of these.

one evening during the first week of my absence and was overcome with longing for me as she listened to the first work on the program. After the concert, unable to get the music out of her mind, she purchased a tape of the piece she had heard the previous evening, which she played in her car over and over again during my absence. Each time she heard this music, intense feelings were evoked in her, and she found herself longing for my return so that she could tell me about it. However, she was now dismayed to find that she could not put into words her many-faceted experience which had seemed so clearly presented in the music. She felt certain that the music had, embedded in it, important aspects of her experience with me in her analysis. "I wish I could just bring the tape here for you to listen to it with me—so that we could think about it together," she said. "But I have the feeling that its meaning is idiosyncratic to me. It's not that I think you would not appreciate the beauty of the music, but I sense that it is *my* experience of this *and* of you—not just a single feeling, like love or hate or excitement, but a whole rainbow of feelings which seem to span my very being."[14]

Of course, this material brought forth with it a torrent of emotion and further material regarding the impossibility of communicating such an experience verbally. The analysis of this, along with my own emotional experience in the countertransference and R's subsequent dreams and associations over the next few months, helped in articulating some aspects of her emotional experience of her relationship with me. I believe that, taken as a whole, the musical interlude must have also approximated for R a very early experience of her relationship with her mother, which had been somehow recorded in the far distant past as an activation contour in unmentalized and encapsulated

[14] Rayner (1992), in a paper discussing the concepts of amodal perception and preverbal attunement in the dialogue between patient and analyst, noted: "Music, being presentational and an efficient vehicle of affect, might also be an appropriate form of communication about the indistinct largely pre-verbal analytic times ['unformulated sequences'] . . . for there is then perhaps a dance or tune of the two protagonists' interpenetrating moods" (p. 40).

form, only to be played out in the transference with the analyst, where it might be presented for the purpose of understanding.[15] It appeared that in the presence of the analyst, R was finally able to develop thoughts to represent her experience which, it would seem, had been relegated to the domain of the unthought prior to the analysis.

This notion seemed to fit the patient's history, since R's mother had been severely depressed both before and for the first year after the birth of R. In such a depressed state, R's mother may not have been able to share or appreciate her baby's intense states of ecstasy or tantrum and all the waves and rushes of affect in between. Unable to be sufficiently mindful of her experience, R's mother may have unwittingly failed R as a containing object, leaving her unable to metabolize and digest (in her mentality) these very early amodal experiences of herself in relation to her primary caretaker. Unable to create a mental record of her early relationship with her mother, R had little in the way of experience-in-memory to fall back on during times of separation, relying instead on external objects and sensory experiences to fill the black hole (Tustin, 1981) created by that early disillusionment, as well as each new experience of loss.

It might be hypothesized that early experiences (e.g., prenatal experiences or very early experiences at the breast), recorded as body memories in the shape of activation contours of vitality affects, could conceivably remain unmentalized, only later to be linked with situations in the present which share that same pattern or contour.[16] The nature of the link is not necessarily cog-

[15] Boyer (1992) reported the case of "a severely regressed man whose unconscious early pre-oedipal ties to his mother were expressed through the concretization of music in a fantasized umbilical cord. The clinical data clearly support the findings of the previous observers that music *per se* serves more primitive . . . functions than do its themes and lyrics, which symbolize, express and defend against more specific unconscious conflicts" (p. 65).

[16] Greenacre (1952), in a discussion of the influence of the birth experience upon the earliest pre- and postnatal narcissistic organization and the predisposition to anxiety, suggested that these nascent experiences are laid down as "unique somatic

nitive-affective (Stern, 1985) or logical-verbal (T. Mitrani, 1992) but may be the specific neural pattern or contour of the sensorial or sensual arousal.

I would here put forth the notion (to use the language of infant observation) that until such time as "Representations of Interactions [with self-regulating others] that have been Generalized (RIGs)" (Stern, 1985, p. 97) have been internally established (what Bion might term introjective identification with mother's alpha function or the container-contained relationship), these activation contours of vitality affects must remain excluded from the symbolic chain. The primordial processes, which are in operation prior to the development of primary and secondary process thinking and which continue to function in the primitive areas of the psyche-soma, perpetuate the production of action symptoms which guarantee survival on one level while at the same time interfering with the development of "Generalized Event Structures (GERs): the basic building blocks of cognitive development" (Stern, 1985, p. 97) as well as verbal memory.

Following the development of what Stern called RIGs, the "sense of a Core Self" (p. 69) begins to form, between two to seven months, along with a concomitant sense of "core others." This core consists of 1) self-agency (e.g., the sense that your leg moves when you want it to; 2) self-coherence (e.g., the body as a whole, moving or stationary; 3) self-affectivity; and 4) self-history.

> These senses are distinct from concepts, knowledge or awareness in that they are meant to connote palpable experiential realities of substance, action, sensation, affect, and time (p. 71).

Stern pointed out that the absence of any one of these four

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memory traces" which may coalesce with later experiences to create a situation of psychobiological tension.

subsenses, which constitute the core sense of self, has dire consequences for psychological health.[17]

Of these subsenses, it appears that the most crucial is the sense of continuity or historicality (very much like Winnicott's [1949] sense of going-on-being). This inner sense of "writing" one's own history depends upon the infant's capacity to *remember,* which is not language based; i.e., it is based on memory that resides "in voluntary muscle patterns and their coordinations" (Stern, 1985, p. 91) and in activation contours of vitality affects (p. 54) which are perhaps analogous to body memories—what Klein (1957) referred to as memories in feelings, or what Winnicott (1949) described as a catalogue of experience. These protomemories must be able to be transformed into internal objects in the mind in order for the structure of the mental apparatus to develop to its fullest capacity.

DETECTING UNMENTALIZED EXPERIENCE

Often, when attempting to use the concept of unmentalized experience in clinical/scientific discussion, the following question arises: How can we differentiate between unmentalized experience and experience which has undergone a destructive process of dismantling[18] (Meltzer, et al., 1975), reversal of alpha function[19] (Meltzer, 1986), or disintegration, fragmentation,

[17] For example, absence of agency can be manifest in catatonia, hysterical paralysis, derealization, and some paranoid states; absence of coherence can be manifest in depersonalization, fragmentation, and psychotic experiences of merger or fusion; absence of affectivity can be seen in anhedonia of some schizophrenias; and absence of continuity can be seen in fugue or other dissociative states (Stern, 1985, p. 71).

[18] Dismantling of the sensual apparatus into its component parts is defined as a mindless, passive falling to pieces in defense of depressive feelings and conflictual states (Meltzer, et al., 1975). It can be seen to be compatible with evasive or evacuative modes of dealing with sense data and affective experiences in the absence of a mind for thinking (Bion, 1962).

[19] The reversal of alpha function is described as the cannibalization of previously

and splintering (Klein, 1946; Rosenfeld, 1950); those passive and active attempts at evading or avoiding the persecutory feelings associated with the paranoid-schizoid position or the guilt and remorse of the depressive position (Klein, 1946)? Toward making such a discrimination comprehensible, it may be helpful to conceptualize unmentalized experiences as constituting a lacuna in the mind, a hole in the ego (Ammon, 1979), a tear in the psychic skin (Bick, 1968), or an area of the personality that lacks a supporting structure.

As Federn proposed (1952), experiences which have been felt but which have not been suffered do not affect the ego; i.e., they do not result in learning, nor do they contribute to the development of mental structure. It might be said that unmentalized experiences leave circumscribed areas of the personality frozen at an extremely primitive level of development. It is as if in infancy the baby has looked into the mother's eyes, only to be met with the "black hole" of her depression, which has rendered her unable to think or to imagine her baby (Winnicott, 1960). Consequently, the baby acquires no meaning for what it experiences. There is only the "presence of the absence" (Bion, 1962).

By way of extending Bick's model of second skin formation, I propose that at times more sophisticated areas of mind and of the personality, which have developed in parallel (Grotstein, 1984) to those areas left barren by unmentalized experience, function as camouflage for those less developed aspects of the personality. This may result in frequent misdiagnoses. Klein (1961), in her narrative of Richard's treatment, talked about memories which provide a "cover" for concrete memories (p. 136) which she observed arising as a consequence of the revival of early infantile emotional experiences in the transference. As I have previously mentioned, Klein also referred to these con-

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bound alpha elements resulting in the creation of bizarre objects, albeit under omnipotent control, i.e., defensively (Meltzer, 1986).

crete memories as memories in feelings (pp. 136, 217, 235, 315, 318, 338). Her description of cover memories gave additional significance to (what Strachey translated as) Freud's screen memories, and she stressed the point that these cover memories lose their importance in analysis unless what is *covered over* is *dis-covered.*

While working with psychosomatic patients, I have found that sophisticated and elaborate defenses often substitute for somato-sensual protections, from time to time filling the lacuna, gap, or hole in the ego (Ammon, 1979) created in the wake of privation (Winnicott, 1960b). This finding is consistent with observations of many workers, among them Alexander (1950), Atkins (1968), Balint (1968), Rosenfeld (1985), and Sperling (1955), who have each written about the alternation between the action symptoms and other diverse symptoms, such as hallucinations and delusions. These substitute protections may be thought of as emanating from the more developed areas of the psyche, bringing along with them the anxieties against which they defend. These seem to compensate for or to cover over the faulty part of the personality and, accordingly, they seem to block out the gap or hole left in the path of privation. Kohut (1977) addressed this phenomenon in his discussion of "defensive and compensatory structures" which function to cover over or to compensate for a "primary defect in the self" (p. 3).

It may help the reader to imagine a whirlpool or a pothole in a fast-moving river. Such holes are barely visible as one traverses the river, appearing only as slight indentations of whirling water because the surrounding waters camouflage the depth and breadth of the void. Consequently, when an object, for example a man in a kayak, nears a pothole, it is forcefully and suddenly sucked down in a spiral motion, sometimes dozens of feet to the bottom of the river bed. Similarly, the analyst may be deceived by what appears to be clearly observable and quite well-structured defenses, anxieties, conflicts, and symptoms in the mind. Entering into the analysis of the content of these, without having had the experience of what lies beneath, may result in

the analyst's being sucked into an endless void of impasse (Rosenfeld, 1987), enclave (O'Shaughnessy, 1992), and collusion in which the psychoanalytic dialogue functions as an autistic shape (Tustin, 1984a) or an autistic object (Tustin, 1980), which further blocks out awareness of catastrophic separation for both analyst and analysand (Gomberoff, et al., 1990).

In my experience working with adult analysands with a pocket of autosensuality (Mitrani, 1992)—within which are sequestered those very early unmentalized experiences—I have sometimes been compelled to "act in" in a very specialized way. For example, in one case I found myself interpreting within the you-me form, called for by the transference material presented; I tied this to the patient's external situation and to the dynamics of her internal object relations, only to find later that I had helped the patient to create quite a cozy state of "at-one-ment" within the transference-countertransference relationship. Only after some time did I come to realize how stuck and stale the work was feeling to me, as nothing appeared to come as a surprise, either to the patient or to myself.

Eventually, when I was able to experience, detect, and understand this mutual enactment, I found it was once more within my power to effect a resumption of the analytic interpretive work, which then could emanate from my experience within this protective niche. What had appeared to me to be material representing the patient's experience as it was being played out in the transference was revealed as an expertly constructed camouflage; it had been all too neatly laid over an experience of emptiness and void which the patient did not dare enter into and which I had been all too willing to help her to "cover up" with "good" analytic interpretive work, firmly rooted in my theories. However, this missed the point of the patient's earliest experiences: the loss of boundary and feeling. The generic experience which I have observed arising in the countertransference, while entrapped within such mindless capsules, is that of deadness, timelessness, flatness, stillness, changelessness, and

numbness: all devoid of anxiety, although permeated by a feeling of despair.[20]

I believe that when we can convey to the patient, with genuine passion and conviction, the experience of this void, we will have truly given the patient a piece of our minds, adding to the patient's own perspective a new vertex from which to operate without robbing the patient of her or his own hard-won solutions to the problems presented (Joseph, 1992). In a sense, the patient's solution to the experience of the absolute zero or nothingness of privation, which is felt as intolerable, is to transform this zero into a minus-one experience (Bion, 1965) of continued misunderstanding. Perhaps the difficulty in describing this phenomenon is a reflection of the unthinkability of the notion of the lacuna left in the wake of mental and emotional privation. Bion (1965) attempted to confront this mathematically, but perhaps artists and writers do it more eloquently and accessibly for us (e.g., Stephen King's [1981] *Dead Zone* of the mind, filled with premonitions of violence which is about to happen to others, all the while obscuring the incident of one's own demise). Filling up the mental void, created in the disaster of privation, with the memories, symptoms, and defenses associated with parallel experiences of deprivation and destructive envy is one way of insuring a precarious sense of survival.

I would like here to put forth the idea that there may be a specific area of our work in which the concept of innate envy has little applicability. When the notion of privation is at issue—when there has been, on a given level, no experience of a good-

[20] Perhaps if we do not allow our patients to touch us sufficiently or to infuse us adequately with these meaningless experiences; if we move too quickly to apply our theories in order to render the unknown known through interpretation, attempting to avoid or evade too assiduously the enactment of the patients' experiences, we may then run the risk of leaving our patients without sufficient containment for such experiences, causing them to fall back upon the use of an already established internal, autosensual enclave or even to convert (or pervert) a physiological function or an organ system into a somatic container.

breast-present against which to define absence (which is experienced as the bad-breast-present)—it makes little sense to talk about an envious part of the infant "which doth mock the meat it feeds on . . ." (Klein, 1957, p. 182).

In privation, there can be no experience of a "mean and grudging breast" (Klein, 1957, p. 183) or a bountiful good breast upon which one must rely for supplies. Therefore, there can be no sense of "losing and regaining the good object," nor can there be operations attributable to "the innate conflict of love and hate" (p. 180). What I am talking about differs from the instance of envy provoked by absence and frustration, as in the case of "deprivation which increases greed and persecutory anxiety" (p. 183) and consequently envy. Instead, there is a black hole (Tustin, 1981) or an intolerable gap in meaningful experience, which results in hyperbolic and distorted efforts to fill the hole or gap—a specialized or defensive use of the reparative drive (Winnicott, 1949; Khan, 1979).

On this level, there are no flickering states of awareness (Tustin, 1981) in which to experience loss against a background of satisfaction or security (in terms of specific or circumscribed areas of experience), only a sensation of nothingness or an absolute zero. Of course, if this were not confined to a circumscribed area or cluster of areas, the infant would not survive at all, or, at best, extensive physiological and psychological pathology would inevitably result (e.g., schizophrenia or failure-to-thrive infants, or the hospitalism babies described by Spitz [1950], many of whom died; these might be examples of the outcome of absolute zero registering in a preponderance of interactional experiences across the board). While the envy involved in the deprivation experience can be observed in those individuals "who can think of nothing but what they have not got" (Riviere, 1937, p. 29), the individual who has experienced privation simply has not got what to think of or with.

Finally, I would like to add that since the unmentalized part of the personality derives from early somato-sensual experiences which have failed to attain mental representation, i.e., which

have never progressed to the level of symbol (e.g., anxiety experienced as the thing-in-itself, not as a signal), this part of the personality cannot be said to regress. Regression implies previous progression, just as disintegration implies or takes for granted previous integration, without which we must use the term unintegration.[21] To the extent that regression can be considered a rather elaborate fantasy, I propose that there are more primitive mechanisms at work with respect to the production of some of the symptoms manifested in our patients. As I have elsewhere suggested (Mitrani, 1993a), the anxiety equivalent/action/somatic symptom may be a primary protective maneuver, a protofantasy executed on a somato-sensual level in reflexive reaction to a primal "prey-predator anxiety" (Grotstein, 1984) experienced on the somato-sensual level. This would be consistent with Freud's idea that in anxiety neurosis a somatic excitation is denied access to the psychical apparatus due to a psychical insufficiency and is consequently expressed in the somatic realm. In sum, I would suggest here that the psychical insufficiency is related to a circumscribed privation experienced in the earliest postnatal environment (rather than to a deprivation) and that such privation consists in the lack of some functionally specific alpha element in the maternal aspect of the nursing couple.

The above notions differ from those of the original Kleinian perspective, from which we might view action symptoms as a means of omnipotent control over the object, which is both loved and envied; or as a means of evacuating persecutory anxiety; or perhaps in the case of obsessional behavior, as a means

[21] The primitive state, which Winnicott (1960) defined as a stage of "absolute dependence," consists in a two-dimensional world of "adhesive identification" (Bick, 1968; Meltzer, et al., 1975; Tustin, 1981) in which there is little or no tolerance for separateness, space, or absence and little capacity to differentiate self from object or me from not-me. While this latter position, in health, is a primarily normative phase of total dependency of the infant upon the maternal environment, the subsequent failure of that environment results in the individual's entrapment in this position, which constitutes Tustin's world of the encapsulated child.

of manic reparation by which a pseudorestoration of the good object is effected in fantasy. While these are all plausible interpretations, I believe they would be more applicable in the realm of some sophisticated mentalized or dementalized state. Such states might coincide with operations of disintegration and its concomitant anxieties or with resomatization and anxiety which have previously attained mental representation. These aforementioned states would be provoked by the deprivation of something which had once been possessed, or they might develop as a result of envious feelings toward the good-object-present.

It is not my intention to diminish the validity or the importance of Klein's theory of primary envy, nor do I mean to imply that envy does not operate significantly and require interpretive attention in the treatment of most of our patients. I wish, however, to propose that in some patients at times, the destructiveness of envy and its paranoid/schizoid and depressive consequences cannot be effectively addressed before the underlying "unthinkable anxieties" (Winnicott, 1962, p. 61), created in the wake of privation, have gained access to and been given meaning through the interaction with the analyst which facilitates mentation. Such anxieties may not be immediately analyzable or interpretable (Mitrani, 1993b). These must first be experienced for the patient (Meltzer, 1986). Only when we can bear to remain in contact with and to think about *our experience of the totality of the patient's experience*, including those endlessly terrifying perceptions of utter helplessness, perpetual meaninglessness, and infinite void (Grotstein, 1990), can we expect patients to be able to remain in contact with themselves as well as with the new perspective which we offer to them in the analytic encounter.

CONCLUSION

I have attempted in this paper to begin to clarify the concept of unmentalized experience, which has been addressed in the lit-

erature in several ways, using many different terms. Since Freud first delineated the area of the unanalyzable anxiety equivalent, notions such as body memories (Federn, 1952), memories in feelings (Klein, 1946), beta elements (Bion, 1962), and activation contours of vitality affects (Stern, 1985) all seem to have been the products of various efforts to describe clinical encounters with those emotional experiences of our patients which have yet to be worked over in the mental sphere. This is a difficult task, since such experiences, which have been ineffable, undergo transformation even as we attempt to speak about them. Such experiences seem to have remained unthought until, in the process of analysis, they have chanced to arrive *in* the analyst, who has been capable of keeping these experiences in mind for a sufficient period of time to be able to suffer and to think them and to give them logical, verbal meaning, to be conveyed to the patient, all in good time.

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Some Reflections on Curiosity and Psychoanalytic Technique

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SOME REFLECTIONS ON CURIOSITY AND PSYCHOANALYTIC TECHNIQUE

BY EDWARD NERSESSIAN, M.D.

Freud's 1913 recommendation that the psychoanalyst listen with free-floating attention has continued to guide psychoanalytic thinking and teaching about the optimal attitude the analyst maintains while listening to the analysand. The author attempts to develop more explicitly the concept of intentionality in the psychoanalyst's listening, a factor which has heretofore been insufficiently recognized. This is demonstrated by a clinical examination of the alterations in the level of curiosity in both the analyst and the analysand, with curiosity in its relatively conflict-free form being conceptualized herein as an attitude of the ego.

Analytic listening and attention have been examined in the psychoanalytic literature from many perspectives. Much as it is integral to our work, however, curiosity has received little in-depth attention, other than as a derivative of conflict-related sexual voyeurism. In contrast, this paper will examine curiosity as an ego attribute that is essential for psychoanalytic work and will emphasize the importance of isolating it as an aspect of technique. Further, close observation of the vicissitudes of the analyst's curiosity will be shown to yield important data about resistance and countertransference issues. The value of considering curiosity when assessing analyzability will also be discussed.

It is true, of course, that lively interest in the exploration of the unknown and uncharted recesses of the mind has long been recognized as a fundamental attribute for the analyst. As Sharpe suggested in 1947, "an essential qualification for any student is . . . an insatiable curiosity concerning man's mental and emo-

tional life" (p. 1), an interest which she pointedly distinguished from the "peeping Tom" variety of curiosity. Greenson (1967) also emphasized it as a required personality trait in the analyst, stating the following:

> [The analyst] should have an inquiring mind, searching for knowledge, causes, and origins. The energy impelling a person in this direction comes from his curiosity, which should be rich in quantity and benevolent in quality (p. 381).

After cautioning about the dangers of too little curiosity and curiosity that is too harsh, Greenson concludes by saying that "this attitude is only possible when curiosity is no longer under the domination of the instincts" (p. 381).

This special mental attitude so necessary to the analyst's work is both like and unlike ordinary, everyday inquisitiveness. The drive to know and to discover is part of all scientific inquiries, but whether this drive is impelled by or is itself curiosity is debatable. Nevertheless, it is clear that relatively conflict-free curiosity, or, as Friedman (1988) has called it "unconfinable" curiosity, is a required attribute for the analyst. The question that remains, however, is: If curiosity is so important an attribute, what role does it play in the analyst's daily work and to what extent does it shape and inform her or his technique? Here, it must be made clear that a distinction is being made between this interest in understanding the patient's mind and problematic curiosity. In its more troublesome manifestations, as Olinick (1980) has described in his paper, "The Gossiping Psychoanalyst," curiosity can often be "a vehicle or . . . a façade for other motives" (p. 441), rather than an important component of technique which is essential for therapeutic work.

The Place of Curiosity in Psychoanalytic Theory

Freud's references to curiosity all came relatively early in his theory development, and it is a topic, unlike others, which he did not repeatedly rework. In the 1905 "Three Essays on the

Theory of Sexuality," Freud linked curiosity to the early sexual explorations of the child. Later, in 1910, he wrote of Leonardo da Vinci and his powerful instinct for investigation, confessing that "about its determinants (which are probably organic) scarcely anything is yet known." (p. 77). In this essay, Freud appears to be making a distinction between the instinct for investigation and knowledge as opposed to curiosity, which, he suggests, does not awaken spontaneously in the three-year-old in the form of his or her many questions, but rather, "is aroused by the impression made of some important event—by the actual birth of a little brother or sister, or by a fear of it based on external experiences . . ." (p. 78).

Freud's reasons for making such a distinction are not clear, but his delineation of three possible vicissitudes of the instinct for research does provide some insight into his conceptualization. As these distinctions continue to be of some use descriptively in clinical work, I will briefly mention them. In the first instance, the instinct for research suffers the same fate as sexuality; repression leads to inhibition of curiosity and to a curtailing of the "free activity of intelligence" (1910, p. 79). In the second outcome, the individual's "intellectual development is sufficiently strong to resist the sexual repression" (p. 79); nevertheless, there is a sexualization of thinking, with excessive brooding. In such cases, "investigation becomes a sexual activity, often the exclusive one, and the feeling that comes from settling things in one's mind and explaining them replaces sexual satisfaction" (p. 80). In the third instance, which Freud saw as "the rarest and most perfect" example, as exemplified by Leonardo, "the libido evades the fate of repression by being sublimated from the very beginning into curiosity and by becoming attached to the powerful instinct for research as a reinforcement" (p. 80). Hence, in all three outcomes, Freud clearly links curiosity to the sexual instinct and only secondarily to what he termed the instinct for research. In this regard, the thesis presented herein differs from Freud, as curiosity is seen as a po-

tentiality or attribute of the ego which only secondarily becomes involved in sexual and aggressive conflicts.

Subsequent to Freud, other psychoanalytic writers continued to focus on the connection between curiosity and the sexual instinct, particularly in terms of its relevance for the understanding of pathology as seen in the clinical setting. Important among these was Abraham, who, writing in 1913, expanded and elaborated on this link in detailed clinical vignettes, repeatedly demonstrating the relationship between scoptophilia and neurotic inhibition and symptomatology. In doing so, he established the tone for much of what followed in the literature, and at the same time rather fixedly set the direction for the usual approach to the understanding of curiosity in psychoanalytic practice.

Years later, in 1961, Nunberg, in an extensive case study entitled *Curiosity*, described in great detail the condition of a man plagued by questions and brooding whose childhood concerns about conception and birth continued to preoccupy him as an adult, in the guise of his excessive, incessant curiosity. Lewin (1970) described the case of a woman with a noticeable inhibition of curiosity, which he linked to the repression of her infantile sexual experiences, noting that neurotic doubt is a sequela of the child's curiosity.

Invaluable as these discoveries have been in guiding the practice of psychoanalysis and in elucidating the genesis of pathological curiosity, they have nevertheless inevitably narrowed our focus and understanding of it in its less conflicted manifestations, a by-product of which has been our insufficient investigation of curiosity as an ego attribute or potentiality.

Outside the field of psychoanalysis, extensive systematic research has been devoted to the study of this subject in both humans and animals by learning theorists, cognitive psychologists, and infant and developmental researchers. In most contemporary research work, as Mayes (1991) of the Yale Child Study Center points out in a recent survey, curiosity is considered to be present very early, as evidenced by the initial explorations of infants, occurring within the first months, weeks, and

even days of life. It is seen as an important component of infants' emerging efforts to grasp the world around them and is generally assumed to have a biological substrate, the result of specific processes that have clear adaptive and evolutionary relevance.

Within our field, the observations of infant and child researchers have contributed the most to enhancing our understanding of the role of curiosity in normal development. Emde (1991) in his delineation of what he calls "early motivational states" emphasizes the importance of the role of positive emotions in curiosity, as, along with other everyday activities such as interest, surprise, and mastery pleasure, he states, it guides "the seeking of the new and the assimilation of the new to the familiar" (p. 29).

The work of Mahler, Pine, and Bergman (1975) also demonstrates the presence of curiosity from very early on and gives it (as well as what they term "wonderment") an important place in explaining the so-called "stranger anxiety" phenomena occurring in the first years of life. The following quotation from their book, *The Psychological Birth of the Human Infant*, is notable both in terms of the role attributed to curiosity in infants and with respect to the place their findings suggest for it in the broader context of the general theory of the mind:

> A positive finding of our study was that stranger reactions at perception of the other-than mother are dependent on broad sensori-motor, quasi-cognitive functions of the ego that go far beyond the affect of anxiety. In addition to anxiety, the stranger evoked mild or even compellingly strong curiosity. That is why we have emphasized throughout this book that curiosity and interest in the new and the familiar are as much a part of stranger reactions as are anxiety and wariness (p. 209).

More recently, Brody and Siegel (1992), in reporting the results of their longitudinal study of character development, emphasized that the "capacity for curiosity lies in the ego," though

like all such attributes, its expression later in life is "under the aegis of the superego" (p. 15).

Whether or not the curiosity of the child who has acquired language is a continuation of preverbal exploratory behavior remains unanswered. It is a question which will perhaps be clarified as new research findings emerge and as these are integrated with the findings of psychoanalysis to give us a better understanding of the place curiosity occupies in the general psychology of the mind. For the purpose of this presentation, aimed as it is at clinical concerns and matters of technique, I shall consider curiosity an attitude or attribute of the ego, which can be clearly recognized in its function and role with the emergence of language and thought. Seen in this way, as a potentiality or capacity of the ego that can be expressed in various forms, curiosity, I assume, can and does undergo all the well-known vicissitudes that are imposed by the psychosexual developmental stages and thus can be part of phase-specific compromise formations. For example, curiosity in the two- to three-year-old is under the sway of the anal phase, whereas for the four- to five-year-old it is colored by the special concerns of the oedipal phase. Given the importance of the oedipal phase, much of the curiosity we encounter in the clinical setting and often refer to as voyeurism or scoptophilia is related to that particular phase of development. It is useful to keep in mind, however, that all of the hierarchies of anxieties persist throughout life, with one or another gaining ascendancy at one time or another in a particular situation or for a particular person. Thus, stranger anxiety and separation anxiety (as described by Mahler, et al., 1975) may accompany certain states of curiosity, and along with castration anxiety and the superego concomitants of the oedipal phase, can influence the amount and degree of it in the individual, coloring the attendant fantasies.

The following comments from Stein (1966) on the relationship of the superego to self-observation (and, I would add, to the attendant curiosity) are pertinent here:

> The role of such superego sanction in the investigation of forbidden secrets is well-known, although it has not been sufficiently stressed. Everything of importance in science, from Freud's investigation of childhood sexuality to the astronomer's search for the secrets of the universe, has had a forbidden quality and often enough has been met with savage reprisals by the elders of the society (p. 291).

In summary, then, I propose, at variance with currently accepted theoretical ideas, that curiosity be viewed as an ego attitude or attribute which becomes a component of phase-specific compromise formations with the usual attendant anxieties and fantasies, voyeurism and scoptophilia representing but one such pathological outcome. In this view, not all curiosity is voyeurism, and, in fact, a central task of analysis—and more specifically of training analysis—is the freeing of this ego capacity from instinctual and superego interferences so that it can be exercised in a relatively conflict-free manner.

Curiosity and Psychoanalytic Technique

If curiosity is so important a part of the activity of both the analyst and the analysand, why has it been a relatively ignored aspect of technique? If, as Boesky (1989) has stated, there is something "so obvious" about the curiosity of the analyst, why does he feel it needs "rediscovery"? Perhaps it seems so natural and so integral to our work as to require no emphasis. Possibly, however, as curiosity implies a drive or a force impelling some activity, there may appear to be a potential conflict between being curious and maintaining the prescribed ideal attitude of evenly hovering attention. Or, it may be that Stein's (1966) insights about the superego prohibitions against investigation apply here—i.e., the "forbidden quality" associated with conflict-laden curiosity may have served to curtail a proper scientific study of the subject. In fact, though, it is my contention that

while most writers have emphasized the technical importance of acquiring and sustaining the capacity to let one's attention hover evenly, the notion of curiosity is embedded in most works dealing with psychoanalytic listening without being made explicit.

Beginning in 1913 with Freud's well-known recommendation about evenly hovering attention, most of the focus in the literature has been on the need for the analyst to suspend his or her ordinary, everyday attentiveness. Fliess (1942) elaborated on this concept, stating that the analyst's activity should be one of "conditioned daydreaming" (p. 219). He used the term conditioned to stress that the daydreaming should be stimulated not from within but from the patient, further insisting, however, that this posture should not be accompanied by "any impairment of the keen operation of any of our intellectual functions" (p. 220), so that the analyst may be able to critically penetrate the material offered. Greenson (1967) also suggested that one listen with evenly suspended, evenly hovering, free-floating attention, adding that this is done in order to achieve one of the goals of the psychoanalyst, which is to translate the productions of the patient into their unconscious antecedents.

In a similar vein, McLaughlin (1975) suggests that the analyst put to the periphery of awareness all else that is around, restricting his or her focus upon outside stimuli only to those the patient provides, while at the same time raising awareness of his or her internal phenomena as these reverberate to the patient's stimuli. Quoting Ferenczi, Fenichel (1941), in his monograph entitled *Problems of Psychoanalytic Technique*, had this to say:

> Analytic therapy requires from the physician 'on the one hand . . . the free play of association and fantasy, the full indulgence of *his own unconscious*; on the other hand, the physician must subject the material submitted by himself and the patient to logical scrutiny and in his dealings and communications must let himself be guided *exclusively* by the results of this mental effort' (pp. 12-13).

Finally, Brenner (1976), in describing the analyst's activity, states the following in his book, *Psychoanalytic Technique and Psychic Conflict*:

> An analyst's attention may be directed, quite properly, to one or another of [a] welter of determinants as he listens to a patient. Not all are equally important at any given moment to the task of enlarging his understanding of the patient. . . . He knows that all are there in the analytic material, nevertheless, and that each will engage his attention at some later time as it has in the past (p. 193).

He goes on to cite Anna Freud, stating that it "is this distribution of interest among the several components of the mental apparatus that [she] described so eloquently . . ." (pp. 193-194).

It is clear from a close reading of the above that while free-floating attention is emphasized as a technique, it is always implicit that there is an intentionality that underlies the listening of the analyst. Brenner seems to emphasize this, and while he does not expressly recognize the role of curiosity, one can see in his comments as well as in those of the other authors cited that they recognize a directionality in the analyst's listening; what has not been stressed, however, is the role curiosity plays in guiding this directionality.

In fact, I would insist that curiosity is the silent partner of attention, a seamlessly interwoven part of technique which usually only becomes apparent in its breach or its distortion. Being curious is not antithetical to maintaining a so-called "analytic stance"; rather it is an important component of the analyst's technique, without which an analysis runs the risk of becoming a sterile, intellectualized activity.

To expand on this point, let us briefly consider those aspects of the psychoanalytic situation of specific relevance to our consideration here, conceptualizing this as consisting of three parts. In this schema, the first component is non-directed listening, which is achieved by non-focused attention. In practice, this means the analyst does not select a priori what she or he will attend to in the patient's associations; rather, almost like a

sponge, the analyst allows all of the associations to reverberate in her or his mind. Second, as a result of these reverberations, some intuitions will gradually form in the analyst's mind. Third, these intuitions will be submitted to intellectual, partially logical scrutiny and will become the basis for the conjectures that will eventually lead to questions and interpretations.

While there are other ways this activity can be described, what is not recognized is the critical role that curiosity, in its relatively conflict-free manifestations, plays in impelling the analyst in his or her quest to understand the mental life of the patient. This active wondering of the analyst is not antithetical to the relative passivity of his or her attention and will not lead to an excessively interventionist attitude, unless the analyst's curiosity is under the sway of unresolved conflict. It is useful to remember here that activity as part of verbalization must be distinguished from having an active mind; while the former often results from the latter, it is by no means an obligatory relationship.

It is therefore my contention that the classical description of psychoanalytic listening can be—and often is—viewed in an inaccurate and misleading way. Intent on securing the place of free association as a cornerstone of analysis, Freud's followers may have overemphasized the role of its corollary—"evenly hovering attention"—in psychoanalytic technique. As a residue of these early days of psychoanalysis, analytic listening has continued to be taught in an unmodified way to candidates, occasionally even in as highly dramatized a fashion as follows: "Let your mind drift in no particular direction and just allow for a receptivity for the patient's free associations to develop. The interpretation or understanding of the latent content will thus come to you when it has reached a certain threshold of consciousness." Leaving aside the problems inherent in the concept of free association and the issue of whether or not evenly hovering attention should be properly thought of as its correlate, I believe it is not overstating the case to say that this directive, with the passivity of mentation it entails, would, if followed completely, lead to sleep.

This is not to imply that a special attitude of the mind is not required for analytic work, but rather to emphasize that this attitude is an active one. While remaining receptive to all the patient says, the analyst's mind also constantly scans the material, and it is this scanning which, to a large degree (though not completely), is impelled by curiosity.

Vicissitudes of Curiosity in the Analyst

Isolating curiosity as a component of technique and examining its vicissitudes during the course of an analysis can be of value in sharpening analytic skills. In everyday clinical practice, this "silent partner" of evenly hovering attention often reveals its existence most explicitly when it has been absent; when, for example, the analyst finds that his or her mind has wandered or that he or she has not been curious about the mental life of the patient, though the analyst may well have been actively inquisitive concerning details of the patient's life. It is on this particular issue which I wish to focus, on those times in an analysis when curiosity is absent, disrupted, or hindered to the extent that the ongoing work of the treatment is impeded. It should be emphasized that as this is not a paper about curiosity in its more frequently used sense, very little attempt will be made to elucidate the voyeuristic issues involved in the disruptions of it in the analyst; instead, the focus will be on how breaks in the analyst's underlying curiosity can affect the analytic process.

Extensive interferences with the analyst's analyzing and listening ability and, by implication, with his or her curiosity, due to insufficiently analyzed neurotic conflicts in the analyst, as well as disruptions that are the result of strong and persistent countertransference reactions, have been dealt with extensively in other contexts and do not need further elaboration. Analysts who find themselves interested in gossip, titillated by interesting facts, straining for stock market tips, and fascinated by political intrigues are either not genuinely curious about their patients'

mental lives or have not been able to develop a curiosity that is sufficiently free of conflict to perform their work without important difficulties. Conversely, so are those analysts who cannot tolerate their patients' sustained curiosity about them and find themselves revealing their opinions, giving advice, and "letting slip" subtle facts about their lives. Complete and long-lasting absence of curiosity in the analyst also belongs in this group.

Of special interest in clinical work are the ongoing vicissitudes of curiosity during an analysis, among which perhaps the most common is the temporary loss of it, accompanied by a reverie or by thoughts about unrelated matters. Such lapses must be distinguished from the phenomenon described in the literature wherein the analyst's reverie or other associations provide a clue to important concerns of the patient. Certainly there are instances in almost every analysis when, during a session, associations, daydreams, or images come to the analyst's mind which upon reflection, reveal an important aspect of the patient's mental life, as Beres and Arlow described in 1974. In their report of a case, a patient tells a dream and the analyst has a reverie which is a manifestation of an unconscious fantasy congruent with the patient's fantasy, following which the analyst is able to interpret the dream without the benefit of the patient's associations. Some years earlier, a similar experience had been described by Otto Isakower (1963) in a discussion with members of the New York Psychoanalytic Institute faculty. At that time Isakower described how, during the report of a patient's dream, a supervisee had an image of Mona Lisa come to his mind. The analyst then introduced this image in his interpretation, only to have it confirmed by the patient's reaction. More detailed examples of such occurrences are given by Gardner (1983) in his book, *Self Inquiry*, as well as a suggestion by Gardner that the analyst should develop a readiness of mind for such reactions.

I believe, however, that these sorts of incidents—dramatic as they are when they occur—are relatively rare. Much more often, the analyst's curiosity is impeded and his or her mind wanders

off for other reasons, such as the natural inability of anyone to be able to sustain complete attention during an analytic hour without occasional lapses into other thoughts, especially during periods of increased life preoccupations. As is true with lapses in the maintenance of free-floating attention, personal worries of the analyst about illness, family, finances, or thoughts about an upcoming vacation, and so on, can also contribute to the many fleeting failures of curiosity which occur in every analysis.

In addition to these relatively benign interferences, there are more important and sustained disruptions in the analyst's curiosity which are an indication of countertransference or a signal that the patient is in a state of resistance. In such instances, as illustrated in the clinical vignette to follow, once countertransference has been recognized, the analyst's curiosity needs to be directed toward his or her own mentation in order to recognize the possible reason that the patient's mental life has ceased—at least temporarily—to be intriguing. Sandler (1992) has addressed this issue from a slightly different angle as follows:

> . . . in the process of self-scanning the analyst needs to ask himself from time to time . . . why his mind has gone in this or that direction, and to reflect upon the possible countertransference implications (p. 196).

Another source of difficulty may arise in certain special situations where there may not be an absence of curiosity per se, but rather a narrowing of the scope of the analyst's inquiry. I hope to demonstrate this with an example from my own practice which occurred during the termination phase, although I believe such constriction of curiosity may be present at any point in an analysis.

Clinical Illustrations

From my own practice, I have selected two cases to illustrate instances of sustained failures of curiosity in the analyst, the first one being the result of countertransference, and the other, a

narrowing of curiosity, growing out of a special situation that also bears on matters of technique and focus in the termination phase.

The first case is that of a man who came into analysis with feelings of depression, a sense of indirection in life, marital difficulties, and other problems having to do with poor self-esteem. He took to the analytic work rather quickly and was soon able to talk freely in the sessions about many of his fantasies, expressing curiosity about himself, his past, and the how and why of his thoughts, feelings, and behavior. Of relevance to my comments here is the fact that for some time, beginning in his early teens, this patient had suffered from a severe illness, although he had been completely cured and had remained so for some twenty years. As a physician, however, I was well aware of the fact that conditions such as his can sometimes recur. Furthermore, at the time, there had been unresolved controversies about the possible psychosomatic status of the patient's condition. Adding to the picture was the fact that during my residency, I had been criticized and considered to be overzealous in my work with an adolescent psychotherapy patient who suffered from the same medical condition. The physicians in charge of this patient's medical care felt I was undermining their treatment by focusing too exclusively on psychological issues and thereby creating unnecessary doubts in the mind of the patient and her family about a proposed radical treatment which they deemed essential.

With this as a background, suffice it to say that I had no more than the usual difficulties remaining attentive and curious about the patient during the first three years of analysis; that is to say, during the early years of the treatment, I experienced no more than the usual, less troublesome disruptions in curiosity mentioned above. As the work progressed, however, and moved into areas which had important connections with some of the psychological issues that had been thought to be involved in the development of his illness, I found myself completely unable to maintain my curiosity about what elicited the patient's insistent

curiosity. My fear that investigating these areas would lead to a flareup in a condition that might not have been cured but instead might only be dormant was dealt with by an inhibition in my curiosity, which was maintained even in the face of the patient's active investigations. Naturally, as is the case with all such countertransference reactions, I found, upon examination, that my response was multiply determined, with many levels of dynamic and genetic determinants, in particular, defenses against my own aggression in the face of emerging intense sadistic fantasies and subtle enactments by the patient. My absence of curiosity was not, in this instance, accompanied by a difficulty in maintaining an attentive stance. Rather, there was a split between these two mental attitudes which are normally so closely intertwined.

Not only can sustained lapses of curiosity be a problem for the analyst, as in the foregoing example, but it is also the case that one's curiosity can become narrowed, particularly during the termination phase when issues may be prematurely put to rest as the analyst focuses more intensely on resistances within the transference. The importance of maintaining curiosity during the termination phase about all aspects of a patient's history, relationships, and fantasies is borne out in the second case.

This patient, an extremely inquisitive man who had only been able to partially channel his curiosity in adaptive ways, came to analysis in a relatively severe state of depression. Things had progressed well in his rather lengthy treatment, and we were in the last months of the analysis when the events I am about to describe transpired. During this termination phase, most of the analytic work centered around the transference and his chronic attitude of wishing to defeat me and/or to provoke me into defeating him. In saying that he had done well in the analysis, I am, of course, referring not only to external and internal changes, but also to the fact that much had been analyzed and understood and seemingly had fallen into place, including his intense voyeurism and its relationship to primal scene fantasies

and to his childhood questions about sexual differences and where babies come from, stimulated as they were by the arrival of his younger sisters.

Of particular interest here is a screen memory involving his black nanny and a man who visited her. The relationship between the two was always imbued with ambiguity in the patient's mind, although he had concluded rather tentatively that the man was his nanny's boyfriend. I had been puzzled by this uncertainty, as well as by why he should attach so much importance to the issue at all, but had not made much headway in clarifying this matter. After much analytic work connected to this memory as well as to a childhood neurotic symptom which had continued into his adult life in the form of a specific inhibition, the inhibition lifted and much of his childhood neurosis was understood. From time to time, however, especially when he was more inclined to point out my shortcomings and failures, the patient would bring up "the black man" as he called the nanny's visitor and would challenge our understanding of him. Having many times tried in vain to use his question to elicit more associations, I had come to the conclusion that he raised the specter of the black man to taunt me and thereby to express his ambivalent rivalry toward me.

During the termination phase, when so much of the analysis centered around the transference, I continued to interpret his question according to my prior understanding—e.g., his need to prove my inadequacy and all that this entailed. I no longer had any curiosity about the nanny's boyfriend since I thought the issues connected to him had been satisfactorily analyzed. One day, while walking down the block toward my office, he engaged in his usual habit of allowing himself certain thoughts and fantasies that he would not allow so easily on the couch. The thoughts went something as follows: "Father was beating up the black man in the kitchen. Maybe he was using a stick or a baseball bat. The black man did not have a penis." Then he interjected an editorial comment about how ridiculous these

thoughts were before continuing. "This cannot be," he said, "maybe it was the maid. Maybe my father was having sex with the maid. I know he had sex with my mother." Then the patient thought of an accident involving his younger sister, which resulted in a gash on her thigh, and of a story about a boy with no penis which he had written as a seven-year-old. Again, he returned to thoughts of his mother, about how she had jet black hair when she was young.

At this point, the patient stopped and asked, "So what do you make of all this? What do you think of the black guy with no penis?" I said his mind had gone from his story about a boy with no penis to his mother and her black hair. Could the black man have something to do with his mother's genitals? His response was atypical; rather than criticizing my comment, he began to talk about something else. The next day, however, to my complete surprise, he vehemently declared that he was not coming back to analysis and was ready to terminate then and there; in fact, he stayed away for the better part of the following week. A period of intense resistance ensued wherein it was gradually possible to further analyze his feminine identification, castration anxiety, and the derivatives of a beating fantasy.

Rich as this vignette is in terms of interesting dynamic issues, pertinent to our consideration here is the way in which my focus had prematurely narrowed; I had ceased being curious about this particular aspect of the patient's thoughts and had only wondered about the transference meaning of his questioning our understanding of the black man. The centrality of transference reactions at the time, which was the focus of ongoing, fruitful work, had led to an excessive focusing of my attention, at the expense of a more open exploration. As Brenner (1976) noted in his comments quoted earlier, to some extent this is unavoidable, but it is equally valid to keep in mind that—insofar as is possible—if one remains curious about the whole range of the patient's mental life, there will inevitably be unexpected, surprising shifts in the data.

Vicissitudes of Curiosity in the Analysand

Having briefly discussed the subject from the vantage point of the analyst, I would like to turn to the other party of the analytic dyad, the analysand. My aim is to focus primarily on two issues, the first being the role of relatively conflict-free curiosity in analysis and the impact it can have on analyzability. Second, I would like to discuss the conflictual or pathological manifestations of curiosity in terms of their effect on the analytic process. Finally, I hope to highlight how approaching clinical material from this vantage point can provide additional avenues of exploration.

In this paper, I have emphasized the importance of curiosity that is relatively devoid of conflict as an essential tool of psychoanalytic technique; similarly, I would underscore its importance in the patient. This ego attribute can sometimes be present from the onset, and, in fact, may have played a role in bringing the patient to analysis. More often, however, its presence takes the form of moderately conflicted sexual curiosity or voyeurism, with the guilt and anxiety associated with these impulses frequently resulting in significant inhibitions. Analysis of those specific conflicts naturally assumes an important role in freeing up the patient's interest in genuine self-discovery; without examination of these issues, analysis is not possible, or it takes the form of an intellectual exercise wherein the patient gains a great deal of information from the analyst without assimilating it in a meaningful way. This being the case, beginning with the preliminary consultations, it is essential that an ongoing assessment of the patient's capacity for curiosity and of its possible inhibitions be part of the evaluation of analyzability; subsequently, it is important for the continuing assessment of the analytic process.

In some cases, the impact of conflictual manifestations on the analytic process can be drastic and persistent and needs to be analyzed *as such* in order to allow for a consistent line of interpretations directed at the underlying conflicts. One such patient

who had important ongoing conflicts around these issues could not develop the ability for self-reflection for a prolonged period of time, well into the treatment. He responded to any question intended to help him think about one or another matter that was preoccupying him by berating himself, with self-criticism taking the place of curiosity.

This patient was born into a poor farming family, and his early life was spent in a small, two-room house, where he and his siblings shared the bedroom while the parents slept in the living room. The children were all about three years apart in age, and it was the custom that each new child spend the first two or so years of life sleeping with the parents. Also of relevance in the patient's development was the fact that his mother was an extremely moralistic woman who rigidly controlled the family while viewing the father as a quarrelsome, peevish, and ineffectual man. (Since my focus in presenting this vignette is solely on the patient's severe superego condemnation of any curiosity, I will omit many of the other determinants involved in his conflicts.)

The patient's inhibition of curiosity, or more precisely, the prohibition against being curious had a very negative impact in many areas of his life, including his profession, in which his naïveté and inability to look into things worked against his advancement; despite being a highly qualified professional, he stayed at the same level of employment for years. Germane to the point presented here was the patient's inability to be curious about himself and therefore to reflect on his thoughts and behaviors. Inroads began to be made when specific attention was given to analyzing his prohibitions against knowing, looking, and being curious. It was only as conflicted voyeuristic impulses with their sexual and sadistic derivatives were analyzed that there was an increasing ability for self-reflection and self-analysis.

I think similar issues, namely, compromise formations demanded by the superego and impelled by the fear of the well-known calamities of childhood, play a significant role in imped-

ing genuine self-scrutiny in analysis and are present in many cases where the analytic work does not progress. In such cases, as in the one presented here, specific work directed toward analyzing the impediments to curiosity can be invaluable.

In other patients, unconscious anxieties related to the curiosity-causing conflicts are manifested in a fear of the unknown. Curiosity about the self is not easily maintained because of various conscious and unconscious fears, and for those patients whose stifled curiosity takes the form of a fear of the unknown, this fear is often projected outside the self.

This can be manifested in a variety of ways. In one patient, it showed up in her lack of curiosity as well as in her considerable anxiety about new places and new things to see and experience. In another, it was his fear of not knowing what he should do during sexual intercourse, despite considerable sexual experience. While these examples do not represent anything unique and are variations on similar issues seen in every practice, I found that looking at the clinical material and approaching it as a manifestation of conflicts involving curiosity was a useful and productive avenue for exploring new material. In the first example above, exploration of the patient's inhibited curiosity about new places and things led to material about the mother's pregnancy and the birth of a brother when the patient was three, while in the second case, taking a similar pathway led to an understanding of the patient's pseudo-naïve curiosity about "what to do" as developing out of conflicts related to childhood participation in a parent's exhibitionistic perversion. In the second example, the value of not satisfying the patient's curiosity in the transference was demonstrated, as the maintenance of an unwavering analytic attitude was essential to the eventual uncovering of the issues involved in the symptom formation.

In addition to the role the analysis of conflicts connected to curiosity and voyeurism plays in the development of ongoing analytic explorations, two other factors serve to augment the patient's genuine self-curiosity. First and of major importance is the gradual identification of the patient with the analyst's benign, nonjudgmental curiosity, eventually resulting in the as-

sumption of a similar attitude by the analysand. I have found this happens almost automatically, over a period of time, leading me to believe there is no need for any special techniques or instructions (such as those recommended by Paul Gray [1986]) to aid the patient in his or her development of the self-directed, relatively conflict-free curiosity needed for analysis. Second, the very fact that the analyst does not answer a wide range of questions leads to what W. W. Meissner (in a personal communication) has termed an "initiation of dialogue between analyst and analysand" and also contributes to a gradual increase in the analysand's ability to wonder—uncritically—about his or her own thoughts, feelings, and behaviors.

Just as it is true that the level of curiosity varies in the analyst in any given session, so it varies in the analysand. It should be noted, however, that for the analysand, such fluctuations may be the clue to resistances which might otherwise be overlooked, and paying close attention to these alterations of curiosity in the patient may well allow the analyst to make more timely interventions than is possible with a different focus. Kris (1982), in his work on the role of free associations, seems to be addressing this issue, albeit from a vantage point that results in conclusions at variance with what I have in mind. I would instead emphasize that free association without curiosity is of limited value. Focusing on the oscillations of curiosity provides a better indication of the patient's capacity for ongoing analytic exploration and therefore for the development of an analytic process, from minute to minute within a session, as well as from day to day and week to week. Parenthetically, assessment of curiosity is useful as an indicator of analyzability not only in a global way, as is usually our focus, but also in the often ignored variable capacity for analyzing from moment to moment.

Conclusion

I recognize that simplification inevitably occurs when one focuses on one facet of the very complex activity of conducting an analysis, as I have done by drawing attention to the importance

of curiosity in the analytic setting. Much more could be said about the subject; however, I would like to close by suggesting a brief addendum to Freud's (1913) well-known remarks to analysts wishing to know how to instruct a patient from his paper, "On Beginning the Treatment." Writing as if he were telling a patient about the fundamental rule, he said,

> So say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside (p. 135).

To do this, the patient needs to be curious about what he/she sees in order to reflect upon it and eventually understand it. Likewise, the other passenger—the analyst—must have his/her attention and curiosity primarily directed to the first traveler, even though, as Lewin (1970) pointed out, the analyst has his/her own window by which he/she is also affected. As the analyst listens equally to all of the analysand's observations on the landscape from the window, the analyst's curiosity must guide his/her attention to both windows, with an eye to eventually making sense of the constantly changing scenery.

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PROJECTION, IDENTIFICATION, AND BI-LOGIC

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The work and postulations of Matte-Blanco are explained in some detail, especially regarding the logical functioning of the conscious and unconscious mind, asymmetrical and symmetrical logic, and bi-logical thought structures. A case serves as an example for the clinical application of Matte-Blanco's ideas to theoretical conceptualization and to the technique of interpretation.

Matte-Blanco's (1975, 1988) general formulations and the concept of bi-logic refer to the logical functioning of the conscious and the unconscious mind. Matte-Blanco bases his ideas on Freud's (1900, 1915) formulations of the unconscious and its five characteristics, on Suzanne Langer's (1953) work on symbolic logic, on Bertrand Russell's (1918) mathematical-logical ideas, etc. Projection and identification are psychological mechanisms, mainly of the ego, described by Freud many years ago (1913, 1921) and later systematized by A. Freud (1936) as defense mechanisms. Klein (Segal, 1964) fused them, coining the term "projective identification" and seeing it as a further mechanism destined to rid the self of bad and dangerous objects or features of objects (part objects) by splitting them off and externalizing them onto other objects. It was Matte-Blanco who decided to look at these mechanisms in terms of conscious and unconscious logic. He has given us a manageable description of how this phenomenon takes place and how it can be understood in logical terms.

I am indebted to Carmen Fink for her advice on classical logic.

To illustrate the clinical relevance of the above formulations I will present the case of a man who suffered from a distorted image of himself. I will highlight the application of Matte-Blanco's ideas in relation to the understanding of the psychopathological mechanisms of the case and also the technique of interpretation when using the concept of bi-logic. But before introducing my clinical material, I shall present Matte-Blanco's ideas in more detail.

Matte-Blanco states that there are two simultaneously acting forms of logic in the mind:

(1) Asymmetrical, Aristotelian, or classical logic is the thought form we use in our everyday conscious communication. This kind of thought process, akin to Freud's secondary thought process, allows the conceptualization of time and space and the differentiation of the whole and its parts. It is ruled by the laws of contradiction or antinomy, negation, causality, numerical, spatial, and temporal sequence, and the ability to distinguish between subject and object. Thus, it is possible to conceive in terms of time, the idea of past, present, and future; in terms of space, the here and there, inside and outside, left and right, above and below, external and internal world, self and non-self, etc.; and in terms of the whole and parts, the idea of part objects versus complete objects formed by many parts, leading to the concepts of individuality, identity, distinction, and classification. This so-called asymmetrical logic performs classificatory and discerning functions which allow our conscious mind to distinguish objects, differentiate and classify them, and place them in time and space. This logic and its function is called the "dividing mode." Asymmetry predominates in the conscious.

(2) Symmetrical logic is a bizarre form of thought if viewed from an Aristotelian vantage point. Symmetrical logic is ruled by two principles: (a) the principle of symmetry and (b) the principle of generalization.

(a) The principle of symmetry says that the system unconscious treats all relationships as equal to their converse. Normally speaking, in terms of Aristotelian logic if John is the father

of Peter, then Peter is the son of John. But in terms of symmetrical thought, it is irrelevant who is the father and who is the son: the unconscious considers that if John is the father of Peter, Peter is also the father of John, or vice-versa. This means, if expressed in logical-mathematical terms, that A is to B as B is to A, or that 1 is to 2 as 2 is to 1, which implies that if A comes before B or if 1 comes before 2, then equally B comes before A and 2 comes before 1. The corollary of this way of symmetrical logical thinking is the absence of succession: there cannot be succession if 1 comes before 2 and equally 2 comes before 1. The lack of sequence means that in symmetrical thinking there cannot be a conception of time or of space.

(b) The principle of generalization says that the system unconscious treats all objects as belonging to a class or set of objects. This class or set is in turn a subclass or subset of a wider class or set which, in its turn, is again a subclass of an even wider class of objects, and so on *ad infinitum*. For instance a given dog is a member of the class, Dogs. The class, Dogs, is a subclass of the wider class, Mammals. The class, Mammals, is a subclass of the wider class, Vertebrates, and so on. The outcome of the principle of generalization is that in the system unconscious members of a class or set are seen as equal and exchangeable: any dog is equal to any other member of the class, Dogs, and in an infinite group all members are equal and exchangeable. Therefore, the outcome of the principle of generalization is that any part of a whole is equal and exchangeable with any other part of it and with the whole itself.

The above ensues because in order to classify an object as a member of a class or set, the system unconscious takes into account only one characteristic or feature of the object, disregarding all other characteristics and making this feature equal to the whole object. Yet all other features allow the system unconscious to classify simultaneously the same object in other infinite numbers of classes or sets. Symmetrical logic allows the functions of symbolization, substitution, association, representation, etc.

This form of thought and its function is called the "indivisible mode." Symmetrical logic predominates in the unconscious.

The importance of Matte-Blanco's idea about a logic duality acting simultaneously in the mind is that it leads to a conceptualization of the conscious-unconscious dyad, not in terms of topography or structure but in terms of a thought form determined by the predominance of one or the other logic. The conscious mind is an area of thought ruled mainly (but not exclusively) by asymmetrical logic and, to a point, is akin to Freud's secondary thought process. The unconscious mind is mainly determined by symmetrical thought with a disregard of the concepts of time, space, and the difference between whole and parts. In the past (Fink, 1989, 1991, 1992) I have said that this kind of thought is akin to Freud's primary thought process, but I have come to the conclusion that it cannot be called a "process" since a process implies a development, and development means a sequence. Therefore, since there is no sequence in symmetry, symmetrical thought cannot be called a process. In the same way as in the conscious mind there is some indispensable symmetry, in the unconscious mind there is also some asymmetry. Without the simultaneous presence of both symmetry and asymmetry in the unconscious and in the conscious, there could be no thought.

In a state of absolute symmetry, with a total absence of time, space, and difference between the whole and its parts, everything becomes equal to everything else; no classification, no differentiation, no distinction, can take place, and therefore no thought takes place. Matte-Blanco postulates that there is a so-called deepest unconscious layer where this situation occurs. He speculates that this state of mind is the real meaning of the inanimate state to which the mind tends to return in accordance with the so-called death instinct formulated by Freud (1923). This condition has its opposite in an absolute reign of asymmetry, where all objects are seen in all their infinite characteristics so that they cannot be classified or associated with any other

object. In this latter kind of state there cannot be any classification, association, or symbolization, and thought comes equally to a complete standstill. The above shows us that there has to be some kind of balance in the proportion of symmetry and asymmetry existing in any layer of the mind, be it conscious or unconscious. The concept of layer is something Matte-Blanco introduces in his latest book (1988) when he proposes a revision of the whole concept of conscious and unconscious, saying that the mind is really composed of layers that go from an absolute conscious to an absolute unconscious, with a series of intermediary stages of more or less conscious or unconscious status.

It is timely to mention here the influence that Hughlings Jackson (1893) has had on Matte-Blanco (1955). The concept of a mind in layers going from the highest conscious to the deepest unconscious is a typical concept derived from Jackson's idea about higher brain (and possibly mind) structures controlling lower ones.

There is still another theoretical problem to outline before I come to the clinical relevance of Matte-Blanco's ideas. This is the concept of bi-logic, which is given by the simultaneous existence and action of symmetry and asymmetry forming "symmetrical-asymmetrical bi-logic structures." These thought structures can be of a different nature: simultaneous, alternating, multidimensional, etc. They are ever present and can be of two types: vital and non-vital. A "vital symmetrical-asymmetrical bi-logic structure" is a thought process which admits fluctuation and changes; in it, the proportion of symmetrical and asymmetrical thought is in constant fluctuation; if it flows from symmetrical to asymmetrical thought, then it means an increase of awareness and an increase of conscious thought process. If the flow is from asymmetrical to symmetrical thought, then we have an increase of the unconscious. In classical terms the former means an increase of ego area, while the latter is an increase of the area dominated by the id. In a therapeutic process the analyst aims at producing a shift of the former kind, namely, an increase of awareness. It must be said here that it is only asymmetry which

permits the recognition of symmetry. A "non-vital symmetrical-asymmetrical bi-logic structure" is immobile. It is a rigid, unchangeable way of thinking, something like a neurotic defense mechanism; the balance of symmetry and asymmetry is wrong and too much symmetrical thought present in this kind of bi-logic structure does not allow any recognition of symmetrical logic distorting the whole thought process. In other words, this is equivalent to a substitution of external reality by psychic or internal reality. Only intense and persistent transference interpretation can transform a non-vital into a vital symmetrical-asymmetrical bi-logic structure (Matte-Blanco, 1989).

After this introduction to Matte-Blanco's theoretical thoughts, the question of their clinical relevance arises. The following clinical material—in this case, of a man who equated himself with his penis—will illustrate their relevance.

The patient, whom I shall call Michael, was referred to me by a fellow analyst after the patient had consulted several doctors and psychiatrists about his deep dissatisfaction with himself. He felt himself to be weak, small, irrelevant, incapable, immature, and so on. He thought it all had to do with his penis, which he felt was underdeveloped. He had asked several doctors to measure it and was very annoyed when he was refused and told it was of a normal size, or when the whole matter was dismissed as nonsense.

Michael was twenty-six years of age, single, and a manual worker at a small food-processing factory where he made up packages for wholesale distribution. He lived by himself in a rented room near his place of work and had little social life. He had very few friends. His main social contacts were with his older sister and his brother, a plumber, who had always looked after him. His mother had died when he was in his early teens, and her death had led to a decline of the family fortunes. Father had lost his job because of alcoholism, but somehow had kept the family together by selling homemade pastries from door to door. He was often found drunk at the end of the day. Michael felt ashamed of his father and pretended not to know him if he

saw him in the street on his way to or from school; he was always afraid his friends would laugh at him if they knew he was the son of the drunken pastry vendor.

By the time Michael had finished his nine years of compulsory education, his father had died. Although Michael would have preferred to continue his studies (he was a good student and felt he could achieve more), he had to start work instead, since his brother and sister could not keep the home and continue to support him. His brother found him a job in a shoe factory where he worked for several years. Later, some time before coming to see me, he moved to the food-processing plant.

Michael was a rather short man with dark hair and a moustache. When I saw him for the first time, he wore a grey suit, red tie, and polished black shoes, and he had a grey raincoat over his left arm. He impressed me as trying very hard to look proper and up to such a high endeavor as psychoanalysis, but not being sure if a working-class man like himself was entitled to it. He explained his humble origins, his lack of a sophisticated education, and the manual character of his work. But simultaneously he emphasized that he was in a position to pay for his treatment and that he had made the necessary arrangements concerning time to attend the sessions. Michael said he needed help in order to deal with his problems: he wanted to improve himself; he had to come to terms with his past and build a future. His speech was coherent and articulate. He sounded far more educated than one would expect of someone with his rather elementary schooling. It seemed to me that he was well read and had tried hard to make up for what he saw as his shortcomings.

We agreed on practical matters, and Michael came to his first session the following week. He seemed not to have any trouble lying down on the couch, and he proceeded straightaway to explain that he felt he was not capable of competing with other men or making any impression on women because of the small size of his penis. He spoke about the doctors he had consulted: everybody had dismissed his complaint and had tried to convince him that his penis was not undersized but in the normal

range. He asked me what I thought, to which I replied that perhaps I should listen to him further before saying anything about something that seemed such an important issue to him. He accepted this and continued talking about his small size in general; he thought of himself as a small person, he felt short, and also small in other ways. He was only a manual factory worker, a very small employee in a large firm. I said that perhaps he also felt I thought he was only an unimportant little man, an irrelevant little patient coming to bother me with his little problems or perhaps even with his little penis. He said yes, it probably was like that. It was something he always felt when in the presence of someone whom he saw as in authority.

I asked him to put me further into the picture about himself and his background so that we both could have an idea of what the problem might be, to which he readily agreed. He then spent the next few sessions giving me an exhaustive history of himself and his family, including his present circumstances. He also spoke about his hopes of becoming a bigger man, more educated, better skilled, better paid, but his feelings were of despair. He felt he could never achieve his aim because he did not have the right equipment. Women would never fall for him because there was no hope of satisfying them with his small penis; he could not compete with larger men. I said to him that he was here trying to feel larger and become larger, perhaps having the secret wish that I would make his penis grow larger. He accepted my interpretation.

Michael spent the first six months of his analysis complaining about his general feelings of failure, his loneliness, his sense of defeat, and his incapacity to fight successfully against his background. He became depressed to such a point that his brother telephoned me to say that he was worried about Michael. He asked if I could perhaps support him more and help him a bit faster. Michael later told me that he had gone to his brother and cried, complaining about his despondency regarding his fate. Nevertheless, after these initial six months Michael seemed to feel more at home in his analysis. He came punctually and

talked with feeling and greater fluency. His external appearance started to change slightly: he somehow began to look less subdued and also less humble. Then one day he requested a change of time, explaining that he had enrolled in an evening course to complete his secondary education. He felt that at long last he was doing something for himself.

This was the start of a long series of actions which marked the road of Michael's transformation. His evening classes were followed by other educational efforts which ended when he became a chartered accountant toward the end of his analysis. His struggle to become educated was reflected in his employment. Little by little, Michael was promoted: he never left the company that owned the food-processing plant, but from being a manual worker, he became a clerk. At the time of his analysis ended, he had become the deputy manager of the enterprise.

Michael's personal life also changed. He moved from his rented room into a small apartment. He became acquainted with the niece of his former landlady, and he started to date her. She was a school teacher. Michael liked her very much, and he also looked up to her from a social point of view. They married when Michael had been in analysis about two and a half years. At that stage he was able to afford a house which they moved into.

All these events that took place in the external world had a counterpart in the analysis. It became noticeable to me that Michael gradually adopted some of my language. He started to use expressions that I employed and, in general, words and phrasing that I could recognize as being characteristic of my way of talking. He also gradually changed his external appearance: he shaved off his moustache, he came dressed in lighter colors, and I noticed that his suits, shirts, and ties came from shops in my neighborhood. Michael slowly lost his manual worker look and behavior. When his finances became sounder, he bought himself a car which made his travels easier, but he did not mention it to me. I only discovered it by chance when closing the window as he was just arriving and seeing him alight from his

new vehicle. When I mentioned it to him, he felt embarrassed, saying he worried I should feel he was competing with me.

All these changes also corresponded to a shift in his view of his penis. This matter, which at the beginning of his analysis arose so often in his associations—almost on a daily basis—was always seen as a portrait of himself and an explanation for his failure in life, especially with women. He had the fantasy that his penis was of such a small size that if he ever managed to have intercourse with a woman, it would be like floating in an immensity. The woman would be unable to feel his penetration, and he would feel as if his penis were getting lost inside her vagina. He never doubted his erection; he did not consider potency a problem; his difficulty was with the size of his organ. Along with the changes in his external appearance and his progress at work, Michael began to talk less about his penis. When he started going out with his woman friend, he still feared he would be too small for her, although he acknowledged that she was not a large woman. He described her as being of average height and weight. Gradually, he stopped complaining and, finally, even mentioning his penis; the problem of its size seemed to vanish into oblivion.

This whole account of Michael's analysis needs an examination and explanation. As I said before, when Michael arrived, he talked about himself as of someone with no value, no stature, no relevance, and no future. He explained with a sense of shame that it all had to do with his small penis, and he suggested that his sexual organ was representative of all his personal insufficiencies. I never argued the point of his small penis with him. Whenever he tried to draw me into talking about penis sizes, what was normal, how it should be, etc., I never responded, except to interpret that he seemed to be talking about himself as a whole and not just about his penis. After some time I started pointing out that his penis was an integral part of him, perhaps an important part that he valued a great deal, but it was not the whole of him: penis was not equal to Michael; there was more to Michael than his penis. Rationally, he started to accept my in-

terpretations, especially when I drew them into a transference stance by saying that he compared himself with people around him whom he saw as superior, as authorities, myself among others, and that in his mind all of us had large penises. I think for Michael his whole image and the image of his penis formed a symmetrical relationship: important, large men in authority had large penises; conversely, men with large penises were important and large and invested with authority. This corresponds clearly to Matte-Blanco's principle of symmetry. The stance, which from the logic of the unconscious would be seen as acceptable, was seen by Michael as logical in conscious terms. In his conscious mind there was an excess of symmetrical logic, a non-vital bi-logic structure was in action, and it could not shift. He was immobilized by the feeling that big penises were equal to authority and, conversely, that authority, power, and success were equal to a big penis. Since he felt himself to have a small penis, he could not have success or power or be in a position of authority.

At this stage it seems important to mention that Matte-Blanco's concept of symmetry should not be confused with the Euclidean geometrical concept of the same name. It is also important to emphasize that symmetry or symmetrical logic is not synonymous with primary process, not only because symmetry cannot be a process since it lacks the element of time, but also because primary process contains symmetrical and asymmetrical logic; otherwise, there could not be a process. The same argument applies to asymmetry and secondary process. If secondary process consisted only of pure asymmetrical logic, there equally could not be a process; with asymmetry alone no association, no symbolization, no abstraction, could take place. Every instance of secondary process contains both symmetrical and asymmetrical logic. The difference between what we call the system *Ucs.* and the system *Cs.* is the larger portion of symmetry in the former and the larger proportion of asymmetry in the latter.

Michael's change of identification and projection brought about by interpretation can be understood when applying

Matte-Blanco's bi-logic in order to comprehend the psychodynamic mechanisms of transference and interpretation. If we look at transference, we can see that it consists basically of unconsciously equating a figure from the here-and-now (the analyst) with an image from the there-and-then, from the past. This phenomenon becomes possible only if time and space are disregarded and if parts and the whole are seen as equivalent. On the basis of Matte-Blanco's work, I postulate that the analyst and the image transferred onto him from the past must be perceived as having some features in common; otherwise, there would be no transference. These common characteristics can, of course, be real or fantasized, physical or psychological, but they must exist in the unconscious mind of the patient, who, by symmetrically ignoring time and space and by making a feature equivalent to a whole, equates a character from another time and place with the analyst and treats the analyst accordingly. This is, of course, an unconscious process: consciously, nobody takes a person from the present as somebody from the past unless a psychotic phenomenon is present. (Psychotic thought disorder is based on and has a high content of symmetrical logic.) The function of interpretation is to introduce asymmetrical thinking into the mind of the patient. When we are are successful in interpreting transference, the comprehension of our interpretation by the patient means that the transference, as such, comes to an end. What was unconscious (symmetrical) becomes conscious (asymmetrical): "Where id was, there ego shall be" (Freud, 1933, p. 80).

But interpretations, especially transference interpretations, become mutative interpretations (Strachey, 1934) only if they act on the unconscious. Reformulating this statement in Matte-Blanco's terms, it is possible to say that transference interpretations become mutative interpretations only if they act on a non-vital bi-logic structure and change it into a vital bi-logic structure. So my interpretations had to address themselves to the non-vital bi-logic structure with predominantly symmetrical logic which held Michael immobilized in a position of believing

himself to be inferior and identified with what he saw as his underdeveloped penis. In terms of transference, Michael had developed bi-logical structured unconscious feelings toward me. I was a powerful authority with a big penis, with whom he could not compete (his fear of telling me about his new car) and also a benevolent figure, but more powerful than his intellectually devalued male models (drunken pastry-seller father and plumber brother). After all, perhaps I could make his penis grow.

During his analysis it became clear to me that Michael had basically a healthy internal object stemming from his early childhood when he was brought up by what seemed to have been a "good enough mother" (Winnicott, 1965). The problem was that she had become devalued by her early death and the subsequent impoverishment of the home. In transference terms, I must have taken on the mantle of this lost mother, but perhaps as a combined ideal mother/father with a fantasied big-enough penis. I could then point out to Michael his identification with the powerful and authoritative image of his analyst in contrast to his previous identification with his weak, drunken pastry-seller father and devalued plumber brother; in this way I could bring about a change in his image of his penis. If he, Michael, is powerful, his penis is big; and if his penis is big, then he is powerful and in a position of authority (direct relation equal to converse). I believe that this shift of identification changed the projection (or perhaps projective identification) onto the penis and therefore shifted his feelings about himself, allowing him to take the necessary steps to become educated, professionally qualified, married, and able to progress in life.

It is now important to discuss projection and identification in light of Matte-Blanco's formulation about the dual actions of symmetry and asymmetry regarding his idea of bi-logic structures. In his book (1988) he refers to the concept of projective identification (mostly based on Klein's work), although he points out that projection and projective identification are not synon-

ymous. In order not to confuse the issues of this paper, I will not enter into the problems of defining projective identification. This concept is now widely used by analysts of all schools and in consequence has acquired several definitions.

When I was a medical student, Matte-Blanco, in his role as Professor of Psychiatry, told us a little anecdote in order to explain projection: he said that one day, while visiting the zoo with his children, he saw a grandfather and his grandson standing in front of the lion's cage when suddenly the big male lion gave a tremendous roar. The little grandson, visibly shaken, said to his grandfather, "Come grandpa, let's go away from here, you are frightened." I have always believed that this little story depicts beautifully the mechanism and the object of projection. But how is it possible for the mind to attribute to an object in the external world a feeling or a feature from its own internal world? Replacement of external reality by the internal world is one of Freud's five characteristics of the unconscious; it becomes possible only if one disregards time and space—the consequences of the principle of symmetry as postulated by Matte-Blanco. Projection consists of a simultaneous interaction of symmetry and asymmetry because it is a matter not only of externalizing something internal, but also of regarding what has been projected as belonging to the external world and disowning it. The act of considering what is projected as separate means reinstating the difference between internal and external, between self and object, which requires asymmetry; that is, the action of the dividing mode, the action of time and space.

The mechanisms of introjection and subsequent identification (introjective identification) seem to function in reverse direction to projection and identification (projective identification). In this case what is external becomes internal; it is integrated into the ego, or perhaps the self, and owned. What is external becomes internal by virtue of the same principle of symmetry and the consequential disregard of time and space. The unconscious is able to perform all its functions only because symmetrical

logic allows the breaching of the rules of classical logic by disregarding not only time and space, but also contradiction and denial.

All of the above phenomena are implicit in my account of Michael's analysis and its evolution. What I wish to emphasize now is the clinical relevance of Matte-Blanco's formulations. His ideas allow a logical understanding of clinical phenomena and in turn permit the formulation of interpretations which enable the patient to comprehend in his or her conscious (asymmetrical) mind what previously was unconscious and structured in a non-vital bi-logical form, and therefore not comprehensible but only prone to actions or to *agieren*, as Freud would have said.

I believe that Matte-Blanco's formulations are also relevant to technique. Since using his ideas, I have seen some change in my way of approaching patients with my interpretations. I now tend to interpret in a dual way: I use what I think is a classical formulation, pointing out defense, resistance, and their possible motives when I refer to the patient's relationship to me and the external world. But, simultaneously, I make some logical suggestion, contrasting what I see in the patient as symmetrical thinking with what would be an asymmetrical view of the same subject. An example is when I pointed out to Michael that he was not equivalent to his penis and that his penis was not the whole of him.

In Michael's case I interpret in two parallel ways: (1) I address the unconscious in a classical way, and (2) I address what seems to be the conscious mind, but is in fact symmetrical thought. It is here that I try to introduce asymmetrical thinking into the non-vital bi-logic structure. I do not call upon the conscious and cooperative adult patient's mind, as explained above. I am still addressing my interpretations to the logic that governs the unconscious, only now I see it as located in what should be the conscious. It is here that classical logic should be ruling the thought process of the patient, yet we find symmetrical logic in its place. The clinical expression of this predominance of sym-

metrical thought is the pathology we find in the reasoning of the patient.

In order to illustrate the above in Michael's analysis, I shall give an instance of my way of interpreting. When Michael mentioned his fears of being too small for his fiancée, I asked him what he meant, to which he replied that he was talking about his penis. He imagined that his fiancée would not acknowledge his penetration because his small penis would be lost in her vagina. I said that perhaps he was telling me that he could not compete with other men, such as when he did not dare tell me about his new car because he thought he was competing with me. How could he, the little patient with his little penis, compete with me, the big analyst who naturally had to have a big penis, a bigger and better car, etc.? He acknowledged what I was saying, and I added: "You are making your penis, your car, and your whole self literally equal to each other, as if they were all the same and therefore materially exchangeable." He agreed that he felt like that. I said that in dreams such as he had brought to his analysis, this could be experienced and seen the way I was explaining it but that it was strange to think in this way while being awake and conscious. He replied that he thought he understood what I meant.

The question arises whether Matte-Blanco offers anything original and new or is just renaming concepts and mechanisms known from Freud onward; whether he is in fact offering the possibility of new techniques for our treatment method. I hope that in conveying some of Matte-Blanco's formulations and insights, I have shown their relevance to clinical practice. They lead us to a clear scientific language which I believe facilitates the communication among psychoanalysts, and also between psychoanalysts and researchers and professionals from other disciplines. Nowadays it is easy to envisage a connection between psychoanalysis, systems theory, and chaos theory (Spruiell, 1993). Philosophy and neurophysiology have never been far from psychoanalysis; moreover, psychoanalysis may well be the

bridge between these two disciplines. I have always believed that psychoanalysis is a science, even a natural science; I have paraphrased Freud when I said (Fink, 1991) that psychoanalysis is "*die Naturwissenschaft des Geistes*" (the natural science of the spirit).

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BOOK REVIEWS

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AGGRESSION IN PERSONALITY DISORDERS AND PERVERSIONS. By Otto F. Kernberg, M.D. New Haven/London: Yale University Press, 1992. 316 pp.

The title of this volume promises both more and less than it delivers. In spite of the important role that discussion of aggression plays in it, it is really more of an encyclopedic collection of theoretical material and clinical observations in the long line of the author's publications. It is remarkably rich in the area of observations and formulations, which makes it a difficult volume to read straight through. Rather, it is rewarding with the kind of organized thinking into which one can dip at will from the variety of chapter headings. Perhaps the most encompassing cement of the volume involves a consideration of severe personality disorders, with Kernberg's emphasis on his understanding of object relations. Without leaving classical Freudian theory behind, he adds an enrichment of the works of many authors, including many of the British school of object relations theorists.

In the opening section, Kernberg stresses the fundamental role of affects in the organization of drives. In an area which has been deficient in psychoanalytic theory, he makes an impressive case for affect states as the essential bridge between the biological givens of the instincts and the psychic drive states. Affects are "biologically given, developmentally activated psychophysiological patterns" (p. 5) which become organized to constitute aggressive and libidinal drives. Affects are seen as comprising cognitive appraisal, subjective experience, and a muscular and neurovegetative discharge. The affects of sexual excitement and rage are the central organizers of libido and aggression. Affects always have an object relations aspect: they express a relation between an aspect of the patient's self and an aspect of one or another of her or his object representations. Ultimately, it is internalized object relations and their corresponding affective investment that constitute the substructure of the ego, the id, and the superego.

After this introductory material, the psychopathology of hatred is given a separate chapter. Rage appears very early in development; its function as an affect is to eliminate a source of pain or

irritation. As is the case with other intense affect states, the analysis of rage reactions always reveals an underlying conscious or unconscious fantasy that includes a specific object relationship. Intense attachment to the frustrating mother is the ultimate origin of the transformation of rage into hatred, which is seen as a stable and chronic state. Lengthy and fruitful discussions of sadism and masochism proceed from these initial formulations.

The volume ranges so far and wide that it is scarcely possible to summarize it in a meaningful fashion. Its many topics are dealt with in theoretical, developmental, and clinical fashion. Copious case vignettes are presented, and many technical suggestions are offered. In a way I would consider the book to be a present-day version of Fenichel's massive work, with Kernberg's own additions and emendations and a special emphasis on object relations views. There are excellent, very useful sections dealing with the analysis of transference and work with dreams.

The last section contains a presentation of the author's views on the psychodynamics of perversion, which are most interesting in light of recent controversies in this area. Although Kernberg acknowledges preliminary work and cites the possibility of significant genetic determination, the principal thrust focuses on psychological and developmental aspects. Stress is placed on the concept of different types of homosexuality, with varying aspects in their genesis. For example, preoedipally determined homosexuality is presented as organized around an unconscious wish to submit sexually to the father in order to obtain from him the oral gratifications denied by the dangerous, frustrating mother. Interesting material on the relationship of a couple suggests that a healthy, stable love relationship must include sexual eroticism derived from the integration of aggression and bisexuality. Polymorphous perverse infantile sexuality serves an important function in the recruitment of aggression in the service of love that characterizes human sexuality; and it is critical at all levels of pathology and normality. Kernberg is convinced that there are radical differences in the dynamic and structural preconditions of perverse behavior. Formulations are made which are quite specific in terms of the perversions that occur within the framework of neurotic personality organization as compared to apparently similar behavior that is found in association with more severe types of personality disorder. Significant differ-

ences between male and female homosexuality are also emphasized.

Throughout the book another important theme is evident. Kernberg offers a careful classificatory scheme of many of the conditions which he discusses; and he unhesitatingly presents their differences in terms of dynamic etiology, description, prognosis, and variations in the treatment recommendations. This aspect of the volume far transcends the utility of any DSM classification. Perhaps it suggests the way in which a really fruitful nomenclature might be reached. Terms that have often been just tossed about or rigidified with little clinical usefulness are carefully expounded. There are important sections on hysterical and histrionic personality disorders, antisocial and narcissistic personality disorders, infantile personalities, and masochism, as well as psychopathic, paranoid, and depressive types of disorders.

Perhaps it is not an exaggeration to say that while this volume is not a "good read," it offers an enormous wealth of theoretical and clinical material for the psychoanalyst who is in search of a deeper understanding of many aspects of our work. Would that I could present many more details from this volume. The obstacles in the way of doing so speak for the depth and diversity of its content.

HAROLD R. GALEF (SCARSDALE, NY)

SUPPORTIVE THERAPY FOR BORDERLINE PATIENTS. A PSYCHODYNAMIC APPROACH. By Lawrence H. Rockland, et al. New York/ London: The Guilford Press, 1992. 308 pp.

In this well-written, easily readable volume, Rockland (with several specialized chapters written by others) presents a detailed view of an important clinical issue—the psychodynamically oriented supportive therapy (given the acronym POST) of borderline patients, extending the work previously presented in his 1989 book on supportive psychotherapy. It should be noted from the outset that, to his credit, Rockland is fully aware of the pitfalls of treating all patients alike:

> Psychodynamic supportive and exploratory therapies in pure culture are models, useful primarily in formulating methodologies at the polar extremes of the supportive/exploratory continuum. . . . The twin tasks of (1) determining the appropriate supportive/exploratory mix for the individual patient at a specific

> time and (2) deciding which conflictual areas are to be explored and which handled supportively, are the ultimate tests of the skill and sophistication of the dynamic psychotherapist (pp. 39-40).

The book is divided into three sections. The first, "Theoretical Background," presents a historical overview of the concept of "borderline" and of previously published treatment approaches. The second, the heart of the book, describes the author's approach to supportive treatment in detail, from the evaluation of the patient through termination, with a strong emphasis on verbatim clinical material. Ingeniously and effectively, Rockland pairs reports of what was said in segments of actual sessions with a running commentary. The last section, "Issues in Treatment," comprises five chapters on topics which require special attention.

The first two chapters, "The Concept of the Borderline" and "Historical Trends in the Treatment of the Borderline" (the latter written by Devra Braun), succinctly present the contributions of specific authors to the development of current thinking in the field, with its areas of clarity as well as confusion. The work discussed here is largely psychoanalytic, although the descriptive approach of DSM-III and the statistical studies of Perry and Klerman, Akiskal, and others are included. Chapter 3 delineates differences between exploratory (psychoanalytic) and supportive treatment, defines the goals and techniques used in the latter, and considers such important issues as the uses of transference and countertransference, the therapeutic alliance, termination, and postulated mechanisms of action of supportive therapy. Here, Rockland recommends the strengthening of ego functions, more stable homeostasis, and improved adaptation as goals to be achieved through a focus on conscious and preconscious material, the discouragement of regression, and a series of ego-strengthening techniques such as confrontation, clarification, identification, education, and advice-giving. In Chapter 4 Rockland describes general indications for supportive therapy (as opposed to analysis, other therapies, or none at all), and goes on to discuss this issue specifically in relation to the borderline patient. Unlike Kernberg, he feels that the majority of borderline patients are best treated supportively, although this may eventually lead to more exploratory work. He speculates, for example, that borderline patients with prominent identity difficulties might best

be treated with exploratory therapy, while those whose symptoms cluster around disorders of impulse expression might require the structure and limit-setting of a more supportive approach. Much of the chapter is devoted to listing and describing clinical characteristics which might (or should) incline the therapist toward one or the other end of the continuum in approaching a given patient.

Part II, the core of the volume, consists largely, as mentioned above, of verbatim clinical material, alongside of which is a running commentary, interspersed with discussions of the therapeutic issues being illustrated. Chapter 5, "Diagnostic Evaluation and Treatment Planning," divides the process into several stages: clinical evaluation (in which detailed material is given from a series of evaluative interviews), diagnostic formulation, treatment planning, and contract setting. Many psychoanalytic readers (but none who have had to fill out forms within a hospital or clinic setting) may find the section on diagnostic formulation, with its emphasis on DSM-III-R Axes I-V, objectionably rigid. Nevertheless, it is one way of ensuring that symptoms, character, physical health, the effects of the environment, and the patient's functional capacities are all addressed.

In describing the formulation of psychodynamic issues, Rockland wisely, but too briefly, mentions constitutional factors, such as attention deficit disorder, dyslexia, and minimal brain dysfunction; many will feel that more emphasis could have been placed on such issues as neonatal temperament, capacity for soothing, early object relatedness, etc. Further, both here and in the earlier chapter on the concept of "borderline," no mention is made of the possibility of early traumata and their concurrent fantasies being recapitulated in these patients' lives—a situation which is not uncommon in clinical practice and which requires attention even in the most supportive of therapies. Indeed, psychogenetic viewpoints, whether relating to oedipal or preoedipal issues, are given little weight throughout the volume—neither Mahler nor Greenacre, for example, is cited anywhere. It could be argued that, since the style of work with patients that is being advocated here eschews genetic interpretations, psychogenetic formulations are unnecessary. Such an argument, however, would eliminate the enrichment of the *therapist's* understanding of the patient and of the therapeutic process

which occurs when early events and fantasies are understood (even if partially) and which informs the therapist's responses to here-and-now phenomena.

Nonetheless, the session material presented is fascinating, in terms of the opportunity both to "watch" the process unfold and to speculate on how the reader, or other therapists, might approach the same issues. Of particular value in Rockland's commentary is his ongoing emphasis on the effort—often against intense resistance—to engage the patient collaboratively.

In the chapters discussing early, middle, and termination phases of treatment, the case material is effectively used to highlight the therapeutic issues encountered in the course of therapy; goal-setting, limiting destructive acting out, working with maladaptive patterns of behavior, the uses of clarification, confrontation, advice-giving, and medication are all addressed. I had several questions as I read these chapters. The therapists and their relationship with Rockland are not identified; clearly, they are experienced clinicians, but I would have wanted to know more—were they in supervision, were the sessions taped, were the patients informed of this use of the material, etc.? We do not even know whether more than one therapist is being quoted, which leads to another concern: the therapists' interventions, while accurately and sensitively addressing the patients' issues, all seem cut from the same mold. There is a strong tendency toward a formal, often pedantic, and somewhat detached style. No doubt this is quite appropriate with many patients, but it is not always so with all patients. Indeed, the dimension of style of speech and relatedness, with its complexities, in terms of the therapist's personality and the patient's need, is not addressed.

Further, I had concerns about the conceptual framework being used. Most of the interactions quoted use a model of ego support within a Kernbergian system in which splitting, in its manifold meanings, is consistently the focus. My own experience, however, has been that a much broader use of analytic (and empathic) knowledge is most often necessary. Even without psychogenetic/exploratory delving, wishes, defenses, and prohibitions often require explication; separation-individuation issues and merging fantasies must be addressed; narcissistic pathology is encountered, and so forth.

The final section of the book consists of five chapters on special issues. These range from solidly useful discussions of countertransference, impulsive acting out, and the use of medication, through an unusual and thought-provoking essay on "Treatment Time" (by Samuel Perry). I found the concluding chapter, on the supportive elements of inpatient treatment, to be particularly excellent. It may be the best summary of this subject I have seen, and should be read and discussed at all levels of inpatient unit staffing.

In sum, this is a thought-provoking book on a topic which is inadequately discussed in the literature while widely practiced clinically. It might be most useful for the experienced teacher as an aid in working with newer therapists.

ABRAHAM JANKOWITZ (NEW YORK)

SHORT-TERM ANXIETY-PROVOKING PSYCHOTHERAPY: A TREATMENT MANUAL. By Peter E Sifneos, M.D. New York: Basic Books, 1992. 223 pp.

Within the realm of applied psychoanalysis, the development and evaluation of psychotherapy has received a great deal of attention and energy. This effort is beginning to repay its debt to psychoanalysis in a new way—by increasing our knowledge of the mechanisms of therapeutic action. Through the study of specific psychotherapies, we have taken another look at our ideas about therapeutic process, interpretation, relationship, influence, and corrective experience; and we are beginning to apply new hypotheses to the more general study of the psychoanalytic process. Peter Sifneos, an eminent clinician, teacher, and researcher, has worked for more than thirty years in the field of brief psychodynamic psychotherapy and has developed a specific mode of brief psychotherapy (short-term anxiety-provoking psychotherapy, or STAPP), which he believes to be highly efficacious and whose outcomes he has studied systematically in earlier works.[1]

He wrote this, his third book on the subject, to provide therapists who wanted to learn his techniques with a training handbook. It is

[1] Sifneos, P. E. (1972): *Short-Term Psychotherapy and Emotional Crisis.* Cambridge: Harvard Univ. Press; (1987): *Short-Term Dynamic Psychotherapy Evaluation and Technique.* New York: Plenum.

organized to intimately guide the therapist through the successive stages of his technique: Sifneos begins by presenting his patient selection criteria, moves on to discuss the opening phase of treatment (emphasizing the creation of the therapeutic alliance, the "use" of the positive transference, and the therapist's activity), and then turns to his central technical issues (the focus, the anxiety-provoking confrontation, and the linkage of present interactions between therapist and patient to the patient's past). He next discusses subsidiary technical issues (avoiding regression and the transference neurosis, for example) and finally termination. He concludes with a 61-page session-by-session demonstration of the technique, followed by two appendices, one on his results, the other reproducing the follow-up questionnaire used to assess treatment outcome (one year after termination, 40 of 46 patients with primarily oedipal pathology were rated as recovered or much improved).

According to Sifneos, STAPP is a brief treatment best suited to motivated, psychologically minded individuals who have achieved a neurotic level of psychic organization and who can tolerate and explore ambivalent feelings. These individuals are differentiated from those requiring psychoanalysis or long-term dynamic psychotherapy by the circumscribed nature of their complaint, a complaint that is translated during the evaluation into the "dynamic focus," an explicitly agreed upon formulation of a current transference conflict that serves as the focus of the treatment (which takes place in once weekly sessions of forty-five minutes each). While unresolved oedipal conflicts are a common dynamic focus, conflicts related to grieving, separation, and loss are also often the focus of the treatment. The therapeutic action of STAPP is thought to occur in the struggle between patient and therapist over the fulfillment of their compact—the exploration of the agreed-upon focus and the construction of links between that contemporary dynamic and earlier experiences. Patients are thought to want to explore the focus because of their "motivation to change" (determined by seven criteria) but are expected to attempt evasive actions because of the anxiety inherent in the transference meanings of that exploration. The therapist provides anxiety-provoking confrontations intended to show patients that they are running away from their compact; the therapist blocks that flight and educates

them about the history of their conflicts and evasions. ("Anxiety-provoking" is a somewhat misleading label, however. STAPP interventions, as I understand them, are not primarily designed to provoke anxiety; instead they are determined not to be deterred by it; they insistently oppose rather than support defensive activity.) While the duration of the treatment is not prescribed at the outset, once the conflicts underlying the dynamic focus are "resolved," a prompt termination is determined by mutual agreement (the duration of treatment is typically between six and twenty sessions).

As a training handbook, *Short-Term Anxiety-Provoking Psychotherapy* is addressed chiefly to the beginning therapist. As a consequence, the psychoanalyst-reader may be ill at ease with overly explicit prescriptions and occasionally troubled by the impression that quite complex and controversial issues have been disposed of by the use of oversimplifying generalizations. This is most evident in the short vignettes illustrating the basics of evaluation and technique, vignettes in which the therapist is often a trainee struggling to grasp an elementary psychological issue. Perhaps the best example of such an oversimplification occurs in the discussion of how oedipal dilemmas can be dealt with by confrontation. The reader is told that certain patients can be definitively classified as suffering only from fantasies of oedipal victory and should be confronted with the "realities" of their situations; if the patient objects, further confrontation is in order: "I know that you don't like to hear me say . . . that *in reality* you were not the favorite of your father, but what we are aiming for is the *truth*. From what I have heard from your *associations*, there is no *evidence* you were the favorite" (p. 105, italics added).

It is, of course, not unusual to discover that psychotherapeutic principles are often inadequately conveyed by theoretical and pedagogical maxims and are instead better captured by demonstrations of therapeutic process, and this is evident in Sifneos's work as well. In reading the material entirely devoted to treatment process (Chapters 5 through 7, describing three patients' evaluation sessions, and Chapter 11, demonstrating a complete treatment of eleven sessions), one is often surprised by what is accomplished by therapist and patient as the therapist fastidiously attends to the details of the patient's exposition and tenaciously opposes evasion.

These fascinating and sophisticated illustrations of technique still

reveal a fundamental difference between the psychoanalysis that Sifneos has applied to his model of brief psychotherapy and the psychoanalysis we have come to know through our reading of the contemporary American and international literature. The difference is most evident in the author's assumptions about objectivity, certainty, and authority, concepts which so starkly colored the confrontational technique that I cited earlier, a technique based upon a declaration that the truth has been perceived, a truth solely derived from the patient's associations. On nearly every page of this book one senses the therapist's allegiance to *objectivity* (he takes precise notes during sessions, for example, and extensively quotes his patient in order to overcome resistance), his reliance on the *certainty* of formulations (uncertainty fostered by the patient's opposition is the result of either resistance or a seriously flawed evaluation), and his belief in the *authority* of the method he practices (both patient and therapist explicitly declare their faith that anxiety-provoking confrontations will achieve the promised "resolution" of conflict, but they do not analyze their acceptance of this authority). The version of psychoanalysis incorporated by STAPP is a one-person psychoanalysis derived from our early years and from Freud's papers on technique; it is the psychoanalysis of the objective analyst observing the patient's struggles from the outside and opposing resistances seen as synonymous with irrationally motivated defense.

In the context of our contemporary ideas about the psychoanalytic relationship, especially in view of our assertion that psychoanalysis is interactional, interpersonal, and intersubjective—whether described from the perspective of a two-person transference-countertransference model or as a mutually created psychoanalytic dyad—we now suspect assertions of objectivity, certainty, and authority as indicators of resistance, of expectations that should be questioned and investigated rather than insisted upon.

We nevertheless have much to learn about the roles of both explicit authority and undetected influence in the mechanism of action of psychoanalysis, and psychoanalysis has much to gain from a careful study of the successes of the psychoanalytically derived psychotherapies. What Freud wrote in 1937 in a related context seems to me applicable to our contemporary study of both the psychotherapies and psychoanalysis: "One feels inclined to doubt

sometimes whether the dragons of primaeval days are really extinct."[2] It remains to be seen whether the dragon of authority is primarily allied with the forces of psychoanalysis or with those of neurosis.

DAVID A. LAKE (PALO ALTO, CA)

TELLING FACTS. HISTORY AND NARRATION IN PSYCHOANALYSIS. (PSYCHIATRY AND THE HUMANITIES, VOL. 13) Edited by Joseph H. Smith, M.D. and Humphrey Morris, M.D. Baltimore/London: The Johns Hopkins University Press, 1992. 307 pp.

All of the essays in this book are epistemologically postpositivist. They assume that psychoanalysis is something other than a natural, or even a social, science. They also tend, in varying degrees, toward postmodernism, especially insofar as they call into question the distinction between fact and fiction, concept and trope, construction and discovery. Moreover, they are by no means introductory. They presuppose a substantial familiarity with hermeneutic and postmodernist concerns. Hence they will not be to everybody's taste. They are, however, of a uniformly high quality. In fact, as one long accustomed to disappointment when it comes to such collections, I was gratified to find so much that was worth reading in so brief a compass.

The collection's parameters are suggested by its opening and closing essays. The former, by Roy Schafer, is a lucid reflection on Freud's legacy. Schafer views Freud as initiating a kind of dialogue or discourse, one that is meaningfully susceptible to linguistic and rhetorical analysis. He is sensitive to the ways in which power (especially the power of psychoanalytic organizations) has influenced psychoanalytic knowledge. And he views clinical psychoanalysis as involving the employment of deconstructive modalities. The latter essay, by Hayden White, is a reflection on the narrative aspects of historical inquiry. White grants that history involves chronicles or sequential records of events; but he emphasizes the ways in which historians employ and tell stories with these facts. Thus, the lines between historical analysis and literary criticism are blurred, and

[2] Freud, S. (1937): Analysis terminable and interminable. *S.E.*, 23, p. 229.

one focuses upon alternative ways of allegorizing events rather than upon their explanation.

The other essays in the volume do not necessarily operate within these parameters, but they do gravitate around them. At one extreme there is Dorrit Cohn's investigation of fictionality in Freud's work. She argues persuasively, against Hayden White and others who tend to reduce theorizing to storytelling, that Freud quite clearly distinguishes these two categories and uses narrative as a means to theoretical ends. Most interestingly, she demonstrates that Freud's authorial voice departs significantly from the voice(s) we find in fiction writing. In this way she turns literary analysis against those who would overextend its range.

At the other extreme are the essays by Cynthia Chase and Humphrey Morris, both of whom offer markedly deconstructionist readings of Freud. They each interpret away from what might be seen as more plausible views of authorial intent; they focus their attention upon tropes and concepts that suggest ambiguity and inherent tension; and they portray "reality" as the perpetually unobtainable object of Freud's theoretical desire.

Chase focuses upon the ambiguities in Freud's thinking about disavowal, using a reanalysis of the Wolf Man case as a way of demonstrating the centrality of the concept and its destabilizing implications. In her case even White's chronicle of events seems to slip out of our grasp. Reading her essay is like walking through an epistemological fun house: its optical illusions are striking, but one cannot help remembering that there is another world outside.

Morris does not go quite this far. Like Donald Spence,[1] he distinguishes between narrative and historical truth. But he claims that we cannot peel off narrative devices to reveal historical realities. In psychoanalysis, narration and history slide through each other in ways that defy all attempts at either/or thinking. Hence, in his view there is a fundamental, epistemological undecidability at the core of Freud's theorizing and psychoanalytic knowing more generally.

Another kind of undecidability is the subject of Robert Winer's

[1] Spence, P. (1982): *Narrative Truth and Historical Truth. Meaning and Interpretation in Psychoanalysis*. New York: Norton. Reviewed in this *Quarterly*, 1984, 53:459-466.

essay, which focuses on the private knowledge issues involved in the reporting of clinical case histories. How cases are reported and how they are read, he contends, necessarily reflect the subjective experience of reporter and reader. Case histories should not be mistaken for cold facts.

Rachel Blass and Bennett Simon investigate the interplay of fact and fantasy in Freud's evolving view of the sexual seduction of children. They argue that neither the canonical psychoanalytic interpretation (Freud's discovery of seduction fantasies) nor the critique of that interpretation (Freud's theoretical repression of the reality of seduction) is adequate. Rather, a close reading of Freud's early work shows that, from the outset, he found it difficult to distinguish fact and fantasy in patient reports—and in his theorizing about these reports. Like Morris, Blass and Simon conclude that such ambiguities are intrinsic features of psychoanalytic knowing.

Thelma Lavine picks up the theme of interpenetrating opposites in psychoanalysis from another angle. Her essay is an appreciative critique of the work of Paul Ricoeur, especially his *Freud and Philosophy*.[2] Briefly put, she contends that Ricoeur fails to recognize that Freud's thinking is rooted in Romanticism as well as in the Enlightenment. The split between science and hermeneutics that Ricoeur finds in Freud is a feature of his interpretive perspective, rather than of the object he is interpreting.

Lavine's essay moves in the direction of a cultural understanding of psychoanalysis. Sherry Turkle extends this line of analysis in her finely wrought interpretation of the dissolution of Lacanianism in France. Turkle is, of course, an expert on the politics of French psychoanalysis, and one reads her with a respect for her mastery of the relevant historical materials. Of special interest here, however, is her portrayal of the "myth of the well-analyzed analyst" (p. 255). She is most of all concerned to show how this myth helped to link the psychoanalytic movement to a broader French psychoanalytic culture. But the concept also has epistemological implications: if the well-analyzed analyst is indeed a myth, then we cannot claim

[2] Ricoeur, P. (1970): *Freud and Philosophy. An Essay on Interpretation*. New Haven: Yale Univ. Press. Reviewed in this *Quarterly*, 1972, 41:436-443.

that our practice frees us from the illusions which we analyze in others. Consequently, we must give up even this claim to epistemological privilege.

The cumulative effect of these essays is to shake us out of our dogmatic positivistic slumbers, if indeed we still have been sleeping. Whether or not one agrees with their conclusions, one must take their arguments seriously—not least because their construals of psychoanalytic epistemology come closer to actual clinical experience than accounts that stress the scientific validity of psychoanalytic inquiry (see also Wolfenstein, 1993, Chapters 5 and 9).[3]

The other three essays are less epistemologically oriented. Joseph Smith traces the origins and functions of aesthetic experience to early infantile experiences of imaging, Richard King depicts various intersections of politics and psychoanalysis, and Barbara Johnson offers a sensitive self-psychological interpretation of works by the African-American novelist Nella Larsen. Johnson also makes the point that the contradictions of selfhood that Larsen portrays "cannot be understood apart from the stereotypical overdeterminations . . . in American society as a whole" (p. 195). Indeed, the one major limitation of this collection is that its reflections on historicity are pretty much sealed off from social history. Only Turkle and Johnson take history seriously. Even King, who gives some attention to Frantz Fanon and the Algerian revolution, tends to reduce emancipatory struggle to psychotherapy.

This disavowal of political reality is hardly accidental. Although psychoanalysis quite properly calls our attention to the subjective dimension of historical processes, it also tends to subjectify objectivities. When this tendency is linked to postmodern epistemological subjectivism, psychoanalysis becomes historically abstract. And, as Turkle's work reminds us, in the United States we lack a psychoanalytic culture that might pull against the hermeticism of organized psychoanalysis.

EUGENE VICTOR WOLFENSTEIN (LOS ANGELES)

[3] Wolfenstein, E. V. (1993): *Psychoanalytic-Marxism. Groundwork*. New York: Guilford.

PSYCHOANALYSIS AND ETHICS. By Ernest Wallwork. New Haven/ London: Yale University Press, 1991. 344 pp.

For years, most commentators have contended that Freud's portrayal of the human subject made any notion of genuine moral agency impossible. Freud, by his own proud admission, was a determinist who belittled the concept of free will. The Freudian subject, as exemplified in quotations from his texts that span his career, is driven by instinctual forces, governed by a principle whose goal is pleasure, consumed by base passions, perennially infantile, narcissistic, and incapable of regard for or attachment to others which is not fueled by self-interest. Quite clearly, such a subject is incapable of what we commonly think of as moral responsibility. Psychoanalysis, in fact, is seen by some as an important prop in the ideology of selfishness and privatism that they see as characteristic of modern Western societies.

Given the predominance of this reading of Freud's subject, psychoanalysts and moral philosophers have generally had little to say to each other. Some philosophers have proposed a different reading, one which finds a quite different picture of human nature—one more amenable to rational choice and agency—embedded in Freud's clinical (as opposed to metapsychological) theory. These authors (notably Ricoeur and Habermas) have developed their view of the psychoanalytic subject by declaring that a deep contradiction runs through Freud's work, what Habermas terms his "scientistic self-misunderstanding."

In *Psychoanalysis and Ethics*, Ernest Wallwork, a psychoanalytically trained moral philosopher, develops a view which challenges these earlier construals. On the basis of a reading of Freud's entire corpus (metapsychology, clinical writings, social theory, correspondence, etc.), he proposes through careful exegesis to make a case for the emergence in Freud's thought of a view of human nature which both allows for rational moral deliberation and action and makes a contribution to answering the questions posed in philosophical ethics. His approach is interdisciplinary. It utilizes meta-ethical analysis to clarify the implications of the psychoanalytic view of human nature. At the same time, it employs psychoanalytic understanding to enrich the moral psychology informing the view of moral agents who are the basis of ethical theory. He seeks neither to subsume

ethics under psychoanalysis nor to demand that it function as a full-blown moral philosophy. Rather, he takes the two traditions on their own terms to see what they might have to offer one another.

The book is divided into four main sections followed by an appendix. Part I takes up the hermeneutical problems of reading Freud and the foundational question of whether the way Freud understands "psychic determinism" undermines moral responsibility. Part II deals with psychological "egoism" and the possibilities of moral conduct by tracing the pleasure principle, narcissism, and object love through Freud's writings. Part III examines the normative implications of psychoanalytic findings and therapeutic practice. In Part IV, Wallwork builds upon the earlier analysis and proposes a general ethical theory compatible with his reading of psychoanalysis. Finally, in a short appendix, he takes up the question, "Why take psychoanalytic findings seriously?"

As Wallwork makes clear at the outset, for the purposes of his analysis, psychoanalysis is taken as synonymous with the work of Sigmund Freud. Of his rationales for this strategy, the most interesting is his assertion that, upon careful examination, all of the major movements in the recent history of psychoanalysis are anticipated in Freud's writings. Yet, this also reflects an important hermeneutical dilemma. Contradictory cross-currents exist not only between texts separated in time but within individual texts. Freud was notorious for maintaining the nomenclature of theories he had long transformed or abandoned without clarifying the changed meaning of terms in their revised theoretical context. Ghosts from the conceptual past pop up unannounced and unexplicated. In addition, Wallwork freely acknowledges that, taken over the course of his writings, Freud can be shown as equivocal on almost everything bearing on moral psychology. Nonetheless, by viewing Freud's thinking as a development through three broadly coherent stages, he plausibly presents a psychoanalytic theory of human psychology which allows for meaningful moral agency as the outcome of Freud's theoretical evolution.

Wallwork's division of Freud's thought into periods provides the context for his discussion of the evolution (and often the confusion about) critical theoretical concepts. The first period, from 1883 till roughly 1899, is the period of the "trauma paradigm" that rests on a "passive reflex model of the mind" in which "excitations" are

conveyed to the central nervous system which seeks to rid itself of stimulation. There is not yet an explicit drive theory. The second period, from approximately 1900 to 1919, is ushered in by the postulate that fantasies are also realities. This period centers on exploring "psychic reality," with the related development of a drive model wherein drives are viewed as determinative and environmental factors as contingent. This drive theory no longer depends upon a neurobiological explanation, since the mechanistic forces are almost entirely within the mental rather than the physical realm. Mind behaves like a "thing," but one with its own internal forces. The third period runs from 1919 to the end of Freud's life. The psyche is now pictured as an organism and a developing self in interaction with its environment. Instincts are identified, increasingly over the course of the subject's development, with their long-range aims. The ego and superego are defined by their structural-functional properties, such as perception, reasoning, and intentionality. Anxiety is tied to the ego's awareness of danger. As Wallwork puts it, Freud "came to accept the facts of ordinary consciousness and intentionality as irreducible aspects of human nature" (p. 47).

It is an attractive scheme. Nevertheless, Wallwork has some big-time explaining to do to make a convincing case against competing interpretations in the light of Freud's own words. Which is, of course, what he sets out to do. Since everything further conceptually rests upon it, he must first show that Freud's conception of "psychic determinism" is not one which would make any notion of moral responsibility meaningless. His argument is that Freud was moving toward an understanding of determinism appropriate to the psychological sciences that would account for the relatively free decisions and choices of comparatively mature, healthy adults. He never abandoned the postulate that everything is determined by causes, but implied that causes which govern not physical things, but mental activities, are of a different character. The psychic determinism to which he subscribed, Wallwork argues, holds that all psychological behavior is *motivated* and guided by the regulatory principles governing psychic behavior. It does not imply that any such behavior could not be other than it is. Once a person has reached a level of maturity, she may, through the exercise of ego functions, self-reflectively examine her motivations and, within the limits of the determined aspects of her behavior, introduce novelty

and affect the future. In other words, she has sufficient free will to be viewed as a genuine moral agent.

Over that hurdle, Part II is devoted to demonstrating that Freud's subject is not a morally hopeless "psychological egoist," constituted so that she seeks—and can only seek—her own welfare or self-interest. If this were so, we would be incapable of being impartial or "other-regarding." Wallwork must make this case in the face of Freud's extensive and acerbic debunking of what he dismissively referred to as "civilized morality" as well as the substantial obstacles posed by the concepts of the pleasure principle, narcissism, and object love, all of which have been used as evidence of the Freudian subject's incapacity for altruism.

Wallwork argues, in line with his dividing Freud's thought into periods, that the pleasure principle evolved from an unmediated mechanism of tension discharge through a conception mediated by the ego's growing appreciation of "reality" (both "inner" and "outer") to a version where pleasure as a prospective goal encompasses "a multiplicity of qualitatively distinct types of experiences" (p. 124), with the ego able to make choices with a long-term view of one's life as a whole. In philosophical terms, Freud's subject may be a "psychological hedonist" (i.e., happiness seeking), but there are qualitatively distinct means to that happiness. It need not be a product of immediate libidinal or aggressive discharge, and it need not rule out behavior or motivations which we commonly call altruistic.

Narcissism poses a similar problem. In Philip Rieff's influential reading, *Freud: The Mind of the Moralist*, psychoanalysis is seen as holding that all human relations are merely devious means of self-love. In this view, Freud implies that even when we appear to be acting on principle or unselfishly, our hidden motivations are basically egoistic. There is no question that we are cognitively capable of taking the interest of others into account, just "whether we are psychologically capable of genuinely intending the good of others for their own sake" (p. 139). Much of what Wallwork takes to be the "superficiality" of this line of argument he believes derives from the ambiguities in Freud's uses of the term "narcissism." He adduces four subtypes: narcissism as 1) a developmental stage (and even here Freud equivocates over which period it refers to); 2) a type of object choice; 3) a mode of relating; and 4) a self-referential atti-

tude. After reviewing the development of the concept through these subtypes, Wallwork asserts that "while narcissitic motives are generally contrasted with object-regarding ones, some types of narcissistic motives turn out to be compatible with, even positively supportive of, genuine object love" (p. 142). While earlier developmental stages always persist alongside later ones, this does not imply that all adult motives are reducible to egoistic ones held over from primary narcissism. Egoistic motives co-exist with more developed ones with which they form complex combinations.

Similarly, there is confusion over the nature of normal (or "anaclitic") object choice, since there are elements of projected narcissism in romantic love. Wallwork shows that what is decisive for Freud is not whether such elements are present, but "whether the self or the object predominates. In loving others, narcissistic motives play a not insignificant role even in the normal case, but non-narcissists do not love the other *solely* for the ways in which they aggrandize or gratify the self narcissistically" (p. 151).

Ironically, the final two senses in which Freud uses the term "narcissism" both assume an achieved level of object attachment. One of these, understood as akin to self-esteem, Freud saw as enhanced by object love, but this was in contradiction of his economic theory of the period. It was this incompatibility of his developing understanding of self and object love with the drive-discharge model which led Freud to the ego psychology of his last works. For a subject capable of moral behavior to emerge from this theory, object love must be characterized as contrasting with narcissism in being significantly non-egoistic. For psychoanalysis, object love is libido turned outward to a representation of an object outside the subject. But whether this implies authentic concern for other persons for their own sake is ambiguous in psychoanalytic writing. While Wallwork shows that even Freud's formulations using the drive theory of the "second period" strain beyond their explicit view of objects as instrumentalities for gratifying instinctual aims, it is again in his work, "Beyond the Pleasure Principle," that "an object-relational account of genuine other-regard" (p. 172) may be found.

In 1920, Freud recast his view of the psyche as fueled by two grand opposing forces, Eros or life instincts and the death instincts. It is through his revised conception of object love under the sway of Eros that we get Freud's most developed picture of both the self

and its relation to others. Eros is no longer merely libido but also "impulses of an aim-inhibited or sublimated nature as well as the instincts of self-preservation" (p. 180). These seek to create "ever greater unities" by prolonging life and bringing it to greater complexity and "higher development." This drive toward unity and complexity profoundly alters the relation of instincts to objects which now exist as separate persons toward whom the life instincts direct the subject throughout development. In Wallwork's reading, Freud's libido has become object-seeking. The object is now seen as playing an essential part in constituting the subject through the processes of identification, internalization, and introjection. Object relations can now be integrated into metapsychology, and a new view of love with various combinations of sensuality and affection, narcissism and selflessness, can now be envisioned without artificially separating out the egoistic aspects of love. Freud can now assert that "genuine morality is instinctually grounded in natural desires springing from Eros, whereas inauthentic morality consists in narcissistic and egoistic obedience to moral principles in order to avoid punishments or gain rewards" (p. 188). Wallwork concludes that "the narrowly possessive and discharge seeking connotation of the sexual instincts in Freud's earlier writings yield in the post-1919 period to a concept of Eros that encompasses sympathetic identification that in turn supports the respect and benevolent concern for others upon which genuine morality rests" (p. 189).

Satisfied that he has established the potential moral competence of the Freudian subject in light of contrary philosophical commentary, Wallwork spends the remainder of the book on the offensive. While not explicitly announced, a perceptible shift occurs. Psychoanalytic understanding is now brought to bear upon the major traditions in Western moral philosophy. The Freudian view of human nature undermines much of ethical theory on "ought implies can" grounds. In other words, it is fallacious to assert that people should act in a certain way or on certain principles if such is not possible for the types of creatures they are. For Freud, divorcing our desires from our ethical reasoning is just such an impossibility. Indeed, only by recognizing the constraints on reason can its province be expanded.

Such a position is at odds with the basic premises upon which

Immanuel Kant founded perhaps the most philosophically influential tradition in ethics since the Enlightenment. Kant characterizes practical reason as a duality between a rational self that generates "categorical imperatives" (i.e., absolute, unconditional moral laws, binding universally on every rational will) and a sensuous self that is "subject to the play of impulse, habit and desire." Kant's "fact of reason" is that will should be determined in opposition to any sensuous desires. No ulterior purposes are ethically permissible, only those that can be made universal through a "categorical imperative." In opposition, Freud argues that conscience cannot be separated from desire, where it is developmentally grounded. Any attempt to sever conscience completely from desire is bound to fail. Wallwork comments, "It is only by understanding the subtle unconscious connections between conscience and desire that we begin to find the degree of distance from desire that is optimal for practical reasons" (p. 234). In this view, the Kantian ideal is the obsessive, but Freud shows how such isolation of affect from practical reason subverts itself not only through rigidity and the breaking through of symptoms, but also intense guilt. Other-regarding sentiments from deep within the self are more reliable than cognitive decisions divorced from affect. They are thus a more genuine basis upon which to ground morality than are "categorical imperatives," as they are reflective of greater authenticity. This is why psychoanalysis opposes "repressive" moralities both within the self and in the larger culture. By resolving "neurotic conflicts based upon excessive superego moralizing," one gains an increased capacity for moral authenticity that comes from getting in touch with genuine other-regarding sentiments. For Freud, psychoanalytic therapy has moral development as one of its goals. But he always places this in the context of individual endowments and experiences. He writes that after a successful analysis, ". . . whoever is capable of sublimation will turn to it inevitably as soon as he is free of neurosis. Those who are not capable of this at least will become more natural and more honest" (243). He does not believe, with Aristotle and the self-realization exponents like Maslow and Rogers, that the model of the relatively happy person is one who freely actualizes her innate potentialities in a particular social environment. Freud's subject can find deep and authentic satisfaction in life only through the

suppression of some and the transformation of most of what is innately given. It is a sober view of the human potential for happiness, but not nearly so pessimistic as the one which we have come to associate with Freud.

Wallwork concludes by reiterating that Freud's important contribution to ethics is his straightforward acknowledgment of unconscious determinants of behavior as well as the depth and ubiquity of narcissism and aggression. This stands along with the strands in his thought which point to the possibilities of genuinely other-regarding behavior as the outcome of normal development and/or psychoanalytic therapy. He believes that we require a "mixed-motive perspective" which directs us to carefully scrutinize the motives for adopting ethical standards with a countervailing suspicion of the unmasking enterprise itself, lest we subvert all reasonable motives and standards. For Freud, the injunction to "know thyself" is, of course, quite central. Self-examination and candor are necessary and primary ethical acts, but equally so is the self-acceptance of one's instinctual nature. His understanding of human functioning entails accepting irresolvable tensions in the moral domain. In his abjuring of impersonal, impartial principles—the so-called "moral point of view"—as based in an impoverished view of the self, he implicitly appreciates the move of Gilligan and other feminist philosophers toward developing an "ethics of care."

As is already abundantly evident, if one has only a casual interest in either the contours of Freud's thought or the basics of ethical theory, this book is not the ticket. While Wallwork keeps debates with other contemporary philosophers over particular points in ethical theory confined to footnotes, these frequently take up half the space on the page. Although these are often fascinating, they also reflect the intended audience for this erudite and admirably well-written work. Both scholars of psychoanalysis and students of moral philosophy will find in this book a treasure of arguments to assess and points to ponder on a wide range of specific and global questions in their overlapping fields. Such a contribution, with, to my knowledge, few peers in the literature, will find a small but appreciative audience.

JOEL GREIFINGER (CAMBRIDGE, MA)

FREUD'S WOMEN. By Lisa Appignanesi and John Forrester. New York: Basic Books, 1992. 563 pp.

Few areas of twentieth century intellectual endeavor have welcomed a greater number of gifted women or afforded them more opportunities to make impressive contributions than the field of psychoanalysis. Yet it is often held, both by those who have a close familiarity with Freud's oeuvre and by those who do not, that Freud's view of women was at best partial, historically contingent, and unresolved, and at worst deprecatory; thus, it seems puzzling that psychoanalysis has nonetheless attracted from its earliest phases up to the present time a dazzling array of brilliant and creative women thinkers. This enigma, central to a consideration of Freud and women is addressed by implication in the book under review here; but, like much else that bears on the polemicized topic of female psychology, it remains to pique us after we have closed the covers of this aptly titled, eminently readable book. *Freud's Women* blends history and theory on low speed in a gentle mix and is destined to please, inform, and entertain a general audience.

Addressed to such an audience, it flings open a wide new gate upon the old city of Freud studies; thus, while we arrive by engaging and picturesque new paths, the sites we encounter are largely familiar. If it can be said that Freud studies seem even now, in this *fin de siècle*, to divide roughly into two camps, the works that remain respectfully within an essentially psychoanalytic framework and those that baldly attack, the book under review here falls squarely in the former camp. It is aptly titled because the women depicted within it remain by the end and throughout its text precisely that, namely, *Freud's* women; that is to say, they are ever women as conceived within the context provided by psychoanalysis. Perhaps by now it is not possible to do otherwise.

Freud's Women delivers a compendium rather than a critical text. Its major sections, devoted in sequence to Freud's family experiences with women (his mother, nurse, wife, sister-in-law, daughters), his array of female patients, his women friends and colleagues, his theoretical work on female psychology, and, ultimately, the trenchant critiques, feminist and otherwise, that have for some half century now been leveled against it with increasingly wide-

spread acceptance are presented in lively detail but left unconnected. Like the separate quarters of the old city, each section of the book stands on its own, and the book's title, like the wall that surrounds what was once ancient Jerusalem, lacks what is needed to integrate as opposed to unite them.

Devoting enormous numbers of pages to detailed reviews of well-ploughed biographical and historical terrain, the book introduces some intriguing anecdotal matter, such as a vignette that recounts Freud's affectionate but firm dismissal of his young fiancée Martha's mention to him that she sensed an undercurrent of erotic feelings brewing in her friend Bertha Pappenheim's treatment with Josef Breuer (p. 82). This vignette, typically however, is never related to a comment previously made that in her mature years, "Martha cultivated her ignorance of her husband's work as part of their agreed-upon division of labour. Her trust in his work was unshakable because it rested on trust in his person. This may have made things easier for Freud at home . . ." (p. 45). Indeed, although Freud's necessarily changing behavior within and feelings about his own lengthy marriage and daily life as a husband and a father are described, they are never connected with his contradictory views of marriage both as a "happy ending," a "safe harbor" for young female hysterics, and as an institution that, as he also believed, bred pathogenic constriction and disappointment for both men and women.

In general, *Freud's Women*, aside from its historical focus, also serves as a competent review of theory, female psychology in particular, culled directly from *The Standard Edition*, and works as a well-honed, carefully researched introduction to Freudiana for relative newcomers or, with respect to clinical and more scholarly readers, a well-organized digest of data gathered from perspicuously selected secondary and primary sources; never, however, does it provide or attempt a synthesis.

Consider the portrayals in the book's early sections. Despite the increased data provided about their lives, the women of Freud's family and early practice rarely emerge on stage fully blooded to speak, nor do they move with energy or lassitude of their own. Rather, as in the past, they appear behind heavy scrims. They remain in purdah. Curiously, the added facts—notably, for exam-

ple, with regard to Freud's first patients, their far greater knowledge and experience of sexuality than Freud had granted when he attributed their symptoms to frustration, inhibition, and thwarted desire—fail to illuminate their complex subjectivity in such a way as to enable us to grasp more sensitively the nuances either of his limitations or indeed of his accuracies. Oddly, although he demonstrably drew from the colorful tapestries of their lives only a limited number of threads to reweave into a recurrent pattern of his own making (in the *Studies on Hysteria* in particular), and although the authors of the book under review here aim to reveal "the tension between biography and psychoanalysis" by restoring these tapestries, the result often fails to bring us closer to the individual women or to a clearer grasp of their suffering.

The preface reads: "Enter the mother." But where is she? Could it be that Freud in the case histories, despite his partial and highly contrived renderings, actually brings us closer to the inner worlds of "Emmy von N." or "Katharina" than we are after acquiring the additional, external information supplied here to the persons of Fanny Moser or Aurelia Kronich, who remain figures impaled behind translucent curtains? Is such a thought *retardataire* or *avant-garde*? Heretical or orthodox? For, while discrepancies between "Anna O." and Bertha Pappenheim, "Dora" and Ida Bauer, are noted, incisive, focused critical questions concerning them are left open: such as whether we are dealing with one fiction versus or supplementary to another, rather than simply fiction versus fact. And the subjective experience of the relevant mothers (Käthe Bauer, for instance) remains tantalizingly remote.

Such unaddressed questions do in this context matter. *Freud's Women*, winningly written, deserves a sequel that pushes harder in two directions one historical and the other theoretical: first, one that seeks to find the *actual* laughter, the tears, the strident sometimes gentle voices of those lost, other, forgotten women; and a second that takes its historical work as a ground for insightful new perspectives on the evolution of twentieth century female psychology and a metacritique of its own methodology.

Contemporary scholars such as Hayden White in his writings on "metahistory," historians Natalie Zemon Davis and Carlo Ginzberg, "new historicist" Stephen Greenblatt, eighteenth century scholar

Ronald Paulson, and the pantheon of influential French cultural critics, among them, Roland Barthes and Michel Foucault, have in recent years redirected our attention to the forms and contexts of history. They have engaged us in searches that refuse to presume transparency. In unique ways, they have attempted to track what might be called "*Wandelsbedeutung*," the meanderings through which stories (histories) pass as they are told at given times and places and by some and to others, how, in other words, their meanings vary. They have queried the subtle codes by which events are given signification or suppressed, and noted their occasional later reprocessing in altered versions under circumstances charged with powerful political and socioeconomic entailments. They have seen that, in history as in case history, new stories are often told in guises that preserve the formal structures of the old and that details which escape observation, sometimes even for generations, suddenly leap out of the grey to be illumined by flashes of recognition and fascination. Implicitly, their work challenges received notions of historical truth; it dares us to say with certainty when revision is distortion and when revision is correction.

Perhaps in Freud studies historical works are needed that go beyond presentation, review, and exploration. Again and again, we hear there must have been mothers Freud ignored in his treatments and adult women in strife over their relations not only to fathers but to husbands, daughters, and sons. On that note, when interpretations are forthcoming here, their (sometimes ironic) links to what has preceded and followed them are occasionally missed. Yet, in wandering through the rich data provided by the authors, each reader will indubitably discover new linkages of her own.

A final word about the shared parenting of this book. A few open moments of discord over conflicting interpretations of data would have been wonderful. Parenting can be a rough business at times, and negotiations over this highly charged material between a male and female author team might have added a special timbre to a crucial note that is now missing. Despite these qualifications, however, *Freud's Women* deserves high praise for the comprehensive and pleasurable tour it gives us through a realm that will never lose its fascination.

ELLEN HANDLER SPITZ (NEW YORK)

FREUD AND THE HISTORY OF PSYCHOANALYSIS. Edited by Toby Gelfand and John Kerr. Hillsdale, NJ/London: The Analytic Press, 1992. 397 pp.

In 1990 the Hannah Institute for the History of Medicine sponsored a conference in Toronto on "Freud and the History of Psychoanalysis." Professional historians and an assortment of other humanist scholars were the principal participants. Practicing psychoanalysts were in short supply. The fourteen papers appearing in this volume were the main products of the conference. All were "revisionist" essays—departures from those "official" and largely laudatory accounts of the emergence of psychoanalysis that tended to be written by psychoanalysts. In varying degrees, all fourteen found Freud and his followers less innovative, daring, and clinically effective than "official" accounts indicate. However, no more than one or two of the fourteen displayed personal animus toward Freud or his movement, and none demanded reformation of current psychoanalytically informed clinical practice. Hence, the "revisionism" was primarily on scholarly grounds. None of the contributors wrote preponderantly as "reformist" crusaders against the psychoanalytic profession.

Conference papers addressed four overlapping topics. One of the most interesting concerned thinkers who had anticipated Freud in various ways. Steven Marcus illustrated convincingly how Wordsworth had developed a narrative mode which closely resembled the psychoanalytic life history. Unconscious desires and ideas were central. Like the psychoanalytic life history, Wordsworth's narrative was circular (i.e., neither linear nor unidirectional); it housed confluent and plural meanings. Rosemarie Sand disputed Freud's claim of discovering alone the central meanings of dreams. Freud had been moved in this direction by Charcot, Janet, and Krafft-Ebing. As he described Freud's stay in Paris in 1886, Toby Gelfand revealed how Charcot not only gave Freud his concept of hysteria; Charcot and his Parisian colleagues also did much to broaden Freud from a neuropathologist specializing in female hysteria toward a universal psychological theorist who focused on men and their fathers. For Marcus, Sand, and Gelfand, then, it was inappropriate to dismiss important predecessors—proximate and distant—for Freud's innovations.

Freud's life and his immediate social-professional setting was a topic that preoccupied several "revisionists." In an exciting exploratory essay, Robert Holt argued that Freud assumed the kind, nurturant quality of his father plus his mother's disposition toward manipulative domination. This explained the empathetic yet authoritarian mix in his leadership style and his therapeutic approach. Because Freud's father evidenced qualities most apparent in women and his mother displayed qualities more pervasive among men, Holt maintained that there was an implicit set of gender conflicts in Freud's work. William McGrath shifted from the familial to the broader historical setting in which Freud developed—the rise and demise of Austrian political liberalism. For McGrath, this contributed significantly to Freud's view of the opening and closing of the human mind. Specifically, his theory of how dreams functioned (concealing and revealing) was linked to the broader political conflict between forces of repression and forces of freedom. Edward Shorter's paper disputed the assumption that Freud built his following from social outsiders. In Vienna, the primarily Jewish practitioners who joined the Vienna Psychoanalytic Society and other psychoanalytic bodies came from the prosperous middle class with deep roots in the city, even though several imaged themselves as outsiders. Finally, Phyllis Grosskurth described the secret committee Freud established in 1912 to support and protect him and to cultivate new local psychoanalytic societies. Contrary to the "orthodox" perspective, the committee witnessed intense struggle and bickering among its members. For Holt, McGrath, Shorter, and Grosskurth, then, conflict was central to Freud's life and activities—the conflict of parental styles, the opening and closing of Austrian political society, the clash between some Vienna analysts' self-images as outsiders and their insider social status, and collisions within Freud's most intimate professional support group. Doubtless, such conflicts contributed (in some measure at least) to Freud's premise of a divided psyche with conflicting elements.

A third topic, Freud's treatment of his patients, preoccupied several contributors to this volume. Based on mid-1960's interviews with twenty-five of Freud's analysands, Paul Roazen concluded that Freud's actual treatment of patients differed markedly from his theories. For Frank Sulloway, the treatment record was disastrous. Freud did not cure most of his patients or even feel that they were

generally curable. Part of the problem was that early psychoanalytic practice tended to elicit material confirming the analyst's theories and expectations. Patrick Mahony focused on the case that "orthodox" history had long avoided—Freud's analysis of his daughter Anna. It was disastrous; Anna found no positive female identification and was not directed toward healthy psychosexual maturation. Hannah Decker concluded that Freud's well-known treatment of Dora was also deeply flawed. He failed to consider the influence of anti-Semitism on the patient; he ignored the role of Dora's mother; he made little of her adolescent psychological development; and he overlooked obvious issues of transference and countertransference. Unlike Roazen, Sulloway, and Mahony, however, Decker found an element of therapeutic success. By taking Dora's symptoms seriously, Freud prompted her to recall that she had been assaulted by Mr. K at the age of thirteen, and Freud gave her the courage to confront Mr. K about his misconduct.

Finally, a few "revisionists" focused on some of Freud's broader theoretical-methodological problems. Adolf Grünbaum maintained that Freud twice revised his dream theory of 1900. He ascribed traumatic dreams to repetition compulsion in 1920 and to avoidance in 1933, but he did not seek to validate either revision. Edwin Wallace underscored Freud's failure to address clearly the mind-body problem. Sensing that the essential nature of mind and matter were unknown, Freud characterized brain events and mind events as a single process with two aspects. Malcolm Macmillan argued that Freud initially adopted Koch's investigatory methods in his work on neurasthenia and not (as supposed) on hysteria. Yet, as Freud researched, he failed to control well for the causes of neuroses, and this would present problems for his successors.

One concludes the papers at the Toronto conference with a sense of the balkanization of "revisionist" historical efforts. Although the papers can be divided into four general topical areas, there were decisive differences in the interests and concerns of the authors within each area. These differences, rather than a clear "revisionist" accord on the main lines of early psychoanalytic history, suggest why conference participants rarely disagreed markedly with each other. Such balkanization was not evident among the prior "orthodox" generation of historians of the psychoanalytic movement. Less immersed in close, detailed historical research, often knowing one

another personally, and guided heavily by Freud's own historic perspective, they provided more integrated and inspiring narratives than the Toronto "revisionists."

One cost of the shift from "orthodox" to "revisionist" scholarship, then, is that wide-ranging narratives are replaced by close, often unlinked specialty projects. A general reader might hope that linkages and overviews can emerge after considerable specialized research is completed. On the basis of the Toronto conference, however, one should not count on this integration for a long while.

LAWRENCE J. FRIEDMAN (BLOOMINGTON, IN)

FROM FETUS TO CHILD. AN OBSERVATIONAL AND PSYCHOANALYTIC STUDY. By Alessandra Piontelli. London/New York: Routledge, 1992. 260 pp.

Piontelli presents the reader with the intriguing and controversial thesis "that there is a remarkable consistency in behaviour before and after birth and that many small children show signs after birth of being influenced by experiences they had before birth" (p. 23). This quotation from Freud prefaces her research: "There is much more continuity between intra-uterine life and earliest infancy than the impressive caesura of the act of birth would have us believe."[1] The young mother of one of the pairs of twins studied observes what many parents of infants tell us: "Babies are all different . . . you can see it from the start. . . ." She then touches on the heart of Piontelli's research: "I don't see why fetuses shouldn't be different too . . ." (p. 128).

Using the recent technology of ultrasonographic scans, Piontelli observed the fetal behaviors of three singleton and four twin pregnancies. After delivery, these infants were observed postnatally at intervals into their fourth year. Piontelli includes six psychoanalytic treatment summaries of young children (the oldest, Alexander, was referred at three years and fourth months) to demonstrate links between their fetal behavior and current pathologies. One of these cases, Giulia, was observed pre- and postnatally as well as during delivery.

[1] Freud, S. (1926): Inhibitions, symptoms and anxiety. *S.E.*, 20, p. 138.

Piontelli reports her observations in summary and verbatim form (which, incidentally, provides insight into the effect on expectant parents of obstetricians' sometimes insensitive comments). She follows observational methods of Esther Bick in which the "participant observer" visits the child and his or her family in their home and focuses primarily on nonverbal behaviors. Piontelli characterizes her research methodology as combining "aspects of fetal behavioural development, ethology, and psychoanalysis" and her reports as "exploratory and descriptive" (p. 1). Her theoretical orientation follows Hanna Segal and Melanie Klein. Her interest in the direct observation of fetal behaviors developed from her clinical work with young children, in which she "met daily with very vivid phantasies and representations of life inside the womb and of birth" (p. 5).

In Chapter 1, Piontelli provides an overview of research pertaining to fetal environment and behavior. She selects fetal motor behavior as the focus of her observations, from which inferences are drawn about mental functions. Movement is understood to be a "means of communication" as well as a method by which perceptual and "central mechanisms" can be indirectly studied (p. 26). The intrauterine environment is understood to vary subtly but significantly during each pregnancy.

The central finding of Piontelli's research is her demonstration of "a subtle link of behavioural and psychological continuity extending from fetus to infant and from infant to child" (p. 234). She believes this primarily motoric continuity to be a literal and "almost all-pervading linear version of their past" up until the ages of four to five, when "pre-natal life also seemed to lose its 'factual' realistic quality and became more and more coloured and changed by the phantasy affect attached to it" (p. 244). One example, Marco, a twin, substituted a quilted pillow-pencil-case for his "placental pillow." Piontelli comments that the source of Marco's continuing need for a pillow appeared deep and remote. Giulia, although a relatively inactive fetus, was a licker—consistently licking the placenta and umbilical cord; and was sensuous—keeping her hands between her legs. After delivery, she preferred licking her mother's breast and was preoccupied with the pleasures of food. When Giulia was three and in treatment, Piontelli felt that the child wanted to remain "wrapped up inside some kind of substitute uter-

ine wall within which she could instantly and constantly satisfy her addiction to pleasure," and the analyst felt herself to be like "a kind of placental background to be licked . . ." (pp. 185-186).

The prenatal study of the of the twin pairs is especially interesting because the scans reveal distinctive motility characteristic to each pair as well as to each twin within a pair.

Questions about the research methodology and the premises of the study are acknowledged and addressed. Methodological issues arise over the medical and psychological effects of the ultrasounds. There is no evidence of medical ill effect, but the verbatim reports demonstrate the shaping of parental perceptions (and the raising of parental anxieties) about their unborn child by what they observe and by the observers' comments which may affect the data on continuity of postnatal behaviors. Piontelli herself recognizes the potential for finding the answers which she was seeking because she was the sole observer at all stages of the research.

More difficult questions arise about the validity of inferences about psychological states made from motor behavior. The problem is illustrated by the ascription of adult-like, intentional motivation to fetal movements by the obstetricians. Dr. S. comments about Marisa and Beatrice (twenty-third week), "they are fighting . . . boxing! . . . literally! . . ." (p. 150). Or a comment about Gianni (twenty-fifth week), "Now the cord is there . . . he is hanging onto it . . . like to a rope! . . . always looking for an anchor . . ." (p. 78).

A second question is posed by Mr. E., the father of Alice and Luca, (twenty-fourth week). "Perhaps it can feel the difference . . . this is me, this is not me, . . . me . . . not me . . . me . . . not me . . ." (p. 131). In contrast to the view that psychological birth begins after delivery, Piontelli speculates that "some very rudimentary form of 'me-not me' differentiation" begins early in fetal life (p. 239). This view is based on the observations of fetal individuality and capacity for spontaneous, purposeful behavior.

Piontelli refers to similarities in traits of parents and of their child (e.g., the "whorishness" shared by Giulia and her mother), as well as to parents identifying traits of their own on the basis of motor actions of their fetus. Pina's fetal activity at twenty weeks labeled her as a potential "pain in the ass." Pina's mother, Mrs. C., assumes, "If it is like me or its father . . . it will most definitely be a pain in the ass" (p. 93). It was outside the scope of Piontelli's research to inte-

grate the psychological effects of parental fantasies, of parenting practices interacting with infant constitution, and of early identifications and the development of structure with the findings on motor behavior. Questions remain in the reader's mind as to whether a particular behavior of a child can be a "linear" continuation from the womb rather than an intrapsychic phenomenon developed within the psychological field of early object relations. When and how fetal motor movements take on psychological meaning and function is not explored as part of the theme of continuity.

Fascinating questions are raised about what form of memories and emotions infants may be able to bring from the womb and about what kind of intrapsychic structure is required for them to do so. Pina was "trying to detach the placenta." Soon the placenta was detached, and Pina was in danger of being "washed away" (pp. 105-106). At age three, just as her mother is to give birth to a baby boy, "Pina shows in a drawing how she herself was nearly 'washed away' " (p. 101). Isn't it possible that Pina's drawing, rather than representing a memory from the womb, expressed her wish to rid herself of the coming rival? Or could it be a reflection of her mother's expressed fears of miscarriage?

Piontelli's research, despite the questions which can be raised about it, nevertheless presents our field with a thought-provoking contribution to our consideration of previously unseen and mysterious fetal life. Psychoanalysts of various theoretical persuasions will differ in their ideas about the possible influence of fetal motor behaviors on postnatal development. Child analysts, working with patients under five, will differ in their views as to the possible influence of prenatal life on children's fantasies, defenses, and conflicts. In raising some intriguing questions, Piontelli has contributed provocatively to our speculations about fetal experience.

PAULA G. ATKESON (WASHINGTON, DC)

THE FIN-DE-SIÈCLE CULTURE OF ADOLESCENCE. By John Neubauer. New Haven/London: Yale University Press, 1992. 288 pp.

The broad scope of this book will fascinate anyone intrigued by the psychological, social, literary, and artistic dimensions of adolescence. That John Neubauer, professor of comparative literature at the University of Amsterdam, focuses on the turn of the century

(roughly 1880-1925) limits his vistas, but it enables him to concentrate on greater detail. He defines adolescence and elucidates the views that psychologists of that period held. He studies the portrayal of teenagers in literature and art, and examines Freud's treatment of Dora. He discusses literature written for and by adolescents. He demonstrates how adult influence spawned educational institutions and led to youth movements that dictated moral standards, some of which were corrupt and prepared the path to Nazism later in the century.

Neubauer's multidimensional approach casts an interesting light on the significance of adolescence. For the most part he goes along with conceptions psychoanalysts use. He recognizes the importance of biological changes at puberty and the role of society in determining the degree of stress, strife, and internal conflict. He writes about identity formation and diffusion as well as about cognitive changes. Then, in a surprise turn, he considers adolescence a "new category" that appeared at the end of the nineteenth century: "The term itself had little currency earlier" (p. 6). The emerging uses of the word determined its cultural significance and even many of its characteristics; in effect, life imitates art. (Young lovers' melancholy pining in identification with Goethe's Werther is an excellent example of this phenomenon.)

In a more radical statement, Neubauer asserts that "adolescence can be defined as a middle-class social formation in industrial societies generated by the expansion of secondary education" (p. 6). However, the author does not restrict himself to this narrow definition. His studies fit the more conventional understanding of teenagers.

Examining fictional adolescents such as Thomas Mann's Tonio Kroger and James Joyce's Stephen Dedalus, Neubauer discusses the overlapping but quite different roles of real life authors and fictional narrators. He compares adolescents as individuals and in group settings as varied as schools, gangs, boy scouts, and prisons. He is interested in the personal significance of the spaces adolescents occupy, whether the rooms they live or study in, the streets, the gardens, or the playgrounds. He describes, analyzes, and illustrates drawings and paintings that Munch, Kirchner, Kokoschka, and Schiele (among others) did of adolescents.

Psychoanalysts will be particularly interested in the chapters en-

titled "The Adolescence of Psychoanalysis" and "The Psychology of Adolescence 1890-1925." Neubauer correctly states that Freud tended to neglect the importance of adolescent experience because he thought it merely repeated the past. Later analytic theory, of course, eschewed this view; we now view development as progressive and changing, although repetitive elements play an important role. Neubauer also criticizes Freud's technique with Dora, but without recognizing the advances in theory and procedure which were developed during the period the book covers, i.e., up to 1925. Neglecting other aspects of technique, Neubauer asserts that Freud's therapeutic method consisted, in essence, of writing a history of the patient's life and that his case histories were "particular kinds of narratives" (p. 124). An unsophisticated reader would not appreciate the complexity of analytic reconstruction or the analyst's attempts to ascertain the truth; such a reader would not recognize the role of the analysis of defenses, drive derivatives, the transference neurosis, and conflict, for instance. Dealing with Freud's case history of Dora as a story, Neubauer perceptively notes that it contains two narratives, the tale of an adolescent's life and illness and the history of her treatment with Freud. It "may be compared to a 'framed' story, where the inner story emerges from an embedding conversation between the narrator [Freud] and his protagonist" (p. 126). The two plots cannot be easily separated.

Neubauer's literary insights embolden him to lash out at Freud. He criticizes Freud for not believing Dora completely, thus ignoring the fact that Freud's agreeing with her about the family manipulation of the girl helped her tremendously. He also fails to see that Freud's search for the truth about internal conflict as well as about external events has greater therapeutic value than focusing on externals only. Simply agreeing with the patient or inventing a story that is a *"bubba meiseh"* does not produce an analytic result; nor does it further analytic research. Not being a clinician, Neubauer does not realize that Freud's failure with Dora resulted to a great extent from his rushing his interpretations instead of proceeding from the surface slowly and cautiously.

The reader, whether a psychoanalyst or a student of literature, will find the studies of Karen Horney's diaries and the teachings of G. Stanley Hall, the psychologist who brought Freud and Jung to the United States in 1909, most rewarding. Indeed, the entire book

provides a pleasurable and broadening experience. The reader will find this integration of knowledge about adolescence, literature, art, history, and society engrossing.

JULES GLENN (GREAT NECK, NY)

CHARLES IVES. "MY FATHER'S SONG." A PSYCHOANALYTIC BIOGRAPHY. By Stuart Feder. New Haven/London: Yale University Press, 1992. 396 pp.

This is an excellent, intriguing biography with a rich narrative. It is not only a biography of Charles Ives and of George, his father; it is also a history of Danbury, the family seat, and of the Northeast of the period. Reading the biography is a visual experience as much as it is an intellectual one, as Feder describes the bands, the movements, the town, the country, the world of Yale, and its inhabitants. Indeed George's childhood is described so vividly that it evokes the watercolors of Winslow Homer depicting country children and their games.

Feder's main theme, richly elaborated in a prose devoid of jargon, is that George and Charlie were secret sharers and that unresolved mourning was a powerful impetus to Charlie's own creative efforts. Charles Ives redeemed his father by living a rich and successful life in music and in business, thereby undoing his father's failure in these areas. This effort was in the service of maintaining an unconscious connection with the dead father who had shared creative experiences with his son in their life together. The consistent idealization of his father in Ives's extensive writings represented a defense not only against ambivalence but also against the narcissistic injury which the recognition of his father's failure would have imposed on the fantasy of the pair in Charlie's mind.

Feder emphasizes the strong identification with his father that permeated Ives's music as he resurrected his father's songs and innovative musical accomplishments. This is not to deny the fact that such identification need not issue from loss. Matisse's identification with his mother as a creative artist was not based primarily on ambivalence. He, like Ives, took on the attributes of the parent as well as the parent's vision of the world, and then creatively modified it. Feder repeatedly alludes to this kind of phenomenon as he

describes Charlie's integration of his father's nineteenth century experience.

Feder comments on the curious absence of references to his mother in Ives's autobiographical writings, although she is said to have been an appropriately nurturant figure. There is evidence, however, that Ives's father took on a maternal role; he was apparently much more active in caretaking activities than were most fathers of the time. During the mother's pregnancy with her second son, Moss, when Charlie was between six and fifteen months of age, his mother would seek tranquility by sending George and Charlie off to the barn, where George would practice. There was a strong, nurturant connection between father and son. Hence, during this developmental period Charlie may have experienced his father as the predominant maternal figure. The birth of Moss, when Charlie was sixteen months of age, would have pushed Charlie more definitively into the hands of his father.

There were repeated separations from the father when Charlie was between two and four years of age. This must have created vulnerabilities in the son which were activated at the death of his father, who had been experienced as both a paternal and a maternal object. Feder points out that Charles's wife, Harmony, a nurse, had maternal qualities and similarly cared for him. Like George, she was a collaborator and a facilitator of his work.

Feder emphasizes that during the period of their collaboration, George developed a veto power over Charlie's creative efforts and thus contributed to his superego function. Charlie's successful integration of George's suggestions and recommendations indicates that they had ceased to be external imperatives and had come close to what Loewald calls the ego core. They had become an integrated part of Charlie's own wishes and intentions rather than superego imperatives, although regressive activation may well have brought these into play in a more primitive form when Charlie approached the age at which his father died.

A central theme is that of separation and death. George died at a time when Charlie was separated from him during his first year at Yale. It would seem that George had more manifest difficulty with the separation than did Charlie, for he was "depressed, somatizing, petulant and troublesome." Moreover, his letter in response to Charlie's announcement of his acceptance at Yale was curiously

unenthusiastic, offering only a brief congratulation and then moving on to complaints about his own emotional and physical state. Feder indicates that this was a period when "Charlie needed him least." Although this was literally true, it is probable that Charlie (as is characteristic during the phase of late adolescence) required distance and separation so that he could properly negotiate movement toward adult independence. The presence of his father, alive though distant, would have been an important facilitator of secondary separation-individuation; and George's death at this time led to difficulty in effective mourning. This was reminiscent of the earlier separations during childhood.

An important feature of Ives's life is his loss of creativity and gradual mental deterioration in his late forties, when he reached the age at which his father had died. There is a suggestion of bipolar illness with paranoid features and a concern about rage and violence. More interesting are the dynamic issues. Feder speaks of survivor guilt which impeded Ives's further creativity, and he connects it with the breakdown of the fantasized collaborative relationship at this time. He points out that George gave up music for Charlie, and Charlie may have felt the need to do this for his father through identification. But one wonders about other elements. Elliott Jaques, in a well-known paper, "Death and the Mid-Life Crisis,"[1] comments on midlife as a critical period of transition as it relates to death. Jaques points out that many creative artists cease to be creative at that midpoint in life or that the quality of their creativity changes from a painterly or more impulsive creativity to a more contained and deliberate sculptural mode. He relates this to the sense that in the middle of life, death asserts itself, leading to psychological change and reorganization. From a descriptive point of view, this, of course, touches on Ives's change and, indeed, on his awareness that he had reached George's age at the time of his death, which may have been experienced as a confrontation with death.

I would wonder about additional elements. Since surrogates are so important in coping with the death of parents in adolescence, what can one say about parental surrogates in Ives's life? There were surrogates during his Yale experience in the form of Parker,

[1] Jaques, E. (1965): Death and the mid-life crisis. *Int. J. Psychoanal.*, 46:502-514.

a music professor, who was an ambivalently viewed figure, and Griggs, a more positively viewed one. But the year 1918, the end of his creative period, also saw the death of Joe Twitchell, Charlie's father-in-law, of whom Feder speaks as a father surrogate, a figure who embodied his search for the love of an older man. In a letter to Twitchell, Charlie said, "Father died when I needed him most," and then he made a direct plea for a surrogate paternal relationship. Three months after Twitchell's death, Aunt Amelia died as well. She, like Harmony, Ives's wife, was a maternal figure. Thus, the most senior members of the family were lost. Did these deaths contribute to the decline of creative power and lead to a deterioration of Ives's personality?

Feder has written a rich, convincing psychobiography of Charles Ives which I heartily recommend. His careful study is replete with information about Ives's life, his creative work, and his world. The reader is invited to join Feder in extending Feder's understanding and in formulating his or her own views.

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Literature

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ABSTRACTS

LITERATURE

Abstracted by David Galef.

The Psychic Struggle of the Narrative Ego in the Conclusion of Troylus and Criseyde. Gale C. Schricker. **Philological Quarterly,** LXII, 1993. Pp. 15-31.

The question of authorial stance, along with the narrator's sympathy for or censure of characters, is an age-old conundrum. This is particularly true of doctrinal texts with a strong element of conflict. In Chaucer's *Troylus and Criseyde*, a fourteenth century retelling of thwarted love during the Trojan War, the Christian narrator should condemn the affair between the two lovers, but the hints of a new humanism instead turn the narrator into a divided self, advocating romantic love while at the same time urging morality.

Schricker proposes the model of a multifaceted psyche, claiming: "The narrator's behavior at the end of *Troylus and Criseyde* may, indeed, be viewed as a neurotic crisis. . . . " At certain times he seems to be vicariously participating in the sexual union, crying, "O blysful nyght," and "Why nad I swych on with my soule ybought . . . ?" (3:1317, 1320). The epilogue is perhaps the trickiest to navigate, split between a sympathy for physical love and obeisance to a higher authority. In a sense, the narrator is performing a self-analysis, trying to identify contrary forces within himself. Schricker relies on a Freudian template, with the narrator as the individual's ego, the plot of the tale as the id, and the twin voices of Christian morality and philosophical ethics as the superego. The narrator's vacillating behavior thus emerges as the ego's mediating between the id of the tale and the objective reality represented by the audience. Or, as the study concludes, the narrator "functions most simply as a human being struggling through the difficult process of making an identity by integrating the conflicting components of self and reality."

"Amor Matris": Mother and Self in the Telemachiad Episode of *Ulysses*. Marylu Hill. **Twentieth Century Literature.** XXXIX, 1993. Pp. 329-343.

Though the vexed issue of family identity is older than Oedipus, Joyce's Stephen Dedalus in *Ulysses* faces a dual bind. Stephen must confront both his biological mother, now dead, and the symbolic mother produced by his anxious consciousness. Both figures lack subjecthood; in fact, as Hill contends, "Only by silencing and objectifying the mother can Stephen satisfy his infantile craving for oneness and his adult need for autonomy." To expand the paradigm: Stephen must resolve the tension between the law of the father and the selfhood of the mother to create the potential for a new self.

As Nancy Chodorow, Jane Gallop, and others have noted, differentiation is based on perceived otherness. The death of Stephen's mother paradoxically precipitates a crisis by forcing Dedalus to accept the fact of her self, recreating her image through language and memory. Yet maternal images in *Ulysses* are often monstrous: the all-encompassing sea in the Telemachiad section, or the rotting corpse in the Circe episode. The creativity, fertility, and sex that she further represents are equally

beguiling and intimidating. Stephen deals with this overwhelming affect in part through his own control of language, turning the dithyramb, "'Tis time for this poor soul/To go to Heaven" into " 'Tis time for her poor soul/ To get out of heaven." Hill compares this maneuver to the *fort/da* game described by Freud in *Beyond the Pleasure Principle*, in which a child makes his toys appear to vanish and return as a means of controlling his anxiety over his mother's absence.

Stephen also wishes to participate in the symbolic order of culture represented by the father (in Lacan's model, the child moves from the imaginary or maternal sphere to the symbolic or paternal realm). In fact, Stephen does catch occasional glimpses of his mother's humanity, recognizing her identity, yet he progresses little further. In the culture Stephen inhabits, given his specific neuroses, he is condemned to re-experience "the dominating character of the paternal order and the figure of the mother which constantly haunts and subverts it."

Code of Silence: Laura (Riding) Jackson and the Refusal to Speak. Peter S. Temes. **PMLA** (Publications of the Modern Language Association). CIX, 1994. Pp. 87-99.

If censorship is a charged topic, self-censorship presents a further polemical complexity. Around 1942, the poet Laura Riding, later signing herself Laura (Riding) Jackson, made the surprising move to reject all poetry, including her own, "casting out along with her poems the vulnerability that attends statement." She also refused others' interpretations of her poems and later prevented the reprinting of her own poetry. As Temes argues, in this way Jackson was able to wrest artistic control from the critics by refusing to write (a pre-emptive strategy of withholding, and perhaps a form of passive aggression as well).

Jackson's poems criticized the patriarchy, from social mores to her relationship with Robert Graves, yet Temes points out the "closed system of self-justification" in her own writings. Analyzing poems such as "Back to the Mother Breast," he notes the images of "Clean bone" instead of milk, with "the vague infant cheek/Turned away to speak." Herein lies a rejection of maternal oneness in favor of a move toward language and individuation. Such, at least, is the substance of things hoped for. In "Memories of Mortalities," the longest of Jackson's pieces in the 1938 *Collected Poems*, the "I" and "you" initially represent the female voice and the male domination of the father, and though the speaker finally attains a moment of separation and empowerment, the period is transitory. Jackson did return to writing in the 1970's, but as a critic commenting on her own and others' work, as an analyst examining the tensions between art and society.

Forum der Psychoanalyse. Zeitschrift für klinische Theorie und Praxis. IX, 1993.

The following abstracts are edited versions of English summaries which appeared in Forum and are published with the permission of the journal.

Why Can't a Woman Be a Man—in the Transference? Frank M. Lachmann. Pp. 1-9.

On the level of their unconscious significance, past experiences may shape the transference irrespective of the real gender of the analyst. By describing an analytic

process, the author demonstrates how traumatic experiences with men unfolded within the transference between a female patient and her female analyst.

"The Expectation of Eternal Fame . . .". Freud's Dream Theory: The History of Its Origin and Its Significance for the Third Generation. Jochen Peichl. Pp. 10-25.

In publishing analyses of his own dreams, Freud gave us an impressive contribution to the early history of psychoanalysis. These analyses not only show Freud's struggle with the further development of metapsychology, but also make clear his conflict over his burning ambition and his desire for "eternal fame" after death. This paper examines the question of whether Freud's self-disclosure has hindered discussion of dream theory.

Imaginary Age. Harry P. C. Stroeken. Pp. 26-34.

People may have perceptions of their age which do not correspond to their actual age; sometimes there is a true split. As with neuroses, one must differentiate between the conscious and the unconscious concept. As one ages, one tries to fool oneself and others. This is illustrated by examples from clinical psychoanalysis, biography (George Simenon, Annie Schmidt), and literature (*Peter Pan* by James Barrie, *The Tin Drum* by Günter Grass, and *The Picture of Dorian Gray* by Oscar Wilde). The author examines the unconscious motives for this fixation or regression, and how analysis can assist in reconciling chronological and perceived age.

The Practice of Long-Term Analytic Psychotherapy. A Re-evaluation of the "Prognos"-Study. Hartmuth König; Peter Schraivogel; Peter Wegner. Pp. 35-45.

The authors present follow-up research on the influential 1988 study, "Psychoanalytic Practice in the Federal Republic of Germany." In the context of present controversies, the data prove the discrepancy, lately suppressed, between the legal fiction and the actual reality of psychoanalytic practice within the guidelines of the insurance system ("*Richtlinien-Psychotherapie*"). No support was found for the contention of a new "standard procedure" (twice a week for 300 sessions) within the German Psychoanalytical Association. The data, on the contrary, suggest a different structure of psychoanalytic practice: concentration on low frequency psychotherapy (one session) and high frequency long-term psychoanalysis (four sessions), often far beyond the arbitrary limit of 300 sessions. Stress is laid on the urgent need to develop research strategies which view the problem of frequency systematically and in a qualitative way.

The "Counter-Will"—100 Years of Scientific Investigation into the Unconscious. Anita Eckstaedt. Pp. 95-106.

In honor of the 100th anniversary of Freud's publication of his first psychoanalytic case study on hypnotic cure, the author examines the wide spectrum in Freud's clinical observation of what constituted his patient's "opposition." It was the very act of acknowledging this "opposition" and the affect belonging to it, as well as the resentment active in the countertransference, that provided the cure. The conjecture of there being opposition in the face of an existing volitional paralysis—the

patient could not breast-feed her child although she "wanted" to—led to the discovery of the unconscious conflict—proof, moreover, that the unconscious and its workings existed in the first place. The author delineates Freud's clinical observations and arguments and then reflects on what the treatment and the core interpretation would look like today. Finally, she takes a critical look at contemporary skepticism or defensiveness in matters concerning the unconscious, the same skepticism that was found in the patient's husband, as well as in the patient herself.

Implications for the Clinical Situation of Reformulation of the Psychoanalytic Theory of Aggression. Henri Parens. Pp. 107-121.

A brief historical review of the theory of aggression reveals that Freud's death-instinct based theory has been questioned by many theorist-clinicians who increasingly see the need to account for a primary nondestructive aspect of aggression, as well as for a primary relationship between aggression and adaptation. There is aggression that is inherently nondestructive, alongside inborn aggression that is destructive though not hostile. Critical is the consensus that hostile destructiveness is not inborn, but rather is "produced" when the experience of excessive unpleasure activates the inborn mechanism which generates it. Such changes in theory have implications for the psychoanalytic clinical situation. For example, the analysis of transference hatred is facilitated when transference interpretations are linked with reconstructions of past traumatic experiences. Parens discusses the influence of this key hypothesis, that "excessive unpleasure generates hostile destructiveness," on interpretations of transference hatred. He discusses cases of malignant hatred, the need for its containment in the transference, the treatment approach, the analyst's need for self-analysis, and the need for benign enactments of transference engagement.

Psychoanalytic Theories of Depersonalization. Wolfgang Wöller. Pp. 124-131.

Depersonalization, which designates a feeling of unreality and alienation of the self, is nosologically unspecific and occurs in mild to severe psychopathology. Psychoanalysts conceive of it as a defense phenomenon and emphasize ego splitting and self-observation, disturbance of the sense of reality and of the sense of self, and the role of unacceptable identifications. While in neurotically structured patients, depersonalization may be utilized by the ego as a defensive affect protecting the ego from painful superego stimuli and contradicting identifications, in developmental pathologies it may be a signal affect denoting an actual or feared challenge to self-constancy.

The Training of Psychoanalysts and the Analyst's Sense of Responsibility. Michael Ermann. Pp. 133-139.

In his closing address to the International Federation of Psychoanalytic Societies Conference on "Psychoanalysis between Conformity and Contradiction" held in Munich in 1992, the author emphasizes the importance of the training system in promoting the psychoanalyst's sense of responsibility. Appealing to Winnicott's concept of the capacity for concern, he affirms the criticism that the present system opposes this goal by integrating personal development processes, especially the

training analysis, into the institutional education program. He believes that lack of change in the training process is caused by the training analysts' unconscious need for intimacy, in collusion with the institutes' desire to maintain power.

Enlightenment or Counter-Enlightenment? On Some Psychoanalytic Mystifications in D. Meltzer's *Dreamlife*. Thomas Pollak. Pp. 140-148.

The author discusses Meltzer's concept of the "dreamlife," which takes the unconscious process to be the continuous flux of our inner life that finds its particular form of manifestation in dreaming. The categories *symbol*, *unconscious*, and *transference* are utilized in discussing Meltzer's theories. In the second part of his argument, Pollak criticizes as a tendency toward counter-enlightenment Meltzer's leanings toward a magical mode of thought and uniform interpretation of the world.

Psychoanalysis of the Body Image in Rheumatoid Arthritis. Helmut Reiff. Pp. 149-160.

Rheumatoid arthritis is connected with a typical body image, characterized by hardened and tightened psychic barriers, a so-called high "barrier-score." This oral mode of body image uses projective identification as its main defensive action. Case material describing work with a rheumatoid patient illustrates the development and change in the patient's body image over the course of eight years of analysis.

The Relationship between Drive and Affect in Perverse Actions. Rainer Krause. Pp. 187-197.

The purpose of this paper is to define a perverse structure without falling back on sexual behavior in the strictest sense. Two drive models and the theory of affect serve as a starting point for this investigation. The definition of drives presented in this paper is not based on the erogenous zones but on the notion of instinct and the genital principle. Krause defines both the instinct and the genital principle as the "mute" organizational framework of behavior comprising the following elements: motivation, desire (*Appetenz*), and terminal action. He regards affects as being wishes which the subject can express vis-à-vis the object. Thus, he regards affects as belonging to the field of desire. As a result of these observations, he considers perverse structures as being "impossible combinations" of affect/desire on the one hand and terminal action on the other. Examples of such impossible combinations are disgust/lust, fear/lust, or anger/lust. All these combinations are used by patients to protect and preserve their identity. They define their identity via a sexualized body image. This behavior is a result of the patients' learning history during which some parts of their body image have been erased as a result of social referencing during drive interactions, such as the handling of the genital area in cleanliness education. He elucidates the assumptions put forward in this paper by citing episodes from cases and by comparing them with those described by other authors. He discusses addictions, bulimia, and anorexia as being closely related nonsexual perverse structures. Finally, he provides some treatment recommendations with a view to the handling of the repetition compulsion centered around disgust themes.

Psychodynamic Aspects of Suicidal Tendencies among Women. Benigna Gerisch. Pp. 198-213.

On the basis of psychotherapeutic experience with a selected group of fifteen suicidal patients, the author demonstrates that psychoanalytic suicide theories do not differentiate between the sexes and therefore can only be partially applied to the suicidal tendencies among this group of patients. Gerisch attempts to describe the specifically female form of suicidal tendencies, in line with more recent psychoanalytic theories of female behavior. In general this study agrees with Henseler's interpretation, in which attempted suicide is an expression of a narcissistic crisis. However, because of differences in suicidal behavior of the sexes, it appears necessary and meaningful to indicate precisely the connection between narcissistic development on the one hand, and the formation of sexual identity on the other. Through the use of an interpretation framework which differentiates between the sexes, the female patients' suicidal tendencies were revealed to be the result of unsuccessful individuation from the mother as well as complex female identity problems, while the suicidal act manifested an analogous desire for liberation and autonomy. As this study deals with the psychodynamics among a subgroup of women, it would be of interest to clarify whether these specific considerations regarding suicidal behavior can be applied to other female patients. In addition, it would be necessary to examine whether the high susceptibility of women to attempt suicide does not generally call for a differentiation in interpretation of theory between the sexes.

Projective Identification and Psychoanalytic Inference. Norbert Hartkamp and Angelika Esch. Pp. 214-223.

Psychoanalytic theorists frequently argue that the transference/countertransference concept should be extended to include aspects of nonverbal and paraverbal communication. New terms have been coined and introduced in the theory of psychoanalytic technique. The present authors maintain that such an extension is not needed. In their view the concept of projective identification is suitable for grasping these extra-verbal aspects of communication, provided this mechanism is seen as a form of archaic affective communication utilized mainly, but not exclusively, by severely disturbed patients.

Grief and Depression after Object Loss: On the Clarification of Concepts and Their Clinical Discrimination. Manfred Beutel and Herbert Weiner. Pp. 224-239.

In opposition to tendencies in recent studies to equate grief and depression, it is proposed that differentiating grief, pathological grief, and depression is essential for diagnostic and therapeutic reasons. Freud's distinction is reconsidered in the light of recent research. Illustrated by case vignettes, clinical criteria are proposed. These include specific affective expression, countertransference reactions, quality of object relation, regulation of self-esteem and guilt, generalized inhibition, helplessness, and hopelessness. The role of processes of introjection and identification are discussed, as well as determinants and consequences of complicated grief.

Specific Parameters of Psychoanalytic Treatment in Unfavorable and Dangerous Social Conditions in the Former Czech Culture. Michael Sěbek. Pp. 256-267.

In the former Czechoslovakia psychoanalysis was practiced since the thirties without interruption until the present time. It survived forty years under the Communist regime in underground conditions. The author describes the specific and historical features of the Czech underground and its tradition in Czech culture. Specific parameters of psychoanalytic treatment under unfavorable and dangerous social conditions are demonstrated. Issues of transference and countertransference problems are discussed. The psychoanalytic theory of reality, its levels, and "compartments" help in understanding how the safe space in the psychoanalytic process could be created and maintained. The special ethical role of psychoanalysts in totalitarian society is underlined. Clinical vignettes are used to illustrate problems of the underground psychoanalytic practice.

Psychoanalysis of the Psychoanalytic Frame. José Bleger. Pp. 268-280.

Bleger proposes to call the psychoanalytic situation the sum total of phenomena involved in the therapeutic relationship between the analyst and the patient. This situation includes phenomena which make up a process and which are studied, analyzed, and interpreted; but it also includes a frame, that is to say "a nonprocess" in the sense that it represents the constants, within whose limits the process occurs. The relationship between them is studied and the frame is explained as the set of constants within whose limits the process takes place (variables). The basic aim is to study not the breaking of the frame, but its psychoanalytic meaning when "ideally normal" conditions are maintained. Thus, the frame is studied as an institution within whose limits phenomena occur which are called "behaviors." In this sense, the frame is "dumb" but not nonexistent. It makes up the non-ego of the patient, according to which the ego shapes itself. This non-ego is the "ghost world" of the patient that lies in the frame and represents a "meta-behavior." The role of the frame is illustrated with some clinical examples which reveal the placement in the frame of the patient's most primitive "family institution." It is the perfect repetition compulsion, which brings up the primitive undifferentiation of the first stages of the organization of personality. The frame as an institution is the receiver of the psychotic part of the personality, i.e., of the undifferentiated and unsolved part of the primitive symbiotic links. The psychoanalytic meaning of the frame defined in this way is then examined, as is the relevance of these considerations for clinical work and technique.

Psychoanalysis and Contemporary Thought. XV, 1992.

Abstracted by Joel Gonchar.

Developmental Reconstructions: Infancy from the Point of View of Psychoanalysis and Developmental Psychology. György Gergely. Pp. 3-55.

The author examines the empirical status of psychoanalytic theory with a view to demonstrating that the assumption among psychoanalysts—that the data derived from the clinical psychoanalytic situation are sufficient to develop an autonomous

and empirically valid psychological theory—is basically flawed. In addition, he holds that this view prevents the integration of psychoanalytic theory with cognitive psychology. The paper concentrates on the validity of psychoanalytic theories about the preverbal phases of child development. Specifically, the author explores the developmental origins of the concepts of defensive splitting and projection from the point of view of two psychoanalytic schools of thought, the Kleinian and the Mahlerian. Gergely states that their respective theories are not based on direct evidence, but are retrospective extrapolations from clinical observations of adult psychopathological phenomena such as the borderline or narcissistic disorders. Further, these theories are based on metapsychological assumptions to which Klein and Mahler were committed. Using the results of current infant and child developmental research, he arrives at several conclusions that call for revisions in theory. The first is in the assumption that in the infant there is a primacy of the pleasure principle over the reality principle. The second calls into question Mahler's undifferentiated phase because of the evidence that infants are able to form object representations in the first months of life. Yet the research also calls into question Klein's theories because the earliest object categories that the infant establishes are not specified in featured descriptions, e.g., of the penis or breast, but more in terms of place and path of movement. The author proposes that such cognitive ego mechanisms as causal and intentional attribution may be innate ego mechanisms which serve the function of adaptation to the social world of the infant, but which later on in the adult form the basis of the defenses of splitting and projection.

Phenomenology of the Emerging Sense of Self. Richard D. Chessick. Pp. 57-88.

Chessick calls for adding a phenomenological approach to the ways in which clinicians look at their patients. He first discusses phenomenology, from its origins in philosophy to its applications to psychiatry and psychoanalysis. Phenomenology studies phenomena not merely as data or as matters of fact, but with an unprejudiced view as these phenomena are experienced. Chessick's central thesis is that the conditions with which we deal in current clinical practice are primarily preoedipal or borderline and have their origin in the period of development before speech is acquired. And it is precisely these conditions that respond best to a phenomenological approach, with its emphasis on getting in touch with what the patient experiences. The author presents clinical illustrations, as well as examples of this approach in the study both of self psychology and of infancy. Self psychology, with its focus on empathizing with the patient, epitomizes the phenomenological approach. This same focus stimulated a great deal of infant research. Chessick cites the work of Winnicott as an example of the phenomenological approach, and discusses both Kohut's and Stern's theories of the emergence of the sense of self. Finally, the work of the philosopher Merleau-Ponty is discussed and shown to be parallel.

The Nonexperiential Unconscious. Eric Gillett. Pp. 89-96.

This paper is one in a series written by the author to argue for a "broad" concept of the unconscious. Gillett discusses Freud's concept of the "descriptive unconscious" as limited to mental contents that may be preconscious or dynamically unconscious; he calls this the "narrow" concept, because under the right conditions, all

mental contents can become conscious. Gillett's thesis is that the "broad" concept, which is divided into an experiential and nonexperiential unconscious, is necessary in order to avoid the confusion that now exists in psychoanalytic literature. In addition, broadening the concept would bring the psychoanalytic view of the unconscious more into accord with that of cognitive psychology. The author's definition of the nonexperiential is "everything mental that is incapable of becoming conscious under any conditions." He includes in this the operation of defense mechanisms and the activation of these mechanisms. In psychoanalytic literature, he finds a confusion between a defense mechanism and defense contents, which are mental contents serving a defense function, and are capable of being made conscious.

The Pathology of Belief Systems. W. W. Meissner. Pp. 99-128.

The central question addressed in this paper is how we as clinicians decide whether a particular belief system, usually a religion to which our patients adhere, is pathological or not. The author differentiates this issue from that of a religion being pathologically used to express a particular neurosis or character disorder. The discussion begins with Freud's view of religion as a delusion of the masses. Meissner makes an important distinction between the pathological quality of a belief system and its truth value. The determination of the pathological standing of a religious belief says nothing about its truth value. Freud seems to have made truth value the test of pathogenicity. Meissner uses what he calls the realm of transitional conceptualization, which is neither exclusively subjective nor exclusively objective, to determine whether a religious belief is delusional or not. A belief system may be pathological without being delusional, but, if delusional, it is also pathological. Other criteria used to determine whether a system is pathological or not are: a) openness verses closedness, b) broadness versus narrowness of perspective, and c) degrees of rigidity versus flexibility. As an example of the use of these criteria, the Manichean belief system is compared with Schreber's "theocosmological" system. Finally, the author discusses belief systems from the perspective of the human needs that these systems meet, as opposed to Freud's sole emphasis on their wish-fulfilling aspect. Meissner thereby recognizes that religions provide illusions that satisfy fundamental areas of human need, which affords these systems a degree of legitimacy and acceptability.

Greek Tragedy and the Place of Death in Life: A Psychoanalytic Perspective. C. Fred Alford. Pp. 129-159.

Stating what he considers to be life's most important question—"what is the significance of annihilation?"—the author proposes that if one is to live well, one must grasp the continuity of death with life, to live with death always in mind, but without being overwhelmed by it. Throughout history the issue of death has been dealt with either in the language of transcendence, or by the humanistic denial of any connection between the living and the dead. In exploring the problem of the continuity of life and death, Alford examines the Greek tragedies and the work of Robert Jay Lifton. He points out that our culture, in lacking images of transcendence, as well as images of family continuity, is similar to the culture of ancient Greece. In the

tragedies, particularly those of Euripides, Alford finds his solution to bridging life and death.

Music and Its Relationship to Dreams and the Self. Shara Sand and Ross Levin. Pp. 161-197.

This paper analyzes both the conscious and the unconscious experience of the individual self, in exploring the psychological effects of music on the listener. Because of the scant amount of evidence available about these powerful effects, music is compared to the dream state. Both music and dream involve controlled regression which provides access to preverbal and primary process imagery and emotion. The psychological effects of music are first explored in the language of drive and ego psychology. The authors then analyze the physiological measures assessing the function and lateralization of the brain while listening to music. Because music provides such a powerful experience of the self, the second half of the paper is devoted to a self psychological focus. The primary function performed by music listened to as a selfobject is that it offers a matching or twinship experience. The listener's mood is matched by the music, permitting the sense of a shared inner experience and an affective moment of attunement with the composer and performers.

Vladimir Nabokov: A Case Study in Pedophilia. Brandon S. Centerwall. Pp. 199-239.

Centerwall convincingly argues that Nabokov was a conscious pedophile who acted out his perverse impulses through his writing. Further, he suggests that pedophilia served as a regressive defense against oedipal anxiety. The author examines both manifest and genetic origins of the perversion. He delineates the effects of oedipal anxieties on Nabokov's life and art, offering evidence from the pattern and timing of his various writings, as well as from biographies written about him. Aside from the strong evidence that Nabokov himself was sexually molested as a child and adolescent by an uncle, his early works describing pedophilic characters fit the pattern of what has been learned about pedophilia in recent years.

Do We Need a Feminist Psychoanalysis? Christa Rohde-Dachser. Pp. 241-259.

Answering the title's question in the affirmative, the author argues for a psychoanalysis centered on women. Psychoanalysis derived from patriarchy conceptualizes women in terms of the unconscious fantasies, wishes, fears, and longings that men have about them. These constructions serve merely to reinforce traditional patriarchal structures of defense. The author examines Freud's concept of penis envy as the motor force in women's development, comparing it with the more recent concept of female individuation. In this new theory, the triangular aspects of the oedipal situation further individuation—in both sexes—away from the omnipotent and always threatening mother. The author stresses that here again a patriarchal view is dictating the construction of womanhood. Rohde-Dachser argues that women need to go beyond the ready definitions of traditional psychoanalytic discourse and to discover their own symbols and an independently derived concept of womanhood.

Heterosexuality as a Compromise Formation: Reflections on the Psychoanalytic Theory of Sexual Development. Nancy J. Chodorow. Pp. 267-304.

Chodorow points out that a great amount of information has been accumulated about homosexuality and the perversions, but that there is a dearth of information about normal heterosexuality in both men and women. Further, she notes that in studies of homosexuality and the perversions, the focus is exclusively on sexuality, while in accounts of normal heterosexuality something "larger than" sex is meant, such as passion, object love, or genital love. We are therefore in need of more attention to the development of passion or love in homosexuals as well. After pointing out the contradiction and flaw in the view that heterosexuality is biologically ordained in men and women, Chodorow reviews Freud's position on the development of sexual orientation with his emphasis on the centrality of the oedipal constellation and castration fantasies. Examining the views of other theorists, she finds that the interpersonal account does not stand up to close scrutiny. Noting that since Freud the dominant psychoanalytic understanding has moved toward treating only deviant sexualities as problematic, she focuses on modern theorists who conclude that heterosexuality, like homosexuality and the perversions, is a compromise formation and in some sense "symptomatic," or a "disorder," or has defensive features. Chodorow concludes that, whatever one's theoretical approach, sexual development and orientation, fantasy, and eroticism need explaining in the individual clinical case.

Psychoanalytic Observations on Adult Development in Life and in the Therapeutic Relationship. Calvin F. Settlage. Pp. 349-374.

In a moving presentation of concepts and three case illustrations, Settlage discusses adult development as it occurs in daily life as well as in the therapeutic relationship. His concepts are based on a child developmental and therapeutic perspective, namely, that in a psychoanalysis with resolution of psychic conflict, an area that had been closed by pathology opens up and allows for further development. The author's basic model for development is the mother-child interaction, out of which the child develops functions and structures that serve self-regulation and adaptation. Settlage goes on to outline criteria for developmental achievement which are derived from a process model of development and are applied within all the life-span stages. When an area of the personality is pathologically involved, there is a closure of the mental system to further development in that area. Delineating the "developmental stance" toward patients, Settlage conceives of the developmental and therapeutic processes as separate but interrelated. They both take place within the therapeutic relationship and are complementary, but one has to do with undoing aspects of pathology and the other with opportunities for development. Creative processes in individuals can also lead to freedom from defensive constraint. The author believes adult development is ongoing whether there is treatment or not; people other than a therapist can act as new developmental objects.

The Contemporary Crises of Psychoanalysis. Robert R. Holt. Pp. 375-403.

The author sounds an alarm to alert analysts to the impending demise of their discipline and to the need to take action to prevent this from happening. Holt

believes that psychoanalytic theory is seriously flawed, from its metapsychology to its clinical theory. He traces these inadequacies to the philosophical contradictions in Freud's theory building, which derive from Freud's assumption that the laws of science are the same in physics and in psychology. This has led to a theory that is metaphysically confused, internally inconsistent, and rife with logical errors and fallacies. For these reasons the theory is incapable of generating testable hypotheses. Holt calls for a concerted effort to restate clinical discoveries in clear language so that testable hypotheses can be generated. He goes on to document where problematic theory leads to less than helpful clinical views, but concedes that experienced clinicians learn to modify these views so that they can approach their patients in a more humane and sophisticated way. Other areas of crisis touched on by Holt are the education of candidates, and the organization of the American Psychoanalytic Association. He believes that intellectual curiosity is being discouraged in favor of conformity among candidates, and that the faculties of institutes are too insular, poorly versed in teaching methods, and closed to what is going on in other areas of graduate education. Holt offers some remedies to these problems. He would have all institutes affiliate with universities so that their faculties would be subject to prevailing academic standards. He would have some members of a psychoanalytic faculty teach full-time and not be entirely dependent on analytic practice for their living. Psychoanalytic research centers would focus on clinical theory by investigating process and outcome, and would require candidates to become involved in this research as well.

The Psychoanalytic Study of Society. XVI, 1991.

Abstracted by John J. Hartman.

Alfred Irving Hallowell: An Appreciation. Melford E. Spiro. Pp. 1-7.

Spiro offers an evaluation of the work of A. I. Hallowell to whom this volume is dedicated. Spiro gives a brief account of Hallowell's intellectual development and reviews some of his major works. He mentions the influence of Edward Sapir in directing Hallowell toward psychoanalysis as a conceptual tool for relating culture and psychology. Hallowell became both an advocate of certain aspects of psychoanalytic theory and a critic of others. His use of the Rorschach in fieldwork represented an attempt to uncover personality dynamics in individuals, as well as an attempt to delineate the cultural context for those dynamics. Finally, Spiro notes Hallowell's pioneering work on the concept of the self and compares it with more recent psychoanalytic theorizing.

A. Irving Hallowell and the Study of Cultural Dynamics. Raymond D. Fogelson. Pp. 9-16.

Fogelson gives his evaluation of Hallowell's role as progenitor of psychological anthropology. He cites his innovative use of the Rorschach in cross-cultural research, his distinction between cultural and psychological levels of explanation, and his criticism of ethnocentric bias in studies of acculturation. His conception of cultural dynamics included different forms of cultural change, as well as mediating

mental processes and behavior. A capacity for self-objectification represents a critical stage in the development of culture. The concept of the self brings together collective and individual consciousness.

A. Irving Hallowell, the Foundations of Psychological Anthropology, and Altered States of Consciousness. Erika Bourguinon. Pp. 17-41.

The author extends Hallowell's interest in dreams by offering an analysis of altered states of consciousness (ASC). She argues that, like dreams, ASC have evolved in human development, with roots in mammalian biology. Their significance in human life derives from the symbolic transformation of experience and the capacity to share intrapsychic states. Unlike dreams, ASC derive from models based on pathological states. Examples are offered from the case of Hildegard von Bingen, as well as from ethnological studies. The author concludes that the foundation of ritualized altered states lies in the development and modification of the group's "behavioral environment." They therefore serve as coping mechanisms for both the individual and the society and thus provide a basis for culture building.

The Self and Kagwahiv Dream Beliefs. Waud Kracke. Pp. 43-53.

Hallowell used the notion of self as a central concept in his explanation of the relationship between personality and culture. Using modern psychoanalytic concepts of the self, Kracke explores the beliefs of the Kagwahiv of South America about their dreams. He found that they have four distinct theories. A dream can be a mental process that transforms a waking train of thought to a representation of a wish fulfilled, a communication about the incipient future, a perception of dangerous spirits, or an emotional communication from others. The author contends that dreams constitute a striking example of differences in the conceptualization of the self in relation to its behavioral environment.

Cultural Schemas and Experiences of the Self Among the Bimin-Kuskusmin of Papua New Guinea. Fitz John Porter Poole. Pp. 55-85.

Poole explores the connection between cultural schemas and personal experiences of the self among the Bimin-Kuskusmin of Papua New Guinea. He attempts to explain the way in which personal differences—matters of individuality—are given shape by the Bimin-Kuskusmin conceptions of selfhood and identity. This concept of self for adult men involves *finiik* and *khaapkhabuurien*, ongoing schemas representing both social and individual aspects of the self. The author uses these to illustrate how local concepts of identity give shape to beliefs learned through socialization and enculturation so that they come to have shared emotive force. He concludes that a strict dichotomy between a Western focus on individuality and a non-Western sociocentricity is misleading.

House Design and the Self in an African Culture. Robert A. LeVine and Sarah E. LeVine. Pp. 87-109.

The authors extend Hallowell's idea that an individual's experience and culturally constituted environment combine adaptive strategies and defensive fantasies. Fan-

tasies of interest from a psychoanalytic point of view may be either personal or collective, but the anthropologist investigates their interrelationship in a cultural context. The authors conclude that an institution is a compromise formation offering participants satisfaction of unconscious motives, together with public approval and other culturally sanctioned benefits. They illustrate ideas by examining the design of houses and household objects among the Gusii of Kenya. They conclude that the traditional Gusii house involves a fantasy, satisfying certain psychologically important needs of men and women, as well as serving as a context for social interaction and ritual performance.

Mazes of Meaning: The Exploration of Individuality in Culture and of Culture through Individual Constructs. Jean L. Briggs. Pp. 111-153.

Briggs attempts to answer a question regarding the usefulness to anthropology of studying the individual. Hers is a study of the "mindsteps" of one three-year-old Inuit child living on Baffin Island. The author analyzes in detail "emotionally charged dramas" which play an important role in the socialization of Inuit children. The adults often ask emotionally powerful questions like, "Why don't you kill your baby brother?" The author explores these dramas and traces the child's frustrations, fears, and eventual coping with these questions during the socialization process. She uses cognitive, psychoanalytic, and social psychological concepts to do so.

Rorschaching in North America in the Shadow of Hallowell. George and Louise Spindler. Pp. 155-182.

The authors recount their extensive Rorschach research among the Menominees of Wisconsin, which was inspired by Hallowell's Rorschach work with the Chippewa and Ojibwa. The Spindlers' studies confirmed Hallowell's hypothesis of a northeast woodland psychological configuration. They also confirmed that this configuration persisted through different transitional acculturative adaptations. Extensions of Hallowell's work included the study of a socioeconomic elite and a peyote cult group. They also devised a precise statistically bound definition of acculturation and analyzed male and female samples separately. In addition, they studied individuals in depth through autobiographical case studies.

Behavioral Evolution beyond the Advent of Culture. Theodore Schwartz. Pp. 183-213.

Hallowell pioneered the idea of "behavioral evolution" and the emerging capacity of human beings for culture. He recoiled, however, from the idea of cultural evolution for a variety of reasons which form the basis of this paper. Schwartz argues against many of Hallowell's objections and proposes a study of the behavioral evolution of the human mind and personality as relevant to cultural evolution. The author advocates "an evolutionary relativism" in which cultures may be evaluated as to their status and history.

Idiosyncrasy and the Problem of Shared Understandings: The Case of a Pakistani Orphan. Katherine P. Ewing. Pp. 215-247.

Ewing states that individuals participate in a social world of shared understandings, but organize their experience in idiosyncratic ways. Anthropologists have ig-

nored the idiosyncrasies and emphasized the cultural aspects of the shared understandings. In this study the author employs two methods of highlighting an individual's particular use of cultural symbols. The first is to use knowledge of culture to capture the individual's particular usage; the other is to monitor one's own emotional reactions to the informant as a potential source of information. To illustrate her conceptual goals as well as these methods, the author discusses the case of a young Pakistani woman whose mother burned herself to death when she was eight and whose father died several years later. The author discusses the woman's conception of fire, inside-outside, proper family, and mother, to demonstrate her thesis.

Circumcision and Biblical Narrative. Melvin R. Lansky and Benjamin Kilborne, Pp. 249-264.

The authors contend that the justification for ritual circumcision of newborn males based on hygiene is inadequate to explain the persistence of this ritual attack on the penis. They offer a textual analysis of six major passages concerning circumcision in the Hebrew Bible to supplant previous anthropological and clinical studies of this subject. Taken together, these passages contain a great number of references to displaced filicidal wishes, as well as "sexual and aggressive savagery." They contend that narrative sequences can serve as an analog to free association in the clinical situation. Circumcision appears in those passages preceding and following accounts of fear of impending sexual or aggressive "chaos" in the family or from neighboring peoples.

Cultic Elements in Early Christianity: Rome, Corinth, and the Johannine Community. W. W. Meissner. Pp. 265-285.

Meissner continues his studies of the early Christian Church by examining lines of opposition within the Christian community against the background of Hellenistic culture and the political structure of the Roman Empire. In the Roman Christian community the divisive factor was Judaic elements; in Corinth it was socioeconomic stratification and dietary restrictions; and in the Johannine community it was high versus low Christology. The author argues that the gradual evolution of a central orthodox church came about through the continued workings of a cultic process. The dynamics of the in-group versus out-group, in this context of competing Christian groups, led to this centralization. He reiterates the central importance of a paranoid process in this group formative evolution.

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Notes

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NOTES

Once again, the editors of *The Psychoanalytic Quarterly* express their gratitude to the colleagues whose work appeared in our Abstracts Section during the past year. Their work involves choosing which of a vast number of articles would be of most interest to our readers, and then condensing what they have chosen into brief but comprehensive, clear abstracts. We know that our Abstracts Section is read and valued by many of our subscribers. That it is so valued is due to the efforts of the persons listed here. Again, we thank them for their excellent work.

THOMAS ACKLIN
MICHAEL J. BADER
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EMMETT WILSON, JR.

CONFERENCE AT THE INSTITUTE FOR PSYCHOLOGICAL STUDY OF THE ARTS

April 7-10, 1994. PSYCHOANALYSES, FEMINISMS.

The Institute for Psychological Study of the Arts, based at the University of Florida in Gainesville, sponsored this conference on the multiplicity of schools of feminism in relation to the multiplicity of schools of psychoanalysis. Where in the past Lacanian and French feminist perspectives had the primary psychoanalytic influence in literature departments, this conference suggested a growing engagement with object relations and other Anglo-American schools of psychoanalysis.

The conference consisted of keynote addresses followed by seminars for which each member had written a paper. The diversity of the participants' interests is reflected in the seminar titles: Psychoanalysis and the Emotions; Gender, Symbolism, and Culture; Femininity and Psychoanalytic Theory; Feminism and Postmodernism; Feminist Literary Criticism; and Feminism and Object Relations Theory. There were more than seventy papers presented, but only some of the keynote speeches and repeating themes within the papers can be described here.

The first presentation was Madelon Sprengnether's "Mourning Freud." Sprengnether has searched through Freud's history for clues as to why he chose to build the theory he did, particularly the oedipal theory, and she suggested alternate routes Freud could have taken. She argued that the oedipal theory compensated Freud for a family situation in which his mother was dominant and his father passive and

nonheroic. She wondered what might have happened had Freud chosen to emphasize mourning rather than the oedipus complex. Looking closely at a dream Freud had before his father's funeral, Sprengnether interpreted its edict, "You are requested to close the eyes," somewhat differently from the way Freud interpreted it. She suggested that Freud's reluctance to deal with his grief may reflect a more conflicted response to his father's death than he acknowledged. Noting that Freud's cheerful emergence from a period of deep depression after his father's death coincided with his construction of oedipal theory, she found clues to the fate of mourning in Freud's reading of *Hamlet*: for Freud, *Hamlet* was a disguised version of *Oedipus Rex*, and his choice to identify with Hamlet as Oedipus was a choice not to identify with Hamlet as mourner. Sprengnether further argued that Freud ignored other possible lines of identification with Hamlet. Biographical material reveals that Freud's reminiscences about his mother and his nurse returned after his father's death; Sprengnether therefore suggested that oedipal theory functioned to suppress his feelings about the dismissed nanny and the preoccupied mother. Freud might have seen Hamlet as equally upset by his mother's misdeed as by his father's death, but he did not. In choosing to suppress the role of the mother—a key feature of oedipal theory—Freud revealed his inability to mourn the failures in maternal care caused by the many losses in his early life. According to Sprengnether, there is less evidence of rivalry with his father in his biography than there is evidence of anxiety about the dislocations of his early life and the wavering attention of his mother. Sprengnether concluded that had Freud chosen to theorize the dynamics of loss instead of the oedipus complex, he might have claimed castration as his own narcissistic wound rather than projecting it onto women. Freud fashioned a family he could live with: a powerful father, an adoring mother, and a lively, upstart son. The implication is that oedipal theory is a narcissistic compensation and should not be considered an essential truth in psychoanalysis; loss and mourning are better starting points for psychoanalysis and for feminism.

Several conference papers were feminist rereadings of Freud that focused on contradictions and repressions in the theory. Most took a detour through Lacan. For example, Karyn Z. Sproles, in "The Feminine Superego," argued for an alternate version of the female's superego, one which is not weaker but rather less rigid, sustaining an awareness of lack without anxiety. At least three papers looked at the implications of Riviere's theory of masquerade. Stephanie Dryden noted that the excessive work expended by men to solve the riddle of femininity mirrors the excessive amount of work a girl has to do to become a "normal" woman.

Several other theorists also criticized what they saw as the (male) fetishization of sexual difference in psychoanalysis. Kathleen Woodward's "Tribute to the Older Woman: Psychoanalytic Geometry, Gender, and the Emotions" drew on Abelin's work to argue that generation is an important building block of identity. Abelin observed two different models of separation and individuation, a male model based on sexual difference and a female model based on generational difference. Critical of the limiting of generations to two in both feminism and psychoanalysis, Woodward argued for a three-generation model which, she feels, produces care and continuity alternatives to hierarchy and authority, the terms of classical psychoanalysis. Woodward made a compelling link between the two-generation same-sex oedipal model and what she sees as the psychoanalytic preoccupation with the strong

or stormy emotions: envy, fear, hostility, guilt, desire, and jealousy. Instead, psychoanalysis should take seriously the quiet emotions, such as connection across generations, which Woodward suggested can be elaborated from what Jessica Benjamin has called emotional attunement and mutual recognition.

Benjamin's "The Fantasy of the Omnipotent Mother" continued her examination of the ways in which a mother's agency is written out of psychoanalytic theory. She argued that the metaphor of the mirror cannot represent the early mother, who, in her play, generates discrepancy and otherness. She claimed that only if the mother survives her destruction by the child in fantasy does she become an object of identification, as fantasy and reality become differentiated. In psychoanalysis (Freudian and Lacanian), as Benjamin analyzed it, the struggle around separation and individuation is never worked through, just redirected onto a rival father, the paternal rescuer. Meanwhile, mother becomes an idealized figure with no sexuality and no agency. In other words, the discourse of the oedipal structure produces the omnipotent mother. Drawing on Fast's work, Benjamin pointed to the omnipotent moment in girls' and boys' development when each thinks of her/his gender as the only one, and the consequences of either renouncing that moment or taking it as the only reality. Benjamin continued to reformulate polarities into tensions as she argued that it is not enough to renounce fantasies of perfection. Rather, what is necessary to mitigate envy of the other gender is the labor of mourning, as had been discussed by Sprengnether.

Several conference papers drew on Benjamin's work in their analyses of literature. Barbara Schapiro's "Sadomasochism as Intersubjective Breakdown in D. H. Lawrence's 'The Woman Who Rode Away' " discussed the complex nature of Lawrence's identification with women. Rosemary G. Feal explored the possibilities for women of deriving pleasure in culturally traumatic circumstances of domination and submission.

Benjamin's criticism of the strand of feminism that focuses solely on women's nurturant capacities and ignores their aggression and sexuality was taken up in several papers: for example, J. Brooks Bouson's analysis of Margaret Atwood's *The Robber Bride*, Rebecca Curtis's discussion of the aggression necessary to protect one's procreative powers, and Barbara Czechanski's discussion of the film, *Thelma and Louise*.

In her keynote speech, "Good Girls, Naughty Boys: Reflections of the Impact of Culture in Young Minds," Ellen Handler Spitz discussed the role of visual and verbal culture in perpetuating gender ideals. She showed slides from several children's books, some of which play on a blurring of gender boundaries, others of which authorize a myopic view of gender. Her discussion of *Angry Arthur* focused attention on the nature and consequences of the "no" spoken by the mother to a boy child, an interesting counterpart to Lacan's *nom du père*, which stresses the psychic importance of the "no" of the father that establishes culture (the incest taboo).

Valerie Traub's "Sodomy and Female Desire in Shakespeare's Sonnets" posed a challenge to those psychoanalytic critiques that generate unhistorical interpretations of misogyny as grounded in female lack, male castration anxiety, dread of female genitals, etc. Traub put the meaning of sodomy into historical context, noting that sodomy was originally defined as all sexuality which did not have procreation as its end, but that its legal codification from 1533 to the late 1600's erased women from

its practice and reduced female sexuality to reproduction. She argued that Shakespeare's sonnets go against this cultural trend by claiming reproductive powers for male-male relations and reducing male-female relations to a nonreproductive sodomitical form. Traub explored Shakespeare's misogyny in the context of a complex struggle over the gendered meanings of sodomy circulating in the culture. Shakespeare legitimized male homoerotic desire by placing the onus of sodomy on the female, whose body is reduced to a sterile sameness that cannot generate the play of difference necessary for signification. One of Traub's many contributions here is to point to how gay male and feminist readings can be played off of one another. "In these poems, the enabling of a male homoerotic poetics seems utterly dependent upon the disenabling of a celebratory feminist reading."

Diane Middlebrook, author of *Anne Sexton: A Biography*, presented a paper titled "Telling Secrets: The Ethics of Disclosure in Writing Biography." She discussed how she had to avoid the temptations of moral superiority in her countertransference feelings toward Sexton. As with analyst and patient, the biographer owes the subject insight, not judgment. She answered the question, "If the biographer knows the subject's wishes about disclosure, should she follow them?," by arguing that the dead cannot have wishes. They can only have wills, and wills delegate the responsibility to someone else. Middlebrook feels that biographers are unethical when they offer speculation disguised as truth or invade the privacy of the living.

Juliet Flower MacCannell, in "Towards an Ethics of Feminine Desire," spoke of "women's speech," which, she argued, is not exhausted by speechlessness, male speech, or maternal speech. She addressed the obstacles to speaking about one's personal life, claiming that acceptance into the academic world pivots on checking one's own life at the door. A woman's voice, she stated, accepts or rejects the contracts defined by dominant speech.

In her talk, "The Economy of the Flesh," Teresa Brennan developed an energy model to account for the way ideas are adhered to and abandoned. Using essentialism as her example, Brennan noted how writing critiques of essentialism allowed some feminists to reconcile two identifications; that being an activist also conferred academic "spending power" on its adherents. Currently, such a position is less political than academic and has become identified with postmodernism. Brennan is interested in what it means to identify with received ideas and how one gets beyond these identifications. She developed the idea of a life drive as the common force that connects being to being. She identified the life drive with Freud's sense that unconscious processes push to make themselves known. The life drive, while not feminine, is more likely to make itself felt in those who have more to gain by disrupting fixity—for example, women and people of color.

Brennan's thoughts about the feminist positions on essentialism and anti-essentialism were evident in a number of conference papers which spoke of "the feminine" and "the masculine" either as knowable essences or as social constructs with essential differences. Geoffrey Carpenter's "Essentialism, Mysticism and Female Nature: A Critique of Spiritual Feminism" warned of the danger of asserting that women have an essential affinity with nature, particularly the danger of re-establishing old gender stereotypes that have kept women in an inferior position. Michele Bertrand's "Intellect and Gender Identity" argued for a feminine pole of intellect, characterized by perspicacity, insight, and empathy, which she counter-

posed to a masculine pole, characterized by theorizing, knowledge, and a desire for mastery. She allied herself with a culturally constructed essentialism.

Attempts at navigation between essentialism and anti-essentialism were especially evident in the papers on "masquerade," the female performance of femininity. Masquerade exposes the failure of the phallic law to ascribe people to fixed gender identities. Kerry Maguire, in "The Cloak of Definition: Women and the Masquerade of Subjectivity," found masquerade to be a useful tool to deconstruct any notion of an essential masculinity or femininity—men and women both masquerade. But Veronique Machelidon, in "Masquerade: A Feminine or Feminist Strategy," worried about the essentialist underpinnings of masquerade. She wondered if masquerade merely re-represents the "norm" in hyperbolic form or if the hyperbole subverts "naturalized" femininity.

The question of how the repetition of normative discourse might be subversive came up in other papers, a few of which centered on Freud's "The 'Uncanny'." In a paper on the defamiliarization of the familiar that characterizes the uncanny, Clara Mucci argued that the fool in *King Lear* is the preoedipal feminine whose job it is to overthrow such binaries as masculine and feminine, subverting gender identity in a neither-nor. The pleasures of gender indeterminacy is a topic widely discussed in feminist psychoanalytic work today. Lynne Layton's "Trauma, Gender Identity, and Sexuality: Discourses of Fragmentation" considered the different ways that fragmentation is discussed in feminist postmodern versus clinical literature (celebratory versus despairing), pointing out that the pleasures of gender indeterminacy are limited when the self is not experienced as cohesive. The relationship between gender and trauma was taken up in papers focused on contemporary literature.

In the seminar, "Femininity and Psychoanalytic Theory," Valerie Traub summed up many of the issues raised by the conference papers. She asked how much of Freudian theory we accept or reject, particularly in terms of developmental narratives. Further, "To what extent does working within binaries—like the very term of our seminar, femininity, tend to reinscribe an essentialist or normalizing project of gender? Must we appeal to such binaries in order to do our theoretical work? What are the attractions of a fluid, processual, interactive notion of identity? What are the attractions of a stable ego? What is the relationship between gender identification and sexuality or object choices—and do these two different processes tend to get conflated in the psychoanalytic use of 'desire' and 'bisexuality'? To what extent is the unconscious itself a historically changing phenomenon? Can resistance be developed out of the psychic materials of patriarchal development, such as the superego?" These questions face those who work at the intersection of feminisms and psychoanalyses today.

My only criticism of the conference is that it honored multiplicity but did not really lend itself to examining the languages that each psychoanalytic school speaks and the investment in one school or the other. Each school has its true believers convinced the other school has missed the very essence of psychoanalysis. However, it is not clear that the schools are mutually exclusive. Unfortunately, the Lacanians spoke to other Lacanians, and object relations theorists spoke to like others. It appeared that connections might be made in some areas—for example, in the discussion of narcissism—but that real differences exist in the way each school constructs the relation between self and other, in its view of development, and in the

value (or lack thereof) that each school places on the category of experience. Although the conference did not formally fulfill this wish for cross-school dialogue, it did provide an exciting opportunity to meet and talk with others engaged in theorizing about the relation between psychoanalyses and feminisms.

LYNNE LAYTON

The 53rd Annual Meeting of the AMERICAN PSYCHOSOMATIC SOCIETY will be held March 2-4, 1995, at the Hilton Riverside, New Orleans. For further information, contact: American Psychosomatic Society, 6728 Old McLean Village Dr., McLean, VA 22101; phone; 703-556-9222.

The Philadelphia Psychoanalytic Institute and Society and The Department of Psychiatry and Human Behavior of the Jefferson Medical College announce the 26th ANNUAL MARGARET S. MAHLER SYMPOSIUM ON CHILD DEVELOPMENT, to be held at Twelve Caesars, Philadelphia, on Saturday, May 6, 1995, from 8:00 A.M. to 4:30 P.M. The topic of discussion will be "Intimacy and Infidelity." For further information, contact: Maryann Nevin, 1201 Chestnut St., Room 1502, Philadelphia, PA 19107; phone: 215-955-8420.

ERRATUM: A typographical error in our July 1994 issue (Vol. LXIII, No. 3) has been called to our attention. On page 545, five lines from the bottom of the page, the word "correction" should have been "connection."