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James T. McLaughlin

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# TOUCHING LIMITS IN THE ANALYTIC DYAD

BY JAMES T. McLAUGHLIN, M.D.

*The matter of limits and boundary violations by both parties in the analytic dyad remains an unsettled technical and ethical concern, whether touching has to do with actual physical contact or is expanded in its meaning to include its psychic equivalents. Touching, probing, and breaching of the idiosyncratic perimeters of the private self of one by the other in the dyadic intimacy are necessary components of the healing contact but pose an inevitable liability for violation, disruption, and damage. Clinical data remind the analyst of the near-physical impact of words. And the data sometimes speak for the legitimate place of restrained forms of physical contact, as nonverbal necessities of analytic communication, in critical instances in which a viable analytic engagement could not otherwise be sustained.*

In the intimacy of the analytic relationship the violation of permissible boundaries remains an enduring and unsettled concern for the analyst and the patient. This is so whether touching has to do with actual physical contact of whatever nature between the pair or is expanded in its meaning to include those psychic equivalents of touching that are powerfully actualized in the analytic dialogue.

The topic of touching has always been complicated by its connections with the unsettled liabilities of physical intimacy, sexual and aggressive, between the analytic pair. The specter of this

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ultimate excess has made almost impossible a dispassionate assessment of the technical implications of lesser forms of physical contact. And the prescriptive power of our traditional taboos has often left us open to, and justified in, well-intended analytic behaviors that breached and traumatized the boundaries and necessities of our patient.

It is my hope in this paper to scan a wide range of analytic touchings, from actual to symbolic, toward a more encompassing appraisal of their place and significance, for both parties, in legitimate analytic work.

The course of any analysis can be described as a mutual exploring of the communicative boundaries of one by the other in the intimacy of the analytic dyad, with the aim of both to reach the core of the other while protecting one's own. Each hopes to get what he or she needs through contact with the other, and to avoid suffering its opposite.

And what each of us needs from the other, whether on the couch or behind it, is at depth pretty much the same. We need to find in the other an affirming witness to the best that we hope we are, as well as an accepting and durable respondent to those worst aspects of ourselves that we fear we are. We seek to test and find ourselves in the intimacy of the therapeutic relationship, to become known to and accepted by the other, in whose sum we may more fully assess ourselves.

A shift to spatial metaphors may help in this awkward formulation, by alluding to the distance, or its lack, between any two of us as the space in which this engagement will take place, for better and for worse. The metaphor allows us to picture another aspect of each of us, that inner and guarded space that Modell (1990) has depicted for us as the "private self" and that Winnicott (1965) before him described as the "true self." It is this true and private self that comprises the core, both good and bad, of what we feel ourselves to be. It is this private self that provides inner stability and nourishment. Yet it is also the hiding place for those most unwanted and troublesome aspects of what we

fear we are and wish that we were not. It is this aggregate that we zealously protect, keep mostly hidden, and cling to as our essence. It is what we bring to the other when we engage in the analytic dyad.

Staying in the spatial metaphor, we can envision each of us as having set up our alerting systems, our defenses, as far away from, or as close to, our private self as we need for comfort. We know how far-flung and concrete these perimeters can be, from national boundaries to the walls of home, from our left front fender to the cut of our clothing and fingernails, from the mote in our eye to the flaw in our loving. In the therapeutic engagement we know that no outreach is beyond the early warning radar of the particular patient and how little it takes at times to set ours jangling.

In order for any good to come from what we do, it is necessary that we try to subordinate the primacy of our own needs, that we never presume to know the ground on which we tread or claim right of access to posted fields.

It is necessary that in our seeking to touch, we will have grown comfortable about our fears for the privacy of the self that we carry in us. Then we may be open to the deepest stirrings of the patient as these touch comparable depths in ourselves. And we will have grown secure enough about our own disciplined control of our liabilities and assets as to be open to their testing and stretching under the challenge of clinical pressures.

Yet in reaching for these ideals we inevitably falter, obstruct the patients' quests or limit their reach to touch and authenticate those depths in them that they need to make peace with through the help of our shared knowing. As we thread our way through the patients' brambles, we trip over the big feet of our self-interest, then stumble to those same feet to resume the quest for the other.

This awkward formulation of a tension inevitable to the effort of any two minds to meet lacks the spare elegance of Buber's distinctions between the I-It of the manipulating relationship

and the I-Thou of mutuality. Yet it may speak more closely to the uncomfortable actualities of an often ambiguous reality we seek to know.

This acknowledgment of an inherent interpersonal tension is now a commonplace in our field. But it is far from the traditional stance prescribed for the analyst, a stance I happily assumed as I emerged from my training in the late forties, and have sought ever since to alter in my own analytic perspective.

The prevailing view of analyst and patient then, and still surviving to this day, tilted the exploratory focus onto the patient as the object of inquiry by a knowing analyst, working from a position of objectivity and emotional detachment. The analyst held the promised comfort of a claim to a superior grasp of reality when up against the turmoil and demands of a patient beset with infantilisms and character deformations. This conception of our privileged position at the same time imposed upon us powerful constraints and ethical expectations that we not exploit the disadvantaged patient for our own sexual and aggressive satisfaction (Freud, 1911, 1912a, 1912b, 1913, 1914, 1915).

The tilt in this view shaped an analytic frame that has prevailed to this day, for better and for worse. It requires that patients put aside most of their habitual and trusted modes of sensing and monitoring their boundaries, and their reacting to possible dangers. Assured of the safety provided by the disciplined and abstinent analyst, patients are asked to relinquish the option to run or fight, forgo the cues of physical touching, and put aside the visual scanning of the face and body of the other that customarily provides cross-validation of what they are hearing.

This analytic mode powerfully channels discourse, particularly for the patient, backward into the body language of skin and gut, where the private self takes its base; and forward into the separateness and distance of verbal-auditory exchange, where the boundaries of the social self can never surely be set.

Small wonder, then, that boundaries are in doubt when words in analysis take on the muscular force and subtlety of fist and

fingertip; when body movements and gurgles speak to be heard by ears that are schooled to hear words.

The traditional analytic stance that was shaped from this perspective has proved its power and utility, given an analyst and a patient capable of living up to its demands and constraints.

This austere stance, at its height in the fifties, became both idealized in the myth of the fully analyzed analyst, and its expectations overzealously inculcated in many of us trained in the United States in the years immediately following World War II. I have recently tried to convey the nature of what this was like for me, and others around me (McLaughlin, 1993a, 1993b). Ours may have been an unusual happenstance. But I doubt it. Robert Coles, in his introduction to his book, *The Spiritual Life of Children* (1990), has provided an account of the constraints of his training in psychiatry and psychoanalysis, in an eastern seaboard analytic center at the height of the heady certainty of the sixties. It adds sound, substance, and continuity to what I found analysis to be like for me a decade earlier.

A more objective and enduring instance is one central to the concerns this paper addresses. Countertransference, as term and concept, until relatively recently carried invidious connotations of defects to be expunged, the telltale mark of inadequate or incomplete personal analysis. As Tower (1956) noted in her protest of the fifties, the open discussion of the private, and especially sexual, experiences of the analyst was near impossible. Only slowly has it become possible, and perhaps even respectable, to speak openly of the psychology of the analyst, an easement to which I have been privileged to add some share (McLaughlin, 1961, 1975, 1991).

Through these freedoms we have become better able to draw upon the counsel and support of colleagues. Consultation with peers is the most effective external guide and restraint we are likely to turn to. I have found it particularly indispensable to my sortings in these matters of intimacy and limits.

I believe that in my papers on the analyst's dynamics I touched common chords of shared experience with any analyst

trained at any time. The struggles to overcome the limitations upon my ability for open searching and seeing, limitations set by a combination of what I was trained to know plus those my own internal constraints imposed, these I believe to be inevitable to our discipline, rites of passage from which none of us is spared.

I have come to see that my hard spots, i.e., an allegiance to the givens that I was taught, often provided justification for my blind spots of personal need and bias. They safeguarded the self-serving adaptations of the narcissistically tinged, I-It mode that is part of our ordinary relating.

At the same time, those ethical constraints that warned of the disasters of sexual intimacy and aggressive excess were indeed helpful in those brink moments narrowly averted. I think such moments to be inevitable to a young analyst still not seasoned in the work, and perhaps not yet based in a satisfying personal emotional life. I know that the memory of such close calls can become a durable part of the analyst's early warning system.

Balanced against these self-serving motivations and liabilities lie, in each of us who needs to be a therapist, those urges which led or drove us to our peculiar calling, with its altruistic demands for I-Thou relating and its constraints upon satisfaction of personal strivings. I see, in myself and others I have been privileged to analyze or supervise, this press to do therapeutic work as deriving from our needs to master unacceptable sexual, aggressive, and narcissistic urgencies directed initially at the primary others of our childhood. Over developmental time our efforts at mastery evolved into character traits, both sublimative and reactive, of altruism and service to others, traits anchored in nurturing maternal identifications.

Such a therapeutic investment fosters the deep involvement necessary for significant work (McLaughlin, 1961). But such commitment carries the liability for the revival of conflict in the therapist in the face of fresh clinical provocation. The work-ego of the analyst (Fliess, 1942; Olinick, 1980) is built out of these old strivings and their neurotic compromises, reworked into new capacities shaped by personal analysis and the lore of train-

ing, and based in identifications and allegiances with our own analyst and other mentors. As new psychic structure, this professional identity is susceptible to strain and breakdown under pressures both within and outside the analytic situation (McLaughlin, 1981).

In my years of analyst-watching, my respect has grown for the integrity and tenacity of the need, in so many of us, to wrestle with our impediments to doing our best work on behalf of the patient. Though the pain of lapse and shortfall has its narcissistic base in prompting us to do better, our dogged return to the engagement with the patient speaks for the strength of our need to relate to and help an other. And it is that rueful readiness to look to our own part in shaping the complications of the analytic venture that points to the deeply personal roots of responsibility felt and taken.

I have lingered in this background context of the dynamics of the healer to provide a richer context in which to address clinical matters, whose common thread will be that of touching and being touched.

Only some of these will have to do with actual physical contact between patient and analyst. Mainly, (and here is a word that neatly speaks of a hand pointing and touching in emphasis), I will be talking about how the sensitivities of both parties are steadily deployed in a highly tactile fashion, groping to be in touch with, and getting the feel of, the allowable limits of the other in the effort to collaborate. Poland's (1975) definitive paper on the function of the analyst's tact alludes to much of the ground that I traverse in this paper. He made clear that tact is the handmaiden of empathy: "Tact follows empathy. . . . Empathy might be considered to be on the sensory end of the analyst's functioning as one source of insight. Tact is on the motor end" (p. 156). And he noted the etymology of what I am emphasizing: that the roots of tact lie in touching, for him in the touch of the mother sustaining contact with the child bent on separation.

The matter of physical touching in the analytic relationship is

worth dwelling upon at this point, mainly for its highlighting sexual and aggressive tensions also at the core of, but less vividly evident in, the multiple levels of symbolic touching that are the main focus of this paper.

### *The Challenge of Actual Physical Contact*

Actual touching, actual physical contact, between therapist and patient, has been the subject of still-unsettled debate in the psychotherapies in general. The manifest issue of the ultimate possibility of overt sexual involvement continues to be so emotionally charged as to make it still difficult to explore the technical assets and liabilities of other levels of physical contact.

Within psychoanalysis there is by now a well-documented history of our group need for some of our time-honored injunctions against sexual and aggressive excess. These are as necessary as ever, insofar as they provide enduring ethical constraints against our most self-motivated and potentially destructive impulsions.

However, it is unfortunate that the prohibitions against these extremes became absolutes that encompassed the entirety of the analytic relationship. In instance: the yield of our reliance upon the verbal carrier has been rich, but we have learned that for many it has limited the comfortable explorations of other levels of communication.

In the years of my greening even a handshake was to be avoided, unless one was a bona fide European, or trying to be accommodating toward a patient who was. I do not recall how many volunteered handshakes I flappingly avoided or cut short without even watching for the consequences of my discourtesy. Some insistent ones persevered and I was wrung, and soon wrung back. I like handshakes, anyway. I have watched this ritual contact over the years, becoming comfortable in shaking hands with some before a session, or after, or both.

Handshakes come and go with some patients, stay consistent with others for the duration. The cue comes from the patient. Without making it a matter of conscious attention, I have somehow found it easy to remain in touch with the individual differences between my patients. I know that I welcome the handshake, and rely upon its varying qualities to receive and convey valuable information; and I am certain that the patient does the same. Sometimes these get our overt analytic attention, but often they do not. Try as I may, I cannot see that this form of touching has obstructed the progress of the analysis. I have far more data, as when a patient, in terminating, reflects back upon our work, and singles out our handshaking as having provided a surer sense of knowing I was there and in what kind of contact, before our longer relating through the verbal-aural reaching could be relied upon. It had been helpful that the handshake had been continued thereafter as another way to check in times of doubt.

Touchings that can occur while the patient is on the couch are more subtly textured. To begin with, the varied meanings of patient-on-couch, for both patient and analyst, tend more readily to be suffused with sexual and aggressive undercurrents. These need ever to be sounded, never taken for granted or treated lightly.

I live with, and feel I must constrain, and do indeed constrain, the impulse to reach out and touch the hand, the shoulder, the cheek of a patient who is in abject misery. My experience of fingers touching, of hands holding, has gradually stretched to my being comfortable in reaching out responsively at times to touch the hand reaching back toward me for support, consolation, or for my presence in the face of the patient's not yet speakable yearnings.

I put these matters vaguely, to suggest the powerful ambiguity of such moments when both the intentions of the patient, and my own press to respond, are yet to be named, let alone understood. As experience, along with aging, has enhanced my

span of ease, I have taken the position that I will make finger or hand contact in match with what is proffered, and without requiring that the appeal be first explored and its meaning understood.

Having grown much more attuned to pregenital stirrings in myself and in my patients, and to have come to some peace about sexual matters, I much prefer to be available to respond to what I have found to be the turmoil around early relational struggles that, more often than sexual or seductive urgencies, drive such reachings-out for hand touch or holding. I find that this responsiveness facilitates, rather than hinders, the patient's consequent analytic seeking. This stance has not prolonged or increased these interactions. The opposite tends to prevail: the need, now satisfied, tends to subside as fuller verbal contact becomes possible between us. Where my responding has stirred some erotic feeling in my patient, it still has remained analyzable.

I know that in stating things in this fashion I am at odds with those of my peers who hold to the letter of complete physical abstinence. Casement (1982) has argued persuasively the merits of this position. In my experience the kind of abstinence he advocates has often led to what I see as iatrogenic wounding and unnecessary suffering (Pizer, 1992).

Admittedly, there is risk and uncertainty always in an analyst's responding to felt needs for sustaining and comfort. Where and in whom, indeed, is the need located? In seeking to find out, I do still draw support from my ethical constraints, and direction from the ideal of my commitment to the patient's best interests. I do not wish to sound complacent about these matters that earlier caused me much concern. There does appear to be a rueful truth to the old analytic adage (its vintage attested to by its sexist phrasing) that "analysis is an old man's game."

One incident from my training years remains in memory as an early breaking of the touching barrier, one that helped me reconsider the generic taboo.

*Clinical Vignette: Ms. A*

I had to handle in ad hoc fashion a problem with a fragile patient in Pittsburgh until I could bring it by train to my supervisor in Philadelphia. Ms. A was an intellectually gifted and chronically anxious young woman who, in her second year of our work, had hinted about having been sexually fondled as a three-year-old by her doting and alcoholic father. Having revealed this, she fell into a misery of intensified anxiety, prompted in part by what later she told me had been my too eager efforts to get her to tell me more. She withdrew into depression and self-recrimination for what she felt to be her betrayal of him to me. She had twice that week, in the midst of bewailing her disloyalty, sat up on the couch and begun wordlessly and tearlessly to bang her head hard against the coarse grasscloth wallcovering. The first time she had gradually heeded my urging her, from my chair, to try to stop and to talk. She stopped, but did not talk. There was a noticeable abrasion on her forehead. The next day, on the same topic, she resumed her head-banging; this time even more vigorously and continuing despite my verbal interventions. I left my chair to place my hand between her forehead and the wall. I told her that I really had to try to keep her from harming herself. She pounded my palm with her head for a few seconds, then grasped my hand with both of hers and fell back upon the couch in convulsive sobbing. Several minutes went by before she released her grip. She got to her feet suddenly and fled. I could sense in neither of us any sexual stirring in the episode. But I wavered between feeling right about what I had done for the patient, and concerned that I had blown the analysis. Fortunately, the next day would be Wednesday, and Philadelphia. My supervisor, a scholarly man with great Viennese grace, listened to my tale and shook his head. He said that he had never had to do that. But it did not seem too bad. I should give some thought, however, about how to keep this from becoming libidinized through rep-

etition. On the train back I did reflect, first about how his counsel reminded me of confessions and absolutions I had known: "Go now, and sin no more." But being also eminently wise, he had added: "There is no way you can rationally assess this until you have thoroughly tried to find out what it meant for your patient." The full implications of this counsel did not strike me for many years, when I had arrived at a conviction about the central importance of such inquiry into the personal reality of the patient, as the basis for any piece of analytic work.

Besides, Ms. A in the next hour seemed back to her usual cautious constraint, perhaps a little less guarded. And I was relieved to be safely and correctly in my chair. She did no more head-banging, and could not be directly engaged in pursuing its meanings. She was able, fortunately for both of us, to let me know that she felt my coming out of my usual silence to explore her relationship with her father was making her intolerably anxious, and she feared she might go out of control. This I was able to hear, and I toned down my conquistador yen to exploit what I had seen as a weakening of her resistances. We came to work well together. My cautious reticence luckily suited her own, and we did no harm to each other as she made her substantial gains.

Several years farther down the analytic road Ms. A was able to tell me that this enactment between us had been crucial to the furthering of her analysis; that to feel her head touching my hand, and not the harsh wallcovering as she banged on it, had been immensely reassuring to her. Here, she had discovered, was a hand that did not try to manipulate her or to poke fingers into her for its own reasons; it did not stay aloof and out of touch in aversion to her as untouchable. Its being tangibly there and protecting her allowed her a dawning sense that I might not take advantage of her were she to reveal her secrets. Sensing this gave her the courage to risk telling me at the time how I had added to her distress, despite her wariness of me as bent on pursuing my own ends.

Others like Ms. A, during these same early years, puzzled and concerned me in their acute sensitivity to my interventions, so

evenly and incisively delivered. Some, when I had got it right, would, in their apparent gratitude and relief, reach back to seek my hand, or hug me on leaving, and I aloof. Sometimes, for good analytic reasons, I would steadfastly put off responding in kind or answering their questions, for the sake of eliciting more data. Certain patients would respond with distress and anger, followed by regressive withdrawal. Some attacked me verbally. Others put their own silence and distance between us, and conspicuously acted out their distress while away from me. Occasionally, on leave-taking in obvious frustration, a patient would grab my hand or hug me in what felt to me a mixture of defiance and appeal.

Here were two very different contexts for being hugged. I was surprised, puzzled, and uneasy over the relative flurry of activity breaking out around me, turmoil that I regarded as the patient's resistive breaching of my analytic rules, and sabotaging our analytic potential.

These actings-in by my patients, moved by what seemed to be very different emotions and reasons, were most troubling to me in this time of my seasoning. My refuge in my presumed detachment had been blown away. Their actions had flushed me out of my illusion of safe distancing, and grabbed us too close for (my) comfort. Inside, I had to deal with fresh surges these immediacies added to sexual and aggressive, pleasurable and repulsive, feelings and impulses between us. I had anxiously been handling these as best I could from the safety of my analytic chair, and was lucky to be able to hang onto the staying powers of those powerful proscriptions of training to shore up my personal constraints.

My distress and sense of uncertain hold upon my analytic capabilities soon pressed me to further personal analysis, this time with an active and articulate woman analyst. This work, so much more engaging and challenging than had been the rather solitary foragings of my earlier effort, opened me more to my feminine side, and to fresh perspectives on the different levels of my sexual and aggressive loadings. I became far more accept-

ing of the hungry need, resonant in me as well as in my patients, for the give-and-take of mother-child physical closeness, and the urgency in us toward action to evade, assuage, or avenge the pain and rage consequent to its lack.

Through that second analytic work I came upon a comfort in resonating to developmental nuances of need and caring that had not been reached in my prior explorations of my masculinity.

I am convinced that this added a gut-level understanding of the sort that makes impulsion to action become less obligatory for me, and then for the patient as well. Some of these patients needed less to hug, to act upon impulse, when I had my own tendencies better in hand, and could listen and respond differently to their urgencies that previously would have struck me as provocatively sexual or aggressive. And in the realm of my personal living I came upon enhanced capacities for gratification in the intimacies of being husband and father.

In this double enhancement that I have just sketched lies an important truism, one vital to matters of analytic boundaries and ethical observances. It is so obvious as to deserve overstatement.

It is this: the real and impressive enhancements that accrue, through personal analytic effort, to the analyst's work ego and capacities for living are at the same time vulnerable to lacks and losses that occur both within and aside from the analytic work. Optimal analytic capabilities are best secured when gratification and sustenance are by good fortune adequately available in the larger context of the analyst's life.

Returning to the complexities of hugging or touching: as I grew more comfortable, I was able to observe that these brief encounters often did not seem to carry for some patients the levels of discomfort and sense of boundaries being violated that I earlier had been apprehensive about. Indeed, their attention seemed more anxiously centered in how my anxieties, or my comfort, had come through in my respondings. These disparities intrigued me. They brought to the foreground the complexities of a proscription that seemed both a bulwark and barrier.

I gradually found that being hugged or touched by patients of either sex became an experience I did not need to cut off, or myself prolong, during the playing out of its many levels of similar or different meaning both for the patient and for me. One obvious finding worth reiterating is that the ease of the analyst in accepting the hugging while continuing to do analytic work will largely determine the course and outcome of the enactment. I base this generalization on the fact that my hugging experiences have become episodic and infrequent, in each patient subsiding in consequence of analytic work done after the act.

A derivative but less obvious point is this. In my experience the proscriptions and stoppings of such huggings, which in earlier years I had insisted upon, did not subsequently produce an analytic yield or relief of distress that were supposed to be the sequelae to well-managed frustration. What followed more reliably was misery and stalemated loggerhead over the continuing demands of the patient. This generalization has held for me. I think we must each cautiously test these loaded matters for ourselves.

I am talking about *being* hugged, about an action manifestly initiated by the patient. For I am old-fashioned enough to forgo initiating any physical contact with my analytic patients except under the most socially casual or professionally emergent circumstances. As I have grown older I have found it easier to assess my sense of need to initiate the hug in these infrequent instances, and to rely on a close following of the consequences as control and guide regarding our enactment.

My use of the word, enactment, rather than our traditional term, acting-in, is intended to convey that the matter of being hugged is not so transparent. From my perspective, action behaviors occurring in the analytic situation are codetermined by the dynamics of the two participants. When the patient is the apparent initiator of the action, as is usually implied by our designation of the patient's behaviors as acting-in or -out, closer study of the context will often reveal that some less than optimal

prior behaviors of the analyst will have provided provocation, seductive or rejecting, for the patient's regression to nonverbal levels of responding, including the urgent need for the analyst's physical response.

This sequence was remarked long ago by Winnicott (1958), then by Kohut (1971), and recently by Schwaber (1983). Schwaber (1992) has demonstrated that the analyst's defensive failures to recognize and acknowledge the patient's signals of distress over some recent breakdown of optimal contact between them will induce defensive and regressive reactions in the patient.

My own contribution to the exploration of these happenings has been to seek to identify the dynamic concerns of both patient and analyst at the time when such an enactment was taking shape. When these are bilaterally explored, there can be seen a potentiating interplay of similar and complementary intrapsychic conflicts in each, now being played out by both in the interactional field of the dyad (McLaughlin, 1991).

Some huggings which occur under these circumstances exemplify, in almost diagrammatic sequence, how our defensive behaviors, as we ward off some felt encroachment into our psychic perimeter of safety, initiate in the patient distress over loss of safe contact with our boundaries. If we can hear and respond to this distress, our first defaulting may be rectifiable and the patient restabilized. If not, the patient, in his or her unacknowledged pain, may regress further to the level of action and touching, and may be driven at least to hug. Should we meet the hug with a stiff or aversive response, this second rejection can be devastating, experienced as indisputable proof of the patient's worst fears.

From this perspective, I wish to relate two clinical instances involving touching, with touching now being raised to include the derivative level of seeing. This shift, from touching to seeing as a way of knowing, is a big developmental step for us as very small people, one impelled by biosocial pressures. "Look but don't touch" moves us from a primary knowing of holding, tast-

ing, touching, smelling what is close by, to another knowing through the reach of seeing across distance. The yield is a gain of range, but a losing of tangible sureness. Yet seeing is as old as touching, and in the welter of neonatal unfolding of our perceptual array, is presumed to be party to the intermodal fluidity of early infant development. This is a ponderous way of saying what our everyday imagery and metaphor show us to be true: that seeing and touching are closely linked with each other, and with the other sensory modalities, so that they easily convey equivalence.

*Clinical Vignette: Mr. E*

This patient had to deal with me in the early seventies as an analyst quite interested in augmenting my knowing by tracking all I could of my patients' nonverbal behaviors as they lay talking on my couch, and to see how best to relate these kinesic data to the verbal data (McLaughlin, 1987).

A slim somber man, stiff in his movements and cautious in manner, Mr. E rarely made eye contact with me in his coming and going, but kept me vigilantly in his peripheral vision as long as he could. Invariably, as he passed me, he would wipe the side of his face nearest me. In the intensity of his half-gaze I would occasionally feel, as time wore on, some transient tingling of my facial skin. For the first year he remained motionless on the couch, hands clasped tightly on upper abdomen. He talked in bursts, his brief phrases difficult to hear, couched in generalities, and framed by disclaimers and revisions. "But I don't know" edited his commentary, and "it could be" and "perhaps" were his coda to mine. My initial appraisal of him was that he was an intellectually gifted man, chronically anxious and inhibited in assertiveness and uncertain in self-esteem, and held back in his full unfolding by obsessional defenses. I have elsewhere described Mr. E in greater detail (McLaughlin, 1992).

His overall immobility on the couch was broken by near-

incessant hand play. I cannot recall another patient whose constantly touching hands held so rich a repertory of hand-to-hand combat, play, and lovemaking. I watched his bursts of vigorous picking at fingertips and nails tattered and deformed, and could imagine many years of habitual cuticle tearing and nibbling. At lesser intensity, his fingers scratched, squeezed, tapped, and banged, or at times gently smoothed and massaged their fellows. His thumbs had their own place in the action, tapping on or twirling around each other, grabbed or nestled in the curled fingers of its own or the opposite hand, the target of attack or caress from the other hand. I had watched these hand behaviors, and their timing with the patient's verbal comments, long enough to have noted that the patient's hand play of attack or caress was often linked to affectional, erotic, and sadistic concerns about his mother, his sister, and himself in intricate and consistent patternings.

Of his history, I learned that Mr. E had grown up as the middle child of three, with a sister three years older, and a brother who came along just two years later. Both parents struggled to survive in separate professional careers that took them early and often away from the home, once brother was born. My patient carried a blur of memories from his early years, of cleaning women and sitters looking in on him and the other two. He had sharper recall of his turning, as did his brother, to his sister for attention.

Mr. E still felt grateful to her for what she provided, although her ways too closely resembled his mother's unreliable bursts of caring. In our work he tended to merge mother and sister in his sortings of his past. He described both as being at times comforting in their solicitude, yet more often taking him over and doing *to* him, while demanding his grateful compliance. Both were capricious and unpredictable in responding or ignoring. If what he did offended, either could turn on him with fury, slaps, and stomping off. He remembered being bewildered and upset, lost and helpless, then growing quiet and cautious.

Father, on the other hand, he portrayed as distant, absorbed

in his difficulties with business and wife, unavailable to his sons in their coping with mother.

Though dealing with me warily, Mr. E seemed to idealize me as a detached, benign presence, and to relax in the doing. He gradually became freer to hint that he perceived my silences as failing to meet his silent wishing that I help him deal better with his emerging rage toward mother, and now his wife. His thumb-picking stepped up in tempo and prominence at this time. As he ventured to air more openly his needs and frustrations felt in relation to both parents, and now toward me, he became more anxious, and began openly to pick at the periungual skin of both thumbs with thumb and index finger of the other hand. The attacks were at times literally bloody. These mutilations finally prompted me, for the first time, to call his attention to what he was doing. I did so partly out of concern for this self-injury; and partly because I knew, from my analytic explorations of my own adolescent cuticle-picking and nail-biting, what rich dynamics of pent-up anger and sexual conflict could lie in this behavior. I had long ago been struck by my awareness that my finger-tearing had taken place at the boundary between myself and the other, where I had the potential literally to caress or claw someone important to me. Here was a most significant datum that I only partly understood. I knew that my old behaviors spoke of my wishes to attack, warded against by guilt and the need not to destroy the one upon whom I vitally depended.

Lastly, I intervened because I assumed that the physical pain he was experiencing must surely be in his awareness.

I was wrong in my assumption. On hearing me ask him to take heed to his skin-tearing, Mr. E showed shock and anxiety; his face flushed, his body became rigid and still. He was unable to speak for the remainder of the hour. I attempted actively to intervene, to reflect upon his apparent state and to explore how what I had said had upset him so. But he made no overt response. Several sessions were spent in my trying to find ways to address his mute distress. Gradually, Mr. E regrouped, and bits and pieces came out. He had been utterly unaware of his skin-

picking; he felt caught, shamed, rendered helpless and about to be given a beating. He felt my words as suddenly grabbing him by his shirt collar, jerking him off his feet; angry words in his face making his skin burn and itch in shame. He expected that I would abandon him. He could feel himself dropped in a helpless heap. He acknowledged that his cuticle-picking was a habit from his early school years, but at that point had nothing to add.

On my part, noting his shock and immobilization, I felt immediate distress in a pattern familiar to me as part of childhood experiences of misdeeds and blundering: chagrin and anxious vigilance, the flush of foot-in-mouth shame and misery over having done irreparable harm. My two analyses and further self-inquiry had largely attenuated this affective state to a signal-cluster that I had come to know as a call for more self-analytic effort. In this instance with Mr. E, my signal was high on my Richter scale. I worked assiduously to re-engage him, chiefly through seeking to learn more about the details of his distress that I had occasioned. It was slow going.

Following our enactment, Mr. E's thumb-picking left the analytic scene for several months, although his thumbs and fingers bore mute witness to ongoing assault elsewhere. Only later did more history of these kinesics emerge, as he worked over his experiencing me as having let him down, having turned on him and changed inexplicably from the comforting helper that he thought he had. Notably, his usual disclaimers and qualifiers became fewer as this piece of work was accomplished, and he became more forthright in his speaking. He could not remember exactly when his nail-biting and picking had begun. It had driven his mother to enraged screaming and face-slapping in her helplessness to break him of the habit. He could recall gloves tied on his hands, foul-tasting stuff smeared on his fingers, and beatings given him by both parents. These memories were entangled in recollections of even earlier battles and chemical warfare around thumbsucking, which struggles mother apparently had won. This later one she could not win.

In the aftermath of trying to resolve what I saw as an enact-

ment painful to both of us, I was able to do better in hearing, and reflecting to him about his pride in his nearly lifelong angry, stubborn ways of holding onto what he could that was his own, victories too often won at the cost of mutuality and intimacy. Recognizing the playing out of this struggle between us opened the way to our fresh seeing his being chronically burdened by his fear of his own temper, his fear of worse retaliation, and dread that he might not ever fully be able to love anyone. He could point out to me how much better it would have been, during our enactment, if I had just conveyed my regret over having hurt him. I thought I had. Mr. E recalled that I had spoken only of my chagrin, a word which he felt spoke only of my distress over my technical lapse, not an acknowledgment of hurt done to him. He would have experienced my direct apology as a soothing, "like having Unguentine spread on bad sunburn."

From my standpoint, it is clear that I was much caught up in watching Mr. E's kinesics in their simultaneity with the rest of his communications. I had reacted to his self-inflicted skin injury and bleeding by attributing a greater intensity of destructiveness than the patient himself experienced. I made an intervention aimed at stopping the self-directed assault, much as I had done years earlier in response to Ms. A's head-banging. My justifications for doing so in his behalf turned out to be more important to me than to Mr. E. He was long familiar with his mini-scarifications and bloodlettings, to which his scars bore witness.

I did work on the meanings this discrepancy in our perceptions held for me, and upon the significance of my signal response to his prolonged regression that I had evoked. The fresh light thrown on my personal conflicts of old sadomasochistic involvements with mother and sisters was considerable, but beyond encompassing within the boundaries of this paper.

One outcome important for me lay in my richer gut-level appreciation of my early ambivalence over my impulses to tear and bite with tooth and nail, my tears and fear when I had done

so. The locus of compromise lay at the tactile boundary between self and other, where the expression of the ambivalent polarity of caressing love or clawing hate depended upon the slightest curl of lip or fingertip. Only token damage, and not total destruction to self or other, would be realized.

I wish also to stress another aspect of my intervention that Mr. E found so shocking. Through prior work with the action behaviors of all my patients I had already come to base my clinical approach to nonverbal behaviors in a distinction made between two sorts of kinesics, and to have technical preferences regarding how best to explore these.

There were conspicuous nonverbal behaviors, often not far outside the patient's own awareness, that could eventually, with a little tact, be pointed to by me without disruption to the patient; and we could engage in their exploration.

On the other hand were small, inconspicuous kinesics that I had found to lie usually outside a patient's awareness. These small, background movements were better left alone. Because they were truly unconscious, my bringing them to the patient's attention was too intrusive, causing the patient to feel caught in a private act. It was best to look upon these as silent counterpoint and commentary, as confirmation or contradiction of the verbal carrier of communication (McLaughlin, 1987).

This time, with Mr. E, I had overridden my own experiential lore to question a habitual behavior that was small in his scheme of things, but had loomed large in mine. Consciously aiming to learn more about him/me, I had to surmise that at another level I wanted neither of us to penetrate into what might be shared and untouchable motivations in us both.

Mr. E clearly felt immobilized, indeed pinned and scorched by my questioning what he was doing as he picked and tore. It is conceivable that his raising the intensity of his attacks to a conspicuous level signaled wishes to reveal to me both his mounting aggression and his anxious need for my intervening. Had I seen his behavior in this perspective, I am fairly sure that I would have found a better way to bring the strife to his attention.

Instead, I spoke in a manner that breached boundaries between us which he had cautiously begun to trust, boundaries that I had set at the outset of the analysis when I had implicitly emphasized that we would focus upon what verbally transpired between us in the associative enterprise. I had added insult to injury (how right these old clichés turn out to be!) in not letting him know that I saw and regretted the hurt that I had done to him. At a more abstract level, I had acted upon my own perception of the patient's reality, out of my own defensive interests and purposes and in violation of his, and did not know it until confronted by Mr. E's response.

The cumulative effect of coming to recognize the iatrogenic wounding inflicted by experiences very like this, unnecessary levels of hurt done to patients often much more sensitive and less stable than Mr. E, drove me to recognize the relativistic nature of the analytic enterprise when perceived from the different reality views of the two participants. Mr. E's shock responses could not truly be understood from an analyst-centered designation of these as resistance and regressive evasion of the analytic process. I had no choice but to address the extent to which my assertion of my own viewpoint ignored the necessary exploration of the patient's experience and undermined his self-esteem (Kohut, 1971).

Working to alter my stance so as to keep my perspective more closely attuned to the patient's reality view, and actively attempting to retrieve that position and repair the damage when I find that I have retreated from it: these technical necessities have been for me a major preoccupation of these last fifteen years. I have become less sure of any generalities about our field, excepting that it is vital that we not act upon what we presume to know about a particular patient, based upon our theory or experience. From this position of assuming little and seeking to be informed I ask more questions, am not so long silent, and volunteer more ideas and observations in a tentative and nonassignative fashion. Tracking the patient's responses to my varied interventions provides clues as to whether the patient feels

touched in ways that offer space and freedom to engage, or feels poked, clawed, or pinned by words that stick to and in him or her (McLaughlin, 1993a, 1993b).

In furthering this endeavor, I have drawn upon the work of Schwaber (1983, 1986), in her exploring the analytic yield of a committed focus upon the psychic reality of the patient, in both its conscious and unconscious dimensions, and upon the nuances of the patient's responses to the behaviors of the analyst.

The commitment to seek out the reality view of the patient inevitably brings us into closer engagement with our own idiosyncratic convictions, and to a sharper awareness of how our own dynamics and defensive needs can influence our responses and the theoretical preferences that support them.

The closing clinical vignette which now follows reflects my gradual shift from a minimal analytic stance to the more active exploratory mode entailed in analyzing from within the psychic reality of the patient. I hope that the data will illustrate how this manner of working can widen and extend psychic boundaries, even in a patient whose profound obsessionality, coupled with my earlier ways of working, had previously limited optimal access to affective depth.

*Clinical Vignette: Mr. O*

Mr. O and I had been working, more or less together, in an analysis that had stretched over more years than either of us cared to contemplate. He had been in a long prior analysis elsewhere and had turned to me when he could not any longer deny his intellectual awareness that he was still stuck in his avoidance of success in work and love. Aloof and pokerfaced, he complacently declared that he had no access to strong feelings, either loving or aggressive, and that he lived his life as an emotional isolate, behind a façade of immersion in his business.

In the early years of this analysis I worked essentially from the austere base of my analytic origins: striving industriously to pro-

vide expectant silences and interventions carefully chosen for their accuracy and objectivity. My best efforts became blunted by his unresponsiveness; denied the feedback and guide of emotionally tagged ideation, I had to draw upon all that I knew of theory, lore, and previous experience involving obsessionality and narcissism. My clear lack of impact had led me often to withdraw in boredom, or to try to get to him and get some response, or call it quits. Mr. O meanwhile seemed always to hover above me as though nonchalantly stretched out in the gondola of a timeless balloon, peering down incuriously on what lay beneath him. His voice was singsong and devoid of affect as he dropped down to me his languid soliloquy about the thoughts that came unbidden and alien, and about which he might or might not speak once he had digested them. In my overt behaviors, I would often become more like Mr. O in my silence and inertness. I heard my voice become flattened out and distanced, or declamatory and insistent when I spoke my piece. For quite a time he basked in the comfort of feeling we were moving along "in stride," when to me it seemed we were marching in place.

We ground along, he making small advances toward minute engagements with me in the work, and half-acknowledged, half-hearted sorties toward involvement with others of both sexes.

As I gradually developed more confidence in the more active modes of analytic working that I described above, I felt my way with Mr. O into more exploring and contributing modes that addressed him differently, offering tentative thoughts about him, following his point of view more closely. While these shifts in me were gradual, he quickly noted them at first with mild alarm: that I was "out of my cage" and crowding him, behaving like a bad analyst. Yet he gave other signs that my altered ways might be reaching him. His nearly fixed postural immobility on the couch—crossed legs in full extension, arms tightly folded and eyes squeezed shut—began to give way to hand gesticulations and leg-stretching, at times his feet flat on couch with knees flexed and spread wide. Old and persistent physical dis-

tress attributed to a sensitive stomach receded, and some genital potency appeared mysteriously after years of dormancy. All this was only grudgingly and elliptically acknowledged by Mr. O, with considerable evidence of both anxiety and pleasure in being "reached." His abiding indictment of both his former analyst and then me had been that we had disappointed his yearning to be reached by interpretations that would "penetrate my defenses with a force that I can feel." He came to make this reproach less frequently.

In this interval one notable change occurred in his habitually desiccated thought processes. Mr. O was intruded upon by an alien thought which he was anxious to reject, but could not dismiss: that as a very young child he had been in some fashion genitally molested by his doting mother. I followed the twistings and turnings of his efforts to explore this unwanted idea and to demolish it, my stance being that, whatever its basis, there was something in the thought that had touched and clung to him. Both of us were aware that his preoccupation had emerged in the context of my moving to put myself more into the space between us. Both this felt present and his not yet tangible past were there between and in us, not yet fully acknowledged and explored.

Here is a brief exchange from an hour during this period. Mr. O on entering my office had remarked in alarm that I had seemed to smile broadly, perhaps even grinned, as I greeted him from across the room. Quickly on the couch, he added that he thought he didn't like it.

> PATIENT: What was it about, what did you have in mind? I've had the thought recently you might like me. No possible basis for that thought. It just comes. Like *you* just keep coming on. You've been like that for quite a while. You ask more details, like after I had that preposterous thought about my mother molesting me; asking what I thought it would have been like for me to have my mother molest me: sounds, body feelings, pleasurable or not. Of course I have no idea; you know that I'm an innocent victim in what happened [said in an ironic way that

might intimate an admission that by now he knew better, but wished to keep his security of not knowing?].

ANALYST: I *have* been more active. We know that no-nothing helplessness has been your way to ward off any meaning for you in your past and present. And you just spoke of my bothering you with my big smile, maybe even a grin; a grin you could not help seeing before you could get to the couch, close your eyes, and be safe.

PATIENT: You say that, and your voice sounds—uh—maybe playful—like you're smiling right now. I don't like that! [his knees, which had been flexed to vertical and pressed together, here move leftward and firmly into the couch back, away from me seated obliquely to his right rear] I want to get away from your face, your smile! [voice had risen in pitch and resonance, now drops] But what if I would like you to smile at me, could let myself --- [about a ten-second pause].

ANALYST: It's a thought you're having, of hearing a chuckle in my voice and seeing my smile, and not quite knowing what might happen if you were to like it; better play it safe?

PATIENT: Well, look at my legs: pressed away against the couch like I was protecting from something. I must be afraid of something. But a feeling in my back—here [slightly raises right shoulder and hip to show me where he has placed his right hand behind his lower ribs and is rubbing] like you had touched me as you smiled. Feels pretty good when *I* do it, but --- [again a brief pause; knees have relaxed in open position].

ANALYST: Good feeling when you rub back there, but --- ?

PATIENT: [a strident note in his voice] My back's tightening up! I hear you like you're seeing something in my "but" that I don't see. --- NO!: "my butt"! I couldn't have said that! [laughing uproariously] Those enemas she sweet-talked me into: was that her molesting? Your molesting? [voice drops, sounds earnest] Something not right about *that* connection. You sort of chuckled after I just laughed; and it's like that made me feel like I was sitting in your lap, my back there and you holding

me, warm and good. Now I'm confused about this idea about enemas, about what's good or bad about all this, what's between you and me, me and my mother. My back feels stiff.

ANALYST: Could you be saying that my comments come at you like I'm after something; then there's my chuckling that's like holding you so you feel warm and safe. How to read these mixed signals?

PATIENT: That feels close. But I think it's more that I'm used to being afraid I'll be taken advantage of, and of not letting myself dare. This is different. I get these ideas of friendly stuff between us and don't know how far to risk getting into that. Then I feel you are pushing something at me, and I'd rather not know what I feel.

There is nothing very striking about this hour, in terms of breakthroughs achieved or fine insights reached. Mr. O was showing and acknowledging a greater affective range, both verbally and in his kinesics. He seemed to have responded positively to the cumulative effect of my closer engagement. I felt that this man, once so grimly remote and impassive, was becoming comfortable enough to acknowledge fantasies and ambivalent wishes for physical warmth and closeness, despite his fears of the intrusion and overwhelming stimulation of a closeness that before had only threatened with its sexual implications.

His imagery and idiom, expressed in his own words and prompted by his anxious yearning, speak to boundaries being stretched, and fear of their yielding. My smile is seen across distance as offering liking and good touching; but more likely it is a predatory grasp. My question from behind him Mr O experiences first as a warm touch upon his back. He quickly translates this into a back-stiffening intrusion from the rear. Yet now he less rigidly defends against this "homosexual" idea that he has previously intellectualized about. He can both slip and laugh at the slip; defensively, of course. But now, for this brief moment, he is able to hear my chuckle as harmonic counterpoint, a sound that felt to him as my holding him in the warmth and

safety of my lap against his back while we look together at his conflicted wishes.

*Discussion*

I have tried to sketch, in an impressionistic fashion, the always-present sense of touching in the analytic relationship. Whether what is sought or feared within the dyad is a tangible, physical touching, or a psychic level touching of core or soul, analyst and patient are raptly involved. Often the interfluidity of imagery makes it nearly impossible to discern the differences.

To paraphrase what I stated at the outset: each of us has needs to make authentic contact with the "real" or "true" core of the other (and putting these words in quotation marks acknowledges the ineffable heart of this matter), in order to be affirmed by that other in some essential goodness, and to have unwanted aspects of ourselves accepted. I am using "goodness" and "unwanted" in a most nonspecific sense, both to acknowledge their idiosyncratic nature for each of us and to point to the primary origins of these feeling-wishes in our early object relations, now transferred onto our present other.

Traditionally, we have expected this to be true for the patient. We have come to find it to be true for the analyst as well. Acknowledging this, we can be more ready to see how our needs suffuse all that we are and do in the work, and how we must endlessly be self-observing to discipline and optimize these tendencies that are both our strength and our liability.

While my clinical samplings have ostensibly been about patients, it is evident that my finger has pointed to the analyst—to the facilitating and hampering of our best work in consequence of our melding of trained indoctrination and personal attributes. My generalizations about touching and hugging speak to limitations in the analyst compounded of blindly accepted training lore and personal defensive adaptations.

In the instance of Ms. A, this combination for a while limited

my apprehension of the crucial importance of metacommunications in analysis at levels other than those of the oral-aural axis.

In the sampling about Mr. E, it is evident that my particular research interests in nonverbal behaviors had coalesced with personal conflict around recognizing deeper meanings in the shared neuroticism of embattled fingertips. Together these led me to shape a specific intervention that asserted my defensive compromises and disrupted a safe place in which Mr. E was cautiously revealing fresh information about his sadomasochistic levels of aggression. Whose fury and pain was it that I chose not to stay with? That they were not yet his forced me to the recognition of my part in the enactment.

The cumulative effect of recognizing what I strongly believe to be iatrogenically shaped deflections and injuries has taught me to work assiduously to learn and analyze from the viewpoint of both the conscious and unconscious perceptual experiences of the patient (McLaughlin, 1981). Working closely to engage all levels of the patient's psychic reality inevitably opens one to a heightened appreciation of the patient's affective intensities, and to a deeper appreciation of one's own emotional resonances. It forces one to see and wrestle with how one's own needs, one's own preferred ways of seeing and coping, inevitably become imposed upon the patient's space and freedom.

The result is a continuing self-monitoring toward a sharper perception of an inherent dialectic, inevitably encountered when two minds attempt to meet in shared intimacy: an awareness of the endless oscillations between the pair as to who may speak to whom, and about what, so that the outcome may be mutually experienced and acknowledged as authentic for both.

I have been struck, and poignantly touched, by how different the quality of the analytic relationship can become in the safer intimacy for both of us which this mode fosters. I hope that some of these qualities are evident in the closing vignette of Mr. O, who in his own words conveys what he was feeling and telling about levels of our relating, and boundary experiences that I

could not anticipate. This small and common phenomenon, of the patient finding his own way, provided for both of us a fine affirmation of the clinical power of working in this mode, and of the cogency, the authenticity of the insights generated, when collaborative moments are realized.

I do not want to give the impression that this optimal state, similar to Isakower's "the analyzing instrument" (Balter, et al., 1980), flows unbrokenly from the analytic mode that I have described. For analyst lapses are inevitable, and these rarely go unregistered by the patient. I spend considerable time trying to work on and repair the consequences of my lapses. This work is necessary, and can firm up the base for fresh undertakings, a possibility that I have come to feel is enhanced by the analytic stance that I have emphasized above.

I also do not wish to overstate the analytic significance and moving power of these retrieved enactments. But these do provide intensities that amplify the affective range of the patient, stir the transference resonances for both parties, and provide the experiential realness that enlivens the core of the analytic relationship.

In the turmoil of these moments, the driving force of the analyst's reparative need to help the patient cope with the distress occasioned between them can, luck mingling with good judgment, be matched by the patient's own needs to help recover a state of good connection. This work of retrieval is more readily addressed when the ongoing analytic stance enhances a synergism by which both may transcend old expectations, and find expanded dimensions of themselves.

There is a healing touch in this that can reach to core levels of both members of the dyad. Herein lies the enduring motivation of many of us to persist in this work that we must do.

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*820 Devonshire St.*
*Pittsburgh, PA 15213*

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# The Ideal of the Anonymous Analyst and the Problem of Self-Disclosure

Owen Renik

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# THE IDEAL OF THE ANONYMOUS ANALYST AND THE PROBLEM OF SELF-DISCLOSURE

BY OWEN RENIK, M.D.

*The principle of analytic anonymity is critically reviewed. A connection between the technical stance of nondisclosure and idealization of the analyst is proposed. Some preliminary suggestions are offered concerning what kinds of information about the analyst are useful to communicate to a patient.*

What constitutes understanding in clinical psychoanalysis? What constitutes authority? How are understanding and authority managed in the relationship between analyst and analysand? These are questions very much under discussion right now, and a number of fascinating philosophical and epistemological issues are implicated; but they devolve, for the practitioner, onto everyday choices concerning technique, perhaps none more crucial than the problem we usually take up under the heading of the analyst's self-disclosure.

I think we have come to the point at which we need to review the way we conceptualize self-disclosure by an analyst and our assumptions about the effect of self-disclosure by an analyst upon the progress of a psychoanalytic investigation. I will propose, in remarks to follow, that our prevailing conceptions about analytic anonymity serve different and less constructive purposes than we have thought, purposes that bear directly on the issues of how understanding is arrived at in analysis and how

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authority in the treatment relationship functions. I will suggest that we can benefit from a more systematic consideration of useful forms of self-disclosure by the analyst that currently have to be bootlegged in and around the edges of a theory of technique which in principle discourages them; and I will outline a logic of self-disclosure that I think may be helpful. My purpose, I should say, is neither to substitute a new set of categorical prescriptions for the old ones, nor to advocate for willy-nilly spontaneous self-revelation by the analyst, but rather to suggest that we can usefully enlarge our clinical repertoire by systematically reviewing and revising certain of our technical guidelines concerning what we say about ourselves to our patients.

## *A Misleading Ideal*

I believe it is generally accepted that analytic work is facilitated when the analyst is able to maintain, as far as possible, a posture of anonymity. Of course, contemporary analysts tend to be "flexible" in their application of the principle of anonymity. A human demeanor for the analyst is widely recommended nowadays and rigid hyperformality frowned upon. Many feel that, as a practical matter, judicious self-revelation by the analyst under certain circumstances can be the least evil. For example, I think there is probably consensus that when an analyst has "made a mistake"—let's say gotten angry and insulted a patient—the analyst should admit it.

Effective clinical analysts tend not to follow the principle of anonymity with absolute strictness; they frequently set it aside or interpret it idiosyncratically, somehow or other finding a way to work around it in order to get the job done with their patients. Self-disclosure by the analyst may be seen as necessary because of particular circumstances (the patient is a child, an adolescent, is especially disturbed) or conceptualized as part of something other than analytic work per se (establishing the therapeutic alliance, maintaining engagement or rapport); but however they

arise, these commonplace departures from the principle of analytic anonymity do not alter its central place in our prevailing theories of technique. On the contrary, they preserve the principle of analytic anonymity by sparing it full accountability.

The premise remains intact and influential that all things being equal self-disclosure by an analyst burdens the analytic work: we are directed by theory to subtract our personalities from the analytic situation as much as we can in order to leave our patients the blankest screen available upon which to project their fantasies. We may have our doubts about the ideal of the-analyst-as-reflecting-mirror and want to feel we have left it behind, but we have not yet really replaced it; we have just made it more user-friendly by not taking it entirely seriously.

A major difficulty with the technical injunction against self-disclosure is that anonymity for the analyst is impossible—not only complete anonymity, but any anonymity at all. This is a radical statement, I know, but I do not think it is an exaggeration. Every intervention hides some things about the analyst and reveals others (see Chused, 1990; Greenberg, 1991); and every decision not to intervene communicates something, since patients tend to be quite aware of analysts' silences. I think we commonly make the mistake of thinking that when we impose inhibitions upon ourselves in the clinical situation (for example, keeping quiet instead of yielding to the temptation to make a potentially seductive remark to a patient) that we *reduce* the degree to which the analyst's personality makes itself felt. Actually, we have only *altered* the manner in which the analyst's personality makes itself felt. Careful examination shows that *any* way an analyst decides to deal with his or her emotional responses is consequential. Since that is so, the question becomes not whether to disclose, but *how* to manage the unavoidable condition of constant disclosure. In my view, to suggest that an analyst can minimize communication of his or her idiosyncratic psychology—emotional reactions, personal values, constructions of reality, and the like—is to advocate pursuit of an illusion.

Elsewhere (Renik, 1993) I have explained in detail why it

seems to me that expression in action of an analyst's affectively charged involvement always precedes his or her awareness of it, making analytic technique irreducibly subjective. I think we can recognize only after the fact how our personal reactions have been manifesting themselves. For present purposes, I would emphasize that an analyst's personality is constantly revealed, *in one form or another*, through his or her analytic activities. We can put our hands over our eyes, if we want; but we will not disappear.

Very much to the point is an observation Singer (1977) makes:

> . . . analysts often appear peculiarly reluctant to comment insightfully and incisively on their clients' communications. . . . they seem fearful that their insight would make self-evident that the analyst, too, "has been there," at least at some point in his life. Their empathic grasp, they correctly sense, could betray pointedly that the basic precondition for empathic communion is given, that is, personal knowledge of the experience under scrutiny . . . *what analysts so fondly think of as interpretations are neither exclusively nor even primarily comments about their clients' deeper motivations, but first and foremost self-revealing remarks* (p. 183, italics added).

Singer's observation underlines not only that anonymity for the analyst is a fiction, but that the need to pretend to anonymity can have a constraining and deforming effect upon an analyst's clinical efforts. What it is best for an analyst to say or not say about himself or herself to a patient at any given moment is an important and consequential decision. *Recognition that all of an analyst's analytic activity involves one form or another of self-disclosure obliges us to reconsider the ideal of the anonymous analyst and to develop new guidelines about what kinds of information about the analyst are useful to communicate to a patient.*

*Anonymity and Projective Identification*

I want to mention in this connection an important influence that has had a liberating effect upon analytic technique, but has,

ironically, at the same time perpetuated the ideal of the anonymous analyst: namely, the conception of the analytic process advanced by a number of theorists who make use in a particular way of the concept of projective identification. Bollas (1987) articulates the conception very clearly when he writes:

> . . . for differing reasons and in various ways, analysands recreate their infantile life in the transference in such a determined and unconsciously accomplished way that the analyst is compelled to re-live elements of this infantile history through his countertransference, his internal response to the analysand (p. 200).

According to this point of view, the analyst's subjectivity in effect presents no technical problem because it is *inconsequential*: such is the patient's power to determine the analyst's experience that the analyst's individual psychology is overriden; the analyst is, therefore, for all practical purposes, *rendered anonymous*.

"To find the patient," Bollas says, "we must look for him within ourselves" (p. 202). The analyst is presented with appealing modesty as a vessel for transference, a "potential space" within which the patient can "live infantile life anew" (p. 200). However, it is also true that the analyst is assumed to approach becoming a perfect observing instrument, transcending his or her idiosyncracy through submission to a powerful analytic process. The analytic relationship is envisioned very much in the tradition of Freud's (1915) romantic pronouncement, "It is a very remarkable thing that the *Uncs.* of one human being can react upon that of another, without passing through the *Cs.*" (p. 194).

Yet we cannot avoid asking: when the analyst looks inside, how is it that the analyst sees a re-creation of the patient's infantile life, rather than the analyst's own experiences, independently determined to a significant extent by his or her own individual psychology? Even if we grant that a patient may strive to elicit in an analyst a duplication of the patient's life struggles,

why does the analyst's subjectivity not constitute a powerful obstacle to faithful re-creation? Bollas explains that an analyst must be well analyzed enough to allow himself or herself to regressively experience and contain the countertransference. If he or she can do that, the analyst's "neutrality" creates a "frame," a "dream screen" against which the transference is played out (p. 201).

Here is the familiar core conception once again—old wine in a new bottle: the ideal of the reflecting mirror remains intact, but has been relocated; now the analyst, rather than the patient, gazes into it. The notion of a patient "out there" who can be studied and known by an anonymous, objective analyst is exchanged for the notion of a patient "within" who can be similarly studied and known.

What is of special interest about this particular conception is that while it retains an idealized picture of the analyst as anonymous observer, it also encourages analysts who subscribe to it to be rather more freely expressive in their interventions than others. Thus, Bollas writes:

> . . . it is crucial that the clinician should find a way to make his subjective states of mind available for the patient. . . . even when he does not yet know what these states mean . . . analyses rarely proceed with such clarity that the clinician knows *in statu nascendi* what and with whom he is meant to become . . . (pp. 200-201).

If an analyst believes that his or her personal reactions are being controlled—in ways and for reasons that may not yet be entirely clear—by a patient's manner of participation in the analytic situation, the analyst need not be reluctant to report those responses to the patient. The analyst will not feel that his or her anonymity is compromised in so doing, because the reports will not be understood, ultimately, to constitute personal self-disclosures; they are merely descriptions by the analyst of the

patient within himself or herself in raw form, reflections of not fully digested transference material.

For my own part, I do not entirely agree with this understanding of the transactions that take place between analyst and analysand. We have to be careful not to fall into teleological assumptions as we try to make sense of clinical events. I think that some patients, sometimes, do try to get their analysts to feel what they feel, or have felt; and in other instances, an analyst does come to have experiences very similar to ones his or her patient is warding off—though not necessarily because of purposeful instigation by the patient. I find the concept of projective identification to have great value, but I think it can be used in a mechanistic, even magical way that describes the movement from one person to another of thoughts and feelings conceived of as concrete objects. When this is done, it seems to me, a fantasy that is sometimes entertained by one, or even both, members of an analytic couple, each in his or her own way, becomes confused with an accurate description of events.

One consequence of the confusion is that the subjectivity of the analyst's perceptions is disavowed, and an undue authority for the analyst as observer preserved. Nonetheless, I believe that the influence upon technique of such a view has a salutary aspect, inasmuch as the analyst is encouraged to state his or her experience frankly and explicitly to the patient. I regard this as a good thing happening, in part, for the wrong reasons!

I hasten to add that many individual analysts manage, through aspects of their personal styles, to descend from the elevated position in which their theories of technique would place them. When Bollas, for example, describes his clinical work, he conveys an awareness of the fallibility of his formulations and a respect for the epistemological privacy of his patients that is certainly communicated to them. Still, we are best off with a theory of technique that does not have to rely on a given analyst's personal modesty to undo its unfortunate implications. The problem of the analyst's position as an objective authority, it seems to me, is hardly confined to certain variants of Kleinian thought.

*Fantasy, Reality, and Anonymity*

Among American analysts, the usual line of reasoning that argues against deliberate self-disclosure is based on a distinction made between reality and fantasy. The mind is conceptualized as in Arlow's (1969) well-known analogy, something like a screen upon which images are being projected from both within and without. If the contributions from without can be reduced, if very little about the analyst is revealed, then there is less interference with the patient's identification of his or her internally generated imagery; whereas, to the extent that the patient is given information about the analyst, it permits the patient to experience his or her perceptions of the analyst as if they were simply appraisals of incoming sensory data, and the patient is not as ready to acknowledge the influence of wishful thinking and unconscious preconceptions. In other words, as it is often put: the more a patient is presented with realities about the analyst, the harder it is for the patient to acknowledge his or her transference fantasies.

Yet we know that every analytic encounter presents the patient with myriad "realities" about the analyst. Furthermore, the things an analyst "really" does when striving for anonymity are just as likely to correspond with a patient's crucial unconscious expectations as are the "realities" presented by purposeful self-disclosure on an analyst's part. If an analyst does not answer questions, remains silent much of the time, and never reports personal feelings or opinions, we are familiar with how easily this can be experienced, by some patients, as confirmation of a belief that the analyst is sadistic and withholding or needs to be in control for competitive reasons; or, on the other hand, the very same reserve and suppression of self-expression can be just as easily construed by other patients to reflect the analyst's selfless devotion, giving credence to the patient's profound magical hopes and wishes.

Whatever an analyst does, he or she is constantly dumping grist into the proverbial mill; and the notion that the quantity of

grist will be limited if the analyst pursues a policy of behavioral minimalism or maintains an impersonal demeanor is received wisdom that seems to me to be contradicted by what our collective clinical observations actually indicate. My own experience suggests to me that whether I choose to comment on my patient's apparent submissiveness to his wife, or tell him that I find his description of his relationship with his son very touching, or attend a dinner party at which he is present, my patient will arrive at certain conclusions about me by a process in which observation and inference are inextricable. What gives us reason to say categorically that a greater quantity of information, or a certain kind of information, provides more "reality" and less opportunity for the generation of "fantasy" than another?

The articles that have been written about extra-analytic encounters and other unusual interactions (e.g., those necessitated by illness in the analyst) certainly indicate that when ordinarily avoided forms of self-disclosure are thrust upon an analyst, subsequent analytic investigation of them can be extremely productive (see Abend, 1986; Ganzarain, 1991). Why do we assume that these are special circumstances, that they burden an analysis, and that the yield we are able to take from exploration of them when they occur essentially represents damage control? If we look at the results actually reported in our literature, we see that all sorts of analyst-analysand interactions, from the most conventionally "interpretive" to the most obviously revealing about the analyst, are occasions for productive analysis (and this does not include those accounts of analytically beneficial, unorthodox encounters that are talked about informally but never get written up because they do not square with existing theory). I think we have to admit that a blanket principle of analytic anonymity does not, in fact, help us determine which forms of self-disclosure are likely to oppose and which facilitate analytic investigation. In my view, the distinction between *reality* and *fantasy* best refers to a judgment each individual makes concerning his or her various experiences as they occur. To regard certain of an analyst's behaviors as inherently "more real" than

others, and therefore more foreclosing of "fantasy," is to reify a set of phenomenological concepts.

It is interesting that the ideal of anonymity for the analyst has not received more explicit challenge within psychoanalytic circles, inasmuch as there are theories of analytic process that would seem to argue implicitly against traditional ideas about self-disclosure and technique. If an analyst places primary emphasis on the importance of healing interactions within the treatment relationship, as opposed to the pursuit of insight, there is no reason for the analyst to strive for a posture of anonymity. Analytic anonymity is not intended to generate new experiences with a new object; it is a strategy designed to maximize conscious scrutiny of a patient's previously unconscious mental life.

For a self psychologist, trying to effect empathic repair of deficits caused by narcissistic injury, self-disclosure per se should not necessarily be contraindicated; likewise, for a control mastery analyst, who is concerned with passing a patient's tests so as to disconfirm the patient's pathogenic beliefs. According to the conceptions of technique that follow from analytic theories that see the treatment relationship as curative, an analyst at various moments in the treatment *wants* to be revealed to the patient as having one attitude or another. Indeed, my impression is that analysts who subscribe to such theories are by and large not quite so meticulously concerned with trying to remain anonymous to their patients. Nonetheless, it seems to me that analysts overall tend to avoid deliberate self-disclosure, even in the absence of specific theoretical justification for the avoidance. I would say that among analysts of all theoretical orientations, there is significant reluctance to completely abandon a posture of analytic anonymity.

### *Anonymity and Idealization of the Analyst*

Why the pervasive tendency to avoid self-disclosure? If we want to try to understand why anonymity for the analyst has

endured as a technical ideal, it may be instructive to consider the consequences of maintaining the ideal. Of course, what is achieved thereby is not actual anonymity for the analyst, but a *pretense* of anonymity. The analyst has the illusion that he or she can remain relatively anonymous in the analytic situation, and via communication of conviction about this illusion, invites the patient to subscribe to it. The result is a collusion in which both analyst and patient disavow revelations of the analyst's subjectivity in the treatment situation and the patient's capacity to perceive them. A kind of *folie à deux* is set up at the heart of the treatment relationship, encouraged by our theory of technique. Hoffman (1983), in discussing this situation, speaks aptly of "the myth of the naive patient." I want to focus on the obverse side of the myth—the image of the *analyst* that is promoted by a pretense of anonymity.

The pretense of anonymity is a cloak worn by the analyst when pictured as an authoritatively objective observer, able to transcend his or her subjectivity in the treatment situation. An analyst's conviction of being able to achieve authoritative objectivity, even to a relative degree, constitutes a very powerful self-idealization; and it is this idealization of the analyst in which the patient is encouraged to participate. Cooper (1993) describes an aspect of the idealization when he speaks of reluctance to acknowledge the analyst's "interpretative fallibility." Denial of the analyst's interpretative fallibility can be discerned not only in some Kleinian conceptions of technique, as I mentioned earlier, but in mainstream "ego psychology" ones as well. For example, consider what is often called "the use of external reality as a defense." Discussing how this defense should be addressed technically, Inderbitzin and Levy (1994) write:

> Reality intrusions . . . interfere with the analysand's capacity for self-observation, especially of derivatives of unconscious id and superego pressures. It is our clinical impression that patients turn to these interactive realities. . . in order to defend themselves against observing and fully experiencing intrapsy-

chic pressures. It is here that the analyst intervenes . . . (p. 777).

One wonders how, according to these authors, an analyst is supposed to know when a patient is attending to "reality" rather than to "unconscious phenomena." The question, "reality according to whom?," apparently does not arise. How does an analyst know when a patient is fully experiencing "id and superego pressures"? Inderbitzin and Levy are not troubled by claiming authority for an analyst's judgments over a patient's about the patient's own experience. They assume that there is only one reality, objectively determinable by the analyst. Since they see the analyst as arbiter of reality, they also see the analyst as having the responsibility of minimizing intrusions of reality into the treatment. They believe that by refraining from self-disclosure the analyst can avoid intruding his or her "real" self into the analytic situation.

An important corollary of the principle of analytic anonymity is the widely subscribed to technical premise that it is not advisable to "reality test" with patients: i.e., it is thought that for an analyst to explicitly state his or her own view of reality constitutes a personal disclosure on the analyst's part that tends to foreclose a patient's exploration of his or her own view. I believe that when put into action, this premise invites idealization of the analyst. By feeling the need to withhold his or her views of reality so as not to influence a patient, an analyst conveys the conviction that his or her views are, in fact, potently authoritative. The analyst communicates the expectation that if a patient were to be exposed to the analyst's views, the patient would no longer be willing or able to think for himself or herself. Thus, any tendency on the patient's part to award the analyst undue authority as an arbiter of reality, instead of being considered unnecessary and held up for scrutiny, is implicitly endorsed as unavoidable.

By contrast, an analyst who regards his or her own constructions of reality as no more than personal views to be offered for

a patient's consideration has no reason to avoid stating them explicitly. Reality testing, if we want to call it that, takes the form of interventions in which the analyst presents a point of view different from the patient's by saying, essentially, "Here's what I see. Here's what it suggests to me. What do you see and what does it suggest to you?" In this vein, Bollas (1987) describes how Winnicott, when making interpretations, treated his own ideas about reality as "subjective objects placed between analyst and patient."

I have been noting that the principle of analytic anonymity encourages idealization of the analyst as an authoritative observer of reality within the treatment situation. Inasmuch as this is the outcome, we must consider that it is the desired outcome. It may be painful for us to acknowledge that a longstanding, fundamental principle of analytic technique is actually designed to promote irrational overestimation of the analyst, but we cannot really be surprised. After all, Freud was unapologetic about cultivating idealization of the analyst in the service of the treatment. His idea that "unobjectionable positive transference" should be used to facilitate the "overcoming of resistance" is well known. Perhaps we never really abandoned it. The desire to maintain a distinct identity for psychoanalysis certainly led analysts who succeeded Freud eventually to reject the idea that suggestion based on the authority of the doctor is a crucial part of our clinical method. To think otherwise would have been to admit that the mechanism of action of clinical psychoanalysis has much in common with all sorts of other psychotherapies—not to mention with hypnosis, shamanistic healing rituals, and the like.

In order to be sure that psychoanalysis is not just another therapy based on covert omnipotent fantasies about the therapist, we have developed an increasingly sophisticated theory of the analysis of transference over the years. The trend has been toward a more and more radical examination, a deconstruction of the analyst as the *sujet supposé savoir* (the one who is supposed to know), to borrow Lacan's felicitous phrase. I would say, how-

ever, that at the same time, maintenance of the ideal of the anonymous analyst has provided a powerful, unacknowledged countercurrent. It may be that in our eagerness to believe we have been successful in devising a method for analysis of transference, including "unobjectionable positive transference," we have disavowed the central way in which we have perpetuated and leaned upon the very phenomenon we thought to be eliminating: *a policy of "nondisclosure" and maintenance of the ideal of an "anonymous" analyst has permitted us implicitly to solicit and accept idealization even while we are ostensibly involved in ruthless analysis of it*. In order to adopt a technical stance that truly seeks to deconstruct his or her undeserved authority, an analyst has to be confident that he or she can operate without it, can offer a cure that is not, ultimately, based on suggestion. How confident are we, really?

I think we can all agree that idealization of the analyst by the patient is a crucial, useful phase in certain analyses, perhaps to some degree in all analyses. Idealization of the analyst is not, in and of itself, something to be avoided or suppressed; it is a phenomenon to be understood when it arises. In fact, if an analyst cannot tolerate being idealized, this can interfere with the necessary unfolding of the treatment relationship and prohibit important analytic work. Also, it is true that the psychoanalytic situation permits analysts to treat their patients better in some ways than analysts treat other people in their lives—what might be called the "actual" idealization of the analyst (see Hoffman [1994] on idealization in interactional terms), leading to earned authority. However, while idealization of the analyst initiated by a patient out of his or her needs, or actual ideal behavior by an analyst arising from the structure of the analytic relationship, is not necessarily counterproductive, when an analyst solicits, consciously or unconsciously, idealization and unearned authority, it has significantly problematic consequences.

Furthermore, an analyst's wish to be therapeutically effective via disavowed authoritative suggestion can dovetail with other wishes. We know that being idealized as an authority can be

personally gratifying for an analyst, can afford the analyst protection from anxieties that he or she otherwise experiences in interpersonal interchanges. Evidence of this is the unhappy fact that we not infrequently see analysts maintaining an "analytic" stance outside the clinical setting: with patients after analysis has been concluded (justified as necessary in case the patient might want to return to treatment), in supervision, and even in ordinary social situations. At the same time, anonymity is often relinquished more easily with those ex-analysands who become analysts themselves. Perhaps this is because shared values, not to mention the likelihood of identification with the analyst and the patient's willingness to enter into a hierarchy at a subordinate position, promise that idealization of the analyst will be maintained.

What is the remedy? Certainly the whole trend of the past ten years or so toward a theory of technique based on an intersubjective conception of the analytic situation has begun to treat analytic anonymity as a myth and to address the idealizations promoted by the myth. For example, Hoffman (1983) emphasizes the importance of recognizing that an analyst's personality is always expressed behaviorally in the here and now. Hoffman defines transference manifesting in the treatment situation in terms of a patient's need, for unconscious reasons, to selectively attend to only one plausible interpretation among many possible plausible interpretations of an analyst's conduct. Thus, the assumption that an analyst can be anonymous and can function as privileged interpreter of a patient's experience ("realistic" versus "distorted by transference") is rejected. Instead, the patient is recognized to be as much a legitimate interpreter of the analyst's experience as vice versa. Aron (1991) illustrates the clinical implications of this view when he says:

> I often ask patients to describe anything that they have observed or noticed about me that may shed light on aspects of our relationship. . . . I find that it is critical for me to ask the question with the genuine belief that I may find out something about myself that I did not previously recognize . . . in partic-

> ular, I focus on what patients have noticed about my internal conflicts (p. 37).

Investigators like Aron and Hoffman are mindful of the fact that an analyst cannot participate anonymously in the clinical situation. They recognize that a pretense of anonymity cultivates idealization of the analyst as authority, and are most concerned to be sure that expressions of the analyst's subjectivity become matters for discussion as treatment unfolds. However, the technical approach that these authors advocate still implicitly assumes the possibility of at least relative anonymity for the analyst: disclosure of the *patient's* perception of the analyst's subjectivity is invited, but explicit communication of the *analyst's* perception of his or her own subjectivity is not equally recommended. A stance of anonymity is not entirely relinquished, even as the myth of the analyst's anonymity is analyzed. Greenberg (1991), for example, offers the following rationale: ". . . self-revelation can foreclose full exploration of the patient's observations and his reactions to them. My technical prescription . . . is not to confess but to follow the often more difficult path of maintaining an awareness of the plausibility of the patient's perceptions" (p. 70). However, I believe Hoffman's (1994) candid admission goes to the heart of the matter: "The magical aspect of the analyst's authority is enhanced by his or her . . . anonymity. There is a kind of mystique about the analyst that I doubt we want to dispel completely" (p. 198). We may not want to dispel it, but I think we should!

It seems to me that if we look at the work of analytic thinkers who are trying to develop a theory of technique that takes into account the truly intersubjective nature of the psychoanalytic enterprise, one that does not cultivate idealization of the analyst, we see general recognition of the need to move beyond our traditional ideas about self-disclosure. However, a systematic conception that can replace the principle of analytic anonymity has not yet been worked out. On the question of self-disclosure, even very innovative thinkers tend not to go beyond open-

ended, nonspecific formulations. Aron (1991) says: "The question of the degree and nature of the analyst's deliberate self-revelation is left open to be resolved within the context of each unique psychoanalytic situation" (p. 43). Ehrenberg (1984) summarizes: "Too much of one's . . . participation can destroy the integrity of the analytic relationship, as does too much caution. What is obviously needed is a delicate, judicious balance which establishes optimal distance" (p. 565). Burke (1992) warns against an "unwavering position" one way or the other on the issue of "countertransference disclosure," and suggests maintenance of a balance between "asymmetry" and "mutuality." We can certainly agree with such general position statements, but they do not offer us very much direction with respect to everyday practical clinical choices about what to tell our patients.

### *Self-Disclosure for Purposes of Self-Explanation*

Clearly, some forms of self-disclosure by an analyst can be helpful and others harmful. I think we have ample reason to conclude that the categorical principle of analytic anonymity—i.e., that, all other things being equal, communication to the patient of personal information about the analyst hinders analytic investigation—is not valid; but what more can we do to develop useful criteria concerning self-disclosure?

Taking into account all that I have noted up to this point, I would suggest that we need to begin by not just discarding the principle of analytic anonymity, but by *contradicting* it: I propose that *it is useful for the analyst consistently to try to make sure that his or her analytic activity is understood as fully as possible by the patient*. I think it is best for an analyst to present a patient with a clear and explicit picture of the analyst's conscious view of his or her purposes and methods. An analyst should aim for comprehensibility, not inscrutability. *I am not advocating imposing one's thinking upon a patient, but I am suggesting that one's thinking should be made available*. For instance, if an analyst's intention in making an

intervention is not self-evident, it can be a good idea for the analyst to make it so; if the understanding that informs an analyst's conduct is not obvious, or if the evidence (as perceived by the analyst) for that understanding is not obvious, it is usually helpful for the analyst to explain them. This is not to say that an analyst always has a clear idea in mind of what he or she is trying to do. Sometimes the analyst's perplexity, or the spontaneous, un-thought-out nature of a remark the analyst has made, is what needs to be stated explicitly for the patient to consider.

Now, my impression is that most of us have been taught to do the very opposite of what I am recommending. We have been encouraged to keep our intentions and assumptions to ourselves, to avoid explaining our activities to our patients. As a result, we tend to be *ambiguous* rather than anonymous. By declining to disclose what he or she has in mind, an analyst does not become a blank screen, or a mirror, or even a Rorschach blot. Rather, by acting without explanation, the analyst essentially poses a riddle. The analyst's behavior could signify a number of things, but the patient does not know what the analyst meant. The patient is asked to select from among multiple choices, one of which is favored by the analyst without the patient's knowledge.

Not knowing the analyst's construction of reality does not help a patient identify and reflect upon his or hers. On the contrary, it interferes and distracts by implicitly inviting the patient to guess what is in the analyst's mind—which is what a great many patients spend a significant amount of time trying to do. Whereas an analyst's effort to be anonymous is supposed to allow the patient greater freedom to associate, the opposite is the case, in my experience. Far from diminishing the analyst's presence, a stance of non-self-disclosure tends to place the analyst center stage. It makes the analyst into a mystery, and paves the way for regarding the analyst as an omniscient sphinx whose ways cannot be known and whose authority, therefore, cannot be questioned. An analyst's preferences, inevitably communicated in the analytic situation, are all the more influential and

inaccessible to review for being inexplicit. By pretending to anonymity, an analyst increases the constraint he or she exercises.

On the other hand, when an analyst tries to communicate his or her thinking in full, respect for the patient as collaborator is conveyed. By publicly (within the treatment) taking responsibility for his or her own psychic reality, an analyst invites and allows opportunity for a patient to do the same. Of course, explanation by an analyst of how the analyst sees his or her analytic activity is no guarantee against idealization by the patient. Obviously, it is at least as easy for an analyst to be idealized for being open, candid, or iconoclastic as for any other reason. We have only to remember the old Jewish man who gazed at himself in the mirror and mused, "You know, I'm not very good-looking; and I'm not very smart; and I'm not very rich; but boy, am I humble!" The point of an analyst presenting the analyst's own view of his or her work as a subject for discussion is not that this *prevents* the analyst from being idealized by the patient, or even discourages it, but rather that self-disclosure of this sort makes the analyst's way of operating, like the patient's, a legitimate subject of joint inquiry. Thus, identification and correction of unproductive technique—including the analyst's wish to be idealized, if that is a factor—is facilitated.

For me, the *what* and *how* of self-disclosure consists of the analyst's trying to communicate what is in the philosophical tradition termed *pensées pensées*, that is to say, the analyst's thoughts as they have been thought. I try to make *my understanding* of *my participation* in our work together as available to the patient as I can. When an analyst intervenes, it is because the analyst feels he or she has something to say that may contribute to the patient's self-investigation; therefore, I understand the logic of self-disclosure to be that an analyst tries to communicate *any* thoughts that are pertinent to the potential contribution, as the analyst sees it.

Often, I believe, discussions of the problem of self-disclosure are inadvertently skewed by casting the question too narrowly, in terms of whether the analyst should report his or her emo-

tional reactions: Bollas (1987) refers to "the expressive use of countertransference," Burke (1992) to "countertransference disclosure," Ehrenberg (1984) to "affective participation," and so on. Since in fact an analyst's feelings and intimate responses are expressed in everything the analyst says and does in the clinical situation, I do not think it makes sense to equate the problem of self-disclosure with an analyst's decision to reveal "affect" or "countertransference," as if these categories denoted distinct and isolable aspects of the analyst's mental life. It makes no sense to consider any one category of personal information about the analyst (feelings, judgments, values, opinions) in and of itself problematic. Instead, it seems to me that an analyst's decision concerns which of his or her thoughts—always an inseparable amalgam of cognition and affect—to articulate; and I would say that an analyst should try to articulate and communicate everything that, *in the analyst's view*, will help the patient understand where the analyst thinks he or she is coming from and trying to go with the patient.

*Decision-Making about Self-Disclosure*

I emphasize *in the analyst's view* because, clearly, patient and analyst may disagree about what it is useful for the analyst to disclose, in which case the matter becomes open for consideration—neither the analyst's nor the patient's view being privileged a priori. For example, a patient has the idea that I was being extremely gentle and careful with him the prior hour because I was afraid of hurting him. I respond that I was not aware of any particular concern on my part, and that, therefore, from my point of view at least, the patient has his own reasons for imagining that I consider him so fragile. I feel it is useful to make explicit my own perception of my emotional state during the hour in question, since it is partly upon that perception that I base my hypothesis that the patient has an ulterior motive for experiencing me as gentle and cautious.

However, at a different moment in the treatment, the same patient feels, when I point out to him that he didn't seem to recognize that a remark made by his girlfriend was very disdainful, that I am trying to influence him to break up with her. He believes I have reached a judgment, based on what he has told me, that he can do better than this woman; and he wants to know from me what impression I have formed about his relationship. I answer that I don't see how whatever private opinions I may or may not be entertaining are relevant to our purposes: his need to deny his girlfriend's disdain seems to me an important matter that does not really indicate in and of itself whether the relationship is worthwhile. In any event, since she is not my girlfriend, it is not my opinion of her that counts. Therefore, I see his preoccupation with getting a judgment from me as an avoidance of exploring the purposes of his denial of his girlfriend's disdain, as well as a wish to have me make his decisions for him.

In each of these two instances, I reached a different conclusion about self-disclosure, based on my view of which of my thoughts were relevant to what my patient and I were collaboratively trying to understand about his mental life. In the first instance, I decided to state a perception of my own; and in the second instance, I decided not to state one.

The problem of self-disclosure by the analyst is sometimes discussed in terms of whether the analytic relationship is mutual or asymmetrical (Burke, 1992; Hoffer, 1992). In my view, the psychoanalytic situation is one of what I would call complete *epistemological symmetry*: that is to say, analyst and analysand are equally subjective, and both are responsible for full disclosure of their thinking, as they see it relevant to the reality of the psychoanalytic endeavor. We might use as a motto for the analytic relationship a remark attributed to the filmmaker Federico Fellini: "The only true realist is a visionary, because he testifies to his own reality."

However, symmetry is not *identity*. The thoughts of analyst and patient are differently organized because analyst and pa-

tient have different functions in the clinical setting; each is oriented to his or her shared endeavor from a different vantage point. Whatever immediate purposes may come into play, ultimately a patient communicates his or her own reality in order to increase his or her own self-awareness, whereas an analyst communicates his or her own reality in order to increase the self-awareness of the other person. Form follows function, which is why self-disclosure for a patient consists of an effort to free associate, whereas self-disclosure for an analyst is deliberately selective. The difference between the self-disclosure of the analyst and the self-disclosure of the patient is not *how much*, but *according to what principle*. Ferenczi's much criticized experiment in "mutual analysis" (in which he and the patient took turns upon the couch saying whatever came to mind) went astray not because Ferenczi's self-disclosure was excessive, but because his self-disclosure was organized in relation to a misguided objective. Ferenczi tried to accomplish the simultaneous analysis of two individuals within a single analytic setting—an overambitious effort that was doomed to failure.

Even when the goal remains analysis of the patient alone, there are many possibilities for how useful self-disclosure is accomplished by an analyst. Different analysts have different levels of ease with exhibitionism. Some talk readily about themselves, others are more reserved; some do not mind meeting with patients face-to-face, others cannot stand being looked at; some are able to lecture when their patients are in the audience, others find this situation constraining. What is important, it seems to me, is that an analyst's personal preferences be dealt with candidly for what they are, not imposed upon the patient in the guise of analytic technique (and not, in the same guise, imposed upon students and colleagues as categorical imperatives).

Certainly, it can be to the patient's benefit that an analyst establishes comfortable working conditions for himself or herself; on the other hand, an analyst's comfort can be obtained at the patient's expense. Relinquishing a stance predicated on the

pretense of anonymity deprives the analyst of protection from a kind of explicit, unameliorated scrutiny that can be most distressing; but we are obliged not to take refuge under cover of technique. I think the *great majority of successful clinical analyses require that at certain points, the analyst, like the patient, accept the necessity to depart from his or her own preferred ways of proceeding and to bear a measure of discomfort.*

### *Collaborating about the Analyst's Self-Disclosure*

By acknowledging that an analyst's judgments concerning what constitutes relevant full disclosure on his or her part are subjective, we indicate a role for the patient as constructive critic of those judgments. This is the reciprocal of the analyst's familiar role as critic of the patient's self-disclosure. We know that when a patient tries to say everything that comes to mind, an analyst is able to point out things the patient overlooks. Similarly, when an analyst tries to make his or her analytic activity as comprehensible as possible, a patient is able to point out things the analyst overlooks. I think Mitchell (1994) describes the analyst's position in relation to self-disclosure cogently when he says, "I am not necessarily in a privileged position to know, much less to reveal, everything that I think and feel" (p. 9).

A patient ends an hour one day by complaining that he senses I am not happy with him. He thinks there is a slight irritation in my tone. He has been talking all hour about a painful rejection, and now, on top of it, he feels rejected by me too. He leaves, and I reflect. He is right. I am a bit exasperated with him. Why? In the treatment recently, we have been talking about a way that I believe he shoots himself in the foot socially. He wonders why he doesn't have more friends. I have been suggesting that the same unconscious competitive strivings that used to cause him so much trouble in his romantic relationships (he has made great gains in that area and is very thankful) are still getting in his way with regard to potential friendships.

This hour my patient has been describing how his colleague has struck up a relationship with the boss. My patient is unable to tolerate his envy, and it is paralyzing him at work. He feels so hurt he can barely talk to his colleague, his boss, or anyone else. He cannot accept the situation, and I am trying to help him understand why. He has a need to be "Number One" that bears looking into; but when I try to address it, he does not seem to understand what I am talking about. He keeps berating the boss for rejecting him and himself for screwing up. "Why doesn't he like me? What's wrong with me?" he asks bitterly. His assumption is that he ought to come out on top, and if he hasn't, it's because he's made a mistake; yet, he doesn't see that this is a very rivalrous attitude, let alone that it may have something to do with why his boss, among others, doesn't take a shine to him. Instead, his view is that his boss rejects him for mysterious reasons; and I am doing it too.

He begins his next hour by restating his complaint about the prior session. I answer that indeed I had felt put out with him because he was thwarting my efforts. I admit that this was an uncalled-for, self-centered reaction on my part. I say further that at the same time, as I reflect on how and why he got under my skin, it seems to me that his way of relating might well have provoked even someone nicer than I: when I tried to invite him to look beyond his self-pity, he ignored what I was saying, then put me down for being unsympathetic. I acknowledge that another analyst might well not have been provoked and might have been able to retain a friendlier attitude; that was my problem. His contribution was an attack on me of which he was apparently unaware. We discuss the preceding hour. He begins to be able to see that he has a tendency to attack anyone who causes him to experience envy, often feeling like a victim all the while he is insisting on his right to be Number One; and in the hours that follow, he realizes that what went on between us is an example of exactly the kind of thing that obstructs his friendships.

My patient's comment prompted me to fuller awareness and

disclosure of my view of him, which opened a way for us to fruitfully investigate his concerns about the reliability of my helpfulness, his characteristic, maladaptive ways of managing envy and competition, and a variety of other important, related factors. Now, the initial irritation in my tone had been quite mild, in my judgment, and I thought my patient's perception of it was strongly colored by his expectations. I could easily have treated my patient's complaint about me as plausible and remained noncommittal myself. I could have asked him to elaborate and explore his ideas about my state of mind. This more traditional approach might have worked out very well. It could also have allowed us to stay bogged down in speculations from my patient about my attitude, leaving him continuing to feel rejected without being aware of his tendency to provoke rejection. In any case, I do not think any opportunity was lost when I followed the course I did. I took responsibility for my view of how I had both attacked and been attacked, which had the beneficial effect of requiring and helping my patient to do the same. It permitted my patient to reflect on his experience of me as an authority, rather than to continue to live it out within the treatment relationship.

I am very much aware of the difficulty of effectively describing how my view of self-disclosure translates into action, let alone what I think are the advantages of my view. Whenever one offers a clinical vignette intended to show the utility of a technical innovation, one is open to the comment, "that's okay, but it would have been better if you'd done it the usual way"—a criticism that can never be disproved, since controlled testing is not possible. Clearly, anecdotal case examples do not constitute evidence; they are merely illustrative. Even as illustrations, they are open to challenge. We often hear said about a specific application of a general technical principle, "I do that sort of thing all the time anyway. Why do we need the conceptual revision you are proposing?" The purpose of improving our theory is to make it something we do not have to be unproductively constrained by or ignore. We want theory to be a tool that helps

us find our way to successful technique more of the time. It is with that goal in mind that I offer a revised view of what I understand to be the traditional ideal of the anonymous analyst. Having stated these caveats, I would like to mention a few more ways in which my approach to the problem of self-disclosure directs my clinical activity.

Because I am less hesitant to make my thinking known explicitly and in detail than I was some years ago, I find that now I am more likely to share with patients certain questions that formerly I would have felt I had to decide for myself as matters of technique. For example, a young man is going over at great length the details of a decision he faces at work. It is my impression that he has passed the point of constructive thinking and may now be engaged in a process of rumination that has a motive not immediately evident to us. I am considering addressing this possibility in some way. At the same time, I know that this young man is extremely sensitive to criticism—throughout his childhood, he experienced his father as dissatisfied with him, finding fault with everything his son did. If I question the purpose of my patient's current thought processes in any way, no matter how diplomatically and respectfully, it is very probable that he will feel put down. This reaction on his part will then of necessity become the phenomenon of interest to us. I can intervene in the way I'm considering, and, if things turn out as I anticipate, investigate the patient's ideas about my disapproval—perhaps externalizations and projections of his own misgivings about his rumination will eventually be unveiled; or I can hold off, waiting to see whether he comes to reflect on his own about the motivations for his apparent rumination. Earlier in my career, I would have regarded this situation as consisting of a technical choice that I, the analyst, had to make. Now I would more likely share the dilemma, laying things out to the patient very much as I have just described them, including my speculations, my objectives, and my concerns.

I think this kind of self-disclosure by an analyst is basic to an attitude in which the clinical enterprise is conceived of as a true

collaboration between peers. In my view, whenever an analyst keeps his or her objectives, methods, or assumptions private, it privileges the analyst's point of view and maintains an idealized image of the analyst as superior to the patient. (This is true even of some of our most benign and humane conceptions of the analytic relationship, e.g., Loewald's [1960] notion of a "gradient," along which the analyst's relative maturity pulls the treatment forward.) Faced with a clinical dilemma, an analyst should feel at least as ready to seek consultation from the patient as from a colleague. Sharing the dilemma between analyst and patient explicitly acknowledges the true state of affairs, which is that each analytic couple has to negotiate its own way of working (see Pizer, 1992). Obviously, we cannot transcend the problem of the analyst's establishing himself or herself as an authority, since it is inherent in any decision an analyst makes, including decisions about what he or she will disclose; but we can acknowledge the problem and begin to establish a mechanism for self-correction by inviting our patients to join us as collaborators, *even in questioning our methods* (including our decisions about self-disclosure).

Because of my view of the utility of analytic self-disclosure, I feel freer than I might otherwise to communicate certain perceptions of my own to patients. For instance, Adler (1994) talks about how, with borderline patients, it can sometimes be very helpful for an analyst to say when he or she thinks treatment has been going well, thus contradicting and identifying as possibly symptomatic a patient's apparently irrational negative evaluation. In my own experience, the sort of situation Adler describes comes up with all kinds of patients; and what Adler conceptualizes as a technical modification necessitated by a patient's unusually severe psychopathology, I regard as consistent with the principles of ordinary analytic activity. I not uncommonly offer impressions, optimistic or skeptical (see Renik, 1995), about the progress of treatment when I think they are apropos. For me, the crucial issue is that the analyst's judgments about analytic events be treated as subjective rather than authoritative. If I am

more positive than my patient about what our work together has achieved, I may have self-serving reasons for being so. If that possibility does not come up for consideration, we have to wonder why. On the other hand, if I question whether an analysis is going anywhere and my patient does not, we ought to at least pay some attention to the idea that a personal frustration of my own might be coloring my judgment.

### *An Ethic of Self-Disclosure*

All in all, I find that self-disclosure for purposes of self-explanation facilitates the analysis of transference by establishing an atmosphere of authentic candor. When my patients experience me as saying what I really think—about them, myself, us—they respond in kind. All too often, it seems to me, clinical analysis deteriorates into a game in which the patient feels free to bring up all sorts of ideas, without taking any of them quite seriously. When the analyst does not disclose what he or she is really thinking, and disclose it as completely, as straightforwardly as possible, the patient is not encouraged to do so either. Disavowal gets built into the analytic discourse from both sides, and the patient's exploration of his or her experience is vitiated by a speculative, hypothetical, "as-if" quality. My experience is that the hardest thing for a patient to do is to discuss with his or her analyst profound convictions about the analyst's real character, to tell the analyst the sort of things that the patient suspects the analyst probably hears from friends and family members. Often, it is only in a second analysis that a patient feels free to consider what he or she *really* thought about a first analyst.

Of course, underlying my thinking about technique is an assumption about the mechanism of action of clinical psychoanalysis: namely, that therapeutic benefits are most extensive and enduring when they are based upon expansion of the patient's self-awareness. Certainly, a great many unresolved questions remain concerning the role of "insight" in a psychoanalytic "cure"; and an analyst's decisions about how to manage self-

disclosure will necessarily be informed by his or her particular theory of how analysis works. However, to the extent we can agree that, when possible, it is best for therapeutic experiences to be consciously examined, the analytic aim of analyzing rather than cultivating unearned authority for the analyst cuts across an array of theories of the analytic process; and therefore it seems to me that an ethic of candor, implemented via self-explanation, applies as an overarching technical attitude (alongside whatever other criteria an individual analyst brings to bear when making decisions about self-disclosure).

We are understandably slow to question our basic assumptions. Being therapeutic practitioners, we are obliged to be careful about changing something that seems to be working well enough. Certainly, a great many successful clinical analyses are conducted by analysts who try to avoid self-disclosure in pursuit of what they think of as a stance of anonymity. On the other hand, we cannot assume that everything that happens in a successful treatment contributes to its success. An analyst can be effective when elements of his or her technique are inconsequential, or even counterproductive. It is also true that a great many analyses conducted from a stance of anonymity and non-self-disclosure founder or become protracted and unproductive; and a great many patients are deemed unsuitable for analysis conducted along such lines.

As I see it, we are now at a point where the evolution of our understanding of the epistemology of the analytic situation requires us to discard the ideal of the anonymous analyst, and we are left with the problem of how to systematically characterize the most useful way to present our thinking to our patients. I have suggested that as a first step we need to redefine self-disclosure. I have tried to describe my own thinking in this regard, and I hope the medium has been the message!

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*244 Myrtle St.*
*San Francisco, CA 94109*

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# Aloneness in the Countertransference

Roy Schafer

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# ALONENESS IN THE COUNTERTRANSFERENCE

BY ROY SCHAFER, PH.D.

*This survey of a variety of ways in which analysands induce a feeling of aloneness in the analyst includes reference to the developmental origins, unconscious dynamics, and characterological settings of these ways. An account is presented of the role of narrative choice in* defining *the phenomena of an analysis not just in reporting pre-existing phenomena. Also included are some technical suggestions.*

## INTRODUCTION

The practice of psychoanalysis has gained a great deal from narrative innovations. These usually appear in the form of themes or headlines to use in giving accounts of clinical work. I prefer to call these innovations story lines because, in an interesting and instructive way, they lay down a line to follow in telling others about a single case or representative instances of a type of case or a type of clinical problem. To mention only a few of them, there is Freud's (1916) "those wrecked by success" and "the exceptions," Anna Freud's (1936) "altruistic surrender," and Winnicott's (1958) "true" and "false self." By following these story lines, the authors were able to organize and keep in focus a large array of clinical phenomena and a set of dynamic variables that seemed to underlie them. Usually, these dramatic and illuminating clinical narratives were not designed to replace more or less standard, systematic formulations, Winnicott (1958) perhaps being the exception here.

To apply the narrational model more exactly than I just did, it should be said that what we call the phenomena of the clinical

situation are themselves modes of description that implement a narrative strategy. Thus, it is not that the phenomena are there in the material, simply waiting for a suitable narrative; rather, the designation of these phenomena indicates that narrative practices are already in play. For example, if in writing a case history you simply say that a man is "unmarried" or "still single," you already place him in the context of a matrimonial narrative, not to speak of your performing an ideological act that upholds the value of the social convention of marriage. You might instead say only that he is "single," which, though related to unmarried, introduces the shadows of aloneness, or you might not mention marital status at all until it becomes particularly relevant, say in giving the man's sexual or social history in detail, which itself will be a narrative account.

I just wrote, "until it becomes particularly relevant." What does? What is the "it"? "It" is nothing except as it is endowed with meaning by a choice of wording that establishes a narrative context: unmarried, single, bachelor, unattached, divorced, widowed, lives by himself or with a male friend or female lover or his mother.

My introductory emphasis on narrative and story line is needed to illuminate a core aspect of my general theme for this essay, which is countertransference, and also my specific theme, which is aloneness in the countertransference. *For I could have referred to both differently*. Because I shall be using countertransference in its broadest sense, I have committed myself to a story line concerning the analytic relationship that is not the same as the somewhat narrower one required by reference to Sandler's (1987) "role responsiveness"; as I understand it, Sandler's concept does not emphasize adequately the continuity between emotional responsiveness and unconscious fantasies that we find in Heimann (1950), Racker (1968), and Joseph (1985). Most likely, as I develop my argument, at least some of my readers will think of still other names for what I am establishing in my account of significant phenomena in some or many analytic relationships. And the reader may even explain my choice

of words as revealing something about my problems, and refer to my essay as an effort to legitimize these problems. I would not rush to object to the use of other terms or to deny personal expressiveness in my choice of narrative; in fact, it is precisely my point that any narrative account is open to that kind of applied analytic interpretation. Is Sandler's "role responsiveness," for example, so perfectly objectivist, impersonal, and neutral that one could not view it as a choice? And, in certain contexts, could one even venture a hypothesis about this choice, especially after taking into account the tensions within the British Psychoanalytical Society between the conservative leanings of the standard Freudian group and the Kleinian group which uses, as I now do, a broad idea of countertransference?

Every narrative enterprise takes its chances in the way I have been discussing. It has always been this way. In another place (Schafer, 1992b), I tried to show that Freud's emphasis on resistance as a core concept said something about a countertransference problem he had in his clinical work. I would argue that those who keep searching for definitive and exclusive terms for any aspect of the analytic process are continuing to think in the objectivist or realist tradition. Fidelity to that epistemological tradition requires one to maintain a blind spot concerning the existence and the further possibility of multiple versions of what it is that we talk about or write about. In my discussion section I shall take up further the question of alternative designations of the experiences subsumed here under aloneness.

## ALONENESS

There are times when analysts feel alone in their analytic sessions. At first they may notice only that they are feeling listless, impatient, distracted, or irritable. Upon reflection, however, they will often recognize in the background that feeling which, here, I call aloneness, though others, in line with their sensitivities and interests, might call it something else, something with no evident links to feeling alone.

Reactive aloneness, which I shall soon detail, might occur during certain phases of most analyses, for example, when the patient is intensely defensive; however, the aloneness on which I shall be focusing is the one evoked particularly by certain analysands, those who are acutely anxious, guilty, defensive, or "omnipotent" to the point where they stir up aloneness so frequently that it begins to seem continuous and unmodifiable. Sooner or later in these cases, the analyst may be tempted to conclude grimly that the analysand cannot be reached, that his or her words keep falling on deaf ears or on ears that can only hear interventions as irrational, inappropriate, incomprehensible, or damaging, and that the analytic enterprise was ill-advised to begin with and is in the end doomed.

The feeling of aloneness need not arise when there are long silences, many latenesses, or unexplained absences; nor need it be present during controversy, bursts of verbal abuse, or difficulty in getting the drift or even the sense of the analysand's associations. Any one of these events may signify close engagement. But when aloneness does set in, it is likely to indicate the existence of some technical problem serious enough to require close attention, reflection, and perhaps intervention.

When I say the analyst feels alone, I do not mean acutely lonely; "acutely lonely" suggests that the analyst is grossly dependent on the analysand to gratify personal needs for company. It is when that loneliness is acute that the analyst is locked into a position that precludes effective analysis of the analysand's contributions to the difficulty. But because, in the usually shadowy realm of countertransference, it is not possible to draw sharp distinctions with confidence or to rule out a mix of influences, one must allow that, to varying degrees, loneliness can and often does enter into the feeling of aloneness. In addition, however, I do believe that many analysts share a longing for a special kind of company that they achieve only through their work, and that ordinarily this longing can both facilitate that work and expose the analyst to being manipulated destructively.

A large part of what follows from this point on is a detailed survey of the phenomena shaped and organized by the story line that the analysand is trying to induce the analyst to feel alone. Knowing how endlessly innovative analysands seem to be and how varied analysts may be in their emotional responses to these patients, I neither aim at nor claim an exhaustive survey of transference or countertransference. In addition to the interpretation already built into the story line of aloneness simply by giving it that name, I shall include some interpretations of the unconscious fantasies that this kind of analysand may be enacting. Later on I shall offer some tentative technical suggestions for working through some problems in this area.

In the first type of "aloneness" inducement to be considered, the analysands limit much or most of their contribution to the analytic dialogue to citation or quotation. For instance, they refer to previous details of this dialogue by saying, "You said I was feeling depressed," "We talked about the idea that I didn't like what you said," and "When I said that, I felt mad. . . ." They speak as though they were the keepers of the analytic archives and reading from files rather than participants in a highly personal dialogue. They convey no sense of having assimilated what they have said themselves or have heard or imagined. They give the impression that nothing has been allowed to work on them or in them. Their fidelity as analysands is limited to acts of remembering; however, the remembering is often inexact, owing to their making much use of projection and issuing many provocative invitations to be abused. Projective distortion and "seduction of the aggressor" (Loewenstein, 1975) ought to be expected from any analysand who is so well defended.

These analysands contrast sharply with the many who engage with others in more or less conventional ways, that is, those who usually mention simply what they felt, meant, discovered, rejected, or took into themselves as valid, however one-sided or exaggerated or misleading these mentionings might be. For example, they will say, "That time I got so angry," or "When I knew you were wrong"; they are less likely to try to limit them-

selves to saying only, "When you said I was angry," and "When I said you were wrong." The archival analysand may talk this other, more personal way more and more if and when the analysis is able to effect change.

Surely, we never expect every one of our interventions to be incorporated and assimilated or even to be remembered exactly. We are prepared to find that much has been modified or transformed, if not repudiated or repressed. And surely, citation or quotation always has a place in psychoanalytic dialogue. Here, I am referring to an extreme quantitative shift that creates the strong impression that the analysand is in so different a place psychologically as to seem inaccessible and to leave the analyst feeling quite alone.

Heavy reliance on citation is a sign that the analysand is trying strenuously to submerge her or his emotional life. These analysands come across as affectless, and their affectlessness announces that any sense of engaged togetherness is not to be hoped for. Consequently, there seems to be no hope of obtaining any of those essential confirmations of the analyst's own identity that depend on the two-way traffic of introjection and projection. Betty Joseph has been much occupied with these analysands in her writings; in one place (1993), she describes them as making it impossible to "resonate" with their subjective experience.

It has been recognized that empathy depends on that two-way emotional traffic. Without that traffic, effective mutual identification is blocked and usable empathy precluded. The conscientious analyst may be tempted to persist in trying to convey an empathic orientation, as, for example, by trying to empathize aloud with the desperateness that underlies and motivates the extreme detachment; however, if one hopes for quick or clear results in doing so, he or she will end up disappointed. Persisting further in this effort will certainly feel forced, dutiful, artificial, and basically defeating to analyst and analysand alike.

It is the analyst's effortful, overconscientious hopefulness that plays into the analysand's transference. For at that point the

analysand's intended transference-countertransference enactment will have begun to take effect. The ground will have been adequately prepared for the full-blown countertransference of discouragement tending toward despair, or of resentment tending toward rage. Either of these reactions may then be compensated for by some impetuous friendliness that is more likely to be a last resort of manic defense than a spontaneous expression of good will. At such times the analyst would be better advised to defer activity and to re-examine the felt need to remain active in the old way, or expressively empathic in a persistent way, or too eager for results. Usually, the analyst can be more helpful by confronting the indications that, at least inwardly and for the time being, the analysand has to insist unconsciously that the situation is hopeless and to stimulate despair in the analyst. And that insistence on mutual hopelessness may not even be just for the moment; it may be permanent. Winnicott somewhere advised the analyst to be prepared to acknowledge his or her genuine hopelessness and helplessness; as I recall, he suggested that the preparedness may even have a catalytic effect on a stalled therapeutic process. I have had some experiences that are consistent with Winnicott's advice. It is, however, a judgment call that is not easy to make and certainly difficult to communicate usefully to one's analysand.

To return directly to citation, it should be useful to mention some of its relatives. One noteworthy cousin is that curious form of continuing self-observation in which the analysand comes across as a bystander or reporter witnessing a steady stream of inner experience. For example, the analysand might make stereotyped use of the immediate past tense, regularly giving associations of this sort: "I was just thinking of my father," "I was just feeling kind of grumpy," and "A second ago I was afraid you weren't listening," or even a day later, "I was wishing you would say something about that." What is missing in these cases are straightforward, declarative, present-tense statements that are the most definite signs that an analysand is engaged in dialogue with a sense of immediacy and not acting as if reporting

to, or sharing observations with, an analytic record-keeper who might just as well be a tape recorder or, if not that, then simply a dulled listener.

Another cousin has been described by Ernst Kris (1956), the so-called Proustian analysand who dwells and dwells on memories in a self-loving way, quite possibly a masochistic way, to the exclusion of effective dialogue. Noteworthy in this case is the impression one gains of the self-indulgence through remembering that is very like enactment of masturbation on the couch. When that is the case, the analyst, as imagined by the analysand, is limited to the role of isolated and perhaps turned-on voyeur. Remembering has become a preferred form of sexual activity, which is to say that it has been sexualized.

A transitional version of this isolating performance is being enacted when the analysand fills the sessions with self-analytic observations that have been made between appointments. This kind of analysis in the past tense may well be another form of masturbatory soloing, and perhaps a masturbatory confession as well. Nor should its competitive, envious, or omnipotent elements be disregarded.

Sometimes these remote analysands refer to emotion by way of inference or speculation. These are the analysands who say such things as "I think I must be anxious," "I would have to be depressed to be having these thoughts," and "I must have been in a rage to have done that." Traditionally, this mode of function has been classified as showing the effects of extreme obsessional reliance on the defense mechanisms of isolation and intellectualization. These analysands counterfeit being engaged in dialogue. Often they strive so hard to give the appearance of bending over backward to be cooperative and responsive that, in the end, they only heighten the analyst's feeling of isolation. That feeling might be further heightened when they try to whip themselves into an intense emotional state by flooding themselves with intellectualized variations on an emotional theme; for instance, getting tearful or irate or enthusiastic over some speculated feeling state in the present or past. In these in-

stances, the analyst experiences no resonance (Joseph, 1993); if anything, his or her feelings run in an opposite direction, so much so that it can be realized after some self-critical self-analysis that he or she is being maneuvered into worrying inappropriately about being cold or hard. These analysands might even complain that the analyst is a "cold fish," hoping thereby to shift attention away from themselves as strangers to themselves, wanderers in a desert of pulverized affect who seem not even to cast a shadow.

Another narrative account of this conduct is this: These analysands are enacting a form of sleuthing for emotional experiences rather than spontaneously letting feeling be included in whatever it is they are saying; however, because they never really get a good look or make a secure inference, their sleuthing is never conclusive and the suspect always gets away, if indeed there ever was a real suspect or even a real search. Their researches are, of course, to be conducted in apparent isolation.

A similar manipulation may be encountered in the realm of ideas. This phenomenon is commonly called "running an idea into the ground." The analysand takes a word, phrase, or sentence that encapsulates an interpretation with emotional impact, and then repetitively invokes it in one context after another; this is often done in such a crudely reductive and mechanical manner as to induce in the analyst regrets for having ventured to convey the idea to begin with. Ostensibly, the analysand is complying, perhaps even "gratefully," by taking up the interpretation and going all out with it; however, the movement seems to be in circles, the words become meaningless, and once again the analyst is left feeling alone. For the analysand's purposes, any words will do: anxiety, envy, compliance, low self-esteem, triangle, and so on and so forth. These incantatory enactments demolish what is often a good enough conjecture or even a firm interpretation and perhaps as well an initial strong emotional response on the part of the analysand.

I turn next to another form of unrelatedness that tends to induce the countertransference of aloneness: the blatantly om-

nipotent narcissistic surface presented by some analysands. Because this surface has been amply described by many authors in recent years, once by me (see, e.g., Kernberg, 1975; Kohut, 1977; Schafer, 1992a), I shall limit myself here to some brief comments. These analysands set themselves up as authorities, passing judgment on their analysts, weighing their interventions judiciously, and when impressed, making sure to say so approvingly, perhaps only after noting with implied surprise that that good idea is something they hadn't thought of themselves. Also, they may hold forth at such length about the analyst, themselves, and the world at large that the analyst may well feel reduced to the role of someone who can only hope to get in a few words edgewise. In this posture the analysands are aloof connoisseurs, omniscient persons who are not really needful, masters who are not willing to let the slave/analyst try his or her hand at doing something useful. One may say that these analysands at best limit themselves to tasting what the analyst offers rather than ingesting it and expecting to metabolize it. Often, instead, they act as though all they are hearing is noise and all they are tasting is poisonous, and if they do not become scornful or suspicious, they become confused and difficult to understand or have difficulty remembering. Most likely, any one of these reactions forcefully enacts their experiencing the analyst as someone who exerts a bad influence by daring to interpret or even to speak, or in other words, interrupt. It is implied that the analyst would do best just to keep out of it, at least for now, that things have gone far enough and may get out of hand.

Not all analysands who are set against feeling needfulness will act in this exaggeratedly lordly manner. It is well known that the defense against feeling needful is extremely widespread. Its extreme forms invariably involve powerful unconscious fantasies of omnipotence. Because for these analysands it is imperative that they never ask for help, they develop the position that they can meet all their needs by themselves. Meeting this pathological requirement for total independence calls for much rational-

ization, projection of needfulness and responsibility, and wariness of what they experience as being seduced by the analyst into a "dependent" position. They often use the idea of dependency as a synonym for abject surrender, humiliating weakness, totally vulnerable helplessness or slavishness. They cannot envision experiences of needfulness as part of the give-and-take of any emotionally intense, ongoing human relationship; however, the practiced eye of the analyst can see signs of warded-off intense feelings of emptiness and ravenous hunger. Even the fact of coming for treatment, with its implied expression of the need for some help, is experienced resentfully by them. And though they continue to come for appointments, they try strenuously to keep out of an unrestrictedly dialogic treatment process and to create in the analyst the feeling of being on the outside, alone, with no one really to talk to and restricted only to being talked at.

The last family of clinical narratives I shall consider before taking up a few technical points involves those who "catch only a glimpse." Catching only a glimpse is one way to limit contact with whatever the individual considers to be the external world. Some analysands show that they belong to this family by never looking at the analyst directly or for more than a split second; a quick look out of the corner of the eye is the most they will venture on their way in and out of the office, and perhaps only after a long while. As the treatment proceeds, the analyst learns that, in various guises, this glimpsing is characteristic of their relationships with persons and events in general. Consequently, these analysands are often unsure of what they have seen or encountered, and they spend much effort in trying to decide. Alternatively, they may slowly let it be known in the analysis that they have not taken the good look that initially they claimed or implied and that they are in fact feeling more or less confused most of the time.

I am especially aware of two major factors that contribute to this mode of functioning: previous traumatization and a sense of forbiddenness. In the first instance, coping with traumatiza-

tion seems to have eventuated in a heightened stimulus barrier against the possibility of encounters with more external stimuli that could do further damage. These glimpsers may have witnessed terrible events, such as psychotic breakdowns or gruesome deaths, or they may have been exposed repeatedly to versions of primal scenes. The second instance, forbiddenness, implies a taboo against seeing clearly. This taboo may express a desperate need to subserve family myths that eliminate recognition and memory of serious transgressions, breakdowns, and deviance of every kind. Traumatization and forbiddenness may also operate together, even synergistically. No doubt, other factors are involved as well.

These two major contributing factors seem to stimulate or reinforce unconscious strategies of always keeping channels for projection open and those for introjection closed. There is overlap here with the group I described as relying on citation. In preference to projection and introjection, however, I prefer to say expulsion and incorporation or, even more concretely, open and closed; my preference is based on these words carrying more bodily connotations and so being more likely to capture the force of what is being unconsciously fantasized. Catching only a glimpse limits what is available to be incorporated, and at the same time it prepares the ground for expelling badness into what the analysand designates as being "out there." By expulsive projections, what is "out there" is made to seem dangerous or disgusting and therefore not safe or fit for human consumption. Instead of badness, however, it may be one's own goodness or sense of power that is expelled and then used to idealize the object to the point where it is out of reach of one's destructive influence. In other words, unconsciously the analysand's commerce with his or her surround moves only one way: bad out and nothing in, or perhaps some good and some strength out, too, and still nothing in.

Blocked incorporation can be protective of the object as well as of the self, in that the rejected object is being spared the fate of immersion in one's inner badness and destructiveness. I be-

lieve that both Melanie Klein (1946) and Fairbairn (1954) were describing something close to this phenomenon, she in connection with what she named the paranoid-schizoid position, and he in connection with what he called schizoid and described as involving centrally the extremely disruptive conviction that one's love is dangerous (see also Schafer, 1995). When one-way commerce is dominant, it may delay the appearance of signs of effective analysis for some time. It is a transference that seems altogether unapproachable by interpretation. In some contexts, it suggests a massive negative therapeutic reaction, which in a way it can be. Most likely, this sort of analysand feels the analyst's interventions as humiliating criticisms, boasts, rotten ideas, evil productions, or commands from on high that had best be obeyed. The analysand blocks any sense of being party to a personal relationship, or so it would seem from the standpoint of the analyst who persists in using the usual array of interventions.

It may well be that in the world of unconscious fantasy these analysands have had extremely painful and infuriating experiences of being the captives of harsh introjects or "presences" (Schafer, 1968). Owing to repression, these experiences seem to date from an early age, and owing to repression, they will seem to have retained much of their initial vividness once they are registered consciously. On this basis, these analysands will feel that they have lived their lives in enemy territory or as though they were standing before burning bushes into which they do not dare to look. Therefore, anything that resembles fraternizing with the analyst, such as eye contact, informality, or familiarity, remains out of the question. Hence, their avoided or furtive looks around. In one respect, their eyes seem to serve as mouths shut tight except for occasional nibbles at what might well be poisonous material around them.

Frightened they are; yet, when described along another line, they may be characterized differently, specifically as occupying positions of omnipotence. They are omnipotent in a limited universe: in one way, rulers of all they survey; in another way, rulers of all they overlook or banish. What they can't see can't

hurt them—so they hope! And, in its more benevolent aspect, what they don't see can't hurt their objects either.

This fantasized omnipotence has other dimensions, such as screening out all evidence that might confront one with a warded-off sense of helplessness and guilt. That these analysands can still readily feel humiliated or overwhelmed does not contradict their ideas of omnipotence, for on further analysis the negative feelings about themselves do not appear to be fundamental. Rather, they are experienced with only partial conviction; it remains most important for these analysands to believe that they cannot be touched by anyone else. Even the painfulness arises only on their terms, by which I mean that the humiliation is that of the extremely vain person and not that of someone trying to preserve ordinary human dignity. In these cases, the great powers ostensibly wielded by others are merely delegated powers, powers that can be exercised only in the analysand's own projective scenario. This aspect of omnipotence plays a crucial role in the analyst's countertransference feelings of fatigue, impatience, anger, even despair in being alone. Because of these feelings, the analyst experiences his or her resources of empathy, neutrality, shrewdness, and tact as being drained without apparent effect, if not put to negative use. It would not be wrong, however, for the analyst to infer that the analysand's implicitly and constantly reiterating, "You can't touch me!" gives a clue that unrelatedness is not all there is to it. Far from it. The countertransference of aloneness is only part of the story.

Other members of this family of glimpsers manifest not so much the avoidance of looking as chronic vagueness of perception or perhaps indefiniteness of registration. In these instances, they look but do not see, consciously at any rate. Sometimes they seem unable to focus; sometimes, distracted from what lies directly before them. In these cases, it seems that disruption has been shifted somewhat toward the internal world. These analysands may not readily retrieve names, addresses, quantities, pronunciations, and times and dates. What they do retrieve is full of gaps, approximations, and expressions of uncertainty

or uncommittedness, such as "sort of," "somehow," and "something like that." Sometimes they carry this vagueness so far as to make it seem that they are clear-cut cases of cognitive deficit or severely arrested ego development. Eventually, however, the path of interpretation through conflictual enactments of traumatization and a sense of forbiddenness and/or destructiveness leads to their being able to deliver definite versions after first having floundered. It is this change that shows that it is retrieval rather than initial registration that is disrupted. Despite their trying to appear agreeably engaged socially and often succeeding at that, they rather obviously invite the condescension, if not abuse, of many around them.

Consequently, of these analysands, too, it may be said that they are engaged in blocking incorporation and facilitating acts of expulsion.

In other terms, it becomes apparent that what seemed like deficits are interpretable as enactments of unconscious fantasies in the context of transference-countertransference. It is, I believe, well known that enacted castration fantasies may be involved (a recent approach to this aspect may be found in Kalinich [1993]); more often than not, however, the analytic work will fall short if it does not take into account more primitive factors, such as omnipotence, envy, and depression. The analyst's search for these essential conflictual enactments must be sustained if it is to result in the definition of neurotic disturbance of ego functions rather than primary deficits. Indeed, it is not rare to find, after extensive analysis, that these analysands are unusually sharp perceivers and that they fear the consequences of realizing or expressing what they have actually picked up. In these instances, the problem is not deficit, it is dangerous or rebellious nonmasochistic use of assets.

## ADDITIONAL TECHNICAL CONSIDERATIONS

I have been emphasizing that it is difficult to deal interpretively with transference that is designed to keep the analyst feeling

alone. One must, of course, always be patient, but beyond a certain point, analysands who exert this effect are likely to experience any exercise of patience as a withdrawal into silence, that is, as a retaliatory, submissive, despairing, or abandoning response. Although I know of no intervention that is guaranteed to work with every such patient or even with any regularity with any one patient, I will venture to make a few suggestions in addition to those I have already made along the way.

With patients who are pathologically sensitive to real and imagined criticism, it can help to suggest that some kind of unclear communication is taking place. For example, at times I have found it helpful to say that an atmosphere has developed in the room that may be responsive to an as yet unrecognized attempt by the patient to make some point to the analyst; it is an atmosphere of personal isolation, and as yet it is difficult to grasp or understand what point the patient is trying to make and about whom. By putting it this way, I ascribed (in my terms) no heavy responsibility to either party to the analysis and in that way tried to avoid reinforcing the analysand's readiness to feel abused. In other instances, I have said that so far I have not been able to think of anything to say that will not come across as disruptive or disapproving, and have then gone on to raise the question why that might be.

It is best to defer reconstructive references to paradigmatic relationships in the past that were equally isolating; it helps to wait until the point has been reached where the analysand is able to acknowledge that there is important meaning to be derived from the apparent impasse in the analytic relationship. It has often been suggested that the analyst might remark that the analysand is letting her or him know now, by showing it or re-creating it in reverse, how it felt during early development when one was put in such an alone position by absent, negligent, uncomprehending, persecutory, or exhibitionistic parents or other caretakers. When it is put that way, the interpretation keeps the focus mainly on the present, where it should fall.

One patient who left me feeling quite alone because she spoke

so softly as to be virtually inaudible responded productively *for a while* to my commenting, "You're talking as if you don't expect to be listened to," an intervention which, while it took in the past, remained directed at the present situation. Another analysand, one who relied heavily on citation and implicit forlornness, responded productively *for a while* to my saying that he seemed to be laboring against an overwhelming prohibition and that it was a prohibition against having a felt relationship with me. When I mentioned his having told me during early sessions that he had felt this way in relation to his mother when the two of them were constantly under the surveillance of his seemingly fantastically possessive father, the effect of this further intervention did not last for long. In another case, I remarked to an analysand who held forth so rapidly that I felt quite excluded, "I always have the feeling that I'm interrupting you or barging in on you when I have anything to say, much as though I'm an outsider. Does it feel that way to you?"

These groping examples are shaped by my sense of the importance of avoiding formulations that come across unequivocally as demanding or blaming, not in the vain hope that I can forestall all projection of demand or blame in this way but in order to maintain a platform from which to speak about distortion, incorporation, and expulsion. Sometimes, a consistent way of speaking in that manner to these extremely guarded patients can have a progressive effect. With these analysands we are considering, it may be necessary to maintain this meditative tone up to the very end. In effect, one is always somehow asking reflectively, "How is it between us?"—a question which does its best to minimize the appearance of invasiveness, controllingness, intolerance, sadistic manipulation, humiliating intent, and the like, and yet is not overcontrolled by the analysand who would like to limit the analyst's response to hopefulness based on denial or despair.

Just as it is important not to be lured into overambitiousness, it is important not to succumb to despair and inactivity. The creation of despair should be taken up once it is unmistakably in

play. For example, the citation that runs the analyst's words into the ground must be addressed in some way that brings out the anxiety, the guardedness, and the sadism in it, the analyst all the while being prepared to find that those efforts, too, may be run into the ground for extended periods.

## DISCUSSION

In taking as my theme the analysand's inducing in the analyst a feeling of aloneness, I have not intended to place that transference maneuver at the base of the hierarchy of motivational and affective factors governing the personality. Rather, I have been trying to construct a narrative of the therapeutic relationship that highlights aloneness. The value of that narrative lies in its both defining and organizing a variety of clinical phenomena and dynamics along lines that stay close to the framing of interventions. Along the way I have emphasized the potential interpretations of omnipotence, sadomasochism, narcissistic preening, and so on.

In developing therapeutically oriented narratives of this sort, we do better when we invoke dynamic factors when and where they seem clinically "in tune" than we do when we try too hard to conform to the requirements of one or another developmental or dynamic schema of personality organization and psychopathology. We do better because we convey more accurately the give-and-take of clinical dialogue. Although, necessarily, that dialogue does imply the analyst's being guided by a preferred schema of development and psychopathology, it still retains the advantage of individualization, concreteness, and timeliness. That kind of dialogue evidently reflects the analyst's empathic estimate of what the analyst as well as the analysand is prepared to deal with.

Narrative flexibility is not fluidity. Its point is to suggest by word and tone that right now and perhaps for some time it is one theme in particular and not some other that seems to be the

most profitable one to try to develop. In this way, what might be regarded by outside observers to be essentially the same issue may be talked about quite differently at different times or with different analysands. There need be no strict limit put on major themes. Only what I have called the master narratives of a system of analytic thought needs to be limited (Schafer, 1992b). But analytic therapy of individual cases presents the potential for a multitude of useful narratives. Existing technical emphases on tact, timing, and dosage imply this thematic flexibility.

Thus, the kinds of cases I have discussed might lend themselves to interpretive themes that center not on aloneness but, for example, on the idea that the analyst is supposed to feel responsible for all the reflective thinking in the room while the analysand feels . . . what? forbidden to participate? shamed into silence? waiting for the axe to fall? Alternatively, the analyst's narrative line might be the psychic deadness founded on identification with a lost object or the emptiness consequent to having been invaded and depleted by powerful persecutory figures in the past. With any of the types of analysands I mentioned earlier, these alternative story lines may have to be included in the analytic dialogue along with aloneness.

One theme I have not emphasized is the place of aggression as a key factor underlying the experience of aloneness in the countertransference. One might readily think of aloneness as the result of the analyst's not taking up the aggression or the sadism in the analysand's inducing this countertransference. My reluctance to emphasize aggression prominently *in this context* is based on the following considerations. (1) Empathy with the unconscious terror of change that besets analysands can justifiably lead the analyst to view the aggressive elements as mostly secondary and defensive and therefore not as assaultive as they might seem otherwise. (2) When the aggression in the room escalates rapidly, the first question the analyst might ask is whether he or she is too eager to be in control of the relationship or too needful of the analysand's cordial company, that is, too ready to feel rebuffed and alone on his or her personal account

and thus too easily frustrated. In this respect, the anger may indicate first of all that a narcissistic countertransference is in play and that it is crowding out empathy with the patient's dread of changing.

In these cases, it usually hinders the analysis to take up the aggressive aspects quickly and directly. It may be more facilitating to place the aggression in the context of great anxiety and guilt over deep-lying problems with relationships or of the need for omnipotence, and to do so later on. Thus, I do not propose neglecting aggression altogether, not even when it is a way of being punitively isolating and frustrating in the transference or countertransference. Rather, the first requirement is that the ground be adequately prepared by the focus on dread, defensive needs, and omnipotent fantasies and controlling enactments.

Finally, I must stress that it does not follow from my emphasis on narration that the patient's psychic reality is simply whatever the analyst makes of it interpretively. I do not believe that it is the case that "anything goes," as is sometimes charged or celebrated. What does follow is that all we ever have are different versions of what we have chosen to call psychic reality. There is no one ultimate, correct version. It is likely that many more than one version will be helpful in any one analysis. The main point is the potential usefulness of flexible application of narrative lines. A 1994 issue of *Psychoanalytic Inquiry* (Vol. 14, No. 3) shows, for example, how a group of Kleinian analysts in London employ to good effect a variety of thematic headings for a number of cases, each of which has many descriptive features in common with the others. This thematic variety has always been valued by clinical analysts for sparking their imagination and technical resourcefulness as they go on trying to be as helpful as possible to each of their analysands.

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*241 Central Park West, #1A*
*New York, NY 10024*

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# The Nature and Function of a Pathological Oedipal Constellation in a Female Patient

Maria V. Bergmann

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# THE NATURE AND FUNCTION OF A PATHOLOGICAL OEDIPAL CONSTELLATION IN A FEMALE PATIENT

BY MARIA V. BERGMANN

*The first analysis of a female patient dealt essentially with separation-individuation and narcissistic issues. During the second analysis a dynamic constellation of narcissistic character pathology, some psychopathic tendencies, perverse fantasies, and enactments emerged. Prominent was an unconscious fantasy of stealing the sexual organs of one parent to sexually satisfy the other parent. The etiology of this constellation and its transmutations in analysis are described.*

In "Maureen's" first analysis (M. V. Bergmann, 1980) her infantile neurosis was characterized by symbiotic-like clinging, phobias, eating and elimination disorders, and primal scene traumata. As an adult she was frigid, and her relationships were dominated by narcissistic pathology. The first analysis dealt with phobias, Maureen's narcissistic problems, and her incapacity to free herself from her closely knit family ties. As a result, an independent, nonclinging self emerged, increasingly able to

As this paper evolved, it was presented at the annual meeting of the New York Freudian Society in 1991, and at the Lindau Psychotherapy Conference and the Berlin Psychoanalytic Society in the spring of 1991. Later versions were read at the mid-winter meeting of the American Psychoanalytic Association, 1992, and the annual meeting of the Washington, D.C., branch of the New York Freudian Society in 1993. I want to thank Drs. Barbara Deutsch, Paula Ellman, Steven Rosenblum, and Leon Wurmser for their discussions, which were rich in ideas. I am also indebted to Drs. Judith F. Chused, William Grossman, Otto Kernberg, Ruth F. Lax, and Elizabeth Lloyd Mayer for reading this paper and offering helpful comments.

move toward autonomy. Maureen achieved considerable separation from her parents, changed professions, and became a performing artist.

After achieving feelings of internal liberation and a new sense of selfhood, Maureen wished to terminate her analysis. Although work on the patient's oedipal conflicts had aided maturation, conflicts related to narcissistic issues had interfered with oedipal resolution. In her relationships with men she needed to be admired rather than to love and be loved. Maureen had developed a more integrated sense of female identity, and I did not believe she could go further at that time, especially since she had never lived in the "real world" as an independent individual. I did not oppose termination, and Maureen left analysis cheerfully content.

Nine years after the first analysis, Maureen returned for a second analysis. She was in love and planned to marry, but felt insecure about being a wife. The second analysis uncovered Maureen's perverse character pathology, fetishistic thinking, and psychopathic traits (Arlow, 1971; Grossman, 1992; Kernberg, 1992). Underlying infantile traumata specifically related to the primal scene had become overlaid by characterologically embedded narcissistic traits. This formed an intermediary defense between the overtly apparent neurotic structure and the more severe underlying pathology. During the second analysis, a network of perverse oedipal fantasies emerged, some of which she had been able to sublimate as a performer.

We discovered a variant on the oedipus complex, in which the patient fantasized stealing the sexual organs of one parent and using them in intercourse with the other. While these fantasies remained active, she remained bisexual.

I first saw Maureen when she was twenty-two. She looked beautiful but sat erect and frozen. Her speech was controlled and her appearance overly neat. With complacency verging on arrogance she reported that, like her father, she saw herself as "special" and "perfect." She conceded that her tendency toward perfection inhibited her artistic strivings. She often felt detached

and "in a fog," her love life was unsatisfactory, and her capacity to express feelings limited.

Maureen's relationship with her mother was phobic and mutually clinging rather than attuned and loving. She force-fed and toilet-trained Maureen with anxious tension. When Maureen could not comply, her mother called her "a rotten kid," Maureen's first memory of not feeling perfect.

Maureen developed early an intense need to be empty. She vomited to protect herself against her mother's feeding assaults. The empty body was a way of coping. In states of fullness she felt she belonged to her mother and wished for an empty body that would be hers alone. This led to a basic affective state: to obtain separation from her mother she became detached from others and self, which sometimes resulted in depersonalization.

For Maureen's father her birth was a miraculous event; he considered her the most adorable person on earth. He could hold and feed Maureen lovingly; he never said "no" to her. The father's idealization was part of his ongoing seductive behavior toward Maureen, and it made her mother jealous. He was exhibitionistic and exposed his genitals. The mother, despite her childlike, sisterly behavior, consistently attempted to counteract the father's exhibitionism. There were open fights in front of the child, which added to Maureen's confusion, divided loyalties, and internal conflicts. The father's maternal behavior toward both mother and daughter, whom he called "his two girls," confused Maureen. She had difficulty in differentiating between herself and her mother and difficulty in developing a sense of female identity or any pleasurable feelings related to her own body and genitals (Mayer, 1985).

There was a further source of depersonalization: Maureen slept in the parental bedroom until puberty. Dreams and memories testified to very early body-image confusion related to witnessing the primal scene. Maureen called her feelings of depersonalization "bedroom feeling" or "being in a fog."

At the beginning of Maureen's menses her mother bought her her first brassieres, which were padded. Mother and daugh-

ter pretended Maureen's mother was a grown-up sister, and that both had big breasts. As she grew up, Maureen continued to wear padded bras. She dealt with anxiety by using more pads, which soothed her. She called her padded bras an addiction because she felt unable to exist or function without them. In contrast to a male fetishist who demands that the feminine object wear a fetish as a defense against his castration anxiety, Maureen seemed to use the padded bra as a magic phallus of her own (M. V. Bergmann, 1982a; Greenacre, 1970). Maureen idealized her mother's breasts, while she felt she only had a large bra. She did not experience her growing breasts as belonging to her developing body. They became devalued and "fake," thus she needed the bra. The bras also appeared to unconsciously represent her father's phallus, which she coveted. The penis-breast equation formed a particularly powerful theme.

In her close-knit family triangle Maureen fantasized from adolescence that she could be her father's "superwoman" or "prostitute" and outdo her mother in attracting him. In her early twenties Maureen, who is white, began a period of promiscuity with black men in which she enacted this fantasy. She dressed in slacks, boots, and padded brassieres under a sweater. She wore gaudy colors and used excessive amounts of perfume. She played at being very sexy and would throw herself on the bed nude, wearing only high heels and theatrical makeup; she pretended to have orgasms. She admitted that "being wanted was my greatest need." Her lovers had to be black to fulfill the fantasy of finding her "nighttime" father. She was frequently angry with her white "daytime" father who belonged to her mother. After intercourse with a black man she fantasized that she had acquired his penis, her way of concretizing a fantasy of fusion with her father. Maureen called this her "second addiction." It was forbidden, intoxicating, and her only way to feel sexual: "It transforms me away from being a woman. I become my father's penis—an animal, a cat. When I don't feel like a woman, I feel like an animal."

A few years after her first analysis Maureen returned briefly

for psychotherapy because she had developed bleeding ulcers, her father's lifelong psychosomatic illness. Her father had died, and she was in an intensely erotic relationship with a man substantially resembling him. Her lover was married and uneducated, like her father. He was submissive to her whims and showered her with gifts. During intercourse she fantasized that she had resurrected and possessed her father. She was his "superwoman" and "prostitute," receiving the narcissistic gratification and sexual satisfaction she craved via the fantasy of regaining her father's penis.

Maureen's fixation on her father made it difficult to free herself from the fantasy that her lover *was* her father. At times the power of psychic reality—the feeling of being in bed with her father—was overwhelming. Although Maureen claimed not to know "what was so wrong with incest," unconsciously she felt she *was* the injured father with whom she identified.[1] She fantasized she could protect her father and bring him back to life. Ulcers also represented the nonnurturing mother. Because of the pressure of the incestuous conflict, Maureen needed to leave her lover, and whenever she returned to him her ulcers began to bleed despite the medication.

Our work together enabled Maureen to understand that her sexual relationship with this lover had prevented her from mourning her father. She was able to leave her lover and treatment as well. Subsequently, mourning her father generated the wish to find a new type of love relationship.

Two years after this episode Maureen fell in love and planned to marry. She returned for a second analysis because she had difficulty coping with the social, economic, and cultural pressures imposed by the new relationship. She had a padded bra sewn into her wedding gown to relieve her anxiety about not being a complete woman.

Whenever Maureen shopped in a department store, she felt

[1] Chasseguet-Smirgel suggests that perverts do not experience "the horror of incest," because oedipal prohibitions are "less absolute" (1986, p. 90).

depersonalized, or had an anxiety attack because she felt that such stores were for "real women" who had "real women's bodies." She expressed the wish to be like me, to feel and look feminine, to be serene and not hostile. She envied women patients she saw in the waiting room whose feminine appearance made her think they had a secret she did not possess. Maureen liked to buy clothes in a thrift shop, which she found sexually exciting because "it was so cheap it felt like stealing." Thrift shop clothing enabled her to "impersonate" a woman since another woman had already worn the garment. She said it was like wearing her mother's skin.

A complicated fantasy system emerged. Unconsciously, Maureen simultaneously gratified her father with breasts and orgasms stolen from her mother and gratified her mother with her father's penis, stolen from him during intercourse. This double theft enabled her to reach her own perverse fantasy version of the oedipus complex.

Whenever Maureen had the illusion that she possessed the genitals of her father, she exhibited distorted reality testing (Bak, 1968, 1974; Raphling, 1989). Through analysis, she came to understand that the theft fantasy had enabled her to attribute magical powers to herself and had prevented her from realizing either her positive or negative oedipal wishes "on her own." The theft fantasy was also a means of healing the narcissistic injuries inflicted in the bedroom. If she had the special attributes of each parent, she could simultaneously possess them and also separate them from each other.

Maureen became consciously aware of the conflict between wanting femininity and sexual gratification with a man and holding on to her fantasies and enactments of the superwoman who "is a fake in bed." These conflicted wishes about her femininity were expressed in a contradictory transference fantasy: she hoped to reach femininity through our magic union via intercourse. She fantasized being the man, and by her wish to experience my body sexually a magical fusion state was fantasized. This fantasy represented a wish for the missed early close-

ness with her mother, and also had the earmarks of erotic feelings characteristic of the negative oedipal phase experienced in an archaic fantasy of fusion. Through intercourse with me she wished to find out how a woman experiences an orgasm.

Maureen had been unable to internalize my interpretations whenever her grandiose fantasies of being the "superwoman" defended her against the full affective experience of being overstimulated and ignored in the bedroom. Interpretations relating to Maureen's infantile traumata and narcissistic injuries, particularly her rage when she felt ignored, had been ineffective. When she was unwilling to accept an interpretation, she sometimes felt force-fed and changed the subject. There were also periods when she acted "constipated," refusing to talk and withholding information.

In the first analysis I had interpreted: "Unconsciously you sometimes feel like a man impersonating a woman. At such times, you really feel you *are* a man, and then you cover this up with an unreal femininity. . . . This way, you conceal from yourself that you feel helpless and angry about being a girl" (M. V. Bergmann, 1980, p. 541). This interpretation had produced an outburst of rage against me. Now I realized that Maureen had not been able to accept this interpretation while she still needed to defend herself against the overwhelming anxiety of ceasing to exist without mother's illusory breasts and father's illusory penis.

As the enactments of "superwoman" and being an "exception" based on her incestuous feelings toward her father became clearer, Maureen developed a genuine wish to feel like a woman and give up her fantasies of possessing her father's penis. Her frigidity became clearer now. We understood that she felt injured by her mother's forced feeding and harsh toilet training in childhood. She felt she had an injured mouth, anus, and vagina, which led to feelings of body inadequacy and self-devaluation. Thus, she disavowed her body and created a self-image of a body with large artificial breasts and a secretly stolen penis.

Analytic work was needed to help Maureen accept ordinary

fluctuations in her husband's attentions. She went through a phase in which she was convinced that I took her husband's side whenever she reported feeling ignored. She relived the extraordinary contrast between being the center of her father's attention in the daytime, and being both overstimulated and ignored in the bedroom at night. Maureen's experience in the bedroom had led to her feeling abandoned and had impeded her capacity to feel empathy for others. Whenever the analysis became "the bedroom," she ignored me, not responding to questions or interpretations, and treated me as though I were not present.

As we were analyzing Maureen's conflicts arising from having repeatedly witnessed the primal scene, she told me that from the age of ten she frequently read pornography and masturbated in the bathroom before a big mirror. She set up a "stage" with lights to see herself better. Dr. William Grossman believes my patient deliberately withheld the information about her masturbation during her first analysis. He has noted similar behavior in several patients in his own clinical experience (personal communication). My impression is that keeping the secret enabled Maureen to differentiate herself from me. She said:

> Rearranging the furniture into a particular position for masturbation I put time and energy into. It was my gift to myself, my entertainment, particularly after a performance [as an adult]—my secret. Sometimes I had the fantasy that it's not my hands I see in the mirror. When I felt father was doing it to mother, I felt disembodied. I also fantasized that father's hand was on me. I was recreating something: being half mother and half father. I experimented with my fingers in the vagina; I fantasized it's my father inside, that I have his penis and . . . that's why I didn't need a man. I obviously prevented myself from knowing what I was missing. I had to be in control—I couldn't just experience, I didn't believe you.

This last statement referred to her first analysis. Maureen only read pornography describing three people making love. These masturbation enactments illuminated unconscious attempts to control the primal scene.

Maureen had a masturbation fantasy in which she was her father stimulating her mother clitorally. She had another fantasy which condensed her bedroom experiences. She was in a prison with bars. The men came one by one for cunnilingus and said she was "the greatest piece of ass" they had ever seen. She recreated this fantasy with each black lover. Maureen associated that the bars might stand for the bars of her crib in the bedroom, that she was lying with her legs stretched through them and her father may have touched her clitoris or made her suck his penis. I said:

> In this fantasy you are "the greatest piece of ass" ever and your father is with you and not with your mother.
>
> Maureen: And what if it really happened? You sound as if you don't believe me.
>
> Silence.
>
> Maureen: I'm not sure I believe it myself. Whether or not it happened I have to get out of the bedroom and stop feeling ignored and angry at my husband. He appreciates my body; why don't I believe it?
>
> I said: You need to find out why you devalue your own body, because as long as you do, you can't enjoy his loving it.

Whether there was an actual seduction in addition to her father's generally seductive behavior—taking her into the marital bed (probably unclothed) after she wet her bed nightly—was never really remembered.

Periodically, Maureen longed for the addictive fantasy state where she possessed her father and became part of his masculinity. In this feeling state she displaced her rage against her father onto her husband and produced dreams and fantasies of having been seduced by her father.

One of her "sexual secrets" was masturbating a little girl she was babysitting. Maureen was ten or eleven and the child less than two. The child "couldn't talk and tell anyone," recreating Maureen's own silence in her parents' bedroom.

Maureen went through a period where she feared she would choke while coughing. She had dreams of little white bodies swimming in mucus, possibly the ocean. Maureen swam only in shallow water because she feared choking. One day she wanted to go to the bathroom for water. I said she could do as she wished, but as there was manifestly nothing wrong except acute anxiety, it would further our understanding if she could put it into words. She became pale and suddenly looked like an old woman. She said:

> Maybe my father really did something to me. Maybe he did put his penis into my mouth and I felt like choking; I couldn't breathe.

She did not remember except in this physical way. Her color became normal again, and she began to look her true age. As she got up, her entire body trembled. When she left, she held onto a chair as if she were afraid she would lose her balance. I commented on that, and she asked to sit in the waiting room until she felt strong enough to go home.

After this episode Maureen dreamed that her husband and a friend she admired for her femininity swam nude together in deep water. Maureen awakened from this dream in a fit of rage and envy. She said it was clear that this dream was about her parents having intercourse. She said:

> I was a caricature: with all these men I was like a man, not like a woman. I could not receive, but I put myself into the role of a receiver. I was aggressive and a performer.

Maureen blamed me for her failure to have a confirming memory. Her reproach became a transference issue; a memory of father would equal a gift from me, giving her the memory equaled giving her father to her. She demanded that she stay in treatment until such a memory emerged. Meanwhile, she could turn her husband into her father, re-enact in fantasy being mother and father in the bedroom, and thereby take revenge

for being ignored and excluded there. This would have put me into the role of the observer in the bedroom.

Maureen was a "survivor of the bedroom." I was uncertain, but decided to treat the idea of paternal seduction as fantasy unless proven otherwise. I felt that had I treated these fantasies as memories, as Maureen wanted, they might have enhanced her fixation. I might unwittingly assist in distorting her psychic reality and reality perceptions. In Maureen's unconscious, fantasy or possible memory were both treated as reality, which was confirmed by her dreams. This very current debate recently became a source of attack against Freud. Not entering into this helped prevent the issue from becoming "politicized" in the transference.

Gradually, Maureen developed a need for "getting out of the bedroom" and a hunger for identification with me. She decided to stop masturbating and threw away her pornographic literature, which she had hidden from her husband.

Ultimately, the question of memory or fantasy lost its centrality. Maureen said:

> Whether it happened or not, whether I remember it or not, before I can terminate, as long as I cling to it I am father's other woman. I am not myself. I need father's penis rather than my husband's and I hang on to not finishing my analysis.

As I continued to interpret Maureen's projections of the bedroom situation onto her present life, her capacity for internalization increased. When she could struggle successfully and find her own answers, she stopped feeling ignored and felt friendly; she began to grow up.

When she began associating to her fantasies as a neurotic patient does, she brought out her rage and anger toward me. She was reluctant to give me anything, such as pay a fee. She envied me and therefore had difficulty identifying with me. She was enormously curious about my life—particularly my sexual life—my way of doing things and my thoughts. She fantasized she would have to get "inside me" to obtain what I had. At the

same time her narcissistic fantasies of grandiosity and bisexuality—"I am a woman from the waist up and a man from the waist down"—defended her from envy and convinced her she had it all and needed no one. Eventually, Maureen was able to accept that her rage against women who were sexually gratified by men stemmed from envy of her mother, as well as envy of her father's erect penis and her mother's gratification by it.

For a time in her treatment she wanted to be the little girl she could not be as a child. She wanted an asexual but tender relationship with her husband in which he represented the nonseductive father. When I interpreted this wish, she experienced vaginal feelings during the hour and reported feeling more feminine than she had for a long time. She understood better her need to fantasize being a man and why she needed to wear falsies and plunging necklines to prove to herself she was female. The mirrors had a similar function. After she began to feel truly feminine, she expressed great sadness about having missed having a child.

Ultimately, Maureen was ready to bring her "tender currents" (Freud, 1910)—love feelings and sexual needs—together. She reached a full vaginal orgasm and said:

> I must have been a normal little girl with normal sexual feelings like other little girls. I wonder what happened to me and how I lost them? I must have lost them in the bedroom. I pretended I could be my mother with my father or my father with my mother. Therefore I never felt like a child. As I wanted to steal my mother's body and be my mother rather than myself, I couldn't have sexual feelings because I wasn't myself. Therefore I didn't know what it was like to be a woman.

## DISCUSSION

Analytic literature has described women with fetishistic tendencies, particularly where primal scene traumata played an important role, as needing the fantasy of using their sexual partner's

penis as their own illusory phallus, which gratifies both sexual and hostile fantasies (Raphling, 1989; Zavitzianos, 1982). Chasseguet-Smirgel (1984, p. 170) notes cases of perversion in which "the wish to steal the longed-for penis of the father . . . and to keep the love object, the father or his penis, inside herself" are prominent.

The fantasy of genital theft—satisfying her mother with the penis stolen from her father and her father with breasts stolen from her mother—defended Maureen against feeling helpless and overwhelmed in the bedroom and organized her deepest conflicts in adult life. She remained an incestuous bisexual fantasy participant in the primal scene and thereby gratified both positive and negative oedipal wishes.

Loewald (1979, p. 396) stated that incest destroys the oneness of mother-infant unity and the narcissistic bond within the family unit. Incest contains the exclusion and destruction of the third person in the triangle; a hateful vengeance is perpetrated on the incestuous object that is wanted or has responded to the rival. I believe that Maureen's stealing fantasy exemplifies this "hateful vengeance" and that she "disappeared" (became depersonalized) as a "third person" when she witnessed the primal scene.

Transference fantasies were dominated by unmastered affects related to primal scene exposure. When Maureen demanded that I "admit" that she was genitally touched by her father in the bedroom, she was attempting to make the treatment itself into a bedroom where I was the observer.

Initially, direct transference material was sparse. In that sense Maureen typified patients who suffer from a perverse character structure and psychopathic traits and who relive early traumata by perverse fantasies and enactments. One has to "read off" the meaning of these enactments and wait to obtain verbal confirmation from the patient. Boesky (1982) has pointed out that action in analysis can be important as a form of communication (p. 46) and that "ontogenetically, action tends to precede thought" (p. 49).

It was characteristic of Maureen's transference, in both analyses and in the intermittent psychotherapy, that enactments derived from the original traumata preceded discussion of fantasies or feelings related to the analyst. Following perverse enactments or fantasies, the patient initially cannot integrate and internalize interpretations (M. V. Bergmann, 1982b; Sandler and Sandler, 1978).

The configuration of the father's seductive relationship to Maureen and the mother's play related to the bras had led to gender identity confusion and promoted fixation on part objects which replaced fully internalized parental images. The ongoing overstimulation of being one of father's "two girls" in the bedroom impeded Maureen's ability to differentiate herself from her mother and may have stunted the development of her ability to distinguish fact from fantasy—for example, to distinguish observing the primal scene from being seduced herself. Thus, when Maureen reached the oedipal stage, an incomplete separation from her mother facilitated the formation of the theft fantasy. Maureen's fantasies resembled more closely those of a perverse individual than those of a neurotic patient struggling with oedipal jealousies.

Classical psychoanalysis held that perverts cannot love because they do not reach genitality. Martin Bergmann (1987) has shown that love and sexuality have different lines of development. People fixated on pregenital developmental levels may be capable of loving, but the nature of their love is different from those who have reached genitality. The capacity to love is based on a long development of internalized object relations and their stable representations. Perverts can also love, but only with the grown-up part of themselves.

Analysis eventually led to the emergence of a significant difference in Maureen's capacity to love. In the second analysis, a gradual desexualization of her relationship with her father, apparent in her dreams, a greater capacity for symbolization, and newly found love for her husband led her to abandon her former sexual preoccupations.

Analysis demonstrated to Maureen the degree to which her "bedroom behavior" had impinged on her reality testing and had led to self-destructive behavior, even in her marriage. When she had read pornographic literature, or masturbated in front of the mirror, she had attempted to re-create the bedroom both as an actor and as an observer. In the analysis, she began to experience "my way" as an advantage. (Originally, this was "opportunistic" and only later internalized.) Gradually, the internalization of the analytic experience made feminine identifications possible and led to psychic change. She realized she had needed her stealing fantasies when she felt hatred; at such times she lacked the ability to feel and internalize love. Before the analysis of her stealing fantasy, she could not experience herself as a little girl who loved her father and may have wanted his baby. When she reached this stage in her second analysis, newly discovered vaginal experiences together with feelings of bodily interiority led to an increased capacity for internalization, which made Maureen more capable of loving.

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*1136 Fifth Ave.*
*New York, NY 10128*

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# The Dream is the Guardian of Sleep

Herbert H. Stein

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# THE DREAM IS THE GUARDIAN OF SLEEP

BY HERBERT H. STEIN, M.D.

*Freud's concept that the dream protects sleep is first applied to a clinical vignette involving combat veterans and then re-examined. Although conceived in the context of the topographical model, it is more compatible with the structural model. The mind produces a believed hallucination mimicking gratification of impulses that would lead to awakening. It is hypothesized that the dream develops in the neonate during the arousal of the REM state to protect sleep from burgeoning object-directed impulses. The clinical vignette suggests that traumatic dreams can use past trauma to insure current vigilance. Traumatic memories may symbolize fantasy complexes in dreams.*

In a group therapy session for Vietnam combat veterans, one veteran reported having had a disturbing dream about the war the previous night. All the members of the group suffer such nightmares frequently. In this dream, he was under fire and could not find his rifle. He looked all around for it. Finally, he found a machine gun, but when he tried to fire it, he found there were no bullets. Then he awakened in a panic.

The group began to talk about the importance of keeping your rifle with you in wartime. One veteran said that he had had a job in Vietnam that forced him to leave his rifle, and that it left him scared. Another veteran described once being overwhelmed with fatigue while on guard duty. He strapped his rifle to his body and propped himself up. When the N.C.O. came by and started to shake him, he kicked out and pretended he had been awake.

The veteran who had had the dream said that he frequently was awakened by the sound of gunfire in his neighborhood, and that he would react by reaching for an imaginary rifle (as if he were in Vietnam). Like all the members of the group, he experienced continual hypervigilance, maintaining preparedness for an attack at a cost of a high level of anxiety. Their hypervigilance was accentuated at the time because of the recent bombing of the World Trade Tower.

Listening to the dream about looking for the rifle, the story of falling asleep on guard duty, and the report of frequent wakening with an impulse to find a rifle, I was reminded of Freud's idea that the function of the dream is as the guardian of sleep. The veteran whose sleep was so frequently disturbed by his fear of attack and the need to defend himself was buying himself a little more time asleep by dreaming first of looking for the missing rifle and then trying to fire the machine gun which proved to have no bullets.

The veteran who had described falling asleep on guard duty provided further support for my hypothesis. He reminded the group of a dream he had reported the week before in which the North Vietnamese were approaching through the jungle. In the dream, he knew that there were various other units—Australian, Thai, and Korean—who would make contact with them before they got to him. He could relax. Somehow, they got past the Australians, past the Thais, and past the Koreans. He awakened as they began their attack upon him.

Most of the Vietnam combat veterans I have treated report that they sleep two to three hours per night. There is clinical evidence that their sleep is curtailed by their intense fear of attack, and their need to be alert to defend themselves. They have been known to sleep with weapons in reach, to protect their apartments and homes by leaving broken glass on the window sill or by use of other booby-trap devices, to go out at night to scout their blocks, and even to have someone they trust sit awake (on guard duty) while

they sleep. Veterans will also talk about the dangers of being vulnerable by being relaxed or asleep. In fact, they take pride in being ready for danger. Van der Kolk (1987) attributes this to a permanent physiological change, but it is difficult to distinguish such a change from the results of continual hypervigilance. Underlying the hypervigilance is a fantasy that, unlike others, they cannot be caught unawares by an attack. On occasion, I have asked groups of Vietnam combat veterans if they would willingly sacrifice their hypervigilance in order to relax. Nearly all said that they would prefer to maintain their vigilance. Of course, I cannot say with certainty that that is not a rationalization of control over something they cannot stop.

The veterans tend to think that the dreams disturb their sleep. In fact, according to Freud's dictum, the opposite is true. The dreams serve to protect and prolong sleep. Sleep is disturbed by impulses that call for action. The dream incorporates those impulses in order to forestall the awakening. That being the case, why did these two veterans not construct more satisfactory dreams? The first veteran might have dreamed that he fought off the attack successfully, the second veteran that the North Vietnamese were defeated by the allied troops. Dreams are, of course, multiply determined. It could be that if we were able to analyze the dreams with more associations, we would find that such solutions did not fill other psychodynamic needs, although we would then have to explain why the protection of such needs made the continuation of sleep impossible. The simplest explanation is that such dreams would not have satisfied the dreamer's need to protect himself. They each had a need to react as if they were really under attack. In such a situation, continued sleep would lead to death. Dreaming that they were safe would be ultimately counter-productive. In order to extend sleep, the dream had to incorporate a relatively "realistic" appraisal of the danger as well as providing the illusion that the dreamer was responding to the danger. In this way, the sleep was maintained temporarily.

*The Implications of Freud's Concept*

Spurred by this experience, I decided to re-examine Freud's concept. Its clarification is of some importance if only because of its role as a psychoanalytic shibboleth. I found it to be conceptually important, but it is often disregarded in the literature.

In "On Dreams" (1901), Freud states:

> When once we have recognized that the content of a dream is the representation of a fulfilled wish and that its obscurity is due to alterations in repressed material made by the censorship, we shall no longer have any difficulty in discovering the *function* of dreams. It is commonly said that sleep is disturbed by dreams; strangely enough, we are led to a contrary view and must regard dreams as *the guardians of sleep* (p. 678).

He goes on to describe the formation of children's dreams on this basis.

> Since a dream that shows a wish as fulfilled is *believed* during sleep, it does away with the wish and makes sleep possible (p. 678).

In "Some Additional Thoughts on Dream-Interpretation as a Whole" (1925), Freud gives his strongest statement of the dream's function of guarding sleep:

> There is only one useful task, only one function, that can be ascribed to a dream, and that is the guarding of sleep from interruption. A dream may be described as a piece of phantasy working on behalf of the maintenance of sleep (p. 127).

Two points stand out:

1. Freud does not describe the preservation of sleep as *a* function of dreams, but as the *only* function of dreams.

2. He sees the sleep preserving function as being directly linked, in an explanatory fashion, to the predominant role played by wish fulfillment in dreams.

References to the dream's function as a guardian of sleep are relatively sparse in the literature on dreams. This is partly due to

the fact that it is not usually of direct clinical relevance. Nevertheless, there have been challenges to the first of these two points. Hollender (1962) disagreed with Freud, arguing that sleep preservation should be looked upon as only one motive for dreams among many. Trosman (1963) argued against the teleological form of Freud's statement, saying that we should not confuse a consequence with a purpose. Other authors have written as if Freud were describing the guardian function as one of the functions of the dream (Lansky, 1990), or even as a secondary function (Fosshage, 1983). Even Lewin (1952), who was very interested in the dream's sleep-guarding function, is ambiguous when he says that fulfillment of the wish to sleep would consist of blank sleep, the "dream screen," and that the sensory aspects of the dream represent other wishes. Fisher (1965) suggests that sleep was protected by the dreamwork, the defensive distortion of the dream that prevents direct expression of drive derivatives, rather than by the entire dream.

The second point extracted from Freud's quotations is that there is an integral cause-and-effect relationship between the dream's sleep-guarding function and its connection with unconscious wishes. This implies that the dream's function of preserving sleep is important for understanding dream formation. Nevertheless, the dream's sleep-guarding function and its link to the predominance of wish fulfillment in the dream is often overlooked in explanations of Freud's theory of dream formation.

To cite a prominent example, Arlow and Brenner (1964) make no explicit mention of the dream guarding sleep when comparing models of dream formation according to the topographical and structural theories. They make reference only to the "decathexis of the mental apparatus" as occurring in accordance with the "wish to sleep of the systems *Cs.* and *Pcs.*" in describing the model within the topographical theory (p. 116). They do not mention the dream as the guardian of sleep in describing the dream in terms of the structural theory. They attribute the special qualities of the dream to ego and superego regression and to the magnified intensity of the unconscious

wishes due to reduced defenses and absence of outside stimulation.

In a later paper, Brenner (1969) states:

> Now for the third point that we proposed to discuss, namely, the fact that instinctual wishes and fantasies stemming from the id play a larger role in dreaming than they do in most adult, waking, mental phenomena. That this is true seems self-evident. The explanation for it seems equally evident: during sleep, the mental representations of external reality are largely decathected. Broadly speaking, the only things that matter to us in our sleep are our own wishes and needs (p. 206).

This attributes the importance of wish fulfillment in dreams entirely to the absence of external stimulation. It ignores Freud's point that the central focus on wish fulfillment in the dream is a direct result of the dream's function of sleep preservation.

I believe that in this instance, Arlow and Brenner missed an opportunity to point out a significant advantage of the structural theory over its predecessor. When Freud made his first statement about the function of the dream, his theoretical model for understanding the mind was the topographical theory. It is difficult to make sense of his belief that the sole function of dreaming is the protection of sleep according to that model. In fact, I would argue that this famous dictum betrays an intuitive grasp of the principles of the structural theory. Freud, however, did not have the theoretical conceptual tools available to elaborate.

According to the topographical model (Freud, 1900), unconscious wishes seeking satisfaction during sleep are blocked from consciousness as thoughts and from motor expression by the preconscious barrier. These wishes follow a retrograde path through the "reflex arc," changing from thoughts seeking motor expression to sensory images. In this model, the preconscious is relatively passive. It "allows" the unconscious wish to find expression in a sensory form. In fact, it has little power to

prevent such expression because of its reduced vigilance during sleep. The hallucinatory quality of the dream is the direct result of the pressure of unconscious wishes. The dream is a compromise between the preconscious barrier to motor expression of the wish and the pressure of the wish. It then seems arbitrary to label sleep preservation as the sole function of the dream. It is the function of the preconscious barrier, but not clearly the function of the entire dream. We could as easily say that the function of the dream is to express the wish, and that the protection of sleep is left to the preconscious barrier and defensive distortions. This has led Fisher to assign the sleep protective function to the dreamwork, and contributes to Hollender's and Trosman's criticisms of Freud's dictum as being arbitrary. Since Freud never revised his model of dream formation, later authors have often used the topographical model to describe dream formation, and have understood the dream as resulting from drive discharge under the influence of the barriers to motor discharge and consciousness.

However, the idea that the dream's sole function is sleep preservation is far more intelligible if we understand the dream in terms of structural theory, incorporating the concepts of multiple function (Waelder, 1930) and the active executive role of the ego functions. In order to understand this, we must first change Freud's teleological statement into a statement of cause and effect. If the sole function of the dream is to preserve sleep, then the dream is a response by the mind, through its ego functions, to any stimulus, internal or external, that would disturb sleep. This is most apparent in cases in which sleep is threatened by an external stimulus. This means that not all stimuli are equally incorporated into the dream. Stimuli will be incorporated to the degree that they push for awakening.

In most cases, the primary source of potential disturbance to sleep comes from unconscious wishes. The wish is, in effect, a demand for action that will lead to gratification. This demand is expressed through the ego functions more or less as part of a compromise formation with other demands upon the mind.

During the waking state, the action called for and gratification of the wish may be perceived as leading to a situation of danger. Various defensive measures may be included in the compromise formation to disguise and divert the wish. In the sleeping state, the situation is different. Because of the relative paralysis that accompanies sleep, the wish is less of a threat to lead to dangerous action. However, by demanding action, it pushes for arousal, and poses a great threat to the state of sleep.

It seems fair to assume that during sleep there is some form of resistance to awakening. The mind of the sleeper is caught between unconscious wishes and other calls to action and this resistance to awakening. Gratification of the impulse requires awakening. Occasionally this happens, as with the two veterans described here. If the impulse is weak, perhaps it will simply fail to threaten the barrier to awakening. But if the collection of impulses is pressing, a successful compromise solution must be found to satisfy the impulses without disturbing sleep.

That solution is the creation of a hallucinatory image, the dream, which mimics gratification of the unconscious wishes and other impulses that might disturb sleep without requiring action and arousal. Without the creation of the dream as we know it, the sleeper would presumably either awaken or experience frustration. Instead, a believable hallucinatory image is created representing the gratification as having been completed. In this sense, the dream formation can be viewed as a defensive device. Even if the dream is accompanied by an orgasm, the drive derivatives represented in the dream are not gratified any more than they are gratified during masturbation.

In this context, Freud's dictum becomes intelligible. The hallucinatory image, the dream, is not simply the imprint of unconscious wishes upon a passive perceptual apparatus. On the contrary, it is specifically created to protect sleep at times of disturbance. Under ordinary circumstances, as Brenner has indicated, the greatest disturbance to sleep comes from unconscious wishes. The more successful the dream is in representing gratification of those wishes, the less the demand for arousal.

(Without pressure from external reality, these wishes can be represented in primary process form through adulthood.) This establishes a direct link between the unconscious wish and the dream, and provides a conceptual explanation for the fact that the dream, more specifically than other mental products, is a direct representation of a fulfilled wish. The fact that the wish must be significantly gratified to avoid awakening helps to explain why the dream is not just one good road to the unconscious, but the *royal* road to the unconscious. Obviously, too open an expression of the wish calls up superego and ego responses that might also call for action that could disturb sleep, so that the manifest dream must represent a compromise with disguised expression of drive derivatives as its core.

### *Modifications Based on Psychophysiological Evidence*

According to this model, we might expect that any disturbance to sleep can instigate a dream. In fact, as Hartmann (1967) has pointed out, this is not the case; dreams occur independently of outside disturbances. Psychophysiological research has demonstrated that with few exceptions, dreams are associated with a particular stage of sleep, referred to as REM sleep because of characteristic rapid eye movements. The functions of REM sleep have not been established, although competing hypotheses have been proposed (Crick and Mitchison, 1983; Vertes, 1986; Winson, 1990). REM sleep occurs in a regularly recurring pattern throughout the sleep cycle. This led Fisher (1965) to suggest that Freud's dictum should be modified to say that the dream is the guardian of REM sleep.

The conditions which Freud postulated for all sleep occur during REM sleep: a generalized hypotonia and motor paralysis, an increased barrier to external sensory stimuli, and a relaxation of inhibitions. REM sleep is marked by an electroencephalographic pattern closer to the waking state than that of other stages of sleep and by evidence of physiological arousal, includ-

ing sucking, smiling, and erections in neonates and erections and irregular rapid cardiac and respiratory patterns in older children and adults. Despite the EEG pattern close to a waking pattern and the state of physiological arousal, REM sleep is more resistant to awakening than the other stages of sleep. REM sleep is present in some conditions that would appear to preclude dreaming. A high percentage of intrauterine time is spent in the REM state, and the neonate continues to experience REM sleep. It is also present in decorticate animals (Fisher, 1965, 1978; Hartmann, 1967).

Clearly, the mechanism of dream formation described here must be modified to conform to this evidence. The simplest way to do that is to apply the mechanism to the conditions of REM sleep. Although other models of dreaming view the dream as a direct outgrowth of the REM stage (Crick and Mitchison, 1983; Greenberg, et al., 1992; McCarley and Hobson, 1977; Winson, 1990), it is also possible that the dream is a *response* to the conditions of the REM stage. Since the REM stage is marked by a state of high arousal, it is easy to imagine that these conditions threaten to disturb sleep. The neonate can respond to this aroused state with discharge motor patterns like sucking and erection without recourse to action that would lead to awakening. When these forms of gratification are insufficient, because of hunger or some other external disturbance, the infant presumably awakens with a cry. Such disturbances can be eliminated in the waking state through feeding or other maternal ministrations, but not in the sleeping state.

As the infant begins to form a rudimentary awareness of need-satisfying objects outside itself, it would begin to direct action toward such objects. The growing infant's REM sleep would be disturbed by both external cues, such as hunger, and by developing drives directed toward objects. These needs could not be satisfied by self-directed behavior, such as sucking, or by the presence of an erection. Satisfaction requires that the infant awaken to pursue the object of its desires. For instance, once the infant has learned the connection between crying out and the

appearance of a gratifying object, it will be pushed to awaken and cry out when inhibitions are removed. At that point, the construction of a hallucinatory wish fulfillment, a dream, becomes useful in maintaining sleep through the REM phase. The infant uses the defensive measure of hallucinatory wish fulfillment to bypass the need for action and to postpone awakening. In effect, the dream, in this model, is designed to cope with the object-directed psychological component of the drives.

Other models of dream formation and the function of the dream have been proposed, both by psychoanalytic authors and by neurobiologists examining the structure of REM sleep. Hobson (1988) has proposed that dreaming is the result of a response in the neocortex to neural stimulation coming from the pons. In his model, the dream is constructed to give organization to randomly stimulated visual images and memories. Crick and Mitchison (1983) have proposed that this stimulation from the pons has a function of erasing mental garbage, maladaptive thoughts that interfere with proper memory storage. They argue that this explains the apparent randomness of dreams. Winson (1990) has also proposed that REM sleep has an important adaptational function, in a sense opposite to the one proposed by Crick and Mitchison. He provides evidence for a hypothesis that during REM sleep, the individual rehearses important adaptational strategies and encodes the best strategies as memory in the hippocampus. In Winson's model, the dream is a mental representation of that activity. Winson's work dovetails with that of such authors as Fosshage (1983), Greenberg and Pearlman (1978), and Greenberg, et al. (1992), who believe that the dream serves, primarily, an adaptive problem-solving function.

All of these authors question the role of unconscious wish fulfillment and defensive disguise in dream formation. However, their models are based on the concept that dreaming is a direct outgrowth of the REM state. In fact, there is new evidence presented by Solms (1995) that suggests that subcortical REM phenomena are not integral to the dream process. He provides evidence from subjects with various forms of neurological dam-

age to show that dreaming can occur despite damage to the structures that produce the REM state and that subjects with certain cortical lesions can experience an absence of dreaming without losing REM stage sleep. Furthermore, subjects who did not dream because of cortical lesions described their sleep as being disturbed, suggesting that the dream does function as the guardian of sleep. Based on these findings and the locations of the cortical lesions, he proposes two hypotheses that are very compatible with the model described here: (1) that "*anything which disturbs sleep can give rise to a dream*. REM activation is but one such phenomenon (albeit a regular and a common one) . . ." (p. 60, Solms's italics); and, (2) that "[n]octurnal mentation is . . . deprived of the characteristic goal-directedness of waking mental life, and the activating impulse is worked over symbolically in visuo-spatial consciousness" (p. 61). In other words, goal-directed motor behavior is inhibited in favor of hallucinations that are influenced by symbolism.

Of those exploring the adaptive function of the dream, Palombo (1978, 1984, 1992) has the most comprehensive approach, integrating the wish fulfillment hypothesis with an adaptive function involving organization and storage of memories. There are promising possibilities of integration of the sleep preservation model with Palombo's work. The sleep preservation hypothesis implies that any strong impulses to action, including current issues of adaptation, would be included in the structure of the dream. Palombo has elucidated mechanisms by which representations of the various contributing elements can be integrated to form the content of the dream.

A detailed comparison and integration of the sleep preservation model of dream formation with the various other models and their psychophysiological bases is beyond the scope of this paper. At this point, the psychophysiological evidence is inconclusive concerning the mechanism of dream formation and the function of the dream. None of the models have been solidly established or disproven. The ultimate outcome should be important for clinical work with dreams, which is often conducted

without awareness that the structure and function of the dream are a matter of current debate.

*Other Determinants of the Two Veterans' Dreams*

In the two dreams presented here, the struggle over maintaining sleep appears in the manifest content. I have suggested that this struggle is more apparent because of the difficulty these men have staying asleep. Nevertheless, other possible and probable factors are known in the formation of the manifest content of these two dreams. The man who reported the dream about being shot at and looking for his gun has frequently reported hearing gunshots in his neighborhood at night. It is possible that this dream evolved partially in response to an actual stimulus.

In both cases, the manifest content of the dream is influenced by the defensive style of the dreamer. The man who could not find his gun is characteristically in a state of frustration and unexpressible anger. He appears to struggle with both his conflict over his own rage and a sense of helplessness about the destruction he saw in the war. Although he has never made the direct connection, the tone of this conflict has a phallic character. He is impotent in the face of the death he observed and his own rage reaction to it. His inability to find a gun, and then to find bullets for it, is expressive of this conflict.

The second man, who dreamed that the enemy was approaching while he waited, is conflicted about passivity in general. It is his style to avoid action, also to contain his significant anger, until he is forced to act. At that point, he tends to overreact to the situation, sometimes becoming violent. The manifest content of the dream suggests a feminine identification that probably plays a part in his conflict over passivity. Even without more extensive associations, these dreams can be seen to reflect libidinal and aggressive drive representations as well as self-protective urges.

*Traumatic Dreams*

It is interesting that both dreamers reacted as if they were faced with an external attack which was incorporated into the dream. The attack is represented in the manifest content of the dream, much as a real stimulus would be represented. Of course, one of the dreams could have been influenced by a real gunshot. Nevertheless, it is as if the dreamer's sense of external threat were so great that it must be incorporated into the dream like an external disturbance.

This formulation resembles Freud's reconceptualization of the traumatic dream in terms of the repetition compulsion in "Beyond the Pleasure Principle" (1920). Referring to traumatic dreams, he wrote, "These dreams are endeavouring to master the stimulus retrospectively, by developing the anxiety whose omission was the cause of the traumatic neurosis" (p. 32). In other words, at the time of the trauma, the individual was unprepared, with an absence of (signal) anxiety, and was therefore overwhelmed. Freud believed that the traumatic dream represented an attempt to master the original stimulus retrospectively, whereas I am suggesting that the veterans use the evocation of the original trauma to keep them prepared for any potential current danger.

The two dreams presented here are not typical traumatic dreams in that they do not closely reproduce a specific traumatic event. I have, however, heard such dreams reported by combat veterans for whom the same conditions of hypervigilance apply. The literature is marked by three approaches to the traumatic dream. One is in agreement with Freud that such dreams reproduce the traumatic event in an attempt at mastery. The second is that the traumatic dream includes subtle distortions in the representation of the event, and that the dream represents a wish fulfillment (Adams-Sylvan and Sylvan, 1990) or a defensive disguise (Lansky, 1990). The third approach does not require distortions in the representation of the event, but identifies wish fulfillment as being intrinsic to the representation of the trau-

matic event. Arlow (see Kris Study Group, 1961) suggested that repetition of traumatic events might be stimulating and gratifying. Renik (1981) argued that the traumatic dream is like the typical examination dream in that it provides reassurance by reminding the dreamer of a danger from which he or she has escaped. He pointed out that the traumatic dream generally occurs only after the traumatic circumstances are removed. Lidz (1946) saw a suicidal wish reflecting hopelessness after the loss of the most important person in the dreamer's life, often a buddy in combat. I would add the possible use of the traumatic memory to help maintain vigilance against any new threat. In such cases, the dream is not directly reassuring, as in Renik's examples, but does indirectly reassure through the fantasy of omnipotence through hypervigilance.

It would not be surprising to find that there are multiple dynamic mechanisms in the formation of traumatic dreams just as there are multiple dynamics in the creation of the post-traumatic state. However, we should expect that there is a common denominator to help explain the repetitive appearance of traumatic memories in the manifest content of dreams, whether those memories are exact or approximate.

My own work with Vietnam veterans has left me with the impression that traumatic war situations actualize fantasies, particularly relating to aggression, and contribute to confusion over the boundary between fantasy and reality in regard to these fantasies. The war "allowed" the soldier, usually in late adolescence, to act out unconscious fantasies either actively or passively (Stein, 1991). Renik (1981) made a similar point, that "[t]he traumatized individual is provided with *actual perceptions that correspond all too closely to dreaded unconscious fantasy*" (p. 177).

Those events that reproduce childhood experience or fantasy most closely are probably maintained as vivid traumatic memories. For instance, one man who endured watching his father beat up his mother is particularly haunted by the memory of watching fellow soldiers torture a female prisoner. Without his childhood experience, such an event would undoubtedly have

touched upon his unconscious fantasy life and conflicts over it, but under the circumstances it clearly served as a nidus for his conflicts over his role in his family and his position as a passive observer. The severity and the nature of the traumata ensure that they will reflect important unconscious fantasy complexes. This allows for the use of traumatic memories to represent, symbolically, particular unconscious conflicts in the manifest content of dreams. That symbolic representation could then be applied to the various dynamics described.

The situation is complicated by the finding that some traumatic dreams occur during non-REM sleep (Schlossberg and Benjamin, 1978; van der Kolk, et al., 1984), establishing the possibility that such dreams function according to a somewhat different mechanism than dreams that occur during REM sleep. For instance, without the excitation of the REM state, these non-REM dreams might have less input from unconscious libidinal impulses. This also raises the question of whether the mechanism of dream formation, either the one described here or one of the other models, can be applied to non-REM sleep under unusual conditions.

## *Conclusion*

The concept that the function of the dream is the protection of sleep remains the basis for a useful hypothesis. By it, we should understand the formation of a dream to be a defensive response to potential disturbances to sleep. It helps to explain the special role of the unconscious wish in the formation of a dream; it should also help to explain exceptions in which other disturbances to sleep predominate. This process must be conceptualized as occurring primarily during the REM stage of sleep in response to object-directed wishes that would disturb sleep. Traumatic dreams have been a source of particular controversy. One possible means of connecting the various proposed mechanisms for traumatic dreams is to conceptualize the

traumatic event as acting as a symbol for important unconscious fantasy complexes.

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*425 East 79 St.*
*New York, NY 10021*

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# A Classic Revisited: K. R. Eissler's "The Effect of the Structure of the Ego on Psychoanalytic Technique"

Shelley Orgel

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# A CLASSIC REVISITED: K. R. EISSLER'S "THE EFFECT OF THE STRUCTURE OF THE EGO ON PSYCHOANALYTIC TECHNIQUE"

BY SHELLEY ORGEL, M.D.

*Re-examining a classic paper by K. R. Eissler forty years after its publication recalled for the author his own "origins" in psychoanalysis in the same period, allowing a vivid context in which to view Eissler's contribution. Eissler's attempt to maintain a disciplined clinical position based on the structural theory as the foundation for psychoanalysis as a science, in the face of many proposed changes in both technique and theory in the decade after Freud's death, made many analysts refer to this paper as a kind of bible for the orthodox. This revisit attempts to explore the questions of how and why such a characterization of this paper has taken place.*

K. R. Eissler's classic 1953 paper, "The Effect of the Structure of the Ego on Psychoanalytic Technique," comes across today as fervent, generous, and imbued with the author's sense of mission. Eissler saw one of his tasks as preserving essential Freudian principles in a period when time-honored technical precepts were being widely challenged by a culture increasingly impatient with reflective thought and belief in the power of understanding achieved by the use of carefully articulated words. American culture was moving inexorably toward the burgeoning of what so dominates the present decade, a direction manifest in the proliferation of theories constructed largely to justify

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This paper is a modified and expanded version of a panel presentation at the American Psychoanalytic Association in December 1992.

the pressures to *act* in order to achieve results quickly and gratifyingly. Eissler was one of those who saw certain new directions in psychoanalysis as threats to the progress that had been made through orderly approaches that adapted the methods of scientific research to psychoanalytic theory and practice. In this paper he attempted to create a rational basis in theory for sanctioning a spectrum of variations in technique. He proposed that variations in the structure and functioning of the ego, especially its defenses, could be systematically correlated with the range of diagnostic classifications, from hypothetical normal (unmodified ego) to psychotic (the ego devoured by its defenses).

Revisiting this analytic classic opens a window for me through which I can glimpse some of my notions of psychoanalysis when I first studied it as a candidate in the fifties. When I first read it, I missed in it the sense of what I now realize must have been Eissler's own struggle. He was strongly drawn, I believe, toward stretching and loosening the boundaries of what the analyst could permit himself or herself and the patient in their relationship, even as he saw his mission as leading a defense of the barricades against the assaults of the interpersonalists. It seemed to me then, however, to be giving the analyst specific instructions, including permissions and strict limits, for conducting an acceptable analysis. I would like now to try to clarify this response to it.

## I

As I recall, I was both strongly attracted to, and constrained by, what I took to be the message of Eissler's paper, and its picture of the analyst that I could be trained to become. To me, this analyst represented "normal ego," functioning optimally in ways that Eissler described as a self-monitoring guardian of the scientifically validatable sequence of steps in a process which could be called standard, classical, or "real" analysis. There were

clearly strong personal reasons for this emphasis in my reading, reasons intensified by only partly recognized residual transferences from a recently ended training analysis. In addition, like all candidates, I was contending with displaced transference-laden distortions which tempted me to attribute both certainty and harsh judgments to teachers, supervisors, fellow candidates, and some of my best friends. Still, the air of my institute was heavy with the conviction that we were being trained to join the ranks of the *better* analysts, in fact, the *true* analysts, as opposed to followers of other schools who soft-headedly derailed and "ruined" the process and lapsed unknowingly into psychotherapy. These others, we observed, *gratified* manifest derivatives of their patients' unconscious wishes, and allowed discharge of the pressing energy of the drives instead of channeling it into verbal thought and speech that would yield insight and structural change.

In my first-year technique class we were taught that we must get the patient on the couch as quickly as possible—ideally during the first meeting—in order to avoid breaches in anonymity and abstinence. Clinic patients were assigned to candidate-analysts, and any decision by either about suitability would best be made *during* the initial *trial* period of analysis, a trial for both fledgling analyst and patient. The analyst quickly withdrew to the safety of his or her chair behind the patient, and could respond with silence or "interpretations" to the new patient's questions, objections, demands.

The right style and demeanor when offering interpretations were prescribed so narrowly that many candidates of my generation who wished to think of themselves as "classical" had serious trepidations much of the time about whether we would be real analysts if we suspected ourselves of caring about how our patients responded to our interpretations. It was as if we could either be "real" analysts *or* real human beings. I was instructed to formulate interpretations in simple declarative sentences, without much expression, because emotion would distort the purely informational message of the interpretation and

make the communication too "interpersonal." There seemed to be so many traps we could fall into which, in Loewenstein's (1958) succinct characterization, would create the dreaded "modifications . . . jeopardizing the formation or analytic resolution of the transference neurosis" (p. 202).

On the other hand, we were promised that if the analyst worked "correctly," the analyzable patients' resistances would become evident, the transference neurosis would emerge, deepen, become ripe for interpretation; genetic antecedents could be connected with the manifestations of present conflicts, particularly in the transference; the transference neurosis would be resolved, and the patient's ego would no longer need the analyst, whose purposes would have been distilled down to those of interpreter and guide to the unconscious. Despite Freud's original definition (1913), my impression is that we were instructed by most teachers that the analytic process, unlike psychotherapy, was sequential. One could plot its course virtually from beginning to end; some even anticipated its probable length—five years was considered a quite long analysis. Termination would happen naturally and relatively painlessly as the analyst was no longer needed as an object. Not so parenthetically, this structure served to obscure for me personally the degree to which my "terminated" relationship with my first analyst still influenced me, and in particular, how my defensive need to idealize his "classical" devotion to analytic abstinence held me back from facing the greater challenges, to me at least, of realizing that psychoanalysis is, first of all, an encounter between two complex human beings that stirs both to the depths of their beings. And that, while analyses terminate, termination is, in fact, interminable.

My first patient in supervised analysis was a young woman who refused, from the beginning, and often several times during a session, to stay put on the couch. She would suddenly spring up, speak loudly, dramatically, yelling, weeping, looking at me sometimes with eyes full of hate and erotic challenge; then she would lie down for awhile, only to spring

up again. I was quite sure that this behavior meant she could not be analyzed, even though my supervisor kept encouraging me to go on.

This experience provided a context for me in which I "understood" Eissler's paper. Did he not say that a normal ego would react *properly* (like an obedient child?) to the basic model technique? I felt that my one chance lay in offering correct interpretations of the many "resistance" meanings of her sitting up, and that these would take away her need to "disobey" me. I think I dimly realized that these interpretations were received as disciplinary injunctions. They were acceptable to me and my supervisor because they sounded like interpretations. (Of course, if an analyst says, "You're doing this now because you feel angry with me, or excited by me in some way, or need to see me react to you"—might he not thereby be saying, "If you understood more, you wouldn't do this?" Implied is a residue of the historically earlier idea that resistance *interferes* with analysis—of content.) What I failed to understand and convey were the meanings to me and to her of my needing and choosing quickly to respond with an interpretation, lest her "unanalytic" behavior and "discharge" through action persist and unmask how scared I was of her.

Where free reporting of what was going through the patient's mind broke off, or where she suddenly *acted*, my responding with interpretations was "safe" in the sense that I was not seeming to encourage her to act in or out (other words to dread!). The ways that transference-countertransference enactments entered with equal ease and even more silently into the *appropriate forms* of interventions were not really a focus of my thinking in those days. A candidate could feel relatively comfortable presenting *interpretative* work to a supervisor. It was judged correct or incorrect, timely or not, tactful or not, but if repeated interpretations over time did not work, that is, if they did not lead to restoring a properly tranquil analytic situation with the resumption of free association, one could question the "normality" of the patient's ego. I know of someone whose analyst, an experi-

enced, highly regarded training analyst, said to him toward the end of a long, clearly disappointing treatment, "I've done a perfect analysis but it has had no effect; nothing has happened."

I will not say much more here about my first patient, but I see now that when I assiduously interpreted her "activity," as though it were a hindrance to analysis rather than a necessary way of being in, and even "working" in analysis, I became one of a series of males in her life to enact a sadomasochistic relationship with this patient whose conscious fantasy life overflowed with scenes of anal penetration, rape, enemas, castration of the male's phallus with her anal sphincter, and her vagina imagined as muscular and jaw-like. As long as my purpose in interpreting the reasons for her refusal to stay on the couch was the "circumvention of resistances" (Eissler, 1958, p. 224), I now realize that I was behaving "unneutrally" toward these resistances. And I was supporting my *own* countertransference resistance against experiencing fully, and acknowledging insightfully, the power, even the potentially disorganizing power of my patient's wishes and defenses (and my own). Obviously, I was hoping to curb them and did not realize that their emergence in forms we could engage and analyze *is* the basic stuff of analysis.

## II

Eissler's paper must have had a "political" as well as a scientific mission at the time: to safeguard and preserve the scientific status of psychoanalysis against the then triple threats to it: first, from the emerging widening scope of patients whose pathology demanded that the parameters of the analytic situation be stretched, pulled, breached; second, the repeated seductive flowerings of techniques aiming for corrective emotional experiences under various names, which undermined the primary position of interpretation as *the* path toward insight; and third, the exponentially expanding practice of analytic-like psychotherapies which declared interactional processes themselves to

be mutative. In stripping the human being (the patient and the analyst) into ideal fictions in imitation of the researches of other sciences, Eissler follows Freud's model of the analyst as surgeon working "ideally" in an aseptic field. This analyst violates the rules only in emergency situations provoked by the patient.

Eissler assumes in this paper that he can discuss the use of parameters to counter resistances in the patient separate from, or even irrelevant to, discussions of resistances arising in the analyst. The paper, in fact, is built on the premise that one can consider the structure of the ego *in the patient alone* as an independent variable in studying a standard technique in a classical psychoanalytic process. This approach reflects the position, a common one then, which derives from "Freud's original view of the [analytic] process as located primarily in the patient and only facilitated by the analyst" (Boesky, 1990, p. 565). And consider the words of Rangell (1954) who said that the analyst "sits at the margin like a referee in a tennis match," showing the patient what he or she is doing from moment to moment, keeping a distance from the "magnetic field" of the patient (p. 741).

The ideal patient of the days of Eissler's paper is one who is worked on, who does not contaminate the field by "resisting." (Analytic definitions merge confusingly here with the common usage of the word "resist."[1]) This ideal patient does not ordinarily evoke significant *feelings* in a well-analyzed analyst. The implication is that the healthiest ego is the one most suited to *accepting analytic interpretations*, as "interfering" resistances diminish to a hypothetical vanishing point. In contrast, I would refer to two contemporary views which far more adequately describe my experience doing analysis.

One is Weinshel's (1984, 1990) formulation that the interpretation of patients' resistances to the analytic work and patients' responses to those interpretations constitute the basic unit of the

[1] Spruiell refers relevantly to certain analysts who "mix up interpersonal resistances and conflicts with the resistances within the mind to certain parts of itself" (personal communication).

analytic process, with the *goal* being affectively richer, more insightful, more honest self-observation rather than "cure" or structural change, a view consistent with Brenner's depiction of the goal as alteration of compromise formations. And I strongly agree with Boesky's liberating view that analysts' and patients' new understandings of themselves and of each other emerge from the tension of the interaction between two welcome, inevitable failures: the patient's failure to follow the fundamental rule (resistance) and the analyst's failures of subjectivity. Boesky (1990) says: ". . . the patient actually benefits not only from the correct final answers" (in other words, the accepted interpretation). "The patient benefits from the process of mutually attempted, partly successful, and partly failed efforts to understand" (p. 577).

These views allow us to realize that the ordinary personality of the particular analyst (including his or her countertransferences) interacting with that of the particular patient results in creating the forms in which the manifestations and origins of unconscious conflicts—and the more and less structured compromises comprising their shifting solutions, including major resistances and transferences—appear and can be studied and understood in the analytic situation. Perhaps, then, some of the patient's stubborn resistances needing to be approached using parameters are, in fact, those which "match" the analyst's own. The analyst's difficulty in working with them interpretatively may then be explored constructively, obviating the necessity, in some instances, to resort to noninterpretative approaches in order to resolve these impasses.

## III

It has become increasingly evident over the years that the sharp distinctions which Eissler and many of my generation believed were required to keep psychoanalysis intact are extremely difficult, if not impossible, to discern and maintain. It even be-

comes questionable in many instances whether the effort to try to keep these distinctions clearly in mind serves the analyst well as she or he works with patients. Among these distinctions, I would note particularly:

First, those between standard technique, variations and modifications (included in this is the question: When does an interpretation function as, and become a parameter?); second, those between the normal ego and the modified ego; third, those between reversible and irreversible parameters, and reversible and irreversible effects of parameters, on transference, for example; and fourth, those between psychotherapy and psychoanalysis. (Included in this are questions about how many, how prolonged, what kinds of psychotherapeutic interventions prepare for, permit, or even facilitate a psychoanalysis versus how much of what transforms an "analytic" treatment into a psychotherapy.[2])

Although I can discuss these interrelated distinctions only very sketchily, the issues they point to continue to deserve elaboration and clarification.

What interferes with the ego's adequate relationship to reality, Eissler reminds us, is its resistance to the awareness of resistances (Freud, 1937). Of course, since such resistances, the very stuff of character, are ubiquitous, one doubts that there can be a "normal" ego in this sense. The borders between the normal and modified ego seem, both conceptually and empirically, to be hazy rather than distinct. In any case, according to Eissler, the suggestion or command that constitutes the parameter circumvents these "secondary" resistances which are not amenable to interpretation alone and are stubbornly and intensely adhered to. Eissler suggests that this emotional intensity means that they are invested with unneutralized energy (a metaphoric description intended to serve as an explanation) because they are mobilized to prevent the spread of the primary defenses. The latter come to use increasingly neutralized energy in the course of an

[2] Issues of "conversion" of therapy into analysis are, of course, also relevant in this regard.

individual's development. The primary layer of defense, represented by repression, is "fully occupied against the id." Hysteria (an entity which seems a heuristically useful fiction), employs only primary defenses, and since these defenses use relatively neutralized energy, they should be readily given up in response to the analyst's rational explanation of their purposes. Similarly, a parameter which theoretically circumvents "secondary" resistances can be self-limiting and temporary in its action, its effects resolvable by the analyst's later explanations. Eissler (1953), critically citing Freud's "Wolf Man" parameters, states: "The effect of the parameter on the transference relationship must never be such that it cannot be abolished by interpretation" (p. 113).

It seems to me that this absolute caveat poses a dilemma. As I think of the usually cited major parameters, including my efforts in the form of barrages of "interpretations" to keep my patient on the couch, it is hard to conceive of *any* which would not permanently alter the transference. Insofar as the patient's ego is *masochistic*, any significant parameter promotes powerful masochistic gratification in the analysis itself and from the analyst, often representing a harsh, omnipotent external superego in the transference. With some patients who may be less masochistic inherently, the analyst's assumption of certain powers may, unfortunately, create or intensify a sadomasochistic relationship where this need not have developed to the same degree with another analyst (or with another of that analyst's patients). And there is some masochism in everyone, just as everyone has a "modified" ego to some degree.

Stone, writing in 1954, on how "complete" an analysis can be, believes that the rule that the parameter *must* terminate before the end of the analysis "seems altogether too severe" (p. 576). Stone's position points toward more contemporary directions in clinical discussions in emphasizing that the long-term effects of parameters also depend on the analyst's motives and purposes in applying them. Stone also stated, and I agree with him, that the degree to which the transference can maximally be resolved

in any analyzed patient is variable rather than absolute.

It is crucial, then, that the analyst know as well as possible the reasons, technical and personal, for abandoning the persistent analysis of resistance. Parameters intended to bypass the resistance, such as threatening to end the analysis unless the patient acts in a certain way, or even announcing termination unilaterally in response to heightened resistance, or replacing interpretations with advice or commands or suggestions or promises of cure, mean that the analyst has actually assumed to some degree the role of prophet, savior, threatening, critical, or idealized superego (see Freud, 1923, p. 50). Conditions allowing a termination process to occur are thereby compromised. The patient's autonomy has been affected in ways *that* analyst may not be able to alter.

I have observed this when I have had the opportunity to work with patients whose previous analysts in some fashion used parameters (advice, suggestions, prohibitions) which changed the course and result of the analyses, not least because true renunciation of the relationship, mourning, and consolidation through further internalization after termination did not really occur. What was impeded was what is increasingly recognized as a goal of psychoanalysis—the analysand's becoming able to take over and carry on the analyst's analyzing functions after termination. Several of my patients in re-analysis had not realized that, or how these interventions affected the transference in lasting ways. Of course, one cannot draw conclusions with any certainty from reports of former analysands about their previous analysts, but their analysts *seemed* not to encourage exploration of this issue. They appear to have been more interested in the result than in their own or their patients' self-observation and curiosity about the effects of such interventions, including gratification of unconscious fantasies.

It seems inevitable that once one feels the need to say, "Obey me now and we'll talk about it later," one shuts off an optimal mutual openness. And, as I know from my own experience with my first patient, it becomes tempting to attribute the incom-

pleteness of the analytic results mainly to the patient's intractable pathology rather than to the complex human situation encompassed by the patient's personality, including pathology, in relation to the analyst's personality, including pathology.

How does an analyst undo the consequences of using suggestion and manipulation in these parameters by later interpretation, as Eissler suggests? This analyst has in effect threatened to create, or re-create, a danger situation in the transference which can be more painful than the present-day derivatives of the original one. For example, when she or he threatens the patient with the loss of the analyst or the analyst's love, the masochistic wishes of the patient may now be more satisfied by the analyst than by the original objects represented in the patient's superego. And so the patient turns, often with suppressed or unconscious rage, to the analyst, now deemed *the* authority, a source of help and gratification if the patient submits to her or his conditions. The analyst who considers these conditions reasonable and aimed appropriately for the patient's benefit, who has decided that the patient is to be less entrusted now with the task of continuing the analytic work of confronting and analyzing resistances, would have limited motivation to explore transference-countertransference configurations in the patient who seemed to respond "favorably" to these measures. Is there not a potentially self-serving circularity in the reasoning that says the structure of the ego (of the patient) justifies the technique while the response to it justifies the diagnosis of the state of the ego?

Eissler understands that the patient's wish to be loved, or pressured, or treated sadistically, etc., may subvert the analyst's reasoning about the "fit" between his or her technique and the patient's ego. The patient *may* be responding to the implicit and explicit *suggestion* inherent in the analyst's interventions (including, I would add, that contained within his or her interpretations). Eissler (1953) says,

> Each parameter increases the possibility that the therapeutic process may be falsified, inasmuch as it may offer the patient's

> ego the possibility of substituting obedience for a structural change (p. 126).

In fact, the result may be an *unacknowledged* analyst-induced corrective emotional experience very much like that resulting from Alexander's suggested titrations of anxiety to induce the patient's greater participation, an approach which Eissler's contribution intended to counter. In both, parts of the analyst's ego and superego "temporarily" substitute for those of the patient's. The greater current attention to the interactional aspects of the analytic work (see Boesky and Weinshel above, for example) leads us to be more aware of these possibilities. And such attention allows us to consider, and incorporate within our theory of technique, the likelihood that the analyst-patient relationship in all its aspects, including the analyst's interpretations, is embedded with suggestion. Our awareness of this inevitability and of the subtle ways suggestion may be present can help us to understand the nature of the gratifications that suggestion affords to both participants, and to bear more steadily in mind the ultimate goal for both: that the patient's ego will have the greatest possible freedom to choose.

Eissler (1953) proposes discussion with the analysand of "the meaning which this parameter has had for the patient and the reasons which necessitated the choice of the parameter" after an obstacle has been removed by its use (p. 127). I wonder how much *retrospective* discussion, as Eissler recommends, can be counted on to undo the effects of using the commonly cited parameters. If I were deciding about such matters as setting a date for termination, suggesting that the patient defer making a major decision, asking the patient to abstain from using alcohol or drugs, changing a fee or the number of hours a week, I would want to work with the patient *first* to try to make the meaning of the intervention clear and sensible to her or him *before* we agreed to the action. Such issues do mobilize sadomasochistic transference fantasies very often, and may provide valuable, intensely engaged material for the analysis. To withhold the reason for

introducing the parameter until later promotes the creation of a magical, powerful father-analyst figure, the voice of reason who does not tell all he knows "to boys" (or girls—pace Goethe). At its most extreme, it makes the analysis into an initiation rite, the analyst a Sarastro presiding over the trials of an unquestioning Tamino as analytic patient who achieves acceptance among the men by holding his tongue as he faces his infantile fears.

## IV

Finally, I would like to raise some questions about the definition and use of the term "parameter." Is it helpful to call something we tell the patient she or he *must* do or lose the analysis a parameter? How much direct or implied pressure creates a parameter out of our ordinary instructions to lie on the couch, associate freely, and refrain from various physical activities in the treatment room? The distillation of "interpretation" into motive-purified communication, the sheer imparting of information, and the distinctions between interpretation and parameter are other absolutes which I think we have learned are untenable. For example, if a parameter is presented as an interpretation, what *is* it? An enactment? (See McLaughlin, 1991.) By 1958, Eissler and others were attempting to redraw some of these distinctions. Eissler (1958) writes about transforming questions and requests made of the patient into interpretations. For example:

> Even a device that, ostensibly, is so far removed from interpretation as the request that a phobic patient expose himself to the allegedly dangerous situation, can be transformed into an interpretation by consistently demonstrating to him the resistance that keeps him from risking the alleged danger while under the relative protection of the treatment (p. 224).

In that 1958 paper, Eissler responds to Loewenstein's earlier discussion in the same panel about interventions used in *all* analyses, which cannot be called interpretations but enable in-

terpretations "to have the desirable dynamic effect or . . . create conditions without which the analytic procedure would be impossible" (Loewenstein, 1958, p. 203). Clinging to the parameter concept, Eissler (1958) proposes a category which he labels pseudo-parameters (pps.) and says: "With the help of pps. one may be able to smuggle interpretations into the pathognomonic area with a temporary circumvention of resistances" (p. 224). Examples of techniques to *bypass* resistance include a joke told at the right moment, repeating back the words the patient has just said, and adjustment in the analyst's ordinary speech patterns to the patient's way of speaking. Eissler's approach here does seem to assume what we have come to appreciate more in subsequent years, that many interpretations, including the choice of what is interpreted and when and how it is articulated, inevitably include suggestion and/or manipulation (Bibring, 1954) as elements of the interpretation contributing to its intended effectiveness. His discussion does, however, bring into question the necessity for the separate term and concept "parameter."

Taking a different stance, Loewenstein's clinical contributions in this same period, forty years ago, brought fresh air into the analytic room and continue to be most pertinent today. His descriptions of noninterpretative kinds of interventions, *not* labeled parameters, which prepare for analytic work and establish conditions which make useful interpretations possible, recognize how peculiar and frightening analysis is to the unprepared patient. They legitimize the analyst's need to help the patient to entrust himself or herself to this strange new world and person, and to understand the rules, the basic procedures, and the accompanying deprivations of analysis. Such recognitions allow the patient entering the analytic situation to feel safe enough with the relatively anonymous analyst to become able to choose to attempt to follow the basic rule. His approaches convey that humane and sensible behavior by the analyst are indeed possible within the rules and frame of classical analysis.

As I think back to the beginning of the analysis of my patient, I wonder if a workable analytic process could have developed

had I begun by simply acknowledging her need for her particular solution to her conflicts by saying to her: "It seems you need to sit up and look at me now in order to continue to talk to me. We can proceed this way if you like. You may lie down again when you can and want to." At least, the treatment might have had a chance to become an analysis.

What I took away from my best teachers, and people like Loewenstein, Stone, and somewhat later, Loewald, was the dawning realization that it is neither necessary nor desirable to draw sharp, inviolable, clearly labeled boundaries in order to sustain adherence to the psychoanalytic ideal. Furthermore, when we inevitably fail to be "ideal" analysts, and feel the pain of self-reproach and anticipate the criticism of colleagues, we risk being tempted to exercise denial of how and why we have intervened, to blame the pathology of the patient for our disappointing results, or to construct new generalizations and theories as umbrellas to cover our actions. As human beings none of us can be immune from a degree of defensiveness which interferes with that fertile combination of detailed clinical study and unhampered self-observation that keeps psychoanalysis alive and well.

## CONCLUSION

In spite of some retrospective reservations I have noted here, I believe Eissler's work contributed substantially to the debates of the fifties while we moved ahead in the first decades of the post-Freudian era. A look back at a classic contribution like his 1953 paper also allows us to evaluate its place in the historical development of psychoanalytic theory and technique toward the greater maturity we believe we have achieved in the intervening decades. One of the results of placing this contribution in its context could be to remind us of the evolutionary nature of our discipline. Today, as in every era of our history, it is a struggle to remember that our knowledge is uncertain and partly defined by only incompletely identifiable historical, let alone personal, forces impinging on us. Secondly, we are reminded that only in

time do we learn not only how we can *use* such contributions, but how we can easily *misuse* them to serve motives of which we may be only dimly aware at best.

Restudying Eissler's paper has illuminated for me much about psychoanalysis, but also has given me a valuable opportunity to appreciate the collaboration of the reader or student in defining what may become the lasting meaning of even a scientific text. Eissler brought boldness and courage to his task, and as we look back at the many riches in his classic paper, we continue to be grateful to him for it.

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*245 East 87 St.*
*New York, NY 10128*

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# Das Raetsel Des Masochismus. (The Riddle of Masochism.) By Leon Wurmser. Heidelberg/New York: Springer Verlag, 1993. 570 pp.

Marion Michel Oliner

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## BOOK REVIEWS

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DAS RAETSEL DES MASOCHISMUS. (The Riddle of Masochism.) By Leon Wurmser. Heidelberg/New York: Springer Verlag, 1993. 570 pp.

In this book, Wurmser, who practices psychoanalysis in Washington and Baltimore, continues his studies of severe psychopathology. The work is ambitious and impressive, in that it not only encompasses the theory and treatment of masochism, but also takes into account social phenomena of cruelty and suffering and a detailed study of Nietzsche's thinking, as well as a chapter on Thomas Mann. Interspersed in many of the chapters are extensive references to psychoanalytic and world literature, and detailed notes from the analyses of patients whose dominant pathology lies in the various forms of masochism.

Wurmser draws from many conceptual frameworks without ever abandoning the centrality of conflict underlying psychopathology. From his perspective, the chief instigator of conflict is conscience, *das Gewissen*, to which he refers mostly in nontechnical terms. However, when Wurmser uses technical language, it is evident that for him conscience includes the superego, the ego ideal, and what many would subsume under superego precursors. Conscience is that which inhibits discharge and underlies defenses. At first reading, this can be disconcerting because of the dilution of the term. However, more traditional analysts than Wurmser have also stressed that nonmoral rules of conduct are internalized in the same way as moral precepts.[1] No other theorist, however, with the exception of Melanie Klein, on whose work Wurmser does not build, has pushed this recognition to the point where the superego is considered the cause of such a wide array of psychopathology.

[1] Arlow, J. A. (1988): Early object relations and the quest for morality. Presented to the New York Freudian Society Annual Scientific Conference, October 15.

Grunberger, B. (1971): *Narcissism. Psychoanalytic Essays*. New York: Int. Univ. Press, 1979.

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Wurmser believes in the centrality of conscience, and in this work the advantages of this conceptualization become apparent. He says:

> . . . the principal superego functions not only relate to oedipal problems. Guilt and shame, as well as the superego's hostility toward drives and conflicts of loyalty, however closely tied to early oedipal conflicts, nevertheless have developed independently of oedipal problems. They are partially rooted in the problems of the search for identity and the need to belong and in part refer back to other archaic areas of conflict—anal problems around control and loss of power as well as especially those conflicts concerning the wish for self-expression and perceiving. Preoedipal segments of the superego are especially significant in the dynamics of shame (p. 328).

Wurmser reshuffles classifications. For him, the differentiation between the superego and the ego ideal is relatively immaterial, because in his thinking conscience enforces rules that punish transgressions of all kinds, including those governing pride and narcissistic vulnerability. In this way, behavior and fantasies that are generally understood as expressions of impulse or drives are interpreted as attacks aimed at externalized guilt or shame.

In the book, Wurmser reviews his previous findings concerning severe neurosis before discussing the problems of masochism specifically. Above all, he sees the ubiquity of the implacable demands of the superego in individuals who were traumatized early in life. He attributes to the superego the creation of a double reality: the reality of perception and the reality of the inner judge, with the latter always being right. He describes instances in which conscience rules like a dictator, leads to dehumanization, and imposes unquestioned loyalty on these people. And he cautions that, because of the suffering inflicted by this constellation, there is the propensity for these standards to be externalized and transferred to the analyst. Wurmser says that this must be avoided through furthering the self-observing function of the personality and the support given to the ego function of self-examination. This, according to Wurmser, prevents a lasting impasse in the treatment.

Despite the originality of his approach, Wurmser has drawn upon the work of many contemporary psychoanalysts. There is an excellent review of the pertinent psychoanalytic literature. The theoretical chapters credit and cite extensively the writings of Shengold, Novick and Novick, Gray, Grossman, Brenner, Meyers, Coen, Kernberg, Bach, and Berliner. Wurmser's study of the conflict be-

tween shame and guilt, however, stems exclusively from his own work and thinking. He says "The feeling of guilt imposes limits on strength; shame hides and covers up weakness" (p. 26). And he illustrates by means of clinical examples how these conflicted aims frequently interfere with adequate functioning in psychopathology.

Wurmser reiterates that the cause of masochism is conflict; he believes that there is no shortcut through notions of fixation at a developmental phase or a type of defense. Causality is attributed to five factors: starting at the surface, there is (1) the core phenomenon of the neurotic process: compulsivity, globality, polarization, suffering; (2) core fantasies that are bridges to the dynamic unconscious; (3) central unconscious inner conflicts; (4) core affects that are unsymbolized, often still somatized, forming the bottom layer of the problem stemming from (5) traumata inflicted by the interaction with the outside world or physical disabilities or accidents.

Part One of the book is devoted to the examination of external masochism by means of clinical examples. The patients fitting this category suffer because the object (no matter how tortured the attachment) is preferred over separation, which is equated with death. Wurmser speaks of external masochism, with its accompanying sadism, as always being secondary to the need for punishment. Re-externalization, according to him, concerns inner conflict and not the attempt to repeat childhood experiences. Therefore, persons taking part in the drama are not the historic parents. He stresses that access to history is barred until this inner conflict has been worked through sufficiently for the memory of the actual trauma to re-emerge. "In the actual work, superego pathology logically precedes object relations pathology, and the reduction of this superego pathology to the original disturbance in the relationship to the external world is very complicated and can only be reconstructed after seeing it through massive refraction in inner conflicts" (p. 130).

The clinical example in this part demonstrates Wurmser's use of Ibsen as a creative bridge between the patient and himself to effect a "special form of transference sublimation." He considers it a replacement by means of less compelling and more reality-syntonic forms of power and gratification. Wurmser thinks that this technique enables patient and analyst to interpret the conflicts on an

enlarged scale and prevents the gratification of the patient's masochism that is unavoidable when the analyst is experienced as cold or withholding. He believes that this technique introduces the dimension of metaphor to patients in whom this mental function is stunted because of their need for actualization and enactment. Despite the introduction of this important parameter, the focus rests on the patient's conflicts.

Wurmser is aware that his technique of guiding his patients in the work of self-observation, as well as the introduction of parameters such as the discussion of literature, coupled sometimes with medication, can easily lead to dependency, but he substantiates how his emphasis on conflict eventually allows the analysis of transference and leads to lasting improvement in patients whose pathology ranges from drug addiction and sexual perversions to criminality. The analysis of a murderer described in the book is not concluded successfully, but even in this case the approach to the patient through the superego yielded important insights into sadism interpreted as countermasochism.

In the chapter on Ibsen, Wurmser returns, as he did frequently in his previous books, to literary examples of the essential conflicts that underlie severe pathology. He describes the struggle of the fictional characters for self-realization, for the avoidance of a thing-like existence, and for escape from oppression into an existence where the avoidance of shame and the exercise of power lead the individual "beyond good and evil," reminiscent of Nietzsche. Here, instead of the widely used term of splitting, Wurmser has recourse to the concept of doubling of consciousness, doubling evidenced in triangular relationships, i.e., doubling as a way of mastering reality in an omnipotent way.

In Part Two, Wurmser discusses inner judgment or moral masochism, which he considers to be at the base of all other manifestations of masochism. Once more the emphasis is placed on the challenge that this type of pathology represents, the propensity for "negative therapeutic reactions," the likelihood that the analyst might assume the posture of a judge assigned to him by the patient, and therefore the need for infinite patience, time, and care in the treatment. He describes how moral masochism imposes a burden on the transference: the analyst is experienced as co-conspirator of the patient's crime of success. He cannot win: if he is seen as non-

judgmental, he is consenting to the patient's sinful thoughts and existence and therefore deserves to be defeated; and if he is the judge who denies the patient success, the patient either submits to his or her fate, seen as inevitable, or rebels and acts out. Wurmser appreciates how difficult it is not to react with anger at the frustration of seeing one's work undone or seemingly destroyed time and again. Nevertheless, he has been able to conclude successfully the treatments of patients in this category.

The author suggests that upon closer scrutiny, patients who appear to be impulse-ridden attempt to live by standards they cannot meet. They are shown to be driven to the need to persecute and destroy the externalized part of themselves that fails to meet the standards rather than give up their lofty ideas of worthiness. Wurmser suggests that the way to patients thus driven goes through the stress on the absolute values by which they attempt to live, not by focusing on the impulses they cannot control as a result of the unbearable inner pressures. This approach avoids reinforcing the superego, and I believe that the patients experience these interventions as supportive without their actually being so.

The clinical example in this section leads to a discussion of castration as a form of punishment. This introduces sexualization in the context of moral masochism and illustrates Wurmser's understanding of sexualization as a defense that is present in all forms of masochism: the classifications organizing the material are only rough, and there is considerable overlap between the categories established by the author. The patient, identified as a moral masochist, also engaged in perverse practices which were compulsive and in which the woman served as the projection of his denigrated self.

Close to the core of the pathology lies the blocking of affect, also described by Shengold as a response to overstimulation, leading to the stereotypical nature of the sessions with these patients who love limits. Wurmser quotes one patient's reference to "the loving arms of limitations" that brought him into contact with himself and not his omnipotence. He identified with the punisher and not with the degraded self, until he rebelled in a sexualized way so that sexuality became vengeance and vice versa. In keeping with the findings of Novick and Novick, Wurmser confirms that ordinary pleasures or competence would threaten the omnipotence of the masochist.

This leads Wurmser to one of his many attempts at schematizing: fundamentally, he sees reification of the self, dehumanization, depersonalization, and estrangement as a result of severe and often repeated traumatization. The next layer is the reaction to this: passive turned into active, resulting in rage and outrage. The third phase is the introjection in which the cruelty of the upbringing becomes a part of the superego. The fourth layer is the externalization of the cruelty of the superego so that others have to suffer the pain inflicted by the inner judge. The most superficial layer consists of the position of the victim. Wurmser suggests that sexualization, when it occurs, takes place as an alternative to turning passive into active and remains a factor throughout the subsequent layers (pp. 259-260). He suggests that shaming and neglect lead to moral masochism, whereas bodily mishandling or surgical interventions tend to result in perversion.

Part Three is devoted to a discussion of sadomasochistic perversion. Wurmser is opposed to the notion of feminine masochism; instead he considers masochism to be a caricature of femininity. He demonstrates that frequently the problem lies in the erotization of power, in which the sadistic lover is valued because of his value as a protector.

Wurmser proposes (p. 302) that perversion be considered a protective armor and effective defense against masochistic character pathology. Therefore, he thinks that perversion yields more readily in treatment than the underlying moral masochism that is embedded in the character. He does not think perversion is radically different from neurosis: it is another attempt at solving neurotic conflicts through compromise formations, parallel to character and symptom neurosis. Narcissistic fantasies with their overvaluation, transgression of limits, entitlements, and idealization are seen above all as the attempt to overcome magically an overly severe superego, to master the helplessness induced by the inner and outer judge (p. 379).

The fourth and last part of the book takes up countermasochism as exemplified by Nietzsche. There is a detailed examination of Nietzsche's will to power, interpreted as an abhorrence of weakness and shame, which drove him into insanity. Later, the same dynamics are shown to provide the basis for Nazi ideology. From Wurmser's perspective, it is a flight from ordinary conscience that

motivated Hitler's followers; his ideology succeeded in reducing guilt to shame. This transformation was illustrated by the Nazi worship of cleanliness and strength: the denigrated, dependent part of the personality was externalized and persecuted. Here it becomes evident that the need to explain the Nazi phenomenon motivates Wurmser as much as the exigencies of his clinical practice. It prompted him to study the works of Thomas Mann, who regarded the Nazi phenomenon as the victory of aestheticism over morality.

This is a rich book and a review cannot do justice to the thoroughness with which Wurmser approaches clinical data and the treatment process. It requires a willingness to follow his conceptualization, which is not in keeping with tradition but does correspond to the vernacular which has adopted terms such as "compulsive eating" to describe behavior analysts tend to label impulsive. As to his analysis of the dynamics of totalitarianism, his diagnosis of the presence of an unbearably strict superego which was projected in the process of defense explains better than other formulations why those who were capable of atrocities had rigid rules of conduct in many other spheres of their lives. The answer lies in their need to escape an overly strict conscience.

I have mentioned that other analysts have postulated that first learning occurs through obedience to parents and only later through the ego's perception of reality. Arlow and Stein explain this by the lack of distinction between ego and superego early in life. Further evidence for this phenomenon is derived from experience with regressed individuals who lack the capacity for assessing danger. Whereas the reaction to danger is assumed to be an ego function, it was found to be related to the capacity to submit to authority so that those whose infantile conflicts with authority have not been overcome are more prone to incur harm. Here it is apparent that superego plays an important part in the foundation of ego; and while there appears to be no opposition to this view, it has been largely neglected. Psychoanalytic literature tends to overlook the role of the superego in severe pathology. Wurmser's work redresses this imbalance.

The part played by the superego in the understanding of drives also has not been sufficiently explored. Recognition that direct interpretations of drive derivatives have to be abandoned in favor of

confrontations with defense or conflict, has led to an unnecessary abandonment of drive theory. Putting the superego first, as Wurmser does, enables the analyst to continue to work on conflict where, in my opinion, some other approaches reinforce excessively the fantasy of the patient as victim. Wurmser's interventions retain the importance of drive derivatives in conflict and continue to place the patient in the role of agent rather than passive victim.

Grunberger added to the previous literature that the drives are subject to "culpabilization" because they frustrate fantasies of omnipotence inherent in childhood narcissism. This means that the shame or narcissistic mortification for the weakness implied in neediness contributes to the "culpabilization" in which shame reinforces guilt. Wurmser's contribution consists of a thorough and exhaustive study of this interaction between shame and guilt. He is sensitive to the shame concerning drives because they are experienced as a narcissistic injury for patients who abhore limitations.

Wurmser's formulations in which he appears to agree with Winnicott on the usefulness of the idea of a false self or the wish to be oneself when this is forbidden seem to me less felicitous. I believe that there is a more accurate conceptualization of maturation: when traumatic circumstances prevent a sense of self from developing, theory should not refer to it as if it existed. I prefer to think of a sense of self evolving in the course of treatment rather than conceiving of the self as latent structure that lies dormant like sleeping beauty, ready to come to life at the kiss of the prince.

Otherwise, Wurmser has demonstrated an original way of looking at severe pathology. I agree with his cautions against any facile deduction from the transference either to the actual history of the patients or to the inner life of the analyst. His recourse to conscience as an explanatory term for the understanding of pathology has proved to be the key to the treatment of many patients. However, his departures from standard technique raise the question about the way others, less gifted and less conscientious, might use his methods. His admonition for flexibility cannot be faulted, and he has also shown that despite the introduction of parameters, he returns to the analysis of conflict whenever possible. Still, one must question to what extent the technique is dependent on Wurmser's personal integrity. There is a danger that others, attempting to take over this approach, might overlook unanalyzed areas, especially

within the transference, which would vitiate the success of the treatment. This problem is not unique to Wurmser's approach: it arises whenever others attempt to learn the technique of a gifted analyst, but the difficulty is greater when the analyst introduces innovations that have to be dosed judiciously.

These reservations aside, reading Wurmser's book is an inspiring experience, one that is denied at present to English-speaking colleagues. It can only be hoped that this review has succeeded in conveying, however briefly, some of the wealth of erudition and thoughtfulness the book contains.

MARION MICHEL OLINER (NEW YORK)

RETELLING A LIFE. NARRATION AND DIALOGUE IN PSYCHOANALYSIS. By Roy Schafer, Ph.D. New York: Basic Books, 1992. 328 pp.

A psychotherapy patient who had just decided to begin an analysis saw *Retelling a Life* on my desk and expressed curiosity about the book. "What," he wondered a bit anxiously, "could a book entitled *Retelling a Lie* be about?" I thought how much Schafer would relish an encounter like the one that developed with my patient. The patient was indeed worrying about his "lying to and with me" and about my "lying to and with him," in both meanings of the word. On another level, continuing Schafer's emphasis on multiple meanings, I thought my patient had raised a critical, challenging question about a central issue in Schafer's theoretical constructs, i.e., that until the truth is ascertained, lies are retold.

This book by Schafer is an eighteen-chapter (twelve of them previously published) exposition of his current theoretical and clinical thinking. It is divided into four sections: Narrating the Self; Narrating Gender; Theories as Master Narratives; and Versions of Practice. This is both an easy and a difficult book to read. It is easy because the writing is vintage Schafer—urbane, lively, unpretentious, and direct. Reading the book is like hearing Schafer lecture in his relaxed, informal style, in which he invites one to think through issues with him while anticipating (some) questions and objections and marshaling arguments to buttress his positions. It is difficult to read because the issues he addresses evoke a constant flow of questions, comments, and intellectual challenges.

Schafer has rewritten some of the chapters which appeared previously. The format and his lecturing style lead at times to repetition. While the fourth and last section is billed as "heavily clinical," excellent clinical vignettes abound through all parts of the book. Without reservation, I can endorse the book as valuable reading for psychoanalysts who think seriously about current controversies in analytic theory and practice.

Schafer's theory has been thoroughly discussed in analytic journals since the mid-70's, and I will not review all those issues here. All of the supporting pillars are here in this book—e.g., language, motivation, action, analysis as a creative narrative act co-authored by patient and analyst, and analysis as a hermeneutic endeavor. Schafer locates psychoanalysis in the domain of art and literature, and he separates it from the domain of science. He argues for the place of narrative as an overarching concept that defines the analytic situation. He demonstrates a shifting interest in truth and fact. Primarily, it is the consistency, meaning, and poetry of the narrative that concern him; but at other times he pursues "truth" in the "external" reality. His devotion to multiple meanings creates a problem in consistency. It would seem necessary, if he were to be consistent, to include quotation marks around the word "fact" every time it is used by him. His antipathy to science is disquieting. He remains among that legion who belabor the difference between science and the humanities. Little[1] has pointed out recently the destructiveness of this position.

The book, surprisingly, begins with a chapter on termination which illustrates the qualities that will characterize the book throughout. Schafer makes acute observations about conflicts evolving out of the negative reaction of "significant others" to positive changes in analysands (although it can be argued that these are not solely termination-phase phenomena), and he provides four excellent clinical examples. This becomes the jumping-off point for his effort to differentiate "self-interest" from "self interest," which eventually dissolves as he demonstrates the shifting compromise formations involved; and he further demonstrates both these terms in their pathological as well as adaptive possibili-

[1] Little, J. M. (1993): Communication and the humanities: the nature of the nexus. *Mayo Clinic Proc.*, 68:921-924.

ties. In the second chapter, there are lucid expositions of the self as agent and the self as object and an incisive critique of some of the theoretical weaknesses in self psychological theory.

The final chapter in this section deals with self-deception, defense, and narration. The big game that Schafer pursues involves what he considers to be the weaknesses in the Freudian conception of defense. He emphasizes the multiple adaptive purposes which are possible for any action, including defenses. He then goes on to establish the primacy of narration and the value of the story-line concept as offering superior theoretical and clinical positions to the analyst. But throughout the clinical material in this book, he demonstrates his operational closeness to Charles Brenner and to Paul Gray (as has been pointed out by Friedman[2]) and, as he acknowledges, the influence of Waelder and of Hartmann.

In the second section, "Narrating Gender," Schafer takes on the politically sensitive issue of gender differences and how they express themselves in symptoms and character. His ideas here will be familiar to analysts, but he proceeds at times almost apologetically as he reassures his readers that, in addition to the intrapsychic dynamics involving guilt, competition, masochism, rage, etc., he is aware that society does "bad things" to women.

In the third section, "Theories as Master Narratives," Schafer repeats his critique of Freud's "19th-century science." He develops at length his position that "the truth" is not knowable; that multiple meanings are involved in all of human interaction. He is critical of analysts who believe that "truth" is latent in patients' communications—e.g., that it lies "under" the manifest content. Freudian analysts, Schafer states, "draw inevitable conclusions" and "their interpretations are indistinguishable from inevitable conclusions or final closure" (p. 179). As he has on many previous occasions, Schafer criticizes Freudian analysis as flawed because it aspires to be an objective, empirical, inductive observation of science. In this section Schafer, for purposes of argument, sets up straw men which he can easily demolish. For example, psychoanalysts, he says, follow their own laws of knowledge and ignore history and the current status of general theories of interpretation. I suggest that psychoanalysts do

[2] Friedman, L. (1988): The clinical popularity of object relations concepts. *Psychoanal. Q.*, 57:667-691.

not necessarily ignore history or other theories, not any more than Schafer ignores other theories, even though he does not use them. But Schafer's desire is not to lob enough hand grenades at Freudian analysis to vaporize it. At the end of this section, he urges analysts to desist from spending so much time and energy looking for common ground, and instead to accept and recognize the benefits of diversity. "Analysts," he says, "have been living with diversity for a long time" (p. 192). Indeed that is the case, although it begs the question which soundly supported theory should attempt to answer.

The final section of the book, "Versions of Practice," is given over to a mixture of excellent clinical advice and observation, theoretical sharp-shooting, and Sisyphean struggles. The first of this trio is exemplified by his discussions of training analysis, brief psychotherapy, pseudoanalysis, and countertransference (especially of analysts who would play good mother or father). They are rich, complex, and full of thought-producing wisdom. The chapter, "First, the Bad News," is a delightful excursion into the dynamics of a frequently seen defense.

The Sisyphean effort is most evident in Schafer's chasing the perennial greased pigs of differentiating (1) psychoanalysis from psychodynamic psychotherapy and (2) psychic reality from other "realities."

The theoretical sharp-shooting is exemplified by Schafer's pummeling the concept of resistance as a form of theoretical "bad thinking." After spending pages arguing that it has no status as a theoretical construct and would best be replaced by an analysis of countertransference, he goes on to urge that the term be retained as useful for descriptive purposes, and he uses it comfortably in subsequent chapters. This is a puzzling position for a theorist who is intent on cleaning up the analytic vocabulary. Schafer offers, I believe, a superficial and overly hurried explanation of the origin of Freud's concept of resistance; he attributes it primarily to Freud's countertransference to Dora. There are times in this section of the book when Schafer utilizes "analyst bashing" as an antidote to what he identifies as "patient bashing."

But throughout this final section, and in earlier parts of the book as well, Schafer reveals himself not so much the iconoclast, but over and over again, as committed to the most enduring concepts of

analytic practice. He demonstrates in clinical examples his analytic commitment to analyzing resistance, transference and countertransference, and conflict, and examining all that comes into the analytic encounter as proper subject matter for analytic scrutiny. He endorses no easy answers and looks all gifthorses in the mouth. Schafer appears in these pages as an "old fashioned" psychoanalyst in the best sense of these words. He acknowledges the sameness and differences of analyst and analysand and, in an emotional final chapter entitled "Analytic Love," quotes Loewald (whose thinking has had much impact on Schafer's) and Rilke who both so movingly wrote that impartiality, scientific detachment, and love and search for the truth create the purest art, love, and psychoanalysis.

NATHAN M. SIMON (ST. LOUIS, MO)

LOSING AND FUSING. BORDERLINE TRANSITIONAL OBJECT AND SELF RELATIONS. By Roger A. Lewin, M.D. and Clarence G. Schulz, M.D. Northvale, NJ/London: Jason Aronson, 1992. 359 pp.

The Freud-Ferenczi controversy regarding technique[1] antedated the tension between Klein's firm interpretive stance and Winnicott's emphasis upon the holding functions of the analyst. In the realm of treating borderline patients, this historical schism has resurfaced in the approaches of Kernberg[2] and Adler.[3] Regardless of how far back this bifurcation of vision can be traced, its resulting technical interventions do differ in fundamental ways. The former approach (Freud, Klein, Kernberg) regards drive-based wishes as basic motivation, conflict as the psychopathological paradigm, transference as a reactivation of infantile wishes (and defenses against them), deciphering covert messages as hallmark of the an-

[1] Haynal, A. E. (1988): *The Technique at Issue: Controversies in Psychoanalysis, from Freud and Ferenczi to Michael Balint*. London: Karnac.

[2] Kernberg, O. (1984): *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven/London: Yale Univ. Press.

[3] Adler, G. (1985): *Borderline Psychopathology and Its Treatment*. New York/London: Aronson.

alyst's receptivity, and providing insight through interpretation as mainstay of the analyst's activity. The latter approach (Ferenczi, Balint, Winnicott, Kohut, Adler) regards unmet developmental needs as the motivational substrate, deficit as the main psychopathological configuration, transference as a healthy search of new objects to facilitate the resumption of arrested development, empathy as the essential facet of the analyst's receptivity, and objectifying and validating "affirmative interventions"[4] as the chief active function of the analyst. The two approaches have been termed "classic" and "romantic" respectively.[5]

The authors of *Losing and Fusing* are unmistakably "romantic" in their stance, with a firm allegiance to Sullivan's interpersonal approach and to the elusive and intuitive pragmatism of Winnicott. Contrary to Khan's assertion that "Winnicott's concept of transitional phenomena has been misunderstood by American analysts with a singular willfulness,"[6] Lewin and Schulz display a striking sophistication in their exposition and application of Winnicott's ideas. I will first summarize their views regarding the etiology, symptomatology, and therapy of such individuals' malady. Then I will comment on the strengths and weaknesses of their work.

Lewin and Schulz regard borderline syndrome as an "affective identity disorder of the self" (p. 21) whose etiology might include temperamental vulnerability, experiential stress, subtle seizure activity, family violence, abuse, sustained emotional insensitivity of parents, and poor child-parent fit. Emerging from a long incubation of such biopsychosocial substrate is a profound vulnerability to threats of object loss or of the cohesiveness of the self. The dual fears of losing the object (while seeking separateness) and fusing with the object (and thus losing the self) form the core of the borderline symptomatology. Caught in this dilemma, the borderline oscillates between intimacy and autonomy, often elevating "inter-

[4] Killingmo, B. (1989): Conflict and deficit: implications for technique. *Int. J. Psychoanal.*, 70:65-79.

[5] Strenger, C. (1989): The classic and the romantic visions in psychoanalysis. *Int. J. Psychoanal.*, 70:593-610.

[6] Khan, M. M. R. (1980): Review of *The Psychoanalytic Study of the Child, Vol. 33. Int. Rev. Psychoanal.*, 7:117.

personal distance regulation to the level of an art form" (p. 30). Negativism acquires adaptive functions in such circumstances, since being oppositional helps the borderline to ward off a sense of fusion and loss of the self. Existing in a dual danger zone, the borderline individual uses cutting, burning, fighting, purging, overwork, and outrageousness as *both* an attempt at self-delineation and (hostile) connection with others.

Lewin and Schulz highlight three other aspects of borderline symptomatology. *First* are the all-or-none attitudes. "Gradations, intermediate steps, mixed feelings, and the emergence of emotions in partial manageable doses are not part of the borderline repertoire" (p. 45). The resulting perfectionism-resignation cleavage impedes learning and growing, for trying is the essence of development. The authors emphasize that the all-or-none concept is superior to the customary "all good"-"all bad" vocabulary; it is experience-near, does not carry a judgmental charge, and is more inclusive of the cognitive and emotional consequences of splitting. *Second* is the bedrock conviction of borderline patients that they are nonentities. While acknowledging that such conviction co-exists with hidden grandiosity and thus approximates Kernberg's[7] map of the borderline's inner world, Lewin and Schulz offer a novel interpretation of this phenomenon. They suggest that the borderline is afflicted with a "self-transference in which the self is seen as not having the rights to experience, autonomous will, meaning, or significance. The self is caught up in seeing itself as it once was but need no longer be" (p. 180). *Third*, they emphasize, is the distinction between suicidality and suicide. Suicidality is "much more than the search for the doorway to death" (p. 240). It serves existentially useful functions for these patients; they do not give up suicidality until they no longer need it. All three features (all-or-none attitude, feeling of nonentity, and suicidality) betray the borderline's defective transitional relatedness. Caught between subjective emptiness and a dreadful need for objects, the borderline helplessly strives for a peaceful intermediate psychic area.

The treatment approach advocated by Lewin and Schulz is

[7] Kernberg, O. (1967): Borderline personality organization. *J. Amer. Psychoanal. Assn.*, 15:641-685.

geared toward facilitating the growth of this very area. Their strategies are anchored in Winnicott's[8] concept of the "holding environment." By holding, they mean

> an action, literal or symbolic, that has the effect of supplementing the existing psychic infrastructure so as to render what might be an overwhelming situation less overwhelming, thus providing the patient a degree of security or increased security that allows for continued developmental effort and experimenting with new ways of experiencing that may have not only more adaptive promise but more promise in terms of self-realization (pp. 116-117).

Lewin and Schulz describe the various stages in the development of holding environment during the borderline's hospitalization. Here, as well as in their discussion of the outpatient therapy, their approach is slow, gentle, and focused on meeting the patient's ego needs and on deciphering the adaptive strivings hidden in the patient's chaos. They warn that failure to note the "attachment to the therapist cloaked and revealed by the patient's negativism deprives the patient of a vital developmental support" (p. 44). They adopt a mentor-like stance vis-à-vis the patient's all-or-none attitudes; "much support and practice and patience is required to introduce the patient to more modulated ways that go step by step" (*ibid.*).

They "applaud first steps because they lead to second and third steps" (p. 48), and they criticize psychotherapeutic efforts that are legalistic and pushy. They recommend that therapists anticipate difficulties, accept projected feelings for a long time rather than righteously refusing them, and offer themselves as models of flexible thinking, delayed action, creative playfulness, and genuinely complex affectivity; this often involves a certain amount of "role sanctioned self-disclosure" (p. 307) on the therapist's part. Lewin and Schulz acknowledge the countertransference toll extracted by such treatment and observe that "work with borderline patients goes much better on the outpatient basis if the therapist is more generous with himself in terms of holding resources" (p. 131).

Lewin and Schulz write in an elegant, often poetic style. Their book provides ample clinical material that brings the authors' ideas to life. Their clinical wisdom shines through aphoristic statements. A few examples: "With only a modicum of the right sort of prov-

[8] Winnicott, D. W. (1965): Ego distortion in terms of true and false. In *The Maturational Process and the Facilitating Environment. Studies in the Theory of Emotional Development*. New York: Int. Univ. Press, pp. 140-152.

ocation, we have the capacity to become every bit as obstinate as our patients" (p. 15). "The psychopathology of the borderline patient is the psychopathology of the core" (p. 29). "Projective identification may be thought of as a form of psychiatric ventriloquism" (p. 37). "Borderline patients can teach us a great deal about the silent and automatic, hitherto insufficiently conflicted workings of our own egos" (p. 119). "When we admit a new feeling, . . . we are facing the task of accommodating within ourselves some aspect of ourselves that we had previously been able to store at least partly outside" (p. 211). Throughout the book, the authors' participating presence is felt, with the result that their work acquires a deeply authentic tone.

The book is not without flaws, however. It is very sparsely referenced. Many chapters are entirely without citations, a practice that is as refreshing as it is solipsistic. It lends the authors' views an aura of originality that is not always deserved. It is unsettling to notice the omission of Erikson[9] from the comments upon identity, Bouvet[10] and Balint[11] from the discussion of optimal distance, Mahler, et al.,[12] from the topic of self- and object constancy, Guntrip[13] and, Burnham et al.,[14] from the need-fear dilemma, and Frank[15] from the "unforgettable and the unrememberable" residues of preverbal trauma. Another problem is verbosity and linguistic cuteness. One can rest assured that "to feel better" will soon be followed by "to be better at feeling," "over looking" by "looking over," "dual" by "duel," "mentors" by "tormentors," "position" by "disposition," "deranges" by "rearranges," and so on. Finally, there seems an inoptimal attention to the etiological and phenomenological aspects of sexuality. This, however, is true of the "romantic" tradition at large and is not restricted to these authors alone.

[9] Erikson, E. H. (1956): The problem of ego identity. In *Identity and the Life Cycle. Selected Papers*. New York: Int. Univ. Press, 1959, pp. 104-164.

[10] Bouvet, M. (1958): Technical variation and the concept of distance. *Int. J. Psychoanal.*, 39:211-221.

[11] Balint, M. (1959): *Thrills and Regressions*. New York: Int. Univ. Press.

[12] Mahler, M. S., Pine, F. & Bergman, A. (1975): *The Psychological Birth of the Human Infant. Symbiosis and Individuation*. New York: Basic Books.

[13] Guntrip, H. (1968): *Schizoid Phenomena, Object Relations and the Self*. New York: Int. Univ. Press.

[14] Burnham, D. L., Gladstone, A. I. & Gibson, R. W. (1969): *Schizophrenia and the Need-Fear Dilemma*. New York: Int. Univ. Press.

[15] Frank, A. (1969): The unrememberable and the unforgettable. *Psychoanal. Study Child*, 24:48-77.

All in all, it seems that *Losing and Fusing* presents a humane application of the "romantic" psychoanalytic tradition to the treatment of borderline patients. It should be read along with texts which delineate a more "classic" approach to the same matter.[2,16,17] I believe an integration of the two divergent approaches yields the most meaningful approach to treating these difficult patients. One early, not entirely nonpartisan, attempt at such synthesis is the chapter titled "Bridging the Gulf" in Balint's[18] *Basic Fault*. Admixture of the two visions is also apparent in the writings of Modell and Volkan. Modell,[19] while betraying a romantic bent, recognizes the importance of oedipal transferences, a proposition of the classic type. Volkan,[20] though aligned with Kernberg's classic style, emphasizes the redemptive power of a deep regression, a notion of the romantic vision. Other hybrid approaches[4,5,21] also exist, and most clinicians perhaps intuitively strike their own variety of balance between the two positions. If and when they need to be refreshed in the knowledge of the "romantic" side of the equation, they can confidently turn to the book by Lewin and Schulz. It will be a rewarding experience.

**SALMAN AKHTAR (PHILADELPHIA)**

ATTACHMENT IN THE PRESCHOOL YEARS. THEORY, RESEARCH, AND INTERVENTION. Edited by Mark T. Greenberg, Dante Cicchetti and E. Mark Cummings. Chicago/London: The University of Chicago Press, 1990. 507 pp.

This volume of fourteen chapters sandwiched between a theoretical introduction and a summarizing epilogue will likely prove heavy

[16] Kernberg, O. F., et al. (1989): *Psychodynamic Psychotherapy of Borderline Patients*. New York: Basic Books.

[17] Yeomans, F., Selzer, M. A. & Clarkin, J. F. (1993): *Treating the Borderline Patient: A Contract-Based Approach*. New York: Basic Books.

[18] Balint, M. (1968). *The Basic Fault. Therapeutic Aspects of Regression*. London: Tavistock.

[19] Modell, A. H. (1976): The holding environment and the therapeutic action of psychoanalysis. *J. Amer. Psychoanal. Assn.*, 24:285-307.

[20] Volkan, V. D. (1987): *Six Steps in the Treatment of Borderline Personality Organization*. Northvale, NJ/London: Aronson.

[21] Akhtar, S. (1992): *Broken Structures: Severe Personality Disorders and Their Treatment*. Northvale, NJ/London: Aronson.

going for most readers, especially those whose interests lie more in the subtleties of clinical intervention than in the intricacies of well-conceived developmental research. One volume in the *Series on Mental Health and Development* sponsored by the John D. and Catherine T. MacArthur Foundation, it is a product of the MacArthur Network on the Transition from Infancy to Early Childhood. Robert Emde—a developmental researcher and theorist in addition to a child psychiatrist and psychoanalyst—was the chair of that Network from 1982 until 1987, and he points out in his Preface to the volume that the studies published here represent the third phase in attachment research.

The first phase of attachment research consisted mainly of the clinical/theoretical work of John Bowlby (who introduced the concept of attachment to psychoanalysts). The second phase of attachment research began when Mary Ainsworth developed the "Strange Situation" as a way of utilizing some of the concepts suggested by Bowlby; this led to two decades of studies built mainly around Ainsworth's paradigm. The third phase—represented by the present volume—goes beyond the previous work both methodologically and developmentally, as researchers have found new ways to "measure" attachment-related phenomena, ways which allow them to move from infancy into the later stages of toddlerhood, latency, and adulthood.

I did not find the excitement in reading this volume that I experienced when I first read Schaffer's *Studies in Mother-Infant Interaction*[1] and Kaye's *The Mental and Social Life of Babies*.[2] Perhaps I've become a bit jaded. Or perhaps the increasing complexity of research designs has begun to overtax my cognitive capacities. A third possibility is that my "nihilist" tendencies have begun to interfere with my appreciation of this kind of research. Is it possible to distill, via careful research designs, a *meaningful* set of data points which, when analyzed appropriately, yield new and clinically useful information about the dimension of human development which Bowlby

[1] Schaffer, H. R., Editor (1977): *Studies in Mother-Infant Interaction*. New York: Academic Press.

[2] Kaye, K. (1982): *The Mental and Social Life of Babies*. Chicago: Univ. of Chicago Press.

called "attachment"? Or, in capturing "attachment" via our research techniques, do we kill it? (I shall return to this point later in my review.)

From what appears in this volume it is clear that the MacArthur Network on the Transition from Infancy to Early Childhood has fostered a growing appreciation among researchers—even very behaviorally oriented researchers—for the "working models" which lie beneath the overt behavior of children and their caretakers (whether these actors are viewed individually or in synchronized interaction). The concept of "working models" is an important leitmotif which appears throughout this volume. As such, it sometimes appears in a rather Kleinian key, reflecting Bowlby's British roots; at other times it is restated in vocabulary reminiscent of Sandler and Rosenblatt.[3] Most often, however, the "working models" conceptualized by the researchers in this volume seem to be a hybrid of cognitive (Piagetian), linguistic, social, and emotional components which touch upon—but differ from—the mental phenomena which are of central interest to psychoanalysts. The present researchers generally do not reserve a place for "fantasy" (conscious or unconscious) within their definitions of "working models."

Many of the chapters incorporate a second theme—that of the need for descriptions of behavior which reflect the dyadic, coordinated character of attachment phenomena. There is a general recognition that (as Winnicott put it) "there is no such thing as a baby [. . . without a mother]"; and there is a growing recognition that there is no such thing as maternal behavior without a child. All (or nearly all) of attachment behavior *must* be conceptualized as essentially dyadic; Bowlby called it "a goal-corrected partnership." Several authors in the present volume add to this insight the idea that the dyadic aspects of attachment are themselves nested within broader "systems" (the family, the extended family, the community).

A third theme—implicit in most of the chapters and explicit in a few—is the idea that attachment does not disappear as a significant

[3] Sandler, J. & Rosenblatt, B. (1962): The concept of the representational world. *Psychoanal. Study Child*, 17:128-145.

"behavioral system" after early childhood. As Cicchetti, Cummings, Greenberg, and Marvin put it in their opening chapter, attachment is

> a life-span task which undergoes physical, ecological, perceptual, and representational changes that dramatically alter its form and organization . . . [but which remains] . . . a continuously developing organizational system . . . undergoing rule-governed transformations through the life span (p. 11).

Concepts such as "working models" and "nested systems" will not startle many psychoanalysts if they think about them for a moment; the behaviors which lie behind these concepts are part of our daily clinical work. What the authors represented within this volume add to these ideas are their suggestions about how we can grab onto some of these phenomena in ways that will satisfy the demands of academic empiricists. They struggle with the fact that the *meaning* of behaviors which are used to assess "attachment" at twelve months has evolved by the time the child reaches toddlerhood. Karen Schneider-Rosen uses the example of "gaze aversion": while in an infant gaze aversion may be "an index of avoidance," in a toddler it may be "an index of distraction or lack of interest" (p. 192). The researchers also struggle with the difficulty of "measuring" attachment in adults in ways which meaningfully represent their early attachment-related experiences.

Since a review of the many topics included in this volume would quickly expand beyond reasonable bounds, I will concentrate most of the remainder of my review on three specific topics. The first has to do with the expansion of the attachment classification beyond the A/B/C categories first proposed by Ainsworth. The second has to do with links between parental experiences of loss and insecure attachments in their infants. And the third has to do with some specific distortions of "secure-base" behavior observed in a very stressed group of mothers and young children.

The classic description of the Strange Situation and the procedures for classifying children's reactions to it is that of Ainsworth, Blehar, Waters, and Wall.[4] The behavioral characteristics associ-

[4] Ainsworth, M. D. S., Blehar, M. C., Waters, E. & Wall, S. (1978): *Patterns of Attachment: A Psychological Study of the Strange Situation.* Hillsdale, NJ: Erlbaum.

ated with "secure" ("B"), "insecure-avoidant" ("A"), and "insecure-ambivalent/resistant" ("C") were derived empirically and have proven remarkably robust. From the beginning of this research, however, many authors have noted that a small group of children did not comfortably "fit" into categories A, B, or C. The chapter by Mary Main and Judith Solomon included in the present volume reviews the evolutionary history of an additional category—"disorganized/disoriented" ("D")—and presents some of the criteria used in its definition. The addition of the D category is particularly important, in that it appears to offer a way of differentiating a group of insecurely attached children who did not clearly fall into either the A or C categories (and who in the past sometimes were forced into the B category).

The importance of the D category appears dramatically in the following chapter by Mary Main and Erik Hesse. Its title—"Parents' Unresolved Traumatic Experiences Are Related to Infant Disorganized Attachment Status: Is Frightened and/or Frightening Parental Behavior the Linking Mechanism?"—tells much of the tale. Main and Hesse are not analysts, and they do not speak directly to the importance of fantasies in mental life. They do, however, offer the following hypothesis:

> *The traumatized adult's continuing state of fear together with its interactional/behavioral concomitants (frightened and/or frightening behavior) is the mechanism linking unresolved trauma to the infant's display of disorganized/disoriented behavior.* Such behavior could be particularly puzzling or frightening to the infant because its immediate cause would often lie in the parent's response to memories aroused by ongoing events rather than resulting from those events directly (p. 163).

Main and Solomon present a very detailed list of "Indices of Disorganization and Disorientation" (pp. 136-140), which nicely expresses the difficulty of this kind of research—attempting, as it does, to bridge the gap between observable behaviors and internal, mental phenomena such as "working models." Main and Hesse put this list to work and find that it is not the experience of a loss (on the part of a mother), but specifically the *lack of resolution of the mourning of that loss* that is associated with the assignment of a child to the D category. They conclude that

> [the] infants [of still-traumatized parents] are confronted with an inherently perplexing set of circumstances. In contrast to both avoidant and ambivalent infants—who may be frightened by difficulties in obtaining caregiver respon-

> siveness in stressful situations—the fear the D infant experiences stems from the parent as its source. . . .frightening behavior on the part of the still-traumatized parent should lead to disorganized/disoriented infant behavior, since the infant is presented with an irresolvable paradox wherein the haven of safety is at once the source of alarm. Moreover, the conflict between opposing tendencies to approach and to flee from the attachment figure stems from a single external signal (threatening or fearful parental behavior); is internal to the infant; is self-perpetuating; and is exacerbated by placement in a stressful situation (p. 180).

Although the chapter by Cummings and Cicchetti, entitled "Toward a Transactional Model of Relations between Attachment and Depression," has, in many ways, the most explicit links to the psychoanalytic tradition, I will simply call attention to two specific elements of their work. First, they present some cogent criticisms of the "linear/main-effects" and "early experience" models of development. They note that these models (1) "posit a cause-and-effect determinism that is not supported by either clinical experience or research"; (2) "disregard the individual's initiative in responding to a supposedly pathology-inducing agent"; (3) "are insufficient to explain variations in the duration of determinants preceding the occurrence of psychopathology or the role of subsequent factors in determining type, severity, and course of psychopathology"; and (4) minimize "the importance of intervening experiences that occur throughout the life span" (p. 355). Second, they provide the reader with a very useful listing of "early risk factors associated with later depression potentiators" (Table 1, pp. 358-359) and with a model of the "causal relations among initial vulnerability to depression, quality of attachment, and adaptation" (Figure 11.1, p. 361). These are useful tools for further research and for teaching.

I turn now to the third topic I wish to highlight from the present volume: that having to do with the distortions of behavior observed in a very stressed group of mothers and young children studied by Alicia Lieberman and Jeree Pawl and reported in their chapter, "Disorders of Attachment and Secure Base Behavior in the Second Year of Life: Conceptual Issues and Clinical Intervention." These authors are the intellectual heirs of Selma Fraiberg, and I think that she would be pleased by the way they blend theory, research, and clinical vignettes. They call our attention to three patterns of distortions in secure-base behavior (a concept which links their work to both Bowlby's and Ainsworth's research), distortions which are

frequently encountered in the "at-risk" group of mothers and children with which they work at San Francisco General Hospital.

> One pattern, recklessness and accident proneness, is seen as a counterphobic defense against perceived danger. A second pattern, inhibition of exploration, is interpreted as a phobic flight from danger. Finally, a third pattern of excessive self-reliance is described as precocious competence in self-protection. In our view, each of these patterns involves efforts to solve the problem of self-protection in the absence of appropriate maternal support for negotiating this developmental task (pp. 379-380).

Lieberman and Pawl view the behavioral patterns they describe in this chapter as derived from several sources, working in dynamic interaction with each other. In their view, *temperamental factors* interact with "*patterns of maternal caregiving*" and "influence the nature and quality of the *working model of the attachment relationship* gradually internalized by the child. The internalized working model in turn exerts a powerful influence on the *child's behavior*, generating a process of reciprocal influences that leads both to an increasing *elaboration of the mother-child interactive patterns* and to a growing consolidation of the *internalization by the child of specific aspects of this interaction*" (p. 395, italics added). They support their model with three clinical vignettes which illustrate both the power and the limitations of their kind of work.

In bringing this review to a close I would like to return to a comment I made earlier regarding the lethal potential of research in an area as clinically vibrant as attachment. I was delighted to see that, even among the most behaviorally oriented researchers included in this volume, there is an increasing appreciation for the fact that overt behaviors mean different things to different people at different points in development. Developmental research walks a constant tightrope: if we define our categories tightly to increase their "reliability," we often have to discard some of the important data that make the work clinically "valid." Alternatively, when we try to capture clinically significant ("valid") data, we often find that honest observers disagree and our "reliability" falls to pieces. What is more, we *never* have control of more than a handful of the hundreds or thousands of "vectors" which together play their parts in human behavior. And yet we continue to search for models which will *predict* the outcome of something as complex as an "insecure attachment."

I would like to suggest that developmental researchers should content themselves with reconstructive work. That is, if they can define some of the important variables which likely have contributed to a specific outcome, they should stand proud. While prediction will remain the *sine qua non* of rocket science, the number of variables which contribute to the trajectory of a rocket is minuscule when compared to those which affect the developmental trajectory of a child. I think that it is quite enough that Main and Hesse have been able to demonstrate that many "disorganized/disoriented" or D-category children have parents who are still struggling with the sequelae of traumatic losses. I think it is too much to ask them to predict which children will prove to be particularly vulnerable or invulnerable to such influences; there are too many intervening variables which lie outside our control. This position, which pleads its own impotence, is one into which psychoanalysts repeatedly have been forced ever since Dora fled her treatment with Freud.

The authors of several of the studies included in the present volume (e.g., Easterbrooks and Goldberg; Maslin-Cole and Spieker; Bretherton, Ridgeway and Cassidy) were disappointed in the relative weakness of their findings. I would suggest that they expected too much of themselves. Although they collected an impressive amount of detailed data and subjected it to some remarkably inventive analyses, they sometimes appear to forget that they are assessing one aspect, or at most a few aspects, of very complex behavior while sailing on a shifting sea which remains quite beyond experimental control.

This is a book that is required reading for a specialist audience of researchers—especially those concerned with normative child development and/or developmental psychopathology. Two chapters are well worth the attention of many psychoanalysts. I have in mind Jude Cassidy's review article, "Theoretical and Methodological Considerations in the Study of Attachment and the Self in Young Children," and Cummings and Cicchetti's "Toward a Model of Relations between Attachment and Depression." And at least one chapter—Lieberman and Pawl's "Disorders of Attachment and Secure Base Behavior in the Second Year of Life"—should be included in every psychoanalytic institute's reading list for its "growth and development" sequence.

PAUL M. BRINICH (CHAPEL HILL, NC)

ABOUT CHILDREN AND CHILDREN-NO-LONGER. COLLECTED PAPERS 1942-80. By Paula Heimann. Edited by Margret Tonnesmann. London/New York: Tavistock/Routledge, 1989. 368 pp.

This is a collection of twenty-four papers written by Paula Heimann over a period of thirty-eight years, starting with her Membership paper of 1939/1942 and ending in 1979/1980 with a paper on her responses to being with a child. She herself was in the process of selecting the papers for publication at the time of her death in 1982. The work of selecting and editing has been completed by Margret Tonnesmann, who adds her own illuminating comments and introduces each chapter with a note about its original appearance. There are six papers which appear in English for the first time. The reader is able to explore and follow Heimann's development as a thinker, clinician, and psychoanalyst, through what were clearly difficult and stormy periods, to her emergence as an individual in her own right—being herself, which I hope all psychoanalysts seek for themselves and their patients. This point is made by Pearl King in her introductory personal memoir of Heimann, in which she recalls the shattering effect within the British Society of Heimann's withdrawal from the Klein group in 1955.

Heimann was a very interesting, influential figure in the history of the British Psycho-Analytical Society. She moved from the classical Freudian world of Berlin and a personal analysis with Reik, to a long and deep involvement with the concepts of Melanie Klein at a time when Klein was fighting for the acceptance of her new and challenging ideas and when both women were refugees from Germany. However, Heimann did not stop there. She seems to have accepted British empiricism, and was always prepared to learn from her clinical work and her personal observations. From this basis, she explored and developed her own thoughts in her particular areas of interest—sublimation and creativity, the innate ego, narcissism, the very earliest nature of the infant's undifferentiated self-other experience, destructive impulses, transference, and, of course, countertransference. This collection of her papers allows the reader to accompany her on her explorations.

Although Heimann may be most widely known for her papers on countertransference, in this book it is her exploration and search

for understanding of the creative aspects of personality and her view that intrapsychic "good" objects are assimilated into the self that I found most fascinating. It is the introjected bad experiences and objects which stimulate destructive behavior and distort ego development, blocking creativity. She stresses the importance of the environment in this unfolding process.

Her original interest in destructive aggression was what drew her to Klein, who was determinedly involved in elucidating Freud's concepts of life and death instincts, particularly the latter. Initially, Heimann was in a social relationship with Klein, and then she entered analysis with her. I found Pearl King's memoir of Heimann in this period both intriguing and disturbing.

In Heimann's papers we can see her taking up the Kleinian position of innate death instincts in her earlier writings, with the correlative understanding of conflict from the outset and sublimation as essentially a reparative act. However, even in her first Membership paper of 1942 she questions whether sublimation is only reparative of objects damaged by the outwardly turned death instinct and is already suggesting that there is more to sublimation than this. This idea is developed in her later paper, "Some Notes on Sublimation" (1957/1959), in which she states that the ego's involvement with sublimation has the primary aim of giving the subject an experience of creative fulfillment and joy and that reparation of damaged objects is a necessary preliminary.

In her later papers, Heimann follows Freud's last ideas about the ego: that it is present as an entity at birth, with its own charge of energy, separate from the id. This is referred to, I feel misleadingly, as primary narcissism; Heimann herself finds this "an unfortunate and contradictory term" ("Notes on Early Development," p. 145). I think Heimann was moving ever nearer to describing the "self"—a somatopsychic, sensory perceptive organism, from which the ego of perception, cognition, memory, judgment, object relatedness, etc., will rapidly emerge. She emphasizes the importance of observing the newborn infant during the first hours and days of life, as object-relating behavior appears early and may obscure this more subtle behavior. (I would concur; I think that recent research showing the infant in quiet, alert states may be indicative of this.)

For Heimann, this ego emerges from the earliest undifferentiated state of subject and object, i.e., from infantile omnipotence,

and it leads to object relatedness. However, there is a residue of primary narcissism, which I would think of as "self," that is not object related but related to the ego itself. It is from here that the roots of true creativity spring or indeed become blocked, leading to the possibility of states of pathological narcissism, including the perversions. It is this aspect of the innate ego that makes sublimation more than reparation, as, in Heimann's view, not only are damaged objects repaired, but a part of the ego directed toward itself is freed to express itself creatively and refind its objects. (One is reminded here of D. W. Winnicott's paper, "On the Capacity To Be Alone," 1958: it is safe to withdraw into oneself when there is the security of knowing that a reliable object will be there when one re-emerges.) This has implications for technique, when it becomes important to distinguish between a withdrawal from the analyst that is an object-hostile response to a potential intrusion into the self and a subject-object withdrawal response that is an attack on the object who is to experience it as such. Her theories seem to differ basically from those of Kohut, many of whose ideas she appears to have anticipated, in that she does not see narcissism developing from a source entirely separate from the ego, although she emphasizes that narcissism develops through the vicissitudes of maturational experiences, as do the ego and object relations.

Heimann's struggles with these difficult concepts ultimately led her to a hypothesis different from that of life and death instincts. I think she takes as fact that the infant has a premonition of life and death from the successes and failures of the environment—the mothering figure's ability to protect the infant from internal and external impingements. The outcome of these experiences for the individual is seen as a matter of adaptation. One consequence of this view is to give the environment much greater importance in development than is implied by Kleinian theories, in which object relations are understood to be present from the start of life. This different theoretical position leads to other ways of understanding certain behaviors, with the changes in clinical technique already indicated.

Since Heimann arrives at the view that the infant has an ego at birth, but that it is undifferentiated from that of the object, primitive conflicts between self and object are initially absent, and so,

too, are the dynamic defenses of splitting and denial. For Heimann, the earliest adaptive responses to environmental failures are shifts in the location of energies—from memory to the perceptual system, in the form of hallucinations, and when this fails, to the experience of somatic and later somatopsychic memory traces, the forerunners of fears of dying.

Her paper, "On Counter-Transference" (1949/1950) is the point identified as the break from Klein. In this paper she states that countertransference is a useful tool in analysis and an important source of information from the unconscious of the patient to the unconscious of the analyst. For Heimann countertransference is a product of the patient and the analyst has the task of recognizing his/her responses, neither repudiating nor acting them out, but allowing them to become part of his/her consciousness in order to relay the understanding back to the patient. In a later paper, she explores the analyst's time lag in understanding the countertransference response, and also debates whether the analyst should communicate this response to the patient. She is clear that the answer is not to.

There are many further areas of richness in her writings, such as the anal stage being the height of conflict between the infant's narcissism and object relatedness, where narcissism is seen as something more than primitive asocial selfishness ("Notes on the Anal Stage" 1961/1962). In the paper on "Fetishism" (1963/1964), shame is most interestingly explored and analyzed in relation to somatic delusions and hypochondriasis.

It is possible to read this book as a history of the development of one woman's observations, thoughts, and concepts as she utilizes her Freudian and Kleinian experiences; and it is enriching and inspiring. One does not have to agree with all she says to respect her focused, detailed thinking. As one gets further into the book, one senses her growing confidence, and even pleasure, in her own views, as the writings become less rigid. However, she never stops listening attentively to the ideas of others. That Heimann's involvement with the work of Melanie Klein was all-important to her development there can be no doubt; I believe she struggled *with* these ideas and then *against* them, when they no longer seemed true to her clinical and personal observations. Her efforts to achieve this

freedom were obviously arduous and painful. One must admire her courage in the pursuit of her truth. This is more than history. It is a search for and a finding of her own creativity.

SHARON STEKELMAN (LONDON)

HERMINE HUG-HELLMUTH. HER LIFE AND WORK. By George MacLean and Ulrich Rappen. New York/London: Routledge, 1991. 305 pp.

George MacLean and Ulrich Rappen have provided child psychoanalysts and historians of psychoanalysis a volume that is rich, rewarding, and unusually illuminating. Hermine Hug-Hellmuth was one of the first lay analysts, the first gentile and third woman member of the Vienna Psychoanalytic Society, and, most notably, the first child psychoanalyst. Why has her work been all but forgotten? MacLean and Rappen attempt to address this question in their volume.

Hug-Hellmuth's life from beginning to end was full of traumas—from her separation-filled childhood until her murder in 1924 by her nephew, Rolf, the illegitimate son of her illegitimate half-sister. Her professional career was marred by the notoriety of her *A Young Girl's Diary*. Hug-Hellmuth eventually said that she was the editor of this anonymous adolescent girl's description of her inner life. Some maintained, however, that Hug-Hellmuth's claim of authenticity was fraudulent and that the editor herself was the author of the diary. Her chief critic was the English psychologist, Cyril Burt. MacLean and Rappen agree with Burt's hypothesis that the diary was written by "an exceptional person who did not live under average conditions," i.e., Hug-Hellmuth herself. They hypothesize that Hug-Hellmuth's motives for writing the diary may have included a wish to counteract the appearance of a rival for Freud's approbation, Anna Freud.

MacLean and Rappen have organized the volume with biographical material (which, in fact, is quite sparse in comparison to other noted psychoanalysts), critical discussion of her analytic work, and selected papers on child analysis, women, and the family. On first reading I found the book difficult, to some extent because of sloppy editing. One example is the heading of Chapter 3: "A Psychoanalytic Career: 1913-1929," rather than 1924 (the year of her death).

The editors also note that some of Hug-Hellmuth's papers read as if they were unedited manuscripts. However, re-reading the volume and overlooking the editorial problems proved extremely valuable. The editors made one very unfortunate choice in their translation. They state that they chose to translate the German, *Seele*, as "soul" because the usual translation, "psyche," "does not reflect the many connotations of this quite overdetermined German word" (p. 48). However, as I read the papers, there was a jarring effect whenever I encountered discussions about a child's soul. I had to consciously remind myself of the editors' intent and suppress the mystical connotations of the translation.

Reading this volume convincingly demonstrates the editors' idea that Hug-Hellmuth's originality as a child analyst well preceded Anna Freud's and Melanie Klein's work. MacLean and Rappen suggest several reasons to explain why Hug-Hellmuth's work has remained largely unrecognized. (1) The Viennese psychoanalytic community was embarrassed by her tragic murder; therefore, the value of her work was disregarded and attributed to someone else, namely, Anna Freud. (2) Although she wrote the first technical paper on child analysis, Hug-Hellmuth overly condensed her contributions to the technical aspects of child analysis. (3) She remained largely untranslated into English until recently. (4) She was not given proper credit by Anna Freud, who took credit for herself. (5) Hug-Hellmuth's identification with education was used to deny her status as a psychoanalyst. (6) The editors consider Hug-Hellmuth's problematic personality as the most important reason for the neglect of her work (p. 279).

Although many of Hug-Hellmuth's papers include seemingly random clinical observations, many psychoanalytic insights are revealed. This is astounding, given the early date of their formulation. Since her entire career antedated the second anxiety theory, her concepts are consistent with Freud's original anxiety theory. Yet, it is striking how many of her early insights, preceding future contributors, have withstood the test of time.

Hug-Hellmuth explicitly stated that her goal was to demonstrate the relevance to children of Freud's ideas and methods. She clarified the differences between child analysis and adult analysis but understood that no psychoanalytic treatment, in either adults or children, can occur without transference; she maintained that the

analyst represented both mother and father. She was extremely sensitive to children's feelings and stressed that the analyst needs to understand childhood narcissism and the effect on the child of blows to his or her narcissism. She cautioned analysts that they do not discuss positive transference feelings with children prematurely because children might experience loyalty conflicts and be forced to choose the parent over the analyst. At the same time she understood the important concept which came to be known as object removal in puberty. "During puberty these [incestuous] wishes are sublimated and displaced to another love object. If this does not happen successfully during puberty, we are left with individuals who lack the strength of will to free themselves from their parents. They feel an inextinguishable guilt because of their strong childhood desire to discover the mystery of their parents. This is similar to the desecration of holy places or habits. These are 'unforgivable' sins" (pp. 92-93).

Hug-Hellmuth proposed a broad role for the psychoanalyst. Her conception of childhood education was that it included overcoming the pleasure principle and accepting reality (p. 165). Underscoring the difference between adults and children, she maintained that in the young

> the curative and educative work of analysis does not consist only in freeing the young creature from his sufferings [but analysis] must also furnish him with moral and aesthetic values . . . [because children and adolescents] are still in the developing stage. [They] have to be strengthened through the educative guidance of the analyst . . . [and] he who is both analyst and educator must never forget that the aim of child-analysis is character-analysis—in other words, education.
>
> The peculiarity of the child-psyche, its special relationship to the outside world, necessitates a special technique for its analysis (pp. 138-139).

Hug-Hellmuth understood the importance of the child's environment to his or her psychic development and, perhaps because of the emotional deprivation of her own childhood, stressed repeatedly that severe deficits result from early childhood deprivation. Throughout her work Hug-Hellmuth reiterated that parents need to understand their children better. This theme, with its preaching quality, indicates to me a personal root which resulted in less empathy for parents and their struggles than for the children and their problems. However, a significant part of her message aimed

to counteract the then current aggressive educational measures. Hug-Hellmuth understood the important role of aggression in normal development and maintained that love was more important than discipline. She wrote the first paper (1912) on the child's concept of death from a developmental framework and, in 1920, stated emphatically that it was impossible for anyone to analyze his or her own child. (What was the effect of this assertion on both Anna Freud, analyzed by her father, and Melanie Klein, who analyzed her daughter?)

In her papers on women and the family, Hug-Hellmuth described a male counterpart to penis envy—fantasies of childbirth—and demonstrated the complex reasons behind manifest behavior. She provided many examples from her practice which, unlike most analysts, included examples of nonconfirmations of psychoanalytic hypotheses. She stated, for example, that in her analysands, adult females regularly revealed fantasies of wishing to steal their father's masculinity, but she could not reproduce these fantasies in younger females (p. 182).

George MacLean and Ulrich Rappen are to be commended for making this volume available to the psychoanalytic community. Despite the editorial difficulties, immersion in Hug-Hellmuth's work and in MacLean and Rappen's discussions will be exceedingly fruitful for the child analyst and the child analytic trainee.

LEON HOFFMAN (NEW YORK)

A PSYCHOANALYTIC THEORY OF INFANTILE EXPERIENCE: CONCEPTUAL AND CLINICAL REFLECTIONS. By Eugenio Gaddini. Edited by Adam Limentani. Foreword by Robert S. Wallerstein. London/New York: Tavistock/Routledge, 1992. 220 pp.

The work of Eugenio Gaddini is inadequately known in North America. A distinguished pioneer in the Italian psychoanalytic movement, he devoted a lifetime of research to the organization of infantile mental life and its effects on adult personality organization. His work is of signal importance to the understanding of psychosomatic disorders and phenomena. The richness and breadth of Gaddini's original thinking combined with his extensive

research and clinical acumen make impossible an adequate brief review of this information-laden and tantalizing book.

This edited collection of papers is primarily from his vast *Scritti*, a work of over 800 pages. Adam Limentani has selected those covering three main themes: imitation, seen by Gaddini as a central factor in early development; ego formation, the processes of instinctual drive arousal and the development of awareness of separateness from the object; and the way the body becomes meaningful to the mind through the elaboration of primitive defensive fantasies. Gaddini's formulations are novel and demand speculative interest, however much one subscribes or does not subscribe to the drive-energic framework.

This review will be limited to brief discussion of "On Imitation" (1969), "Early Defensive Fantasies and the Psychoanalytical Process," (1981), and "Formation of the Father and the Primal Scene" (1977).

Most interesting of all to this reviewer is Gaddini's ascribing paramount importance to the growing human organism's earliest sensory experiences and protofantasies in the evolution of personality structure. In one of Gaddini's last recorded remarks, he noted that the primitive perceptions described by Fenichel were truly sensations and that the movements from sensations to perceptions led him to understand the importance of mental development in relation to the early, primitive body development. He was also impressed with the extent to which the development of bodily functions conditions the mind, creating models of functioning which are to be discovered later at the mental level. His untimely death prevented his exploiting vast clinical material to validate his hypotheses further. He worked in close collaboration with his wife, Renata De Benedetti who, like Winnicott, is a pediatrician who became a psychoanalyst.

Here we discuss imitation and some of Gaddini's thoughts about psychosomatic disorders. Much of what follows relies on Limentani's synthesis.

It is important to distinguish between imitation and identification. Imitation is a basic defense and a part of ordinary development, normally leading to identification through the integration of imitation with introjections, essentially an oral mechanism. Maternal functions are imitated very early. Early frustration can lead to

pathology, such as rumination, or merycism, which can occur as early as eight weeks of life and, untreated, can lead to death. It affects the alimentary system as a form of regurgitation, when previously swallowed food is regurgitated, rechewed, and reswallowed. The assumption is that this activity is accompanied by a fantasy in which the baby *imitates* the milk-giving activity which the mother has withdrawn from him or her. Treatment involves rectification of the mother's attitudes and capacities.

Gaddini turns to a much neglected area of psychoanalytic investigation: the role of the father and the primal scene in the early development of the infant and child. Here we see Gaddini moving away from the conception of the simultaneity of the "imitative" ("psychosensory") and the "introjective" ("psycho-oral," "oral-instinctual," or sometimes just "instinctual") modes of experiencing in early infancy, toward conceiving of them as successive phases. The father and "the primal scene process" are in part the means by which the infant moves out of his or her illusory world of imitative identity into the troubled world of instinctual conflicts, desire, object recognition, awareness of the parents' relationship, and development of identification.

The child has a series of experiences of the parents' relationship that are elaborated in fantasy and are subsequently condensed into a special defensive construction which may make it appear as though the child has witnessed the intercourse but once. The infant is overwhelmed by the primal scene experience, which is that of an attack on his or her imitative identity, leading to a sense of self-mutilation. There is an experience of loss, abandonment, and disintegration due to the child's aggressive drives being aroused and turned inward. We must remember that during the first few months of life, auditory, tactile, and all other sensory stimuli are all-important. Gaddini posits that the libido comes to the rescue by being stimulated and mobilized to counteract the aggressive drives.

Gaddini believes that the infant cannot distinguish between self and non-self after nine months inside mother. For several months the infant will be unable to distinguish between self and environment. A part of what the infant believes is that its body is in reality the mother's body. If a baby is hungry, a breast appears, but the baby does not know it is not its own. All the surround is a product of magical omnipotence. If all is well, experience is not unlike uter-

ine life. It follows that memory *in utero* is not necessary, so it is unlikely we shall recall that period of life.

To Gaddini, pathology is most enlightening. The appearance of skin disorders is predetermined through the mental meanings assigned to physical sensations and their role in preserving the integrity of the self. Before the perception of the external world gains mental significance, external stimuli are assimilated through the physical sensations they produce, resulting in remembered body changes. The earliest mental organization is fragmentary and primarily occupied by bodily sensations and needs, especially the need to keep the fragments assembled within a boundary. Survival is the dominant aim, and the non-self is appraised in the light of the infant's first experiences of being rudimentarily aware of being separate. Atopic dermatitis may develop at about four months of age, when some awareness of separateness is developmentally appropriate.

A distinction is made between two kinds of fantasy. There are fantasies *in* the body that are rudimentary and proceed from body experiences in the service of defense. They lack the kind of images that are revealed through a functioning of the body activated by the mind, as in merycism. These fantasies are usually enclosed in the primitive and exclusive body-mind-body circuit and are not available for further mental elaboration. Such fantasies are followed by fantasies *on* the body which are based on the idea of space in the developmental process and are associated with imagery. They are visual and represent the first mental image of the separated self.

When fantasies *in* the body are transitory and linked with psychophysical syndromes, they may be expressions of a fragmentary, nonintegrated early organization of the self and may be related to fear that the organization might fragment. This *anxiety of nonintegration* is one of two main expressions of anxiety of loss-of-self, the other being *anxiety of integration*, which is a fear that whatever change occurs in the nonintegration state will lead to ultimate catastrophe. In Gaddini's view, splitting occurs only after an integrated state has been achieved.

Space limitations prevent the inclusion of the rich clinical examples offered in Gaddini's complex and original book. Reading the book is strongly recommended.

L. BRYCE BOYER (BERKELEY)

THE MOSCOW LECTURES ON PSYCHOANALYSIS. Edited by Arnold Rothstein, M.D. Madison, CT: International Universities Press, Inc., 1991. 172 pp.

*The Moscow Lectures on Psychoanalysis* arose out of a 1989 meeting between Arnold Rothstein, Sander Abend, and Marat Vartanian, the Director of the National Mental Health Research Center of the (then) Soviet Union. Vartanian responded to this meeting by inviting a group of western analysts to teach psychoanalysis within the institution of Soviet psychiatry; it was the first such invitation in sixty years. Vartanian indicated at the time "that Soviet mental health workers knew very little about psychoanalysis because prior to *glasnost* and *perestroika* the idea of the unconscious had been 'outlawed'" (p. ix). In his preface to *The Moscow Lectures*, editor Arnold Rothstein points to this striking fact as a reminder of the power of ideas. He also informs us of one of the major purposes of the book, namely, the transmission of the basic concepts of psychoanalysis to an audience with a background in mental health, but with little knowledge of psychoanalysis.

*The Moscow Lectures* presents the newcomer to psychoanalysis with a brief history and an orientation to the major concepts of the field, unified by a focus on conflict and compromise formation. The more sophisticated reader is treated to a series of thoughtful expositions on a number of topics, including the relationship of psychoanalysis to psychotherapy, the treatment of severely ill people, and a review of the development and application of child analysis. This is an excellent collection of contemporary psychoanalytic lectures, and aimed as it is toward an audience not necessarily experienced in psychoanalysis, it is a needed and especially welcome contribution.

In the first two chapters, Abend provides a clear account of the beginnings and evolution of psychoanalysis. Within the context of charting the developing theory, he explains such key concepts as unconscious mental processes, free association, resistance, childhood sexuality, and psychic reality. He also identifies the volume's contributors as coming from a particular group within psychoanalysis, one that "believes childhood unconscious instinctual conflicts of a sexual and aggressive nature have lasting and central importance in human development, and that a study of their influence,

particularly through the transference that develops in a properly conducted psychoanalysis, leads to explanations of and improvements in patients' emotional suffering" (pp. 42-43).

The third chapter, by Charles Brenner, takes up the centrality of psychic conflict and compromise formation in the psychoanalytic understanding of mental functioning. He defines a conflict as made up of a wish, a feeling of unpleasure, a defense, and superego manifestations. He tells us that the consequence of psychic conflict is compromise formation, and explains how compromise formations underlie both our pathological choices, or symptoms, and our "normal" choices.

Rothstein, in the fourth chapter, shows how the concepts of conflict and compromise formation can be used to illuminate the clinical phenomena of narcissism, masochism, sadism, and transference. And, in chapter five, Dale Boesky applies the ideas of conflict and compromise formation to clinical examples of sublimation, enactment, and identification. He emphasizes that "the notion of 'compromise formation' is a theoretic construct" (p. 77), and that one can decide for oneself if it is a useful construct by applying it to clinical data and seeing if it helps one understand the patient.

Homer Curtis, in a superb sixth chapter, describes the differences between psychoanalysis and various types of psychoanalytic psychotherapy. He demonstrates how each of several kinds of treatments might be most appropriate, depending on the needs and capacities of the patient. Curtis stimulates the reader to consider how new interpersonal experiences within and outside of the treatment can lead to change. He notes that people may get relief from suffering in many ways, including through "spontaneous, unwitting social relationship[s]" (p. 88). Yet he also depicts how specifically psychoanalytic techniques lead to a particular kind of understanding, symptom relief, and change.

In chapters seven and eight, Scott Dowling provides a concise and informative history of child analysis, as well as an account of its characteristics and applications. He shows how psychoanalytically informed observation and advice—ranging from Spitz's studies of infants in institutions to the books of Spock and Brazelton—have made an impact on how we care for children. Some of Dowling's remarks are clearly intended for his Soviet audience, such as his statement that in psychoanalysis, "the goals of the state are explic-

itly subsidiary to the goals, needs, and satisfactions of the individuals who make up the state" (pp. 113-114). In the implicit contrast drawn between the Soviet and our own practice environment, we are reminded of how seldom we consider the larger sociopolitical context in which our practice of psychoanalysis is situated.

Abend, in the final chapter, touches on a number of perspectives on the treatment of severely ill patients. He provides a thoughtful discussion of the drawbacks of conceptualizing severe psychopathology in terms of stage-specific trauma. He acknowledges the interplay between constitutional factors and environmental trauma, and then demonstrates how the basic principles of compromise formation can, and perhaps must, be applied to the understanding of sicker patients (e.g., those classified as having borderline conditions). Abend also casts an eye to the future, wondering how psychopharmacologic advances may be best combined with psychoanalytic treatments.

Overall, *The Moscow Lectures* provides an excellent introduction to, and opportunity to reflect on, a particular way of looking at the mind and working with patients. It is especially helpful for those considering how best to convey psychoanalytic ideas to a capable and interested audience. What concepts are basic to our thinking? Which of these concepts are easily accessible and which require a more thorough explication? Such questions not only have relevance for conveying clinical and theoretical ideas across cultural boundaries; they are just as relevant for those of us who may try to communicate these ideas to students and practitioners within the mental health field in our own communities.

One problem with the book is that although it aims to be accessible to the uninitiated, there are some case vignettes in which too little is revealed of the premises or evidence upon which the analyst's clinical inferences are based. One vignette in Boesky's chapter, for example, would have benefited from a more thorough elaboration of his clinical observations. I am sure that had he done so, his conclusions would have been clearer; an introduction to psychoanalysis suffers when overly condensed case vignettes mystify the inexperienced. Another minor concern I have with the book is with Rothstein's statements that in analysis, "The relationship of patients to their therapist is analyzed, rather than reacted to in any other way" (p. 75), and then later, that "*Analysis* of the transference

is not only vitally important, it is unique to analysis" (p. 76). If Rothstein meant to express a somewhat extreme view of how one responds to transference in analysis as opposed to psychotherapy, I simply disagree with him. If he was simplifying, for heuristic purposes, to convey the differences between psychoanalysis and psychotherapy, I would take issue with this approach, as the clinician readers might find it difficult to reconcile this portrayal with their own experience of the powerful emotional pulls of transference or of interpreting the transference in psychotherapy.

This volume would have benefited from telling us something of the responses of the Soviet audience. I wonder in what ways the lectures and seminars were illuminating to their clinical work. Abend tells us that "only through a personal experience of psychoanalysis, and preferably, some experience analyzing others as well, can [scientists and thinkers] acquire the perspective needed to evaluate psychoanalytic propositions" (p. 16). The other side of this coin may be that when we explain ourselves to mental health professionals with different theoretical bases, or those beginning in the field, we become more aware of our own assumptions and look with a fresh eye at the concepts central to our enterprise. It will always be important for us to be in dialogue with nonanalysts, both for them and for us.

TERRENCE C. BECKER (SAN FRANCISCO)

CONVERSING WITH UNCERTAINTY. PRACTICING PSYCHOTHERAPY IN A HOSPITAL SETTING. By Rita Wiley McCleary. Hillsdale, NJ/ London: The Analytic Press, 1992. 156 pp.

This book is an unusual case history, valuable in several regards. The author recounts her experience as a trainee at a state hospital treating a borderline adolescent. Her tactfully self-revealing account begins with her initial anxieties as a therapist-in-training saddled with responsibility for a severely disturbed adolescent girl. Her patient, Kay, arrived, having failed numerous previous attempts at treatment, with a history of violent and self-destructive outbursts and prostitution, attended by allegations she had sexually abused two preschool children. The author has a gift for rendering complicated material in a clear, well-organized fashion. She faithfully

conjures the intricate web of patient/therapist and therapist/staff interactions which are the life of a psychodynamically oriented inpatient milieu. Students struggling to fashion a unique professional identity from a variety of disparate influences will no doubt find a kindred spirit in this book.

The author emphasizes that, unlike most other accounts of clinical work, her case history highlights "the role ideas played both in [her] constructions of and extrications from clinical situations" (p. 115). This is the central theme of this book and its special contribution. How do therapists need and use ideas in their clinical work? A beginner in need of an explicit structure, she was first drawn to the reassuring definitiveness of Masterson's formulations of the borderline adolescent. So fortified, she was able to enter the clinical storm, while remaining open to "back talk" from the clinical situation, which led her ideas to evolve in new directions. Her need to understand the intense feelings her patient evoked in her led her to an interest in projective identification, which became the ideational touchstone of the middle period of her training.

The author asks why she embraced a given idea at a particular time, and her answers are searching and discerning. For example, she came to understand that her reliance on the concept of projective identification at times allowed her to sidestep conflicts with staff. At one point she felt identified with her patient—the staff did not like Kay, and they did not like her either. The concept of projective identification allowed her to attribute her own conflicts with staff to Kay. Relinquishing her defensive reliance on the idea of projective identification allowed her to appreciate more fully the importance of the milieu, an understanding she achieved in the final period of her training. The therapist may embrace an idea to satisfy a personal need or to resolve a conflict. This is an important point, and the author makes it persuasively.

For an individual case history to be of broad interest, it should either bring to life familiar ideas in a vivid way, which this book does, or introduce a new idea or original emphasis, which this case history certainly does in its invitation to all therapists to engage in a self-analysis of their personal intellectual history. However, for all the author's clarity regarding the developmental sequence of her own ideas, I was left wondering what impact these ideas had on Kay, the other subject of the case history. Although the author

notes on several occasions what appears to be developmental steps for Kay, as when Kay tells her she is not angry at *her* (suggesting the patient has been able to differentiate the therapist from inner bad objects), Kay's growth is less apparent than the author's. Was Kay's discharge contingent on intrapsychic and behavioral change, or on hospital policy requiring a limited length of stay and student turnover in June. The final sentence of the book has the quality of an afterthought which leaves the reader uncertain about Kay's clinical course. "As the nurse supervisor remarked when I spoke with her last, Kay seems to have done as well as we could expect" (p. 132). How well did Kay do? What can one expect? What relevance do the clinician's working ideas have to patient outcome?

In her final chapter, the author quotes at length from Lawrence Friedman's *The Anatomy of Psychotherapy*.[1] Friedman characterizes theories as "practical aids to attention" which allow therapists to avoid responding "normally" to what their patients evoke, which in turn allows something new and different to happen in the therapeutic relationship. Contradictions in clinical theory matter less if ideas are seen primarily as facilitators of a creative interpersonal process, which itself eludes description. In her review of clinical ideas, the author notes numerous contradictions, which at times lead to antithetical prescriptions for treatment. For example, one of her supervisors tells her there is "too much noise" in her sessions, while Ogden's ideas about projective identification suggest that "the noise" is the essence of the treatment.

How much do such contradictions matter? The author's trouble with contradictory ideas diminishes (I think too easily) when she understands the utility of ideas in her own development. Just as not any idea would do for the author, not any idea should do for Kay. What role did the author's ideas play in changing Kay? Do patients perceive the workings of ideas in their therapists? Did one idea provide a more effective treatment prescription than another, or are ideas primarily for the therapist? To what extent do clinical theories conform to the mind and needs of the therapist rather than to a definable reality in the patient? More about these issues would have been a natural complement to the author's excellent

[1] Friedman, L. (1988): *The Anatomy of Psychotherapy*. Hillsdale, NJ: Analytic Press. Reviewed in this *Quarterly*, 1990, 59:273-275.

descriptions of other parallel processes in the milieu, and would have further strengthened a fine book.

MICHAEL GARRETT (NEW YORK)

MADNESS AND MODERNISM. INSANITY IN THE LIGHT OF MODERN ART, LITERATURE, AND THOUGHT. By Louis A. Sass. New York: Basic Books, 1992. 595 pp.

*Nietzsche: "The growing consciousness is a danger and a disease."* This quotation sets the basic thesis of the book: the hypertrophy of consciousness and consequent devitalization of the schizophrenic experience are extreme manifestations of the modern malaise reflected in modernism and postmodernism.

While the philosophical roots of modernism may go back to Descartes (the world is experienced *as* a view), Kant is seen as its true source: the observer helps both create and curtail the world of perception, making the structures of reality subordinate to those of the knowing subject, and bringing about an unbridgeable gap between the human "phenomenal" realm and actual "noumenal" existence. This has had far-flung and opposite effects: a dizzying sense of power from seeing reality as self-constituted, or a despairing meaninglessness.

In modernism and postmodernism one finds defiant antitraditionalism or alienation, perspectivism and relativism. There is a loss of the self's sense of unity, capacity for effective action and significant external reality. This triple loss results either in impersonal subjectivism or totally nonempathic objectivism. The ego becomes an impotent observer or else is transformed into a machinelike entity in a world of static and neutral objects.

Modernist and postmodernist literary works abandoned traditional forms of organization along lyrical, narrational, or mythic lines and cultivated neutral description, especially of static objects. Aesthetic self-referentiality circles back upon itself, watching itself in action. Irony, disengagement, and scornful laughter are turned on life as well as on art. There is an extreme inwardness or solipsism that would deny all reality and value to the external world or, the opposite, an extreme, alienating materialism devoid of human qualities.

Thus, "the twentieth century seems . . . to be characterized by the

pursuit of extremes, by exaggerated objectivist and subjectivist tendencies or by unrestrained cerebralism and irrationalism . . . understood either as expressions of an extreme self-consciousness or . . . attempts to escape from alienation and hyperawareness . . . result[ing] in artworks that . . . can seem as difficult to grasp, as off-putting and alien as schizophrenia itself" (p. 38).

The book follows the sequence of the schizophrenic process beginning with first encroachments of an alien world and ending in the more bizarre reaches of world catastrophe. It shows that with each of the various aspects of schizophrenia there are closely analogous forms of experience commonly found in twentieth century art and literature. For example, the onset of schizophrenia is often accompanied by the feeling that everything is strange or different and either takes on special meaning or seems meaningless. Correspondingly, the visions of Beckett and Ionesco take meaninglessness for granted. Rilke shows a combination of meaninglessness and meaningfulness. The French surrealists and Russian formalists consciously sought after these experiences. They even described techniques for inducing them to bring about uncanny hyperclarity and jolt the audience out of complacent dailiness to become aware of the discontinuous nature of existence and the absurdity of conventional systems that can only bring about the illusion of coherent understanding.

In the premorbid personality of a schizoid person destined to develop full-blown schizophrenia one often finds a fundamental awareness of distance, fragmentation, difference, and disconnection (cf., Kafka's hypersensitivity or Baudelaire's cultivated disdain). The schizophrenic qualities of alienation, irony, and masquerade may be viewed as declarations of the perceived inauthenticity of the outside world. In modern culture, too, there is a division between the real, individualistic, private, authentic self and the false, public one of social role.

Features of modernist sensibility that appear to be close to schizophrenic thinking are: fluidity of perspective (Alfred Jarry, analytic cubism, T. S. Eliot), radical contrariness (dada, surrealism), and an immobility or escape from time (Robbe-Grillet). Styles of schizophrenic language (desocialization, autonomization, and impoverishment) have analogues in modernist and postmodernist literature. They share the tendency to reject or ignore social imperatives

and realistic concerns in favor of private concerns, preoccupation with the ineffable, and a focus on language as language—leading to isolation and self-involvement.

The loss of self and world that one finds in the full-blown psychosis is also prominent in modern art. The certitude of the Cartesian, "I think therefore I am" becomes "It thinks and therefore I am not" (p. 235). An externalizing introspection contributes to its own self-alienation.

The various expressions of modernist aestheticism are suffused with their own subjectivity, experiencing the self as the transcendental foundation of all existence, and reflecting an ambition for absolute consciousness: totality (encompassing all points of view), transparency (all elements of self and world appear as objects of awareness), self-sufficiency (without dependence on either the body or the social milieu).

Ultimately, the extreme subjectivism and solipsistic grandiosity of both modernism and schizophrenia flip over into a disconcerting sense of responsibility, ontological insecurity, and devitalization of self and world—bringing on a fear of nothingness, death, and the void. Extreme subjectivism or hyper-reflexiveness ultimately "undermines itself and erases the very conditions of reflexivity and alienation that made it possible in the first place" (p. 313). That which is experienced as object turns out to be nothing other than the experiencing subject which has been projected outward before itself. The self now collapses outward into its world, turning out to be even more evanescent than other representations and the universe becomes composed only of shadows and reflections—a twilight realm almost beyond language.

Thus, searching for the self can dissolve it, transforming the sense of awesome ontological power into abject metaphysical terror. There is a deep interdependence between these two—the loss of self and unrestrained solipsistic grandeur. These dualities of schizophrenic experience are also basic to modern thought: rationality comes to generate forms of irrationality. Nietzsche: "Our knowledge will take its revenge on us, just as ignorance exacted its revenge during the Middle Ages."

Franz Kafka's story, "Description of a Struggle," contains nearly every feature of modernism (derealization, dehumanization, perspectivism, detachment). The plot structure is organized in a series

of concentric circles. Every aspect of schizophrenia is described, from mild schizoid phenomena to extreme forms of solipsistic experience, making Kafka a sort of Dante of modern times. The world is assimilated to the self, and vice versa. The world is constituted by the mind, such that the world will cease to exist if one does not attend to it. Every remedy only aggravates the condition, triggering a final cataclysm.

Some critics hold that many of the modernist and schizophrenic modes of hyper-reflexivity are perversions of authentic human existence that should be "characterized by a sense of contact, by active engagement and participation in meaningful social action rather than by doubt, distance, and unreality" (p. 347). But the postmodernist deconstructionists, Derrida and De Man, would view the malaise and upheaval consequent to hyper-reflexivity and alienation as necessary by-products of true insight into human reality, and the ability to tolerate them as paradigms of heroism.

This evenhandedness is also seen where the author considers the possibility that schizophrenia could in some sense be a cause of modern culture, or vice versa, and is properly modest in warning against oversimplistic generalizations. It is seen likewise in the Appendix, where he finds that the neurobiological evidence is as compatible with models postulating hyperconsciousness or hypertrophied rationality as, more conventionally, indicating regression, instinct domination, or a decline of rationality—a judgment which by the end of the book has become a hallmark of the text and its significant mind-opening conclusion.

Minor irritants, such as that there is no mention of the fact that imaginative writers from the fifth century B.C. to the present have always been concerned with madness as a revelation of mind and a manifestation of uncontrolled imagination,[1] in no way detract from the text or its impressive body of accompanying notes (163 pages, fully one-fourth of the book). It is an accomplishment of bold scope and erudition—a major contribution.

GILBERT J. ROSE (ROWAYTON, CT)

[1] Feder, L. (1980): *Madness in Literature*. Princeton, NJ: Princeton Univ. Press.

BISEXUALITY IN THE ANCIENT WORLD. By Eva Cantarella. Translated by Cormac Ó Cuilleanáin. New York/London: Yale University Press, 1992. 284 pp.

This scholarly discussion of bisexuality in ancient Greece and Rome will be found instructive by psychoanalysts and sexologists alike. Eva Cantarella, the author, is professor in the Institute of Roman Law at the University of Milan. The translator, a lecturer in Italian at Trinity College, Dublin, has obviously done justice to the author's intentions. *Bisexuality in the Ancient World* is cogent, lucid, and well organized.

The book is full of information and sound thinking about sexuality. A historical perspective is particularly helpful for clinicians working in the field of sexual orientation, because it helps clarify the extent to which sociocultural factors influence ideas about psychopathology and treatment. For example, Aristotle endorsed matrimony and condemned homosexuality, considering it a manifestation of a "morbid" disposition. And, of course, Aristotle was not aware of basic facts about reproductive physiology. He believed that the semen plus menstrual blood worked together to create an embryo. The role of the semen was active, and that of the menstrual blood was entirely passive. Aristotle apparently approved of the decision made by the gods to acquit Orestes of matricide on the grounds that the mother was not actually a "parent" in the full sense of the term, but merely a passive receptacle of the father's vital fluids. It is striking that as influential a figure as Aristotle based his sexual values on such erroneous beliefs about the "natural world."

A critical look at contrasting ideas about what has been considered to be "natural" sexual behavior at different times and in different places is provided by Cantarella in a helpful and thought-provoking fashion. Extremely informative is her discussion of how differently homosexuality was viewed in Greece and in Rome. The history of pederasty in Greece, for example, with its courtly rituals and its emphases on initiation into manhood and education of the young, is contrasted with the aggressive stance taken toward homosexuality in early Rome. In Greece, pederasty was an institutionalized form of behavior regulating relationships between citizens. In Rome, pederasty between citizens was condemned; and sex

between males was originally seen as an expression of dominance. It was socially approved for a Roman citizen to have sex at his will with slaves, including male slaves. As the dominant partner in the interaction, the initiator and penetrator was not perceived as being "homosexual" in the modern sense of the term. The passive partner who was probably usually raped, was viewed with contempt and had no rights. Although homosexual *activity* was so common as to be the norm in both classical Greece and the early Roman republic, affectionate sexual relationships between totally homosexual, consenting adults were sanctioned in neither civilization. Both Greece and early Rome, however, endorsed open bisexuality occurring in a prescribed manner between individuals in carefully specified groups.

Although cruelty toward certain people engaged in homosexual activity was also common in Greece and early Rome (particularly passive recipients of anal intercourse and male prostitutes), brutal punishment for homosexual activities was not legally prescribed until the period of the Roman Empire. In A.D. 342 the punishment for passive homosexuality was castration, in 438 it was to be burned alive, and by A.D. 529 the punishment for all homosexual activity was death. Cantarella discusses some of the influences leading to this historical trend.

One of the most dramatic facts to emerge from this monograph is that in both Greece and Rome, with the notable exception of Sappho, little attention was paid to female homosexuality. Sappho, born about 612 B.C., left a legacy of poetry about the love and desire of women for women that was unique. Most writers who subsequently attended to the topic of homosexuality in women condemned it on the grounds that it represented uncontrolled passion. Cantarella's discussion of the relationship between the role of women in ancient Greek and Roman society and the apparent lack of interest in female homosexuality in both societies is illuminating. The tendency for Western European societies to focus more on male than on female homosexual behavior has been notable. The psychoanalytic literature has tended to devote much more attention to male than to female homosexuality as well. Whether the reasons for this are to be found in a continuation of trends begun in ancient Greece and Rome is not clear, but the possibility must be considered.

In summary, *Bisexuality in the Ancient World*, although not written for a psychoanalytic audience, is a valuable contribution to scholarship about sexual orientation. I recommend it without reservation.

RICHARD C. FRIEDMAN (NEW YORK)

THE SUBVERSIVE FAMILY. AN ALTERNATIVE HISTORY OF LOVE AND MARRIAGE. By Ferdinand Mount. New York: The Free Press, 1992. 282 pp.

This volume is a historical-sociocultural critique of many of the myths which surround the family. Throughout the book Mount debunks those myths which he claims have "soaked through into our ideas of history." In so doing, however, the author promotes an even larger myth or oversimplification: that "the family is a subversive organization . . . the enduring permanent enemy of all hierarchies, churches and ideologies" (p. 1).

The first myth he challenges, one promulgated by the historian Edward Shorter, is that the "nuclear" family is a modern phenomenon. He cites many scholars as well as the more recent statistical studies of Peter Laslett who demonstrated that "the nuclear family has always been the normal family."

Mount then counters the myth, popularized by Phillippe Aries in *Centuries of Childhood*, that the family has treated its children in ever more enlightened ways. Once subjected to infanticide and indifference, children, since the Middle Ages, according to Aries, are an increasingly differentiated and cared for segment of the population. Mount points out, in letters and memoirs going back to Plutarch, that children have always been dearly cared for by their parents.

He also takes on the idea, set forth by C. S. Lewis and Denis de Rougemont, that romantic love was discovered by the troubadours in the Middle Ages. From the inscriptions on the walls of Pompeii to many recent medievalists he shows that feelings of love, including conjugal love, have been present through the ages.

Then arguing against much feminist family history, he claims that women, throughout history, rather than being devalued, have often been seen as equal members in a joint enterprise. He seeks to debunk these myths in support of his contention that the family

has, from the beginning, included love and a sense of equality between husbands and wives, as well as affection for children. It is largely because of these loyal attachments, that, according to the author, the family has been necessarily in subversive conflict with the outside world. He supports this thesis first by citing the conflicts between the family and religion. He notes Christ's call to his followers to abandon their families for God and for the greater collective good; he goes on to demonstrate the Church's perennial hostility to sexuality, other than for procreation, as well as its attempts to control various aspects of family life throughout the centuries.

To religion's hostility to the family can be added that of the State. From Plato's *Republic* to Marx and Engel's attack on the bourgeois family as a reflection and a symptom of capitalism, Mount illustrates how governments have regularly tried to control the emotional intensity of the nuclear family.

Curiously, this book contains no chapter on the various ways that corporate institutions currently impinge on family life. With both men and women working outside the home in greater numbers, there are constant conflicts over how to balance work and family responsibilities. One wonders why Mount did not mention how the workplace uproots families geographically and is so frequently reluctant to offer such benefits as on-site child care and paid parental leave. A couple of years ago the media covered the intense public reaction to a football team management's objection to one of its players missing a game to attend the birth of his child.

What is it about the family that leads to controversy, engenders such distortions and mythmaking, or, as the author puts it, results in "more . . . spoken and written lies than any other subject?" (p. 7). Later he asks "Why do they [the historians and intellectuals writing about the family] hate the family so much?" (p. 159).

The author leaves this question largely unanswered because *The Subversive Family*, primarily a work of social history, is virtually apsychological. Only once does Mount, in passing, cite Bettelheim's depiction of the dilution of affective family ties in the kibbutz setting. There is no mention of Freud. There is no acknowledgment of *Civilization and Its Discontents*, in which Freud, in addition to demonstrating how civilization is in conflict with individual in-

stincts, spells out the rift between wider society and the interests of the family.

For this reader, Mount's book suggested thoughts on two subjects: 1) the ambiguous place of the family in psychoanalytic theory and practice as it pertains to the author's claim that most institutions are hostile to the family, and 2) ways in which psychoanalytic theory may help explain the tendency to distort descriptions of family life.

Psychoanalysis was itself once a revolutionary movement with its own early critical etiological views of the role of the family in mental illness. We are familiar with Freud's abandonment, almost one hundred years ago, of the seduction theory which originally laid the traumatic origins of hysteria at the feet of family caregivers. The seduction theory was then replaced by the central role ascribed to unconscious and intrapsychic conflicts. The widespread and continued misunderstanding of this subsequent discovery of infantile sexuality and innate aggression remains a problem for our field. We are accused by many of minimizing the prevalence of real as opposed to fantasized experiences. Most of us do not see these as mutually exclusive determinants, but rather as the complex interaction of psychic and external reality.

In practice, however, we have been reluctant to treat, where appropriate, those patients whose externalizing defenses and external reality initially preclude individual treatment. Thus, in a curious way, psychoanalysis, in its insistence on the individual psychoanalytic method when that method is often inapplicable, can be seen as a example of Mount's observation of an aversion to or at the least benign neglect of the families of its patients. In 1917, Freud would ask how psychoanalytic treatment could succeed "in the presence of all the members of the patient's family, who would stick their noses into the field of the operation and exclaim aloud at every incision."[1] Our field, which has developed the most comprehensive theory and treatment of the human mind, has not applied that theory comprehensively to the family unit, where distorted perceptions (transferences) in family life and joint collusive resistances to healthier interaction are so prevalent.

[1] Freud, S. (1916-1917): Introductory lectures on psycho-analysis. *S.E.*, 16:459.

This brings me to the unanswered question raised by this book. What possible explanation is there for the perennial and almost universal distortions of and hostility toward the family that the author documents so well? Psychoanalysis has for nearly one hundred years demonstrated that these distorting tendencies are part of our psychological make-up. We must all surmount the universal anxieties of infancy and early childhood. We must separate from nurturing caretakers (with attendant object loss and related depressive affect), suffer the indignities of conforming to adult expectations (with concomitant feelings of shame, persecution, and lowered self-esteem), as well as struggle with conflicts triggered by gender differences (with accompanying envies and resentments felt toward the opposite sex). In addition, there are also guilt-ridden conflicts over rivalry with siblings, as well as oedipal conflicts intertwined with preoedipal ones.

Can there be any question that we emerge from these difficult developmental stages with both unconscious and conscious ambivalence toward that family crucible within which we experienced such discontents? When moderated by the family's capacity to love and also contain the inevitable aggression associated with these early vulnerable years, neurotic conflict with its attendant distortions of reality can be minimized. Mostly, though, we do just what Mount has described historians of the family doing. Objectivity about the family eludes us because unconscious conflicts contribute to defensive idealizations and devaluations of the family and its members. We create family romances, and in myriad ways transform or relive our early family experiences in the transferences of everyday family life, and we share in the many myths, scientific as well as historical ones.

This provocative book, which creates its own myth while debunking numerous others, serves to remind us that our personal views of our own families and our shared collective views of "the family" are, while multidetermined, invariably distorted. The family cannot be viewed simply or primarily as a subversive institution. It nurtures and socializes each new generation to adapt to the unique characteristics of ever changing sociocultural contexts and pressures. We can agree with the author that the family has been around for a long time and will continue to be for a long time to come. However, it cannot be easily categorized. Juxtaposed between the needs of

individuals and those of its surrounding institutions, the family will be ambivalently viewed by all who pass through it. Its children and its historians will see it alternately as supportive of, or in conflict with, the members who make it up, as well as supportive of, and in conflict with, the institutions with which it must deal.

FRED M. SANDER (NEW YORK)

HOW CAN TALKING HELP? AN INTRODUCTION TO THE TECHNIQUE OF ANALYTIC THERAPY. By Roy M. Mendelsohn, M.D. Northvale, NJ/London: Jason Aronson, Inc., 1992. 314 pp.

The title of this book is a deceptively simple question which masks the author's ambitious goals. While he calls his effort *An Introduction to the Technique of Analytic Therapy*, in my opinion this book is not for beginners. Mendelsohn is attempting to summarize the major concepts and controversies in the theory of analytic therapy. However, his focus is primarily on psychoanalytic psychotherapy and especially child therapy. For some inexplicable reason, he makes no effort to clarify the distinctions between therapy and analysis or between the treatment of children and that of adults. The experienced, analytically oriented clinician knows very well that there are many important differences, but the beginning therapist, attempting to use Mendelsohn's book as an introduction, will not read about them and, I think, will become confused.

The book's major strength is in its clinical vignettes which provide examples not only of the techniques under discussion, but also of Mendelsohn's clinical sensitivity as a therapist. The volume is divided into two parts: an introductory chapter, in which the author presents his basic orientation and argues for his particular point of view, and the rest of the book, which is divided into chapters on each specific technical concept, with clinical examples provided.

In the introduction, the author takes care to clarify that his primary interest is in preoedipal psychopathology, arising from either deficit or conflict. In his opinion, a specific "action response" to promote growth is called for from the therapist in these conditions. Mendelsohn divides intrapsychic forces into those attempting to maintain pathology and those constructive forces that lead to

growth. He feels that it is the therapist's task to understand the patient's unconscious communications and to intervene on the side of constructive growth. He discusses the principles of analytic therapy which he thinks will guide the therapist in executing this very complex response.

In the first few chapters, Mendelsohn describes the process of interpretation with those patients with neurotic transferences and then differentiates the type of interpretation needed with prestructural transferences. The importance of an "ideal therapeutic attitude" is presented as necessary for positive identification.

In a chapter on regression, the author differentiates a controlled therapeutic regression from a destructive and dangerous one. His thesis is that the therapist's ability to contain and manage the regression is based on a flexible, empathic understanding of the patient's needs. He points out how the therapist's silence can be destructive, not neutral, with these sicker patients.

In the fifth chapter, he argues that it may be necessary for the therapist to provide concrete experience to supply what was lacking in the patient's development. Here the blurring between child therapy and the treatment of adults may contribute to what is a controversial recommendation.

In this same chapter, Mendelsohn courageously presents a treatment failure to show that not all patients will respond to his approach. However, he emphasizes his overly optimistic stance that most patients can be helped if only they can be understood and responded to in the way that they need. His use of a case of a severely ill schizophrenic young man whom he determined to treat without medication represents to me an exception to standard practice.

In a chapter on empathy and countertransference, Mendelsohn emphasizes the value of empathy as the therapist's guide to a proper growth-producing response. At the same time, he does discuss the danger of countertransference when providing empathic responses. While stressing the value of the therapist's empathic immersion in the psychotherapy of more primitive patients, such as advocated by Kohut, he points out that "emphasizing the role of empathy makes it important to be thoughtful about its limitations" (p. 233). Empathic impressions should be verified by other means, and a balanced perspective should be maintained.

In an informative final chapter on re-enactment and acting out, Mendelsohn highlights the multiple functions of these phenomena. The therapist's empathic awareness of the patient is the most important guide in these situations. The author's experience with children leads him to be particularly sensitive to the multiple functions and meanings of acting out and enactment and the need to respond differently to each. He stresses that, in primitive patients, often what is communicated nonverbally is the result of infantile trauma. Concrete action by the therapist is needed to enable new solutions and ego functions to arise.

In the summary, the author presents his psychotherapy with a bright, verbal, six-year-old neurotic girl. He uses the case to restate his therapeutic principles: ". . . the determination of the specific condition of the treatment, the management of the ground rules and boundaries, the timing, depth and content of the interpretations, and if indicated, the consideration of the noninterpretive interventions should emanate from a patient's unconscious communication rather than the authority of the therapist!" (p. 285).

In answer to the question posed in the title, *How Can Talking Help?*, the author notes, "It depends entirely upon whom you talk to, what you say, the way you say it, and most important of all, the response you receive" (p. 297). This book represents the author's efforts to defend his ideas about the technical concepts needed for a growth-producing response.

**R. PEERY GRANT (ATLANTA, GA)**

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# Mind/Body

Steven E. Locke

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# ABSTRACTS

## MIND/BODY

*Abstracted by Steven E. Locke.*

**The Political Economy of Mind-Body Health.** C. R. Halpern. **American Journal of Health Promotion.** VI, 1992. Pp. 288-291.

While the efficacy of mind-body interventions is slowly gaining credibility, it is still primarily viewed as part of the alternative medicine "counterculture." However, emotional support, controlled diet, and a healthy, active lifestyle can often prevent health problems, and have also been shown on some occasions to lessen or alleviate existing problems. In this article the author discusses the merits of a therapy that is inexpensive, readily available, and can be administered by lay personnel; he also acknowledges sources of probable resistance, particularly existing medical institutions. Employers and insurers looking to cut health care costs, and physicians who take a humanist approach to medicine are suggested as potential advocates of incorporating a mind-body approach into sanctioned medical care. The author concludes with a series of suggestions for addressing the legal, economic, administrative, and perceptual practicalities of mainstream acceptance of a mind-body approach to health care.

**Neuroanatomical Correlates of Normal Human Emotion.** R. D. Lane, et al. In press.

Positron Emission Tomography (PET) is a neuroimaging technique which measures brain activity as reflected in regional cerebral blood flow. This study used PET technology to localize the neural experience of normal human emotion, and to examine the effects of sensory versus recollected emotional stimuli. Twelve healthy, right-handed, female subjects aged eighteen to thirty who exhibited intense emotional responses to pretest material were presented with happy, sad, disgust, and neutral stimuli as both film and as recall of personal experiences. Both the film- and the recall-generated emotions showed activity in the medial prefrontal cortex and thalamus, suggesting that these areas are not specific to sensory versus recall emotion. However, film-generated (sensory) emotion was associated with symmetrical brain activity significantly greater than that of recall-generated emotion in the occipito-temporal and temporopolar cortex, amygdala, hippocamal formation, hypothalamus, and lateral cerebellum. The authors suggest that the medial prefrontal region, as a possible site for working memory, could be involved in the conscious experience of emotion, execution of the task that generates emotion, or regulation of the expression of emotion. Other studies have already associated areas of the thalamus with the integrated expression of emotion. It is also proposed that the amygdala and hippocampus as implicated in animal studies of emotion may be responsible for attaching emotional significance to external sensory stimuli, and may not be involved in internally generated emotional responses. (This paper won first prize for best poster at the Annual Meeting of the American Psychosomatic Society, Boston, MA, 1994.)

**Alexithymia Ratings in Bulimia Nervosa: Clinical Correlates.** D. C. Jimerson, et al. **Psychosomatic Medicine.** LVI, 1994. Pp. 90-93.

Alexithymia is a syndrome which has been characterized as difficulty in recognizing and describing affective feelings as distinct from bodily sensations, combined with a lack of imagination and symbolic thinking. Past studies have linked alexithymia to anorexia nervosa and to depression. Although it has also been linked to bulimia nervosa, previous studies did not control for a depressive component. This study compared normal-weight female bulimics without symptoms of anorexia nervosa or major depression to age- and weight-matched controls on a variety of depression, anxiety, and personality scales. Of particular interest were subjects' scores on the Toronto Alexithymia Scale (TAS), which indicated a significant difference between patients and controls on the ability to differentiate between bodily sensations and other feelings and on the ability to express these other feelings, but there were no differences between patients and controls on fantasy or metaphorical thinking. Results suggest affective dysregulation in bulimic patients, without a disruption of creativity. Patient scores on the TAS were lower than those of previous unscreened bulimic studies, indicating a component of alexithymia secondary to depression contributing to previous results. The authors note that bulimics' affective deficits may have impact on the efficacy of psychodynamic therapy, making them better candidates for cognitive behavioral therapy, in which they may concentrate on identifying and resolving these cognitions and affects.

**Hypnotizability, Dissociation, and Bulimia Nervosa.** N. A. Covino, et al. **Journal of Abnormal Psychology.** CIII, 1994. Pp. 455-459.

A putative relationship between dissociative symptoms and bulimia, not only in cases with histories of childhood abuse and subsequent severe psychiatric disorder, but also in relatively healthier bulimics, has been discussed in the literature. In some studies, scores on the Dissociative Experiences Scale (DES) even predicted binging. In many cases, bulimic symptoms have responded to hypnosis therapy, which allows the patients to relax, control the dissociative feelings, and manage the emotions that lead to binging behavior. Some previous studies have suggested that bulimics and anorexics who binge/purge are more hypnotizable than other patients with anorexia nervosa, scoring higher on the Stanford Hypnotic Susceptibility Scale: Form C (SHSS:C). This study presents the results of an investigation of bulimic females, screened by interview and psychological testing for the absence of other major psychiatric disorders, as compared to normal controls. The study found that bulimics scored higher than controls on the SHSS:C for hypnotizability, with 15/17 scoring in the highly hypnotizable range (the norm is 10 to 15%), and bulimics also scored higher on the DES for dissociative experiences. In both instances, there was no correlation between test scores and severity of bulimia, as determined by frequency of binging/purging or duration of illness. The only correlation between the SHSS:C scores and DES scores was found in bulimics ($r = 0.61$, $p < 0.01$); even highly hypnotizable controls did not tend to have elevated DES scores. The authors propose that the relationship between dissociation and bulimia suggests that the dissociative symptoms may be caused by nutritional insufficiencies that generate metabolic disturbances, and that the dissociation is not necessarily a defense mechanism,

nor may it be directly related to hypnotizability. The suggestibility of bulimic patients as shown on the SHSS:C, plus a cognitive style that is not rigorously analytic, may lead to their acceptance of a cultural model of thinness, and thus may partially explain the success of cognitive behavior therapy. The binging and purging itself may have reinforcing properties that relieve the anxiety and depression preceding an episode.

**Is Alexithymia Related to Psychosomatic Disorder and Somatizing?** K. Cohen; F. Auld; H. Brooker. **Journal of Psychosomatic Research.** XXXVIII, 1994. Pp. 119-127.

The authors emphasize the physiological components of alexithymia, making the point that, from Sifneos's original characterization, alexithymics would be expected to experience the physical components of stress but not the emotional ones. From this perspective, the authors hypothesize that alexithymia should be related to the degree of "experience and expression of physical signs and symptoms" and not necessarily to psychosomatic disorders, which have been linked to alexithymia in previous studies. In this study, three groups of subjects were compared: somatizing inpatients complaining mainly of chronic unsubstantiated pain; psychiatric outpatients, complaining of a variety of intrapsychic, interpersonal, and vocational conflicts; and controls comprised of patients undergoing routine dental examinations. The Toronto Alexithymia Scale (TAS) and the scored version of the Archetypal 9 Test (SAT9) were used to measure alexithymia; additionally, the Basic Personality Inventory and various subscales of the MMPI were administered, and physicians were asked to quantify the organic basis of the somatizing patients' complaints. The best predictor of alexithymia as measured by the TAS was the tendency to report signs and symptoms; neither somatization nor other psychiatric disorder was significantly related to TAS alexithymia score, nor was the physician estimate of organicity related to the somatizing patients' TAS scores. Thus, the authors suggest that alexithymia is part of a response set to trauma and is not related to actual physical disorder. The authors note that the correlation between TAS score and tendency to report signs and symptoms derives mainly from the first two TAS factors: ability to identify and distinguish bodily sensations from feelings, and ability to communicate feelings—thus, these may be correlated because they in fact both measure the reporting of signs and symptoms. Alternatively, they propose a relationship through a common factor of depression since that is often accompanied by physical symptoms.

**Changes in Cognitive Coping Strategies Predict EBV-Antibody Titer Change Following a Stressor Disclosure Induction.** S. K. Lutgendorf; M. H. Antoni; M. Kumar; N. Schneiderman. **Journal of Psychosomatic Research.** XXXVIII, 1994. Pp. 63-78.

One of the consequences of chronic stress is suppression of the immune system, leading to susceptibility to infection. Epstein-Barr Virus (EBV), a common herpesvirus, lies latent after infection; successful regulation by the immune system can be measured by the titer of serum EBV antibodies. Thus, EBV antibody titer can be used as a reflection of immunological strength and has been shown to be sensitive to

psychosocial stressors, both acute and chronic. In this study, the authors examined efficacy of interpersonal verbal disclosure of a stressful or traumatic event in decreasing EBV antibody titer (indicating increased suppression of the virus). Normal college undergraduates underwent a series of three weekly sessions during which the experimental group related a stressful or traumatic experience that they had not disclosed to many people, while a randomly assigned control group filled out psychometric questionnaires. EBV antibody titer was measured at the beginning of the experiment and also at the end of the three weeks. No difference in antibody titer change was found between the experimental and control groups, but individual differences in the experiences and reactions of the experimental group were able to account for 78% of the variance of antibody change in that group. High levels of emotional involvement in the disclosure, presumably reflecting introspection and facilitating therapeutic changes, along with a decrease over the three weeks in cognitive avoidance behavior, were the most important factors in predicting a decreased EBV antibody titer, as long as the traumatic event occurred at least five months prior to the experimental disclosure. As cognitive avoidance paradoxically requires hypervigilance to avoid reminders of the stressful event, it consequently involves sympathetic autonomic arousal, leading to high blood pressure, increased heart rate, and other symptoms of physiological arousal which can be damaging in the long term. The authors suggest that EBV titer may be particularly useful in monitoring the coping abilities of immune-compromised populations such as HIV seropositive patients, and that short-term interventions may have a positive effect on maintaining their health status.

**Emotional Disclosure through Writing or Speaking Modulates Latent Epstein-Barr Virus Antibody Titers.** B. A. Esterling, et al. **Journal of Consulting and Clinical Psychology.** LXII, 1994. Pp. 130-140.

Epstein-Barr Virus (EBV) antibody titer has been shown through meta-analysis to be "the most consistent and significant correlate of psychosocial stressors," worldwide. Stress's negative impact on the immune system can apparently persist over several years of repression or suppression of emotion. In one study, more than forty years after the Holocaust, the act of verbalizing the experience resulted in significantly fewer doctor's visits and fewer reports of health problems among survivors during the next year, particularly for those whose narratives used the most emotional words. Use of emotional words may reflect interpersonal coping style, which apparently moderates the effect of disclosure: sensitizers who are quick to express negative feelings demonstrate lower skin conductance level and higher heart rate than repressors who tend to deny negative feelings. Based on such findings, these authors examined changes in EBV antibody titer in repressors and sensitizers for either oral or written disclosure of a traumatic or trivial event. Using undergraduates, they found that oral disclosure of a stressful event resulted in a greater decrease in EBV antibody titer than written disclosure of a stressful event, and that disclosure of a stressful event was more successful at lowering EBV antibody titer than disclosure of a trivial event, which had no effect. Repressors (categorized using the Millon Behavioral Health Inventory) were at a disadvantage compared to either sensitizers or subjects who were neither sensitizers nor repressors, although there was no ap-

parent extra advantage to being a sensitizer. The authors constructed a linear regression model which accounted for 53% of the variance in EBV antibody titer change over the three weekly sessions: the experimental group (written/oral, stressful/trivial) accounted for the most variance (28%), with the rest consisting of interpersonal coping style (5%), the relative use of negative emotional words (6%), and cognitive change, increased self-esteem, and seriousness of the event (totaling 14%). The authors suggest that EBV antibody titer may be useful in monitoring immune competence and inferring the potential status of other pathogens, particularly in high-risk and HIV-1 seropositive patients, where psychosocial stressors and EBV reactivation may have immunological consequences.

**Rivista di Psicoanalisi.** XXXIX, 1993.

*Abstracted by Anna Meregnani and Antonino Ferro.*

**Field Theory and Transgenerational Fantasies.** Claudio Neri. Pp. 41-60.

The author examines the literature on the inheritance of transgenerational fantasies and phantasms and says that, making use of the "ego-alien factor" and "transgenerational" hypotheses in his work, he found that, though they were relevant to his patients' situations on different occasions, some aspects contrasted significantly with the clinical details of certain cases. What concerns the author most are the elements in disharmony with the transgenerational fantasy in his clinical experience. The most important difference consists in the fact that in some cases the analyst was not facing identification with one of the parents (or a chain of identification), but an almost total fuzziness between generations. "Content" was not inherited by one person from another, but, in a sense, spread around like gas, without being halted by the barriers set up by generations' and individuals' "psychic skin." Quite to the contrary, it was the "content" that kept together people who were "unstructured" and undifferentiated in relation to that particular aspect of their identity.

Neri provides two interesting examples from his clinical practice and introduces the notion of *field* to deal with a specific aspect of his theme: whether mental and relational fields can cross over several generations. He concludes that the transgenerational and transindividual propagation of fields can find an explanation if we consider the existence of a protomental stage in which the phenomena are simultaneously physical and mental and in which the individual is part of a system, even when a distinction has been achieved at other mental levels. According to this explanation, the protomental system can be considered the physical-mental basis by means of which specific characteristics of relational and mental fields propagate. As the notion of a protomental system is highly abstract, for the purposes of clinical work the author thinks it useful to associate it with the idea of the existence of conditions and fantasies connected with "being one and the same," and briefly considers this fantasy. In the final part of the paper the author deals with problems of technique in situations where a "limiting oppressive field" occupies the potential analytical space.

**Holy and Profane Mental Anorexia.** Walter Bruno. Pp. 79-98.

The author has found great interest in the book by Rudolph M. Bell, *Holy Anorexia* (Univ. of Chicago Press, 1985), according to which anorexic behavioral patterns are

a social as well as intrapsychic phenomenon, in the sense that they are a response to the patriarchal social structure in which women are forced to live: it is the type of culture which decides whether anorexia should be considered a holy or a nervous phenomenon. Under the influence of Bell's book and of a seventeen-year-old anorexic patient, Bruno was intrigued by the monastic world and was stimulated to read the "Legenda Major," the main source for the life of St. Catherine of Siena. This reading opened his eyes to a meaning of anorexia he had not yet considered: by refusing food the patient is searching for a special, secret relationship with her father, her ideal self. The very physical sensation of an empty stomach is capable of restoring her perception of what she was afraid of losing, i.e., *her bond with an ideal figure*. The precarious nature of an equilibrium based on this ideal relationship is experienced as intense anxiety about an inner void, countered by a strong physical sensation similar to that which causes pain. Strong physical sensations have a reorganizing effect on certain basic body sensations which, thus stimulated, lead, as they develop, to psychic self awareness.

According to the author, it is important to be able to identify the patient's intentions by distinguishing punitive fasting (the wish to punish the other who has not come up to expectations, or oneself for not loving with enough intensity) from fasting whose function is to recall the lost object and re-establish an idealized link with it. Furthermore, these two must be distinguished from fasting whose function is to stimulate the perception of one's own body image and the ability to influence one's own feelings, by an omnipotent flight from dependency. The paper points out how some anorexic behavior patterns, though they take on a guise of rejection and self-punishment, express more deeply the need for union and self-individuation. In the final part, the author considers countertransference and interpretation problems roused by anorexic patients.

**Rigidness of Expectations and Fear of Disintegration.** Giulio Cesare Soavi. Pp. 99-110.

Soavi notes that psychoanalytic research is devoting increasing attention to how the self is structured, in particular to its deficiencies and how they may be repaired through analysis. He makes the theme of rigid expectations the principal object of scrutiny and considers that some patients have a very limited capacity for extracting gratifying elements from the situations in which they find themselves. If reality does not correspond exactly to their expectations, fits of rage and feelings of bitter disillusionment ensue, with involvement of body organs and the sensation of falling apart or going underground.

The author gives some clinical examples and observes that all the cases described were victims of early deprivation to a varying degree. All the patients came from united, functioning families, were comfortably well-off, and had had a good education. The deprivation can be seen as resulting from a fantasy organization present in one or both parents. The author notes that the patients all had partners; it is as if this type of expectation can find full expression only in the presence of the fantasy that one's partner, or the world, has clear obligations toward us.

According to Soavi's clinical experience, the crisis is triggered by an apparently trivial event, but what is reactivated is the experience of being used to satisfy needs

which are not one's own, of not being loved, or not being seen, and finally, of not existing. Encounters with reality are seen as a kind of challenge; an expectation, based upon past experiences of absence rather than presence, anxiously waits to be denied. When the negative experience is confirmed, the subject has a feeling of annihilation, of going to pieces, and the ensuing rage is to be seen as an attempt to compensate. Subsequent to disillusionment, besides the immediate responses to the sensation of falling apart, there is a long period of loss of vitality and interest, and psychosomatic disorders may appear, linked to the threat to the self and to the internal organs. The author briefly discusses the links between this type of mental mechanism and masochism, and concludes with a description of the problems in managing the analysis of patients with these characteristics.

**Endopsychic Perception/Functional Phenomenon.** Fausto Petrella. Pp. 113-132.

The paper opens with the definition of endopsychic perception and with the consideration that Freud's notion of it has not won a place in the lexicon of psychoanalysis. It does not even appear as a separate entry in *The Language of Psychoanalysis* by Laplanche and Pontalis who dedicate an entry to Silberer's "functional phenomenon," a close relation of endopsychic perception. The paper attempts to do justice to the concept which, in the author's opinion, occupies a significant place in the psychoanalytic conception of the psychic: the questions touched upon are not merely historical, lexical, or academic; they are also theoretical and clinical and involve the practice of interpretation. Petrella gives a concise, clear summary of the history of this notion, which undergoes two distinct phases in Freud's works, one preceding and one following the writings of Herbert Silberer. He then gives a brief summary of the history of Silberer's functional phenomenon and of Freud's reactions to it. According to the author, it is likely that the positions assumed by Freud played a role in eliminating the functional phenomenon from psychoanalytic theory, and with it endopsychic perception, with which it had been identified.

The author's final considerations are of great interest. Freud intuited and used the notion of endopsychic perception to ascertain that the mind functions self-referentially, but he was unable to develop adequate paradigms for a phenomenon which appeared circular, flawed, and tautological. What was needed was the idea of a cognitive circle that was not vicious. Such an idea has been proposed only recently in a new model of circularity. In connection with endopsychic perception, it should be pointed out that dreams, like human discourse in general, have the quality of representing, along with the story, the stage on which they are played. This means that the analyst and the patient, in addition to constructing stories which they re-elaborate incessantly, become the actors, spectators, and witnesses in a psychic process: the process itself may become the subject of the story or even the main theme of the narrative.

The notion of endopsychic perception introduces a particularly crucial issue of considerable interest: the unsettling circularity existing between the theoretical conception of the psychic and the fantasies one may have about it, or the existence of a self-representation which reflects the psychic process in visual images and is at the same time mirrored in the figures of the discourse used to speak about it, in other words, similes, analogies, metaphors, and allegories. Theory at a certain point re-

sembles a dream or a fantasy, and fantasy seems to contain more reality (both psychic and historical) than one may expect. Endopsychic perception shows the analyst that he is dealing with images that speak about images. And these images, even those that seem to concern the most remote outside world, always speak about us.

Finally, the author says that the identification of "functional aggregates" by Bezoari and Ferro, in the fantasies and talk of the patient and analyst, seems to point to a functional phenomenon that does not speak about the subject's mind but presents, rather, an imaginative reflection of the conditions of a relational field: thus imagination is treated in connection with a domain different from that of the mind—that of the field—of which the imaginative phenomena of the analysis are considered a function.

**How Much Reality Can We Bear?** Loredana Micata. Pp. 205-215.

The paper opens with two quotations which are worth mentioning:

> Go, go, go, said the bird: humankind
> Cannot bear very much reality.
>
> T. S. Eliot, "Burnt Norton"

> Oh God! May I be alive when I die.
>
> D. W. Winnicott

The author provides two examples from her clinical practice: the first one is a situation in which reality is also used to allow the further development of an imaginary relationship and, in a circular manner, one leads to the other. The second one is a situation in which there is little room for the perception of reality. The patient has a tendency to reify the relationship and to block anything that could introduce elements of change. As a matter of fact, he does not want the analyst to function as a living object and tends to keep the relationship with her in a state of petrification. In doing so he has recourse to the same operation, which is peculiar to perverse organization, that he performs with the whole of reality. He fails to recognize it at the very moment he is forced to recognize it.

The author carries on the thesis of a previous paper ("Observations on Perversion," *Rivista di Psicoanalisi*, XXXVII, 1991, pp. 866-911), according to which, as far as the object relationship is concerned, the specific defense of a perverse individual consists in partially acknowledging the emergent object's existence, though failing to recognize its individuality and independence. Thanks to the stage of development already reached by the perceptual apparatus, rather than deny reality or split it, the perverse individual attempts to deceive it, remaining poised between recognizing it (with certain modalities and at certain levels), and keeping alive the illusion of being able to subordinate it to his or her needs.

Moving from this paradoxical analytic experience that has reached the limit of practicability, Micati makes some observations and poses some questions. She underlines a radical change which has taken place in our way of thinking about and experiencing the analytic situation: attention has gradually moved from the patient

to the analytic pair. This change implies that it is not the patient who is solely responsible at the outset, but that it is the analytic pair who share responsibility for one of the many possible successions of events which are initiated. The analyst's availability is limited by his or her fears, anxieties, conflicts, by areas of personality that are still (and might always be) blind and obtuse.

Micata concludes by stating that it would be surprising if anybody nowadays were to continue thinking that the analyst's personality is not a significant variable in analysis. Whatever analytic operation the analyst performs, in reacting to the patient's requirements and during their common activity, the analyst changes as well. Micati's final answer to the question, "How much reality can we bear?," is that we cannot delude ourselves that we are capable of bearing too much reality. There may be a moment when the analytic pair feel they can come to a halt and ought not go further than their limit.

**Bulletin of the Menninger Clinic.** LVI, 1992.

*Abstracted by Sheila Hafter Gray.*

**Two Neuropsychological Models and Their Psychotherapeutic Implications.** Lisa Lewis. Pp. 20-32.

The brain is an organ that develops neurodynamically through childhood and into adolescence, much as the mental apparatus develops psychodynamically. This allows experience to modify both brain structure and brain function. Thus, one may speak of a brain-mind-self complex. Studies of split-brain patients, those in whom neural connections between the hemispheres are severed or attenuated, elucidate the functional asymmetry of this organ. Each hemisphere has its autonomous streams of consciousness and modes of thought that are unavailable to the other. Recent investigations suggest that the brain may be split not only anatomically but also physiologically. Absence or inhibition of callosal activity provides a model for repression and dissociation. It follows that psychotherapy will cure if it allows integration of right and left hemisphere activities. Similarly, studies of hierarchical brain organization yield a triune brain model that proves useful for understanding anxiety states and psychosomatic disorders. There is a comprehensive list of references that are readily accessible to a clinical psychoanalyst.

**The Psychiatrist as Informed Consent Technician: A Problem for the Professions.** Thomas G. Gutheil and Kenneth Duckworth. Pp. 87-94.

Informed decision making is a process in the course of which a competent individual learns from a physician of the risks and benefits of a medical intervention and agrees to undergo the procedure (informed consent) or to decline it (informed refusal). Psychiatrists are often consulted to ascertain whether a patient is competent to engage in this process. This manifest request may conceal a problematic agenda—to entice the psychiatrist to obtain the consent on behalf of another clinician, sometimes from a patient who is only marginally competent. This approach reduces psychiatrists to the status of informed consent technicians. By placing the burden of ethical deliberation on the psychiatrist alone, it tends to exempt other physicians

from developing ethical standards. Also, defining the aim of consultation as the simple production of a consent document degrades the quality of patient care. The authors argue that the appropriate role of the psychiatrist is to evaluate and to treat patients and to educate colleagues about the psychiatric aspects of patient care, including the presentation and management of incompetence.

**Short-Term Hospitalization: An Aspect of the Psychoanalytic Treatment of Character Disturbance.** Raymond G. Poggi. Pp. 95-112.

A thirty-five-year-old patient entered a psychiatric hospital because of serious depression with suicide potential. She had sought psychotherapy two years earlier because of profound feelings of inadequacy. Her status had improved markedly in the course of a psychotherapy that was characterized by an intense idealizing transference. During this progress, she escalated demands for the therapist's time and attention, and eventually the latter could not safely manage the case on an outpatient basis.

The explicit goal of treatment was to reduce the psychotic transference to the therapist. After the treatment team members had established an alliance with the patient, they deliberately interfered with her relationship with the therapist. Their explicit aim was to facilitate her developing at least one significant relationship with someone in the hospital. The team planned to study the emerging transference-countertransference feelings with this person under controlled conditions, and to help the patient resolve them. The author reports how this plan was implemented and how it succeeded.

**Evils in the Private Practice of Psychotherapy.** Stephen A. Appelbaum. Pp. 141-149.

Contemporary psychotherapy is practiced in situations in which clinical and ethical guidelines tend to be ambiguous. This allows a practitioner's self-interest, personal or economic, readily to conflict with the clinical needs of patients. Psychotherapists may direct patients who present for evaluation toward treatments the clinician knows or prefers, rather than to someone who can provide a different, more appropriate modality. For example, nonmedical psychotherapists may be reluctant to consider medication, or a psychoanalyst may avoid short-term focused interventions. A busy psychotherapist may select patients more for their attractiveness or capacity to pay than for their need of treatment. Sometimes a patient's stated goal may be rapid relief of a specific symptom; experience with time-limited psychotherapy suggests that this is a realistic goal. The author regrets that this observation has not been submitted to systematic verification. He urges psychotherapists to reassess their practice patterns, and to develop an efficient mental health system that meets the current needs of patients by providing a variety of treatment modalities that include but are not weighted toward long and intensive procedures.

**Assessing Boundary Violations in Psychotherapy: Survey Results with the Exploitation Index.** Richard S. Epstein; Robert I. Simon; Gary G. Kay. Pp. 150-166.

The authors asked 2500 randomly chosen psychiatrists to evaluate their psychotherapeutic work using the Exploitation Index (*Bull. Menning. Clin.*, 54:450-465.), to

determine whether it identifies a clinician's latent tendencies toward violation of the boundary between professional and personal relationships. Items were designed to elicit characteristics of one of four factors: erotic attitudes toward a patient, inappropriate friendliness, financial greed, and "enabling" a patient's pathological behavior. The overall response rate was 21.3%, lower than that of similar studies, but still appropriate for intensive statistical analysis. A majority reported that they and their patients addressed each other on a first name basis (56.5%); and a large majority reported accepting referrals from current or former patients (83.8%). These items proved to be invalid signals of exploitive attitudes. A third of the psychiatrists in this study found three or more items that alerted them to problematic activity of which they were formerly unaware, or that motivated them to change. The full questionnaire is appended to the article.

**Transitional Objects as Objectifiers of the Self in Toddlers and Adolescents.** Johanna K. Tabin. Pp. 209-220.

Toddlers often use the transitional object as a prelinguistic external representation of self, an "objectifier." This allows the child to reduce anxiety stemming from experiences of helplessness in the hands of a caregiver, and to develop a sense of continuity and control. The author postulates that adolescents and some adults use transitional objects in the same fashion, particularly to maintain continuity of the self in stressful circumstances. One adolescent patient who suffered from chronic separation problems always carried with her a stuffed toy kitten she had owned since her fourth year. She used it to manifest an aspect of self she disavowed but seemed to value. In the course of treatment, she became able to integrate these characteristics into her own identity. There are two additional cases illustrating the point that after individuals achieve coherent ego identity, they can relinquish the primitive external representation of fragmented parts of self, the transitional object.

**Addiction as a Form of Perversion.** L. Eileen Keller. Pp. 221-231.

The author concludes that the psychoanalytic treatment of addiction has proved ineffective largely because clinicians view addiction as a symptom or manifestation of psychopathology rather than as a disorder in its own right. She argues that it is a perversion. Four common aspects of addictive disorders thwart a psychoanalytic approach: denial, secrecy, conditioned responses, and the use of the substance as a fetish object. The last allows patients to maintain an illusion of self-reliance that counters the emergence of a therapeutic alliance. As substance dependence replaces realistic human dependency, addicts isolate themselves from actual relationships. The psychopathology one observes in these patients is not amenable to interpretation; it is frequently secondary to, and not the source of, the addictive process. In the author's experience, psychoanalytic treatment combined with a twelve-step program to achieve abstinence offers the possibility of a successful outcome. An extensive literature review and bibliography document the history of the psychoanalytic treatment of addiction.

**Psychotherapeutic Interventions with Brain-Injured Children and Their Families: I. Diagnosis and Treatment Planning.** Martin Leichtman. Pp. 321-337.

The psychological lesion of acute brain injury entails not only the specific consequences of neurological damage but also those of psychic trauma. These injuries are cataclysmic events that lead to a true post-traumatic stress disorder. They disable the child's capacity to cope with ordinary developmental challenges. The child often experiences difficulty integrating newly lowered adaptive capacities with prior identity as a masterful individual and may engage in disruptive, aggressive behavior as a defense against the narcissistic injury. The traumatic event is traumatic as well for the family, which must revise its own identity and aspirations to care for the disabled child. The treatment in such cases is multifaceted, requiring the responsible clinician's guidance and coordination to assure that it will coherently address the whole child and the family. The author illustrates this approach with a detailed presentation of the evaluation and treatment of a bright child who was damaged in an anesthesia accident during minor surgery before his fifth birthday.

**Psychotherapeutic Interventions with Brain-Injured Children and Their Families: II. Psychotherapy.** Martin Leichtman. Pp. 338-360.

The patient suffered significant acute brain damage just before his fifth birthday. His neurological rehabilitation was fairly successful, but two years after the event he exhibited numerous symptoms derived from anxiety, depression, and neurotic conflict. Since the family lived far from any source of mental health services, treatment consisted of episodes of brief intensive psychotherapy for the young patient and casework for other members of his family. The author served as primary clinician and case manager for a treatment that lasted between ages seven and ten. Despite his neurological deficits, the patient was able to work in an expressive, insight-seeking mode. He resolved his oedipal conflicts and entered latency. Subsequently, there were brief contacts to deal with common developmental crises. Long-term follow-up indicated the treatment had been successful. The author concludes with a coherent exposition of a model of psychotherapy for brain-injured children, and with a comprehensive bibliography.

**Headlock: Psychotherapy of a Patient with Multiple Neurological and Psychiatric Problems.** James R. Buskirk. Pp. 361-378.

The patient was twenty years old when he entered an active treatment mental hospital in the hope of averting lifelong custodial care. He had suffered brain injury in an automobile accident in his eighteenth year. Before this event, he may have been depressed. His academic skills had been suboptimal, he had behavior problems, and he had misused various substances. The accident was caused by his driving while intoxicated. His intellectual skills were significantly impaired by the brain trauma; for example, he had trouble remembering names and events, he had regressed to a preverbal, preoedipal emotional state, and he was unable to bear the slightest frustration or to control his impulses; his substance misuse escalated. The author delineates in vivid detail the course of the first ten years of intensive dynamic psychotherapy in which the principles of child psychotherapy were applied to help

this damaged individual achieve emotional stability and a measure of object constancy.

**The Perversion of Mothering: Munchausen Syndrome by Proxy.** Herbert A. Schreier. Pp. 421-437.

A parent may fabricate symptoms or induce serious illness in a child in order to establish close contact with a physician or other health care provider or institution. The author believes this behavior is far more prevalent than has formerly been surmised; it represents a significant public health problem of which physicians must be aware. It is seen more often in women than in men, and most often in individuals who were inadequately loved in childhood. It is characterized by pathological lying, imposture, compulsive and repetitive mistreatment of the child, fascination with risk to life, and excitement when the child is at the point of death. These parents are caring and concerned; but at the same time they coldheartedly endanger their children. The author proposes that this syndrome is a perversion, a variant form of masochism in which the child is viewed and used as a fetish to obscure the painful distinction between reality and fantasy and thus to assuage the parent's early trauma or incomplete mourning. The distress of the child-fetish facilitates the parent's obtaining masochistic emotional gratification from an intense unbroken connection to a loved and feared parental surrogate, the physician.