The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: http://www.tandfonline.com/loi/upaq20

Race, Self-Disclosure, and "Forbidden Talk": Race and Ethnicity in Contemporary Clinical Practice

Kimberlyn Leary

To cite this article: Kimberlyn Leary (1997) Race, Self-Disclosure, and "Forbidden Talk": Race and Ethnicity in Contemporary Clinical Practice, The Psychoanalytic Quarterly, 66:2, 163-189, DOI: 10.1080/21674086.1997.11927530

To link to this article: https://doi.org/10.1080/21674086.1997.11927530

Psychoanalytic Quarterly, LXVI, 1997

RACE, SELF-DISCLOSURE, AND "FORBIDDEN TALK": RACE AND ETHNICITY IN CONTEMPORARY CLINICAL PRACTICE

BY KIMBERLYN LEARY, PH.D.

In this paper I attempt to extend the psychoanalytic conversation about race and ethnicity by discussing the intersubjectivity of race and racial difference. I present clinical material from an interracial treatment in which disclosures about race played an important role in deepening the clinical process. The resulting interactions permitted the patient to admit more of herself into the treatment space. I suggest that contemporary psychoanalytic formulations and multicultural perspectives from outside of psychoanalysis can together create more meaningful conceptualizations which take into account the lived realities of race and the ways in which these may be shaped by individual psychology.

In an interview with uncommon relevance for the present day, Ralph Greenson and Ellis Toney (Greenson, Toney, Lim, and Romero, 1982) shared their thoughts about the impact of race on their analytic work. Toney's training analysis—conducted by Greenson from 1948 through 1954—was one of the first analyses to involve a black and white analytic dyad. Greenson, reflecting on the analysis, commented on his realization that "we lived in two

The author wishes to thank Michael Bader, Nancy Chodorow, Glen Gabbard, Guadalupe Gutierrez, James Hansell, Robert Hatcher, Marvin Margolis, Mary McKinney, Michael Miletic, and Richard Hale Shaw for their helpful comments on earlier drafts of this paper.

different worlds and we were trying to understand each other's. It took an unusual amount of courage on Toney's part and on my part to admit that we were millions of miles apart in certain ways of thinking, values and so forth" (p. 186). Toney, in reply, delineated trust as one of the most difficult areas in black-white relationships: ". . . practically every black individual today has been traumatized in some way by the white person. If blacks have not been traumatized directly by whites, then through talk and hearsay, they have incorporated experiences that were traumatic" (p. 188). This interview—remarkable for its participants' candor and willingness to consider analytic interactions with respect to race—stands out as an effort to open up a psychoanalytic discussion on race, culture, and the analytic process.

The aim of this paper is to extend psychoanalytic conversation about race and ethnicity. I will consider some of the ways in which race and ethnicity—and the social milieu in which they come to have meaning—influence the frame of psychoanalytic work both explicitly and subtly. To do so, I will present material from an interracial treatment in which interactions around race played an important role in deepening the clinical process. I will try to articulate some of the intersubjectivity of race and racial difference that characterizes contemporary life, from which the psychoanalytic situation is not immune. I will suggest that our understanding of race and ethnicity may benefit from a consideration of contemporary psychoanalytic formulations and multicultural perspectives from outside psychoanalysis. These approaches may together define a new site for psychoanalytically meaningful conceptualizations of race which take into account both social realities and personal psychology.

Some forty years after Greenson's analysis of Toney, race relations remains one of the most pressing problems of contemporary social life in the United States. In recent years, the popular imagination of this country has been captivated by public events in which race figured prominently. Race and racial resentments, never far from center stage, are again the focus of social consciousness through events like the Clarence Thomas hearings, the

acquittal of police in the beating of Rodney King, and in the open debate over Herrnstein and Murphy's *The Bell Curve* (1994). Nowhere was this more evident than in the aftermath of the O. J. Simpson criminal trial and the differing reactions of many blacks and whites to the verdict of not guilty. At the instant that many whites recoiled in stunned silence, many African-Americans cheered either because it seemed entirely plausible that Simpson had been framed by a police department long recognized as racist or because Simpson—guilty or innocent—was one of few black men in history who could marshal the resources necessary to use the legal system to his full advantage, making his success an ironic affirmation of social progress.

If nothing else, these reactions to the Simpson verdict confirm a postmodern social reality: in significant ways, most blacks and whites construct and are constructed by vastly different social worlds. At the same time, when these multiple realities interact, the result is far from a postmodern ideal of the coexistence of contradictory points of view. Instead, the clash of opposing realities often generates violence of one kind or another. For example, while whites feared blacks would riot in Los Angeles following the Rodney King verdict, many African-Americans expected that whites might enact some revenge for Simpson's acquittal in legislatures and courtrooms by further undermining affirmative action and other social programs.

At the *fin de siècle,* we remain a country obsessed with the problem of racial division and its multiple realities while we are often paralyzed in our attempts to respond effectively. As one columnist recently put it, "[N]othing is more important in America than what blacks and whites do in the name of race, to themselves or each other" (Rosenthal, 1995). In this respect, we have moved from the notion of a melting pot to the recognition that the pot is boiling over. How then does the racial divide of our culture affect the culture of the consulting room?

When I open the door to my waiting room to greet a new patient, the fact that I am a person of color carries important social meanings. Race and ethnicity—particularly when they are

observable features of the analyst's self—represent a kind of self-disclosure. Although I have not conveyed anything in particular about myself, the fact that race is written on my face shapes the clinical dialogue to follow. While it is reasonable to argue that any of our particularities as individuals (e.g., age, gender, or the way that we furnish our offices) also represent disclosures of this kind, I believe that the valence of race may be of a different order in the present climate of the racial divide.

When I work with patients of color, most of them directly acknowledge our shared racial background or shared status as members of minority groups. Many have elected to see me because I am a person of color. In due time we usually discover together the particular realities and fantasies that undergird their choice. By contrast, many of my white patients do not explicitly mention our racial difference. At the same time, their metaphors, allusions, and other derivatives suggest to me that it is very much on their minds—for example, in the case of a patient in consultation who repeatedly states his "ability to get along with everybody, I mean everybody" when this is ostensibly not a part of the difficulties he is trying to communicate to me. When racial similarity or difference is not mentioned during the early part of a treatment, I have found it useful to comment on this. In such a case, I might acknowledge the social climate surrounding open talk about race in this country and then wonder with the patient whether, for example, his thoughts about his ability to get along with all people represents his way of speaking about something he did not feel he could approach more directly. In this way, I am offering the patient an opportunity to consider the expanded possibilities for communication provided by treatment.

At the same time, I am also responding to the social milieu in which we practice. In contemporary America race carries profound meaning. While it is undoubtedly true that my observation that the patient has avoided mention of our racial difference focuses attention on only one aspect of the interactive field, it seems to me that clinical silence about race is equally directive. Failing to acknowledge racial difference is not neutral. We might consider,

for example, what is conveyed when the clinician does not speak to her/his blackness, or when her/his whiteness is assumed to speak for itself. Clinical silence about race may be perceived—and with some justification—as a commentary on the analyst's effort to stay out of the fray, to opt out of the tension that comes with open talk about race. Ambiguity of this sort can close off the clinical encounter in ways that are at odds with what we ideally wish to offer our patients. Most of the time, my observation that the patient and I have not yet talked about the fact that the patient is white (or Japanese, or Latina, etc.) and I am African-American does not prevent exploration of the patient's racial meanings or obviate fantasy. If anything, I think it facilitates the admission of fantasy to the treatment relationship and sets a tone for the exploration to follow (cf. Greenberg, 1995), as that which had been excluded from conversation is invited to assume a voice in the consulting room. If the invitation cannot be accepted, understanding the reasons for this over time defines an equally important analytic exploration.

When previously unmentioned racial difference is brought into the treatment relationship, my experience has been that white patients respond nearly universally by saying the difference is "not a problem," although this is usually then followed by an implicit statement of exactly the problem that the patient expects will complicate the treatment, namely, the fear of saying something that would be perceived as racist or discriminatory. Holmes (1992) has commented that this is a familiar fear for patients in cross-race treatment dyads. She notes that patients worry that they will express aggressive urges in racist attitudes and often hope that racial material will not be interpreted even if it enters their associations. Simpson (1993) suggests that therapists also fear that their countertransference will be coded in racial terms. He further notes that it is "strange that those of us who are prepared to accept our murderous wishes, for example, towards members of our families cannot, or will not, accept that we might have 'racist' thoughts or feelings" (p. 291).

It seems inevitable that all of us—patients and analysts—will

have racial thoughts and feelings that are libidinally and aggressively tinged. Just as the analyst may become aware of the patient's explicit and subtle immersion in cultural and personally idiosyncratic dialogues about race, it is also quite likely that the patient will, in time, catch the analyst in some unintended racial reflections of his or her own. Speaking to the patient's concerns about racist content and the sociocultural realities of race can become a way of understanding the patient's relationship to ideas, feelings, and behaviors that evoke anxiety and vulnerability. I believe that a parallel process may occur with respect to the analyst's racial countertransference.

Clinical Illustration

Ms. C was a thirty-year-old white woman who entered treatment in an effort to cope with the divided loyalties she felt between progressing in her career and staying at home to raise her two young sons. She felt trapped by either option: she was critical of women who "abandoned" their children to day care to fulfill their personal ambitions, and she was unhappy with the prospect of being what she termed a "fifties housewife with no brain," dependent on her husband for financial security. At the same time, Ms. C wanted very much to be a good mother and worried that she was not. She felt constant anger toward her husband, whom she believed was untroubled by comparable soul-searching, and she was extremely critical of him in ways that dismayed both of them.

Ms. C felt very uncertain about what she really wanted for herself. She also felt guilty that she was in the privileged position of being able to decide. She criticized herself equally for wanting to return to work and for desiring to remain at home with her children. Although Ms. C was friendly and warm during her sessions, at times she seemed excessively polite. I had the impression that she was expecting our interactions to deteriorate into animosity. From the start, she was anxious about the prospect of talking

about herself. She wished to speak freely, and she understood the need for candor but was worried about what her treatment would reveal about herself.

In the early sessions, we discussed some of the reasons behind Ms. C's concern and aspects of her history which seemed to relate to this issue. She recognized that feeling criticized and being critical in turn were problems that regularly occurred in her marriage. A similar difficulty had pervaded her relationship with her mother, which had soured when Ms. C entered adolescence. Mother and daughter argued violently until Ms. C was well into her twenties, reaching a rapprochement just before Ms. C's own marriage. Since then, good will between them seemed to have been purchased through the patient's defensive idealization of her mother.

Ms. C's expectation was that I would come to feel as critical of her as she felt about herself and she feared exposure. When I wondered what she feared I would find fault with, she mentioned our racial difference. She acknowledged that upon first meeting me, she had been surprised to discover that I was black. She told me that the analyst who referred her to me had not mentioned that I was a person of color, and the thought that I might be black had simply not occurred to her. For Ms. C, and perhaps for most patients, the expectation is for the therapist to be white. Ms. C was quick to reassure me that she didn't expect "a problem." All the same, she worried openly that she might say something that would be offensive to me, or, worse, that she might unthinkingly make a comment that would otherwise strain our ability to develop a relationship. Her fear of her aggression, particularly her worry that she would be unintentionally hostile, was now located in her relationship with me. At the same time, Ms. C's social concern about these issues was also a significant resistance. Her apprehension about the misunderstandings, antagonism, and sensitivities between blacks and whites in the wider culture gave credence, she believed, to her view that her treatment would be interrupted by these same problems. As a result, although she tried to be open, she felt it reasonable to "play it safe."

During a session after I had been away on vacation, Ms. C greeted me in the waiting room and immediately noticed that I was now wearing an engagement ring. As she walked into the office, she asked excitedly, "Is that an engagement ring?" Settling into the hour, she repeated her question and appeared crestfallen when I responded with a query intended to help her expand upon her observation. I asked about her thought. She reasoned in a perfunctory fashion that while it certainly *looked* like an engagement ring, she couldn't be sure. Perhaps the ring was for some other purpose. She obliged with a series of associations, offered in a lackluster manner. My efforts to discover what had interfered with Ms. C's attempts to decide that the ring was an engagement ring, or what her feelings were about it, did not meet with success.

When I thought about this session later, I realized that Ms. C and I had engaged in something of ritualized encounter. I was aware that her question about my engagement ring was a request that we interact more personally. Although I had in effect introduced my personal life into the session by wearing the ring in the first place, I believe that my reluctance to acknowledge simply that I was engaged was a retreat into stereotyped technique and reflected a hesitation to engage with my patient more fully.

In the next hour, I acknowledged that I had not answered Ms. C's question and told her that my ring was indeed an engagement ring. She became animated. She had been sure that it was an engagement ring but wanted confirmation. This time, however, her associations about my engagement were more productive and contained expression of her ambivalence about marriage and motherhood, including a joke about what I was getting myself into.

I wondered with Ms. C why she needed me to acknowledge something she already knew. She said that she was not sure, but my unwillingness to answer had felt strange to her and vaguely dishonest. Over the next several weeks, this same sequence was repeated: she would raise a question about a piece of information which she in fact already knew about me and present it for my confirmation. As an example, she saw my name on a fund-raising

list for our local institute and wondered if the name next to mine was that of my fiancé, even though all of the other paired names were those of married or partnered couples. When I provided corroboration—and noted that I thought she also knew the answer—her thoughts would soon encompass some piece of racial content, usually a reflection of some event from the media or some reference to the fact that she was white and I black. The reference would not be connected to the previous content in any way that I could discern.

After I became aware of this sequence, I noted it with Ms. C, and we pieced together the following understanding. From her perspective, we were engaging in forbidden talk. She said that although she liked the idea that I answered her questions, from what she understood about therapy she believed that I was breaking some rule by directly responding. Both of us were doing something we shouldn't. I said that it seemed important to her that we were both doing it and then wondered if that might be the reason why her questions and my answers were followed by her talking about black issues or black-white problems. I said maybe her thoughts about blacks and whites felt like a risky thing to discuss, especially as a topic between us. Ms. C agreed. Although she had known some African-Americans, they had not talked about racial issues with each other even when this was something she had wanted to do. When reading the newspaper or watching television news, she felt worried about the state of race relations in the United States. She was concerned about crime in urban areas (that were usually black) and troubled by how little contact she had with blacks (apart from me) and how little personal involvement blacks had with whites. At the same time, she felt that people needed to be "careful" around this topic because something problematic could emerge (e.g., something racist), and the situation would only get worse.

Ms. C and I now discussed more openly the implications of her fears about the sensitivities that blacks and whites have with respect to each other. Whites are afraid of being labeled racist and blacks fear mistreatment based on past history. Ms. C mentioned

the likelihood that if I or any black person were to drive through her neighborhood, it would be assumed that we were en route to work rather than to our residence. Similarly, she wondered how welcome she would be in my black community. She worried that her openness with me would result in my seeing racist attitudes in her that she herself might miss.

Ms. C, however, seemed to express her thoughts more freely following this discussion—talking with more feeling about the problems of her adolescence and the friction with her mother. She became more attentive to the similarities and differences between us as women. She could now acknowledge feeling competitive with me (because I had what seemed to her to be a successful career) while permitting herself to express certain feelings of superiority (which she connected to being the mother of a new baby son). She remained hampered in her ability to express her aggressive thoughts and feelings more overtly and in her capacity to talk openly about those that did emerge.

I believe that these interactions show that my willingness to answer my patient's questions established a tacit negotiation and represented an enactment. To the extent that I engaged in talk she considered to be forbidden (providing some answers to questions), she would too (by mentioning racial issues previously identified as something about which she was fearful). These interactions seemed to allow the patient more associative freedom than before. She gradually allowed herself to experience a greater although still restricted range of feelings toward me.

From one perspective, Ms. C's request that I answer questions already known to her could also be viewed as her making a parody of our clinical exchange. Her effort to denigrate and devalue me may have been expressed in this aspect of our interaction as was revealed more directly later on in the treatment. During this phase, however, my predominant experience was that Ms. C's questions allowed her to evaluate whether or not I was being truthful with her, since she in fact already knew the answer. In this way, while her hostility was perhaps actualized through her distrust, my response, I think, conveyed my sense that our interaction

could weather it. At the same time, it is also conceivable that at this juncture I was operating with a blind spot and was not yet willing to recognize the portion of my patient's aggression that was directed at me.

My willingness to answer questions to which she already knew the answer prompted Ms. C to raise the stakes. She began to ask more personal questions, although these were the kinds of topics that would naturally emerge between two co-workers in almost any setting other than a clinical treatment. In general, her questions concerned some aspect of me as an African-American woman. She reported that she felt more vulnerable now because she did not already know the answers. As an example, she wondered about my plans for Martin Luther King Day. Since she did not have a Monday session, she wondered if I would be working. She was curious about where I had grown up. Specifically, she wondered what sort of racial setting I had lived in. More cautiously, she allowed herself to fantasize about my marriage, and eventually asked if my husband was also African-American. I decided that I would try and answer the questions that she asked to the extent that I felt it opened up our dialogue and as long as we could also learn more about the questions themselves and the ideas that prompted them. This also made sense to Ms. C. Sometimes a question would remain between us for several sessions before I answered.

My sense was that my willingness to respond to her in a reasonably direct way and my allowing her to know more about myself resulted in a lessening of her constraint and an increase in her ability to be affectively expressive. My experience of Ms. C's questions was that her interest was not superficial or voyeuristic. She confined many other of her thoughts about me (e.g., curiosity about my sexual life) to her associations alone and did not ask questions about them. It was my impression—shared with the patient—that she was trying to get a fix on me as an African-American woman against whom she could reference herself. Her questions seemed designed to assess my racial self in terms of my difference from and similarity to her and the danger and safety she could expect with me.

Our interactions around the questions were also important. Ms. C was relieved by my responsiveness. Admitting my racial self into the consulting room in a way that could not fail to implicate me personally seemed to permit her to grapple with herself more extensively and to expand what she could convey about herself. She was also able to express some ambivalence about my willingness to respond. She and I talked about the discomfort and several times assessed whether talking in this way was helpful to her. On this point, she was unequivocal in saying that "it makes me feel like we are both here." On my side, I felt as though my answers were a kind of "talking out of school." I felt some anxiety about working in a way that left me feeling particularly vulnerable even when I noticed that it seemed my ability to do so assisted my patient in speaking more freely about a greater range of her experience.

Ms. C began to describe her emotional reactions in greater detail. She seemed more comfortable with her awareness that her attention to racial issues reflected her interest in me and what went on in my mind. She spent the better part of a session captivated by the film *Pulp Fiction,* especially the relationship between the characters played by Samuel L. Jackson and John Travolta—who enjoyed a casual and philosophical relationship with one another even while they were involved in a considerable amount of violence. She thought that the characters—one black and one white—spent their time together "getting into each other's head." This reminded her of some of the experience she had had with me. I also understood it as a commentary on her view of the interactive relationship between us, which for Ms. C seemed to have an outlaw status.

Ms. C was disturbed (and fascinated) by the racial epithets used in the film by both blacks and whites. In talking with me, she hesitated to use the word "nigger"—the term used in the film—in her discussion. She was worried that the term would offend me but was also able to be curious about how I would react if she did. She talked about the fact that blacks could use this term among themselves with impunity but whites could not. When I pointed

out that whites certainly had used the term in the film, Ms. C wondered what blacks really thought about whites. She wondered how comfortable a black person could really feel with a white person, given the discrimination blacks encountered. I pointed out that this, of course, also raised the issue of what whites really thought about blacks. This became elaborated in terms of Ms. C's relationship with me.

Ms. C became preoccupied for a time with thoughts about racial violence between blacks and whites, as well as black-on-black crime. Consciously, she recognized she could also think about white-on-white violence but this "didn't mean anything" to her. Here, she was also talking about the way in which her own ethnic identity as a European-American mainly acquired its meaning to her in relation to someone of color. Talking about violence in black communities, she was puzzled about how people "in the same group and the same community" could do this to each other. Her associations led her to discuss unacceptable impulses in herself. She began to talk about the extent of the trouble she was experiencing as a mother to her young sons. The struggles between Ms. C and her boys reminded her of her adolescent rebellion against her mother. Ms. C feared that her children were deliberately provoking her as she had done to her mother. She was frightened of her extremely angry responses, felt much less in control of them than she had been able to let on, and worried that she would hurt her sons if she did not get help. Until this point, Ms. C had been silently struggling with her feelings of rage because she felt too ashamed to admit them.

Ms. C's sense of her unacceptable feelings led her to think more about her feelings of racism. She remained fearful of what she would unintentionally reveal about herself but now tried to talk about those feelings of which she was aware. She discussed her recent reactions to blacks, focusing on the negative judgments she had made and hated herself for making. These included her expectation of trouble when she saw young black men walking down the street and her dislike of several local African-American politicians.

It is clear that Ms. C's selective focus on violence in African-American communities (a selectivity echoed in our culture at large) was a means of contending with aggressive impulses from which she struggled to distance herself. Although she could now permit herself to be more openly critical of me, she continued to expect that I would be damaged by any rebuke or anger. This was especially the case when her racial reflections included talking about her profound ambivalence about affirmative action. She expected that I had received some benefit from these programs, and the tenor of her comments pointed to her fantasy of me as second-rate and unable to make it on my own. Aware now of the devaluing message she was conveying, Ms. C attempted to rescue both of us by associating to the social realities of racism in this country. Reversing herself, she spoke about the way in which racism can impede people of color regardless of their talents and abilities, making affirmative action necessary if controversial. She now felt worried about my reaction.

I noted that Ms. C seemed troubled by her fantasy because we shared the awareness that racial meanings carry cultural weight and pack considerable firepower. I acknowledged openly that her fantasy contained an idea designed to injure, and that most African-Americans would agree. I said because I had grown up having to deal with these kinds of ideas, it was possible that I wouldn't be hurt by them in the ways that she feared. From my perspective, however, I thought that what was more important was why she needed to offend, and I would try to help her to understand this. This then permitted us to examine in more detail what it meant to Ms. C to subject others to her anger and devaluation only to restore them later, as had occurred repeatedly in her relationships with her sons, her husband, and her mother. It also opened up an additional pathway to explore her own self-criticism and denigration.

On other occasions, Ms. C's racial reflections had a more libidinal cast and included expression of longings previously warded off. Her associations about black cultural life included envy of the

familiarity and close connections she observed between many blacks. By virtue of my blackness I could belong and have access to an involvement from which she felt excluded.

Reading an article on black feminism in the aftermath of the O. J. Simpson criminal trial, Ms. C became interested in the question of whether African-American women would side with Simpson because he is black or withhold support because of his history of domestic violence. Were African-American women more committed to racial solidarity than to their connections with other women? This echoed concerns Ms. C had in her relationship with me. Expecting the article to confirm her ideas about race (namely, that commitments to race superseded all else), Ms. C was surprised to read that younger African-American women, in particular, self-consciously differed from their mothers in permitting themselves more latitude, especially in finding important connections in their relationships with other women. She seemed particularly intrigued by the idea that mothers and daughters could think differently from one another and tolerate their differences, something she had not experienced in her relationship with her own mother. Ms. C also responded with some excitement to a phrase in the article which indicated that some younger African-American women declared that being black did not mitigate their attachments to whites ("some of whom we love"). Now Ms. C felt that there might be room for her in my world. That this might also include an erotic bond was revealed through her articulation of the fantasy that I was biracial, a product of a sexual tie between black and white. Her fantasy also suggests another meaning for her designation of racial talk as forbidden. Her involvement with me seemed to stir up conflicted wishes for an intimacy that she perceived as dangerous and destabilizing.

It remains my sense that the talk about race and racial difference between Ms. C and myself—once a forbidden topic—ushered in her ability to approach other material that felt risky to her, especially her fears about harming her young sons. Her present-day concerns about herself could then be admitted to the

session for our joint consideration of their place in her history, although they remained under the rubric of "forbidden talk" for some time.

Race, Ethnicity, and Culture in Psychoanalytic Treatment

As Goldstein (1994) notes, self-disclosures can take many forms: disclosing information requested by the patient (e.g., Epstein, 1995); countertransference disclosure (Ehrenberg, 1995); the analyst's own difficulties in the analysis (Miletic, 1996) as well as the analyst's difficulties in his/her own life (Abend, 1995; Dewald, 1982), all of which may require the patient to accommodate to the analyst's subjectivity. Similarly, analysts write that while they disclose for a variety of intended and unintended purposes, the motivation is often either to create room in the treatment space or to repair a breach. In this way, the therapist's interactive availability constitutes the bricks and mortar of dyadic transactions. Just as two houses can have different designs requiring different plans for effective maintenance, clinical work requires the flexibility of employing different tools at different times.

My clinical illustration concerned two types of disclosure: an implicit self-disclosure occasioned by the therapist's being a person of color and a series of explicit answers in response to questions asked by the patient about the therapist's racial experience. The therapist confirmed a reality (that the ring she was wearing was indeed an engagement ring) following a mild rupture occasioned by the therapist's use of stereotyped technique and a rebuff of the patient's interest in a more personal response. Thereafter, disclosures were employed in the context of clinical interactions directed at assisting the patient in saying what was on her mind (Kris, 1982). My initial willingness to answer questions about information already known to the patient did increase her desire to know more and led her to formulate a more specific, personal inquiry about my life circumstances and attitudes. The patient did not, in my view, become "insatiable" (Freud, 1912), although her

involvement in her treatment deepened. As was evident here, patients' and analysts' talk about race can enliven a psychoanalytic dialogue. In some treatments, in fact, the talk about race may be the only way to enter into a psychoanalytic encounter, so great are the social challenges of race in contemporary society.

Psychoanalytic clinicians have convincingly argued that clinical attention be directed at racial issues and racial stereotypes, especially when they overlap with conflicted affects and desires in the transference (Holmes, 1992; Schacter and Butts, 1968). Race and ethnicity are understood to be the context for expression of the patient's personal psychology and may be deployed to serve psychodynamically relevant agendas. Holmes (1992) offers one example of this approach, describing how her patient's belittling attack against the analyst's race and gender served the protective function of warding off recognition of the patient's own feelings of self-loathing and rage. In this way, race comes to be treated as a psychoanalytic issue.

Although clinically valuable, this perspective may have the unintended consequence of obscuring the way in which race is both a psychoanalytic and a cultural experience. Talk about race becomes a vehicle for a psychoanalytic conversation and recedes as a matter of importance in and of itself. There is a tendency for race to become something to get past rather than something to live within. Race becomes only "skin deep," rather than an intimate and enduring aspect of personal social identity. As a further illustration of this point, while psychoanalysis has a richly complicated and contested theory of gender and sexual identity, there is no comparable body of psychoanalytic work with respect to racial and cultural identity.

Even when race and ethnicity are considered more broadly, they are often treated as qualities that pertain only to patients or analysts of color. There is little in our literature, for instance, about the meaning that a shared racial background has when both members of the analytic dyad are white. Frankenberg (1993) suggests that whiteness is an unnoticed aspect of identity for most Americans. In recognition of this, Chodorow (1995) notes that

her work with European-American women has not typically "problematized their whiteness and its contribution to their sense of gender and sexuality" (p. 526, n.).[1]

In a great many ways, psychoanalysis has maintained a contradictory relationship to culture. Psychoanalysis is cut from the very fabric of culture, albeit a very selective cloth. Our psychoanalytic models are based nearly exclusively on the protections and pathologies afforded by the Western nuclear family, which is itself a cultural entity. Although psychoanalysis resonates with the Western culture in which it is chiefly practiced, for most of its history it has also considered itself as offering a universal scientific rendering of human experience (Mayer, 1996).

In a recent paper, Elliott and Spezzano (1996) argue that psychoanalysis is no more impervious to its cultural surround than was modern thought to the imprimatur of psychoanalysis. During the last fifteen years, cultural shifts on how human beings understand themselves and the very nature of reality have occasioned major changes in the clinical theory of psychoanalysis (Mitchell, 1993). The technical emphasis on the analyst's anonymity and abstinence shares the stage with models attending to the facilitative utility of the analyst's presence, self-disclosure, and therapeutic provision (e.g., Bader, 1995; Lindon, 1994, Renik, 1995). Postmodern critiques are now increasingly imported into contemporary psychoanalytic practices (e.g., Barratt, 1993), although these

[1] Connecting whiteness to European-American identity is itself a problematic cultural affair. Berke Breathed, the creator of the comic strip, *Bloom County,* offers us one perspective on the difficulty in a piece he published in the late 1980's. Oliver, an African-American youngster, walks into the local drug store to buy a copy of *Ebony* magazine. When the clerk asks him what *Ebony* is about, Oliver tells him "black persons, written for black persons, with exclusively black persons in the ads," then cheerfully purchases the latest issue. Moments later, Binkley, a white youngster, enters the store inquiring about *Ivory* magazine, whereupon the clerk anxiously shoos him out, saying, "I run a progressive newsstand here." For many Americans, white identity is synonymous with the idea of white supremacy. The hidden narrative is that whiteness can mean only one thing—a self-conscious, violently inclined superiority that must be kept under wraps. Ironically, this hidden idea remains protected when whiteness is not assumed to be a meaningful marker of identity and is not deconstructed psychoanalytically or culturally.

are not without their pitfalls (cf., Dunn 1995; Glass, 1993; Leary, 1994).

As Elliott and Spezzano indicate, it is also clear that psychoanalysis contributes to and is moved by cultural changes of all kinds. Renik (1990) suggests, for example, that the oedipal constellation—sexual rivalry in the context of love—is an important psychic organizer because of the prevalence of nuclear families and the way that relationships are structured within them. He notes that "future social changes may alter the shape of normative psychosexual development" (p. 201). It seems likely, for example, that ongoing revisions of the psychoanalytic theories of development and mind will be required as psychoanalysis takes seriously the extended family structure of African-, Hispanic- and Asian-Americans, families headed by gay partners, as well as the new reproductive technologies currently reshaping the contemporary definition of "family."

Contemporary Psychoanalytic Practice and Multicultural Perspectives

The interactive landscape that psychoanalysis now occupies (Mitchell, 1995) means that the analyst's authoritative rendering of the analysand's subjectivity has given way to attending also to the psychology of the analyst at work. The analyst is assumed to be a real counterforce in the treatment with a subjectivity of his/her own. As a result, psychoanalytic treatment has been increasingly recast as involving negotiated (Goldberg, 1987; Hatcher, 1992; Pizer, 1992) and intersubjective processes (e.g., Stolorow and Atwood, 1992).

The cultural landscape with respect to race and ethnicity has also shifted—a fact that is not yet represented in the psychoanalytic literature on race. On the surface, psychoanalytic formulations of race in the consulting room would already seem to embody the quality of pluralistic meaning endorsed by contemporary practice: race is treated as a carrier of cultural meaning which can be employed to serve any number of transference or defensive purposes.

A closer look at these conceptualizations, however, shows these racial meanings as highly constrained at best, rather than pluralistic or multifaceted. Rather than offering multiple perspectives, race here actually carries a number of cultural meanings. It most often symbolizes devalued, repudiated, or pathological contents. What is usually under discussion in most psychoanalytic writing about race is less about race per se than it is about racism and racial status. In consequence, much of the existing psychoanalytic literature is better appreciated for illustrating the psychodynamics of racism than for offering a commentary on race or cultural identity.[2]

Culturally sensitive treatment perspectives, including an emerging model of culturally sensitive psychoanalysis (e.g., Akhtar, 1995), begin with the assumption that culture plays a significant role in the development and maintenance of the self. Comas-Diaz and Greene (1994) note that people in majority and minority cultures in the United States have multiple sources of identity which clash, leading to interpersonal and intrapsychic conflict. Employing the construct of projective identification, as articulated by Burke and Tansey (1985), Comas-Diaz and Jacobsen (1987) have suggested that patients attribute ethnocultural characteristics to their therapists that relate to conflicts in their own ethnocultural identities.

These models of ethnocentric identity and psychotherapy (e.g.,

[2] Psychoanalysis does offer several useful models with which to articulate the psychic reality of racism. The racially different other becomes a container for projected wishes that the majority repudiates in themselves. Other theorists concerned with the narcissistic dimension of human experience suggest that racism is a response to the pain attending difference. To notice distinction is to become cognizant that another mind, person, or group possesses something that one does not. In consequence, the racially different other disturbs the sense of self-sufficiency and so evokes desire (Young-Bruehl, 1992). In either case, the group in power makes the other the repository of concerns that reflect its own preoccupations and effect a false sense of containing their disturbance by marginalizing the other. This becomes one means by which individual and group dynamics become translated into social policy with the result that psychic and social life become intertwined (Kaplan, 1993).

Greene and Comas-Diaz, 1994), emphasize that race may have a greater array of meanings culturally and psychologically than those occasioned by racism. Consider the following examples. Despite discriminatory practices, the United States is also home to a stable African-American middle and professional class whose considerable earning power has not gone unnoticed, as evidenced by advertising campaigns focused on people of color. Although at least four African-Americans have considered or attempted to run for the presidency, there was widespread speculation in 1996 that Colin Powell might have been able to win. Furthermore, "identity politics" (Sampson, 1993) offers another choice for the cultural life of people of color by endorsing, for example, an Afrocentric cultural ideal of racial solidarity which can include an affirmative separatism. Whether or not one agrees with these approaches, they now represent alternatives to the devalued representations of people of color implicit in stereotypes. Race can and does mean more than a devalued content, at least to some people. We would therefore expect that these new cultural meanings would have their own agendas, even as they enter the psychoanalytic consulting room to serve psychodynamically relevant agendas as well. This expanded array of racial meanings must become recognizable to psychoanalysts if it is to enter into the psychoanalytic lexicon (Chodorow, 1994).

While most models of culturally specific treatment recognize that the racial self is multiply determined, they also argue that in the social climate of the United States, racism remains a powerful and a significant commonality for people of color (Greene, 1993). The terms in which racism is expressed have undergone some revision. While de facto exclusion and marginalization are apparent and widespread, particularly in our cities, contemporary racism also shows itself in institutional practices, "glass ceilings," and environmental attitudes. Furthermore, while these forms of racism are maddeningly evident to people of color and are experienced as an inescapable aspect of American social life (Smith, 1993), they are often dismissed by many in the majority culture.

From this perspective, while race is a social construction and

specific racial meanings are socially determined, the fact of a racially identifiable body also puts constraints on the psychological experience of African-Americans. For this reason, Comas-Diaz and Minrath (1985) have suggested that therapeutic work in an interethnic/racial patient-therapist dyad can progress only if both the manifest and the symbolic meanings of race and ethnicity are carefully worked through and if the reality of societal discrimination is acknowledged (including the possibility that discrimination exists in ways that the therapist cannot yet apprehend).

Cultural change, changes in contemporary psychoanalytic practice, and the emergence of alternative formulations of race in treatment models largely outside of psychoanalysis suggest the need to define new, psychoanalytically useful conceptualizations of race. First, race functions as a kind of positivistic fact: it is undoubtedly real and pertains to real world history. Second, it operates within the realm of postmodern possibility: particular racial meanings represent social constructions that are elastic and shaped in accord with specific prerogatives, personally (as was the case for Ms. C) and culturally (as evidenced by enduring stereotypes).

I believe that a psychoanalytically meaningful approach to race for contemporary practice is situated in the conceptual space in between these perspectives. Race, in this sense, cannot be taken for granted as a material entity and does not speak for itself. Neither is it only a socially constructed harbinger of multiple rereadings. A psychoanalytically productive conceptualization of race is, as a result, dynamic and context-dependent, even as race remains something that is "really real" (Greene, 1993).[3] As a result, the conceptual and clinical space in which racial experience may be apprehended is fragile. It inheres in creative tension rather than settling for one perspective or another.

[3] Kaplan (1993) articulates a similar position: "Race and gender are constructs that produce material effects, material oppressions, even as one battles against such constructions and argues that they *are* alterable" (p. 510).

The approach to race that I am developing has much in common with Chodorow's (1994, 1995) recent theorizing with respect to gender. She argues that while psychoanalysts need to recognize the inextricable cultural and linguistic contributions to psychological gender experience, gender is also "not entirely culturally or politically constructed" (1995, p. 517). Gender, she argues, is given psychic life via a universal process of subjectivity, namely, the human capacity to endow experience with nonverbal emotion and unconscious fantasy meanings. This shared quality of subjectivity, however, does not give rise to universal or stable contents. Gender and sexual experience inhere in the way an individual personally appropriates cultural stories (Chodorow, 1994). Like race, gender is worn and lived similarly *and* differently by each of us. The analysis of gender experience in psychoanalysis is a "product of interaction between therapist and patient as they work to create a consensual account of what is initially (and throughout) emotional, partially unconscious [and] fragmentary" (Chodorow, 1995, p. 525). Though Chodorow does not herself put it in these terms, her formulations suggest that gender flourishes in the tension between universal and unique experience.

Issues of race are sensitive in our multicultural, multiethnic, and multiracial society, just as sexuality was a sensitive issue in Freud's day and continues to be in our own. As recent events like the Simpson verdict show, it is difficult to discuss the texture of our different world-views. It is clear that we as a country have considerable difficulty negotiating the racial divide. I am not sure that we fare that much better in the consulting room.

To the extent that one endorses the view that race exists in the tension between lived actualities and constructed possibilities, the psychoanalytic clinician requires a clinical stance that admits both poles of the tension into the treatment encounter. The whole of psychoanalytic practice now recognizes that features of the analyst's self are always at play, influencing the treatment interaction. This has led to a new interest in how the analyst may best make use of herself/himself in order to further the goals of the treatment,

namely, the patient's capacity to better understand his or her own psychological experience.

Renik (1995) has offered a cogent critique of the notion of the anonymous analyst, noting that the principle of anonymity, rather than clearing the field, instead promotes active idealization of the analyst by assuming that if the analyst's ideas were known, the patient would no longer be in a position to think for himself or herself. He offers the technical prescription that the analyst should articulate everything that in his/her view will help the patient to understand where the analyst is coming from and where he/she wants to go with the patient. As Renik notes, this may require the analyst to depart from his or her preferred ways of proceeding and to bear a measure of discomfort, just as the patient is asked to do. The analyst's understanding is always open to a countercritique by the patient (Renik, 1995).[4] Disclosures may be said to acquire their meaning in the tension between the principles by which the analyst is guided in offering them (Renik, 1995) and the treatment effects of these disclosures as evaluated by both patient and analyst.

I believe the interactive process between Ms. C and myself facilitated the clinical work because of the particular way in which race was discussed. Race and racial difference were sustained within a dynamic tension: Ms. C and I worked within a context in which race was treated as an actuality and as a sociocultural fact, even as it was also available for the patient's idiosyncratic scripting of it to serve dynamic agendas. In this case, the shared acknowledgment about the difficulty of speaking openly about race actualized a sociocultural reality and was real life between us. My

[4] It is also the case that once the analyst discloses something to the patient, or analyst and patient highlight an implicit disclosure as being important, its status changes in the clinical encounter. Simply put, it becomes "for real." It cannot be retrieved or "taken back," even though analyst and patient may disagree about the meaning of what was conveyed. Furthermore, as Greenberg (1995) notes, "if it is true that everything we do reveals something, it is equally true that everything we do conceals something else" (p. 195). Disclosures alone do not resolve the problem of the analyst's anonymity.

disclosures and the resultant open discussion about race and racial difference permitted the patient to gain access to the reality of me as a racially distinct subject with vulnerabilities of my own. This permitted race and racial difference to exist between us as something that enabled the racial divide to lead to a bridge to more meaningful clinical process (Margolis, 1996). Although this occurred in the context of a tacit negotiation that emerged as an enactment—engaging in forbidden talk—it also allowed the patient to enter more fully into her own subjectivity, including the ability to allow previously warded-off material into her therapy.

It is clear that race and ethnicity exist as a potent force in the social milieu in which psychoanalysis and psychoanalytic psychotherapy are situated. It makes sense to assume that it operates as a powerful and pervasive influence on the treatment process in ways that clinical psychoanalysis has not been in a position to appreciate before. Increasing attention to cultural issues at large is drawing attention to the culture of the consulting room. This, in turn, may point to the utility of critiquing not only the anonymous analyst, but the racially anonymous one as well.

REFERENCES

ABEND, S. (1995). Discussion of Jay Greenberg's paper on self-disclosure. *Contemp. Psychoanal.*, 31:207-211.

AKHTAR, S. (1995). Immigration and identity: a psychoanalytic perspective. Presented at the University of Michigan, October.

BADER, M. J. (1995). Authenticity and the psychology of choice in the analyst. *Psychoanal. Q.*, 64:282-305.

BARRATT, B. B. (1993). *Psychoanalysis and the Postmodern Impulse: Knowing and Being Since Freud's Psychology.* Baltimore/London: Johns Hopkins Univ. Press.

BURKE, W. F. & TANSEY, M. J. (1985). Projective identification and countertransference turmoil: disruptions in the empathic process. *Contemp. Psychoanal.*, 21:371-402.

CHODOROW, N. J. (1994). *Femininities, Masculinities, Sexualities: Freud and Beyond.* Lexington: Univ. of Kentucky Press.

——— (1995). Gender as a personal and cultural construction. *Signs*, 20:516-544.

COMAS-DIAZ, L. & GREENE, B. (1994). Overview: gender and ethnicity in the healing process. In *Women of Color*, ed. B. Greene & L. Comas-Diaz. New York: Guilford, pp. 185-193.

——— & JACOBSEN, F. M. (1987). Ethnocultural identification in psychotherapy. *Psychiat.*, 50:232-241.

——— & MINRATH, M. (1985). Psychotherapy with ethnic minority borderline clients. *Psychother.*, Suppl., 22:418-426.

DEWALD, P. A. (1982). Serious illness in the analyst: transference, countertransference and reality responses. *J. Amer. Psychoanal. Assn.*, 30:347-363.

DUNN, J. (1995). Intersubjectivity in psychoanalysis: a critical review. *Int. J. Psychoanal.*, 76:723-738.

EHRENBERG, D. B. (1995). Self-disclosure: therapeutic tool or indulgence? *Contemp. Psychoanal.*, 31:213-228.

ELLIOTT, A. & SPEZZANO, C. (1996). Psychoanalysis at its limits: navagating the postmodern turn. *Psychoanal. Q.*, 65:52-83.

EPSTEIN, L. (1995). Self-disclosure and analytic space: some issues raised by Jay Greenberg's paper on self-disclosure. *Contemp. Psychoanal.*, 31:229-236.

FRANKENBERG, R. (1993). *White Women, Race Matters: The Social Construction of Whiteness.* Minneapolis: Univ. of Minnesota Press.

FREUD, S. (1912). Recommendations to physicians practising psycho-analysis. *S.E.*, 12.

GLASS, J. M. (1993). *Shattered Selves: Multiple Personality in a Postmodern World.* Ithaca/London: Cornell Univ. Press.

GOLDBERG, A. (1987). Psychoanalysis and negotiation. *Psychoanal. Q.*, 56:109-129.

GOLDSTEIN, E. (1994). Self-disclosure in treatment: what therapists do and don't talk about. *Clin. Social Work J.*, 22:417-433.

GREENE, B. (1993). Psychotherapy with African-American women: integrating feminist and psychodynamic models. *J. Training and Practice in Professional Psychol.*, 7:49-66.

——— & COMAS-DIAZ, L., Editors (1994). *Women of Color.* New York: Guilford.

GREENBERG, J. (1995). Self-disclosure: is it psychoanalytic? *Contemp. Psychoanal.*, 31:193-205.

GREENSON, R., TONEY, E., LIM, P. & ROMERO, A. (1982). Transference and counterinterracial psychotherapy. In *The Afro-American Family: Assessment, Treatment and Research Issues,* ed. Barbara Bass, Gail Wyatt & Gloria Powell. New York: Grune & Stratton, pp. 183-203.

HATCHER R. (1992). Negotiation between the Patient and the Therapist in the Psychotherapy Hour. Presented at the spring meeting of the American Psychological Association's Division 39, Philadelphia.

HERRNSTEIN, R. & MURPHY, C. (1994). *The Bell Curve.* New York: Free Press.

HOLMES, D. E. (1992). Race and transference in psychoanalysis and psychotherapy. *Int. J. Psychoanal.*, 73:1-11.

KAPLAN, A. (1993). The couch affair: gender and race in Hollywood transference. *Amer. Imago,* 50:481-514.

KRIS, A. O. (1982). *Free Association: Method and Process.* New Haven/London: Yale Univ. Press.

LEARY, K. (1994). Psychoanalytic "problems" and postmodern "solutions." *Psychoanal. Q.*, 63:433-465.

LINDON, J. (1994). Gratification and provision in psychoanalysis: should we get rid of "the rule of abstinence"? *Psychoanal. Dialogues*, 4:549-582.

MARGOLIS, M. (1996). Personal communication.

MAYER, E. L. (1996). Changes in science and changing ideas about knowledge and authority in psychoanalysis. *Psychoanal. Q.*, 65:158-200.

MILETEC, M. (1996). Practical aspects of self-disclosure. Presented at the spring meeting of the American Psychological Association's Division 39, New York.

MITCHELL, S. A. (1993). *Hope and Dread in Psychoanalysis.* New York: Basic Books.

——— (1995). Interaction in the Kleinian and interpersonal traditions. *Contemp. Psychoanal.*, 31:65-91.

PIZER, S. A. (1992). The negotiation of paradox in the analytic process. *Psychoanal. Dialogues*, 2:215-240.

RENIK, O. (1990). The concept of a transference neurosis and psychoanalytic methodology. *Int. J. Psychoanal.*, 71:197-204.

——— (1995). The ideal of the anonymous analyst and the problem of self-disclosure. *Psychoanal. Q.*, 64:466-495.

ROSENTHAL, R. (1995). Upwardly mobile bigotry. *New York Times.* Section A, p. 11, October 13.

SAMPSON, E. (1993). Identity politics. *Amer. Psychologist*, 48:1210-1218.

SCHACHTER, J. S. & BUTTS, H. F. (1968). Transference and countertransference in interracial analyses. *J. Amer. Psychoanal. Assn.*, 16:792-808.

SIMPSON, I. (1993). Discussion of a paper by Farhad N. Dalal. *Group Analysis*, 26:290-293.

SMITH, D. (1993). Let our people go. *Black Scholar*, 23:74-76.

STOLOROW, R. D. & ATWOOD, G. E. (1992). *Contexts of Being: The Intersubjective Foundations of Psychological Life.* Hillsdale, NJ/London: Analytic Press.

YOUNG-BRUEHL, E. (1992). Discriminations. *Transition*, 60:53.

University of Michigan
527 East Liberty St., Suite 209D
Ann Arbor, MI 48104

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: http://www.tandfonline.com/loi/upaq20

Play in the Treatment of Adolescents

Henry Markman

To cite this article: Henry Markman (1997) Play in the Treatment of Adolescents, The Psychoanalytic Quarterly, 66:2, 190-218, DOI: 10.1080/21674086.1997.11927531

To link to this article: https://doi.org/10.1080/21674086.1997.11927531

Psychoanalytic Quarterly, LXVI, 1997

PLAY IN THE TREATMENT OF ADOLESCENTS

BY HENRY MARKMAN, M.D.

I propose a view of the treatment process with adolescents which places interactive play at the center. The adolescent plays by creating a highly charged interpersonal drama with the analyst to work out specific developmental conflicts. These conflicts involve struggles for greater autonomy and the formation of a solid sense of identity in the face of regressive pulls. The analyst unwittingly is taken up in the play and uses his or her sense of involvement as material for interpretation to further the play or resolve periods of strain when play falters.

> A child's play is determined by wishes: in point of fact by a single wish—one that helps in his upbringing—the wish to be big and grown up.
>
> FREUD (1908, p. 146)

INTERACTIVE PLAY

Analysts have long been intriged with the meaning of a child's play and its possible therapeutic value. Less attention has been paid to how adolescents play. The gap in our knowledge also applies to how the treatment situation is conceptualized: play therapy is a technique exclusively connected to work with children. How do adolescents play, and how does that play influence the clinical work?

The purpose of this paper is to describe *interactive* play as a

central element in the therapeutic engagement between adolescent patient and analyst. Adolescent play is interpersonal action aimed at securing greater autonomy and a stronger sense of identity. It is progressive action. Adolescents play by creating dramatic engagements with the analyst in order to master developmental conflicts. They do this by experimenting with various roles with the analyst, to feel out the range and limits of their sense of self. While trying on various aspects of self and expressions of conflicted impulses, they press the analyst to respond in tightly scripted ways and will not let the analyst remain uninvolved.

From the analyst's perspective, interactive play often feels free, open, and experimental. The interaction lacks that sense of freedom when the analyst rebels, for his/her own reasons, against the role given him/her; when the analyst acts in ways that increase the patient's anxiety; or when the patient's autonomous strivings lead to anxiety which evokes regressive compromises. The play is interrupted when anxiety overwhelms the patient, or when regressive solutions to transference wishes predominate, and these reactions may often relate to the way the patient experiences the analyst's contribution to the play.

I believe viewing the interaction as play offers specific technical choices, and participating in the play is constructive clinical activity which deepens the work. The analyst participates in the play so that material can be elaborated as he/she closely monitors the patient's sense of autonomy and ability to work with the analyst. The analyst's attention is usefully drawn to ways the play progresses or is interfered with by his or her own behavior, as seen in the patient's response. Interpretation, the central activity of the analyst, is informed by the meanings gleaned from the play and from observations of the patient's anxiety and resistance to play in the moment-to-moment interchange.

Many motivational threads determine the patient's interaction with the analyst, shaped by wishes and defenses throughout development. Play is a compromise formation motivated primarily by attempts to master developmental conflict. The greater the conflicts related to autonomy and the stronger the pull toward

regression, the less free the play will be. In a complementary way, there will be a greater tendency on the analyst's part to enact with the patient regressive solutions to developmental conflicts. Adolescents with perverse solutions to developmental conflicts generally cannot play. These are patients whose efforts are aimed at denying important aspects of reality.

My view of adolescent play may be clarified by first comparing it to the way younger children play in treatment. By suspending reality considerations, play allows the child to experiment with creative solutions to conflict. To play, the child must be able to differentiate reality from fantasy. Freud (1908) commented that "[t]he opposite of play is not what is serious but what is real" (p. 144). Play is interrupted when there are real consequences. Solnit (1987) writes:

> . . . play is pretend, another way of using the mind and body, in an indirect approach to seeking an adaptive, defensive, skill-acquiring, and creative expression. . . . *Play enlarges the child's sense of himself, his capacities and his effectiveness in altering the reality in which he lives.* In that sense play enables the child to explore safely how he can become active in shaping his world and not feel helpless or dependent on it more than he prefers or can tolerate (pp. 214-215, italics added).

Neubauer (1987) states that "play demands . . . enactment" (p. 4). He emphasizes that an important function of play is a "*'trying on,' an exploration*, an attempt to resolve a problem in order to achieve a new level of competence or developmental organization" (p. 3, italics added). The "problem" is the specific developmental task challenging the child at that moment. Neubauer attributes developmental progress to unencumbered play through mastery.

There are a few points worth emphasizing. First, there is an *action* element in play. Second, play is motivated by specific developmental conflicts and tasks. Finally, though serious, play is not real. It is not felt to be real by the child or by the analyst (except when countertransference reactions predominate).

Let us consider an example from a child analysis. Karl is a nine-year-old boy who worries about being abandoned and left out of important decisions which affect him. His parents are busy professionals who travel frequently, often on short notice, leaving him with sitters. He defends against feeling powerless and anxious about the strong reactions to these separations by denial and omnipotence. Recently, the parents have decided to move east for better jobs. Karl is upset about this but has resorted to his usual means of coping, with grandiosity and denial of the importance of others. This is expressed in the transference as indifference to me, to what I have to offer, and to our separations, including the final one when he leaves. In one session he invents a game where I am drifting in a spacecraft minimally armed. He asks me to chart a course through the galaxies on a blank piece of paper, presenting me with impossible, dangerous situations along the way. It is clear that Karl is playing out his anxieties by placing me in his difficult emotional position, feeling helpless and sad about our imminent termination, and frightened about not having enough provisions on board to deal with his dangerous trek away from me. I comment on all this to him. My comments are acknowledged by him, and the game continues in a different vein; my craft spots a space station which has needed supplies. I then comment on his sense of the understanding that he gets from me in our play together which makes him feel stronger and safer. I also tell him he is expressing the wish that we will not part.

I am assigned a specific role in the game. My first response is to accept the role given to me and to reflect on the emotional position I am in, facing these frightening situations. I express these emotions as I participate in the game. For example, I say, "It's scary to deal with these unexpected problems all alone, especially when I feel I have so few weapons." The play is to some extent built on my participation—e.g., my articulating and fleshing out the part he gives me. I need to be immersed in his play so that it can be elaborated and so that I may have direct contact with the transference. Although I have some personal reactions to the position he puts me in, it is clear that this is the patient's creation,

and I think it useful to "play along" and not refuse the role given to me as I form an interpretation. My interpretations are aimed at helping him understand what he is communicating to me about his internal conflicts while not disrupting the play. I feel there is value, in itself, in his attempt to master his anxieties through the play. At the same time I believe that insight would give Karl greater mastery over his conflicts enabling him to achieve more adaptive compromise formations other than grandiosity or denial.

My participation in the game Karl creates by fleshing out the role given to me and interpreting the meaning of the play is similar to playing with adolescents. What differs with adolescents is the high-action quality of the play and the fact that the material for the play is not a game but the actual interaction and roles in the exchange. This difference arises from the specific developmental challenges facing the adolescent which inspire the content of the play: autonomy and identity formation. The *form* the play assumes is determined largely by the adolescent's tendency toward action. This predilection for action, as Chused (1990) points out, is a form of experimental thought appropriate to this phase. Action is adaptive as an antidote to the omnipotence of thought and the fluctuating extremes of adolescents' grandiose and devalued experiences of themselves. Adolescents attempt to define themselves and feel more autonomous through action, especially in relationships.

These developmental urges are in great conflict during the adolescent phase. The intensity of libidinal attachments to primary objects clashes with wishes for greater autonomy and desires for new objects. Katan (1951) describes a process of object removal, in which libidinal cathexis of incestuous objects is "once and for all" shifted to new objects, as the adolescent begins to "love as an adult" (p. 50). This shift leads to deidealization of parents, leaving the adolescent narcissistically depleted and temporarily unable to fill the void with realistic self-appraisal, which leads to wide swings in the experience of the self. The superego and ego ideal are modified as identifications are revised. The adolescent challenges parental roles to secure this greater autonomy and to es-

tablish a stable sense of self. This process of emerging autonomy involves guilt and anxiety as the adolescent gradually assumes the functions heretofore performed by the parents. With regard to the therapeutic relationship, the analyst and his or her role often become the target of these struggles.

What is the analyst's role in the play? The analyst must first tolerate the role given to him/her and begin participating in the play in a way which articulates and fleshes out that role. This conveys to the patient the analyst's understanding that it *is* play. The analyst then begins to interpret the patient's conflicts while staying within the play. For example, a patient recently gave me a contemptuously toned lecture on the current fashions for young men. I could sense his wish to embarrass me by focusing on my attire, which was so unhip. The way he did this had an open, teasing, and playful quality. I did not think he was out to destroy me—at least that was not the dominant wish at the moment. I expressed to him my sense of how difficult it is to have just the right dress, especially when one feels everybody is evaluating you and will be quick to put you down. Gradually, through a series of similar interactions, this boy came to tolerate his own sense of shame—which he had previously warded off by withdrawal or arrogance—and we could pursue that conflict more directly, especially in the transference.

The young patient will usually present me with various roles which will either enhance or constrict his or her sense of autonomy. The patient is, in part, attempting to establish greater autonomy despite other wishes. Just as Karl wanted me to confront his conflicts through the game he invented, the adolescent places the analyst in emotional situations that challenge him. How one responds to this situation determines to a large extent whether the play continues or is interrupted. I assume I am always contributing to the play in some way, often outside of my awareness. I am looking carefully at the patient's capacity to pursue anything on his or her own, even if that pursuit violates my sense of what "should" happen in therapy. I assume, unless the patient is very troubled and cannot play, that the patient wants to play in this

way, and resistances to the play are often expressed in the transference (as resistances to free association are with adults). One goal is creating conditions of safety for this kind of play while attempting to understand the ways my responses might lead to strain and a breakdown in play. Ultimately, I want to interpret the meaning of the play to the patient.

My involvement is similar to Sandler's (1976) description of "free floating behavioral responsiveness," in that I am responding to unconscious cues from the patient in order to assume/enact a particular role. I am catching myself in mini-actions which are indicators of those cues from the patient. It is important to emphasize that I am not advocating taking a role with the patient. My responses are genuine, often unconscious reactions to the patient in the play. In that sense I am playing too, allowing myself to be involved in the play and responding in ways whose meaning can only be revealed retrospectively, as the play takes form (just as the patient does not know what he or she is doing with me until a clear form emerges). My play is free, but not unrestrained, as it is guided by a general sense of my countertransference tendencies and a clear view of my ultimate role in the therapeutic enterprise: to help the patient understand his or her compromise solutions to conflicts which curb autonomy.

The analyst's involvement in play differs from the concept of countertransference enactments, in that enactments represent a breakdown in the play. Enactment is described by Chused (1991) in this way: "During an enactment, the patient has a conviction about the accuracy of his perceptions *and* behaves so as to induce behavior in the analyst which supports his conviction" (p. 617). Most analysts believe that enactments are inevitable. The question is whether they are useful and, if so, in what way. For example, Renik (1993) writes: "... we regularly observe that successful analytic work unfolds via a process of continuous mutual active embroilment between analyst and analysand" (p. 138). Renik observes that awareness of countertransference is retrospective, and that much of what the analyst does with patients is outside of his or her conscious control. I believe Renik is saying it is more prof-

itable to monitor all the ways he enacts at each moment with the patient than to attempt to constrain his actions. As Sandler (1976) has emphasized, these enactments are the royal road to the understanding of the patient's transference and must be lived out in order to have emotional credibility for the patient.

My view of the analyst's involvement and orientation in the therapeutic process is similar to Renik's and Sandler's. As I will try to show with clinical material, I also believe these enactments vividly actualize for the analyst the patient's transference. However, I view enactments as a breakdown in the play. If the play breaks down and I continue to respond in ways which the patient experiences as limiting his/her autonomy, then I would use the term enactment. If the patient and analyst are playing, there is serious exploration of conflict without the conviction that the analyst is a retaliative or seductive parent, for example. Actually experiencing the analyst that way will stop the play and limit the patient's capacity for autonomy with the analyst. I am looking at the differences in the patient's capacity to work autonomously with me as the prime indicator to distinguish play, which is developmentally progressive, from enactment. As I will discuss in the next section, the analyst's approach differs, depending on her or his assessment of the nature of the interaction.

Chused (1991) believes there is something useful in the inevitable enactments with children and adolescents:

> . . . the inequality of the doctor-patient (or adult-child) relationship often functions as a resistance to an integration of the analyst's words with the analytic experience—the words become encrusted with authority because of the source and are discredited at the same time they are ostensibly accepted (p. 623).

This is true especially with adolescents, due to their sensitivity to control. For Chused, enactments are a "shared experience" that "enhances the sense of a collaborative effort" (*ibid.*). My point of view is that play—and the patient's sense that the analyst is free to play as well—is an important element in the building of a collabo-

rative experience which can deepen adolescents' sense of their autonomy.

INTERRUPTIONS IN PLAY

The adolescent's relationship to the analyst is one of great stress. The analyst, as an adult offering an intimate relationship, heightens preoedipal and oedipal wishes and anxieties during a time when the adolescent is struggling to develop a more solid sense of autonomy and is turning his/her desires toward new objects. Ambiguity in the analyst's role creates great anxiety. Play collapses when the "as if" relationship with the analyst becomes "real." The relationship feels frighteningly real when the analyst's actual behavior confirms a transference fantasy—when the analyst cannot be distinguished emotionally from the patient's internalized primary objects. In my view, adolescents are especially susceptible to the collapse of play and the "as if" relationship. The analyst's task is to enhance the patient's self-awareness and autonomy. This increased autonomy can occur only in an atmosphere of safety from the fearful oedipal temptations presented in the analyst-patient relationship.

The signs of strain are found in the patient's behavior and the analyst's subjective state. There is a sense of deadlock, immobility, and heightened resistance in both participants.[1] The patient's behavior demonstrates common cues to resistance: flat affects, material which does not deepen, pressure on the analyst to do something. The analyst often feels bored or trapped in the sense that any comment seems futile in changing the present state between patient and analyst.[2]

During periods of strain the adolescent lacks sufficient ego autonomy to sense that interpretations come from a neutral or helpful source and therefore experiences the analyst's activity as an

[1] The clinical observation of strain has been most fully explored by Myerson (1990).

[2] Spruiell (1984) and McLaughlin (1988) beautifully describe examples of this state of mind.

effort to coerce or seduce. The analyst's attention can productively be directed toward his or her own behavior and ways he or she contributed unknowingly to the strain via participation in the play. This process of self-examination opens the way for an interpretation or change in behavior, allowing the patient to function more autonomously with the analyst.

INSIGHT AND INTERPRETATION

When play is the primary mode of interaction, the analyst allows the material to develop, and the timing of interpretations is a central technical question. The content of interpretation is a translation of the meanings in the play. Insight in the context of emotionally vivid experience is the major means of change since it affords the greatest opportunity for mastery of conflict.

Interruptions in play, when strain predominates, provide greater challenges to the interpretive function of the analyst. At those moments interpretations are often experienced in ways which raise the patient's anxieties further. The best way to address strain in treating adolescents is by creating an atmosphere—either through interpretation or behavior—in which the patient can take the lead. Interpretations then should focus on increasing the patient's autonomy and capacity for self-observation—that is, the interpretation of developmental rather than neurotic conflicts.[3] Interpreting transference wishes not related to conflicts over autonomy is too threatening or inaccessible to the adolescent, especially during times of strain.

I have noticed that promoting the play and relieving strain without interpretation has also led to change. I have seen this primarily in patients who could not use interpretations during

[3] Although schematic, it is useful to distinguish developmental from neurotic conflicts. Developmental conflicts are phase-specific conflicts which involve an acquisition of new capabilities while tolerating the partial loss of previously held secure gratifications. Neurotic conflicts are compromise solutions to enduring conflicts in the preoedipal and oedipal phases.

long periods of the treatment, if at all. There are also patients who create noninterpretive conditions in the treatment until there is sufficient safety or ego autonomy to hear interpretations as helpful. These positive results have been described in many ways: transference cures, corrective emotional experiences, making use of the real relationship, passing tests—all relating to the experiential, noninterpreted realm of treatment. I view this aspect of the process as a therapeutic benefit of play—a form of problem solving that occurs in the metaphoric realm in interactive play. Change can occur in play without direct insight. I am not suggesting, however, that this is the most enduring or reliable source of change in the patient.

Progress made in the play without insight can be usefully interpreted later on, and interpretations help consolidate those gains. Play which is not interpreted often closes off some aspect of the patient's autonomy. For example, some time ago I treated a fourteen-year-old boy who, among other things, struggled with a soccer inhibition: he would not kick a goal even when great opportunities presented themselves. The treatment was not going well: hours of silence, boredom, and chitchat had replaced our strong beginning. At one session he greeted me in the waiting room with a sheepish grin. He had forgotten his bicycle lock and asked if he could take his bike into my office. It turned out to be quite an impressive bike. I found myself admiring it and asking questions. We spent the session praising his powerful, fast, and sleek bike. He never brought the bike again, nor did we focus on the soccer problem, but shortly after this session his inhibition resolved. While admiring the boy's bike, I was offering a suggestion—I like you, you're valuable, big, strong, etc. This kept the boy's conflict in the interpersonal sphere and so was not used as insight into his own conflicts about growing up and the ways he closed off, avoided, and attempted to solve that conflict. Yet that interaction was necessary before he could approach the internal conflict. Later in treatment, the boy was able to express the fantasy that he could only grow up, be big and powerful, if the analyst admired him and took him under his wing (and did not compete with

him). Through interpretation he saw that his own competitive wishes led to significant inhibition as he feared the loss of the analyst. Initially, we could only approach this through play.

CLINICAL ILLUSTRATIONS

Three cases will be presented to illustrate the points developed thus far. The first case illustrates how strain was negotiated without interpretation—which nonetheless led to enduring change. The next case demonstrates increasing use of interpretation as the vehicle of change. The final case addresses the problem of patients who cannot play and describes my attempts to create an atmosphere in which play could occur.

Case 1

Paula benefited from a repetitive, highly scripted playful interaction which could not be interpreted, but led to progress in treatment and in her life. She was a depressed, green-haired, black-clothed fifteen-year-old girl who evoked a profound sense of futility in me from the very first session. She sat silently with a hostile glare, rarely responding to questions. When she did respond, it was monosyllabic. My efforts could not budge her. Usually, I am more relaxed in these situations, but I felt a greater than usual pressure to engage her. The silence was tense and even more uncomfortable for me than for her. Paula's only spontaneous remark came at the end of the session: a sarcastic "keep trying."

That first session was but a pale version of what lay ahead. For several months every session had the same dreaded structure: I would scramble to engage her by asking innumerable questions or speculating about her life. More often than not my questions were met with silence. Occasionally, I received monosyllabic responses. I felt useless; I could not imagine what she got out of our meetings. I surmised she got something out of casting me in the role of

interested dunce. I did note moments of humor and excitement when she thought I asked a particularly stupid question.

This playful interaction of Paula's was dead serious: she played the inaccessible passive one and pressed me to be constantly alive and interested, without controlling her. However, in an effort to deal with my own discomfort, I interpreted her conflicts to her: her need to control me, her sense of inadequacy and vulnerability, and so on. By becoming active and interpretive I refused the role she assigned me. She became more withdrawn in response to my nonplayful activity, and on one occasion fell asleep. By interpreting, I was enacting the intrusive parent she must fend off, and the play stopped. But commenting on that enactment would lead to infinite regressions. I could not escape the enactment through interpretation. In this case interpreting would avoid the more salient conflicts around independence and separation. If she wanted to be in charge, why not let her?

I recognized my own resistance to allowing the therapy to go her way by not participating in her play. She was not there to analyze, learn about herself, discover her conflicts. She was there to do, to create, and she had written my part out quite clearly. The main resistance I encountered in myself was to the direct attack on my conception of my role as analyst. In a paradoxical way, my being useful to her, at least initially, was to tolerate (and articulate) my sense of uselessness and to hope that playing that given role would continue the play that might lead to insight and consolidation in the future. (I also paid close attention to how her life was progressing outside the therapy as an indication of the use she made of the treatment.) I thus gave her free range to create the therapy as she saw fit. This led to a change in my general attitude and behavior. I began to ask questions in a quite agreeable way. I joked about my ignorance and foolish wish to know more about her. Many sessions went by in the form of questions and yes/no answers. And yet some changes were evident. She became less depressed, and her outside life changed. Gradually, over two years, her responses lengthened. Her relationship with her

mother improved, she began excelling in school, had a boyfriend, and went off to a fine college, where she majored in psychology.

The form of the play in therapy remained the same. I occasionally commented on the nature of our interaction. It came to be a running joke between us: "You're playing analyst," she would laugh, returning to her quiet pose to await another question from me. We were never able to directly interpret this interaction.

A session late in treatment will serve as an illustration of the play quality of the work and her genuine involvement in it. Paula came in looking tired. She insisted she was not bored. We went through the usual question and answer routine for fifteen minutes. She then grabbed a psychiatric magazine from my shelf and joked about the ads for drugs to cure emotional problems: "People have to understand themselves—that's how they get better." (Her previous psychiatrist had recommended antidepressants.) She then opened her purse and showed me its contents: cosmetics, money, wallet. "I have pictures," she said sheepishly, showing me one of her boyfriend. She then flipped through her business cards and read them off. She had two cards of mine from different offices. The hour was up. She joked that she thought she had a half hour more. "Time flies when you're having fun," she quipped sarcastically, revealing her disappointment about the end of the hour.

The work, by therapeutic standards, was a success. The form of the hours had remained unchanged, but the emotional quality was completely different. We enjoyed each other, we joked about our respective roles in the enterprise, and she became passionate in describing aspects of her life in response to my questions. We had successfully negotiated a difficult resistance in the treatment that threatened a stalemate. After much strain, the patient and analyst came to create an interaction which served Paula in many ways. How was this change accomplished without interpretation?

The first phase of the therapy, in which I urgently pressed to engage her, was a countertransference enactment. In essence, I refused to play. The obvious cues were increased strain and resistance and no evidence of change in her life. I realized that inter-

preting her conflicts or the nature of our interaction immediately led to strain, and interpreting her reaction to my interpretations led to further withdrawal on her part. Once I could relinquish my agenda and remove obstacles to her sense of autonomy with me, she/we began to play.

The specific conflicts managed in her play, with increasing autonomy, were her need for my constant interest and attention, along with her great vulnerability to and fear of being exposed. She feared my intrusiveness as well as the possibility of abandonment and rejection. She had a great wish for autonomy but feared her own activity, aggression, hostility, and wishes for separation. Her erotic wishes and narcissistic vulnerability were fended off by casting me in the role of the bungler pursuing her. Gradually, she became freer to enjoy seeing me and could express more aggressive and tender feelings within the structured interaction she created.

One interesting aspect of the treatment with Paula was her intolerance of my clinical activity as an interpreting analyst. Any interpretation about the play disrupted it, increased her anxiety and sense of shame, and led to various regressions—not unlike dilemmas encountered in treating certain narcissistically vulnerable patients. When Paula returned to treatment two years later, she functioned quite differently. Gone was the structured play; she appeared curious and insightful. Most strikingly, she could make use of interpretations. When I asked her about this change, she replied, "When you talked before, you took up all the room in my head and I couldn't think." This vivid description revealed her fragile sense of identity and the loss of autonomy that my interpretations created.

Case 2

The next case illustrates play which was interpreted or in itself led to new material and progression. In contrast to the previous case, the therapeutic action is primarily in the interpretation of

the play. The play had certain similarities to that of Paula: Rick created dramatic exchanges in which I pursued him in various ways, often aggressively, which was exciting and enlivening to him. In contrast to Paula, Rick tolerated and made good use of interpretation. He also felt threatened and play was disrupted when his desires for the analyst were felt to be too great, or when he experienced the analyst as distancing himself. His sense of autonomy was much firmer than in the previous case, as we shall see.

Rick was a sixteen-year-old boy referred to me because of his parent's concerns about his sadistic treatment of a younger sister. The parents divorced when Rick was seven as a consequence of his father's numerous affairs, and both quickly remarried. Rick alternated weeks living with each parent. He exclusively chose girls as friends and avoided the rough and tumble of sports or other competitive activities. Although good grades came easily to him, he seemed indifferent to his work and lacked interest in pursuing any projects or ideas of his own. He appeared to lack any passion except with regard to his sister, whom he terrorized with abandon.

The boy was in a quiet rage about many things: the closeness of mother and younger sister; the sense of inadequacy regarding his masculinity; his estrangement from his father who seemed more interested in his new family. All was submerged beneath an attitude of indifference and passivity. The atmosphere he created in the therapy was one of intense boredom and disinterest. He yawned constantly. He was bland and passive, apparently submitting himself to the parents' demand for treatment. Yet he came promptly, never resisted the frequency of sessions, which was three times a week, and looked at times anxious to please. Of course, he insisted over and over again that therapy was his parents' idea, that he saw no need for it, and that it was an utter waste of time. I could see clearly the trouble this fellow was in: his longing for and fear of a relationship with a potentially helpful man, his fear of his aggressiveness and creativity, which he considered masculine qualities, and his defensive identification with mother, whom he viewed as weak and helpless.

Despite this understanding, I found myself acting in ways which

troubled me. I subtly tried to convince him of his need for therapy and to awaken him; my tone with him often had a hint of sarcasm with a "come off it attitude." In general I was more challenging than I wanted to be. To complicate the picture, his father would call asking when treatment would end, stating that his son found no use in it. I spoke to his father the way I had to his son: justifying treatment, feeling irritated, and responding sarcastically at times. The interaction with the patient was one of quiet warfare: pushing him, needing to see verbal evidence of his interest and commitment to therapy, sharp interpretations aimed at his passivity. I took a confrontational, aggressive tone with his stance as a passive, reluctant little boy. This interaction was created by both of us and formed the structure of the play. It was play because I did not sense strain in these exchanges (though I felt it myself), and as I will describe, it led to progress in his life and greater autonomy with me.

I am not advocating sarcasm or subtle forms of warfare as inherently useful aspects of analytic technique. I am suggesting that Rick, in fashioning this role for me, could make progressive use of it. I also realize that with another patient my behavior could have led to regression, overwhelming anxiety, or stalemate. But, though troubled by my responses (I do not like feeling angry at or frustrated with my patients, and felt that my technique at those moments fell short of my analytic ideal), I realized that my responses had not created obstacles in the treatment for Rick, and in fact led to progress.

So Rick gradually became more and more openly argumentative and hostile in response to my aggression. He dropped his bland style and became openly contemptuous of me and our work. He could be vicious. All the while he continued to come regularly and on time, never missed a session, seemed distressed by one of my cancellations, and started making progress in his outside life. He joined the track team and was successful. He started to go out more with friends and became actively involved in a creative writing class. Most of this information at first came from his parents; Rick indicated to me that nothing had changed.

In this instance the patient was using the play to identify with my aggressiveness in the sessions and outside: "If he can be tough with me, so can I." I am sure he could also sense my interest in him and involvement in our work, as well as my impatience—which made him feel quite powerful. It is important to underscore that this was in no way a conscious stance on my part, but one that took shape spontaneously in the give-and-take of the interaction. In my view the patient uses aspects of the analyst's character as a palette to color the roles and create the necessary scenes.

In any case, neither the patient nor I could acknowledge the value he placed on the relationship and his defensive maneuvers around it. I then did something which made available to both of us the nature of the playful interaction, opened up ways to interpret that interaction, and led to the emergence of new material. During one of our usual conversations disguised as "educating the patient about therapy," I said to him, in a faintly accusatory tone, "When are you going to come out of hiding?" (I could have added "and fight like a man.") I was startled I had made a remark which so completely revealed my frustration with him. The patient responded with a smile. He then proceeded to tell me about the call I received from his father earlier in the week. I had changed offices, and on the night before the first visit to the new office, he told his father that he had forgotten the address. He had given my new card to his father some weeks earlier. His father could not find the card and called me in a panic to get my address. The patient was playing his passivity to the hilt with his father, and his father was jumping through hoops. Of course, Rick did show up at my new office.

I told him I could see how much pleasure he got in seeing his father work so hard on his behalf. The aggressive component to this was clear to both of us. But what it disguised was the wish for his father to take an interest in him and prove it. I commented on those wishes toward his father and toward me. Rick said he had known my new address quite well. In fact, he had gone by the office a few times before I moved to make sure he could find it easily. This was a clear acknowledgment of the importance of the

therapy to him. During the next few weeks Rick spoke about how he had secretly enjoyed talking and, especially, arguing with me. He was not sure it was doing any good—perhaps changes in his life would have happened anyway—but he generally wanted to continue the treatment. This was the beginning, touched off by my remark, of his understanding of his identification with me, as well as awareness of his admiration and competitive feelings.

As one might expect, there was a strong defensive reaction to experiencing this wish for me to be interested in him and the recognition of the importance of our relationship. The defensive compromise took the form of a euphoric state of mind: he was active and busy in his life. He had no time for therapy as he became more engaged in after-school sports and a whirlwind social schedule. He requested a reduction in the frequency of meetings. Although his request had the appearance of increasing independence, it was also motivated by fear.

Rick confronted me with his dilemma which was part of the play. I enacted part of his externalized conflicts by agreeing to cut down on the frequency of the sessions, and the play stopped. Some of the goals of treatment were being realized: increasing confidence, a greater sense of masculinity, more aggressive and competitive activity, and a budding interest in girls, albeit from a safe distance. His current conflicts in the transference were aggressive wishes he feared I would not tolerate and continued wishes for me to be involved and interested. He could not resolve this because he could not imagine my interest in him as an aggressive, independent young man. If he wanted to be big with me, he feared I would squash him; if he wanted my interest, he must be submissive and castrated. Thus, he could only be strong and active out of my sight.

Even though I interpreted to him my understanding of the conflicts involved in the play, I did agree to reduce the frequency of the meetings—perhaps ultimately susceptible to his seeming wish for independence. For some reason I did not include in my interpretations of his conflict the position he put me in vis-à-vis the request. This represented a countertransference reaction. I

enacted with him the role of the proud, distant father with the confident son.

Rick appeared less excited when we met now, and he resumed his bland, bored attitude toward his activities. The play had stopped. Due to our previous interpretive work, Rick was able to see this blandness as defensive. I told him I thought he missed our meetings, and he experienced my agreement to cut down the frequency as a lack of interest in him. I also pointed out the conflict he was in: wanting, yet fearing my involvement, trying to solve that dilemma by fleeing from me. The result of this interpretive work was that he could remain in treatment at the same time feeling strong and independent, tolerating wishes to submit to me until a mutually agreeable termination date was set. The termination phase also dealt with his fantasy that he would lose his potency when on his own; he needed magical contact with me in order to maintain his masculinity. Thus, the termination shed light on the meaning of a previous enactment: his listless behavior when we decreased the frequency.

The treatment focused on the analysis of what was revealed in the play, especially conflicts surrounding his wish that the analyst take great interest in him. From my perspective, the play drew me into responding in active ways, searching him out. Once the meaning of this play was interpreted and emotionally recognized by Rick, he took to flight which resulted in an enactment of the aloof father and overly confident son. Finally, Rick could experience both of us as strong together.

In contrast to the first case, Rick could explore these interactions in terms of his motivations and what my actions meant to him. He first understood the complicated but predominantly frustrating compromise he adopted to deal with central conflicts. These conflicts had to do with an intensely ambivalent relationship with his father involving a wish for closeness and feelings of rejection, a wish to submit and fears of emasculation, as well as a wish to triumph over his father as rival. He also came to understand something about his reactions to his younger sister and his fantasy that he could be close to his mother only if he were a girl.

All these insights occurred in the here and now of the interaction with me. Most important was his understanding of the common ways of dealing with conflicted wishes for closeness, independence, and triumph over rivals of both sexes.

Case 3

The next case deals with a prolonged countertransference enactment with a patient who could not play and my effort to develop the patient's capacity to play. Daniel created real situations with the analyst to take responsibility for himself and his life, expressed as shirking responsibility for all aspects of his treatment. I believe that Daniel could not play due to a perverse solution to conflict which allowed him to deny central aspects of reality.[4] He could not pretend because serious defects in reality testing existed. I only became aware of this patient's difficulties through understanding his resistance to play.

I contributed to the countertransference enactment by a kind of interpretive activity which confirmed his belief that I would take care of him. Daniel presented rich and interesting material, and my interpretations led to a stalemate. Characteristics of this enactment were intense strain, stasis, boredom, and deadness, with little real change in his life. The stalemate was resolved through the successful analysis of a problematic interaction around the fee.

Daniel was a terribly confused and frightened college freshman when I first saw him in consultation. He had just left home for college and had serious concerns that he was losing his mind. He was tormented by sadistic sexual fantasies. He had no friends, was frightened of girls, and was failing at school. And he was struggling with a long history of cross-dressing while masturbating.

Daniel was anxious about his sadistic wishes toward women and competitive strivings toward men. He dealt with these conflicts

[4] See Grossman (1993) and Renik (1993) for descriptions of such patients and the clinical problems involved.

with fantasies of being a girl, social withdrawal, omnipotent fantasies of being a rock star, and finally, depression. A few comments of mine in the first part of the analysis aimed at pointing out his anxieties concerning aggression, and the futility of his approach to solving them, resulted in dramatic symptomatic improvement. His grades improved, he started dating women, had sex for the first time, and started making friends. He stopped cross-dressing. This change was not primarily due to my interpretive acumen but rather to the magic of being with a man who sponsored him in the world and gave him power. The transference relationship had a talismanic effect. I did not interpret this at the time but chose to let him use me in this way for a while.

A new anxiety arose from our collaboration, however: he became afraid of my influence. He was also frightened of his wish to get power by submitting to a man he perceived as stronger. To deal with these anxieties, he withdrew into hostility and passive aggressiveness. For a year there was great strain in the treatment; many hours went by in silence; he missed sessions without canceling. Interpretations of his anxieties had no effect. Gradually, I became aware of my search for the perfect interpretation to recapture the magic we once had. I recognized that I wanted my interpretations to do something, to change him. The content of my interpretations focused on the neurotic elements in the transference. I pointed out anxieties connected to his wish to surrender, to control me, to take my power and render me impotent, and the solutions (and gratifications) involved in casting our relationship in a sadomasochistic mold. I did not emphasize the developmental conflict, which involved anxieties around autonomy. My transference interpretations were "correct," yet they simultaneously enacted a view of him as a little boy without resources of his own—the truth had to come from me.

I now want to focus on the central enactment of the work: my assuming responsibility for the continuation of his analysis. The understanding of this enactment allowed for interpretation of his difficulties with reality and led to the beginning of his ability to play. The enactment had to do with the arrangement of

the fee. In the first session Daniel convincingly presented himself as extremely confused. He suggested that I should first talk to his father about the details of the fee and then send him the bill. I agreed to this although, my usual policy with late adolescents is to give the bill to the patient. This departure was engendered by my view of the patient as helpless. At the time it seemed appropriate, yet clearly it served several purposes for Daniel which he played out with me. One was to keep money or any other practical matters far away from our relationship. He would then feel that I was treating him solely out of interest. Another disguised motivation for this arrangement was to create a conflict between his father and me. He knew his father was tough and stingy with money, and he wanted me to justify the treatment and negotiate the arrangements. This put more responsibility for the treatment immediately in my hands; and he could imagine, with excitement, his father and me slugging it out. One aspect of this fantasy was that Daniel and I were joined together in combat with his father. I was his proxy in this combative fantasy. He aimed to create a situation in which I would take over the treatment; at the same time he would triumph over his father (and me) through his passivity. The negative oedipal conflicts are also clear in this scenario.

Through our work Daniel's motivation for the handling of payment became clear, and I changed the arrangement so that I gave the bill to the patient. Payment was now his responsibility. A few weeks later he told me his father wanted to change the arrangement again so that I would collect from the insurance company rather than from him. He said that his father was firm on this due to cash flow problems. Rather than calling the father and getting embroiled in that, I chose to keep it in the analysis with Daniel. I compromised: I would allow a three-month lag time; if no payment was received I would collect from the patient. Daniel, and I assumed his father, agreed to this.

This arrangement brought out in concrete ways the transference-countertransference enactment previously described in the process. The patient became quite passive about money. He would forget to give his father the bills; he would forget to contact the

insurance company. He became a spokesman for his father's concerns about the cost and length of treatment. Three months would go by without payment. He would promise to resolve it, then forget or not mention it unless I brought it up. And he seemed completely at ease with his forgetfulness to a very irritating extent. It became evident that he was doing the same thing with his father. Daniel had not told him about our three-month arrangement.

Any discussion of the financial situation led nowhere. I was faced with a dilemma. If we adhered to my three-month policy, I would terminate the treatment. Or I could intervene by calling the father and taking it out of Daniel's hands again. Neither approach was particularly attractive. The money became the center of the analysis as the hostile transference reached its peak. Daniel created a situation in which, it appeared, I needed things from him, not the other way around, and he was provoking me to do something. My interpretations were an attempt to describe the situation and the present dilemma, including what I thought were the patient's motivations for creating the situation. Yet I felt that my interpretations were also designed to change him and his behavior. I justified this by reassuring myself that change would come through insight.

Insight finally came: Daniel became more aware of his hostility and fear of my influence. Nevertheless, the debt increased. In an especially frustrating session I told him he must take responsibility for the money and resolve the debt if he wanted the treatment to continue. I interpreted again his motivations for the present situation yet I also made clear that we would not continue working together if the debt was not settled. He appeared shocked by my reaction. (If this were play, his response would not have been shock; shock indicated that the interaction and my role in it as keeper of the analysis was a complete reality for him despite the apparent insight he could verbalize.) For the next few weeks he made no direct reference to my comment, but he did take the initiative by calling the insurance company and his father in an attempt to resolve the impasse.

What I believe motivated him at that point was seeing the reality of our relationship after witnessing my genuine reaction to the setup he had created. In a sense he had used my neutrality, or my attempt to control my reactions toward him, to confirm his fantasies. I also clearly showed him that living out a particular fantasy with me would lead to real consequences: the loss of the treatment. Daniel gradually began to distinguish, in an emotional way, reality from fantasy.

I also felt freer to see how I had been colluding with the patient by treating him like a child and interpreting his wishes in an accurate yet overly active way. The way I arranged the fee was a concrete expression of the collusion: e.g., that I must take responsibility for the treatment or it would stop. I had also neglected to point out all of his attempts to sabotage his autonomy. I was able to communicate my understanding of these conflicts to him. This period in the analysis was a prolonged collusion without play. The role I assumed as keeper of the analysis was "real" and allowed for the patient to maintain a position of passive omnipotence infused with sadomasochism. To play assumes the ability to maintain a tension, flexibility, and boundary between fantasy/play and reality. As a direct result of our work concerning my threat to stop treatment Daniel became more autonomous and took greater responsibility for his treatment, as well as for projects in his outside life.

CONCLUSION

There are many ways to describe interactions in treatment: enactments, corrective emotional experiences, passing tests, projective identifications, etc. How does the concept of play add to this rich and varied literature? Play offers a concept of the interaction with adolescents which focuses on developmentally progressive interpersonal actions. This means that the analyst's attention is taken up in closely monitoring the patient's moment-to-moment expressions of ego autonomy and capacity for introspection. The analyst

is also continuously attempting to understand how his or her actions in the play affect the patient's autonomy. This approach may sensitize the analyst to the way adolescents take in interpretations and understand our therapeutic/analytic efforts. As a result, clear technical choices emerge.

The analyst can use the perspective of interactive play in ways similar to the technique of free association and assume that his or her activity which enhances play/free association will allow the patient to be more deeply immersed in the process, while obstacles to play must be identified in the patient-analyst dyad. For the analyst, a focus on resistances to play/free association is the most useful intervention—either in the form of interpretation or changes in behavior. Similar to our view of adult work, in which the understanding of resistances is central and patients will tell their story and understand the story once free to hear it, adolescents will understand themselves in a useful way when they see the story they are creating with the analyst. Likewise, resistances are, in play, interpersonal enactments, which provide useful material for interpreting patients' conflicts.

Viewing the interaction as play may also allow the analyst to tolerate, or contain, the intense interpersonal pressure brought to bear by adolescent patients. Pick (1988) vividly describes the way the analyst tends to be "swept up" in the adolescent's passion and interests. Through the lens of play, analysts can remain fully engaged in the interactional mix-up, thus allowing themselves to be used by the patients to create their personal drama. But play is a relativistic concept. Viewing young children at work in their playroom may convince us of a *drive* to play (perhaps an ego instinct). Yet within the play—its content and structure—are various solutions of a more or less progressive nature. There are certainly adolescents whose play has more resistive elements, whose attempts are pathological solutions to developmental conflicts. The range of solutions will have a direct effect on the analyst's interaction.

Are there patients who use play primarily as resistance, to avoid more urgent concerns? I do not think patients can ever avoid their

urgent concerns since they are expressed at every moment. Yet some patients tend to repeat interactions. In working with these patients, one can sense life and meaning being drained out of the interaction. It is possible that repetitive contact in a sterotyped way is the aim. The interaction is not experienced symbolically by the patient, and he or she is suffering from a more primitive anxiety than one concerning autonomy.

This brings us to a discussion of those adolescents who cannot play. I believe these patients have problems in reality testing. They cannot suspend reality considerations and must make the interaction "real"—i.e., not ambiguous or open to interpretation. Perhaps these patients suffer from some form of character perversion. The painful realities of early childhood—the differences between generations and sexes—is certainly revisited with intensity in adolescence, and perverted solutions of grandiosity and denial do mark the adolescent patients I have treated who could not play.

There is a developmental line in play, yet oedipal and adolescent patients play in similar ways. The play for both is highly dramatic and interpersonal, often bringing in the analyst in proscribed roles. But adolescent play differs in two important ways. First, the primary developmental thrust is to secure greater autonomy (and achieve object removal), which is not the case in oedipal children. Second, the intensity and subtlety of the play is very striking with adolescents.

Something changes in late adolescence and young adulthood, as the first case illustration indicated. Play in the manner described diminishes. One sees a stronger expression of ego autonomy and a solid sense of identity, so that roles are not the central thing. Interpretations can be tolerated and experienced as useful, and transference is more available to interpret. Laufer (1976) describes a similar shift in late adolescence, when the sexual organization becomes solidified and less available for revision.

I believe the concept of play is useful in thinking about work with adults, though the sense of a driven quality to the play and

interaction is much less. Perhaps what one sees more with adults is playfulness, imagination, and creativity in analyzing and playing with transferences (though the transference itself is just as driven). And correspondingly, the lack of capacity to play signals some trouble with the patient's reality testing—especially the capacity to consider one's wishes and fantasies apart from reality.

This paper examined the interactional elements of the treatment process with adolescents. I proposed a view of play and a model of the process which may help orient the analyst in the clinical encounter. To be useful, that orientation should free the analyst to pay attention to how the patient and analyst interact and affect each other. Perhaps the most important aspect of the analyst's function is his or her ability to become aware of the nature of the involvement in and contribution to the process, thus clearing the field for understanding the patient and dealing with the analyst's own resistance to analyze.

REFERENCES

CHUSED, J. F. (1990). Neutrality in the analysis of action-prone adolescents. *J. Amer. Psychoanal. Assn.*, 38:679-704.

——— (1991). The evocative power of enactments. *J. Amer. Psychoanal. Assn.*, 39:615-639.

FREUD, S. (1908). Creative writers and day-dreaming. *S.E.*, 9.

GROSSMAN, L. (1993). The perverse attitude toward reality. *Psychoanal. Q.*, 62: 422-436.

KATAN, A. (1951). The role of "displacement" in agoraphobia. *Int. J. Psychoanal.*, 32:41-50.

LAUFER, M. (1976). The central masturbation fantasy, the final sexual organization, and adolescence. *Psychoanal. Study Child*, 31:297-316.

MCLAUGHLIN, J. T. (1988). The analyst's insights. *Psychoanal. Q.*, 57:370-389.

MYERSON, P. G. (1990). Managing strain in classical analysis: re-establishing the therapeutic relationship or interpreting unconscious wishes. *Psychoanal. Q.*, 59:741-765.

NEUBAUER, P. B. (1987). The many meanings of play: introduction. *Psychoanal. Study Child*, 42:3-9.

PICK, I. B. (1988). Adolescence: its impact on patient and analyst. *Int. Rev. Psychoanal.*, 15:187-194.

RENIK, O. (1993). Countertransference enactment and the psychoanalytic pro-

cess. In *Psychic Structure and Psychic Change: Essays in Honor of Robert S. Wallerstein, M.D.*, ed. M. J. Horowitz, O. F. Kernberg & E. M. Weinshel. Madison, CT: Int. Univ. Press, pp. 137-160.

SANDLER, J. (1976). Countertransference and role-responsiveness. *Int. Rev. Psychoanal.*, 3:43-48.

SOLNIT, A. J. (1987). A psychoanalytic view of play. *Psychoanal. Study Child*, 42: 205-219.

SPRUIELL, V. (1984). The analyst at work. *Int. J. Psychoanal.*, 65:13-30.

2424 Russell St.
Berkeley, CA 94705

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: http://www.tandfonline.com/loi/upaq20

On Knowing What One Knows

Donald M. Marcus

To cite this article: Donald M. Marcus (1997) On Knowing What One Knows, The Psychoanalytic Quarterly, 66:2, 219-241

To link to this article: https://doi.org/10.1080/21674086.1997.11927532

Published online: 07 Nov 2017.

Psychoanalytic Quarterly, LXVI, 1997

ON KNOWING WHAT ONE KNOWS

BY DONALD M. MARCUS, M.D., PH.D.

The author presents vignettes of a type of experience that is familiar to many analysts. He suggests that analysts and analysands know much more about each other than is generally recognized and that much of the important communication is subliminal, out of conscious awareness. Evidence of our unconscious knowledge surfaces in the form of emotion, fantasy, images, intrusive thoughts, and physical feelings. Often it seems uncanny. Recent experimental evidence and neurobiological research seem to explain and validate these analytic experiences.

Bion, during supervision, was fond of asking, "Why can't this patient know what he knows?" Although he never asked this question in print, he did much original work concerning problems in thinking, which began to answer his question. In Bion's (1967) opinion, the mind requires the truth the way the body requires food, water, and air for proper growth and development. Lack of truth leads to stunted mental growth and, in the worst case, to death of the personality. This truth we all require refers to the truth about our emotional experience and the environment in which we live.

According to Bion (1962), we have raw experience that has to be processed mentally into ideas or building blocks which are suitable for mental work such as memory and dreaming. He called the raw sense data, beta elements; the mental transformational process, alpha process; and the sense data which could be thought about in dreams, alpha elements. He chose the Greek letters to preserve an unknown quality which could lead to a fuller understanding through investigation. Bion's idea was that the baby projected its raw experience into the mother who performed alpha

process, converting the beta elements into alpha elements which she could then give back to the baby, along with some of her capacity for performing alpha process. Bion called the mother's state of mind in which she performed alpha function "reverie." He described how the analyst can get into a similar state of mind by eschewing memory, desire, and premature knowing. Freud (1912) had described a similar state of mind when he talked about "evenly suspended attention" and the analyst's allowing himself or herself to be attuned to the patient like a telephone receiver.

I suggest that what brings our patients into analysis is that they are unable to "know what they need to know" about the truth of their emotional experience and their environment. As analysts, we believe that it is better to know, and we present that opinion to our patients who often disagree with us because it is too painful. Most patients, however, seem to stay with us in the analysis, which suggests that no matter how painful it is, some part of their personality does agree with us, perhaps because their current situation is even more painful. The situation is one in which one part of their personality wants us to understand their emotional experience and thus be able to tell them about it, while another, often stronger part of their personality is doing everything possible to prevent our understanding. Even more important, what the patient needs to communicate to us is generally not known consciously and therefore can only be communicated unconsciously. In order to receive the communication from the patient's unconscious we must use our unconscious. Once our unconscious has received the communication, we can process it and frame an interpretation, or use it in some other way that we think will be helpful to the patient.

In *Cogitations* Bion (1992) seems to imply that what he calls "dream state alpha" is occurring all the time, but it is not ordinarily available to us when we are awake. Nevertheless, it is possible for an analyst, if he or she can get into a good analytic state of mind, to be aware of his/her unconscious response to the patient, and it is this unconscious response which can get close to

the patient's truth. Gerard, Kupper, and Nguyen (1993) have nicely demonstrated that the clues we take in, which are processed by our unconscious, are subliminal, and in fact, often could not have been noticed consciously. This means that we may not be able to know how we know what our patient's unconscious has communicated to us. All we can do is to allow our minds to be open to our "awake dreams" during the session and trust that they are stimulated, at least in part, by our patient's unconscious communication.

Doucet (1992) and Jacobs (1991, 1994) have come close to what I have in mind, using their countertransference responses to do some self-analysis, and then to understand the patient. While some self-analysis is always valuable, I think it is time to consider our unconscious response as our most valuable tool in understanding the patient. Schust-Briat (1996) has written a beautiful paper on the use of her own imagery in understanding her patients. I would like now to extend that to the full range of our unconscious reactions to the patient.

In his book, *Dream Life*, Meltzer (1984) writes:

> From this point of view one might imagine that every attempt to formulate an interpretation of a patient's dream could imply the tacit preamble, "While listening to your dream I had a dream which in my emotional life would mean the following, which I will impart to you in the hope that it will throw some light on the meaning that your dream has for you" (p. 90).

This is something that I now try to do with all patients. I try to have "an awake dream." It is important to distinguish an awake dream from a dream we have while asleep. I am not suggesting that it is appropriate for an analyst to fall asleep during a session, although I have heard of instances where analysts have fallen asleep and have had dreams which clarified the session.

I will present some material, both personal and clinical, to convey something of the way I believe it is possible to use our unconscious understanding, perhaps better called our intuition, to understand our patients. What I hope to make clear is that we know

much more than we realize we know, perhaps more than we can bear to know.

In order to create the best possible conditions for having an awake dream or an unconscious reaction to the patient, I do my best to follow Freud in maintaining evenly suspended attention, and Bion in eschewing memory, desire, and reaching for premature understanding. In addition, I try never to respond or intervene until I have had a nonverbal response to the patient which feels as though it has come from my unconscious. To the extent that this can be achieved, it means acknowledging that I do not understand for long periods, but it seems to me that not understanding is better than misunderstanding or getting caught up in what is superficial or already known.

The first vignette is not clinical but comes from personal experience. One day my daughter came into my study and asked if she could talk to me about what was going on with her boyfriend. She talked for ten to fifteen minutes about all the things that were wrong with him and with the relationship: the difference in their religious backgrounds and how they would raise their children being among the major issues. I listened with my analyst's "third ear" to see if I could find something to add. I had already heard most of what she was telling me. Also, the words of a song kept obtruding. When she finished, she asked me what I thought. She was quite disappointed when I told her I had nothing to add. However, the obtruding song seemed to get louder in my head. I decided that it might be pertinent and would allow her to decide for herself. I told her that I didn't know what it meant, but I could not get the song out of my head. The words were the beginning of the song Sancho Panza sings in *Man of La Mancha*, when he is asked why he follows Don Quixote. He tries to come up with a logical reason but cannot. Finally he sings, "I *like* him. I *really* like him." My daughter broke out in laughter. The song captured her internal experience exactly. One part of her mind was asking why she went with her boyfriend while pointing out all the reasons why she should not. She, like Sancho Panza, was having a very difficult time explaining logically why she went with her boyfriend. All she

could say was "I *like* him. I *really* like him." And she was then able to tell me all the things she liked about him, especially how well they got along with each other and how nicely he treated her.

I have thought a lot about this experience. My daughter is a singer, and she and I have often listened to music together, including *Man of La Mancha,* which we both love. However, we had not talked about the show or the music from it for at least a year. Nevertheless, my unconscious mind had chosen a song which could shed some light on what she was trying to say. What is fascinating about the experience is that my first impulse was to try to rid my mind of the song, which I felt was interfering with my capacity to concentrate. It was not until later, when I could not get the song out of my mind, that it occurred to me that it might be some sort of unconscious commentary on what she was trying to tell me. In retrospect, neither she nor I could figure out how the communication was made. It was not in the overt meaning of the words. She was not conscious of what she wanted to tell me, and it came as a great surprise to both of us.

Because of the outcome and the very positive effect this experience has had on my relationship with my daughter, I am certain that my use of unconscious "understanding" could hardly have been better. But would it have been appropriate if she had been my analysand? In that case, I might have considered that the song in my head was an unconscious comment on what she was telling me, and I would have searched for confirmatory data. Then, if I got the confirmatory data, I might have made an interpretation.

On the other hand, if no confirmatory data emerged, should I have just waited and tried to do some self-analysis, or should I have gone into supervision for my countertransference? Certainly self-analysis is always in order and needs to be an ever-present part of our work. In this instance, the song in my mind led to no personal associations so that it seemed possible that it was mainly an unconscious comment about my daughter's communication. If one accepts this idea, then it follows that my unconscious mind knew more than I knew consciously, and also that my daughter's unconscious knew more than she knew. Normally, as analysts, we like

to take what we know and use it to frame an interpretation, but perhaps we are giving our analysands more than they want or need. I think what I gave my daughter was enough, in that it allowed her to decide if my "awake dream" was useful. She is certain that if my response had not conveyed understanding, she would have rejected it. I had no great confidence that it was pertinent and would certainly have accepted her opinion, whatever it was. We do not do any harm, in my opinion, as long as we do not insist that we are the sole possessor of the truth. A theoretical objection arises as to whether it is wise to divulge our own unconscious response to the analysand. This is an important question which I will take up later.

The next vignette, from clinical practice, and others to follow, while rarely found in print, are the kinds of experiences that analysts talk about privately. When a patient I have seen in analysis off and on for many years said one day that it was not right for her to continue calling me Dr. Marcus, I agreed with her and asked her what she would like to call me. She said she would like to call me by my first name but was not sure that I would approve. I said that whatever she called me would be fine with me. She expressed surprise and said that she had always thought of me as being very formal and needing to be called doctor. Now she could see that it was her problem, and it frightened her not to call me doctor. She was more comfortable with my imagined formality. She then asked what my friends called me. I told her that some call me Don and others call me Donald. She felt that she would like to call me by my first name and be friendly but did not feel able to do it yet. She felt that it was somehow not right. She then fell silent, and after a few moments I had a fantasy in which she was calling me "honey." After about five minutes of silence in which my fantasy became stronger, I suggested that perhaps she would prefer to call me something more familiar such as dear or darling. After a short pause she said, "I call my sons honey" in such a way that it was clear that it was "honey" that she would like to call me.

This vignette is particularly interesting to me because while in my fantasy I heard her calling me "honey," I was reluctant to use

the word because, as I imagined myself suggesting that she might want to call me honey, I felt quite anxious. I felt the intimacy would be too upsetting, so I chose "dear" and "darling" which to me, at that moment, sounded slightly less intimate, and enabled me to feel less anxious. The fact that she corrected me with a word I did not use, strongly suggests that I was not projecting into her. I am calling my experience a fantasy, but I am not sure it is an accurate term. The experience popped into my mind without warning. I heard my patient "speak" the word honey, but I also knew that she had not actually said it. I had an image of her face from the front, rather than from the side and rear as I see her when she is on the couch. It was not a hallucination, but an experience parallel to external reality, something like a dream except that I was awake and in touch with the experience of my patient's silence on the couch. Because of the accuracy of my perception, I am inclined to think of it as an example of projective identification used as nonverbal communication.

Many attempts have been made to study this process, usually under the rubric of countertransference. None, to my knowledge, have yet shed much light on the extraordinary sensitivity of one unconscious to the communication of another unconscious. Stern (1985) and other infant researchers have observed the extraordinary sensitivity that occurs between mothers and babies, and Gerard, Kupper, and Nguyen (1993) have demonstrated a possible mechanism in which subliminal stimuli are received and have powerful effects.

Countertransference, once something to be overcome, is now recognized as a very important tool in analytic work. I have come to believe that for me it is the best way to make emotional contact with all patients. It has become so important in my work that I am reluctant to use the term countertransference, preferring instead to describe my emotional reactions as precisely as possible. How much of my emotional reaction is idiosyncratic, that is, based on unresolved personal issues; how much is the reaction to the analysand's transference; and how much is a part of the enactment caused by the analysand's projective identification are all

open to exploration. I have come to believe that the analysand can be of great help in this exploration, and I actively seek it.

An example of the way I work follows: A woman was talking about her fear of allowing herself to feel the full extent of her loving feelings toward me. A lot of material came out which was well known to both of us, providing good reason for her to distrust me. There was, therefore, no reason for me to comment, but as she was talking, I noticed her right cheek (why at that moment, I do not know) and had the thought of touching her right cheek with my left cheek. It had a loving quality and seemed to pop up from my unconscious and was not related, as far as I could tell, to anything she was saying. In addition, I could not get the thought out of my mind. When she paused to await my response, I told her that I was having a response that I did not understand. I then told her of my persistent thought of putting my cheek next to hers and asked her if she could shed any light on it. She said, "You're weird," in a way that caused us both to laugh. After a while she said, "You are thinking of a kind of experience I always longed for with my mother but couldn't have because her illness caused her so much pain that even the slightest touch made her pull away." The rest of the session went in an entirely new direction and led to new understanding of her fear of her own strong feelings. She felt that she had hurt her mother and would hurt me if she expressed these feelings aloud with all the emotion of a little girl.

What is especially interesting about this vignette is that the patient was talking about her fear of me as a man who might take advantage of her sexually, but my unconscious picked up an entirely different message. While I had only the image of my cheek touching her cheek, it was enough to enable the patient to recall her deeper longing for physical closeness to her mother and her fear that I, as the mother in the transference, would become ill and pull away from her as her mother did. We were both curious about how my unconscious had correctly perceived her message, of which she was unaware until I was able to play it back to her. Nevertheless, neither of us could figure out how she had managed to make the communication.

Sometimes the communication of the patient's unconscious appears wordlessly and almost instantaneously. Many colleagues have told me stories similar to the following. A woman was sitting in my waiting room wearing a very attractive black and white jumpsuit with short pants. As she passed me to enter my consulting room, I had an image of her wearing a red dress which she had worn during a session in which she had told me of her emerging sexuality. I was surprised by the image but quickly put it out of my mind. Toward the middle of the session she told me of having a fantasy of jumping into my lap wearing a particular red dress (not the one she had worn before). In her fantasy she was not wearing shoes and was very uninhibited. As we explored further she recalled that she had dressed carefully that morning and had considered wearing her red dress but had decided against it.

While I have no conscious awareness of how I arrived at my image of her in a red dress, I can imagine how it happened. She was wearing an attractive outfit which I had not seen before, and she had thought about wearing a red dress. Short pants had a suggestion of sexuality about them, and I knew of her associations of sexuality with her red dress. My unconscious mind could have processed all this and dressed her in the red (sexual) dress. Still, it is impressive that my unconscious mind could receive and process so much information so quickly and with such accuracy. I am quite certain I could not have done it consciously.

Often our unconscious mind transforms the patient's message into physical sensations which we then need to interpret by giving the physical sensations verbal meaning. For example, a male analysand entered the office and quickly lay down on the couch after taking a look at my clock. He noted that he was on time and then began to make noises which I can only describe as moans. I said, "You sound as though you're in pain." He replied that he didn't want to come today. He often says that early in the session. He then became silent, as he often does. My usual experience of the silence is that I have been left alone. It is very peaceful and my mind wanders. I have no inclination to intervene, but I have learned from experience that if I wait too long, he feels terribly

abandoned. I use my emotional experience to give me the clues I need to formulate the interpretation. As I was paying careful attention to my experience on this occasion, I was aware of a sensation in my genitals which I labeled as mild sexual excitement. I tried to think about it from every angle I could. Was this my sexual response to this man? I had been seeing him for three years without having sexual feelings, so why on this occasion was I having sexual feelings? Was it a communication about his state of mind? The verbal content and his other productions gave few clues.

As the silence continued, I noticed that the sexual excitement did not increase in intensity but rather seemed to be subject to some type of suppression. I remembered that I had had a somewhat similar experience with a previous patient. She had been suppressing her sexual feelings because they terrified her. Did this tell me anything about my male patient? Was this some experience of mine which had little to do with either patient? I was convinced my experience with the woman came mainly from her because of the way the session evolved, and the associations and verbal confirmation. I wondered if my male patient might be conveying the idea of suppressed excitement other than sexual. As the silence continued, the sense of some sort of suppression of feeling became stronger and somewhat painful.

An intervention seemed to be called for, but what could I say? I wanted to be careful not to lead him on, and so I finally said, "I can't be sure, but it seems to me that something is being cut off." He responded immediately by saying "my dick." Then he added that he didn't know why he had said that. It had just popped into his mind, and it surprised him. Needless to say it surprised me, too. What then emerged was that he had enjoyed the previous day's session very much because he had expressed himself freely, saying things that his parents would never have permitted and that would, in fact, have made them very angry. In the transference he fully expected that I too would be angry with him for speaking his mind and having different opinions. "Cutting his dick off" was his way of stifling his aggression and making it possible to get along in his family. In the office with me he felt he needed to protect

himself from my anger (a pretense of castration to prevent the real thing at my hands). This session appeared to have great importance, but my interest here is trying to understand my emotional (and physical) experience which allowed me to begin to understand this patient.

When I have a physical or emotional reaction in the office, I have learned from experience that it is almost always connected to a communication that I am picking up from the analysand. The experience is mine, but it is influenced in some way by the analysand's communication. The analysand needs my help to interpret his or her communication. If the communication is so powerful that it has a disruptive effect on me, then I may have to do self-analysis first, or, failing that, get supervision. Usually, however, this is not necessary, and I use my experience to help me frame an interpretation, or at least present an opinion of what I think could be going on.

In the example above it should be noted that I was very tentative in saying "I can't be sure, but it seems to me that something is being cut off." The purpose of my interpretation was to let the patient know as much as I could of my experience in the room at that moment, in the hope that the patient could help me understand why I was having the experience I was having. In my view, my experience was an "analytic fact" and the only fact that I had. I did not insist that my experience had anything to do with my patient, but I have no doubt that he detected my belief that it did. The point is not whether I am correct but whether I am able to maintain a dialogue. I believe I pick up a communication from the patient, and I respond to this communication. If the patient can respond to my communication, we are well on our way to getting closer to the truth of the patient's experience. In this instance, my unconscious appeared to pick up much more than I knew. My comment suggests that I "knew" about the patient's castration fear although I had no conscious knowledge of it and, in fact, I tried to make a comment which would not contain an analytic theory but would leave the field as open as possible for the patient.

Often what we pick up unconsciously is of such a nature that we are hesitant to use it, especially if it is overtly sexual. A patient was silent. After a while she mentioned that when she was in the waiting room she wondered what she would talk about in the office. Her mind had wandered and she could not decide what to talk about. As she was talking my mind wandered to a television program in which there was a passionate love scene. I wondered why I thought of that particular love scene. After a while, as she remained silent, I had the image of my stroking her thigh as though I wished to arouse her from her lethargy. I was aware of wanting to help her get started but had no idea of why I had that particular image. As her silence continued I had the image of fondling her breast, again to arouse her. These were very quick images and disappeared quickly.

Soon a joke came to my mind about two girls: one said to the other that it's hard to be good. The other replied that it's got to be hard to be good. I wondered why *that* joke. I had not thought of it in years. It occurred to me that she might be silent as a way of not revealing sexual thoughts. I tried to pay careful attention to my bodily sensations but was quite certain that I was not having any sexual feelings. I did have the feeling that she needed something from me but I had no idea what.

Toward the middle of the session, which had been mostly silent, I said that I had the feeling that she needed something from me. She readily agreed and added that she thought that it was odd because in the previous session she had wanted me to wish her a happy birthday and I had done so. I suggested that perhaps it had not been enough. She agreed and added that it hadn't been enough because she couldn't be sure that I really meant it. Thinking of the passionate sex scene imagery, I said perhaps it was not said with enough passion. "No," she replied, "that's not it. The problem is you could still be pretending." Thinking of the two images, I said, "Perhaps you need me to touch you." She replied that that would be nice but she still couldn't be sure that I really cared. I asked what she thought would convince her? She didn't know, but at that moment I thought of the joke of the two girls.

She was silent and I was unable to push the joke out of my mind. Finally, toward the end of the session, after much internal debate, I said, "Perhaps you would need me to have an erection." She smiled and said, "I don't have any verbal reaction, but my body just relaxed so I'm sure that's right."

Her associations then went in a new direction as she recalled her early realization that she could not trust what her parents told her. Even actions could not be trusted. She could only depend on something out of conscious control, like an erection, which she felt expressed the truth. Unfortunately, her father had misused his erection when he tried to have sex with her when she was eleven. What she wanted was for me to have an erection while caring enough to control my impulses. This is an important issue with patients who have been sexually traumatized, and I will come back to it later. What I wish to call attention to here is how much my unconscious seemed to know early in the session. As part of my processing what I knew unconsciously, my unconscious came up with a number of associations which seemed to be different ways for understanding the stimuli to which I was exposed. I had no idea what the stimuli were, but I suspect they were too subtle to be observed consciously.

A somewhat similar vignette follows. During the course of a "good session," a young woman was able to express her feelings freely. I noticed her face, and she seemed very pleased. In my mind I heard her say "I love you." It felt like an interference, so I put it out of my mind. After another few minutes of silence I had an image of my patient getting up from the couch, coming over to me, and kissing me on the cheek. The image was very sharp and impossible to dismiss. After another minute or two I asked her what was going on in her mind. She said she did not want to tell me. I asked if there was some action she would like to take. She hesitated, making it clear that she was too embarrassed to tell me what it was. After a while she asked me what I thought. Rather than engage in a struggle, I told her that I had an image of her kissing me. She said "no," and then after a pause she added, "but I did have a fantasy of kissing you on the cheek." I replied that

that was what my image was. She then added that prior to that fantasy it had occurred to her to tell me that she loved me. In this instance I can understand that I had seen a lot in her face and had correctly interpreted it, but the exactness of my image and the words I heard I find to be quite fascinating. I am no longer startled, however, since I have come to believe that it is an aspect of what is called intuition. Intuitive understanding always presents the problem of which person is generating the feelings, and this is an especially sensitive matter when the feelings are sexual. An intervention based on intuition must be made with tact and an awareness that it could be saying more about the analyst than about the analysand.

Intuition is not limited to analysts. Our analysands are at least as perceptive as we and are often aware of what is going on in us despite our efforts to hide our feelings. Sometimes this sensitivity can be uncanny. One day my urologist called me to tell me that my PSA titre had risen sharply and that it was necessary to do a biopsy to rule out cancer of the prostate. I felt anxious, and it was still on my mind when I ushered in my next patient. She lay down and said, "Cancer. I don't know why that came to my mind. I had not been thinking about cancer." She associated to the word cancer for several minutes, but there seemed to be no link to her opening comment. I could not help wondering if she had correctly read the anxiety in my face and explained it to herself with the diagnosis cancer. I was reluctant to tell her anything about my state of mind lest I introduce something unnecessary, but it does seem to me that she was reading me very accurately. The next day she revealed that at the beginning of every session she carefully scrutinizes me, my face, and what I'm wearing, but usually says nothing to me because she fears it would hurt my feelings. This led to some productive analysis of her experiencing me as her father whose feelings were easily hurt. I wondered, however, if it might not have been more productive to let her know how accurate her intuitive reading of me had been.

The analysand's unconscious knowledge of the analyst often appears in dreams and can be quite uncanny. A colleague re-

ported a patient's dream in which the patient was living in a small house behind a larger house. As the patient described the property in the dream, the analyst was unnerved to note that the description matched his own property down to many small details. The patient gave no hint that she knew consciously about his home and the analyst chose not to inquire. Jacobs (1994) has reported the case of a young woman who intuited the day of the week that he met his supervisor, despite the fact that he had never given her that information. He suspected that on those days, knowing that he would be presenting process material, he was more alert, more tuned in, more engaged.

Patients often dream about the presence of a third person when a supervisor has had an effect on the analyst's work. This no longer surprises me. What was astonishing recently was for the analysand to note the presence of a supervisor and to describe the supervisor quite accurately in a dream. While the character of the supervisor could be ascertained from the change in the analyst's work style, it is beyond ordinary comprehension that the analysand could describe a supervisor's appearance. Of course, the analysand was consciously unaware of what she "knew," which could only appear in her dream.

A final vignette demonstrates how transference distortion can prevent an analysand from knowing what she knows when it is too frightening. A woman in the terminal phase of a successful analysis, having worked through a number of transference distortions, was perceiving me quite realistically. She remembered that she had in fact "known" what I was like early in our first meeting but had immediately become frightened. She was so frightened that she strongly considered choosing another analyst and even had a consultation with him before coming back to work with me. She was aware that the real qualities she observed in me—especially my openness to her experience—were what she needed, even though they terrified her. She quickly relieved her terror by the use of transference distortion. She was unable to know what she knew because it was too frightening, and she could not reclaim this knowledge until close to termination.

DISCUSSION

Informal discussions with colleagues lead me to believe that the experiences I have described are common and familiar to many practicing psychoanalysts. Some analysts have told me about experiences which are more startling and frightening than the ones I have described. What is intriguing is how little can be found in the literature. I suspect there is a general reluctance to write about what seems much too close to mysticism and is not explainable by science. Nevertheless, it is important that we, as scientists, accept the truth of our experience even though we may not be able to explain it. Some workers like Stern (1985), who have studied the mother-baby interaction, have been able to note complex communication back and forth by means of cues which are quite subtle. Trevarthen and Aitkin (1994) have reviewed the relevant literature on the mother-baby interaction from both the behavioral and neurobiological points of view. They make it clear that, unless there is a brain defect, we are all born with the neurological equipment for communicating very rapidly at a deep preverbal level.

In doing supervision, I have found that students often feel guilty about their powerful emotional reactions to analysands. They tend to think of their feelings, imagery, or fantasy as countertransference that needs to be dealt with by means of personal analysis. While this may be true, the analyst's feelings or dreams are always in some way in response to the analysand's communication and should be considered of great value in understanding the analysand. Boris (1994) says this well:

> The analyst is the medium in which the patient happens. It is the patient occurring within and upon him that provides him the data. It is necessary for the analyst to ignore the patient who is in his consulting room in favor of the patient who is happening at the very center of his own inner experience (p. 173).

Bion (1970) called the truth of an experience "O" and a person who could tolerate contact with "O" a mystic. Using Bion's

language, I am tempted to talk about the analyst's capacity to function as a mystic when he or she dares to receive the analysand's "O" and to remain in contact with it long enough to be able to put it into words. I suspect that we are all born with the capacity to become mystics, but in some babies it may be more necessary while in others "O" may be too terrifying. For those of us who become analysts, the need to understand our own truth must be very strong, particularly as it concerns the understanding of our primary caretakers, and we spend a lifetime working at it. Analytic institutes are not always friendly to students who see things in a new and original way, and I think the capacity to function as a mystic is often inhibited. Fortunately, the capacity can be recovered if it is encouraged by supervisors. What is feared is what was once called "wild" analysis, which was guided by the analyst's attempt to interpret according to known and established theory. The wildness which results from use of what one learns from one's unconscious understanding is exciting and surprising, and is guided by the analysand's communication. Neither party knows consciously where the dialogue will go, although the patient may know unconsciously. If Bion is correct, that the only thing worth noting in an analysis is what is unknown to both parties, we need to develop a theory which explains the kinds of experiences I have described. In this endeavor, psychobiologists may be of help.

Gerard, Kupper, and Nguyen (1993) demonstrated experimentally that subliminal stimuli which bypass conscious defenses affect our behavior. All of us are affected by subliminal or just barely liminal stimuli. Babies and their caretakers and analysand and analyst need to be open to such stimuli. The analytic state of mind of evenly suspended attention, or of eschewing memory and desire, promotes the taking in of subliminal stimuli. Holding too closely to a theoretical system and a therapeutic agenda tends to block the taking in of low-level stimuli. The important messages from our analysands are not conscious, meaning that they are often subliminal. The analyst must allow the subliminal message to reach the unconscious where it can be noted, processed, and

"dreamed." The analyst can then note the dream and use the dream to further the analytic work.

Mitrani (1995) has shed some light on why these important communications are subliminal. What needs to be communicated is unmentalized or raw experiences, what Bion calls beta particles and Bollas (1987) calls the unthought known. These have never been worked on by alpha process so they cannot be thought about and can only be communicated by projective identification and not by words. It is therefore only the analyst's unconscious mind which can receive the message, process it, and think (dream) about it. The analyst can then (with the analysand's help) try to understand the dream, which will clarify the analysand's message. Mitrani states that the raw experience that needs to be communicated is associated with terror, which the analyst must bear for the analysand until understanding can take place.

The analysand knows something he/she does not know he/she knows because it has no words or images, and therefore the analysand is unable to process it. According to Bion, this unknown known is a beta element suitable for projective identification. Analysts leave themselves open to perceive the projections by getting into the state of mind called reverie. This state lowers their defenses and allows the reception of subliminal stimuli as described by Gerard, Kupper, and Nguyen. It could well be that something like this goes on when one person correctly reads the unconscious of another. We may have a scientific explanation for what seems uncanny.

How much should the analyst reveal to the analysand about his or her emotional response? If I am correct, the analysand always knows, at some level, the truth of the analyst's emotional responses. This truth is generally not fully available as it is distorted by powerful transferential projections. Nevertheless, projections, to be effective, are made into some aspect of the truth which the patient knows. A good interpretation acknowledges the truth so that the transference distortion can be made clear. We often make interpretations in ways that either validate the patient's correct perceptions of us or inform the patient of how we feel without

directly acknowledging how we feel. We give the patient information, but since it is couched in the form of an interpretation, we believe we have not broken the analytic frame. Singer (1977) goes further when he notes that "analysts' interpretations are neither exclusively nor even primarily comments about their clients' deeper motivation, but first and foremost self-revealing remarks" (p. 183).

We do not wish to burden our analysands with information they do not need, but I believe there are times when patients do need to be sure that we have an emotional response to them and to know exactly what it is. One severely disturbed borderline patient was surprised and delighted to learn that she had a powerful disruptive effect on me since she seemed to have had little effect on her parents. Once she knew about her powerful effect on me, her need to disrupt my capacity to think diminished remarkably. Previous attempts to interpret her behavior had had little effect. She needed to know that she actually had a powerful effect on me and also that it did not destroy me.

The problem of self-disclosure has received much attention in the literature in recent years. Wachtel (1993) believes that "the particular requirements of a given patient at a given moment in the work must guide the therapist's choices" (p. 223). As quoted by Renik (1995), Aron, Ehrenberg, and Burke are in general agreement with Wachtel. Renik himself maintains that

> *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* (p. 479).

Renik suggests that we "discard the ideal of the anonymous analyst" (p. 494) and 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" (p. 485). I agree.

At certain times, with some patients, we may feel that an interpretation is required but we have only a feeling. By communicat-

ing what we feel, we may be giving the patient just enough to make contact with what is below the surface. This is what happened in the vignette of the man who responded that what was being cut off was his dick.

In his groundbreaking book, *Mapping the Mind*, Levin (1991) presents two vignettes which have much in common with those I have given. In the first vignette, he uses a strategy of verbalizing "such things as particular songs that might then be running through the analyst's head in response to what the analysand has just been saying." Levin called these "pump-priming associations" which seemed frequently to set off a rich tapestry of other associations (p. 52). In the second vignette he would hum a tune or sing words to remind the patient of some important feeling or associations (p. 53). Levin theorizes that repression is caused by a blockage of information from the right (emotional) cerebral hemisphere to the left (verbal) hemisphere, and disavowal is caused by a blockage of information going from the left to the right hemisphere. Psychoanalytic interpretations serve as bridges between two hemispheres, overcoming the blockage and undoing the repression or disavowal (p. 80).

Applying Levin's theories to the work I am presenting, I could say that the analysand knows some things in the right brain which cannot be communicated to the left brain because of repression, so the analysand cannot know in words what he or she knows in his or her right brain. The analyst, by means of reverie and intuition, listens with the right brain directly to the analysand's right brain. If the analyst does not need to repress the communication, it can then go to the analyst's left brain where it can be thought about in words and communicated to the analysand in the form of an interpretation. The interpretation can be understood in the left side of the analysand's brain, thus bridging and removing the repressive block in the analysand's mind.

Perhaps most troubling for the analyst is the analysand who was molested as a child and needs to enact or re-enact the childhood molestation in the transference in order to re-experience the trauma or perhaps to experience it for the first time. This is es-

sential so that it can be fully experienced and digested. In Bion's terms, the patient can have the experience that he or she could not have as a child and can now learn from it. In order for the patient to have the experience, the impulse to molest must be projected into the analyst who needs to have the desire to molest the patient. In the case of a woman with a male analyst, it means that the analyst must experience a desire to have sex with his patient, and the patient needs to know that the analyst has that desire, that is, that he actually contains the projection. The analyst makes his most powerful interpretation by demonstrating to the patient that he can contain the experience and not act it out. Once the patient is assured that the experience will remain in the realm of thought, she may become angry but will also feel safe, and it is then possible to think about and learn from the experience. Levin (1991) seems to make this point when he writes:

> It is also likely that the analysand learns as much from identifying with the analyst's methodology and mode of being as from the specific content of the analyst's interpretations (p. 82).

If I am correct, interpretations about the patient's wish to seduce the analyst, while partially correct, miss the main purpose, which is to re-enact a traumatic experience. In addition, the patient may get the idea that the analyst refuses to accept the projection of sexual desires because he or she is also afraid of them, and a crucial aspect of the analysis will be avoided. The analyst's lack of anxiety about sexual desires is reassuring to the patient who learns that sexual desires can be contained and thought about. I believe the analyst must acknowledge to the patient, in some way, that he or she is having a sexual response. Each analyst will do this in his or her own style. On the other hand, if the analyst receives the projection and has a sexual response but denies it or refuses to acknowledge what the patient can sense, the patient is prevented from having and making use of that analytic experience. If the analyst does not feel a sexual response, it probably means that anxiety is keeping the analyst too distant from the patient, and no real analysis will take place.

Finally, a few comments about the analyst's making public his or her private thoughts, fantasies, and feelings as I am doing in this paper. We are seeing more of it, but analysts mainly write about anger, hatred, and even murderous fantasies. Little can be found about the analyst's loving and sexual feelings. I doubt that the discrepancy is because the latter feelings are less frequent. Winer (1994) states that he will reveal his lustful feelings toward his patients only on his deathbed, if ever. While I agree that going public with one's feelings toward patients is risky and anxiety-provoking, I believe that it only reveals what is already well known, and I hope that others will share their experience long before they are on their deathbeds.

REFERENCES

BION, W. R. (1962). *Learning from Experience.* New York: Basic Books.

——— (1967). A theory of thinking. In *Second Thoughts: Selected Papers on Psycho-Analysis.* New York: Basic Books, pp. 110-119.

——— (1970). *Attention and Interpretation: A Scientific Approach to Insight in Psycho-Analysis and Groups.* New York: Basic Books.

——— (1992). *Cogitations.* London: Karnac Books.

BOLLAS, C. (1987). *The Shadow of the Object: Psychoanalysis of the Unthought Known.* New York: Columbia Univ. Press.

BORIS, H. N. (1994). *Envy.* Northvale, NJ/London: Aronson.

DOUCET, P. (1992). The analyst's transference imagery. *Int. J. Psychoanal.*, 73:647-659.

FREUD, S. (1912). Recommendations to physicians practising psycho-analysis. *S.E.*, 12.

GERARD, H. B., KUPPER, D. A. & NGUYEN, L. (1993). The causal link between depression and bulimia. In *Psychoanalytic Perspectives on Psychopathology*, ed. J. M. Masling & R. F. Bornstein. Washington DC: APA Books, pp. 225-252.

JACOBS, T. J. (1991). *The Use of the Self: Countertransference and Communication in the Analytic Situation.* Madison, CT: Int. Univ. Press.

——— (1994). Nonverbal communications: some reflections on their role in the psychoanalytic process and psychoanalytic education. *J. Amer. Psychoanal. Assn.*, 42:741-762.

LEVIN, F. M. (1991). *Mapping the Mind: The Intersection of Psychoanalysis and Neuroscience.* Hillsdale, NJ/London: Analytic Press.

MELTZER, D. (1984). *Dream Life: A Re-Examination of the Psycho-Analytical Theory and Technique.* Perthshire, Scotland: Clunie Press.

MITRANI, J. L. (1995). Toward an understanding of unmentalized experience. *Psychoanal. Q.*, 64:68-112.

RENIK, O. (1995). The ideal of the anonymous analyst and the problem of self-disclosure. *Psychoanal. Q.*, 64:466-495.

SCHUST-BRIAT, G. (1996). "Fertile eyes": considerations on visual phenomena in the analyst's mind at work. *Psychoanal. Inquiry*, 16:376-389.

SINGER, E. (1977). The fiction of analytic anonymity. In *The Human Dimension in Psychoanalysis*, ed. K. A. Frank. New York: Grune & Stratton, pp. 181-192.

STERN, D. N. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

TREVARTHEN, C. & AITKEN, K. J. (1994). Brain development, infant communication and empathy disorders: intrinsic factors in child mental health. *Development and Psychopathology*, 6:599-635.

WACHTEL, P. L. (1993). *Therapeutic Communication: Principles and Effective Practice*. New York: Guilford.

WINER, R. (1994). *Close Encounters: A Relational View of the Therapeutic Process*. Northvale, NJ: Aronson.

9735 Wilshire Blvd., Ste. 445
Beverly Hills, CA 90212

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Interpretation as Comparison

David L. Raphling

To cite this article: David L. Raphling (1997) Interpretation as Comparison, The Psychoanalytic Quarterly, 66:2, 242-258, DOI: 10.1080/21674086.1997.11927533

To link to this article: https://doi.org/10.1080/21674086.1997.11927533

Psychoanalytic Quarterly, LXVI, 1997

INTERPRETATION AS COMPARISON

BY DAVID L. RAPHLING, M.D.

Analytic subjectivity may not be the problem it seems. What is crucial for patients is not that analysts possess the objective truth, but that patients see a truth for themselves. How they accomplish this may depend on the analyst's showing them a view of themselves that differs from their own and can be compared to it. Each aspect of experience is defined by its relation to another reference point. I propose that the interpretive process is a medium for knowing one's mind in relation to that of another. This has implications for issues of analytic authority and autonomy.

Contemporary psychoanalysts have come to appreciate the highly subjective nature of psychoanalytic interaction as compared with our earlier, idealized view of analysis as rooted in scientific objectivity. We have begun to assess the impact of subjectivity on the understanding of patients (Renik, 1993) and to question the analyst's authoritative stance as an external observer and scientific interpreter of the patient's intrapsychic world. Recognition of the mutual engagement of patient and analyst in the vicissitudes of transference and resistance has made it imperative that the inherent subjectivity of the psychoanalyst's work be acknowledged and researched.

Much of contemporary analytic theory has been directed, wisely and profitably, toward elucidating the mutual influences in the interaction of analyst and patient psychologies (Hoffman, 1991; Jacobs, 1991; McLaughlin, 1981; Tansey and Burke, 1989). In the ordinary analytic encounter, the analyst's idiosyncratic transference disposition makes his or her view of the patient a subjective one. In addition, when analysts are most affectively engaged in the analytic process, they are subjected to enormous pressures from

their patients, whose wishes to transform them directly influence analysts' ways of perceiving, thinking, feeling, and acting. Both the analyst's transferences and countertransferences contribute to a highly personal understanding of the patient and to an ad hoc application of a standard theory and technique.

For practical purposes, there are some objective measures of meaning by which analysts may scrutinize their unique responses to and understanding of a patient's material. These measures, articulated by Arlow (1979), are a reasonable basis for a more positivistic and scientific validation of the admittedly subjective interpretations of analytic data. Formal criteria such as continuity, contiguity, and repetition of themes, for example, can be applied to a patient's material. The analyst compares these objective clues with data made subjective by her or his theoretical, technical, and personal biases, as one means of testing interpretive hypotheses.

The analyst attempts to interpret from within the patient's perspective. What he or she presents to the patient, however, is ultimately the analyst's own point of view. The analyst's perspective, though subjective, may be considered a valid counterpoint to or alternative version of the patient's experience. The analyst can be likened to a translator of the patient's material. And, like the translator of a piece of literature, the analyst should be more or less faithful to the text. The ease with which a translator may betray a text, reflected in the similarity between the Italian word for translator (*traduttore*) and that for traitor (*traditore*), also characterizes the psychoanalyst's interpretive work.

The analyst's subjective view of reality may not be the problem it appears at first glance, because what is crucial for the patient is not that the analyst possess the objective truth, but that the patient see a truth for him/herself. How patients accomplish this may depend on their being shown by the analyst's interpretation a view of themselves that differs from their own. One important aspect of the analyst's interpretation of the patient's experience is that it differs from the patient's own interpretation. Even if an analyst's external perspective is considerably influenced by a patient's transference and projective identifications, the analyst's view is

ultimately his or her own, by virtue of compromises between his or her personal and analytic motivations and that which is activated by the patient.[1] Patients are offered an opportunity to see themselves revealed by the details of how the analyst's externally derived interpretation differs from their own inward experience. These differences need to emerge from an analytic inquiry in which the analyst is as empathically attuned as possible to the immediacy of the patient's experience.

The analytic situation brings two separate subjective experiences into mutual interaction over a long period of time. This may limit the power of subjectivity over both participants, since their interaction provides ample opportunity for each to compare subjective experience with the other's perception of it. One individual's verbal and nonverbal reactions to the other can create a check and balance to the subjectivity of both.

What is problematic about one's subjective experience is that it is too easy for an individual to believe it to be the only true reality. Britten (1995) has recently proposed that belief is what makes a psychic reality seem real, although he defines psychic reality not as a combination of internal fantasy and external influences (Arlow, 1969), but as a strictly inner reality in contrast to external objective reality. When an individual is convinced of the *reality* of psychic reality, significant new insights and other realities become difficult to assimilate. A pervasive and formidable obstacle to insight and learning for a patient is the extent and tenacity of investment in her or his own world-view and self experience. It is a narcissistic defense that protects the patient from challenges to a familiar and stable sense of existence in the world. The analytic interchange threatens patients while simultaneously offering them an opportunity to learn something about themselves. The challenge offered by the analyst's interpretive view and analytic stance is unlike mirroring (Kohut, 1977). It addresses "a universal and apparently ineradicable tendency in human beings to overvalue their own beliefs and to resist giving up a favored viewpoint"

[1] See Sandler (1976) on role-responsiveness.

(Rubovits-Seitz, 1992, p. 146), especially if doing so creates dysphoric affect and psychic disequilibrium. This tendency applies not only to the analyst's interpretive activity, referred to by Rubovits-Seitz, but to patients' interpretive view of themselves and of the analyst as well. Psychoanalytic treatment enables patients to examine the beliefs that make their transference/resistance-based version of reality seem to them *the* reality.

Psychoanalysis is an interactive process that creates a dialectic between the belief in a reality held by the analyst and one held by the patient. The dialectic is a special instance of a more universal "process in which each of two opposing concepts creates, informs, preserves and negates the other, each standing in a dynamic (ever changing) relationship with the other" (Ogden, 1986, p. 208). In her paper on the philosophy of mind, Cavell (1988) suggests "that dialogue requires acknowledging that the other has beliefs and desires that require interpretation, since they do not necessarily agree or harmonize with one's own" (p. 877). The psychoanalytic process confronts each party with the immediacy of the other's version of reality. The superordinate goal of analysis—to know one's own mind—can be achieved only in relation to the mind of another, since "only a person who is or has been in communication with at least one other creature can know his or her own mind" (*ibid.*).

Thus, self-knowledge obtained in isolation is limited by the absence of a frame of reference. Patients' interactions with the analyst, whose view of them cannot exactly match their own self concept, tend to diminish the effects of solipsism on their thinking. Communication between two individuals explicitly acknowledges that each has differences with the other. It is one's recognition of these differences that contributes to an appreciation of another individual as separate and unique. I believe this is a key to understanding how the psychoanalytic interpretive process leads to insight, learning about oneself, and eventual autonomy.

The analyst's consistent verbal interpretations of, and continuing affective and nonverbal responses to, patients' experience and beliefs present an emotionally and cognitively relevant counter-

point that heightens patients' awareness and provides them with a sustained and emotionally intense contrast to their own sense of reality and inner experience. This contrast as it is manifested in the powerful vicissitudes of transference and resistance, illuminates patients' self experience. The process may lead ultimately to self-reflection based on transient identifications with the analyst's observing ego (Friedman, 1992; Sterba, 1934), but inevitably begins with, and reverts to, attention to the experience of differences between analyst and patient.

Structuralist literary theory (Lévi-Strauss, 1966) provides a concept suggesting that ideas or images and, by extension, affective experiences acquire meaning only in relation to one another. An idea, image, or experience, then, is as much defined by what it is not (some other idea, image, or experience) as by what it is (Eagleton, 1983), since "an element which had no different relation to any other would remain invisible" (p. 103). This is even more pertinent to the psychoanalytic process where thinking involves either an inner or an outer interlocutor, or both, acting as a foil to provide contrast and thereby defining meaning. One's own voice seems always addressed to another presence, an external responsive person with a mind of his or her own, or possibly to an image existing in fantasy. Meaning is thus determined within a dialogic context (Bakhtin, 1981).

Comparisons and contrasts between patients' and analysts' senses of reality arise out of the verbal and nonverbal, cognitive and affective, experience of two different minds in an interactive dialectical process. The articulation of differing psychic realities heightens each one's "reflective self image" (Schafer, 1968) and self-awareness. The analytic process provides a patient with a sustained and emotionally intense contrast to her or his own sense of reality and inner experience. This contrast, as it is manifested in the powerful vicissitudes of transference and resistance, illuminates the patient's self experience.

Knowledge of the world, especially of one's own inner world, is categorized by and dependent upon frames of reference. Phenomena are distinguished by comparison with other phenomena.

Each aspect of reality is defined by its relation to another. A phenomenon becomes what it is by comparison to what it is not. The psychoanalytic situation and process become the media for an exchange of views from the vantage of each party. These comparisons of aspects of one reality with another have the effect of objectifying each individual's experience by giving it an external frame of reference from which it can take its measure. We begin to see ourselves as others see us. Knowing one's mind in relation to another person's apprehension or knowledge seems a valuable way of knowing. The differences in psychic reality and point of view between the two parties engaged in a psychoanalytic process appear to be more powerful in defining each individual than any point of view that they share.

Clinical Illustration

The following is an illustration of a patient processing an analytic interpretation. This interpretation was a hypothesis about the patient that had been offered previously in various contexts as the analysis progressed, but had not seemed to her to accord with her conscious experience. I conjectured that she desired power over men, including me. That she attempted to wield power over men, especially power expressed by feminine seductiveness, had become evident to her over the course of her two years in analysis. Her experience, however, was not that she desired power over men, but that she needed power to protect herself from being vulnerable to them.

The most obvious (and for me, tedious) expression of my patient's wish for power and control was her habitual tardiness to sessions, accompanied by profuse and abject apologies. She was also frequently absent-minded about paying her bill on time. Her unconscious motives were revealed most vividly in a session when she brought me her payment after days of intending to pay, but forgetting to do so. She handed me the check and thanked me. When I inquired about why she was thanking me for paying me money, she replied that it did seem odd, but she guessed she was

thanking me for not being angry with her. I asked what she thought about my being angry with her. She responded, "I don't want to embarrass you by your having to accept what I do to you. I breeze in here late and force you to deal with my lateness. But it really bothers me that by not paying you on time, I could put you in a real detrimental position—that you could be short of cash and need the money."

I said, "You mean that you really could hurt me? It sounds like you are concerned that your actions could affect me in very specific ways you have already imagined." She replied, "But you're the one with the power here. Oh, there must be something to this, though, I feel sweaty and anxious all of a sudden. You believe what I'm really afraid of is that I could be attractive to you. But, I've got to use all my power to protect myself from you. I don't want to be attached to you." I commented, "It must feel more acceptable to you to use your power in self-defense, since it bothers you to think that you could use it to hurt me for any other reason." She replied, "I feel I'm grappling with things that aren't really the way I say they are. I'm listening to what I've been saying, and listening for other possible meanings. It's unsettling. I felt this yesterday at work. My view was challenged by B and A who have different ideas about the project. I feel anxious when it's someone I respect who also has some authority, like B. B has the authoritative voice in the organization, but for some reason she seems so put upon by my voice. I'm very alert to others' perceptions. It matters to me a lot to sense where other people are coming from compared to my own perceptions. To be open to others' perceptions, you have to have a certain fluidity and a sensitivity to another point of view. This sounds like such crap. I should take seriously what you say, but I can't be timid when I disagree."

Discussion: Subjectivity and Analytic Authority

I arrived at the content as well as the timing and tone of my interpretation of my patient's tardiness as an expression of her aggression toward me, as a consequence of my cognitive and af-

fective responses to current and previous material. I simply inferred that she felt the need to thank me for not being angry with her, because she felt guilty about a wish she assumed would anger me. This inference was also prompted by the background of my awareness of annoyance at her for frustrating me in this way from the beginning of the analysis.

My patient's fantasy of having the power to affect my finances adversely was consciously experienced and expressed by her as concern for me. My interpretation directed her attention to her not having had to be concerned about me in the first place if she hadn't thought up a way to harm me. Her response, "But you're the one with the power here," was an attempt to convince us that I can take care of myself, that she couldn't hurt me, and if she did, it would only be in self-defense. Her attempt to deflect the truth of the interpretation, however, was not sufficient to protect her from the anxiety it had evoked in her.

My interpretation included something of which my patient was herself unaware so that she could not help but experience it as challenging her sense of herself. The difference between a patient's and an analyst's view most affects a patient when the analyst's view threatens to provoke unpleasure or other distressing affect. At certain moments the difference between them produces in the patient a disturbing disequilibrium which, while provoking defensive reactions, also allows the patient to see herself in a new light. This opportunity is maximized when analytic interpretation makes explicit the specific connections between the patient's experience and the analyst's discrepant view of it (Renik, 1995). Interpretation, as a cognitive and relational link between disparate experiences of analyst and patient, offers a patient the opportunity to take a novel idea, self-image, or role relation, and try it on for size (L. Friedman, personal communication).

My patient was caught between allegiance to her own conscious convictions and a receptivity to another point of view, something taken on my authority which was not so immediately available to her awareness. The clinical material proceeded to convey a tension between the patient's disposition to experience my interpre-

tation as an authoritarian pronouncement and her potential for viewing it as an alternative explanation, related to her own experience.

An interpretation, I believe, can be rendered less authoritarian by including in its content, as I did, the evidence from the patient's material upon which it is based. More specifically, the analyst can make clear how the patient's own interpretation may exist in tandem with certain of her fantasies which have become the basis for the analyst's interpretive conjecture while remaining outside of the patient's awareness. I attempted to do this by relating the particulars of my interpretation about the patient's aggressive motives to what she had already stated in her fantasy. Making this comparison is the essence of teaching analysands to observe their own intrapsychic function (Gray, 1973, 1982).

The issue of the relative subjectivities of patient and analyst is interwoven with concerns about authority, expectation, and influence. The analyst's interpretation should not be imposed upon the patient, but juxtaposed for the sake of helping the patient define herself through contrasting views.

The analyst's view of reality is not so much imposed on the patient in an effectively conducted analysis as it is held up for comparison with the patient's own view of reality. This does not mean, however, that there is no difference between appreciating the plausibility of another point of view and necessarily agreeing with it (Leary, 1994). An analytic interpretation is an empathically timed and tactfully stated assessment of the patient's mind at a given moment. It differs from the patient's interpretation of his/her own mind at that moment, not only because it is an externally derived subjective approximation of the patient's mind, but because it is also a statement of something that the patient is unable to perceive about him/herself (Bibring, 1954). As such, the analyst's interpretation is the statement of an authority whose difference from the patient's interpretations disturbs the patient because it *is* a difference. Analysts realistically claim authority for their interpretations on the basis of their clinical knowledge and experience, their expert general understanding of mental func-

tioning, their professional role (Almond, 1995), and their disciplined ability to scrutinize their subjective responses (even if only after the fact) by virtue of their training, personal analysis, and continuing self-analysis.

The analyst's interpretation inherently challenges patients' own sense of authority and threatens to compromise their autonomy—their sense of having a mind of their own. A patient's transference disposition may, however, exaggerate the degree of interpretive authority the analyst has already implicitly claimed for him/herself. Although the analyst's authority is not absolute it does provide a contrast to the patient's authority. The patient's conflicted reactions to the authority of the analyst should prompt analysis of the transference and resistance needs either to defy or to submit to the analyst's authority. Analysis of the patient's distortions of the analyst's legitimate and reasonable authority is, in fact, a most crucial and mutative aspect of exploring comparisons between analyst's and patient's points of view.

Goldberg (1987, 1994), addressing himself to implicit issues of authority in the interpretive process, has developed the notion that the correctness of an interpretation is the result of an accord reached by negotiation between analyst and patient, wherein they create a shared meaning. Although this sharing of a perspective may occur eventually as a result of the interpretive process, the analyst's admittedly biased interpretations are more immediately a foil for the patient's own subjective interpretations. Their differences encourage the use of the patient's powers of self-observation as a necessary prelude to ultimate consensus on interpretive meaning.

In the analytic situation, most of what represents each individual's view of the other is a consequence of the dynamic interweaving of current experience with long-established transference dispositions. While the analyst-patient interaction occurs in the present moment, the raw materials out of which it is crafted have been around for a long time before the analytic couple ever got together. Enduring genetic determinants from all of a patient's developmental history influence the present moment through un-

conscious fantasy (Arlow, 1969) expressed as the intrapsychic basis for transference and resistance responses to the analyst and the analytic situation. This applies to the analyst as well, though tempered by virtue of an expertise that results from analytic self-knowledge.

To a certain extent, the type of analytic interaction that takes shape—its here-and-now manifestations—will be unique to a specific analytic pair, though its fundamental characteristics would likely be discovered over time to be the same as those present in any other dyad. In the course of analysis each individual, to a greater or lesser extent, chooses to react to characteristics of the other in accordance with an inner template that has been organized by and reflects the developmental history of innate drive propensities and ego and superego dispositions. This is not to say, however, that there is no novelty in the analytic process. If so, transference and resistance could not be modified and therapeutic action and change could not possibly occur.

Patients' insight into the nature of their transference-influenced version of reality arises out of their experience compared to that conveyed by the analyst. Patients' experience is, however, uniquely their own, an intrapsychic developmental organization producing certain transference predispositions that are merely activated by the analyst's participation in the process. The independent autonomous intrapsychic phenomena that become known to analyst and patient through the interactive process are not wholly created by that process. The patient's and analyst's psychologies seem to be a priori determinants of an analytic interaction that becomes known and interpreted in the context of the analyst's and patient's contrasting versions of the patient's mind. Transference and resistance manifestations of the inner life of a patient join the responses of the analyst to them to produce an analytic developmental experience. The patient brings a potent and influential intrapsychic organization to bear on the analyst, whose responses, in turn, will determine to some extent its expression in the analytic setting. There would be no hope of analytic or therapeutic change otherwise. The analyst and

the analytic process do not create a patient's inner experience, but they certainly influence it through interpretation and the medium of interaction.

Concordance, Discordance, and Autonomy

The tendency of analyst and patient to assert their individual differences contrasts with their concomitant desire for concordance, for mutual validation and affirmation of each individual's point of view. Though each party is inclined to seek the other's confirmation of his or her own version of reality as veridical, their individual sensitivities to self experience are actually heightened by the perception of their differences. Both analyst and patient desire accord at some level. Nevertheless, their aims often diverge as a result of powerful resistances that may paradoxically include just those transference-based strivings for concordance. Although concordance between analyst and patient would be most immediately gratifying to both, disjunctive events in the psychoanalytic process are what stimulate self-awareness. Greenberg (1995) has noted: "Just as moments of concordance mask the occurrence of interactions and even of events, moments of discordance highlight them" (p. 17) and, "It appears that the act of interpretation itself requires some degree of discordance in the analytic dyad. . . . The need to interpret and the act of interpretation itself grow out of moments of personal discordance between analyst and analysand" (p. 20).

Patients will attempt to modify in their own minds the analyst's interpretive frame of reference to conform with their own defensive and wishful expectations. Patients desire confirmation and affirmation of their view—and not exception to it. They attempt to make an analyst's alternative view accord with their own, often by mishearing, or otherwise distorting the analyst's interpretation. This applies to patients' perceptions of the analyst's attitude toward them, as well as to the factual content of the interpretation.

The patient's need for correspondence, however, interferes with learning and eventual autonomy from the analyst's influence.

Although an optimal degree of correspondence between analyst and patient is necessary for a viable analytic process, its agreeable mutuality conceals those areas of difference and disagreement that effectively define an individual. For example, a patient's transference can be reciprocated by a similar countertransference, based on shared fantasies (Blum, 1986, 1988), with the possibility of obscuring the patient's transference. In a global sense, analysts' and patients' personality traits and transference dispositions can be so similar that the analyst's understanding of the patient is compromised.

The concept of the therapeutic alliance (Greenson, 1967; Zetzel, 1970) has contributed to a cultivation of congenial agreement between analyst and patient at the expense of analyzing their significant differences. Stein's (1981) discussion of the unobjectionable transference alerts analysts to how aspects of the therapeutic alliance can be used as a vehicle of resistance.

In analytic treatment there is a tension between the desire to reach a consensual view of reality and the need to respect and learn from differences in constructions of reality. Analysis of the patient's and analyst's conflictual wishes to reach an accord or to maintain a disjunctive state between them is a major aspect of the therapeutic process. There is an enormous amount of conflict associated with these contrary tendencies. Strivings for a state of unity and merger, which evokes archaic experiences and reverberates throughout development as wishes for accord and valued shared experience, are opposed by equally powerful needs to maintain separateness, individuation, and autonomy. The transference and resistance aspects of this struggle are heightened by the central importance of interpretation to the analytic process. The epistemologic problem of relative objectivity or subjectivity of interpretation is precisely this issue.

Both the wish to reach an accord with the analyst and the need to differ are nearly always operative in the search for meaning in the analytic process and, as a result, contribute significantly to establishing that meaning. In the clinical situation, epistemology and the fallibility of interpretation (Cooper, 1993) are interwoven

with patients' concerns about the developmental polarities that reflect aspects of concord and discord: independence/dependence, attachment/separation, passivity/activity, phallic/castrated, dominance/submission, and masculinity/femininity.

These currents in analytic treatment appear to run counter to each other, but together actually contribute to the therapeutic effect of analysis. The patient's susceptibility to the analyst's authority and the conditioning effect of analytic influence (Raphling, 1995) can be balanced by that aspect of analytic intervention (e.g., interpretation of resistances) which characteristically accentuates the discordance between analyst and patient, and optimally promotes autonomy as well as the patient's confidence in her or his own authority. This opportunity does not come without anxiety for the patient who anticipates losing the support and affirmation of the other as the price of independence and autonomy.

The immediate experience of resistance by both patient and analyst, in contrast to resistance as an abstract concept (Raphling, 1995), is based on the difference between a patient's current state and the analyst's expectations of the patient at that moment. This interface between analyst and patient contrasts the patient's transference and resistance expectations of the analyst, with reciprocal expectations of the patient by the analyst. Experience of a dialectic is created by the differences in analysts' and patients' expectations of each other. The difference in each analytic party's expectations of the other is perhaps the most informative experience by which a patient delineates a sense of self and learns of the powerful unconscious intrapsychic forces that shape self experience.

Olinick (1993, 1996) describes his important insight into the experiential essence of transference and resistance as essentially agonistic. While Olinick (1993) acknowledges psychoanalysis as "a causal, rational theory of therapy, in practice it includes tension, struggle, and oppositionalism" (p. 314). The contrast between the analyst's expectations and those of the patient throws the patient's self experience into bold relief. The analysis of transference and resistance is, at its most fundamental level, the analysis of contending passionate desires of analyst and patient (Friedman, 1988).

Articulation of the differences between a patient's self-appraisal and an analyst's understanding of the patient occurs not only as a result of explicit analytic interpretation, but is an intrinsic experiential consequence of the agonal nature of the transference and resistance. There is a tension inherent in the analytic process, generated between a patient's transference and resistance demands and expectations of the analyst, and the analyst's response to them. This tension is complemented by reciprocal demands and expectations of the patient made by the analytic method and situation, colored by the analyst's own more or less mastered transference and resistance dispositions. These mutual struggles between analyst and patient become the data upon which explicit psychoanalytic interpretations are formulated, and in addition, are themselves an aspect of what Chused (1996) has called "informative experience." The patient's experience of the analyst's experience of the patient is obtained most vividly from the analyst's interpretations, but not insignificantly through the nonverbal exchange of informative experiences. What makes these agonal experiences informative is that they reveal, actually highlight in action, differences between analyst and patient that make each one's individuality more distinct and autonomous.

Without comparison to the other possibilities and potentialities raised by the analyst's expectations and differing assessment of the patient, the patient's experience would be seamless and ego syntonic. The patient's struggle with the analyst's external view of the former's inner experience defines that inner experience in a novel way that constitutes a learning process. The analytic situation and process distinguish and highlight for the patient the expression of her or his unique characteristics by their contrast with those of the analyst.

REFERENCES

ALMOND, R. (1995). The analytic role: a mediating influence in the interplay of transference and countertransference. *J. Amer. Psychoanal. Assn.*, 43:469-494.

ARLOW, J. A. (1969). Fantasy, memory, and reality testing. *Psychoanal. Q.*, 38:28-51.

——— (1979). The genesis of interpretation. *J. Amer. Psychoanal. Assn.*, Suppl., 27:193-206.

BAKHTIN, M. M. (1981). *The Dialogic Imagination.* Translated by C. Emerson & M. Holquist. Austin: Univ. of Texas Press.

BIBRING, E. (1954). Psychoanalysis and the dynamic psychotherapies. *J. Amer. Psychoanal. Assn.*, 2:745-770.

BLUM, H. P. (1986). Psychoanalytic studies and *Macbeth:* shared fantasy and reciprocal identification. *Psychoanal. Study Child*, 41:585-599.

——— (1988). Shared fantasy and reciprocal identification, and their role in gender disorders. In *Fantasy, Myth and Reality: Essays in Honor of Jacob A. Arlow, M.D.*, ed. H. P. Blum, M.D., Y. Kramer, M.D., A. K. Richards, Ed. D. & A. D. Richards, M.D. Madison, CT: Int. Univ. Press, pp. 323-338.

BRITTEN, R. (1995). Psychic reality and unconscious belief. *Int. J. Psychoanal.*, 76:19-23.

CAVELL, M. (1988). Interpretation, psychoanalysis, and the philosophy of mind. *J. Amer. Psychoanal. Assn.*, 36:859-879.

CHUSED, J. F. (1996). The therapeutic action of psychoanalysis: abstinence and informative experiences. *J. Amer. Psychoanal. Assn.*, 44:1047-1071.

COOPER, S. H. (1993). Interpretive fallibility and the psychoanalytic dialogue. *J. Amer. Psychoanal. Assn.*, 41:95-126.

EAGLETON, T. (1983). *Literary Theory: An Introduction.* Minneapolis: Univ. of Minnesota Press.

FRIEDMAN, L. (1988). *The Anatomy of Psychotherapy.* Hillsdale, NJ: Analytic Press.

——— (1992). How and why do patients become more objective? Sterba compared with Strachey. *Psychoanal. Q.*, 61:1-17.

GOLDBERG, A. (1987). Psychoanalysis and negotiation. *Psychoanal. Q.*, 56:109-129.

——— (1994). Farewell to the objective analyst. *Int. J. Psychoanal.*, 75:21-30.

GRAY, P. (1973). Psychoanalytic technique and the ego's capacity for viewing intrapsychic activity. *J. Amer. Psychoanal. Assn.*, 21:474-494.

——— (1982). "Developmental lag" in the evolution of technique for psychoanalysis of neurotic conflict. *J. Amer. Psychoanal. Assn.*, 30:621-655.

GREENBERG, J. (1995). Psychoanalytic technique and the interactive matrix. *Psychoanal. Q.*, 64:1-22.

GREENSON, R. R. (1967). *The Technique and Practice of Psychoanalysis, Vol. 1.* New York: Int. Univ. Press.

HOFFMAN, I. Z. (1991). Discussion: toward a social-constructivist view of the psychoanalytic situation. *Psychoanal. Dialogues*, 1:74-105.

JACOBS, T. J. (1991). *The Use of Self: Countertransference and Communication in the Analytic Situation.* Madison, CT: Int. Univ. Press.

KOHUT, H. (1977). *The Restoration of the Self.* New York: Int. Univ. Press.

LEARY, K. (1994). Psychoanalytic "problems" and postmodern "solutions." *Psychoanal. Q.*, 63:433-465.

LÉVI-STRAUSS, C. (1966). *The Savage Mind.* Chicago: Univ. of Chicago Press.

McLaughlin, J. T. (1981). Transference, psychic reality, and countertransference. *Psychoanal. Q.*, 50:639-664.

Ogden, T. H. (1986). *The Matrix of the Mind: Object Relations and the Psychoanalytic Dialogue.* Northvale, NJ/London: Aronson.

Olinick, S. L. (1993). Structural actualities of the transference and their effects on the analyst's functions. *Psychoanal. Inquiry*, 13:310-325.

——— (1996). An aspect of transference: the struggle to become an analysand. *J. Amer. Psychoanal. Assn.*, 44:475-489.

Raphling, D. L. (1995). Interpretation and expectation: the anxiety of influence. *J. Amer. Psychoanal. Assn.*, 43:95-111.

Renik, O. (1993). Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanal. Q.*, 62:553-571.

——— (1995). The ideal of the anonymous analyst and the problem of self-disclosure. *Psychoanal. Q.*, 64:466-495.

Rubovits-Seitz, P. (1992). Interpretive methodology: some problems, limitations, and remedial strategies. *J. Amer. Psychoanal. Assn.*, 40:139-168.

Sandler, J. (1976). Countertransference and role-responsiveness. *Int. Rev. Psychoanal.*, 3:43-48.

Schafer, R. (1968). *Aspects of Internalization.* New York: Int. Univ. Press.

Stein, M. H. (1981). The unobjectionable part of the transference. *J. Amer. Psychoanal. Assn.*, 29:869-892.

Sterba, R. (1934). The fate of the ego in analytic therapy. *Int. J. Psychoanal.*, 15:117-126.

Tansey, M. J. & Burke, W. F. (1989). *Understanding Countertransference: From Projective Identification to Empathy.* Hillsdale, NJ: Analytic Press.

Zetzel, E. R. (1970). *The Capacity for Emotional Growth.* New York: Int. Univ. Press.

5225 Connecticut Ave., N.W.
Washington, DC 20015

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: http://www.tandfonline.com/loi/upaq20

Beyond Empathy: Confronting Certain Complexities in Self Psychology Theory

Richard H. Tuch

To cite this article: Richard H. Tuch (1997) Beyond Empathy: Confronting Certain Complexities in Self Psychology Theory, The Psychoanalytic Quarterly, 66:2, 259-282

To link to this article: https://doi.org/10.1080/21674086.1997.11927534

Published online: 07 Nov 2017.

Psychoanalytic Quarterly, LXVI, 1997

BEYOND EMPATHY: CONFRONTING CERTAIN COMPLEXITIES IN SELF PSYCHOLOGY THEORY

BY RICHARD H. TUCH, M.D.

Empathy is often a poorly understood concept. While some feel its value to psychoanalysis cannot be overstated, others feel it has been overemphasized as has the value of properly managing empathic failures that arise during an analysis. This paper will attempt to (1) demonstrate how patients sometimes resist empathy and erect barriers to being understood; (2) illustrate how empathy may sometimes be unachievable due to the difficulties encountered when one tries to empathize with the various aspects of another's experience that are in conflict with one another; and (3) propose that analysts may need to go beyond the common definition of empathy in order to help patients question and discard certain cherished beliefs they hold about themselves.

INTRODUCTION

Self psychology is founded on the idea that healthy narcissistic development depends upon the availability of objects who prize and admire the child ("mirroring") and who can be idealized (and then gradually de-idealized) by the child. Objects that provide for these bipolar needs are termed selfobjects. Caregivers who function as selfobjects help regulate the child's narcissistic equilibrium from without while the child gradually develops an ever increasing ability to self-regulate.

Kohut (1971, 1977) believed that a child's ability to regulate his or her own sense of self results from the proper handling of instances when the caregiver fails to satisfy the child's selfobject

needs. The caregiver's demonstrated appreciation of the child's response to that caregiver's intermittent failures to function as an adequate selfobject substantially moderates the intensity of the child's disappointment. Tolerable disappointments of these selfobject needs ("optimal" or "micro" frustration) lead to a process termed *transmuting internalization*, which then leads to an ever increasing ability to tolerate narcissistic insults. Intolerable disappointments lead to traumatization and to a continued overreliance on external selfobjects for self-regulation.

Self psychology places a special importance on the role of empathy in the development of healthy narcissism. Empathy operates in three very specific ways. First, empathy provides the understanding that enables caregivers to best provide for the child's selfobject needs. Second, empathy informs the caregiver about how best to interact with the child in order to help re-establish the child's narcissistic equilibrium after the child has been narcissistically injured by the caregiver's failure to provide adequately for the child's selfobject needs. Finally, empathy facilitates comprehension of the child's affective state so that caregivers can put into words or otherwise demonstrate their appreciation of "where the child is at."

When a caregiver fails to satisfy the child's need to idealize or to be mirrored, we call these *selfobject failures* (Stolorow, Brandchaft, and Atwood, 1987, p. 17, n.). When that person fails to understand how and why a child feels a certain way, we call these *empathic failures*. While empathic failures may contribute to selfobject failures, it is essential that the two terms not be considered synonymous. A failure to differentiate the two has led to murky thinking, especially with regard to the concept of optimal frustration.

Not all empathic failures entail a selfobject failure. This is true because the need to feel understood or empathized with is not one of the bipolar needs that originally defined a selfobject. Sometimes the need for empathy has been elevated to the status of basic need, on a par with the needs of the bipolar self, to idealize and to be mirrored. Some feel that if analysis could be conducted free of empathic failures (an admittedly impossible task), analysands

would undergo sufficient change just by having their needs for emotional attunement met, and the venture could be regarded as truly psychoanalytic.

Kohut's (1971) original description of transmuting internalization involved the optimal therapeutic aftermath of an analyst's having failed to adequately satisfy a patient's selfobject needs. By demonstrating the analyst's understanding of how and why his or her actions affected the patient as they had, the analyst helps the patient re-establish narcissistic equilibrium. In this way, empathy prevents a selfobject failure from becoming so traumatic that it irretrievably damages the analytic relationship. "Optimal frustrations" of the patient's selfobject needs are made optimal by virtue of their falling within a given patient's ability to tolerate them, followed by the demonstration of the analyst's empathic attitude toward the patient's experience of having been let down.

Bacal (1985) and others have written in support of shifting emphasis from optimal frustration to optimal responsiveness. He writes: "It is possible that the gratification of being understood by one's selfobject is of central importance in the curative process. Our responses must satisfy (a better word, perhaps, than gratify) the frustrated need for understanding of a particular patient or they will not be helpful" (p. 207). Bacal questions whether optimal frustration is, in fact, as critical to an analytic cure as Kohut thought. He writes further: "The patient brings to the analyst his frustration at not being understood so that any additional frustration caused by the analyst's lack of understanding cannot be regarded as optimal" (p. 210). However, Kohut's concept of optimal frustration never involved frustrating the patient's need to be understood! Quite the contrary, part of what made optimal frustration optimal was the analyst's continued ability to understand why his or her actions had affected the patient as they had.

Given the extent of the current confusion in this area, the time seems ripe to review what constitutes an empathic failure and to explore how such failures relate to selfobject failures. To this end, I will critically examine two assertions found in the literature: first, that empathic failures which arise in the course of treatment are

primarily due to the *analyst's* failure to be properly attuned to the patient; second, that empathy is a life-sustaining "psychological nutriment" (Kohut, 1978, p. 705) which, by definition, is something that is yearned for, even needed, and accordingly unlikely to be experienced as unwanted, intrusive, or distancing. Such thinking disregards what patients may contribute to their own failure to be understood. Resistance to empathy is seldom considered. Finally, I will demonstrate how an analyst's consistent empathic responsiveness may prove insufficient to produce lasting psychological change.

DEFINING TERMS

Although empathy has emerged as a critical concept within self psychology, there is in fact no consensus regarding its meaning. Some equate the term empathy with affect resonance. Greenson (1960, p. 418) spoke of empathy as "the experiencing of another's feelings" in order to "emotionally know" what another person is going through, while *A Glossary of Psychoanalytic Terms and Concepts* (Moore and Fine, 1968, p. 67) defines empathy as a "mode of perceiving by vicariously experiencing (in a limited way) the psychological state of another person." However, many take issue with defining empathy as the firsthand experiencing of another's feelings. Schafer (1959) argues that becoming "angry, anxious, or guilty when another is angry is thus not empathic . . . though it may be a preliminary or signal stage of empathy" (p. 349), while Stern (1985) argues that empathy is more than affect resonance because empathy requires "the abstraction of empathic knowledge from the experience of emotional resonance" (p. 145). In a similar vein, Shapiro (1974) describes how empathy "permits *comprehension* of another's predicament rather than simple *recognition*" (p. 22).

Taking such objections into consideration leads to an expansion of the definition of empathy to include the mental processing of the raw data of affect resonance which then leads to the com-

prehension of why others feel as they do. But this definition fails to consider the fact that affect resonance is *not* the only raw data upon which empathy is based. In fact, one of Kohut's (1971) earliest definitions of empathy—"a mode of cognition which is specifically attuned to the perception of complex psychological configurations" (p. 300)—makes no reference to affect whatsoever. Basch (1983) states that empathy "includes, but is not limited to, an affective experience" (p. 110).

This brings us to my proposed definition of empathy: "Empathy describes the methods by which one comes to know how and why others feel as they do." This definition includes both the method and its goal (empathically derived understanding). The methods by which empathy is achieved are purposely left unspecified. Sometimes the empathic process begins as an affective response to the patient. Sometimes empathy comes to the analyst's mind in the form of a seemingly personal and idiosyncratic fantasy which is ultimately understood as "a commentary on the patient's experience" (Beres and Arlow, 1974, p. 39). Even theory can inform empathy. The fact that knowledge of developmental research or psychoanalytic theory can guide empathy is something Kohut (1984a) said "cannot be affirmed too emphatically" (p. 84). He spoke of how self psychological theory can alert an analyst to "perceive configurations that would otherwise have escaped his notice" (*ibid.*).

It is irrelevant whether empathy begins as an affective response, a fantasy, an insight, or a theory. Ultimately, empathy may involve all these realms. The definition I have proposed emphasizes the cognitive aspect of empathy. Some may complain that "knowing" seems too limiting a process to account adequately for a phenomenon as complex as empathy. However, I believe that empathy's usefulness as a psychoanalytic tool is determined by the extent to which it leads to insight. This insight need not be shared with the patient via interpretation. It may do nothing more than direct the analyst's interactions with the patient. This definition stops short of the broader definition of empathy as "understanding how and why another person's mind works." This later definition considers

more than just affects and includes defenses, mental structures, and a host of other mental mechanisms. To refer to all of that as empathy would so broaden the term as to render it meaningless.

The definition of empathy proposed above underscores the fact that empathy involves knowing not just how but *why* others feel as they do. It accordingly requires that one understand enough about the individual's situation (the context in which the affects arise) in order to *comprehend* how such feelings fit into that person's life and make sense, given that individual's personality and past. While this definition fails to account for instances in which one feels an immediate sense of empathy toward a stranger—someone whose life we think we know nothing about—such instances of empathy are most likely based on how we expect the "average expectable" person to react under similar circumstances. Such "generic" empathy may come close enough as long as the stranger approximates the average expectable model.

It is noteworthy that what has been left out of the definition is the concept of empathy as a mode of relating to others. One often hears of how an analyst had been "empathic" with a patient when what is meant is that the analyst used his or her understanding of how and why the patient feels in a way that demonstrates compassion (sensitivity or tenderness) toward that patient's feelings. The term "empathic failure" is sometimes erroneously equated with interventions that either lack compassion or are intentionally hurtful. But empathically derived knowledge can also serve "inimical ends," as Kohut (1978, p. 706) pointed out. For example, effective sadism relies heavily on an empathic understanding of one's victim.

Others have also used the term empathy to describe something that an individual needs from others in order to thrive emotionally (Grotstein, 1984; Kohut, 1978). They write that empathy can be sufficient, without the aid of illuminating insight, to cause meaningful and lasting psychological change. Kohut (1971) initially expressed apprehension at going beyond his original, narrower concept of empathy as "a tool for the gathering of psychological data" (p. 300), but subsequently wrote (1984b): "I must

now, unfortunately, add that empathy per se, the mere presence of empathy, has also a beneficial, in a broad sense, a therapeutic effect—both in the clinical setting and in human life, in general" (p. 85).

While empathy may help an analyst ascertain what it is that the patient needs, empathy should not be confused with the satisfaction of those needs. This is not to say that analysts should not be warm or sensitive toward their patients. Certainly they should. But it is incorrect to refer to such behavior as "empathic" or to consider such tenderness sufficient to produce substantial psychological change. Basch (1983) emphasized this point when he wrote: "Empathic understanding is not curative in the psychoanalytic sense; cure is the function of interpretation. By the same token, empathic understanding is not a substitute for interpretation; rather, it lays the groundwork that makes interpretation appropriate and effective" (pp. 123-124).

All of this leads to a definition of empathic failure as "a failure to understand accurately either how or why individuals feel as they do." Though such misunderstanding needs only to exist in the analyst's mind, empathic failures usually are not detected until the analyst's *actions* demonstrate to the patient whether she or he has been well understood. This occurs either when analysts act on an inaccurate understanding of their patients or when analysts fail to take into account what they accurately understand about their patients in their interactions with them. Such empathic failures become evident either through "faulty" interpretations (ones that are overly inaccurate or poorly timed) or through some mismanagement of the relationship (i.e., by expecting the patient to be able to tolerate what, for them, is intolerable). Empathic failures may also develop when an analyst's understanding of a patient fails to have any effect on her/his affective responses to that patient.

Conveying one's empathic "findings" to a patient, who is then jarred by such an interpretation, may be referred to by some as "unempathic." This usage of the term "unempathic" seems to run counter to the definition proposed above. However, it is not

the intervention's effect on the patient per se that determines whether empathy is lacking. A patient's being jarred or disturbed by an intervention is not, by itself, grounds for calling that intervention "unempathic." However, if the analyst is unable to anticipate how a patient will react upon hearing a given interpretation and therefore is surprised by the intensity of that patient's reaction, then one can call this lack of understanding a lack of empathy.

Bacal (1985) writes of how an analyst has "to consider what response will be optimal in relation to the current level of his patient's specific developmental capacity to utilize empathic understanding of his selfobject needs for human relatedness" (p. 224). Offering interpretations about what the patient's behavior means, even when those interpretations are empathically derived, can be experienced by the patient as the analyst's thinking about the patient at a distance (observing) rather than being with the patient (participating). Feeling distanced by the analyst may disrupt the patient's sense of having been with the analyst in a way that felt containing and reassuring. Interpretations about the unconscious meaning of latent content about which the patient is unaware may be experienced by the patient as "intrusive" rather than "holding" or "containing"—especially when such interpretations are at odds with how patients understand themselves (Reed, 1984). Such interpretations may be experienced as the intrusion of foreignness, which represents the "otherness" of the analyst.

THE CAUSES OF EMPATHIC FAILURES

While empathic failures are most often thought to result from the *analyst's* failure to properly understand the patient, empathic failures may occur for other reasons as well. What follows is a discussion of the various factors which may contribute to empathic failure: 1) the analyst's contributions to empathic failures, 2) the

patient's contributions to his or her failure to be understood by the analyst, and 3) instances when empathy cannot be achieved simply because it is impossible to empathize with different aspects of another's experience when those aspects are in conflict with one another.

The Analyst's Contribution to Empathic Failures

Psychoanalysts are considered "particularly empathic" when they understand a wide variety of patients a high percentage of the time. But even "particularly empathic" analysts are subject to instances when they fail to understand their patients empathically. All psychoanalysts are susceptible to finding a particular patient's experience so foreign that they are unable to call upon their own analogous experiences and, as a result, are unable to achieve empathic understanding (Freud, 1915; Kohut, 1959, 1971). Basch (1988) describes occasions in which "a patient's appearance, viewpoints, life style, and/or background are so foreign that one feels less curious and interested in the person and more in the grip of 'stranger anxiety' " (p. 168).

Some psychoanalysts are generally inhibited in their ability to empathize. Greenson (1960) points out how some analysts may be "unconsciously unwilling to leave the isolation of the position of the uninvolved observer" because they feel threatened by the temporary decathexis of their self-image which is necessary in order for them to feel another's feelings or put themselves in another's place (p. 420).

One important source of empathic failure is the analyst's tendency to rely too heavily upon his/her own experience in order to understand patients. While some consider the analyst's own experiences to be faulty grounds upon which to base empathic understanding of patients, Freud felt otherwise. He wrote (1915) that making the behavior of others intelligible requires that we draw analogues between their experiences and our own. "[W]e attribute to everyone else our own constitution and therefore our con-

sciousness as well, and . . . this identification is a *sine qua non* of our understanding" (p. 169).

Constructs about patients which are primarily based on the analyst's own experience run counter to the contemporary concept of empathy which eschews projecting oneself into the other as a way of understanding. For instance, Schwaber (1981, p. 385) emphasizes the importance of being open to how the other person feels regardless of how we might feel or react under similar circumstances. She and others feel that accurate empathy requires putting oneself aside in order to function as a kind of pure receiver, an instrument that resonates in keeping with the experiences of another without contaminating that resonance with one's own experience. Renik (1993) takes issue with Schwaber's position when he refers to the impossibility of "isolating or subtracting" an analyst's personal responses from the rest of his or her analytic activity.

> Instead of saying that it is *difficult* for an analyst to *maintain* a position in which his or her analytic activity objectively focuses on a patient's inner reality, I would say that it is *impossible* for an analyst to be in that position *even for an instant*. . . . Everything an analyst does in the analytic situation is based upon his or her personal psychology. This limitation cannot be reduced, let alone done away with; we have only the choice of admitting it or denying it (pp. 560-561).

Stolorow (1994, p. 45) also takes issue with the idea of the analyst's "banishing his own psychological organization" in order to be empathic. He argues that doing so defies the intersubjective nature of the analytic process.

Identification permits us to understand how another person feels without actually having to experience that person's feelings. We remember having had experiences similar to those which the other is now having, and on the basis of our own experiences we make assumptions about what it must be like for the patient. Those who relish thinking of empathy as an experience-near phenomenon might take issue with any definition that places the

empathizer at a distance from the patient's experience as it is happening. But many feel that such a distance is a necessary precondition for the analyst to be able to do something with the affect that is different from what the patient is doing with it. Little (1951) writes of how "[t]he analyst necessarily identifies with the patient, but there is for him an interval of time between himself and the experience which for the patient has the quality of immediacy—he knows it for past experience, while to the patient it is a present one. That makes it at that moment the patient's experience, not his" (p. 35). Basch (1983) states that "[t]o be empathic an individual must be able to separate himself sufficiently from his feelings and emotions so that instead of simply reacting to them he can establish their genesis and the significance they have in the context in which they are experienced" (p. 119).

The Patient's Contribution to Empathic Failures

Even though empathy is considered by some to constitute "emotional manna" or sustenance, patients may nonetheless resist being empathized with (Buie, 1981; Kohut, 1971; Olinick, 1984). Some patients, Greenson (1960) notes, "consciously and unconsciously want to remain ununderstood; they dread being understood. For them, to be understood may mean to be destroyed, devoured, unmasked, etc." (p. 422). Buie (1981) states that such patients "withhold or distort cues which would enable others to gain the empathic understanding of them which they fear would make them vulnerable" (p. 302). Grotstein (1984) writes of patients who "seem immune to or contemptuous toward any demonstration of empathy by the analyst" and, as a result, must first be "made safe for empathy" (p. 207).

One reason patients resist being lured by the promise of empathy is that feeling deeply understood can reactivate childhood wishes and longings that the patient may hope will be satisfied by the analyst. The dread of being retraumatized by hoping for and

again failing to get these needs met "may *heighten* the conflictual and resistive aspects of transference" (Stolorow, Brandchaft, and Atwood, 1987, p. 102, n.). A second reason for resisting empathy is that the analyst's empathy threatens some patients because it endangers the security afforded by "the protection which the narcissistic isolation affords the personality" (Kohut 1971, pp. 306-307). Some patients take comfort in thinking of themselves as unique and incapable of being understood by others. Feeling understood may jeopardize some patients' ability to continue thinking of themselves as unique and hence superior, thus robbing them of a much needed compensation for their fragile selves.

Inherent Difficulties Due to Conflicting Needs or Self States

Some empathic failures result not as a consequence of the analyst's failure to understand nor as a consequence of the analysand's resistance to being understood, but as the result of something inherent to the situation. Empathizing with one aspect of a patient may preclude the analyst from being able to establish empathic contact with other aspects.

For example, there are times when patients need to feel that they have had an emotional impact on their analyst. At times like these it is not the analyst's empathy patients are primarily seeking. For instance, analysts' enjoyment in, or celebration of, their patients' ability to be angry with them can act as a kind of barrier which protects analysts from directly experiencing the full force of their patients' rage. Such an analytic stance may be heard by the patient as the analyst saying, "You cannot get to me." Needless to say, such a message will leave patients feeling that the analyst is "out of reach" and that their efforts to have an emotional impact have fallen short. Recent literature on "enactments" emphasizes the importance of instances when analysts become so drawn in by their patients that they momentarily lose their rational objectivity as they spontaneously and emotionally react to patients before realizing they are doing so.

While such experiences may prove pivotal in analysis, reacting emotionally to the patient in this manner can just as easily prove traumatic. By operating at a distance from the emotional reactions aroused by the patient, the analyst often increases her/his ability to be useful to the patient. Sharing our understandings of the patient *with* the patient may prove reassuring because it teaches the patient how we avoid taking their attacks personally. The patient may then feel free to vent anger without worrying we will be destroyed or driven off in the process. Sometimes patients want us to maintain distance so that we do not get caught up in their emotions while at the same time requiring that we be close enough for them to be able to affect us sufficiently to cause a visible reaction. Satisfying both of these needs inevitably leads to empathic failures no matter how carefully and thoughtfully we position ourselves.

Attempting to empathize simultaneously with different aspects of the patient can prove to be an impossible task. How do we as analysts decide which of the patient's current experiences deserves foremost attention? Do we empathize with patients who need us to be emotionally drawn in to the point of enactment or to patients who need the reassurance that we have not been injured by their behavior? Do we empathize with patients as they are, or with the patients that they could become (Loewald, 1960)? Do we empathize with patients who are grandiose (and feel so different as to be unfathomable to others), or with patients who yearn to be fathomed but fear becoming ordinary as a result (Kohut, 1971; Tuch, 1993)? And, do we empathize with the patients who want to kill themselves and want others to understand such a wish, given their circumstances, or with patients who want to live and fear that another's empathic understanding of their situation will decrease their resistance to act on such impulses?

A CASE ILLUSTRATION

Mr. O is a married executive in his early forties who sought treatment for depression. He felt no joy in life. Though usually a hard

worker, he began sitting in his office with the door shut, unable to work. Everything was an effort. He had become fixated on the idea of suicide and had begun cutting himself. The patient felt empty inside and sought stimulation to fill his inner void. He experienced his father as a tyrannical, manipulative, and controlling man who demanded that his children recognize how great a dad he was. The patient thought that his inability to see how great his dad was meant that there was something wrong with *him*. "Father had to be right and told us all how to think. Disagreeing with him was not tolerated." Now that Mr. O was about to become a father, he wondered how he would ever be able to think for himself in order to be a good parent for his son.

Mr. O described his mother as self-centered: "She just goes on and on about herself. She sucks everything out of people by making conversations be just about her." His mother seemed concerned only with show and not with who the patient was as a person.

Mr. O had never felt he had any control over his life. He was forever conceding to others' wishes, expectations, or demands. He would accede to his wife's ultimatums rather than deciding for himself. In general, he was passively aggressive. He refused to act, shrank from confrontation, and got others to make decisions for him.

Making his own decisions became impossible because it threatened to reveal the patient's "secret self"—a self he felt sure that others could neither understand nor tolerate. Experience had taught Mr. O that others did not even think it was necessary to try to understand him. While others could demand to be understood and accommodated, he could not. Experience had also taught him that others would not tolerate his emotions. If he became excited, he could anticipate his father's bursting his bubble. If he complained to his father that he had been hurt by him in some way, he could expect his father to tell him he was wrong for feeling that way—and selfish for putting him down.

The patient feared that his true self would be minimized or destroyed if revealed in therapy. He was scared of bringing any

"good" feelings into sessions out of fear that I would be disinterested. He came in hoping that I would join in his excitement, but anticipated only disappointment because of how things had been for him in the past. He felt that all I wanted was "pathology" we could work on—material with which to prove my brilliance as an analyst.

The patient was quick to become confused about what he wanted and how he felt. This confusion protected him from having to expose his true self. "If someone starts to question me as to why I feel as I do, I begin to lose my mind—I can't offer logical explanations to support my position so I conclude I must be mistaken—the other person must be right. I have a hard time sticking to what I feel is true. Confusion defines me. I can't imagine being without it."

Mr. O's confusion was typically followed by his accepting the other's position as correct. "I'd be lost if it wasn't for others who help determine who I am by what they expect of me." Yet he felt angry at others for not letting him be himself and live his own life.

When the patient was angry with me, he feared that I would not understand why he was angry, and that I would try to talk him out of his anger by questioning the legitimacy of his feelings. "You'll throw your hands up and tell me you've had it with me." In fact, the patient felt his relationships were in jeopardy whenever his own opinions differed from those he depended on. Becoming confused dissolved these differences, thus protecting his object ties. In this way, Mr. O became "mush in other people's hands."

After some months in treatment, the patient began to talk about how he hated coming to treatment. "It's like cod liver oil, something that must be good for me but tastes terrible." The patient wondered, "Can you tolerate my feeling this way about coming to see you?" Sometimes, when the patient had been particularly depressed throughout a session, he would apologize as he left the session for his having been a "drag." He needed to be able to leave sessions depressed and to believe that I would allow him to feel this way. But he feared that I wanted him to leave uplifted on account of the time we had spent together.

The patient imagined that my other patients could not wait to see me, loved every minute they spent with me, and got depressed at the session's end. "If I can't feel that way about therapy, it makes me feel like I'm doing this wrong and letting you down. I'm not a good patient because I don't relish coming and I've yet to lay down on the couch."

Facing the Couch

The prospect of using the couch was upsetting to the patient because he did not know if he could "do it right"; that is, "do it the way everyone else does it." He wanted to be accepted, but hid behind "conventional behavior," all the while understanding that this brought him no closer to feeling understood by me since his secret self remained hidden. To be seen by me was to be naked and open to ridicule.

The patient was conflicted about using the couch. He felt I expected him to comply and feared he would "cave in" to my wishes in order to avoid my ire. For him, the couch became yet another "mold" he was to adapt to. He viewed his "trip to the couch" as something he would be doing just for me. He felt my watching him walk to the couch would fill me with triumph at his expense, since all he could imagine feeling was defeat. He could not imagine being allowed to take the credit for getting on the couch, assuming instead that I would want the credit.

For weeks the patient was in an obsessional quandary over whether or not to try the couch. He experienced the chair as a kind of prison he wished to break out of, while getting himself to the couch meant that he was electing to do something, rather than being directed to do it. Being exposed as someone who had wishes and goals left the patient feeling emotionally naked. Doing something on his own also meant being abandoned, being totally responsible for the consequences of his actions. The patient feared that if things did not work out, he had only himself to

blame. He wished not to be left on his own to make that decision. If only I could give him a push—tell him to try the couch next session—then maybe he could feel we were in this thing together—that we shared the responsibility for however it turned out.

In a misguided attempt to encourage the patient off his ambivalent "fence," I placed a napkin on the couch prior to the following session. I had momentarily abandoned my typical analytic stance and succumbed to the urge one often feels to help the obsessional patient by siding with one side of the conflict. I had committed the regrettable error that Anna Freud (1936) had cautioned about when she spoke of the need for analysts to remain "equidistant" (p. 28), and by so doing, I had enacted something from the patient's past.

My action failed to have the desired effect. The following session I sensed that the patient was angry with me for what I had done. He felt pushed by what he experienced as my need and expectation that he "lie down now." But this was not what he expressed. The patient justified my behavior as having been "well intended." I understood that the patient was upset that I had failed to anticipate correctly how my preparing the couch would make him feel. But I had not anticipated how intensely he would react upon hearing that I understood how upsetting this had been for him.

I interpreted that he felt I was insensitive. He responded by saying he felt conflicted about having been angry with me. He anticipated that if he expressed his anger, I would just get angry in return, and then he would feel sorry that he had gotten angry in the first place. To circumvent this problem, the patient turned his anger back on himself for resenting the very person who was trying so hard to help him. At the same time, he wondered why it was that I hadn't been more sensitive and understanding about how the napkin would make him feel. He supported this defense by admitting that these feelings of anger were "really meant" for past objects who had treated him in the way he now "assumed" I

was treating him. Through explorations of this kind the patient ultimately decided to try the couch and now feels comfortable with it.

Facing Suicide

At other times in the analysis the patient felt so miserable that he considered suicide his only way out. "Anything has to be better than what I'm going through," the patient reasoned. He regarded suicide as the only choice left to him that was totally his own. "To be myself, to live for once, requires that I act to end my life." The patient fixated on the idea of suicide. He "cruised" gun shops in search of an implement. I feared for his life and felt forced to take measures to protect him from acting on these impulses. I placed him on medication and suggested hospitalization once I became convinced he intended to act.

The patient's reaction to my alarm was twofold. He felt encouraged that, for once, someone was taking him seriously—that I was not dismissing his feelings as nothing more than crying wolf. Maybe he had finally found in me someone who could believe him when he spoke of how miserable his life was, rather than telling him, as others had, that "things can't be that bad" and that "nothing could be so bad as to justify suicide." But as much as he felt encouraged by my reaction to his suicidal ideas, he also felt unsettled. Did my taking him seriously mean that he had more to worry about than he thought? How close *was* he, he wondered, to killing himself.

Case Discussion

This case illustrates a number of points about how empathy is used in the psychoanalytic setting. The patient often left sessions dejected and worried that I felt let down by his not loving every minute we spent together. I understood that the patient was also saying that he feared growing dependent on me and that needing

the sessions made him feel too vulnerable. It was as if he said, "You'll have to buy my contention that I don't like being here because if you rip that mask off, it will be intolerable." Ultimately, the patient did come to understand his need to hide his attachment and dependency on me, but only after being allowed to deny that fact for some time. He felt that he had no model for getting close to men—interpreting such feelings as homosexual. For him, feeling understood had the meaning of seduction.

In my handling of the "couch" issue, I failed to understand how strongly the patient would react to what I considered the "gentle nudge" of laying a napkin on the couch. My wish to be helpful to the patient by acceding to his wish that I would share in the responsibility of his moving to the couch led to the first of two empathic failures. Empathy helped me see through the patient's contentions that he was not upset in the least by what I had done. But by insisting on interpreting the patient's reaction to my empathic failure, I created yet another empathic failure.

I interpreted that he felt I was insensitive in how I had handled the issue of the couch. This was understood by the patient as demonstrating that I, unlike his father, was someone who did not always have to be right and who could tolerate his criticism and anger. However, by prematurely offering that interpretation, I seemed once again to be insensitive to the patient. I had been out of touch with his need to get "good and angry" with me so that he could, once and for all, risk revealing that side of himself. He felt that I had taken the wind out of his sails by "apologizing prematurely." He was also worried that my seeming to take responsibility was not genuine but my way of cutting off his anger by preempting it.

Attempting to empathize with the patient's suicidal impulses created other problems. I wondered how I could show the patient that I understood just how miserable he felt without seeming to support this solution for his problems. Might not expressing my understanding to the patient tip the balance in favor of the patient's acting out suicidal impulses which ran counter to another part of him? Which patient was I to empathize with? Was the only

way back to life to enter into the patient's suicidal world and risk what might result? Ultimately, I concluded that this was the case, and I believe that decision has proved to be in the patient's best interest.

BEYOND EMPATHY

Empathy implies that the analyst understands the patient's current affective state, ego state, or self state. Going beyond how patients currently experience or think of themselves is considered by some tantamount to an empathic failure. In particular, some consider it "unempathic" to add something of ourselves to our interpretations because doing so introduces our "otherness" into what it is about the patient that we are presently trying to understand.

Whether it is possible or even desirable for analysts to keep themselves out of their interpretations is a matter of great debate. Such an "intrusion" of the analyst's personality may prove to be just what it takes to get patients beyond how they are currently experiencing themselves. This may prove quite helpful in breaking the closed system that the patient had maintained. Introducing new elements in this way may provide a nidus for change within the patient. Bacal (1995) refers to a seemingly unnoticed "lacuna" in self psychology theory when he notes how that theory "has neglected the fact that people suffer not only from self-depletion but also from self-distortion" (p. 355).

Empathic mothering includes empathizing both with the side of the child that feels himself/herself incapable and the child who is, in fact, capable but does not yet believe it. Loewald (1960) speaks about how "[t]he parent ideally is in an empathic relationship of understanding the child's particular stage in development, *yet ahead in his vision of the child's future and mediating this vision to the child in his dealings with him.* This vision . . . is, ideally, a more articulate and more integrated version of the core of being which the child presents to the parent. This 'more' that the parent sees

and knows, he mediates to the child so that the child in identification with it can grow'' (p. 20, italics added).

In psychoanalysis, addressing the patient's ''potential self'' may go beyond how the patient is currently experiencing herself or himself. This must be done in such a way that the patient does not experience this as something expected or needed but, instead, as the faith the analyst has in the patient. Some feel that even this, representing as it does a part of the analyst which is separate from the patient, may be considered tantamount to an unempathic stance and a rupture of selfobject functioning. Believing in a patient's ability to overcome adversity may paradoxically feel unempathic to a patient who cannot locate such hope from within. Some believe we fail at being empathic if we go beyond who the patient experiences herself/himself to be at any given time. Schafer (1959) points out how psychoanalysts must be able to empathize with the patient's experience of feeling utterly helpless while, at the same time, conveying the sense that they have the capacity to handle the situation.

In conclusion, providing optimal selfobject functioning is considered by some analysts to be necessary for the maintenance of an analysand's narcissistic equilibrium. They believe that disruptions of a patient's narcissistic equilibrium indicate a lack of empathy on the analyst's part since they equate empathy and optimal selfobject functioning. However, saying something to a patient which the analyst knows will prove to be jarring is sometimes favored over the continued maintenance of optimal selfobject functioning when it is done for the sake of the patient's development. Must doing this be considered ''unempathic''?

Bacal (1995) writes that

> the maintenance of an empathic stance may or may not, however, be experienced as a *therapeutic* response by the analysand. Analysts of all theoretical persuasions encounter instances in which the *invalidation* of the patient's experience will be experienced as more therapeutic than its empathic tracking or validation. . . . Sometimes a confrontation is more effective than an

empathic echo or empathically elaborated interpretation (p. 358).

Kohut's work promoted the development of psychoanalysis by emphasizing how empathy could and should be used as a tool to better grasp the patient's experience. Since the introduction of his ideas, some have elevated the role of empathy to one of being the essential curative agent in any psychoanalytic venture. According to this view, empathy is considered something that will promote development at any given time. If this is so, one would reason that, at times, it is "unempathic" to be satisfying certain selfobject needs. I believe that defining empathy as whatever will best promote development at any given point claims too much territory for the term.

It is sometimes necessary for the analyst to go beyond empathy in order for change to occur. The analyst's view of what the patient may be capable of becoming may not reflect how the patient sees himself/herself. Nevertheless, this situation may be the very one the patient needs in order to change. Kohut's work forced the pendulum to swing in favor of a deeper appreciation for the role and power of empathy in the psychoanalytic setting. Since then, the pendulum has swung toward an overvaluation of empathy's powers. Appreciating the limitations of empathy should help correct this overvaluation by emphasizing what empathy is and is not, what empathy can and cannot achieve.

REFERENCES

BACAL, H. A. (1985). Optimal responsiveness and the therapeutic process. In *Progress in Self Psychology*, ed. A. Goldberg. New York: Guilford, pp. 202-227.

——— (1995). The essence of Kohut's work and the progress of self psychology. *Psychoanal. Dialogues*, 5:353-366.

BASCH, M. F. (1983). Empathic understanding: a review of the concept and some theoretical considerations. *J. Amer. Psychoanal. Assn.*, 31:101-126.

——— (1988). *Understanding Psychotherapy*. New York: Basic Books.

BERES, D. & ARLOW, J. A. (1974). Fantasy and identification in empathy. *Psychoanal. Q.*, 43:26-50.

BUIE, D. H. (1981). Empathy: its nature and limitations. *J. Amer. Psychoanal. Assn.*, 29:281-307.

FREUD, A. (1936). *The Ego and the Mechanisms of Defence.* New York: Int. Univ. Press, 1946.

FREUD, S. (1915). The unconscious. *S.E.*, 14.

GREENSON, R. R. (1960). Empathy and its vicissitudes. *Int. J. Psychoanal.*, 41:418-424.

GROTSTEIN, J. S. (1984). Some perspectives on empathy from others and toward oneself. In *Empathy, Vol. I*, ed. J. Lichtenberg, M. Bornstein & D. Silver. Hillsdale, NJ: Analytic Press, pp. 201-215.

KOHUT, H. (1959). Introspection, empathy, and psychoanalysis: an examination of the relationship between mode of observation and theory. *J. Amer. Psychoanal. Assn.*, 7:459-483.

——— (1971). *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders.* New York: Int. Univ. Press.

——— (1977). *The Restoration of the Self.* New York: Int. Univ. Press.

——— (1978). The psychoanalyst in the community of scholars. In *The Search for the Self: Selected Writings of Heinz Kohut, 1950-1978, Vol. 2*, ed. P. H. Ornstein. New York: Int. Univ. Press, pp. 685-724.

——— (1984a). *How Does Analysis Cure?* Chicago/London: Univ. of Chicago Press.

——— (1984b). Introspection, empathy, and the semicircle of mental health. In *Empathy, Vol. I*, ed. J. Lichtenberg, M. Bornstein & D. Silver. Hillsdale, NJ: Analytic Press, pp. 81-99.

LITTLE, M. (1951). Counter-transference and the patient's response. *Int. J. Psychoanal.*, 32:32-40.

LOEWALD, H. W. (1960). On the therapeutic action of psycho-analysis. *Int. J. Psychoanal.*, 41:16-33.

MOORE, B. E. & FINE, B. D., Editors (1968). *A Glossary of Psychoanalytic Terms and Concepts.* Second Edition. New Haven/London: Amer. Psychoanal. Assn. and Yale Univ. Press, 1990.

OLINICK, S. L. (1984). A critique of empathy and sympathy. In *Empathy, Vol. I*, ed. J. Lichtenberg, M. Bornstein & D. Silver. Hillsdale, NJ: Analytic Press, pp. 137-165.

REED, G. S. (1984). The antithetical meaning of the term "empathy" in psychoanalytic discourse. In *Empathy, Vol. I*, ed. J. Lichtenberg, M. Bornstein & D. Silver. Hillsdale, NJ: Analytic Press, pp. 7-23.

RENIK, O. (1993). Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanal. Q.*, 62:553-571.

SCHAFER, R. (1959). Generative empathy in the treatment situation. *Psychoanal. Q.*, 28:342-373.

SCHWABER, E. A. (1981). Empathy: a mode of analytic listening. *Psychoanal. Inquiry*, 1:357-392.

SHAPIRO, T. (1974). The development and distortions of empathy. *Psychoanal. Q.*, 43:4-25.

STERN, D. N. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

STOLOROW, R. D. (1994). The nature and therapeutic action of psychoanalytic interpretations. In *The Intersubjective Perspective*, ed. R. D. Stolorow, G. E. Atwood & B. Brandchaft. Northvale, NJ/London: Aronson, pp. 43-55.

——— BRANDCHAFT, B. & ATWOOD, G. E. (1987). *Psychoanalytic Treatment: An Intersubjective Approach*. Hillsdale, NJ/London: Analytic Press.

TUCH, R. H. (1993). Blocks to creativity: writer's block as seen from the self psychological perspective. In *The Widening Scope of Self Psychology: Progress in Self Psychology, Vol. 9*, ed. A. Goldberg. Hillsdale, NJ/London: Analytic Press, pp. 243-257.

1800 Fairburn Ave.
Los Angeles, CA 90025

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: http://www.tandfonline.com/loi/upaq20

How can we Study the Efficacy of Psychoanalysis?

Sherwood Waldron Jr.,

To cite this article: Sherwood Waldron Jr., (1997) How can we Study the Efficacy of Psychoanalysis?, The Psychoanalytic Quarterly, 66:2, 283-322, DOI: 10.1080/21674086.1997.11927535

To link to this article: https://doi.org/10.1080/21674086.1997.11927535

Psychoanalytic Quarterly, LXVI, 1997

HOW CAN WE STUDY THE EFFICACY OF PSYCHOANALYSIS?

BY SHERWOOD WALDRON, JR., M.D.

Psychoanalytic efficacy has been demonstrated in general, but not in comparison with other therapies, nor with detailed study of the relationship between process and outcome. The steps necessary to accomplish such studies are outlined, along with a review of our present readiness. Crucial dimensions of such work are explored, including the use of single case studies, and ways of looking at sequences of interaction between analyst and patient as they change during various phases of treatment. Methods of using control and comparison groups and follow-up studies are described, and various promising specific strategies are proposed.

What attitude do most Americans have toward psychoanalysis? Many analysts would, I believe, agree with the following characterization: that psychoanalysis is an alien procedure to most Americans, who would rather simply talk to someone about their problems than seek the aid of a psychoanalyst. Furthermore, even educated people are unfamiliar with the idea that psychoanalysis may be more effective than psychotherapy for ordinary problems. Many students in introductory psychology courses have heard that mature college professors without psychotherapeutic training are as effective in helping troubled students as trained psychotherapists are—an unwarranted conclusion at best (see Strupp and Hadley, 1979[1]). Few, certainly, have been

[1] Although the study cited was carefully carried out, the conclusions that may be drawn from it are severely limited, as the authors themselves are aware. First, there were significant differences between the two groups, in that the students treated by

told that persons with psychoanalytic training have more success in helping people than those with other credentials or no credentials at all, in part because systematic studies have not been conducted which would demonstrate the difference in results, if any.

Today, a century after Freud's first case reports, the outcomes of different psychoanalytic treatments[2] have rarely been compared with one another in a methodical, scientifically valid manner (Bachrach, et al., 1991). Many thoughtful professionals regard this as negligent, and it certainly jeopardizes support for psychoanalysis as a therapeutic procedure. In view of the difficulties besetting such studies, it is understandable that psychoanalytic organizations have not given them high priority. Now, however, many of these difficulties can be surmounted by methodologies currently under development and research strategies applicable in the immediate future. The purpose of this paper is to discuss these possibilities.[3]

---

them were not randomly chosen: for the most part, the therapists treated students seeking help at the university's mental health facility, while the professors treated students who had responded to notices that had been distributed at large in order to generate more patients for the study. Second, because there were only about fifteen patients in each group the statistical value of the study was slight. Third, the patients were selected on the basis of elevated scores on the MMPI scales of depression, psychasthenia, and social introversion, reflecting their feelings of alienation on campus. Contact with mature professors on the same campus, chosen for their warmth and ability to relate to students, was ideally suited to provide them with a "corrective emotional experience" or at least a powerful supportive intervention. Fourth, treatment was restricted to twenty-five twice-weekly sessions, a schedule that gave the therapists only limited opportunities to apply their skill. Finally, there was evidence that professional skill did indeed contribute something unique for those patients who had a positive rapport with their therapists. These facts might not come to the attention of those informed of the results of the study. For further evidence contradicting the hypothesis of the Strupp and Hadley paper, see Jones, Cumming, and Horowitz (1988).

[2] Throughout this paper, I refer to "psychoanalysts" and "psychoanalysis." I hope, however, that most of the points made will be useful in regard to psychoanalytically oriented psychotherapies as well. Systematic differences between psychoanalyses and psychoanalytic therapies have not as yet been established empirically (Wallerstein, 1986).

[3] In the spring of 1988, the current and incoming presidents of the American Psychoanalytic Association, Homer Curtis and Richard Simon, asked the Association's

It is by no means implied here that a systematic study of psychoanalytic cases will *of itself* necessarily lead to clear-cut, uncontroversial conclusions. There are many issues involving the development of psychoanalytic theory and the interpretation of results which will influence the proposed empirical studies. Scientific advancement in the social sciences is far more complex, far more of a *social* phenomenon, than in the natural sciences (Mishler, 1990), and psychoanalysis is no exception. Hence the impact on our field of the findings from empirical studies cannot be predicted. There is, however, little basis for pessimism in regard to the value of conducting such studies, fraught though they are with difficulties in interpreting the significance of individual findings (Edelson, 1984).

What aspects of the patient, the therapist, and the treatment would constitute important variables in empirical studies? Unfortunately, these have not been successfully defined even for short-term treatments, and long-term treatments are much harder to study for practical reasons. One would hope that theories of psychoanalytic and psychotherapeutic technique would serve as a basis for specifying the significant aspects of the treatment procedure, but as yet there has been little systematic study of data in relation to such theories (Fine and Fine, 1990). Thus, there are few if any agreed-upon criteria, except of the broadest kind, for distinguishing one treatment from another, and little empirical data to verify such distinctions. An important example is the role of interpretation as opposed to the role of the relationship, including so-called corrective emotional experiences and corrective object relationships. The relative importance of these two aspects has never been systematically assessed.

Committee on Scientific Activities to summarize the research literature on the efficacy of psychoanalysis. A subcommittee, including Henry Bachrach as chair, Robert Galatzer-Levy, Alan Skolnikoff, and myself, was formed to accomplish this task. The first result of this effort was a review of previous studies on psychoanalytic efficacy (Bachrach, et al., 1991). The present article grew out of the subcommittee's continuing efforts to explore efficacy. Although I am indebted in many ways to the other members, the responsibility for the views expressed is solely mine.

It has been suggested that we can reduce the complex variables in such studies by focusing exclusively on short-term treatments, in the hope that findings can be generalized to long-term treatments, and by ensuring that a specified treatment has been given strictly according to manuals that instruct the practitioner in correct procedure—what is described as "manualized psychotherapy." These suggestions, which leave the experienced professional doubting whether crucial human interactions could possibly be captured by such abbreviations and oversimplifications, are not recommended here.

Clinicians and others who have expressed a wish for a study demonstrating "the results of psychoanalysis" are often unaware of the need to study the process as well. There are particular problems in studying the process because the clinician must engage in some fairly extensive and inherently uncongenial data collecting; nevertheless, the field is unlikely to advance unless we carefully examine what actually takes place in treatment. Psychoanalytic procedures vary a great deal in practice, as every clinician knows, and because of this variability, it would be hard to interpret the results obtained from studying outcomes alone. Psychoanalyses need to be studied *over their entire course,* and *the processes as actually observed* must be related to outcomes. Yet difficulties in the development of reliable measures of process have been the major impediments to research (Schlesinger, 1974). The development of such measures is therefore a major focus of these papers. For example, a core aspect of psychoanalytic or psychotherapeutic process is the quality of interventions. In a recent NIMH review about psychotherapy outcome research (Borkovec and Miranda, 1996, p. 15), the authors offered their opinion that "despite initial attempts for some types of therapy, there is no valid way to measure quality for any therapy technique." It is clear that studies which do not develop and use some valid way of evaluating the quality of psychoanalytic work are unlikely to contribute to advances in our understanding of the relationship between process and outcome (see later discussion of the Analytic Process Scales [Waldron, et al., 1995] for an example of a reliable approach to

assessing quality). The relationships between processes and outcomes are also complex and in some ways a matter of changing definitions, which need to be carefully evaluated in carrying out studies (see excellent discussions in Stiles, Shapiro, and Harper, 1994).

This paper attempts to suggest the methods that will be required to study the efficacy of psychoanalysis and related therapies, while recognizing the hazards of premature commitment to incompletely developed methods. The attempt appears worthwhile to me despite the hazards, because, up to now, no extensive systematic efforts have been made to study material derived directly from psychoanalytic treatments with a view to evaluating the process and relating it to various indices of outcomes.[4] It is time for the psychoanalytic profession to follow in the footsteps of Freud who, in *The Interpretation of Dreams*, used new, untried, and controversial methods of data collection. We must collect a representative body of cases and further develop the methodology to study them, even though many thoughtful individuals will object to each of the possible methods, and the ultimate benefits of such studies cannot be predicted. Two steps need to be taken to accomplish process-outcome studies:

Step 1. *The clinically relevant dimensions of psychoanalytic processes must be reliably assessed by outside observers as well as by the treating analyst.* A number of important developments have occurred in recent years in the methodology for assessing psychoanalytic and psychotherapeutic processes. Close study of the available instruments will show that although many of them have demonstrated promise, further work is necessary to determine fully their validity and reliability.

Step 2. *The scores derived from these assessments must differentiate one treatment from another in a clinically meaningful way.* In other words, evaluators will have to be able to distinguish the characteristics of a treatment—those of the patient, the therapist, or the patient-

[4] The Menninger study (Wallerstein, 1986) is an important exception, but its approach was more indirect and impressionistic than would be currently desirable.

therapist interaction—that have important predictive properties. Studies must therefore be designed that permit valid estimates of the relationships between specific dimensions of psychoanalysis and the outcome of treatment. Here we are on much less firm ground than in the first step: there has been little systematic study of the relationships between observed processes and ultimate outcomes (Wallerstein, 1986). This is largely because, in the past, the goals of the first step had not been achieved.

In order to orient the reader to the issues involved in designing efficacy studies, I will begin by addressing the broadest aspects, mentioned in step 2, even though they depend upon developing the instruments described in step 1. In subsequent articles I will present detailed considerations of data collection, ways to assess and characterize psychoanalytic and psychotherapeutic processes using the data, and specific studies that can then be undertaken.

General Considerations in Designing Efficacy Studies

Psychoanalysis is quintessentially a complex process. Research efforts inevitably entail simplification, but any effective study must retain sufficient complexity to permit advance. In a comprehensive discussion about oversimplifications in psychotherapy research, Elliott and Anderson (1994) describe a number of pitfalls which should be avoided in designing psychoanalytic research as well. These include oversimplification by the use of only one variable or perspective in assessment, or only one level of measurement of a central aspect (such as quality of intervention, for example), or only a few points in time. Of equal importance is the failure to take into account the patterns or configurations of various elements (such as the relationships between the type of intervention and its quality, and the patient's state of readiness at the time of the intervention). Many previous efforts have failed to contribute to our clinical knowledge because of failure to take into account the complexity of the subject matter. This problem

needs to be addressed by collaboration between experienced and sophisticated researchers with equally experienced and sophisticated clinicians.

There is a conflict between the established methods of psychoanalytic investigation and those most often utilized in the natural sciences: the former emphasize understanding the peculiarities of the individual, while the latter focus upon large numbers of individuals studied under standard conditions. It is not surprising, then, that some of the most interesting methodological developments (L. Horowitz, et al., 1975, 1989; Jones and Windholz, 1990: Kächele and Thomä, 1993, p. 121; Nye, 1991, etc.) have dealt with individual cases, for types of data analysis based upon understanding such cases in depth directly reflect psychoanalytic thinking and are the most feasible with our current methodologies. Once a study of a particular case or cases has demonstrated a potentially important relationship between an aspect of the process and the outcome, the next step is to establish how well this relationship applies to a spectrum of similar cases. Then a finding can be stated as applying to *a population* of psychoanalyses (Edelson, 1984).

Single Case Designs

There is an extensive recent literature on the merits of single case studies (Kazdin, 1986).[5] The study of individual patterns may well overcome the skepticism of the many experienced analysts who, citing the uniqueness of each patient, have questioned the utility of systematic research. As soon as one can specify dimensions that are relevant to a particular individual, whether in regard to symptoms (Battle, et al., 1966), defenses and character traits (Perry and Cooper, 1986; Perry, Augusto, and Cooper, 1989; Vaillant, 1986), ego capacities and functions (DeWitt, et al., 1991;

[5] The author thanks Robert Galatzer-Levy for contributing the original draft of this discussion of single case studies.

Wallerstein, 1988; Zilberg, et al., 1991) or personality styles (M. J. Horowitz, et al., 1984), there are many possible ways (to be described further subsequently) of ascertaining how these specific characteristics are engaged in the analytic or therapeutic process, and what changes are then observable *in these specific dimensions of the individual.*

It has become paradigmatic to investigate a sample of a population in order to discover how one set of variables (e.g., initial diagnosis) relates to another set (e.g., analytic outcome). Investigators implicitly or explicitly generalize from the individuals studied to the larger population from which they were drawn. This is the classical method of population sampling, for which statistical methods have been developed. Over the years ever more sophisticated procedures have been elaborated to allow investigators to draw reliable conclusions from samples and even, in many instances, to provide quantitative estimates of the probability that a given conclusion is valid for the larger population (Stigler, 1986). The level of sophistication that statistical methods have reached, their quantitative results, and their fruitful application to a wide range of technological and scientific problems have led to their current prestige.

These methods are, however, limited in two respects. They are inapplicable to problems that do not meet their underlying assumptions, as when the object of study is a unique or rare event—a major historical occurrence, for instance—and no underlying statistically distributed population exists from which a sample can be taken. They are also inapplicable when the technical requirements for achieving an adequately studied sample far exceed the capabilities of the investigator. For example, as the number of variables increases, the size of the sample needed to demonstrate the significance of the contribution of any one variable likewise increases. In highly complex systems with many interesting variables, statistical sampling may become wholly impractical. The immense prestige of sampling methods should neither blind the psychoanalytic investigator to the virtues of other methods nor lead him or her to equate them and *only* them

with methodological rigor (Edelson, 1984). It would be a mistake to assume that the limited value of sampling methods for studying psychoanalysis means that scientifically rigorous investigations are impossible.

An important alternative to sampling strategies is the case study, which attempts to reach valid conclusions by exploring a single situation in depth (Jones, 1993). It has acquired an undeserved reputation for being less rigorous than other empirical methods, largely because it has been misunderstood as a variation on survey or quasi-experimental designs (Cook and Campbell, 1979). Useful case studies are characterized by a careful design that lays out the study's goals and methods, the situation to be investigated, the logic that links observations with conclusions, and the criteria for determining to what extent that link is satisfactory (Nachmias and Nachmias, 1976).

Case study methods have been extremely fruitful and informative in a variety of situations. In medicine, case studies were the principal means of investigating diagnosis, pathology, and therapeutics until the middle of this century.[6] The accumulation of case histories over the centuries led to those formal generalizations that constitute the most important basis for the classification of physical illness. Biology also owes a great debt to case study methods. Darwin's researches, for example, focused primarily on case studies of organisms living in various environments. From these, he generalized principles in a manner that illustrates the power of nonexperimental methods to reveal underlying mechanisms. Case study methods have proved highly effective in disciplines ranging from the history of science (Conant, 1957) to the study of business enterprises (Cheape, 1985; Dalzell, 1987; Popple, 1974; Smith, 1966; Tolliday, 1987). Anthropologists have relied on the case study method in the development of their field

[6] As will be discussed below, multiple case studies are distinct from population sampling methods. For example, a report in which a pathological finding is associated with a disease in twenty cases is simply a report of twenty cases and not a statistical sample.

(Geertz, 1983), and similar methods have played a central role in sociology (Yin, 1989).[7]

Kazdin (1986) has pointed out three major advantages of the case study method for psychotherapeutic research. First, comparative studies of populations provide information only about a composite "average patient," whereas case studies can provide insights into the mechanism of individual change (Barlow, 1981). Second, single case design allows a sharper assessment of whether an observed change resulted from treatment or some other cause. The flexibility of the single case study permits quasi-experimentation to produce a clearer picture of causal links than a population study can normally provide: phenomena of interest can be isolated and examined in more detail as they occur in a particular case; further instances can be sought in case material from the same patient. Finally, information about idiosyncratic features of patients that may be central to their psychopathology (Kazdin, 1982) or to their treatment is lost in population studies.

Yin (1989) has described situations in which the case study method is appropriate. Survey and sample methods are better suited to questions formulated in terms of who, what, where, how many, and how much; case study methods to questions of how and why a phenomenon occurs. They can also be used for preliminary exploratory investigations. In studies involving other methodologies, they can be used to describe and explain complex phenomena. The multiple case design, in which several case studies are performed, is an especially valuable research tool, in that it permits the replication of results and the comparative study of cases. It should be carefully differentiated from investigations based on sampling methods applied to a population of individuals. However, sampling methods in a case study can indeed be applied, but

[7] The use of statistical methods in a case study does not turn it into a sampling statistics study. For example, in a case study of the economic development of a single community, statistical sampling techniques may be used to investigate the community's economics, but the object of the study is still a single entity, the community's economic development.

the sample is based upon individual instances of interest in the same case (such as a particular symptom, hour, utterance, or behavior). A failure to address the issue of sampling from instances in a case study can limit the significance of the findings as severely as does improper design in any study. Findings are based upon sampling from many individuals in a population study, whereas findings from a given single-case study may turn out to apply only to that case, or to some subset of cases, or to the entire population of cases. Just how widely these findings apply may be determined by multiple case studies. As there is no *absolute* differentiation between case studies and population studies, the issue of *how representative* is a given series of cases needs to be addressed (Edelson, 1984). Psychoanalytic writings have often suffered from a failure to do this. This failure can and should be remedied.

The inevitable personal involvement of the researcher in the material she or he is studying has led social scientists to recognize that case study data must be specially treated to lessen the impact of bias (Becker, 1958, 1967). Psychoanalysts have long recognized this problem in the analytic situation, but the research situation commonly poses problems of a similar nature with which even the most conscientious analyst is unlikely to be familiar. We expect distortions, resistances, and other defensive operations in analysis, and we need to investigate these issues in the research arena as well. An awareness of our own irrational attachment to psychoanalytic ideas and the means by which we defend ourselves against contradictions to them (Edelson, 1984; Greenacre, 1966) can help us to deal with the impact of distortions arising from our own psychological needs in the analytic situation, and the same caution is needed in case studies. The analyst who employs case study methodology has to work hard to be aware of bias in his/her investigations. We can benefit from the techniques developed by social scientists to reduce observer bias in their own case studies. These include training in case study methodology, adequate protocols that include precise descriptions of the work to be done, and systematic review by peers (Yin, 1989).

Studying Sequences of Interaction between Analyst and Patient

Investigation of psychoanalytic processes in individual cases will often be enhanced by understanding the *temporal* relationship of events. An emphasis on the temporal aspects of analytic material has been the hallmark of much highly respected teaching since Freud. A group of analysts based largely in Washington, D.C., has been developing systematic understandings of these temporal relationships: Paniagua (1985) described a systematic approach to what he calls "surface material" (see also Levy and Inderbitzin, 1990), of which Davison, Pray, and Bristol (1990) have published a detailed example in seeking evidence of mutative interpretations. Their efforts to classify the relationship between analysts' interventions and patients' responses were preceded by only a small body of systematic work (Garduk and Haggard, 1972; Jones and Windholz, 1990; Luborsky, et al., 1979; Sampson, et al., 1972; Silberschatz, et al., 1986, 1988), a paucity that probably reflects the inherent difficulty of studying sequences of events in a complex system. Some important recent methodological developments will be described below.

Gedo and Schaffer (1989) have developed methods of sequentially assessing alterations in interplay between analyst and patient, based upon ten randomly chosen sessions from early in a 324-hour analysis and ten from late hours. They coded the therapist's statements as to whether they were interpretations, and the patient's statements as to whether they demonstrated insight. Both the patient's and the therapist's statements were then coded to indicate whether they referred to the transference, using the Gill and Hoffman (1982) coding scheme, which assesses various aspects of transference relatedness. The ratings for the presence of insight were not as reliable as the authors had wished; nevertheless they were able to characterize the degree to which the patient changed in producing more insights and more sequences of insights later in the analysis. They also showed how the patient's insights were quite responsive early on to transference interpre-

tations of the analyst. They used a Markov chain approach to analyzing sequential material.[8]

In another study of the same patient, Nye (1991) developed ways to systematically assess whether both patient and analyst were telling stories or *transforming* them. She found it feasible to rate sections of the transcribed work in regard to whether the meaning of statements was being transformed or not. The resulting ratings served to make operational the concept of whether the speaker's words represented an effort to develop insight. The concept of insight is in turn related to whether something is being analyzed, and if the speaker is the patient, whether a self-analytic function is in evidence at that time. Her conclusions illustrate the *kinds* of findings possible with this approach.

> Changes in narrative process over the three phases of treatment corresponded to predictions made based on the psychoanalytic literature on the acquisition of the self analytic function. Early in treatment, the analyst provided the function of questioning and exploring narrative meaning; during the middle phase, the function was performed jointly, and during the end phase the analyst was less active and the patient assumed the function (p. 28).

Using totally different methodologies, both Gedo and Schaffer's study and Nye's were able to show evidence consistent with the hypothesis that interpretations contributed to changing the patient's self-understanding in the course of an analysis. Further research is required to explore to what degree the relationships found reflect cause and effect, since the findings could be explained by other hypotheses as well.

Examination of the interaction between variables considered crucial to analytic work is illustrated by the two studies just described. Interpretation and insight were the objects of study, both being dimensions of analytic work generally agreed to as important among analysts. Progress along such lines has, however, been

[8] This consists of comparing the probability of any given remark being an insight with the probability of its being an insight *following an immediately prior interpretation.*

limited by past unreliability in describing or measuring crucial psychoanalytic dimensions. It is still often believed by many that psychoanalytic ideas are inherently unmeasurable (compare Seitz, 1966). With these problems in mind, a research group of senior analysts in New York (Waldron, et al., 1991) has developed reliable rating scales of analyst and patient response characteristics on many dimensions significant to analysts. Called the Analytic Process Scales (APS), they are applied to audiotapes and transcripts of sessions after raters have oriented themselves by listening to the three previous sessions to establish context. Ratings are made of the types, aims, characteristics and quality of interventions. Ratings of type include the degree to which an intervention is an encouragement to elaborate, a clarification, an interpretation, or a different kind of intervention, such as one that provides education, direction, praise, support, or analytic work-enhancing strategies. Aims rated include the degree to which the analyst approaches and works with resistances, transference derivatives, the patient's conflicts, and problems of self-esteem, as well as the degree of developmental focus in the intervention. Characteristics assessed include how confronting the analyst is, and how much the analyst's feelings are manifestly influencing his or her conduct with the patient. Finally, the quality of the intervention is assessed: how well does the analyst's response follow the patient's preceding material, and how optimal overall is the intervention for the patient? The patient is also assessed according to how well she or he conveys experiences in a way that permits the rater (and presumably the analyst) to understand the patient's conflicts, both in regard to the analyst and to the rest of the patient's life. Then the patient's productions are assessed as to analytic productivity and the degree of productive use that has been made of the analyst's previous interventions. Each analyst and patient variable is defined in a coding manual, and illustrative examples are provided for scale points. Anchoring the variables to actual clinical examples has resulted in much more reliable ratings of essential aspects of psychoanalytic work than have been accomplished before. This approach has the advantage of working with psychoana-

lytically meaningful dimensions in a way that is both scientifically acceptable and interesting to clinicians, and provides measures which can serve to explore in a more systematic way the interacting forces at work between analyst and patient. Early findings from this group have included clear-cut differentiation of patient-analyst pairs from each other on a wide variety of dimensions. Phases of treatment have also been differentiated. Differing responses of patients to different analytic interventions have been seen in a pilot sample, and the *pattern of scores* when examined through the course of sessions has revealed meaningful relationships as well (Waldron, 1997).

The establishment of reliable scores on the APS is an example of the importance of examining recorded material in sufficiently full context. Nevertheless, strategies for studying the interaction between analyst and patient may effectively *omit* portions of the material or alter the original sequence, for some limited purposes. For example, leaving out interventions allows researchers to evaluate the changes from one segment to another without being influenced by their preconceptions about the particular interventions made. L. Horowitz, et al. (1975) removed all statements indicating that the patient felt that certain insights had previously been warded off, in order to provide the raters themselves an unbiased opportunity to assess whether a change in self-awareness had occurred. Similarly, scrambling the sequence in which material is presented, so that it cannot be determined whether it came from early, middle, or late sessions, enables researchers to test hypotheses about change without being influenced by their knowledge of where the material occurred in the treatment. Such careful and ingenious planning can enhance the value of a study. If the impact of the observer's preconception or bias is minimized, the reliability of conclusions drawn from a study becomes greater.

Two special methodological problems have to be surmounted in studying interaction. One of these is the problem of *segmenting* the material in such a way that the researcher can score what is going on at a particular point in the treatment, then use it as a basis for comparison with other points in the same treatment. We

rightly regard an analysis as a continuous process throughout its course, one that may continue even after sessions have stopped; therefore, a division into segments, with its unavoidable implications of discontinuity, will inevitably involve assumptions that may obscure more than they clarify. The other problem concerns the statistical aspects of *how to assess changing relationships* between variables in complex systems over time. Special tools, which will be described under the general heading of *Time Series Analysis*, have been developed to deal with this.

1) *Segmenting.* Perhaps the simplest, most intuitive solution to this problem, and one that is unquestionably effective in many situations, is to divide an analysis into sessions and regard each analytic hour as a discrete unit. Causal relationships can be hypothesized on the basis of which changes took place in earlier hours and which changes followed. For instance, if an analyst makes a certain kind of transference interpretation in regard to transference sexual fantasies or wishes, and a significant alteration in the analytic atmosphere occurs in subsequent hours, a causal inference can be proposed. Jones and Windholz (1990) successfully used the one-hour division in applying their Q-sort instrument to a series of hours throughout a lengthy analysis.

Often, however, investigators wish to explore the *immediate* responses of patients to specific interventions. This requires them to separate the analytic material into units shorter than whole sessions so that they can focus more precisely on the interaction. Many analysts, for example, believe that the analysis of resistance is central to our endeavors (Gray, 1990; Weinshel, 1984). To study this relationship, it would be appropriate to divide the material into segments directly reflecting the interaction. Once this has been done, various measures can be applied which include whether the analyst addressed resistances, such as the analytic process scales described above (Waldron, et al., 1991). Another application could be that of a reliable resistance scale recently developed by Schuller, Crits-Christoph, and Connolly (1991).

How then may a session be divided? In some studies, the segment has been an arbitrary unit, such as the fifty lines of typescript

used by the current group at Menninger (Horwitz, et al., 1989). Certain computer-based studies, such as the application of Spence, Mayes, and Dahl's (1994) study of the "analytic surface" using the co-occurrence of first- and second-person pronouns, employ a 1,000-character search space in an effective way. Many researchers, however, would prefer to divide their material less mechanically, according to natural changes in the process. Although change of speaker is a simple, natural, and widely used criterion for division, it has marked disadvantages because the size of each segment reflects inversely the activity of the analyst, as well as whatever patient factors may stimulate differences in analytic activity. It is better to use a method that is conceptually driven, such as one that identifies significant changes of topic, whether the analyst comments on them or not. Bucci and Stinson (personal communications, 1990) have developed a system of "Major Thematic Units" and "Thematic Units" to demarcate the boundaries of topics in texts. Other investigators, including my group (Waldron, et al., 1991), have found their method both reliable and easy to use.

Two studies may be cited to illustrate the fruits of well-conceived segmentation procedures. Gassner, et al. (1982) revealed that, with one exception, in the first hundred hours of Mrs. C (a fully recorded case which has been extensively studied) warded-off mental contents emerged *without* the analyst specifically interpreting them. Similarly, in a study of psychotherapy, Elliott (1991) used discourse analysis[9] to show that the client's developing an important insight did *not* follow specific interpretations. Studies like these, by exploring the conditions leading to the development of insight, could lead to important changes in the theory of therapeutic action; and this in turn would help to clarify the role of interpretation *and other factors* in therapeutic change. Kris (1982), for example, has discussed the impact of the free associative procedure and of interventions aimed solely at facilitating the completeness of free

[9] "Discourse analysis" is not a set of theories or procedures, but is more loosely defined to include the ideas and methods developed by those interested in discourse.

associations. His views, among others, would provide an admirable basis for research into the preconditions of insight.

2) *Time Series Analysis.* When studying sequences of patient and analyst activities, researchers always encounter problems in assessing the patterns of change over time. These can be handled using a statistical approach called time series analysis, a well-defined discipline applicable to a wide range of fields, including the social sciences (Gottman, 1981; Gottman and Roy, 1990). Statistical methods are required to demonstrate meaningful correlations between a series of events, because unaided human observers generally do a poor job of distinguishing chance variations from significant differences. Time series analysis aids the exploration of the source of change by assessing the statistical significance of patterns of change. For example, determining whether a change in average temperature over time reflects seasonal variation or some other phenomenon would be a question for time series analysis.

Time series analysis has been widely used in the social sciences to study discourse (Gottman, 1981; Gottman and Parker, 1986). Gedo and Schaffer (1989) have applied it to the psychoanalytic process. To illustrate, one time-series method involves comparing the score for a variable in a patient segment with the score for that same variable in a previous segment, the latter serving as a baseline. One then compares the score with another variable, such as accuracy of interpretation, from the intervening analyst segment. This process is repeated for successive segments, thereby enabling one to ascertain what impact the analyst's intervention had on the patient's functioning in that dimension, as studied over a whole series of interventions. If, for example, one assessed increases in analytic productivity by means of time series analysis and found that they followed accurate interpretations of transference much more frequently than would be expected by chance, this would support the hypothesis of a causal relationship.[10] There are many pitfalls and problems in designing and carrying out such time

[10] See Sexton (1993) for a sophisticated example of studying such change sequences in group therapy.

series analyses, and the newer techniques of analyzing time ordered data do not provide sure-fire answers to design problems (Elliott and Anderson, 1994, pp. 83-86). However, careful attention to the measures used in relation to the goals of the study can lead to valuable results. It is possible to study the bi-directionality of influence in the psychoanalytic situation (pp. 90-91) and assess the degree to which the analyst's approach is influencing the patient and vice-versa. For example, in the Analytic Process (APS) study described above (Waldron, 1997), there was a patient-analyst pair showing a much more successful analytic process than was the case for two other pairs. For this successful pair, there was a *strong* relationship between the quality of the intervention and immediately subsequent patient productivity. There was also a *moderate* relationship between the patient's productivity and the quality of the immediately *subsequent* analyst intervention. In other words, both parties to the analytic process had a facilitating role, *and* analysis of the interaction patterns supported the view that the quality of interventions made a special contribution to a successful analytic process.

The Use of Multiple Measures in Efficacy Research

For many years the use of multiple measures has been recommended to assess any characteristic of interest (Waskow and Parloff, 1975). Agreement between findings from more than one approach increases our confidence in their validity and enhances our ability to generalize from them. There are important areas of overlap among the various measures that we can apply to treatments, and determining precisely where they differ and where they resemble one another would do much to establish their value. For example, Wallerstein's group has developed what it calls "Scales of Psychological Capacities" (DeWitt, et al., 1991; Sundin, et al., 1994) to tap the kinds of changes that most analysts believe are especially furthered by psychoanalysis and intensive psychoanalytic psychotherapy. These scales reflect capacities in living, and are clearly relevant to the quality-of-life issues that I will

discuss shortly. They also reflect aspects of defensive functioning when "defenses" are understood in a broad sense. It would be extremely valuable to apply these scales to patient material *together with* the much more complex method of assessment developed by M. J. Horowitz and his co-workers (1984).

The Horowitz method defies succinct characterization, but certain comments can be made about it here. The assessment of a patient at multiple points in a treatment leads to thirteen dimensions in regard to symptoms, relationships, and the self, which are summarized in an instrument called the "Patterns of Individual Change Scales." Changes in the patient are represented graphically in a way that is highly specific for the patient and clearly captures the actual changes (or lack thereof) brought about through treatment. Both the Wallerstein and Horowitz measures have the great virtue of reflecting how psychoanalysts actually think about their patients, especially in regard to important qualities in which they hope to effect change. Bringing these measures into a careful relationship with each other would therefore produce a whole greater than the sum of its parts.

Multiple measures are useful not only for validation but—and this is perhaps more important—for identifying changes in the psychoanalytic process through changes in the relationship of one measure to another. Skolnikoff (1985) compared the results of two different forms of data collection. First, he dictated process notes immediately after each session. These were transcribed at the end of the week and read by his collaborator, Emanuel Windholz. He then began the following week by recounting in a free-form manner the previous week's work with the patient. This report was tape-recorded. The collaborators found many discrepancies between the process notes and the tape-recorded recollections; moreover, these discrepancies were greatest at times that, in retrospect, had proved to be especially productive. In short, the analyst's departures from neutrality tended to coincide with analytic progress.

This discovery lends experimental support to Boesky's (1990) view that effective treatment requires a complementary response in the analyst to the patient's conflicts, a response usually marked

by discomfort and a temporary departure from neutrality. Further studies should be planned of the *variation* in the reactions of both the analyst and the patient, using *more than one source of information at various points in the analysis.* A whole range of psychoanalytic process variables can be based upon this approach. Von Benedek (1992), for example, has reported extensive recorded interviews with twenty psychoanalysts at the initiation of treatment and one year later, providing documentation of the complexity (and imperfection) of the analyst's response to the patient over time.

Process notes normally focus on the analyst's observations about the patient, while tape recordings of sessions provide only the spoken words of both participants. In keeping with an increasing emphasis on the emotional reactions of the analyst her/himself, new sources of information have come to include the analyst's unspoken thoughts and feelings, and even unspoken associations, visual imagery, and bodily sensations (Gardner, 1983; Jacobs, 1973). So far, however, there has been little systematic accumulation of such information. Many analysts might be more willing to write down their reactions during or immediately after a session if they felt assured that they would not be embarrassed by subsequent exposure. Tape recording the same sessions would allow comparisons to be made between the analyst's internal experience and the external discourse. Using a special diary as a data source, Calder (1980) has demonstrated the value of such self-scrutiny in his study of self-analysis. Meyer (1988), in a small but elaborate study, has compared recorded sessions with "retro reports" dictated by the analyst immediately after each session. His clinical exploration of analytic thinking using this method appears to me to be well thought out and may hold much promise for future developments (see also, Kächele, 1988, p. 66).

Evaluating Outcomes by Combining Process Variables and Quality-of-Life Variables

Evaluating the quality of the patient's life after treatment is obviously central to any attempt to ascertain the efficacy of psy-

choanalysis. Multiple measures are very important in this regard, because so many different aspects—the quality of relationships, relative freedom from severe symptoms, and the capacity for a productive daily life—contribute to a person's overall level of mental health. However, this task is not as difficult as it may appear: research has shown that measures that assess the various dimensions of mental health from interviews have become increasingly more reliable, in that clinicians and others agree far more often than one might expect about how healthy or sick a given individual is.

This remarkable and encouraging finding emerged from the use of the Health-Sickness Rating Scales (Luborsky, 1962; Luborsky and Bachrach, 1974). After determining the general level of the individual's health, on the basis of the study of a particular data source (process notes, case reports, tape recordings and so on), a manual containing thirty-four case illustrations graded on a 100-point scale is consulted, and the health-sickness rating is arrived at by deciding whether the individual in question is more or less healthy than a given case illustration. This has turned out to be a highly reliable method of evaluation, one that produces little disagreement about the degrees of illness exhibited by a wide range of patients from radically different backgrounds and with radically different symptom pictures. In other words, these studies have shown that mental health has to a considerable degree a *unitary* quality. Furthermore, there is a strong correlation among the various subdimensions of mental health (Luborsky, 1962; Luborsky and Bachrach, 1974; Ogles, et al., 1995; Waldron, 1976), leading us to believe that the health-sickness rating represents an important property of the individual that is completely relevant to psychoanalytic efficacy research. Hartmann's (1939) concept of a unitary adaptive function appears to be supported by these empirical findings.[11]

[11] There remains the thorny problem of whether, ultimately, such agreements about the mental health of individuals simply represent a shared cultural bias. However, I present the HSRS in such a positive way because the findings still represent a major

Clinical assessment methods can be applied to various forms of primary data derived from diagnostic or therapeutic interviews. Global assessments of mental health derived from such materials tend to correlate strongly with such "objective" indices of social impairment as educational and job history, marital status, criminal record, and so on (Robins, 1966; Waldron, 1976). Epidemiological and developmental studies from several centers concur in this finding (Dohrenwend, et al., 1980; Robins, 1966; Vaillant, 1974, 1975, 1976, 1978, 1986; Vaillant and McArthur, 1972; Vaillant and Vaillant, 1981, 1990). Wallerstein (1986) has provided perhaps the richest evidence for the interplay between "objective" indices and the course of a person's psychological unfolding over decades.

Quality of life measures. The psychoanalytic understanding of mental processes has long recognized that an absence of symptoms cannot be equated with mental health. Nevertheless, psychiatric study has tended to focus on target symptoms because they provide a definable area for research (Battle, et al., 1966). Recently, many researchers have come to realize that the measures for evaluating the outcomes of clinical interventions must reflect more than an absence of pathology (Greenfield, 1989). In evaluating coronary care units (Ellwood, 1988), health care systems (Brooks, 1991; Nord, 1991), treatment of end-stage renal disease (Parfrey, et al., 1989), and treatment of cancer (Reizenstein, 1986), the question has become not merely whether intervention has eradicated the disease, but whether it has made the patient's general *quality of life* better or worse; and investigators have developed methodologies to this end (see also, T. M. Gill and Feinstein, 1994; Markowitz, et al., 1989; Stewart, et al., 1989; Wells, et al., 1989). Research into psychoanalytic outcomes should follow their lead.

Psychological tests are an important source of information about patient functioning, especially as they are largely protected

---

contribution, in my opinion, and an important advance in our field, even if ultimately there are important limits to the generalizing of findings across cultures.

from contamination by the motivations of either the patient or the analyst. Recently, Blatt and his co-workers (Blatt, 1990, 1992; Blatt and Berman, 1984) have developed measures of object-relatedness based upon the Rorschach test, and these have been productively applied to the protocols at the outset and termination of most Menninger Psychotherapy Research Project patients. They have found an interaction between the patient personality type, the type of treatment applied, and the results of the treatment. This illustrates the advantage of carefully appraising the treatment actually given and the patient's actual response to it. Such a corroborative source of information about outcomes would be a valuable addition to any efficacy study.

We can also evaluate quality-of-life using several validated self-report instruments that correlate with assessments by experienced clinicians (Fisher, et al., 1989; L. Horowitz, et al., 1988). Analysts generally regard psychological data derived from self-report instruments as superficial; however, if the instruments are well chosen, such information allows us to evaluate the results of analytic work in settings where clinical evaluations and follow-ups are not feasible. These instruments may be useful in situations where repeated assessments are needed and in gathering data on control groups or comparison groups.

Developing process measures which correlate with quality-of-life measures. One reason to study the relationship between treatment and outcome is to find out whether we can use materials derived from treatments to assess their benefits with reasonable accuracy.[12] For example, can we assess the quality of relationships, capacity for productive involvement, and relative freedom from crippling symptoms with the aid of detailed process notes or tape recordings made toward the end of treatment? Such methodological advances would provide an important springboard for substantive studies.

Process-outcome studies in the closing phases of treatment could

[12] The concept of patient-treatment-outcome congruence from the Vanderbilt research group (Strupp, et al., 1988) is a useful one in this regard.

proceed by assessing how the patient relates to the analyst, or by assessing other aspects of the patient's functioning on the basis of the patient's reports *during treatment* of her or his ongoing daily life. Clinicians have often observed changes in the way their patients relate to them as a successful analysis draws to a close; however, these changes have not been systematically studied except by Pfeffer (1959, 1961, 1963) and those inspired by him. It would appear that patients re-experience the same core transference pattern during the brief period of the follow-up, but it no longer holds the same unbending sway over them, and they are able to mobilize adaptive responses, especially that of self-analysis (see also, Schlessinger and Robbins, 1983).

There have been other systematic findings that reflect the way patients relate to the analyst, to others in their lives and to themselves toward the end of treatment. Dahl found less stereotypy in frames toward the end of Mrs. C's analysis. A change of this nature makes clinical sense, reflects desirable shifts of personality, and can be confirmed by other observers.[13] Similarly, Luborsky, et al., (1988) have ascertained that in psychotherapy that has been judged successful on other grounds, patients describe events ("relationship episodes") in a less stereotyped manner toward the end of treatment. The patients' scores on the Core Conflict Relationship Theme (CCRT) changed correspondingly, the greater variety of themes directly indicating that they were no longer stuck in their old patterns to the same degree. Bucci's studies of changes in referential activity (RA) permit additional confirming (or disconfirming) assessments of changes in patient material (see Dahl, et al., 1988).

Other process measures can be developed which may prove valuable in assessing the change that occurs from the beginning to the end of an analysis. For example, if we could measure the degree to which the patient associates freely, we might be able to directly evaluate the quality of the work of analysis (Kris, 1982).

[13] Remaining to be established would be evidence of the generalization of these changes to the rest of the patient's life.

Spence, Dahl, and Jones (1993) have made such an effort in looking at lexical co-occurrences in relation to changes through an analysis. Changes in symptomatic impairment as manifested in the analytic hour can readily be studied (compare Jones and Windholz, 1990); and the quality of the patient's life outside analysis, at least from the patient's perspective, can be rated from what she/he tells us about her/his relationships, productivity, and symptomatic impairment.

To date, no study has explored the relationship between such process-derived measures of outcome and the gathering of information by various means at follow-up. There is a large body of data, comprising the more than fifty cases that have been studied using the methodology of Pfeffer (1959, 1961, 1963; Norman, et. al., 1976; Oremland, et al., 1975; Schlessinger and Robbins, 1983), which might be used for this purpose. Collected material could be studied from two points of view, that of outcomes as judged by the process and that of outcomes as described by patients to the follow-up analyst. Other studies along similar lines could be conducted within treatment centers at our institutes, in which systematic efforts at data collection would be made in order to assess process and outcome at beginning, end, and follow-up using multiple measures. Studies of this kind are particularly important because the *validity*[14] of any assessment of efficacy of psychoanalysis is best established through convergent measures.

Our efforts would be greatly facilitated if it could be determined whether outcome measures derived from material *recorded toward the end of treatment* accurately predict outcome measures derived from material *collected during follow-up.* Follow-up studies are difficult to arrange at best, whereas it is relatively easy to record treatments (although it is not easy to persuade analysts to record). For this reason, establishing the relevance of process-derived outcome measures to ultimate outcomes would make a much broader sample of cases available to researchers interested in evaluating

[14] See Cook and Campbell (1979) for a helpful discussion of various aspects of problems of validity.

efficacy than could possibly be obtained from follow-up studies alone.

The Problem of Control Subjects in Outcome Research

In the Menninger study (Wallerstein, 1986), a large proportion of patients showed substantial positive changes in their health-sickness ratings (Luborsky, 1962).[15] This is an encouraging finding; however, in the absence of a control group—a group of subjects who were treated by other methods or not at all—for comparison, we cannot assume with complete confidence that these improvements resulted solely or even primarily from treatment (Malan, et al., 1975). It is true that clinicians are generally convinced that the changes they observe in their patients are influenced, at least to a considerable extent, by the therapeutic relationship; on the other hand, it is also true that people *do* make improvements on their own, or with the help of Alcoholics Anonymous, various self-help groups, organized religion, and other aids. Longitudinal studies have shown changes during the life cycle which sometimes suggest very substantial improvements (Vaillant, 1976; Vaillant and McArthur, 1972; Vaillant and Vaillant, 1981, 1990; Wallerstein, 1986), and these are sometimes brought about by individuals reflecting on their own characteristic behaviors, without any significant psychotherapeutic intervention. Vaillant (1976) has reported instances of this in connection with midlife crises. If outcome studies are to support the value of psychoanalysis and other allied therapies, it is not enough for them to demonstrate that positive changes occurred; they must also demonstrate through the use of control groups that these changes were substantially less likely to have happened without treatment.

It would be grossly unethical, of course, to withhold treatment from persons who need it in order to create a control group. It would be possible, however, to do collaborative studies comparing

[15] See Bachrach, et al. (1991) for a statistical summary of these changes.

the immediate and long-term outcomes of patients treated by analysis with those of patients treated by nonanalytic modalities. This approach is consistent with thinking in regard to controlled studies of cancer patients: the emphasis has changed from having only one control group to having different kinds of comparison groups (Gehan and Freireich, 1974). The study of *any* comparison group can tell us something about the relationship between the processes of treatment and outcome.

To a certain extent, cases within the study population itself can provide a kind of control group, since in virtually any study there will be persons in whom "analytic process," however defined, will not occur. For instance, some patients will not develop reflective self-awareness specifically tied to understandings derived from interpretations. Studying the differences between these patients and those who develop a more typical psychoanalytic process would accomplish our goal of relating process to outcome, whether or not a given treatment was *intended to be a psychoanalysis*! In other words, one source of comparative information about the impacts of a typical psychoanalytic process may be the differences both at the time and subsequently, between those who *do* and *do not* work with their psychoanalyst in a way characteristic of a psychoanalysis. The Menninger Psychotherapy Research Project (Wallerstein, 1986) provides the best systematic documentation of the way many cases assigned to a psychoanalysis ended up having very different actual treatment experiences (see also, Erle, 1979; Erle and Goldberg, 1984).

Another kind of control group for psychoanalysis might be found in a community large enough to provide a sufficient number of patients but in which analysis is unavailable—for example, rural Stirling County in Maine, which provided the population for the extensive study of mental health in a community by Leighton, et al. (1963). Data might be collected from such a control group with only moderate funding and the services of a single supervising analyst, who would coordinate data collection longitudinally during regular visits to the community. In fact, the data from studies like the Stirling County one may already be suitable for

forming comparison groups. Such longitudinal projects, including the one reported by Vaillant (1986), have accumulated extensive databases that might well be adapted to yield comparison data bearing on the natural course of health-sickness. If the measures applied to analyzed cases (Waskow and Parloff, 1975) can also be applied to other longitudinal databases, we will be able to compare changes in health-sickness following nonanalytic therapies with those following psychoanalysis.

The Need for Follow-up Studies

In order to demonstrate that the benefits of psychoanalysis are not only real but *lasting,* follow-up studies are indispensable (Wallerstein, 1992). Unfortunately, there have been very few efforts to collect follow-up data across a broad range of patients. The data collected in follow-up of the Menninger cohort over a period of up to thirty years (Wallerstein, 1986) is available; the studies using Pfeffer's methodology (Norman, et al., 1976; Oremland, et al., 1975; Schlessinger and Robbins, 1974, 1983) are in effect follow-up studies; and the termination of analysis has been studied systematically by Schachter (1990; Panel, 1989) and by Firestein (1978). The work of Knapp, et al. (1960), Klein (1960), and Kantrowitz, et al. (1987a, 1987b, 1990a, 1990b, 1990c) is also relevant in this regard. Admittedly, follow-up investigations pose formidable practical problems, not the least of which is securing the necessary long-term commitment and funding. However, the widespread belief that it is harmful for an analyst to contact former patients should not be allowed to complicate an already difficult situation. The experiences of the investigators that I have mentioned, especially those of Schachter's group (1990; Panel, 1989), convinced those who collected the data that, far from being harmful, such contacts were actually *beneficial* to many patients. Of course, this finding needs further confirmation by other studies.

Follow-up research can also provide opportunities for studying

the mechanism of therapeutic action. To the best of my knowledge, the relationships between the patient's initial problems, the subsequent course of treatment, the patient's report of what seemed beneficial in retrospect, and the analyst's report have never been systematically studied. Some of the data collected by Schlessinger and Robbins (1974, 1983; also Schlessinger, 1987) could be studied in this regard. It would be informative to study the degree of agreement between analyst and patient, and the degree to which core transference issues have been worked through. Information gained from this approach could help to illuminate the mechanisms of change in psychoanalysis (Appelbaum, 1977) and clarify the role of the match between patient and analyst (Kantrowitz, et al., 1990c).

Follow-up studies can also contribute a great deal to the education of analysts. With this in mind, it would seem reasonable to build follow-up agreements into the understandings reached with patients treated in our low-cost clinics. The benefit to students and faculty alike of systematic follow-up might be considerable.

The Need for Collaboration and Organizational Support

The extensive goals that I have described here cannot be achieved without extensive collaboration. The efforts required to initiate and sustain such collaboration are warranted when the findings can be expected to be of interest to most psychoanalysts, and to benefit the field as a whole. The scientific yields of collaboration were illustrated at the 1985 meeting of the Society for Psychotherapy Research (SPR) in Ulm and in the book by Dahl, Kächele, and Thomä (1988) that resulted from this meeting. The meetings of the SPR have provided opportunities for scientific discussion, and the International Psychoanalytical Association (IPA) has recently begun an annual research meeting in London. However, these forums are not sufficiently accessible to most American psychoanalytic clinicians with a research interest, and the presentations at the SPR are generally distant from the central

interests of psychoanalysts. There is as yet no central coordinated ongoing effort in the nature of a Task Force on Research under the aegis of the American Psychoanalytic Association, or its allied organizations. The efforts led by Wallerstein on a twice yearly basis, entitled the Collaborative Analytic Multisite Program (CAMP), have not so far led to a coherent enterprise with significant funding. Expenditures on research in psychoanalysis on an annual basis are minute, compared, for example, to the funding for research on brain wave imaging which has caught the imagination of many. Unfortunately, educated people have not become convinced so far that exciting advances can readily be attained in psychoanalysis through systematic research on a sufficient scale. The paths of research described in this paper could, I believe, lead to such exciting advances.

A broader problem is that of the role of research in psychoanalytic education. A recent survey by Richards (1991) reveals that research teaching in most institutes is severely limited. Few even have a person specifically knowledgeable about research on their curriculum committees. Despite some conspicuous exceptions that I have discussed in this paper, there has been too little cross-fertilization of ideas between clinicians and researchers in the psychoanalytic community: in fact, psychotherapy researchers and clinicians in general have had hardly any effect at all on one another's thinking (Bachrach, et al., 1991; Kazdin, 1986; Luborsky and Spence, 1978).

National organizations should exert themselves to promote the exchange of ideas. Individuals or groups within each institute and society could be designated to facilitate the planning of collaborative studies of specific topics, and a consultative arm of the American Psychoanalytic Association could be formed to make experienced researchers with a knowledge of clinical work available to members who have research questions. This in turn might lead to engaging more clinicians in research efforts of interest to the clinical psychoanalytic community. In addition, coordinated efforts to raise research funds are sorely needed.

It is hoped that the broad overview presented by this paper may

serve to inspire interest and support. I have prepared two subsequent articles to provide a further stimulus: the first considers in detail issues about data collection and utilization, and the second describes a series of specific studies which spring from the general principles espoused here. Many of the issues described here have been more extensively discussed in a recent volume edited by Miller, et al. (1993), which includes chapters by many of the authors cited in this paper. In addition, a volume edited by Shapiro and Emde (1995) has thoughtful contributions addressing many of the same issues (see also, Galatzer-Levy, et al., 1997). Finally, many technical issues of importance are thoughtfully discussed in *Reassessing Psychotherapy Research* (Russell, 1994), as indicated in the several selections from this work cited in this paper.

REFERENCES

APPELBAUM, S. A. (1977). *The Anatomy of Change: A Menninger Foundation Report on Testing the Effects of Psychotherapy.* New York/London: Plenum Press.

BACHRACH, H. M., GALATZER-LEVY, R., SKOLNIKOFF, A. & WALDRON, S., JR. (1991). On the efficacy of psychoanalysis. *J. Amer. Psychoanal. Assn.*, 39:871-916.

BARLOW, D. (1981). On the relation of clinical research to clinical practice: current issues, new directions. *J. Consult. Clin. Psychol.*, 49:147-155.

BATTLE, C., et al. (1966). Target complaints as criteria of improvement. *Amer. J. Psychother.*, 20:184-192.

BECKER, H. (1958). Problems of inference in proof in participant observation. *Amer. Sociological Rev.*, 23:652-660.

——— (1967). Whose side are we on? *Social Problems*, 14:239-247.

BLATT, S. J. (1990). The Rorschach: a test of perception or an evaluation of representation. *J. Personality Assess.*, 55:394-416.

——— (1992). The differential effect of psychotherapy and psychoanalysis with anaclitic and introjective patients: the Menninger Psychotherapy Research Project revisited. *J. Amer. Psychoanal. Assn.*, 40:691-724.

——— & BERMAN, W. (1984). A methodology for the use of the Rorschach in clinical research. *J. Personality Assess.*, 48:226-239.

BOESKY, D. (1990). The psychoanalytic process and its components. *Psychoanal. Q.*, 59:550-584.

BORKOVEC, T. D. & MIRANDA, J. (1996). Between-group psychotherapy outcome

research and basic science. *Psychother. and Rehab. Research Bull.*, #5. Rockville, MD: National Institute of Mental Health, pp. 14-20.

BROOKS, R. G. (1991). EuroQol—health-related quality of life measurement—results of the Swedish questionnaire exercise. *Health Policy*, 18:1.

CALDER, K. T. (1980). An analyst's self-analysis. *J. Amer. Psychoanal. Assn.*, 28:5-20.

CHEAPE, C. (1985). *Family Firm to Modern Multinational: Norton Company, a New England Enterprise.* Harvard Studies in Business History, No. 36. Cambridge, MA: Harvard Univ. Press.

CONANT, J. (1957). *Harvard Case Studies in the History of Science*, ed. J. Dunner. Cambridge, MA: Harvard Univ. Press.

COOK, T. D. & CAMPBELL, D. T. (1979). *Quasi Experimentation: Design and Analysis Issues for Field Settings.* Chicago: Rand McNally.

DAHL, H., KÄCHELE, H. & THOMÄ, H., Editors. (1988). *Psychoanalytic Process Research Strategies.* Heidelburg/New York: Springer-Verlag.

DALZELL, R. (1987). *Enterprising Elite: The Boston Associates and the World They Made.* Harvard Studies in Business History, No. 40. Cambridge, MA: Harvard Univ. Press.

DAVISON, W. T., PRAY, M. & BRISTOL, C. (1990). Mutative interpretation and close process monitoring in a study of psychoanalytic process. *Psychoanal. Q.*, 59:599-628.

DEWITT, K. N., et al. (1991). Scales of psychological capacities: development of an assessment approach. *Psychoanal. Contemp. Thought*, 14:343-361.

DOHRENWEND, B. P., et al. (1980). Nonspecific psychological distress and other dimensions of psychopathology, measures for use in the general population. *Arch. Gen. Psychiat.*, 37:1229-1236.

EDELSON, M. (1984). *Hypothesis and Evidence in Psychoanalysis.* Chicago/London: Univ. of Chicago Press.

ELLIOTT, R. (1991). Five dimensions of therapy process. *Psychother. Research*, 1: 92-103.

——— & ANDERSON, C. (1994). Simplicity and complexity in psychotherapy research. In *Reassessing Psychotherapy Research*, ed. R. L. Russell. New York: Guilford, pp. 65-113.

ELLWOOD, P. (1988). Outcome management: a technology of patient experience. *New England J. Med.*, 318:1549-1556.

ERLE, J. B. (1979). An approach to the study of analyzability and analyses: the course of forty consecutive cases selected for supervised analysis. *Psychoanal. Q.*, 48:198-228.

——— & GOLDBERG, D. A. (1984). Observations on assessment of analyzability by experienced analysts. *J. Amer. Psychoanal. Assn.*, 32:715-737.

FINE, S. & FINE, E. (1990). Four psychoanalytic perspectives: a study of differences in interpretive interventions. *J. Amer. Psychoanal. Assn.*, 38:1017-1047.

FIRESTEIN, S. K. (1978). *Termination in Psychoanalysis.* New York: Int. Univ. Press.

FISHER, J., et al. (1989). Psychological effects of participation in a large group awareness training. *J. Consult. Clin. Psych.*, 57:747-755.

GALATZER-LEVY, R., BACHRACH, H., SKOLNIKOFF, A. & WALDRON, S. (1997). *Does Psychoanalysis Work?* New Haven: Yale Univ. Press. In press.

GARDNER, R. M. (1983). *Self Inquiry.* Boston/Toronto: Little Brown.

GARDUK, E. L. & HAGGARD, E. A. (1972). *Immediate Effects on Patients of Psychoanalytic Interpretations. Psychol. Issues, Monogr. 28.* New York: Int. Univ. Press.

GASSNER, S., SAMPSON, H., WEISS, J. & BRUMER, S. (1982). The emergence of warded-off contents. *Psychoanal. Contemp. Thought,* 5:55-76.

GEDO, P. M. & SCHAFFER, N. (1989). An empirical approach to studying psychoanalytic process. *Psychoanal. Psychol.,* 6:277-291.

GEERTZ, C. (1983). *Local Knowledge: Further Essays in Interpretive Anthropology.* New York: Basic Books.

GEHAN, E. & FREIREICH, E. (1974). Non-randomized controls in cancer clinical trials. *New England J. Med.,* 290:198-203.

GILL, M. M. & HOFFMAN, I. Z. (1982). A method for studying the analysis of aspects of the patient's experience of the relationship in psychoanalysis and psychotherapy. *J. Amer. Psychoanal. Assn.,* 30:137-167.

GILL, T. M. & FEINSTEIN, A. R. (1994). A critical appraisal of the quality of quality-of-life measurements. *J. Amer. Med. Assn.,* 272:619-626.

GOTTMAN, J. (1981). *Time Series Analysis: A Comprehensive Introduction for Social Scientists.* New York: Cambridge Univ. Press.

——— & PARKER, J., Editors. (1986). *Conversations of Friends.* Cambridge: Cambridge Univ. Press.

——— & ROY, A. (1990). *Sequential Analysis: A Guide for Behavioral Researchers.* New York: Cambridge Univ. Press.

GRAY, P. (1990). The nature of therapeutic action in psychoanalysis. *J. Amer. Psychoanal. Assn.,* 38:1083-1097.

GREENACRE, P. (1966). Problems of overidealization of the analyst and of analysis. Their manifestations in the transference and countertransference relationship. *Psychoanal. Study Child,* 21:193-212.

GREENFIELD, S. (1989). The state of outcome research: are we on target? *New England J. Med.,* 320:1142-1143.

HARTMANN, H. (1939). *Ego Psychology and the Problem of Adaption.* Translated by D. Rapaport. New York: Int. Univ. Press, 1958.

HOROWITZ, L., et al. (1975). On the identification of warded-off mental contents: an empirical and methodological contribution. *J. Abnormal Psychol.,* 84:545-558.

——— et al. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *J. Consult. Clin. Psych.,* 56:885-892.

——— et al. (1989). Psychodynamic formulation, consensual response method, and interpersonal problems. *J. Consult. Clin. Psych.,* 57:599-606.

HOROWITZ, M. J., et al. (1984). *Personality Styles and Brief Psychotherapy.* New York: Basic Books.

HORWITZ, L., et al. (1989). Menninger Study of Psychotherapy of Borderline

Patients: Expressive vs. Supportive Interventions and the Therapeutic Alliance. Unpublished.

JACOBS, T. J. (1973). Posture, gesture, and movement in the analyst: cues to interpretation and countertransference. *J. Amer. Psychoanal. Assn.*, 21:77-92.

JONES, E. E., Editor. (1993). Special section: single-case research in psychotherapy. *J. Consult. Clin. Psychol.*, 61:371-430.

——— CUMMING, J. D. & HOROWITZ, M. J. (1988). Another look at the nonspecific hypothesis of therapeutic effectiveness. *J. Consult. Clin. Psychol.*, 56: 48-55.

——— & WINDHOLZ, M. (1990). The psychoanalytic case study: toward a method for systematic inquiry. *J. Amer. Psychoanal. Assn.*, 38:985-1015.

KÄCHELE, H. (1988). Clinical and scientific aspects of the Ulm process model of psychoanalysis. *Int. J. Psychoanal.*, 69:65-73.

——— & THOMÄ, H. (1993). Psychoanalytic process research: methods and achievements. *J. Amer. Psychoanal. Assn.*, Suppl., 41:109-129.

KANTROWITZ, J. L., et al. (1987a). Changes in the level and quality of object relations in psychoanalysis: followup of a longitudinal prospective study. *J. Amer. Psychoanal. Assn.*, 35:23-46.

——— et al. (1987b). The role of reality testing in psychoanalysis: followup of 22 cases. *J. Amer. Psychoanal. Assn.*, 35:367-385.

——— et al. (1990a). Followup of psychoanalysis five to ten years after termination: I. Stability of change. *J. Amer. Psychoanal. Assn.*, 38:471-496.

——— et al. (1990b). Followup of psychoanalysis five to ten years after termination: II. Development of the self-analytic function. *J. Amer. Psychoanal. Assn.*, 38:637-654.

——— et al. (1990c). Followup of psychoanalysis five to ten years after termination: III. The relationship between the resolution of the transference and the patient-analyst match. *J. Amer. Psychoanal. Assn.*, 38:655-678.

KAZDIN, A. E. (1982). *Single-Case Research Designs: Methods for Clinical and Applied Settings.* New York: Oxford Univ. Press.

——— (1986). The evaluation of psychotherapy: research design and methodology. In *Handbook of Psychotherapy and Behavior Change*, ed. S. L. Garfield & A. E. Bergin. 3rd ed. New York: Wiley, pp. 23-68.

KLEIN, H. R. (1960). A study of changes occurring in patients during and after psychoanalytic treatment. In *Current Approaches to Psychoanalysis*, ed. P. H. Hoch & J. Zubin. New York: Grune & Stratton, pp. 151-175.

KNAPP, P. H., et al. (1960). Suitability for psychoanalysis: a review of one hundred supervised analytic cases. *Psychoanal. Q.*, 29:459-477.

KRIS, A. O. (1982). *Free Association: Method and Process.* New Haven/London: Yale Univ. Press.

LEIGHTON, D., et al. (1963). *The Character of Danger.* New York: Basic Books.

LEVY, S. T. & INDERBITZIN, L. B. (1990). The analytic surface and the theory of technique. *J. Amer. Psychoanal. Assn.*, 38:371-391.

LUBORSKY, L. (1962). Clinicians' judgments of mental health: a proposed scale. *Arch. Gen. Psychiat.*, 7:407-417.

——— & BACHRACH, H. (1974). Factors influencing clinicians' judgments of mental health, eighteen experiences with the health-sickness rating scale. *Arch. Gen. Psychiat.*, 31:292-299.

——— CRITS-CHRISTOPH, P., MINTZ, J. & AUERBACH, A. (1988). *Who Will Benefit from Psychotherapy? Predicting Therapeutic Outcomes.* New York: Basic Books.

——— & SPENCE, D. (1978). Quantitative research on psychoanalytic therapy. In *Handbook of Psychotherapy and Behavior Change*, ed. S. L. Garfield & A. E. Bergin. Revised Edition. New York: Wiley, pp. 331-368.

——— et al. (1979). Preconditions and consequences of transference interpretations. *J. Nervous Mental Disease*, 167:391-401.

MALAN, D. H., HEATH, E. S., BACAL, H. M. & BALFOUR, F. H. G. (1975). Psychodynamic changes in untreated neurotic patients: II. Apparently genuine improvements. *Arch. Gen. Psychiat.*, 32:110-126.

MARKOWITZ, J. S., et al. (1989). Quality of life in panic disorder. *Arch. Gen. Psychiat.*, 46:984-992.

MEYER, A.-E. (1988). What makes psychoanalysts tick? A model and the method of audio-recorded retroreports. In *Psychoanalytic Process Research Strategies*, ed. H. Dahl, H. Kächele & H. Thomä. Heidelburg/New York: Springer-Verlag, pp. 273-289.

MILLER, N., LUBORSKY, L., BARBER, J. & DOCHERTY, J. (1993). *Psychodynamic Treatment Research: A Handbook for Clinical Practice.* New York: Basic Books.

MISHLER, E. G. (1990). Validation in inquiry-guided research: the role of exemplars in narrative studies. *Harvard Educational Rev.*, 60:415-442.

NACHMIAS, D. & NACHMIAS, C. (1976). *Research Methods in the Social Sciences.* New York: St. Martin's Press.

NORD, E. (1991). EuroQol—health-related quality of life measurement—valuations of health states by the general public in Norway. *Health Policy*, 18:25-36.

NORMAN, H. F., BLACKER, K. H., OREMLAND, J. D. & BARRETT, W. G. (1976). The fate of the transference neurosis after termination of a satisfactory analysis. *J. Amer. Psychoanal. Assn.*, 24:471-498.

NYE, C. (1991). Discourse analysis of narrative process in a psychoanalytic case. Presented to the meeting of the Society for Psychotherapy Research, June.

OGLES, B. M., LAMBERT, M. J. & SAWYER, J. D. (1995). Clinical significance of the National Institute of Mental Health treatment of depression collaborative research program data. *J. Consult. Clin. Psychol.*, 63:321-326.

OREMLAND, J. D., BLACKER, K. H. & NORMAN, H. F. (1975). Incompleteness in "successful" psychoanalyses: a follow-up study. *J. Amer. Psychoanal. Assn.*, 23: 819-844.

PANEL (1989). Evaluation of outcome of psychoanalytic treatment: should fol-

lowup by the analyst be part of the post-termination phase of analytic treatment? M. Johan, Reporter. *J. Amer. Psychoanal. Assn.*, 37:813-822.

PANIAGUA, C. (1985). A methodological approach to surface material. *Int. Rev. Psychoanal.*, 12:311-325.

PARFREY, P., et al. (1989). Development of a health questionnaire specific for end-stage renal disease. *Nephron.*, 52:20-28.

PERRY, J., AUGUSTO, F., & COOPER, S. (1989). The assessment of psychodynamic conflicts: I. Reliability of the idiographic conflict formulation method. *Psychiatry*, 52:289-301.

——— & COOPER, S. (1986). What do cross-sectional measures of defense mechanisms predict? In *Empirical Studies of Ego Mechanisms of Defense*, ed. G. E. Vaillant. Washington, DC: American Psychiatric Press.

PFEFFER, A. Z. (1959). A procedure for evaluating the results of psychoanalysis. A preliminary report. *J. Amer. Psychoanal. Assn.*, 7:418-444.

——— (1961). Follow-up study of a satisfactory analysis. *J. Amer. Psychoanal. Assn.*, 9:698-718.

——— (1963). The meaning of the analyst after analysis. A contribution to the theory of therapeutic results. *J. Amer. Psychoanal. Assn.*, 11:229-244.

POPPLE, C. (1974). *Development of Two Bank Groups in the Central Northwest: A Study in Bank Policy and Organization.* Harvard Studies in Business History. Cambridge, MA: Harvard Univ. Press.

REIZENSTEIN, P. (1986). Quality of life in cancer patients. *Med. Oncol. Tumor Pharmacother.*, 3:51-54.

RICHARDS, A. D. (1991). The role of research in Institutes of the American Psychoanalytic Association. Presentation, First IPA Congress on Research, London, April.

ROBINS, L. N. (1966). *Deviant Children Grown Up.* Baltimore: Williams & Wilkins.

RUSSELL, R. L., Editor. (1994). *Reassessing Psychotherapy Research.* New York: Guilford.

SAMPSON, H., WEISS, J., MLODNOSKY, K. & HAUSE, E. (1972). Defense analysis and the emergence of warded-off mental contents: an empirical study. *Arch. Gen. Psychiat.*, 26:524-532.

SCHACHTER, J. (1990). Post-termination patient-analyst contact: I. Analysts' attitudes and experience; II. Impact on patients. *Int. J. Psychoanal.*, 71:475-486.

SCHLESINGER, H. J. (1974). Problems of doing research on the therapeutic process in psychoanalysis. *J. Amer. Psychoanal. Assn.*, 22:3-13.

SCHLESSINGER, N. (1987). Evaluation of the outcomes of psychoanalysis. Presented at the mid-winter meetings of the American Psychoanalytic Association, New York.

——— & ROBBINS, F. (1974). Assessment and follow-up in psychoanalysis. *J. Amer. Psychoanal. Assn.*, 22:542-567.

——— ——— (1983). *A Developmental View of the Psychoanalytic Process: Follow-Up Studies and Their Consequences.* Madison, CT: Int. Univ. Press.

SCHULLER, R., CRITS-CRISTOPH, P. & CONNOLLY, M. B. (1991). The resistance scale: background and psychometric properties. *Psychoanal. Psychol.*, 8:195-211.

SEITZ, P. F. D. (1966). The consensus problem in psychoanalytic research. In *Methods of Research in Psychotherapy*, ed. L. Gottschalk & A. H. Auerbach. New York: Appleton-Century-Crofts, pp. 209-225.

SEXTON, H. (1993). Exploring a psychotherapeutic change sequence: relating process to intersessional and postreatment outcome. *J. Consult. Clin. Psychol.*, 61:128-136.

SHAPIRO, T. & EMDE, R. N. (1995). *Research in Psychoanalysis: Process, Development, Outcome.* Madison, CT: Int. Univ. Press.

SILBERSCHATZ, G., CURTIS, J. T., FRETTER, P. & KELLY, T. (1988). Testing hypotheses of psychotherapeutic change processes. In *Psychoanalytic Process Research Strategies*, ed. H. Dahl, H. Kächele & H. Thomä. Heidelberg/New York: Springer-Verlag, pp. 129-146.

——— FRETTER, P. & CURTIS, J. (1986). How do interpretations influence the process of psychotherapy? *J. Consult. Clin. Psychol.*, 54:646-652.

SKOLNIKOFF, A. (1985). Consensual analysis: a case study. In *New Ideas in Psychoanalysis: The Process of Change in a Humanistic Science*, ed. C. F. Settlage & R. Brockbank. Hillsdale, NJ: Analytic Press, pp. 235-243.

SMITH, B. (1966). *The Rand Corporation: Case Study of a Non-Profit Advisory Corporation.* Harvard Political Studies Series. Cambridge, MA: Books On Demand.

SPENCE, D. P., DAHL, H. & JONES, E. (1993). Impact of interpretation on associative freedom. *J. Clin. Consult. Psychol.*, 61:395-402.

——— MAYES, L. C. & DAHL, H. (1994). Monitoring the analytic surface. *J. Amer. Psychoanal. Assn.*, 42:43-64.

STEWART, A. L., et al. (1989). Functional status and well-being of patients with chronic conditions. *J. Amer. Med. Assn.*, 262:907-913.

STIGLER, S. (1986). *The History of Statistics.* Cambridge, MA: Harvard Univ. Press.

STILES, W. G., SHAPIRO, D. A. & HARPER, H. (1994). Finding the way from process to outcome: blind alleys and unmarked trails. In *Reassessing Psychotherapy Research*, ed. R. L. Russell. New York: Guildford, pp. 36-64.

STRUPP, H. H. & HADLEY, S. W. (1979). Specific vs. nonspecific factors in psychotherapy: a controlled study of outcome. *Arch. Gen. Psychiat.*, 36:1125-1136.

——— SCHACHT, T. E. & HENRY, W. P. (1988). Problem-treatment-outcome congruence: a principle whose time has come. In *Psychoanalytic Process Research Strategies*, ed. H. Dahl, H. Kächele & H. Thomä. Heidelburg/New York: Springer-Verlag, pp. 1-15.

SUNDIN, E., ARMELIUS, B. & NILSSON, T. (1994). Reliability studies of scales of psychological capacities: a new method to assess psychological change. *Psychoanal. Contemp. Thought*, 17:591-615.

TOLLIDAY, S. (1987). *Business, Banking, and Politics: The Case of British Steel, 1918–1939*. Cambridge, MA: Harvard Univ. Press.

VAILLANT, G. E. (1974). Natural history of male psychological health, II: some antecedents of healthy adult adjustment. *Arch. Gen. Psychiat.*, 31:15–22.

——— (1975). Natural history of male psychological health, III: empirical dimensions of mental health. *Arch. Gen. Psychiat.*, 32:420–426.

——— (1976). Natural history of male psychological health, V: the relation of choice of ego mechanisms of defense to adult adjustment. *Arch. Gen. Psychiat.*, 33:535-547.

——— (1978). Natural history of male psychological health, VI: correlates of successful marriage and fatherhood. *Amer. J. Psychiat.*, 135:653-659.

——— (1986). *Empirical Studies of Ego Mechanisms of Defense*. Washington, DC: American Psychiatric Press.

——— & MCARTHUR, C. (1972). Natural history of male psychological health, I: the adult life cycle from 18-50. *Seminars in Psychiat.*, 4:415-427.

——— & VAILLANT, C. O. (1981). Natural history of male psychological health, X: work as a predictor of positive mental health. *Amer. J. Psychiat.*, 138:1433-1440.

——— ——— (1990). Natural history of male psychological health, XII: a 45-year study of predictors of successful aging at age 65. *Amer. J. Psychiat.*, 147: 31-37.

VON BENEDEK, L. (1992). The mental activity of the psychoanalyst. *Psychother. Research*, 2:63-72.

WALDRON, S., JR. (1976). The significance of childhood neurosis for adult mental health: a follow-up study. *Amer. J. Psychiat.*, 133:532-538.

——— (1997). Psychoanalytic work and benefit to the patient: preliminary results from the analytic process scales (APS). Presented to the meeting of the Western New England Psychoanalytic Society, March 1.

——— FIRESTEIN, S., GOLDBERGER, M. & SCHARF, R. (1991). Development of rating scales of psychoanalytic process for use in time series analysis of interaction between patient and analyst. Presented at Research in Progress Series, midwinter meetings, American Psychoanalytic Association, December 21.

WALLERSTEIN, R. S. (1986). *Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy*. New York: Guilford Press.

——— (1988). Assessment of structural change in psychoanalytic therapy and research. *J. Amer. Psychoanal. Assn.*, 36: Suppl., 241-261.

——— (1992). Followup in psychoanalysis: what happens to treatment gains? *J. Amer. Psychoanal. Assn.*, 40:665-690.

WASKOW, I. & PARLOFF, M., Editors (1975). *Psychotherapy Change Measures, Section on Psychotherapy and Behavioral Intervention*. Clinical Research Branch NIMH DHEW Publication No. (ADM) 74-120, Chapter 19, pp. 233-242.

WEINSHEL, E. M. (1984). Some observations on the psychoanalytic process. *Psychoanal. Q.*, 53:63-92.

WELLS, K. B., et al. (1989). The functioning and well-being of depressed patients: results from the Medical Outcome Studies. *J. Amer. Med. Assn.*, 262:914-919.

YIN, Y. (1989). *Case Study Research Design and Method.* Revised Edition. Applied Social Research Method Series, Vol. 5. Newberry Park, CA: Sage Publications.

ZILBERG, N. J., et al. (1991). A conceptual analysis and strategy for assessing structural change. *Psychoanal. Contemp. Thought*, 14:317-342.

1235 Park Ave.
New York, NY 10128

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: http://www.tandfonline.com/loi/upaq20

On the Shoulders of Women. The Feminization of Psychotherapy. By Ilene J. Philipson. New York/ London: The Guilford Press, 1993. 177 pp.

Paula C. Wolk

To cite this article: Paula C. Wolk (1997) On the Shoulders of Women. The Feminization of Psychotherapy. By Ilene J. Philipson. New York/London: The Guilford Press, 1993. 177 pp., The Psychoanalytic Quarterly, 66:2, 325-360, DOI: 10.1080/21674086.1997.11927536

To link to this article: https://doi.org/10.1080/21674086.1997.11927536

BOOK REVIEWS

BOOK REVIEWS

ON THE SHOULDERS OF WOMEN. THE FEMINIZATION OF PSYCHOTHERAPY. By Ilene J. Philipson. New York/London: The Guilford Press, 1993. 177 pp.

This provocatively titled book was written by a clinical psychologist, but is predominantly a work in sociology. Philipson performs an important service by providing her observations of crucial trends taking place in mental health care. Primarily, she describes the emergence of an occupational bifurcation along gender lines, with economic and psychological implications for the mental health profession as well as for society as a whole. Her analyses of the causes of these trends and her prescriptions for change are less powerful than her observations.

The book is divided into seven chapters that read quickly and interestingly. Philipson begins with a description of several current forces affecting the field of psychotherapy. She documents the increasing numbers of women entering the field and the decreasing numbers of men. She reviews the decreasing federal and insurance dollars allocated for psychotherapy and the current emphasis on biological explanations for behavior. Further, she describes the abbreviated forms of treatment offered by the managed care firms and the limited flexibility that the mostly women therapists are given by these firms. She emphasizes that it is the men who are becoming the managers, and she stresses the heavy workload they impose on the female treaters. Philipson hopes that the rest of the book will begin a discussion about what the feminization of this "field portends—not only for psychotherapy but for our society, its priorities and commonly shared ethics and beliefs" (p. 21).

Putting this in the sociological context, the author explains that occupational sex segregation has always been the case. A historical concomitant to occupational gender shifts, she informs us, has been the "declassing" and "deskilling" of the occupations that open to women. Her description of "deskilling" is convincing, in that many professional schools with lowered acceptance and graduation standards have flooded the field with women, who are more easily coerced by the HMO's.

Philipson includes an interesting history of psychology and psychia-

try in this country, especially with respect to the exclusion of women. She describes how both feminism and more women in the fields of family therapy and psychoanalysis changed the theoretical framework and techniques of each. The shift in psychoanalysis that she focuses on is the increased emphasis in theoretical discussions on the preoedipal period and in technical discussions on various relational models. She claims that the shift in psychoanalytic thinking occurred merely because of the increased numbers of women in the field. This is contrasted with the field of family therapy, where Philipson maintains the shift was due to a conscious feminist perspective. She states that another possible determinant of these shifts may be the "changing social reality of family life." She offers impressive statistics that support her notion that women are increasingly being left with the emotional and economic responsibility for rearing children on their own. Further, it is important for us to be aware that these women and children are more likely to be in the poorer households.

In the last chapter Philipson makes some suggestions designed to alter the trends described earlier. She recommends the recognition of the oversupply of practitioners and a much greater attention to standards in clinical training. She emphasizes the need for women practitioners "to insert themselves in the creation and definition of managed care" (p. 161). Philipson concludes her book decrying what she describes as a national denigration of any kind of dependency, in conjunction with an overvaluing of "self-sufficiency."

Several issues raised in this book are of particular interest. The first has to do with Philipson's assertion that the field of psychotherapy is degraded. If we lump all "therapies" together, there is no question that what she says is true. However, four hours with a clinician in an HMO is not psychotherapy or psychoanalysis. It does not bear on their value that these processes are no longer subsidized, or that many people trained to do them seem willing to provide something quite different. Nonetheless, her discussion serves as an important and timely warning, particularly for the field of psychoanalysis. It behooves us not to allow the deskilling she describes. Her caution about preparing theoreticians and researchers is also well taken. If, for example, psychoanalysts are not prepared to contribute to the elucidation of how meaning is transduced into physiological events, they will not be players in important discoveries about the human condition. The ability to make these kinds of contributions will re-

quire that analysts remain fluent in the study of the brain as well as the mind.

Another discussion of particular interest to me was in the section entitled "Psychotherapy as the Professionalization of Motherhood." Here Philipson mentions many aspects of the work that attract "mothers" to psychotherapy, i.e., the flexible work schedule, homelike office settings, necessity for empathic attunement, etc. However, this section lacks any mention of the differences between being a mother and being a psychotherapist. In my experience, the intellectual challenge of trying to elucidate with a patient her or his *Weltanschauung* and its relevant determinants is strikingly different from the intellectual challenges posed me by my children. Further, the task of collaboratively assessing to what extent those determinants are extant is very much a part of the therapeutic process and less part of being a mom. On the other hand, the nature of the emotional demands of being a mother are largely more unremitting. There is no question that being a "good enough" mother is a more complicated, demanding, socially relevant task than is recognized by those in our society who have more status and often excessive remuneration. Being a mother is different in important ways from being an analyst/therapist, and if in the feminization of psychotherapy we lose sight of that, our patients will be less well served.

In the discussion of the paradigm shift in psychoanalysis it is striking that Philipson credited these shifts to the mere presence of more women in the field. She does not acknowledge the importance of the kind of women who are in the field or the extent to which they, as well as their male colleagues, have been influenced by a feminist perspective. Further, for all of Freud's fallacies with respect to the preeminence of the phallus in mental life, he did at least popularize the notion of a dynamic unconscious as determining behavior, and he did set down a beginning methodology for paying attention to free associations. These are foundations for the possibility of a paradigm shift.

Regarding Philipson's assertion that to be dependent is to be less than human, it has already been shown that there is no condition of self-sufficiency. Rather, there are a variety of ways we may deny, project, obscure, or otherwise not know about our dependency. From my perspective the culprit is our difficulty in acknowledging aspects of the human condition that threaten us—such as dependency.

The problem of dispelling fear of difference, whether it is gender, race, or religion, confronts us at every turn. While Philipson cites the work of Nancy Chodorow, she does not elaborate on the relevance of that work to the solution Philipson seeks. I would have been interested in some ideas about how to make operational Nancy Chodorow's notion that if men were more involved in the rearing of children, many of the attitudes Philipson decries would be alleviated.

In sum, *On the Shoulders of Women* is an important book, filled with keen observations of relevance to men and women alike. It documents changes we are well advised to address. While some of her analyses of causes and their remedies are less compelling, the book nonetheless deserves to engender the discussion Philipson wishes to promote.

PAULA C. WOLK (BOSTON)

PSYCHOANALYSIS IN TRANSITION. A PERSONAL VIEW. By Merton M. Gill. Hillsdale, NJ/London: The Analytic Press, 1994. 179 pp.

The late Merton Gill possessed one of the great minds of modern psychoanalysis. In numerous contributions, he elaborated core concepts in classical metapsychology and the theory of technique. *Psychoanalysis in Transition,* which appeared posthumously, is neither a summation of Gill's thought nor a final statement of his views. It is an exploration of the latest—and regrettably last—stage in the continuing evolution of Gill's thought: the investigation of the implications of *constructivism* for clinical theory and psychoanalytic technique.

The perspective on the psychoanalytic situation that Gill presents in this book is that psychoanalysis is a constructivist, hermeneutic science. The facts and meanings with which it is concerned are subjective, unconsciously motivated, and mutually, as well as multiply, determined. This is as true for the analyst as for the analysand, because in all human psychological functioning the experience of the external world is influenced and determined by the internal world and vice versa. That is, internal and external factors are not only mutually interactive but mutually determinative. Each is shaped in part by the other.

The constructivist view implies that a full and proper conceptualization of the psychoanalytic situation requires the addition of a two-

person psychology to the one-person psychology of classical theory. In regard to that core concept of psychoanalytic clinical theory, the transference, Gill writes:

> Constructivism not only implies that the analyst makes a contribution to the patient's experience, but also that the patient's experience is ambiguous, that the sources of the analyst's views and actions are not fully known, and that the analyst and patient act to cocreate interactional realities, both through enactments in transference and countertransference and through searching for new ways of being in relationships (p. 38).

In regard to transference analysis and the conceptualization of technique, Gill asserts that whatever the analyst

> does or does not do is an action that will have its interpersonal meaning, that [the analyst] has a major responsibility to search for this meaning and, in interpreting that meaning, to recognize that his response [including silence, if that is the analyst's response] is a stimulus to bring about a response on the analysand's part. And the analysand's response will not simply be an irrational reaction without any basis in ongoing interaction (p. 47).

What Gill is arguing for is a view of the psychoanalytic relationship and the experience that it generates for both participants that is mutually determined (i.e., co-constructed). He proposes, therefore, that, like the transference, the patient's associations are joint products, influenced and determined not only by forces within the patient—although surely these are centrally important contributors—but by the combined interaction of conscious and unconscious forces within and between both analyst and analysand.

One important implication of this view is that the analytic situation is inevitably interactive. The analyst's interpretations are *experienced* by the patient not only as informational—i.e., attempts to impart insight—but also as actions. However, they also *are* actions—i.e., suggestions, if only the suggestion to stop behaving in the way we conceptualize as "resisting"—that inevitably derive from conscious and unconscious forces within the analyst.[1] For Gill, interaction is not just a contaminant of the analytic situation; it is intrinsic to it (p. 62). Put more succinctly, "both the theoretical predilection and personality of the analyst will be potent factors in the analytic process. The idea of

[1] See also Levine, H. B. (1994): The analyst's participation in the analytic process. *Int. J. Psychoanal.*, 75:665-676.

the spontaneous [pristine] unfolding of the patient's neurosis is a myth" (p. 149).

This view of the analytic situation as an inevitably interactive one, where analyst and patient are always influencing each other, raises serious problems with the concept of neutrality. Gill attempts to resolve these by suggesting that "mutual influence [of analyst and analysand] cannot be avoided; it can only be interpreted. It is the analyst's awareness of this unremitting influence of patient and analyst on each other and his attempt to make that influence as explicit as possible that constitutes [the analyst's] 'neutrality' " (p. 50).

Ultimately, it is the analyst's recognition that his or her presence is a determining influence on—i.e., constructive of—the patient's transference neurosis and the analyst's commitment to investigating and interpreting the effects of that influence that Gill proposes as the criteria for determining whether or not a given treatment situation is truly psychoanalytic. "The *decisive* criterion of psychoanalysis, one intrinsic to that therapy as against [what for Gill are] its extrinsic features [such as frequency, use of the couch, and duration] is that the transference—the patient's experience of the interaction—is analyzed as much as is possible" (p. 62). This intrinsic criterion serves to separate those therapies that are truly psychoanalytic from those that are not. "If the intent is to analyze the interaction as much as possible, the situation is a psychoanalytic one; if it is not, the situation is a psychotherapeutic one" (p. 63).

Gill proposes that when conducted in the way he has described, psychoanalytic psychotherapy and psychoanalysis proper have more in common with each other than with other forms of therapy and are both deserving of the name "psychoanalytic therapies." Whether it is more or less useful to choose to conduct a given treatment in a given way or "advisable to develop an analytic situation in any given circumstance [are] matter[s] of individual assessment and require . . . much research" (p. 66). What Gill is "struggling against [is] the rote acceptance of the idea that an analysis can be conducted only with at least 4 or 5 sessions a week on the couch . . . that anything less than 4 or 5 times a week and the couch requires a kind of therapy different from proper psychoanalysis" (p. 76). Rather, given his constructivist belief that "the optimal frequency and position are as much a function of the analyst as the patient" (*ibid.*), he would like to see "the

frequency to be the least that is compatible with an analytic process for a particular patient . . . [and] the position to be the one most conducive to analytic progress for that particular patient" (*ibid.*).

The subtitle that Gill chose for *Psychoanalysis in Transition* is "A Personal View." From the foregoing description of the argument that this work contains, the reader can see that it is personal in the best sense of the term. Written in the same rigorous spirit of scientific discovery that allowed Gill to critically re-evaluate his own thoughts, change his mind, and persuasively argue against some of the very positions that he had previously championed and helped establish as part of the psychoanalytic canon, this book will challenge readers to rethink much of what was once held to be fundamental in psychoanalytic clinical theory. It is a bold, thoughtful, incisive reexamination of the psychoanalytic situation, one that is decidedly the product of an individual who was a master of his craft. It deserves to be read, debated, and reread, with the same critical acumen and passion for observation and truth that Merton Gill brought to all of his work throughout his long and productive life. It is a fitting tribute to its author and should endure as a classic contribution to our understanding of the analytic situation.

HOWARD B. LEVINE (BROOKLINE, MA)

THE PRIVATE SELF. By Arnold H. Modell. Cambridge, MA/London: Harvard University Press, 1993. 250 pp.

In the history of psychoanalysis the current era will probably be known as the age of the self. Beginning some decades ago with the studies of object relations by the British psychoanalysts, especially Fairbairn and Winnicott, the self has assumed increasing importance in the gradual evolution of contemporary psychoanalytic theory and practice. This is not to say that psychoanalysts generally, or even most psychoanalysts, have abandoned ego psychology to become self psychologists. Still, it seems to many observers, including myself, that a discernible shift has occurred among the burning topics of current interest in our literature. We read less about instincts and more about intersubjectivity. To the limited extent that one can gather what goes on nowadays in analytic consulting rooms, the clinical emphasis there also seems to have undergone a change from attention to neurotic

symptoms and character to personality disorders and their associated disturbed relationships. From the reports of individual analysands I gather that for them the analytic ambience is reflected in a less austere and more widely attuned experience than was usual thirty years ago. Admittedly, these observations are merely subjectively toned impressionistic findings and not the result of a scientific study. Be that as it may, they serve as a background to what is a serious and scholarly book about a topic that stands in the center of current concern in philosophy, psychology, and psychoanalysis: the self.

Arnold Modell, psychoanalyst and author, has been a leading commentator and contributor to these discussions since the 1968 publication of his first book *Object Love and Reality: An Introduction to a Psychoanalytic Theory of Object Relations*. Subsequently, in his last book prior to the present volume, *Other Times, Other Realities*, he addressed himself to the theory of psychoanalytic treatment. Modell is never satisfied with merely digesting and summarizing the state of the art, but by adding his own original thought, he lifts the often controversial discussions to a higher level. So it is in the present book in which he attempts to clarify the age-old unresolved philosophical problem of how an individual's private experience of self can be treated as a scientific, objective reality. After reviewing in some detail the relevant contributions of philosophy, especially of William James, and of psychoanalysis, especially of Freud, Fairbairn, and Winnicott, Modell proposes his own theory of a *private self* which is greatly influenced by the work of the neurobiologist, Gerald Edelman.

Modell extends his previously stated view that paradox is an intrinsic quality of the human mind to include the self's paradoxical nature. The self is both autonomous and dependent. It is both coherent and enduring over time in endowing the individual with a sense of identity while simultaneously coterminus with the ever-changing, on-and-off phenomena of consciousness. Conceptually, the self is both an aspect of psychology while at the same time being rooted in biology. Modell links his acceptance of the paradoxical nature of the self with an ability to tolerate inconsistency and contradiction, as well as intellectual openness and playfulness. He is only mildly critical of those whose temperament forces them into dichotomous thinking. Most thinkers have described the self either as a psychic structure or as coterminus with consciousness, or they have avoided the problem altogether. According to Modell, Freud rejected the phenomenologi-

cal subjective account of self experience as unscientific by avoiding the term self (*selbst*) in proposing his structural theory of the ego. Instead of *selbst* Freud used *ich* ("I") which allowed him to jump back and forth between the domains of an objectified *ich* and of an experiencing *ich*, as needed. Thus Freud explicitly distanced himself from pure subjectivity while implicitly embracing self experience.

Unfortunately, as a result of the distortion introduced by Strachey's translation of *ich* into ego, Freud is presented as apparently neglecting the subjective aspects of self. Modell discards Hartmann's concept of self-representation as a return to a Cartesian objectification of the self that was introduced by Hartmann to avoid Freud's anthropomorphism and the scientific problems inherent in a phenomenology of the self. However, neither is Modell a friend of Kohut's phenomenology of the self, which he sees as a radical antithesis of Hartmann. He dismisses both Hartmann and Kohut as providing no solution to the self/ego dilemma and rejects them both as clinically and philosophically inadequate. He criticizes Kohut for downgrading the importance of object loss as only an extrospective observation. But is Kohut not a psychoanalyst at his best when he focuses on the self's experience of depressive affect, low self-esteem, loss of available energy, and impaired coordination of functioning—in other words, on the data of introspective/empathic psychology that indicate a loss of the experience of being selfobject-connected rather than on the extrospective data of object loss that may or may not have brought about the internal calamity?

In his concept of a *private self* Modell seeks to safeguard some core aspects of traditional concepts of the self against being totally overwhelmed by the current tendency to overemphasize the dependence of the self on continuous and lifelong social input. He marshals convergent observations from psychoanalysis, infant research, and neurobiology in support of his *private self*. He cites individuals who have been able to create a coherent identity in spite of extremely traumatic childhoods and who thus demonstrate a capacity to "bootstrap" themselves from within. Similarly, he finds in infants periods of disengagement alternating in equal importance with periods of engagement with their mother. Modell posits a sense of being fueled from within during the infants' times of disengagement and associates it with taking joy in mastery and in a sense of pleasure in being free to follow their own interests.

Other important topics discussed by Modell deserve mentioning here. Among these are the psychology of merging and separateness, issues of values and of creativity, and the relation between agency and the creation of meaning. All of these are connected by the twin emphasis on self-generated selves rooted in biology. It is a book rich in ideas, well referenced with extensive notes and bibliography. It is also a demanding book, densely written and requiring the focused attention of the reader.

All authors in trying to make a point show a certain tendentious selectivity in quoting from others. Modell seems intent on demonstrating either the similarity or the contrast between his *private self* and the self concepts of others. Thus, he nearly equates William James's *spiritual self*, Winnicott's *true self*, and Edelman's *neurobiological self* with his own *private self*. On the other hand, Freud's ego, Hartmann's *self-representation* and Kohut's *selfobject-generated self* are painted in colors that harshly contrast with Modell's *private self*. I believe the differences, especially, are more subtle and probably based on linguistic choices and emphasis rather than on basic disagreements. Is not Kohut's self, which follows the trajectory of its unique life curve determined by its unique configuration of ambitions and ideals toward a uniquely personal point of fulfillment, a version of private self? The fulfillment of the self's life plan, indeed, takes precedence over environmental input, even though past experiences with others have had a part in shaping the particular aims and ideals.

I believe that for reasons related to Freud's rejection of the term *selbst*, Kohut's language tended to overemphasize *self* and *selfobject* at the expense of proper emphasis on *selfobject experiences*. I think if he were reading Modell's *Private Self* today he would find himself in harmony with its spirit even if not with its language.

ERNEST S. WOLF (WINNETKA, IL)

THE ESSENTIAL OTHER. A DEVELOPMENTAL PSYCHOLOGY OF THE SELF. By Robert M. Galatzer-Levy and Bertram J. Cohler. New York: Basic Books, 1993. 468 pp.

Drawing from the writings of diverse fields, including psychoanalysis, psychology, sociology, anthropology, and literature, this book is the first effort to provide an overview of development of the self from a

Kohutian perspective. In the past, psychoanalysis has emphasized the interpersonal autonomy characteristic of Western cultures and has not adequately attended to the lifelong importance of others for maintaining the morale and integrity of the self.

In the first chapter, the authors discuss the rationale for using various methods and perspectives in the preparation of their book. The succeeding chapters focus on the role of essential others for development, first in infancy, then in toddlerhood, early and middle childhood, adolescence, young adulthood, midlife, and late life. Their major conclusion is that essential others constitute the central means by which people maintain meaning, personal integrity, and morale.

In the past, most psychoanalytic writers viewed adolescence as a time of tribulation and both internal and interpersonal conflict. Contemporary investigators of adolescent development do not emphasize the so-called generation gap as much as they did several decades ago. Many studies of adolescence indicate that most adolescents do not experience repeated stress or turbulence; rather they experience pleasant, nonturbulent development. Contrary to the opinions of many, the authors assert, "the social and political views of adolescents are better understood as continuations of parental opinions than as originating in the peer culture" (p. 185). The problems of identity, diffusion, and the *Sturm und Drang* of adolescents have been mistakenly taken for normal adolescence by social scientists as well as by some psychoanalysts, such as Anna Freud.

The authors' claim is that mental health professionals mistakenly view separation from parents as a normal and desirable end-product of development. They write, "The clinical impression that it would be good for adolescents to be less enmeshed with their families derives from a systematic observational error. Youngsters in treatment are much more likely than the general population to have disturbed and disturbing families. In certain *pathological* family situations the best solution is to separate as much as possible from parents" (pp. 190-191).

They argue convincingly that the old paradigm in psychoanalysis and elsewhere that overemphasizes autonomy and independence has not only caused much psychic pain and suffering, but has also limited the understanding and study of individuals and their relationships. The conflicts and dilemmas of separation so common in our society

do not arise in cultures such as those in the Orient which do not idealize separation and self-reliance.

They write, "Grief and loss are part of the psychological price exacted by the cultural demand for autonomy. We believe that much of the distress described in relationship to young adulthood and adolescence results from societal norms of independence that are dissonant with young people's psychological needs" (p. 221).

The authors are most critical of the separation-individuation models of Mahler, Blos, Stierlin, and others. In their view, separation-individuation theory does not account for or recognize the value of the interdependent ties of individuals. The ways in which family members and other groups continue to care for one another is not consistent with the idea of independence as the goal of development. In their view, the goal of development at all stages should not be psychological autonomy but maintenance and development of appropriate interdependence. They dispute Margaret Mahler's notions of separation-individuation. Her views, they claim, were based on her recurrent life experiences of separation and uprootedness. Like many Jews in Central Europe, she was forced from her homeland by the Nazis. They believe her theories originated in a need to make personal painful realities into norms.

"Emerging perspectives," the authors write, "in psychoanalysis, from Fairbairn's (1952) idea of mature dependence and Winnicott's (1953) idea of the transitional object to Kohut's (1977) formulation of the selfobject suggest that a major aspect of the child's psychological development across the first years of life is the emergence of a relational self (Stern, 1985) that includes giving care to others" (p. 282). They decry the lack of psychoanalytic knowledge, data, and theories about young adulthood, and they argue cogently that with rare exceptions, analysts have not investigated adult development except as a mirror of childhood.

The authors summarize the conclusions reached by researchers who have made longitudinal or other searching investigations of both child and adult development: (1) success in one phase of life does not necessarily entail success in other phases, the effect of early life on later functioning is not so great as posited by most psychological theories of development, and no single phase is primarily important for later development; and (2) significant personality development continues through the second half of life.

Mental health professions, including psychoanalysis, have been shaped by a vision of expectable or normal development that is at odds with the way individuals ordinarily lead their lives. The traditional vision depicts people developing toward self-reliance and independence. In contrast, the findings reviewed in this book demonstrate that people increasingly seek interdependence and use others to enhance self-affirmation at all times but more especially during times of emotional upheaval and psychological growth. In the authors' opinion, the goal of psychological intervention should be to assist individuals to obtain satisfaction and self-coherence through essential others, as well as to receive greater satisfaction and comfort from a continuing use of others throughout their lives. They argue persuasively and at length for their view that "the descriptions of interdependence as typical of ordinary human psychological functioning in virtually all contexts are supported by overwhelming data based on a variety of methods" (p. 357).

Psychoanalytic writings often put a mistaken emphasis on the self as an isolated entity and erroneously view development as a movement from immature dependence to mature self-reliance. These and other errors, in the authors' view, arose because of the unfounded *assumption* that separation and self-sufficiency are normative.

Although I agree with the authors about the widespread neglect of the value of interdependence, I believe they have gone too far in condemning the values of independence and autonomy. They have unfortunately thrown out the baby (that is to say, the baby who sometimes and in some ways needs to be independent) with the bathwater of an obsolete theory of development.

I question and doubt the value of their choice of the term "essential other" rather than selfobject. They justify this usage in this way: "We have chosen the term *essential other* to refer to the necessary function of other people in psychological life in order to emphasize their central psychological importance and to move away from ideas of psychological primitivism commonly associated with the term *self-object*" (p. 29). The notion of primitiveness is not a necessary constituent of the term selfobject; Kohut in his later writings, as well as other contemporary self psychologists, distinguishes between archaic and mature selfobjects.

Although Kohut's work portrayed the significance of selfobjects in the support of the self, his work did not fully address the importance

of others for the integrity or coherence of the self for stages beyond early childhood. Galatzer-Levy and Cohler make a unique contribution in integrating and collating the contributions of many fields and explicating the role of significant others for the self through the individual's entire life-span. Their extension of the selfobject concept includes emphasis upon the continuing psychological use of others for self-affirmation and for the enhancement of personal integrity, as well as for the provision of solace during times of stress.

This book is highly recommended for all who are interested in contemporary studies on human development.

THEO L. DORPAT (SEATTLE)

IMPASSE AND INNOVATION IN PSYCHOANALYSIS. CLINICAL CASE SEMINARS. Edited by John E. Gedo and Mark J. Gehrie. Hillsdale, NJ/London: The Analytic Press, Inc., 1993. 320 pp.

A major problem in our literature is that we cannot adequately convey in writing how we analyze. No other field in the arts or sciences has such difficulty showing its work. Furthermore, we know very little about whether the way an analyst writes—the tone, for example, or the level of certainty—tells us much at all about the way she or he analyzes. What carries over from one context to another? For better and worse, analysts behave very differently in the office than they do in other settings.

This book takes a unique approach to closing that gap. By effectively demonstrating how Gedo thinks, supervises, teaches, and forms judgments about patients, we think we can feel the man at work. And that is a remarkable achievement. To be sure, Gedo conveys primarily those facets of himself and his work which he chooses to make public, and so, as with any other author, we still do not see the context out of which these representations emerge. But this book is pure Gedo, and if you want a closer look at his opinions, his character, his arguments, and his honesty, this is where to find it.

The book is based on verbatim transcripts of a seminar Gedo taught in 1988-1989 in Chicago. The seminars focus on four case presentations, one by Gedo, one by another faculty member, and two by candidates. Each comprises a different chapter in the book. Following each case discussion, there is a commentary by Gehrie and then a series of notes written by Gedo to elaborate

or respond to points raised by Gehrie or by the seminar discussion itself.

The patients are all difficult ones, with whom, as the title suggests, an "impasse" has been reached, usually because, in Gedo's opinion, the analyst has been attempting to apply too classical an approach for the given patient. Each case then becomes an opportunity for Gedo to suggest how his approach might be more useful, hence the "innovation" of the title. Gedo's technical approach is linked to his hierarchical model, which he has been consistently elaborating for more than twenty years.

If the book is most effective in conveying how Gedo thinks about patients and what he thinks about other analysts and their alternative approaches, it also gives us a striking vertical cross section of a highly specific analytic milieu, Chicago in the late 1980's, again as viewed by Gedo. This is a world largely without proponents of ego psychology, who, as Gedo notes, "had little influence in Chicago" (p. 292) at the time. And that fact is reflected in the book. We hear Gedo's arguments with self psychology in general and with certain individuals from various schools, who figure prominently as points of departure for Gedo's arguments, most notably Kohut, Gill, Brenner, and Schwaber. Although Gedo occasionally and usefully suggests several alternative technical approaches to a particular problem, for the most part other points of view do not stand a chance in this ring.

Given Gedo's general message, that the analyst must be "supple" enough to alter technique to suit each patient, it is curious that the cases and the "innovation" all sound rather similar to the untutored ear. Furthermore, given the highly systematic hierarchical model that Gedo has evolved, it is striking that he seems to rely as much as he does on personal response, countertransference, and intuition. Considering Gedo's wish to bring clinical art and judgment increasingly under the discipline of theory, one wonders to what extent his own theories have been shaped by his character and personal preferences. Indeed, how the analyst's character shapes his technique and, I would add, his theory, is one of Gedo's interests. We are invited implicitly to take this book as data for just such a phenomenon, and we can do so the more easily because Gedo presents himself so straightforwardly.

Authenticity, in fact, is a prominent theme of the book: the analyst must be genuine, not fraudulent. Let us note that in voicing this theme, Gedo is speaking about a particular kind of genuineness, one

associated with *his* approach. Despite his comment praising Brenner's *"présence"* (p. 164), it is never clear why the classical approach seems by definition to be less genuine than his. Perhaps, rather than classicism *per se*, he is arguing against the misuse of classicism with its artificial stereotypes. This distinction is never made clear.

Gedo is also highly observant of degrees of authenticity in the patient. Here he works some of the same territory as do several of the Kleinians who, from a different theoretical perspective, describe patients who give the appearance of being present but are not. Gedo commands our attention with patients who "do not regard their associations as valid representations of their convictions" (p. 289) and so experience their free associations as increasingly fraudulent; patients who cannot "think" without threatening their sense of the relationship with the analyst; and, more generally, patients who cannot utilize "lexically encoded interventions" but rely on the action system instead. In other words he is fascinated with patients who, because of their own difficulties, cannot comply with the most fundamental aspects of the analytic enterprise.

Once he defines analysis "according to its goals rather than its technical procedures" (p. 133), Gedo does not regard these patients as unanalyzable. That designation he reserves for those who demand from the analyst not simply affect, but action as well. As with many of the sharp distinctions Gedo draws, these two types of patients are not so easy to sort out in practice as they are in principle. In fact, Gedo's method of polarizing different points of view, while pedagogically useful, tends, I find, to misrepresent the mixture of states one sees in analytic work and to imply that if one were only thinking clearly, that mixture would clarify into sharply differentiated phenomena.

There are many tantalizing opinions in this book, which stimulate and provoke. See, for example, Gedo's view of neutrality: "the concept of neutrality becomes meaningless" in the absence of "full structuralization" (p. 135). What is "full" structuralization? Is it ever full or only a matter of degree and judgment? Do such polarizations allow Gedo to adopt less neutral positions more easily?

We hear the hyperbole elsewhere: a patient who demonstrated a "complete absence of useful behaviors referable to more mature modes of functioning" (p. 66); Gedo's technical advice: "Analysis is like fencing—you know, one false move and you're dead. I think it has to come totally spontaneously or it's no good" (p. 236); and his

self-observations: "the lavish manner in which I have furnished my office . . . is a permanent reminder to my analysands that they may hope for something better than their past disappointments" (p. 286). You may find these amusing, helpful, or annoying, but credit him also with turning a critical focus on himself, as when he confesses to his own impatience and his own limitations: "I would drive this patient out of treatment by being much too hard-line" (p. 240).

Many of Gedo's more stimulating arguments are with self psychology: about idealization, which he views as "epiphenomenal" (p. 128); about specious forms of empathy; about psychic reality, which, he emphasizes, is a much broader domain than mere subjectivity; and about the dangers of the analyst's allowing himself or herself to be abused by "masochistic" forms of technique.

Gedo places heavy emphasis on assessing the reality of the patient's situation and history and the patient's own capacity for reality testing. He sees part of the analyst's task explicitly "to determine what the realities were" (p. 182). Gedo sidesteps the epistemological question of how he can be so sure of the patient's historical reality or, for that matter, the patient's reality testing. Nonetheless, he is assuredly not afraid to oppose the patient's own point of view and, accordingly, becomes a refreshing spokesman for the inevitable and, perhaps, necessary adversarial component in analyzing.

In the course of the book we hear a great deal about the pitfalls of underestimating the patient's pathology but little about the risks of overestimating it. In other words, Gedo focuses on the dangers inherent in other approaches, with less regard for the risks involved in his own. As a general consideration, for example, if we define psychoanalysis according to its goals rather than its procedures, how does changing the procedure affect where we end up?

Given the number of important questions this book raises, it is a pity that we are not given data in a form that would allow us to explore some of these questions ourselves, for the book is long on conclusions and short on the sort of process material which could be evaluated with an independent eye. The only other criticism I would make of the format is that in its effort to provide a faithful account of the seminars, it is inevitably somewhat redundant and on occasion difficult to follow syntactically. Sometimes the reader is drawn into the seminar group itself, but more often we feel like outsiders, not quite in step with the process, watching through a one-way mirror.

Gehrie's commentaries help to bring us into the action by anticipating some of our responses, and Gedo's notes do so as well; but we could use more of Gehrie's most confrontative questions—Gedo's tone so invites them. If Gehrie is sometimes Gedo's foil, sometimes his explicator, he comes into his own very effectively in the last two cases, when he challenges Gedo's capacity to judge the patient's reality, for example, or when he discusses Gedo's use of his countertransference at the very moment when the reader senses its influence on both Gedo's clinical judgment and his theory more than he has acknowledged.

Gedo has persistently challenged us to rethink our theories and our techniques. This book will do no less. How you react to it will be determined by how you react to Gedo. He may inspire you; he may exasperate you; he may do some of both. You be the judge. He would not want it any other way.

HENRY F. SMITH (CAMBRIDGE, MA)

BETWEEN AUTHOR AND READER. A PSYCHOANALYTIC APPROACH TO WRITING AND READING. By Stanley J. Coen. New York: Columbia University Press, 1994. 210 pp.

Stanley Coen is one of a small but growing number of analysts who argue that the analyst's passionate feelings, his or her countertransference love and hate, are inevitable and ultimately necessary ingredients of the analytic mix between patient and analyst. This is a postmodern view of the emotional position of the analyst. As Leary has recently described, a postmodern social constructivist view of the analytic situation "asserts that human knowledge and reality are not given but are instead created by people through social processes and for social ends. . . . Under the terms of social constructivism, the analyst cannot stand outside the interaction with the patient. Patient and analyst continuously and mutually influence one another. . . ."[1]

This same process, Coen asserts, can take place between an author and reader, the written text substituting for the analytic dialogue: "writing and reading become exciting, creative literary and psycho-

[1] Leary, K. (1994): Psychoanalytic "problems" and postmodern "solutions." *Psychoanal. Q.*, 63:448-449.

analytic experiences of working out and working through. Both author and reader struggle to work through conflicts in the acts of writing and reading, seeking creative expression and integration" (p. 4). From this vantage point, Coen not only tries to develop a psychology of writing and reading, but also suggests this approach as a way for psychoanalytic clinicians to begin to understand the psychology of certain writers who seek intense self-conscious involvement with their readers. Consciously and unconsciously, these authors often intend to evoke strong affects in their readers. As the analyst analyzes her or his emotional responsiveness to the written text, the analyst is likely to understand why the writer wants to elicit such responses in the reader. The parallel analytic event is the analyst's attempt to understand the patient's psychology (and his or her own) as the analyst analyzes countertransference reactions. To illustrate this thesis, Coen has selected writers he sees as having been very dependent, "who sought imaginary contact with their readers" (p. 5). The texts Coen "examines [suggest that the authors] seem preoccupied with their need that their readers respond enthusiastically, admiringly and acceptingly to what these authors find most reprehensible within themselves" (*ibid.*). As his recent book[2] demonstrates, Coen has closely studied pathological dependency. He has greatly enhanced our understanding of how individuals with intense dependent longing can and do misuse people.

Of the four writers Coen discusses, he has previously described three: Jean Genet, Louis Ferdinand Céline, and the Marquis de Sade. The fourth is a surprise—at least to me: Sigmund Freud himself. What these writers have in common, for Coen, is that each "was depressed at the time of his writing and each sought to be healed through writing" (p. 174). "[And] each author (including the early Freud) seems to feel that his destructiveness cannot be managed within, that he needs a literary outlet for it, a space within which he can attack others—characters and imaginary readers" (p. 179).

For Genet, Coen selects three early works to study: *Our Lady of the Flowers, The Maids*, and *The Thief's Journal.* In a careful examination of these texts, Coen illustrates his hypothesis "that the relationship between a perverse writer and the audience may approximate a perverse

[2] Coen, S. J. (1992): *The Misuse of Persons: Analyzing Pathological Dependency.* Hillsdale, NJ/London: Analytic Press. Reviewed in this *Quarterly*, 1994, 63:129-132.

sexual experience'' (p. 32). Anyone who has read even one of these books will readily agree with this assertion. Coen argues that Genet's attempt to engage his readers in perverse sexuality cannot simply be written off as literary technique. ''[Instead] the relationship between narrator and reader is situated actively in the foreground rather than as the background upon which the story is told'' (p. 42). Genet intends to induce in his reader strong visceral reactions ranging from excitement and admiration to repulsion and alienation. More than just author of the written text, the writer becomes ''the implied author of an additional text constructed between reader and writer—a text created out of the intense psychological neediness of the writer.'' The implied author ''seeks to establish a controlling relationship with his audience that is deprived of its own independent responses, unable to make a move without him'' (*ibid.*).

What does Genet hope to accomplish? A magic transformation of himself. He wants to ''turn death into life, give birth to himself, become his own creator with the audience-mother as midwife'' (p. 43). ''The audience is to provide him with affirmation of his existence and value, to admire and encourage him, to support his self-esteem, which he has been unable to do alone'' (p. 44). And lastly, ''by his constant preoccupation with destruction and murder, 'Genet' reveals his fearfulness of his own destructiveness toward others and himself. He needs to idealize destructiveness, to enact it as theatrical ritual and ceremony, obscured by illusion and imposture, to reassure himself against the destructive danger in himself or in the other'' (p. 45).

Coen's second author, Louis Ferdinand Céline, is not as well known as the first. Born at the end of the nineteenth century, Céline was a physician as well as a writer. He was deeply disappointed by the critics who paid little attention to his writings of the 1950's. Céline, after all, had won considerable acclaim for works twenty years earlier. He was described by his biographers as ''a depressed, angry, provocative, irritable, difficult man who needed others to respond and pay attention to him. Often he seemed to provoke angry responses in others; he said that was his goal'' (p. 51).

Coen selects the novel *Castle to Castle* to analyze the relationship that can develop between Céline and his readers. Evidently, it is a very confusing novel in which the content is less important than the manner in which it is told. ''The narrator/author struggles with his in-

ability to differentiate reality from fantansy. . . . [This] is so presented as to keep the reader mixed up, to emphasize that the reader cannot count on the reliability of the narrator. . . . 'The story' mixes together, as if time could be arrested, as it seems to be within the narrator's imagination, death and life, past reality and imagined present fantasy, violence, persecution and helplessness—all balanced by the power of the writer's creative imagination. . . . mood, tempo, punctuation, words . . . capture the reader in the procession and feelings of the abruptly changing scenes. Shit overflows the toilets and hallways; an insane surgeon is operating without anesthesia on Céline's bed; the narrator asks for help. Instead he is handed his own death sentence, proclaimed by the French Resistance" (p. 58).

Coen has read the novel many times. He discloses his changing reactions on successive readings. Initially, he felt very lonely and imagined the author must also be a lonely man. Successive readings brought Coen "to wanting to repeat the pleasure of feeling thrown from one seemingly (un)stable image to another, of enjoying losing my bearings and being carried away by the narrator's imaginative twists and turns. . . . But as I become more accustomed to this happening repeatedly, I come to expect and delight in this" (p. 53). He arrives at the following conclusions about the fantasied author of *Castle to Castle*: he is desperate to have his readers' attention, fearing they will ignore him as the recent critics have. "He seems to keep wanting to surprise, startle, shock, in order to maintain his reader's interest, and to keep attention focused on the creative process and on the narrator himself. . . . Art does not seem to be an approach to life as much as a substitute for it; literary relationships seem superior to live relationships with other people" (p. 62).

Coen convincingly answers "Why Is Sade Angry?," the title of the chapter which explores this mad author's impact on the reader. Sade's rage, helplessness, and monumental self-justification mount in crescendo style during his long imprisonment at Vincennes, the Bastille, and Chareton Asylum. In his letters from these prisons Sade "describes the awfulness of being imprisoned, enclosed in a small, cold dreadful space, and his terrible isolation" (p. 98). Sade becomes desperate to undo and reverse his sense of himself as helpless and insignificant. To achieve this he exerts his "(anal) power over his

characters—*and over his readers*—to move and eliminate them at will" (p. 100). Sade intends to trade places with his reader. It is the reader who is helpless, completely and humiliatingly controlled and worthless—not Sade.

Coen arrived at this conclusion in reading Sade's novel, *120 Days of Sodom*. First Coen had to more fully tolerate his own sadism, masochism, and destructiveness. Only then could he begin to resonate with these qualities in the author/narrator. There is virtually no escape from Sade's aim to imprison the reader, except to lay down the book. Sade intends to subject the reader to every variety of perverse sadomasochism imagined by him. "Just as the writer cannot gain release from imprisonment, especially solitary confinement, and from crippling depression, so too must the reader be endlessly bombarded by the writer's repetitive outpourings. Indeed, endless repetition, with so little variation during prolonged intervals, makes the reader feel helplessly shackled. . . . Intense feelings of despair and immobilization seem to be countered by insistence on an omnipotent entitlement to dominate and extract sadistically from others whatever one needs" (p. 100). This intent allows Sade, at least in fantasy, to preserve his object relationships and his self-esteem. He connects to people via a hate-filled bond. "It is as if the sadist continues to claim that others, having neglected and deprived him, are responsible for his plight and owe him care" (p. 101). Coen concludes that "a predominant motivation in Sade's disguised pathological dependency may be a need for another to regulate and contain his destructiveness, so that he and his object world can survive" (p. 105).

In his chapter on Freud, Coen examines the Freud/Fliess correspondence to illustrate a "psychoanalytic prototype of the supportive literary relationship" (p. 67). Coen frankly acknowledges his reasons for this selection. "[My] interest in this study derived, in part, from my own wishes and conflicts with writing and creativity. Studying Freud's use of a supportive literary relationship helped me get at aspects of similar needs in myself. There is nothing new or unusual in this. Psychoanalysts have long turned to Freud in order to better understand themselves" (p. 68). Coen makes it clear he does not intend his portrait of Freud to be veridical. Rather he intends to present a psychological study of letters as text for creating his constructed "Freud."

Early on, Freud confesses to Fliess his need of him as an audience for his fears, hopes, and ideas. Across the span of the correspondence there is a significant shift in the tone which demonstrates how the letters were indeed very supportive. First there is the aura of a dependent submission to an idealized authority. "Freud [then] learns through his relationship with Fliess that hypocrisy, absurdity, and humor are interrelated modes for defended expressions of anger" (p. 80). Slowly, Freud understands his ambivalence at feeling dominated by his internally created tyrant. Ultimately, he understands he wishes to invest authority in himself.

After documenting this shift, Coen makes this interesting and provocative case: "Thus I have been linking Freud's creativity with his self-discovery of what was present in himself. As he could become less fearful, critical, and accepting of that dark side of himself, even viewing this as the pathway to creativity, he could become more confident of himself and of what lay within him. He then, to a degree, was less needy of the protection, approval, and assurance offered by a supportive relationship" (p. 82). For Coen, this demystifies one pathway toward successful creativity. To be creative requires not only a tolerance but a love and acceptance of such conflicting feelings of femininity, passivity, and hostility.

Coen concludes this slender volume with a reprise of his views of developing a psychology of writing and reading. His ideal model is a practicing clinical psychoanalyst who, at the same time, is a practiced literary critic. "He or she should be able to read texts carefully and closely *and* have enough access to her or his own internal psychic resonances with the text to be able to utilize *some* of these to understand the text" (p. 170). In writings that are heavily freighted with the author's internal conflict which resonates with similar conflicts in the reader, a force field can develop between author/narrator and text. Analysis of this force field gives life to the "constructed author" of the text.

This scholarly, often brilliant text is, for me, more than a road map for a psychoanalyst/critic deconstruction of a literary text. It powerfully illustrates how one psychoanalyst has entered his own dark tunnel of powerfully destructive and shameful forces to emerge into the light of his own creativity.

MORRIS L. PELTZ (SAN FRANCISCO)

READING FREUD'S READING. Edited by Sander L. Gilman, Jutta Birmele, Jay Geller and Valerie D. Greenberg. New York/London: New York University Press, 1994. 303 pp.

In the summer of 1992, Sander Gilman directed a National Endowment for the Humanities Summer Seminar on the topic of "Freud's Reading." Twelve renowned scholars met at the Freud Museum in London for two months and read Freud's library from a variety of perspectives. *Reading Freud's Reading* contains some of the fruits of this seminar, as well as contributions from a few additional colleagues. In this collection of essays, the authors explore Freud's literary interests and ask how they may have contributed to the evolution of his theory. They pay close attention to Freud's marginalia and markings as well as to which books he actually read, which pages remain uncut, the books he chose to bring to London, etc. This volume inaugurates a new series on literature and psychoanalysis. The aim of the series is to create a healthy and equal dialogic relationship between psychoanalysis and other disciplines, rather than emphasizing the ways that psychoanalysis informs and explains literature and art.

The excellent essays in this collection range from classical philology to physics, and the authors bring the questions, methods of inquiry, and modes of inference of their respective fields. In a brief review, it is impossible to mention all of the various essays, or discuss any in detail. Two essays, however, that explore the significance of Freud's fascination with Moses illustrate the differences in outlook, emphasis, and approach in this collection.

In "Freud and the Figure of Moses," Harold Blum explores the Moses leitmotiv in Freud's life and work. His emphasis is on Freud's understanding of literature, historical data, and also what Freud's own writings may reveal about his intrapsychic conflicts, development, and transformations. Blum states that Moses had a special significance for Freud beyond other historic or literary figures and that "Moses was a deeply personal, haunting preoccupation, an attachment and identification rooted deeply in his Jewish heritage, a Biblical, historic, and legendary figure elaborated in his own mythopoetic fantasy" (p. 109). Blum traces the meanings Moses may have had for Freud from earliest times in his birthplace until the completion of *Moses and Monotheism* and his writing of his last will and testament in London. The work is detailed, thorough, and compelling.

Richie Robertson, in "On the Sources of Moses and Monotheism,"

explores the relationship to prior sources as well as the use Freud made of them and the spirit in which he approached these sources. He emphasizes the "interpretations that make *Moses and Monotheism* above all an articulation of the cultural forces whose conflicting pressures Freud registered" (p. 267). He also illustrates ways in which he thought Freud could be more or less critical of sources, depending upon whether or not they supported his theories. Following this thread, Robertson's final comments are about the significance of the anthropologist Wilhelm Schmidt's work as an important context for *Moses and Monotheism* and Freud's enmity with Schmidt. Robertson states that "each man held to his convictions the more strongly for their lack of scholarly foundation" (p. 281). He also suggests that Freud and Schmidt developed different theories regarding the transmission of the doctrine of monotheism: Schmidt's theory posited diffusion, and Freud's cited repression. Robertson links this concern over how doctrines survive to the threat to Judeo-Christian civilization posed by both Nazism and Communism.

These illuminating essays provide the reader with a rich, multifaceted intellectual context for Freud's writings. They particularly provide psychoanalysts with the opportunity to become acquainted with methods used by other disciplines in their approach to Freud and psychoanalytic theory. One difficulty limits the degree to which many readers may be able to fully appreciate and benefit from this book. The editors appear to assume that the reader possesses a level of general scholarship enabling him/her to follow sophisticated arguments in philosophy, postmodern thinking, etc., and understand in depth what each author is trying to do. The editors might have provided a preface addressing this issue or perhaps have asked the authors to explain their methods within their respective essays.

Reading Freud's Reading is a pioneering work and a valuable contribution to the literature. I recommend this book and would encourage psychoanalysts to become familiar with these authors and essays.

STEPHANIE SMITH (BOSTON)

MEETING FREUD'S FAMILY. By Paul Roazen. Amherst: University of Massachusetts Press, 1993. 220 pp.

Paul Roazen, who at the time of the writing of this book, was a professor of social and political science at York University in Toronto, is well known to the psychoanalytic audience, having written a

number of controversial books about Freud and psychoanalysis. These include *Freud: Political and Social Thought*, biographies of Helene Deutsch and Erik Erikson, *Brother Animal: The Story of Freud and Tausk*, and *Encountering Freud: The Politics and Histories of Psychoanalysis, Freud and His Followers*, as well as several others.

In this volume Roazen utilizes notes from interviews he obtained with noted psychoanalysts early in his career in the 1960's. Interviews were conducted with members of Freud's immediate and close family, as well as with some of those who worked very closely with him professionally in Europe.

The saga begins in the fall of 1964 when the author had just received a full-time faculty appointment at Harvard University after completing his doctoral training there in social science. It was then that he began attending a weekly clinical psychiatric seminar at the Massachusetts Mental Health Center. There he was exposed to the clinical discussions of eminent psychiatrists, among whom were some outstanding psychoanalysts. He was thus inspired to pursue his interest in psychoanalysis, impressed by the preeminence of psychoanalytic thinking and the influence of prominent psychoanalysts in the leading academic psychiatric departments in the country. Roazen cogently comments on the unique cachet psychoanalysis enjoyed within psychiatry during the early 1960's in contrast to the contemporary scene in which preeminence has flowed to the exponents of biological psychiatry and psychopharmacology.

The book is annotated on a chapter-by-chapter basis, with specific references to literature citations, many of which are the author's own. This can be troubling at times, since various characterizations are offered and anecdotes are related which are attributed in the notes to the author's other publications without reference to primary sources. Roazen writes in a highly personal style, very much in the first person, giving the reader a sense of an author who is revisiting emotionally affecting early experiences. Throughout the book his focus vacillates between occasional brief discussions of substantive psychoanalytic issues and serious attempts to illuminate, if not capture, the personalities of Freud and some of the leading figures around him. There seems, however, to be an underlying obsessive tendency to expose the "warts and pimples" of the personae being scrutinized. Roazen is not in the least reticent or parsimonious in his sharing of his highly

subjective impressions of the individuals interviewed. One comes away with the impression, however, that his characterizations and assessments of the leading interviewees whom he discusses are all too strongly influenced by his perception of their responses to him. Thus, for instance, his obvious adulation, if not idealization, of Helene Deutsch is in contrast to his all too apparent animus toward Anna Freud which, he records, was reciprocated by his subject.

The reader is presented with a generally neutral picture of Freud as a person through the portraits painted by the interviewees; and I cannot say that one learns anything dramatically new about him in a biographical sense. The only possible exception would be Roazen's discussion of the information which has emerged about Freud having analyzed his own daughter Anna, which one would assume is already generally known to this volume's readership. While this is a piece of information that certainly arouses interest and serious questions, it is presented in a tone which suggests the discovery of a "smoking gun," presumably leaving the reader poised to discredit the substance of the contributions of the founder of psychoanalysis.

On the positive side, the book does provide us with more detailed portraits of a variety of people with whom we were already acquainted. Ernest Jones, for instance, is not presented in a complimentary way while Sándor Ferenczi seems to come across in a much more positive light. We meet a number of people with whom we have less acquaintance, such as Freud's sons, Martin and Oliver, his daughter, Mathilda, and his daughter-in-law, Esti, as well as nieces, nephews, and family friends. Certainly, their descriptions flesh out the interpersonal ambience in which Freud lived, socialized, and worked while leaving us impressed with the interesting lives that most of these people lived. Clearly, this book is no hagiography. One has the impression that the author may well have been searching for skeletons in the closet, such as the analysis of Anna, which would arouse antipathy if not indignation on the part of readers. In that regard the book is experienced as more of a lay biography than as a scholarly inquiry.

Much is made by Roazen of the defensiveness of certain interviewees who were in Freud's closest circle about revealing intimate information about him and his family. One gets the impression that a conspiracy was afoot to keep such information out of the public

purview. This was most evident in the attitude of Anna Freud, as conveyed by the author. While this may be in large part attributed to a healthy respect for privacy, and even if the author exaggerates this "wagons in a circle" ethos, there certainly seems to be an overinvestment in secrecy. This suspicious posture is most unfortunate. It may well be one of the primary virtues of the book that it examines this quasi-paranoia, which was most assuredly counterproductive, in that it aroused further suspicions about the probity of the founder of psychoanalysis as well as the discipline which he created. Ominous speculations emanating from transferential reactions to Freud would inevitably have occurred, but, in my opinion, this secretive attitude probably exacerbated such responses. Conjectures about the extent of Freud's relationship with his sister-in-law, Minna, for instance, have been frequent topics of focus in the media, and this has certainly been without any solid shred of evidence. Indeed, this book adds no information which would illuminate that relationship beyond what we already know. Secretiveness and defensiveness no doubt encourage just such speculations.

If one does not expect to make startling new discoveries, this book will entertain those who are already somewhat informed about Freud's personal biography as well as about his familial and intellectual circle. It also will add considerable dimension about the personalities who surrounded him, most of whom were interesting and charming.

WARREN H. GOODMAN (GREAT NECK, NY)

THE COURSE OF LIFE. VOL. VI. LATE ADULTHOOD. Edited by George H. Pollock, M.D., Ph.D. and Stanley I. Greenspan, M.D. Madison, CT: International Universities Press, Inc., 1993. 550 pp.

The title of this volume in *The Course of Life* series is a misnomer, inasmuch as more than half of the book has nothing to do with "Late Adulthood." While almost all of the contributions are interesting, the volume itself does not hold together.

George Vaillant and Sara Koury's article, "Late Midlife Development," addresses the controversy over whether personality does or does not change in adult life. They focus on the later Eriksonian tasks of generativity (specifically the subset entitled "keeper of the mean-

ing") and integrity. They see midlife crisis as providing a catalyst for a reassessment of the personality and a means for the mature individual to give away aspects of the self, such as wisdom. The "keeper of the meaning" idea concerns the individual in guiding groups in the preservation of past cultural achievements. Integrity entails an acceptance of one's own life cycle.

"Transformational Tasks in Adulthood," by Roger Gould, deals with the adult's changing sense of time. By liberating ourselves from the codes and regulations of those who formed us, we gain freedom but have to give up the illusion of absolute safety and the familiar assumptions we have lived by. We must also realize that we are no longer young, and we urgently question what we have done with our lives and what actions we need to take in the remaining time allotted.

Morton Lieberman's "A Reexamination of Adult Life Crises: Spousal Losses in Mid- and Later Life" is one of the best chapters in the book. The author draws on five studies of spousal bereavement. The most novel finding from the first two studies was that the respondents who showed little or no grief after their spouses died were the best adapted over a seven-year follow-up. Those with limited grief did not find psychotherapy as helpful as the other types. All groups improved over time, so reactions to spousal loss may be intrinsically self-limited. In another study, those with limited grief patterns showed the least dependency, guilt, and anger, whereas the prolonged grievers showed the highest dependency, guilt, and anger toward the deceased. The limited grievers received the highest amount of support from friends and made more new friends than the chronic grievers. The less stunting the prior marital relationship was, the more limited was the grieving. Those who dealt best with loss underwent personal growth. Grief reactions were not universal and were not highly predictable from the dynamics of mourning. In addition, classical risk factors which we assume, such as prior losses and an ambivalent relationship to the deceased, do not account for most of the variations in adaptation. This article should make us re-examine our theories of depression, inasmuch as it is contrary to prevailing psychoanalytic wisdom.

Stanley Palombo's "The Archaic Adaptive Ego" focuses on the primitive mental processes Freud assigned to the id. He delineates three structures which are the basis of the excitation-memory pairs

Freud referred to as the content of the id. He further sees the id as an archaic portion of the adaptive ego.

In Paul Dewald's "Adult Phases of the Life Cycle" adulthood is seen as a continuing unfolding of the processes of change, rather than as a static state. He describes a number of sources for potential adult psychopathology and delineates various developmental tasks. There is, however, little focus on late adulthood, except for brief mentions of aging and death.

"From Mistrust to Trust: Through a Stage Vertically," by Kalman Kaplan and Nancy O'Connor, beautifully traces the development of trust through the Eriksonian phases of the life cycle. They add a stage not covered by Erikson, the oldest old, which is initiated by physical decline and awareness of mortality. The core pathology of doubt that there is anything beyond the present life leads to disengagement and trivialized attitudes. Another interesting finding is that for both men and women, there is a dissipation of the rigid gender differentiations evoked at earlier life stages.

Jean Carney and Bertram Cohler, in "Developmental Continuities and Adjustment in Adulthood: Social Relations, Morale, and the Transformation from Middle to Late Life" have written the most interesting article in this volume. They note that studies show that health, not social relations, is the most important predictor of feelings of well-being in later life. Also a large number of studies find little or no linkage between morale in old age and the amount of interaction with other people. This is contrary to my own clinical experience, but I bow to the wisdom of the larger sample they present. Another fascinating finding is that the experience of having had children is not found to be crucial to life satisfaction in old age. In addition, the grandparent role, particularly among women, is either independent of morale or contributes to lower morale. Further, frequency of interaction with siblings or friends does not seem to correlate well with morale. The authors suggest that infantile conflicts may lose some of their power in older age, and other conflicts may replace them. Again, this is contrary to my clinical experience, but the authors' work is challenging and forces us to rethink our data.

E. James Anthony's "Psychoanalyst and Environment" reviews the analytic literature on the impact of the environment on the individual. The author discusses a developmental environment which

subsumes all the dynamic features contributing to any particular stage of development (internal, transitional, external). He then delineates the effect of different abnormal environments on development.

"Psychoanalytic Nosological Considerations" by John Frosch is a very long and detailed historical consideration of the literature on nosology and of the impact of analytic thinking on psychoanalytic nosology and psychiatric diagnoses. The sections on psychotic characters and on impulse disorders are most interesting.

Louis Gottschalk's "Psychoanalytic Perspectives on the Affective Disorders: Neurobiological and Psychosocial Interactions" is noteworthy in its sections on mood and affect. Where it falls down dramatically, and where it reveals the likelihood of its having been written a number of years ago, is in the absence of any mention of the serotonin reuptake blockers, such as fluoxetine, in the sections on psychotropic drugs and neurotransmitters.

While Edward Wolpert, in "From Metapsychology to Pathopsychophysiology: Toward an Etiological Understanding of Major Affective Disorders," also omits any mention of the serotonin reuptake blockers, his discussion of circadian and infradian rhythms is most elucidating. Again, this article has nothing specifically to do with late adulthood.

Clarence Schulz's "The Contribution of the Concept of Self Representation/Object Representation Differentiation to the Understanding of the Schizophrenias" and Arnold Modell's "The Narcissistic Character and Disturbances in the Holding Environment" are both excellent articles, but really belong in a volume devoted to early, rather than late, adulthood.

WAYNE A. MYERS (NEW YORK)

MUSEUMS OF THE MIND. MAGRITTE'S LABYRINTH AND OTHER ESSAYS IN THE ARTS. By Ellen Handler Spitz. New Haven/London: Yale University Press, 1994. 190 pp.

In her first book, *Art and Psyche,* Ellen Handler Spitz set forth a lucid and well-reasoned program for the application of psychoanalytic principles to the study of the products of culture—in particular, works of art in a broad spectrum of media and styles. The present

volume, her third, is less sharply focused, but brings to bear her gifts as art historian, aesthetician, and psychoanalyst on a wide range of topics from the work of René Magritte to contemporary comic strips; it includes, as well, matters of interest to her that are, strictly speaking, marginally relevant to psychoanalysis.

A substantial element binding together the book's disparate content is a tribute to her mentor, the late Martha Wolfenstein, whose studies of child development, children's humor, and, most importantly, Magritte, clearly served as a base of inspiration for Spitz's explorations. Thus, the first half of the book is devoted to a survey of Magritte's work, taking off from Wolfenstein's thesis that the determining factor in the artist's imagery was his reported childhood memory of observing the seminude body of his suicidal mother, dragged from the river with her nightgown drawn up over her face. Although Spitz demonstrates that this "memory" represented a "narrative" rather than a "historical" truth, she adheres to her mentor's view (and that of other psychoanalytic commentators) that the incident constituted, nonetheless, the nuclear trauma that, in one form or another, shaped Magritte's life and work and was, in one disguise or another, figured in the content of the bulk of his art.

To this reviewer, this reductive thesis does scant justice to the richness of Magritte's powerful intellect and to the broad scope of his interest in semiotics and language theory and, above all, to the classic surrealist preoccupation with the irrational and the dream. It attaches central importance to a (presumed) occasion of "shock" trauma that current developmental research would not support. Spitz is certainly aware of all of these matters, but she tends to slight them, forcing her approach even to Magritte's famous *"Ceci n'est pas une pipe"* into a trauma-generated mold. This is not to say that all of her interpretations are thus tendentious; many are stimulating, even persuasive, but they leave too little room, I believe, for nonconflictual motivations and alternative meanings. It goes beyond reason, I think, to suggest that in all his work "as artist, sorcerer, magician," his sole aim was to "undo the trauma and bring his mother back to life" (p. 47).

In Part Two, Spitz ranges widely, addressing issues in philosophy, popular culture, drama, music, and art education. A thoughtful discussion of the "absurd" builds on the work of the philosopher Thomas Nagel, to argue that "creative acceptance of coexisting conflicting

points of view is the progressive position''—with the caveat that it can also be used regressively in obsessional doubting, hypocrisy, and indecisiveness. An extended celebration of the popular comic strip ''Calvin and Hobbes'' reveals the subtlety of its satiric reflections on contemporary culture, relating it to some of the paintings of Pieter Breughel in its use of children to express the ambiguities that pervade human life at all ages and at all times. Spitz demonstrates some of the tropes and disguise mechanisms—defensive operations, if you will—used by the creator of the strip to achieve this inventive synthesis of naïve humor and witty, sophisticated social criticism.

Spitz is, I think, less successful or less convincing in her analysis/appreciation of yet another item of popular culture, the film *Dead Poets' Society*. She fails to make clear what, for her, outweighs what some critics, including this one, considered its manipulativeness and sentimentality. She does offer sensitive rereadings of *Antigone* and of a Hopkins sonnet that, however personal, do enrich them with a psychoanalytic sensibility. The chapter on teaching aesthetics to children describes work that engaged Spitz at an early stage in her career, and sets forth a program that, although meritorious and effective, seems hardly likely to be implemented in this era of anti-intellectualism and governmental penury toward education in general and such ''frills'' as aesthetics in particular.

There are a few factual errors. The surrealist collaborative drawings were known as *''cadavres exquis''* (not *''corps exquis''*), and it was to her handmaiden Belinda, not to Aeneas, that Dido delivered her famous lament in Purcell's opera. Spitz's style is fluent, her scholarship impressive, and her grasp of philosophic and psychoanalytic ideas sure. Altogether, however, this book seems more diffuse than her previous efforts.

AARON H. ESMAN (NEW YORK)

PSYCHOANALYTIC EXPLORATIONS IN MUSIC. SECOND SERIES. Edited by Stuart Feder, M.D., Richard L. Karmel, Ph.D. and George H. Pollock, Ph.D. Madison, CT: International Universities Press, Inc., 1993. 323 pp.

Once again the editors are also contributors to this collection of original presentations for those readers interested in both psycho-

analysis and music. The material is very well organized, with some overlapping of topics which enables the reader to learn about an area from several points of view. This fosters an increased capacity to integrate the material and leaves one with the satisfying sense of having considered many controversial topics. All of this is accomplished with minimal confusion and maximal enjoyment.

The first section, "On Music and Method," opens with an essay by Feder on how he conceptualizes the link between a work of art and the mental life of its creator. His title, "Promissory Notes," is a play on words that fulfills the promise, for he clearly elucidates the principles of the leap from mind to music. He speaks of three principles for psychoanalysis applied to creativity. These are overdeterminism and multiple function, infinite displaceability, and infinite representation. It is fruitful to analyze creative works using these principles, just as one can use them to understand free associations in psychoanalytic work. Feder illustrates these points by examining a song by Schubert, his poignant "Moment Musical." A marvelous aspect of this book is that in many instances the musical score is printed along with the explanatory text. The clarity of the illustration makes the principles accessible to the interested but technically unsophisticated reader and inspires further thought and study in the area. The reader can at last fulfill his or her own promissory note to go deeper into these creative ideas.

Martin Nass follows with an original study on creativity and psychopathology that is equally interesting and accessible. He convincingly presents the point that creativity, which by definition must involve a greater contact with internal processes, is not a sign of psychopathology. In fact, the reverse is true, for the composer must "trust his own abilities which requires a high level of autonomy and ego strength. . . . to view this as pathology is absurd" (p. 37). Thus, Nass deals emphatically with the distorted notion that greater access to internal process is a sign of psychopathology. People perform brilliantly in creative ways in spite of disease, not because of it. Musicians have a heightened sensory awareness which is probably constitutional: a capacity to deal with loss, an ability to persevere in their own line of thinking, and a capacity to tolerate ambiguity, nonclosure, and anxiety.

The second section, "On Affect in Music," is more technically sophisticated, but still the presentations are available to the nonmu-

sician. There is discussion about how music conveys affect, and here there are differences of emphasis ranging from cultural and social factors down to the biological and neurological. For example, from David Epstein's essay, "On Affect and Musical Motion": "Tempos that fall into meaningful proportional relations seem to gratify both a physiological and a psychological need for periodicity. . . . they are thus congruent with our neural functioning and thereby gratify deep seated anticipations" (p. 121).

Pinchas Noy offers a psychologically based perspective that outlines several possible ways in which music may affect emotions. He quotes Kohut and Levarie, who state, "Music may reach the ear as a chaotic stimulus which arouses anxiety. . . . Ego then masters this by organizing those sounds. Affect is felt as pleasure because the organizing efforts succeed" (p. 127). Noy then delves into the theories concerning musical expression and the origins of musical language. This is a thorough and fascinating journey from the earliest levels of human development to the appreciation of the most complex music. Music can evoke the earliest experiences of human life from the preverbal phase of communication. At the same time music can be culturally dependent, with meanings arbitrarily assigned. Every affect may have its specific form in music as if music is a tonal analogy of emotive life. He concludes that there is truth in all of these ideas that is useful in understanding music. A controversial idea here is that music, especially complicated music, may stimulate brain circuits and thus contribute to actual physical neural development.

Gilbert Rose has written a fascinating chapter which addresses the question of how the formal structures of music become transduced to a new level of personal emotional experience on the part of the listener. This is discussed and amplified by Eugene Goldberg's commentary.

The third section, "Studies of Composers and Compositions," is a joyous romp through everything you always wanted to know about some of the most famous composers, including Bach, Mozart, Schumann, Wagner, and Satie. The article by Pollock on incest themes in Wagner's Ring Cycle is a particularly absorbing piece of applied psychoanalysis. Feder's "Tale of Two Fathers," in which he discusses Bach and Mozart is similarly fascinating. The careful organization of the book shows in the overlapping and complementary subject mat-

ter which contributes to the reader's perception of having really learned something by the end of this volume.

The last section consists of two historical essays on Freud and music. Contrary to the popular belief that Freud, although living in a most musical city, was virtually musically illiterate, the two authors convince otherwise in their careful studies. The essay by David M. Abrams on Max Graf is particularly rewarding because of the description of the psychoanalytic approach in several aspects. Abrams states that "Graf's greatest contribution was his in depth application of topographic theory to the composing process" (p. 303). There is also discussion comparing romantic and classical music: classical music separates out dissimilar ideas, comparable to secondary process in thinking, while romantic music mixes many dissimilar elements together, more like primary process.

This book should not be missed by anyone interested in music. For psychoanalysts who love music it is a special treat to be savored.

RITA W. CLARK (BROOKLYN)

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Literature

Murray M. Schwartz

To cite this article: Murray M. Schwartz (1997) Literature, The Psychoanalytic Quarterly, 66:2, 361-375, DOI: 10.1080/21674086.1997.11927537

To link to this article: https://doi.org/10.1080/21674086.1997.11927537

Published online: 07 Nov 2017.

ABSTRACTS

LITERATURE

Abstracted by Murray M. Schwartz.

An enormous number of books and articles relating literature and psychoanalysis have continued to appear in recent years. Every category in interaction between the two fields is amply represented. Literary critics apply psychoanalytic ideas and methods to literary texts and authors; analysts interpret literary works; literature and psychoanalysis are seen as variations on general narrative strategies; critiques of the relation between the disciplines appear regularly. As the boundaries of each field shift and expand, so their contributions to one another become at once richer and more difficult to fix with certainty.

Despite the difficulty of fishing in a fast moving stream, I have chosen several book-length examples to represent valuable work that has appeared recently. *Dostoevsky: The Author as Psychoanalyst* (New York: New York Univ. Press, 1989), by Louis Breger, can serve as a model of (and for) contemporary applied psychoanalysis. Breger explores Dostoevsky's creation of fictions as a psychoanalytic process. As "the Freud of fiction," Dostoevsky created characters who are then set free to develop in ways that enable their author, an observing ego, to use them in his own self-development. Breger moves comfortably between biography and interpretation of Dostoevsky's major works, with brilliant chapters on *Crime and Punishment, Notes from Underground,* and the significance of Dostoevsky's gambling. His Appendix on epilepsy is likely the most concise and lucid statement of "how feeling and meaning were integrated into life and art" in the applied psychoanalytic literature of the past decade. Without reduction or jargon, Breger shows how physiological-psychological experience "was the enactment of a fantasy of idealized merger, rageful attack, death like punishment, guilt and resurrection." Breger's scholarship, confident use of evidence, and clear, engaging writing have resulted in a book of great and equal value to students of literature and to psychoanalysts.

A very different style and ambition animates Harold Bloom's *The Western Canon: The Books and School of the Ages* (New York: Harcourt Brace, 1994). Primarily an inimitable defender of great books against the reduction of aesthetics to ideology and "the School of Resentment" (e.g., pushers of deconstruction, feminism, new historicists), Bloom is relevant here mainly for his sections on Shakespeare and Freud. He defends literary genius against those who see literature as an epiphenomenon of social processes and has some stunning insights into the psychology of character in his discussion of King Lear, Hamlet, and Othello. The chapter called "Freud: A Shakespearean Reading" is much less successful, even, one suspects, willfully wrongheaded. Bloom argues that Freud "always discovered that Shakespeare had been there before him, and all too frequently could not bear to

confront this humiliating truth." Despite lively and original readings of Freud's extensive interpretations of Shakespearean plays and characters, Bloom is intent on bringing Freud under the spell of "the anxiety of influence," his theory that authors enact their genius by creative misreading of their precursor-rivals. Like a number of other literary critics, Bloom treats Freud as if he were *only* a writer, diminishing to insignificance the clinical dimension of his work and the complex provisionality of his theoretical struggles. For sheer provocativeness and imaginative fertility, however, Bloom is in a class by himself.

A less grandiose but important example of a literary critic reinterpreting Freud is Alexander Welsh's *Freud's Wishful Dream Book* (Princton, NJ: Princeton Univ. Press, 1994). Welsh argues that *The Interpretation of Dreams* was motivated primarily by Freud's ambition, his desire for fame. For Welsh, Freud's stance as a scientist was a pretense; he was actually a creator of myths, an engaging rhetorician preoccupied with secrets and the wish to please his readers. Welsh claims that "Freud put the cart before the horse" by locating the source of personal conflicts in childhood rather than in one's contemporary social relations. Freud's claims for unconscious motivation are actually manifestations of nineteenth-century scruples about "comfort and correctness." Astonishingly, Welsh never asks what Freud meant by a wish. Though it will certainly invite dismissal by serious students of the history of psychoanalysis, Welsh's book is significant for two reasons, one positive, the other negative. Positively, Welsh embeds *The Interpretation of Dreams* knowledgeably in the social framework of Victorian culture. He appreciates Freud's seductive stylistic strategies, his humor, and his impact on our understanding of personal history and narrative. Negatively, Welsh adheres to simplistic notions of scientific reasoning and the relation between psychological and "social" explanation. His book joins a growing list of attacks on Freud, most of them less urbane and congenial than his, that deserve to be taken seriously if Freud is not to be read back into the nineteenth century at the end of the twentieth.

Debates over Freud's place in social and intellectual history have not deterred Shakespeareans. From the burgeoning library of psychoanalytic readings of plays and poems, I have selected three recent additions. Janet Adelman's *Suffocating Mothers: Fantasies of Maternal Origin in Shakespeare's Plays, Hamlet to The Tempest* (New York/London: Routledge, 1992), a work of enormously inclusive scholarship, explores the deep fantasy of the threatening sexualized body of the mother in Shakespeare's imagination. Adelman has absorbed the body of previous psychoanalytic criticism of the plays and transformed it into a coherent, lucid reading both of the individual plays and of Shakespeare's development through his final "romances." If the tragedies enact the consequences of malevolent maternal power, Shakespeare's final plays struggle to transcend the splitting of the parental couple, succeeding best in *The Winter's Tale.* She shows how pervasively the fear of maternal engulfment governs family relations in Shakespeare, suffusing his language and his conception of tragic and post-tragic form. In a rare display of

generous scholarly dialogue, Adelman's 120 pages of footnotes are a feast of acknowledgment and debate worth reading in themselves.

Adelman's book is complemented by a collection of essays edited by B. J. Sokol, *The Undiscover'd Country: New Essays on Psychoanalysis and Shakespeare* (London: Free Association Books, 1993). Collectively, the essays challenge the more hyperintellectual trends in Shakespeare studies by focusing on the theatrical and emotional realities of Shakespearean drama. Contributors are drawn from several countries, and their interests are broadly interdisciplinary. The essays by Jonathan Miller on *King Lear*, Philip K. Brock on *The Phoenix and the Turtle*, and Ruth Nevo on *Pericles* are especially interesting. For serious students of Shakespeare and psychoanalysis, the bibliography of criticism from 1979 to 1989, by Christine Levey, is extremely valuable. Levey updates the bibliography by David Willbern in *Representing Shakespeare: New Psychoanalytic Essays*, edited by Murray M. Schwartz and Coppelia Kahn (Baltimore: Johns Hopkins Univ. Press, 1980), which covers the period from 1964 to 1979. Willbern's bibliography is itself an update of Norman N. Holland's *Psychoanalysis and Shakespeare* (New York: Octagon Books, 1979), which contains a listing of works up to its first publication in 1964. Together, these three bibliographies provide a thorough and continuous listing of a century's work in this field.

William Kerrigan's *Hamlet's Perfection* (Baltimore: Johns Hopkins Univ. Press, 1994) affirms the centrality of character in the tradition of *Hamlet* criticism since the Romantics, a tradition in which Freud and Jones are firmly embedded. Unlike Adelman, who derives her readings from object relations theory, Kerrigan's interest is in the revenge tradition and the effects of the splitting of the feminine on Hamlet's ideals. His exploration of night fantasies in the play is brilliantly illuminating, and he regards splitting as a fact of life. "There will ever be splits. Splits are life. So I will not moralize about the two-faced woman in Hamlet's mind. If the choice were between idealizing or condemning this psychic configuration, I would prefer to idealize it." Implicit in the differences between Adelman and Kerrigan is, roughly speaking, a debate about masculine and feminine approaches to literary texts, with Kerrigan confidently on the side of intellectual history in the "masculine" tradition. Kerrigan's approach yields a powerful reading of Hamlet's tragic dilemma and his achievement of a new understanding of revenge.

Object relations concepts are the explicit framework for reading nineteenth and twentieth century authors in Barbara Ann Shapiro's *Literature and the Relational Self* (New York: New York Univ. Press, 1994). Shapiro's introduction usefully summarizes this post-Freudian perspective, with its emphasis on preoedipal development as conceived by such analysts as Winnicott, Kohut, Stern, Chodorow, and Benjamin. She then develops cogent readings of a variety of authors from Wordsworth and Jane Austen to John Updike, Toni Morrison, and Anne Beattie. Shapiro highlights contemporary concerns about nurturance, trust, and the need

for sustaining others as these issues emerge in the clinical setting, in the shape of theory, and in our culture of narcissism and its vicissitudes.

The contemporary dialogue between psychoanalysts and literary critics is very usefully and soberly assessed in Stanley J. Coen's *Between Author and Reader: A Psychoanalytic Approach to Writing and Reading* (New York: Columbia Univ. Press, 1994). Coen reviews and comments on an extraordinary range of psychoanalytic views regarding the relations between readers and authors, both real and implied. He moves easily between the clinical experiences of a practicing analyst and formulations of literary theory that range across schools of criticism, evaluating, agreeing, and disagreeing as he goes. Coen is straightforward and concrete, and he takes on an impressive array of topics and authors, including reader-response criticism, psychoanalytic theories of literature, Freud and his translators and critics, Céline and Sade. Coen aims to demystify both the creative process and the uses readers and authors make of one another. For readers and authors, "Creativity and destructiveness go together; they are not opposites, they cannot be separated." Coen's book can serve both as an introduction to the field of psychoanalysis and literature and as a set of responses to its current practices.

Finally, let me mention a truly extraordinary book by Jeffrey Berman, *Diaries to an English Professor: Pain and Growth in the Classroom* (Amherst, MA: Univ. of Massachusetts Press, 1994). Berman studies the diaries kept over a fifteen-year period by his students in literature and psychoanalysis classes at The State University of New York at Albany. His book eloquently shows how a gifted teacher can bring psychoanalytic understanding into close contact with the personal concerns of students as they explore their relationships to one another and to literary texts. The diaries themselves movingly reveal the wishes, fears, expectations, and preoccupations that students bring to the classroom experience. Berman's final chapter on teaching empathically, and the Afterword by Maryanne Hannan are substantial and welcome contributions to psychoanalytic pedagogy.

The Dutch Annual of Psychoanalysis. II, 1995-1996.

Abstracted by Jonathan Dunn.

Section 1: Traumatization and War

Psychical Disorders among Inmates of Concentration Camps and Repatriates. Jacques Tas. Pp. 16-24.

The author chronicles his psychiatric work with the inmates at Bergen-Belsen, a Nazi concentration camp. He describes the psychopathic behavioral problems, enuresis, nightmares, and rageful aggression that developed among the children and adolescents in the camp. Causes of these problems included: hunger, fear, exhaustion, parental absence and irritability, denial of the environmental horror, and the constant witnessing of the Nazis degrading their parents' dignity and

authority. While cases of reactive psychosis in adults were evident, many inmates who were mentally ill before incarceration actually improved in the camp, whereas some who were healthy beforehand now became morbidly depressed, anxious, or worse. The unconscious need for punishment, now satisfied by the Nazis' brutality, may have alleviated already existing symptoms, while the focus on external terror may have refocused and lessened pathological anxiety that before the war stemmed primarily from unconscious fantasy. "Survivor guilt," struggles against dying from apathy and lack of hope, and suicide attempts are also discussed.

The Wish for War. Antonie Ladan. Pp. 40-49.

All wars are "personal" wars: for each individual, war has a unique intrapsychic meaning, and an attempt to resolve unconscious conflict underlies our wishes for war. While we assert that war is unavoidable, we also believe war is avoidable through military buildup. Three other illusions serve to deny the psychological and external reality of war: 1) that we know what war is; 2) that war is a conscious choice; and 3) that our war is morally righteous. Facing our own death through risking it in war unconsciously aims to enhance our sense and value of life, which our denials of death have diminished to a pathological extent. War also satisfies our omipotent wishes to annihilate, which stem from narcissistic rage and primitive fantasies of revenge. The possibility of actualizing such annihilation wishes through nuclear warfare makes acknowledgment of our wishes for war all the more difficult. Concomitantly, the awesome sophistication of war technology that enables us to act out annihilation fantasies strains our ability to tolerate and contain our impotent rage. Projection of violent impulses and wishes into the other (the enemy) intersects with our wish to wage war. We rationalize our warring actions by believing we are protecting what we love from the other's wish to destroy it. An analysis of some of the underlying motives and reaction-formations of "peace movements" ends the paper.

Traumatic and Non-Traumatic Damage to Psychic Structure. Han Groen-Prakken. Pp. 50-65.

It is necessary to distinguish between pathology caused by identifiable traumatic events and pathology caused by ongoing developmental interferences from external sources; the latter does not result in the degree of psychic paralysis and dysfunction that specific trauma causes. A literature review of trauma is given: the author supports Anna Freud's call for a specific definition of trauma—helplessness of the ego in the face of overwhelming stimulation. In treatment, the reality of the external event must be disentangled from the patient's related unconscious fantasies. The author also discusses the debate over whether or not the effects of trauma are fully resolvable; in this regard, specific difficulties, including proneness to various kinds of disavowals and acting out behaviors, are

described. The many pre-existing conditions influencing the effects of trauma are listed, and the concept of helplessness of the ego is further examined. The author discusses the concepts of trauma and developmental disruption in reference to observations of the effects of Nazi concentration camps.

Going into Permanent Hiding as a Way of Postponing Mourning. Louis M. Tas. Pp. 118-125.

Some Holocaust survivors continued to stay in hiding after the War; in so doing, they froze their sense of time, denied their guilt and grief, and never fully mourned their losses. Avoidance of commitment and inability to take life seriously, believing that their hiding was just a game, and extreme secretiveness about their war experience are all signs of blocked mourning; others are extreme passivity from "learned helplessness," denial of any need for sympathy, projection of guilt, and masochism. The negative effects of such denial on the survivor's children and loved ones are detailed. Active fantasies about the dead person can be employed to either deny his/her absence or to acknowledge it, and conscious assertions that the deceased is gone may mask underlying disbelief. A case vignette of agoraphobia related to repressed fantasies underlying a truncated mourning process is presented.

Am I My Brother's Keeper? On the Partners of Persons Who Were in Hiding During the Occupation. Hendrika C. Halberstadt-Freud. Pp. 126-137.

The author discusses her impressions of the psychodynamic makeups of non-Jewish wives of men who as children were in hiding during the Nazi occupation. The wife may have unconscious needs to make reparation and to rescue; falling out of love, leaving their husbands, or failing to make them happy for whatever reasons may carry an extra burden of guilt for these women. Masochistic enactment, in which the wife's suffering can never equal that of her husband's, may make any acknowledgment of her aggression extremely difficult—all she is permitted to do is comfort and serve, even if this means being an object into which he may project his rage, guilt, fear, misery, blame, regressive longings, etc. Other difficult issues in these relationships include: 1) the "foster-child" husband always feeling unaccepted, thus arousing the wife's insecurity; 2) the husband's entrenched sense of obligation and gratitude to those protecting him by "taking him in"; 3) the husband's entrenched passivity or constant activity from tremendous fear of being passively overtaken; 4) inflexibility in dealing with the natural changes of life; 5) the husband's shifts from autonomy and pride to dependency and humiliation; 6) lack of self-worth and depression; and 7) deep-seated rage which comes out only at home—a sense of exceptional entitlement to reparation from his family. The author also discusses the effects of hiding on the man's fathering capacities and on his offspring. One possible pitfall for the wife is that her husband will eventually find prideful freedom and pleasure in regaining his

Jewish identity, while she feels alone and exploited because he no longer needs her as he did.

The Significance of Absent Objects in the Analysis of Transgenerational Conflicts. John A. Bruggeman. Pp. 147-157.

The author presents a remarkable analysis of a young woman whose psychodynamic conflicts revolved around her parents' Holocaust experience. This included the parents' annihilation fantasies and their identification with dead relatives. In general, Holocaust survivor parents' secretiveness, guilt, and unresolved mourning may trivialize the child's grief. Acknowledging anger and reproach toward such parents may be too psychically devastating for the child. The parents may use the child to deny their anguish and guilt, and the child may internalize or "borrow" the parents' guilt. Problems with identity are a likely outcome as well.

The author had to tolerate much "acting out" of the buried trauma before a transference neurosis developed in his case: for example, gifts of rocks from Sobibor and Auschwitz, and, without warning, the patient inviting her mother to one of the sessions (perhaps representing parts of herself she could not acknowledge). Bitterness over her Jewish fate (and rage and envy toward the gentile analyst), unconscious identification with the father's dead sister, and penis envy toward her younger brother were prominent themes in the analysis. Self-denigration of her feminity, aggression, loyalty conflicts, and fears of losing her mother were also significant. The patient unconsciously identified herself as the killer of her "gassed" relatives: when she was a child her father would accuse her of killing her pets, while she buried mice that he killed in ovens.

Section 2: Theory and Technique

Dead Certainties: Thoughts about Feelings. W. F. van Leeuwen. Pp. 182-206.

Feelings are a unique adaptive form of cognitive action that anchor, and are anchored in, the myriad ways humans perceive and evaluate their internal and external worlds: feelings are crucial factors that make pure objectivity a fiction. Feelings are inherently linked to specific social contexts and objects; thus, they must be defined in both intrapsychic and relational/empathic terms. Just as external stimuli provoke feelings from within, feelings also locate our external world, and in this sense bring all that is external to life. Here feelings are seen as continual phases of evaluations, as ways of being in and of the world.

Feelings are also orienting signals for basic organismic survival. At the same time, they help us create and maintain our value systems that go beyond such vital needs. Psychic conflict emerges from contradictory and rigidified aspects of unquestioned feeling-laden evaluations—"dead certainties." Psychoanalytic therapy helps patients better attune to their feelings in order to reappraise and recreate

their conscious and unconscious value systems. This process allows for greater psychological integration, cognitive flexibility, and human engagement. The author also discusses feelings in relation to psychic defense (not the mechanisms but the matter of which value wins out), resistance, unconscious fantasy, guilt, anxiety, language, moods, memory, and time. Van Leeuwen also speculates as to why feelings are so often understood as passive experiences.

The Concept of Transference, with Special Reference to Transference Neurosis, Transference Psychosis and Transference in Perversion. W. L. Ietswaart. Pp. 207-219.

The literature on transference has been highly inconsistent because of 1) the idiosyncratic nature of psychoanalytic work; 2) transference's origins in hypnosis; 3) the psychically charged and often contradictory philosophical assumptions concerning authority and power so central to the concept of transference; and 4) the ambiguous and dialectical nature of transference phenomena. Normal transference, in which notions of reality are *always* filtered through the lens of our subjectivity, is distinguished from pathological transference, in which a part of the past is "split-off" in the mind and this lives on as present reality (though never fitting into it).

The concept of transference neurosis within the orthodox, Kleinian, and modern positions is compared. All these schools must cope with the enmeshed relationship of past and present in transferences, the episodic nature of transference phenomena in treatment, and the intense psychic difficulties the analyst must endure to live empathically with and through the patient's transferences. However, for the orthodox group transference is the past imposed on the present. They distinguish an infantile (i.e., oedipal) transference neurosis from general transference reactions, and their treatment aims to recover the past. The Kleinians focus on countertransference, do not give special importance to the oedipal period, and consider extratransference interpretations unimportant. The moderns emphasize the present interreactions of the analytic dyad and see the patient's current state of mind as the lens through which the past is constantly redefined; becoming more conscious of the present as it manifests itself in *all* transference reactions is the goal of treatment. The author compares the neurotic and psychotic transference with the sexualized, isolative, secretive, and part-object nature of the transference of the perverse character.

Psychotherapy with the Elderly. Andries van Dantzig. Pp. 220-226.

The author asserts the efficacy, value, and ethical responsibilities in providing psychotherapy for the elderly. Adhering to general laws about aging violates the ideographic, individualistic value of psychoanalysis. Social and biological definitions of age also limit clinicians—the various personal meanings that old age and death have for any one person must be explored on a case-by-case basis. More-

over, the unconscious is timeless; thus, the core elements of the elderly person's passions and conflicts are as fresh as when they first emerged in childhood. The moment of genuine, emotional insight for an elderly patient is as eternal and as inspiring as for anyone else. No matter the age of the person, the experience of loss is transcended at these moments and life feels timeless (a clue to mystical experience?). The author offers case illustrations on how elderly patients may defensively use issues related to growing old to obscure profound conflicts that concern aspects of their inner and outer lives other than their aging.

From Hearing to Listening. Frans Schalkwijk. Pp. 227-238.

The author contrasts hearing (the act of taking in sensations) with listening (when intellectual effort is made to transform these sensations into something comprehensible). Two conceptions of the listening process are also compared: 1) the analyst-as-mirror; and 2) the analyst as a participant-observer and co-creator of the analytic material. The pitfalls of the authoritarian analytic listener are illustrated by a case vignette. A distinction is also discussed between *receptive/subjective* listening, designed to register empathically the patient's phenomenology of the here-and-now, and *restructuring/focused* listening, which is oriented toward developing psychodynamic and genetic formulations: these two forms of listening should alternate in a rhythmically balanced manner. The article concludes by comparing analytic listening to listening to music. The constant background/foreground alternation of the patient's unconscious and conscious productions is analogous to the primary chord structure underlying secondary melody in music. A case vignette shows how this rapid alternation itself may have particular interpretable purposes and meanings for the patient.

On the Analyst's Norms and Values. Antonie Laden. Pp. 239-250.

The analyst's value systems and "unconscious ideology" inevitably influence his/her perceptions of the patient and the analytic process. Three popular yet erroneous assumptions impede analysts' self-awareness of the impact of their unconscious ideology: 1) the analyst as passive nonjudgmental recorder of external stimuli; 2) the analyst as listener *only* to the patient (and not also to his/her own associations); and 3) the analyst as a more valid judge of reality. The analytic participants are enmeshed in dyadic interaction, and analytic process cannot be considered as emanating from two separate autonomous individuals. Every analyst filters psychoanalytic theories through his/her personal lens, motivated by a primal need to resolve his/her conflicts and gain self-understanding: the paper emphasizes the importance of constant self-scrutiny for effective clinical functioning. Case assessment, especially that of candidates, must focus on the intersubjective nature of the analytic pair, rather than on the prospective patient as an independent entity. Idealization of one's theory and personal analysis leads to authoritarian attitudes that spawn difficulties in empathically identifying

with, understanding, and respecting the patient's subjectivity. The reality embedded in the patient's feelings and perceptions about the analyst must be respected; otherwise, the patient will register interpretations of intrapsychic conflict, defense, and enactment as an attack on his/her subjectivity.

Section 3: Applied Psychoanalysis

The Huxley Brothers: On Creativity and Siblings. Antonius Stufkens. Pp. 252-268.

The relationship between Julius and Aldous Huxley is used to explore the psychological process of creativity. The author speculates that the surviving brothers' bond was supported by their mutually repressed, guilt-laden murderous impulses toward a third brother who committed suicide. However, the reparative motive to counter fantasied or actual destruction is not sufficient to explain creativity. While aggression is connected to the creative act, a separate, expansive urge to purely create is also at work, as is a loving curiosity that constrains destructive intentions. The hallmark of creativity is a unique synthesis of opposing aspects of phenomena; an ability to see the unique way that contradictory elements can be integrated. The author also discusses the relationship of creativity to the act of thinking and to the nature of thought.

American Imago. LI, 1994.

Abstracted by Thomas Acklin.

Jewish Masochism: Couvade, Castration, and Rabbis in Pain. Daniel Boyarin. Pp. 3-36.

Recognizing the male envy of the female body as a psychic universal, Boyarin considers the phallus myth a kind of couvade, the denial of the male desire to be female and the primitive desire for female plenitude constituting a crisis in male subjectivity. He explores Freud's resistance to investigating male patriarchy and Lacan's refusal to grant signifying power to the female body, and he sees the fiction of the phallus as the denial of the desire to have babies. He examines the anxiety about the paternal function in Rabbinic culture, viewing masochism as a series of acting out of childbirth, and castration as an attempt to achieve the status of femaleness.

In both Christian and Jewish religions the eroticization of pain in religion is analyzed as an identification with the mother: desiring to bear the father's child in a painful re-enactment of childbirth, and acting out the female demand for recognition from God, the male other, through accepting and even desiring pain. Womb envy is thus identified as the cross-cultural motivating force for much violence toward women. The possibility of nonphallic masculinity is presented: a male who resists or renounces the myth of bodily coherence, power, and unim-

pairability symbolized by the phallus and who is nonetheless the "good enough" male, renouncing the masculinity represented in the dominant culture.

Plasticity, Paternity, Perversity: Freud's *Falcon*, Huston's *Freud*. Lee Edelman. Pp. 69-104.

Edelman considers *The Maltese Falcon* of John Huston and Freud's "true anxiety dream" discussed in *The Interpretation of Dreams*. He sees the figure of the falcon as representing the privilege of the phallus, a privilege which is precisely called into question through its multiplication exposing the falcon/phallus as a plastic simulacrum, "such stuff as dreams are made on." In symbolic discourse, signifiers refer only to other signifiers. The phallus, God, is always invisible, the Thing that refers to no object and that has no qualitative presence.

Freud awoke from his anxiety dream, and grew calm only when he saw his mother's face, the primal referent of formal identity, including the formal identity of the phallus as the visible form or figure of the ego. Castration anxiety is the fear of being separated from a highly valued object, and in its earliest form is the primal anxiety of birth, of separation from the mother. Gay male sexuality acquires its phobic meaning for the dominant heterosexual culture as the displaced referent within the logic of reference. If the phallus takes form as the materialization of anal pulsions, those whom the order of meaning construes as reactivating the alternative logic of the anus and its alternative libidinal reality must in turn be wasted by a symbolic order, misrepresenting itself as the order of the representation of the meaning of reality itself.

Homoeroticism and the Father God: An Unthought in Freud's *Moses and Monotheism*. Howard Eilberg-Schwartz. Pp. 127-159.

Freud's account of monotheism, particularly in *Moses and Monotheism*, ignores the dependent, loving side of the oedipus complex, the love of God connected to the Father's love. Feeling that the prohibition against making images of the Father God reflects the concern over closing the eyes, as in the dream of his dead father, the unthought of Freud perhaps was the wish not to see or imagine his father's naked body. Freud also seems not to have been able to make the connection between the prohibition on images and scopophilia, the sexual pleasure in looking.

The Hitlerian Superego—An Introduction. Jean Imbeault. Pp. 197-212.

Imbeault discusses Freud's work, *Civilization and Its Discontents*, particularly its often ignored conclusions that civilization is above humanity and exerts an incessant influence upon humanity. This results in demands being imposed that are impossible for humanity to meet, leaving humanity divided between the demands of civilization and egocentric motivations. For Freud, Christianity and all religions impose inhuman maxims, which at the same time constitute religions as the most

elevated and perfected of human ways of linking humanity with the process of civilization. Nazism put into practice a murderous racism which had existed throughout history and brought its force into thought, ideas, science, and human reason. Melancholic incorporation of Hitler, "Hitler within us," added a further twist to the spiral of Western guilt where religion has coexisted with the fact of extermination, a finishing touch to the Christian superego. Yet the emancipation from the incorporative representations of the superego constitutes humanity's only possible genuine encounter with civilization which Freud sought to achieve through psychoanalysis.

Why Did You Tell Me I Love Mommy and That's Why I'm Frightened When I Love You. Michèle Montrelay. Pp. 213-227.

In a study of the Lacan seminar on "The Object-Relation" as well as the case study by Freud of "Little Hans," the Lacanian signifier, like the penis, is considered in its many sorts of meaning, depending on its removability and its relation to other elements of signification. While Freud places the emphasis on the threat of castration, Lacan emphasizes the traumatic effects of the mother/child separation. For Lacan, mother is the object of the work of symbolization, unplugged from her too immediate and too threatening reality, changed into a mere element of a set, losing her absolute power. The eventual displacement through privileged organic zones does not end the jealously guarded pleasure men find in their own femininity, the primordial femininity of the small boy as the boy of his mother. Both Freud and Lacan have been embarrassed by the homosexual component of the negative oedipus complex, the love addressed to the father which can be even more anxiety-provoking than rivalry with him. Without this unconscious reciprocity of the love linking father and child, there could be no transfer of the penis into the signifying order. Sadomasochism is considered as the penis's femininity being offered to the ministrations of a father who is the owner of a phallus that can be transmitted through contact from one sex organ to another, from one body to another. The reciprocal love between the boy and his father allows him to move into the further phase of the oedipus in which the penis finds its way back to the female as the object of grown-up men's desires, without considering the female genitals excessively as a risk.

Little Hans and the Poetics of Anxiety: Taking Analysis to Task. Geoffrey Hale. Pp. 247-277.

Hale considers the "laconic" postscript Freud added in 1922 to his case study of Little Hans, reflecting upon the importance of this postscript in light of Freud's reformulation of his understanding of anxiety. Moving beyond his first theory of anxiety in which he considered it the libidinal transformation of pleasure into nonpleasure through repression, in *Inhibitions, Symptoms and Anxiety* Freud described anxiety as the reaction to and anticipation of a situation of danger con-

ceived as foreign and external though actually seated in the ego. In anxiety the libido is detached from its own representations, and the symbolic function in the formation of symptoms acquires its capability by its relation to repression, as Freud had already realized in his earliest theory on anxiety. Repression presents itself in place of a perception, indistinguishable from perception of the ego, and a phobic object even replaces the perception in the fully developed anxiety hysteria.

Hale considers the contributions of Laplanche and Pontalis in recognizing the ambivalence not only of the symbolic content of the phobic object but in the word itself. Memory symbols taken up within anxiety acquire the constancy of linguistic expression so that anxiety hysteric fantasy scenarios develop into a linguistic system, achieving a certain independence and freedom for the anxiety. While Freud recognized not only the ego side of anxiety but also an unknown side of anxiety connected more essentially with the id, he failed to consider the latter systematically. Hale asserts that perhaps the id-driven side of anxiety explains the way in which yet unanalyzed anxiety went to work on little Hans in his forgetting the analysis itself. This anxiety is the primal anxiety of birth, the experience of loss, essential to all later developments of anxiety, certainly to be found in the desire for the mother and in her failure to appear. Hale traces the development of this separation anxiety into castration anxiety of the phallic phase and the moral anxiety at the point when the superego emerges. The significance of Hans's father writing down his case, as Freud subsequently did, can be grasped in the way in which anxiety protects itself against the writing of a fixed text of the unconscious, rejecting the translation from the unconscious system into the conscious system of ego and perception, and rewriting the representational limit by means of the anxiety symptom.

Eyolf's Eyes: Ibsen and the Cultural Meanings of Child Abuse. Michael Goldman. Pp. 279-305.

Considering Ibsen's *Little Eyolf* and other plays, Goldman discerns the image of our secret self in the image of a beautiful child, always already abused. The feeling of belatedness, that there is no substantial reality to hold on to, of being controlled from outside, of thinking one is being thought instead of thinking, all these feelings have analogies with the symptoms of child abuse. In the intertwined fantasies of victim, abuser, and observer, a story which can never be told outside the fantasy, lie the foundational traumas to the imagination upon which the mental life of the adult is built.

Good and Naughty/Boys and Girls: Reflections of the Impact of Culture on Young Minds. Ellen Handler Spitz. Pp. 307-328.

Ellen Handler Spitz reviews some children's literature and its contribution to the process of helping children to assimilate culture, and she discusses a number

of stereotypes of gender and parentage. Some of the influence of these stories and stereotypes is quite objectionable, such as the way our culture continues to perpetuate that a man must have prodigious physical strength in order to be worthwhile, lovable, and effective as a man, while girls are expected to live in submission, passivity, cleanliness, and order and to be giving, nurturing, and kindly.

Pinocchio and Pinocchiology. Jennifer Stone. Pp. 329-342.

Considering the various ways in which Carlo Lorenzini's work, *The Adventures of Pinocchio*, has been analyzed, Stone demonstrates how any supplement to or revision of the theory of the oedipus complex only serves to verify that it is a resistance to castration theory. She notes in the story of Pinocchio the fantasy of the phallic mother before sexual differentiation, and how the abandonment by the mother ultimately is abandonment by the phallus.

Child's Play Amidst Chaos. Marsha H. Levy-Warren. Pp. 359-368.

The psychotherapist must negotiate the translation of cultural experience from the world of the child in therapy to the play of the therapeutic world. In order to achieve such a translation, therapists must grapple with their own culture and experience as well as with that of the children they treat, demonstrating to the children that the world has meaning which can be put into words—all this through the chaos of child's play and amidst the chaos of the world to be translated.

What Theories Women Want. Elisabeth Young-Bruehl. Pp. 373-396.

Departing from the need of psychoanalysis to purge itself of some of its scientific assumptions, Elisabeth Young-Bruehl challenges Freud's phallocentric understanding of female psychology. While penis envy is obvious in many clinical contexts, it is not generally an identity-determining factor and need not be considered as arising at any particular developmental moment, but rather assumes different forms at different developmental stages. Neither anatomy nor instinctual drives are destiny, and erotogenic zones do not reflect any inborn program of biological maturation. The mature individual envisioned in the new feminist psychoanalysis is not simply someone who has negotiated transformations of puberty, achieving a satisfaction of genital sexuality, but one who is capable of loving outside the original family, someone who has developed self-esteem and relational capabilities. Such a person fulfills the ideal of the so-called cultural feminism.

Both the Freudian phallocentric and the preoedipally oriented relational psychoanalysis are rejected by Elisabeth Young-Bruehl as being inadequate. Both the old model of inborn sex difference and the new model of socially constructed gender difference emphasize male-female difference and sustain either/or thinking. Young-Bruehl also cautions against therapeutic practices which celebrate

victimization and re-enact stereotypes of femininity, noting the processes of idealization and denigration to be found in theory making.

Female Castration Anxiety. Louise J. Kaplan. Pp. 471-489.

Louise Kaplan takes issue with the object relations psychoanalytic approach which maintains dichotomies between men and women, suggesting that women also experience desires and anxieties traditionally associated with men, such as those centered around ambition. Kaplan notes how the manifest fear of loss of the object's love may serve as a screen for castration anxiety, and a vivid figuration of absence may be a screen for a threatening presence, or vivid figurations of presence may screen out a threatening absence. A female's fantasy of her genital lack may be a fantasy of absence screening out the presence of her own genital and reproductive organs which arouse anxiety, with a corresponding genital desire which arouses anxiety. Thus, Freud's concept of screen memories bears a close resemblance to fetishism where the strongly figured presence alerts us to the absent figure.

In male perversions the drama of castration is usually in the foreground, whereas in female perversions it is marginalized with other subplots coming to the foreground, such as dramas of abandonment, separation, and object loss. For female psychology, there is a potentially more threatening quality to castration anxiety: the fear of bodily damage that is diffuse and unlocatable that involves a vast and enigmatic inner genital world, and even beyond this, damages her entire being. The female regressive solution of needing a love object keeps unconscious the profound fear of bodily mutilation, as well as the wish for self-assertive independence which would repudiate masculinity. The male regressive solution makes a phallic narcissistic ideal dominate in a way which keeps unconscious the profound need for the love object, repudiating feminine wishes to surrender and be dependent.