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REALITY AND DANGER IN PSYCHOANALYTIC TREATMENT

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In recent papers there has been considerable interest in the disclosure of the analyst's erotic countertransference. In our view this discussion touches a more fundamental issue: must something "real" take place between analyst and patient in order for real change to occur? And if what takes place is "real," will it not be dangerous and potentially destructive? Tracing the history of psychoanalytic understandings of what is "real" in the patient's life and what is "real" in the transference, we explore these questions in a clinical vignette and discuss the implications of this issue for our understanding of the process of psychoanalytic treatment.

"The psycho-analyst knows that he is working with highly explosive forces and that he needs to proceed with as much caution and conscientiousness as a chemist. But when have chemists ever been forbidden, because of the danger, from handling explosive substances, which are indispensable, on account of their effects?" (Freud, 1915, pp. 170-171).

Versions of this paper have been presented at the Spring Meeting of the Division of Psychoanalysis (39), Washington, DC, April, 1994; the Institute for Contemporary Psychoanalysis, April, 1995; the Moscow Psychoanalytic Society, June, 1996; and at Charles University, Department of Psychology, Prague, June, 1996. We would like to thank Lewis Aron, Jody Davies, Sue Elkind, Jill Gentile, Patricia Hertz, Irwin Hoffman, Stephen Mitchell, Barbara Massar Pizer, Stuart Pizer, Karen Rosica, Sue Shapiro, Malcolm O. Slavin, and Hanoch Yerushalmi for their careful reading of various drafts of this paper.

In a recent series of papers, Davies (1994a, 1994b) and Gabbard (1994a, 1994b) engage in a thoughtful and provocative discussion of the disclosure of the analyst's erotic countertransference. Working from a relational psychoanalytic model, Davies (1994a) argues that analyst and patient will inevitably become enmeshed in "complicated reenactments of early, unformulated experiences with significant others" (p. 156). Moreover, such reenactments are not only unavoidable, they are the medium through which fundamental change in internal relational paradigms can occur. As Davies (1994a) puts it:

> . . . something essentially different must happen in order to render this reenactment only a partial one. The analyst, by dint of her very presence and ability to provide certain protective, holding and containing functions, fundamentally changes the patient's earlier experiences . . . (p. 157).

Indeed, in Davies's view, the analyst's participation in the reenactment represents a basic way of knowing the patient, especially those aspects of the internal self and object world which have been split off and disavowed. In her candid and courageous paper, Davies suggests that the analyst's somatic and erotic responses must be included in this understanding of a relational approach to treatment:

> As a full participant in the analytic endeavor the analyst must be willing to feel and process her own somatic states accompanying the interplay of self and object in the erotic countertransference. . . . I would suggest that ultimately, though with careful timing, the patient must come to know the analyst as subject of her own erotic sensation and desire (p. 161).

Coming to know the analyst as subject of her own erotic desire corresponds, in Davies's view, with a revised understanding of the oedipal configuration in which the parent is also a full participant in the "mutuality of benign seduction endemic to oedipal love" (Davies and Frawley, 1994, p. 233). That which has not been benignly traversed in the original developmental experience can

now be safely re-enacted, with a new outcome, in the analytic relationship:

> It is only when such erotically charged material can be spoken of, changed, modified, withdrawn, renewed . . . [that] the mutual pleasures of a fully reciprocated oedipal love can be experienced, enjoyed, and taken in as a permanent template for the mature love that will, with a little luck, ultimately fill the future (Davies, 1994a, p. 169).

In his response, Gabbard (1994a) emphasizes the fundamental danger he sees in the disclosure of the analyst's erotic countertransference. Citing the too frequent violation of basic professional and ethical boundaries in sexual contact between therapist and patient, Gabbard suggests that the disclosure of the analyst's sexual feelings breaks the "as if" nature of our understanding of transference and countertransference. By making the enactment all too "real" and therefore all too dangerous, it collapses rather than enlarges, as Davies argues, the "potential space" for the working out of transference-countertransference enactments. Moreover, although Gabbard agrees that enactments are both inevitable and useful, he is concerned that the perception of a deficit in the patient's developmental experience, which must be reworked in the transference-countertransference enactment, will lead to a "heroic reparenting response from the analyst" (p. 209), which may ultimately interfere with the renunciation of transference wishes.

In raising the question of the loss of the "as if" nature of transference and countertransference and the related issue of reparenting (that is, "really" providing, or trying to provide, a new outcome), Gabbard has placed his finger on what we view as one of the essential points of controversy in this discussion and as a critical question for how we understand the psychoanalytic process. Although Davies and Gabbard disagree on whether the disclosure of erotic countertransference enlarges or collapses the potential space, implicit in their discussion is a larger, perhaps more fundamental issue: must something "real" take place be-

tween analyst and patient in order for real change to occur? And if it is "real," will it not be dangerous and potentially destructive?

Reality and Transference in Psychoanalytic Discourse

As analysts listen to the unfolding of their patients' narratives and examine the interplay that occurs between them, a certain kind of doubt almost inevitably filters into mind. These doubts are in two major areas. One is about the patient's experience: is the "reality" of the patient's life as difficult as the patient represents it, or is it only the patient's "experience" of events? Were the parents truly so cruel, absent, depriving, and abandoning? Did the traumas really happen? Couldn't much of it be fantasy? Might the patient be embellishing it, or using it for some covert purpose? A parallel and very familiar arena of doubt concerns the analyst's motives and behavior in the treatment relationship—the question of the analyst's countertransference. What is the analyst really doing? Is it "really" for the patient, or for the analyst's own hidden purposes? Is some seduction taking place, perhaps taking the patient through another damaging experience? These questions, experienced directly or indirectly, have permeated psychoanalytic perspectives in training (Slavin, 1997), supervision, and theory. They inevitably stir the analyst's uncertainty both about the patient's experience and about the analyst's own motives in the process.

The common factor in these questions is uncertainty about reality: what is *really* going on in the treatment, and what *really* happened in the patient's life? Indeed, these very questions permeate not only the exchange between Davies and Gabbard; they have haunted psychoanalysis from its beginnings.

In 1897 Freud announced a fateful change in his thinking: he had abandoned the "seduction theory." The search for historical reality and the recollection of trauma was replaced by an effort to understand the internal forces that shaped an individual's psychic reality. Developmental events became important only to the ex-

tent that the patient's experience of them was shaped by the internal drive forces at play. What was "real" for psychoanalysis had changed. The internal world became real, or more real, and the individual's actual interpersonal world became but a shadow and reflection of this inner reality.

Loewald (1973) describes this difference eloquently:

> When we speak of psychic life everything depends on the standpoint we take. If we take the standpoint of the . . . drives . . . anything short of direct achievements of their aims . . . represents at best a detour, at worst a failure. Seen from this point of view . . . psychic structure formation, [and] internalization appear to be a second-best born of frustration, disappointment, and fear, a defensive flight from reality. . . . [However,] seen from the standpoint of the inner life . . ., this reality tends to seem an illusion. The objects, whose loss . . . were supposed to make such an inner world of substitutes necessary, from the standpoint of that mental world seem themselves like substitutes, fleeting, ephemeral, insubstantial in comparison with the enduring inner reality (p. 69).

This shift in focus was accompanied by an equally radical shift in the psychoanalytic understanding of the sources of responsibility for one's difficulties. From trauma administered by an outside force over which the child had no control and did not desire, responsibility for what happened in one's life, and even for how one *perceived* what happened, shifted to one's internally derived wishes and fantasies. As a result of these shifts, the fact of real trauma (especially childhood sexual trauma) and its psychological impact were lost in psychoanalytic thinking for several decades.

In a provocative paper on transference, Szasz (1963) points out that a parallel shift occurred in relation to Freud's understanding of the treatment relationship. Szasz recounts the episode in which Anna O throws her arms around Breuer, who immediately flees the scene, transfers the patient to Freud, and embarks on a lengthy trip with his wife. Szasz notes that because Breuer had no context for understanding what had happened, not only did he

ditch the patient, but this episode precipitated his flight from psychoanalysis.

Freud was able to avoid a similar fate by what Szasz implies was a deft piece of mental gymnastics. He introduced the concept of transference. In so doing, Freud inserted a major shift in our thinking. This too was a shift in understanding of what is real and where responsibility lies. According to Freud's understanding of transference, what is "real" is not the feelings that the patient voices about the analyst. Rather, what is real is the patient's feelings toward someone not in the room. It is not the analyst who has engendered these feelings, but it is the patient who harbors them long before the encounter with the analyst.

As Szasz describes it, the discovery of transference was not simply the discovery of a new fact of psychic life, it was also an important defense for the analyst. The concept of transference enabled analysts to believe that what was being stirred in the patient was not about them; they were not provoking it, and this enabled them, in contrast to Breuer, not to flee.

As Freud (1925) put it:

> In every analytic treatment there arises, *without the physician's agency,* an intense emotional relationship between the patient and the analyst *which is not to be accounted for by the actual situation* (p. 42, italics added).

The possibility that analysts might have some responsibility for the feelings of their patients was relegated to the arena of intrusion of personal countertransference, rather than being understood as a part of the complex influences at stake in the analytic relationship.

Early efforts to reintroduce these elements of "real" experience, in developmental terms and in terms of the transactions that take place in the treatment relationship, encountered an extreme reaction. Ferenczi (1933) tried to redirect the attention of psychoanalysis to the issue of "real" abuse and exploitation, and to real developmental experience generally. He was the first to call attention to one of the most important consequences of childhood sexual abuse, namely, the damage it does to the individual's

psychic integrity and capacity to trust one's own mind (Slavin and Pollock, 1997). Moreover, in his technical experiments Ferenczi tried to provide his patients—in the actual transactions between them—a kind of loving tenderness which he felt was necessary to heal the damage done by past experience. His ideas and his technical experiments challenged both of the realities that had been excluded. He reintroduced the reality of trauma and the analyst as a real object in the patient's life and in the healing process. As a result, Ferenczi was characterized as disturbed, and his thinking remained unintegrated into the mainstream of psychoanalytic thought (Aron and Frankel, 1994).

A similar fate awaited the views of Alexander (1954). Looked at from a current perspective, Alexander's effort to provide a *real* "corrective emotional experience" is simplistic and anchored in outmoded assumptions about what the analyst can presume to know. Yet his thinking encountered a reaction similar to the vitriolic hostility that greeted Ferenczi's. To this day, the epithet of providing a "corrective emotional experience" (not unlike efforts at "reparenting" that concern Gabbard) is one of the most damning comments one can make about the clinical work of an analyst.

What accounts for the virulence of this reaction? In suggesting that the analyst had to provide something "real" in order for the relationship to be healing, both Ferenczi and Alexander were attacking the very foundations of classical understanding of what needs to be accomplished in treatment. Moreover, they were undermining the defensive function of the concept of transference, which had enabled analysts to believe that their own personal participation was not a factor in what developed between them and their patients. Undermining this defense changes our view of the analyst's responsibility for what is engendered and threatens to introduce something dangerously real into the psychoanalytic enterprise, namely, the possibility of real feelings, real love, real hate, and, at worst, real exploitation.

Reintegrating "Reality" in Psychoanalytic Treatment

Psychoanalytic discourse is currently confronting the challenge of reintegrating—without returning to a simplistic, positivist

model—the reality of the patient's life experience and the reality of what is transacted in the treatment relationship. Two developments bring these issues into sharper focus. The first is the increasing readiness in psychoanalytic thinking—fostered by the recognition of childhood sexual abuse as an event that really happens—to acknowledge the more general reality of childhood trauma and deprivation, and to recognize its impact on psychic structure. The second development is the understanding of the analytic process that emanates from current relational theories.

While the ubiquity and inevitability of transference-countertransference enactments have been generally accepted across the psychoanalytic spectrum (as Gabbard notes), it is only very gradually that their *essential* therapeutic function has been articulated. Davies (1994a), Hoffman (1983, 1991), Mitchell (1988), and others speak of a crucial reworking of interpersonal paradigms that occurs as old patterns are repeated with new outcomes. The analyst's participation not only in repetition and interpretation, but in the creation of a new outcome, is regarded as essential. Indeed, the interpretive process itself is inherently the provision of a new form of interaction (Slavin, 1992), in the context of the repetition of an old, affectively driven transference event, which enables the patient to differentiate the old from the new. Although the term is often experienced as a derogation, there is no question that, in these relational perspectives, the analytic process is essentially and inherently a corrective emotional experience (Renik, 1993). It is not of the contrived and concrete kind envisioned by Alexander, but an experience in which both patient and analyst learn together what is old and what must be provided that is new.

Thus, it appears we have come full circle. What was "real" in the patient's life and what is "real" in the treatment relationship now must somehow be taken into account. However, with this change comes the danger that Szasz so perceptively demonstrates was avoided in the classical concept of transference. If the analyst must inevitably provide something new that alters the outcome of recreated paradigms, then what the patient feels cannot simply be

attributed to transferences from figures outside the consulting room. The love and the hate experienced by both patient and analyst are not just occasioned by transferences and countertransferences; they are the outcome of the real interchange between them. The analyst can no longer be viewed as hermetically sealed off, but is deeply implicated in what transpires.

Although Gabbard focuses on the danger of the analyst's erotic response, the question of the therapeutic value or danger of something "real" taking place applies, we believe, to how the analyst responds to the full range of feelings and urgencies that may be stirred in the treatment relationship. The analyst's concern, curiosity, anger, wish to protect, and other feelings may be very intense and may lead to interactions which can be understood as potentially healing or potentially dangerous.

The danger is not only the possibility of real exploitation and abuse, as Gabbard warns, or even of erotic or other feelings. The danger is also that analysts can never know, in a clear way, that the feelings they have and the actions they take are truly designed to foster their patients' interests rather than their own. It was this clarity that was so carefully guarded by classical, positivist views. In current relational paradigms—which understand the analytic process as characterized by the continuing reciprocal influence of two subjectivities—that clarity disappears. As Renik (1993) has framed it:

> Since an analyst acting on his or her personal motivations is inherent in productive technique, how are we to say where analytic work leaves off and exploitation of the analytic situation by the analyst begins? There is no avoiding this very disconcerting question. In struggling to answer it, we cannot afford to deny the fact of an analyst's personal involvement (pp. 564-565).

As Renik suggests, a recognition of the power of the analyst's subjectivity in the therapeutic transaction simply exposes the danger, not only of patent acting out, but rather of a more subtle kind of exploitation. In asserting that something really happened in the

patient's life—not just in fantasy—and that something is "really" happening in the room, a real sense of danger is introduced.

Clearly, patient and analyst must strive to look together at the positions they each take and the positions into which they place the other. At the same time, analysts must be able to do this in a way that differentiates their responses from those of past figures in their patients' lives. The fundamental question in this context is whether analysts' efforts to do this—impelled by complex motives about whose meaning they may be quite uncertain—will inevitably place them in the position of exercising just the kind of power that may become, in a certain sense, too real and too damaging. How inevitable is it that the power of analysts to provide a "real" and different outcome will be inherently disempowering of the patient? Are there "benign" seductions, or are they inherently "malignant"? Let us look for a moment at a treatment conducted by one of the authors of this paper.

Clinical Vignette

When L began to talk with Dr. S about some of the personal issues in her life, she had already been a student in a seminar he had taught. Indeed, it was in the midst of a meeting of that seminar that L first recalled the sexual abuse she had suffered between the ages of five and ten. Dr. S was the first person L ever told about the abuse. Something in the way he spoke about it in the seminar made her feel that he would believe her. Although she had been in treatment since childhood, the issue of abuse had never been suspected.

L was in a subsequent seminar with Dr. S, and he took an interest in her and became something of a mentor. In this context, L met members of Dr. S's family, and Dr. S was helpful to L during her recuperation from surgery at a time when circumstances prevented family members from assisting her. Over time L became attached to Dr. S, and he liked her very much. From time

to time she would raise her unhappiness with her current treatment, a supportive therapy with a therapist who seemed not to know how to deal with her history of abuse nor with her involvement in emotionally and sometimes physically abusing relationships.

As their conversations deepened, L gave Dr. S a beginning glimpse of the degree of psychic pain she suffered. Although L was an extremely talented professional whose difficulties did not seem to affect her work, she otherwise lived in a frightening and lonely world, connecting hungrily to abusive relationships with men, feeling like a small child overwhelmed with nameless and chaotic "bad feelings" that seized her in a constant and uncontrollable way. As the enormity of L's suffering became clear, Dr. S recommended that she seek a consultation and consider changing therapists. Although she knew the treatment was not helping her, the prospect of starting with someone unknown was beyond tolerating. She said she could think about it only if it were with Dr. S. He felt compelled by L, by the extent of her pain, by her attachment to him, and by the warm and loving feelings he felt for her. Emotionally he wanted very much to be her therapist. But he also felt concern about the extent of his attachment, about the appropriateness of working with someone who had come to know him in other ways, and by the narcissism that he felt must be embedded in his feelings that he could help her.

As L's despair grew worse, Dr. S agreed to meet with her on a more formal basis to discuss the possibility of their working together. Dr. S referred her to a consultant and talked the situation over with two trusted colleagues. The consultant felt that L needed to learn that someone other than Dr. S could help her. Surprisingly, Dr. S's colleagues suggested that he work with L. They felt that his emotional attachment was an important communication about what L needed. Dr. S was somewhat reassured by this affirmation that his feelings might not be totally self-serving.

At their follow-up meeting, L was distraught at the thought of not being able to work with Dr. S. And for Dr. S, not working with

L seemed inconceivable. Dr. S was honest and direct with L. He told her he very much wanted to work with her, but given the relationship that they had had, it was very hard for him to know whether and how to trust these feelings. He said that one of the things that had occurred in her life was that she could not trust anything about herself, her feelings or her perceptions. Her clear feelings at this moment, and his, now told them that it made sense to try to work together, despite the complexity of their prior relationship. Dr. S felt they both should trust that. He suggested that they work together for awhile and see if, indeed, it felt right. L agreed. In the next hour, L spoke of her inconsolable despair and panic at the thought of losing her relationship with the man who was then her boyfriend. Dr. S was struck by how these feelings seemed to parallel the ones he had had in the session before. It occurred to him that perhaps his emotional response might indeed be an accurate reflection of part of L's experience.

L is the younger of two daughters. Father is a business person and mother has not worked outside the home since her marriage. As L described it, the parents exist in a verbally abusive and masochistic relationship, with father making nasty and deeply hurtful comments that are later passed off as jokes, and mother silently absorbing them. The first twenty-five years of L's life were spent in a frantic, dissociated haze. She does not recall a single moment of feeling anchored or calm. She was easily frightened by almost anything, a sudden move, a loud noise—a hair-trigger startle response, almost as though she feared she was about to be beaten, although she has no recollections of ever being beaten.

A frightened, cowering child lost in an overwhelming world. This was L's life and this was the experience inside her mind. One of L's earliest memories, around age three, is of riding her tricycle around the block. Suddenly she couldn't find her house, she didn't know what direction to go in. She pedaled furiously around and around the block in an increasing, heart-stopping panic, crying tearfully as she hunted urgently for where she lived. At about age five or six L began to be sexually abused by a family acquaintance several years older. She has dim, partly dissociated memories of lying on the couch as he would touch her genitals.

When L was ten, her parents departed for a vacation while the children were left in the care of grandparents. She went into a frenzied, psychotic panic. She sat on the floor of the bathroom for hours, day after day, unable to eat, swirling in her mind, feeling like the world was disappearing. And no one recognized what was going on. L's fear of repeating this kind of experience cemented her entrapment with boys, with whom she became involved at age twelve. She would do anything, if only they would not abandon her. Her memories of her sexual experiences are filled with a sense of immense shame and humiliation, not only for what she did, but for the feeling that she was participating in her own degradation.

In the first years of treatment, L was reluctant to complain about her parents. She viewed her mother as the only safe, containing, and rescuing figure in the world. The hint of even the slightest disruption in the connection with mother would send L into spasms of fear and panic. She felt that her parents were "liberal" in comparison to others. She remembers occasions when the parents would have nude swimming parties. She recalls an episode in childhood of walking into her parents' bedroom when they were both on the bed naked and looking at her father's penis. She recalls him saying, "What are you looking at?" As she told it, it seemed as though a provocation was literally put in her face, and then she was asked why she was provoked. Like the hurtful "jokes," the episode seemed emblematic of an insidious toying with a child's reality.

L was always a brilliant and successful student, and her professional work afterwards was extraordinary. But she was so dissociated that she felt as though she never took anything in. She felt like an immigrant to this planet, and some of the most elementary things about the world seemed incomprehensible.

The initial months of work with L were overwhelming. Dr. S was shocked by the intensity of her difficulties: she was in a state of constant panic. She lived in a haunted world of globally bad feelings and no coherent sense of the trustworthiness of her own experience. She needed to be seen almost every day and was in frequent phone contact with Dr. S.

During the first months of treatment the following exchange took place:

PATIENT: I don't feel good . . . ummm . . . [moaning] I don't feel good. . . . bad. . . . I don't feel good. . . . bad and it hurts [moaning, sobbing]. . . . I hurt my arms. . . . I don't feel good . . . I can't get it back . . . I can't get it back. . . .

ANALYST: We're going to make it, okay.

PATIENT: You think so? [sobbing]

ANALYST: Yes. I do think so. Did you bang your arm?

PATIENT: I hurt my hand. I just hit the walls . . . Last night. Hard! Because I'm angry! I know that I'm angry. I know I don't feel good because I'm angry! I know that. I don't want to be angry though. . . . I don't want to be angry! Why? Why? Everything's still here and the world is all here [tearful] but it doesn't look the same! I have to make it look the same for today because I have to go to work and I have to get it back, fast.

ANALYST: Take your time and slow down. We'll get it back together. Let's take one step at a time.

PATIENT: Okay. [dazed] I can't do it [sobbing]. I woke up and I was just like "Oh shit!" It was sooo horrible. It was so horrible. I woke up and I was just like "oh no, oh no, oh no." I just can't . . . I can't do this.

ANALYST: You wanted to be dead.

PATIENT: That's right. God didn't mean for me to live because it hurts too much. It's not right. It's not normal. It's too much.

ANALYST: I'm thinking about the time that your parents went on vacation and you lost it when you were ten. And that there must have been a way that their readiness to just go, despite the fact that they could see that you were crazy, or at least should have seen that you were completely out of reality. . . . It must have felt like the coldest thing that anybody could do. And I think when you feel that deep coldness in someone else . . .

PATIENT: I feel so sad.

ANALYST: I know. I really know.

Dr. S felt very much like he did really know. Indeed, he had never encountered, nor felt as an assault on his mind, the intensity of emotional pain that L suffered on a minute-by-minute basis. It was unimaginable that she could function at all and not be in a hospital, but somehow she did.

For more than a year L gripped tightly to the relationship with Dr. S. While this felt calming and holding, her life outside of treatment continued to be filled with the most raw and disruptive pain. She went from one abusive relationship to another, although with clearer recognition of the meaning of her urgent feelings with men. She lost a dangerous amount of weight. She despaired of ever having a moment of peace in her own mind.

There was some relief when L decided, with Dr. S's support, to confront the person who had abused her. Although his acknowledgment of the abuse helped affirm her fragile sense of reality, it proved only temporary. She woke up every morning with a sense of dread. She took high doses of medication, but there was no peace, except in the meetings with Dr. S. Occasional disruptions in their relationship (for example, when Dr. S. questioned L's decision to miss an appointment to see an abusive boyfriend) stirred enormous panic and dread. L found it comforting and validating when Dr. S. spoke openly and directly about his own feelings of what was being enacted between them.

For Dr. S, each hour with L felt compelling, and he was gripped by the rawness of her pain and by her courage to persevere through it. A major change occurred when the treatment was in its second year. L was hospitalized for a physical illness and Dr. S visited her. He found himself taking her in, frail, thin, vulnerable and yet at the same time compelling and sexually appealing. Dr. S was totally unaware of this reaction until L became aware of his gaze. She looked about herself frantically as if to find what might be in disarray and said, "What are you looking at? What's wrong? Everything seems to be swirling." Dr. S suddenly became conscious of what he had been doing. In an instant of thought he knew that he could not sacrifice L's reality testing in order to protect himself. He said, "We need to look at what happened." L screamed in terror and said that she could not. She held her head

in her hands, sobbed intensely, and vehemently insisted that they could not talk about it. L suddenly looked up, a look of horror on her face. "I had this crazy thought," she said. "I thought I need to call Dr. S and talk to him about this, but then I thought Dr. S is here and it made me want to go away and die."

Dr. S insisted again that they talk about what happened. She listened as he described his experience, all of it. He said she must have felt horrified at the thought of his having any sexual feelings for her. But even more horrifying, he said, was her expectation that he would not acknowledge his feelings or what had just happened. He said, "You felt you had to violate your own mind and bury part of what you saw in me in order to hold on to me as the Dr. S you could call." She became calm. "The world looks clearer," she said. They spoke at some length—the first of many such discussions—about what had happened and what L had felt.

Two weeks later L came to see Dr. S on a bright fall day. She looked out the window and said, "foliage." Dr. S repeated, "foliage?" She said, "People always used to talk about the foliage, but I never knew what they meant. I was not on this planet. It's really beautiful, the foliage." Dr. S said, "It is really beautiful." It was clear to L that what had occurred in the hospital had anchored her in the world in a way that felt truly different. In the next weeks she felt calmer, less constantly panicked, and she got through Dr. S's vacation much more solidly than either of them had anticipated. Some time later, recollections emerged of L's father's lifelong preoccupation with the contours of her body, and her own feelings, from an extremely early age, of wanting to feel "sexy."

In the following months there was a dramatic change in L's life. While she could still experience "bad feelings" and have moments of panic, for the most part her daily life felt far more real and less filled with urgent, hungry anxiety. At the same time, L was able to begin to explore, in a way that felt much safer, the importance to her of the power she had experienced for much of her life in the unconscious use of her body and sexuality in order to try to hold desperately onto a relationship and have an impact.

There was also a change in the treatment. L ended the nearly daily contact and was able to allow herself to take vacations and

have other priorities in her life without the same level of anxiety that it would destroy her or her connection to Dr. S. The work felt increasingly oriented toward the content of her life, past and present, as well as toward the treatment relationship as we usually understand it. Later in the treatment this included, at first through her dreams, the emergence of sexual feelings toward Dr. S and toward her father.

As L began a new, serious, and stable relationship, the first one she had ever had which was neither physically nor emotionally abusive, she and Dr. S discussed the changes she had felt in herself. In an hour during the fourth year, L discussed the ending of a relationship with a boyfriend who was verbally abusive but on whom she had felt extraordinarily dependent:

PATIENT: I need to be with somebody who can appreciate me. Who I am. And it's so sad to me because I know it's not him. And I'm so sad. But on the other hand, . . . it's like I get to be free from some of the things that were imprisoning me. The fear to get out of the relationship. The terror, the desperation that kept me in what was sometimes not a healthy relationship. And I need something that leans more towards healthy. [Pause] I'm scared about feeling sad again.

ANALYST: I know.

PATIENT: Because I know I'm going to. But can I feel more sad than I already felt when we came to the decision about breaking up?

ANALYST: Yes. You could have been like you were when I first started seeing you.

PATIENT: That's what I was thinking when I was driving here. I was thinking that I *am* a different person. I am a totally . . . I am a different . . . *I am a person*! I feel like not only am I a different person, but I almost didn't exist. You know? So really so much has happened for me in the past three years.

ANALYST: Are you trying to make your therapist cry?

PATIENT: [Laughs] Yeah . . . No [cries].

At one point, when Dr. S made a suggestion about how to

handle a very complex difficulty with a problematic supervisor L said, "I think that is a very good idea. I have to address it and I will . . . in my own way." Dr. S felt a distinct thrill in hearing her say she would do it in her "own" way (Bollas, 1989) and told her so. It seemed like a real change had occurred in her capacity to possess and own her own self. And she knew that things were different in a very substantial way:

> PATIENT: The first worst thing was to have the boyfriend mad at me. The second worst thing was to have my mom mad at me.
>
> ANALYST: It wasn't exactly a big discovery to see that you were the most terrified person in the world I'd ever met. It's like you didn't have to do a lot of convincing. So I think something was seeable but it wasn't seen. . . . I wish I knew how this all helped you.
>
> PATIENT: Yeah, that's the part that . . . well we can figure it out. But I'm glad it has! [laughs] It's . . . so basic though . . .
>
> ANALYST: Say what you were going to say.
>
> PATIENT: I think I feel like you really care about me. All you did was listen and believe me and care about me a lot. That's it [tearful]. I mean, a lot . . . more than that. But that's like so small . . . [tearful].
>
> ANALYST: I know.
>
> PATIENT: But it did a huge thing for me, you know.

Discussion: Transference, the "Real" Relationship, and Analytic Action

We chose this vignette because it seems to represent clearly many of the possibilities and problems at stake in considering the issues of reality and danger in psychoanalytic treatment. What "really" happened between the patient and the analyst? Was it real, or was it "as if"? Who seduced whom? Was it benign or malignant? Was it empowering or exploitive? The treatment de-

scribed here provides us with an opportunity to examine these questions in terms of the analyst's consistently "real" and open stance with the patient and in the context of two defining, "real" aspects of the relationship: the decision of the patient and analyst to work together in the context of the real connection they had shared prior to the treatment; and the situation in the hospital, where something undeniably exposing of the analyst's feelings occurred between them.

What are the dangers in the analyst's working from a position so anchored in real experience? As we see it, there are two areas of concern: 1) that the relationship is all too real, potentially undermining the development of the transference and the analyst's capacity to speak effectively as an analyst regarding the patient's contribution to the process between them; and 2) that the relationship is too infused with pre-existing, intense countertransference and transference feelings and biases which may interfere with accomplishing analytic work. These intertwined questions speak to the central issues we are raising.

With respect to the first question—the realness of the relationship and its impact on the capacity of the analyst to analyze—the premise of actually preserving (as well as holding as an ideal) the analyst's anonymity in order to preserve transference potentialities has been thoroughly critiqued from Hoffman (1983) to Renik (1995). Across almost the entire range of psychoanalytic thinking it has become accepted that analysts are inevitably real, and through their participation (whether that be through interpretation, the decision to remain silent, or their general manner of conduct) analysts inevitably reveal themselves. From this perspective, analytic restraint in personal disclosure flows naturally from a focus on the patient's concerns and struggles (Renik, 1995; Slavin, 1994) rather than from an effort to minimize, for specifically "transference-enhancing" purposes, what the patient might see. As we understand current thinking about the analytic process, there is no place to hide and, indeed, it may not be a good idea to try to hide very much.

Yet, somewhere in the process of the mutually created "real"

experience analysts must also have the authority (Hoffman, 1994) or voice to speak their views, right or wrong, and have them heard and taken seriously (Renik, 1993). As Mitchell (1988) has explained it:

> The struggle is to find an authentic voice in which to speak to the analysand, a voice more fully one's own, less shaped by the configurations and limited options of the analysand's relational matrix, and, in so doing, offering the analysand a chance to broaden and expand that matrix (p. 295).

We can envision relationships that would preclude the ability of the analyst to be taken seriously as a voice that can offer such an alternative perspective. But it is not clear to us that this capacity is based on completely predictable criteria, such as how seemingly "real" the relationship is. Indeed, as we see it, it may be precisely the analyst's realness and independent agency which can enable that voice. There are no generic relationships. Sometimes an intimate friend can say things with an objectivity and have them heard in a way that perhaps no one else in a person's life is able to do. Might it be, in such instances, that, despite its "realness," something can be heard and taken in because the individual feels truly loved? And is this what McLaughlin (1995) refers to when he states that "what each of us needs from the other, whether on the couch or behind it, is at depth pretty much the same. We need to find in the other an affirming witness to the best that we hope we are, as well as an accepting and durable respondent to those worst aspects of ourselves that we fear we are" (p. 434). We are not suggesting that intimate friends enter into psychotherapeutic relationships. Rather, we are suggesting that what may be inherent in an intimate relationship that sometimes permits it to be healing (that is, its very realness and the real love of the person and vision of who she or he can become) is also what will characterize a truly therapeutic treatment.

The other consideration or danger that was at stake in Dr. S's work with L, that of the analyst's and the patient's strong and established feelings for the other, goes to the heart of the argu-

ment in this paper. Specifically, the entire thrust of the developing relational perspective in psychoanalysis, as we see it—and as represented in the work of Davies (1994a), Ehrenberg (1984), Greenberg (1986), Hoffman (1991, 1992), Mitchell (1988), Renik (1993, 1995), J. Slavin (1992, 1994), M. Slavin and Kriegman (1992), and others—has been that the analyst is inevitably and usefully not only a "real," but a deeply affected participant in the evolving relationship and treatment process. The process of change occurs in the emotionally powerful revival and reworking of the essential internalized interpersonal paradigms and schemas that the patient brings to the treatment relationship. Mitchell (1988) has expressed this eloquently:

> Unless the analyst affectively enters the patient's relational matrix or, rather, discovers himself within it—unless the analyst is in some sense charmed by the patient's entreaties, shaped by the patient's projections, antagonized and frustrated by the patient's defenses—the treatment is never fully engaged, and a certain depth within the analytic experience is lost (p. 293).[1]

And, Dr. S was certainly compelled by L and she by him. But is this too transferential? Or too real? At some point the distinction loses its viability, as Strachey (1934) alluded to in his classic paper:

> The analytic situation is all the time threatening to degenerate into a 'real' situation. But this actually means the opposite of what it appears to. It means that the patient is all the time on the brink of turning the real external object (the analyst) into the archaic one (p. 146).

We are contending that all deep treatments will, sooner or later, skirt the edges of something "too real" at the same time that they are infused—perhaps precisely because of the realness—with powerful transferences and countertransferences. And it is in this

[1] Similar sentiments have been echoed by more classically oriented theorists such as Boesky (1990): "If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis will not proceed to a successful conclusion" (p. 573).

work that therapeutic change occurs. As many have described (Davies, 1994a; Hoffman, 1994; McLaughlin, 1995; Mitchell, 1988), it is the analyst's task to be able to be truly *in* the process and somehow to manage also to stand outside in order to further the work in the patient's interest. In the case of Dr. S and L, complex feelings had begun before the formal initiation of treatment, thereby intensifying the danger of something potentially too real, or too transferential.

Dr. S's decision to work with L and, subsequently, to disclose his experience in the hospital room, as well as his consistent openness about his experience of her and feelings about her, were—like many decisions we make in daily analytic work—not made exclusively logically.[2] In a lovely philosophical essay on the subject of the sources of one's decisions—which may speak to how analysts must use themselves and their real experience in the analytic process—Polen (1988) suggests that decisions based upon weighing the relative merits of rational factors do not truly represent the personal exercise of choice, but are rather simply a calculus made according to some predetermined external criteria. An authentic decision, Polen suggests, emerges "from the very essence of who we are. It has a compelling quality, a feeling that things could not be different than they are. . . ." But, Polen argues, this does not mean that the decision is arbitrary or capricious. Rather, "it is the deepest unfolding of our true selves" (p. 23).

Although Dr. S felt that his actions should include a deliberate weighing of the factors involved through the best self-examination he could undertake, the decisions he made truly arose from within. They were "real" in the sense that they reflected Dr. S's deepest feelings about himself, this patient, and the work. Indeed, throughout this treatment there is an urgent sense of the patient's need for someone trustworthy and real. L chose to confide in a person whose approach she already knew a good deal about be-

[2] Indeed, Renik (1993) suggests that the analyst's "irreducible subjectivity" inevitably means that the analyst will be "passionately and irrationally involved" (p. 570) in the clinical work.

fore treatment began. She tested Dr. S out in "real" ways, which was a major, if not fully conscious, factor both in her choice to ask him to work with her and in his decision to do so. And her experience throughout the process—and in the hospital room—of the "real aspects" of Dr. S provided her with the anchorage she needed to reclaim her own sense of being real. L suffered a split between a regressed, frightened child and a competent, grown woman; between a body that existed and attracted and the feeling of a self that did not exist and was erased. The split continued until those moments of "real" connection in the reactions of her analyst. As L later said: "I always needed you to see both sides of me. And you always have. You never lost sight of both sides. It's huge. That's real. You see me really as I am. And I really am all those things . . . and I know it, and you know. Because you have seen it all and never lost any of it, I feel all of it can exist in one person." The same person reacted both to her body and to her inner self, to the frightened child and the extraordinary adult. From this, a process of joining her self to her self began.

Yet, in this very process lies one of the dangers, as well as potentialities, of psychoanalysis: if we base our decisions and actions on our own inner inclinations alone, it leaves patients' safety dependent on the purity of our motives. But, as analysts, we know that there are no pure motives. We constantly wrestle with our countertransference, trying to sort out our own interests and motives from those of our patients. The question of the analyst's motives, we are arguing, is at stake in all treatment.

Reality, Danger, and Analytic Integrity

To sum up, in our view the transference and countertransference feelings engendered in psychoanalytic treatment are not "as if," as Gabbard views it. The feelings in one kind of relationship (sexual feelings with a potential lover, for example) will be different from apparently similar feelings in another (sexual feelings with a patient). Feelings in any relationship are constrained and shaped to some extent by the context of that specific relationship.

But the feelings are no more or less "real" in one or the other. And as a result they are indeed potentially dangerous. What differentiates them is not their level of "reality," *but how they are used.* In the treatment relationship there is not a commitment not to have real feelings, or to have different feelings. As Renik (1995) has said, "the patient's exploration of his or her experience is vitiated by a speculative, hypothetical, 'as-if' quality" (p. 493). The commitment is to examining the feelings that may emerge in a manner that is different from that of most other relationships.

Psychoanalytic work can be structured to try to avoid, or at least to avoid acknowledging, these feelings. It is one approach to the danger of recognizing the real contribution that both analysts and patients make to these feelings, as well as to the danger that analysts will be unable to differentiate their own motives and interests from their patients'. Our contention, however, is that this avoidance is illusory.

The solution to the danger that accompanies the recognition of the reality of what occurs in treatment is not a return to an older paradigm that denied it. Rather, it is a recognition of the patient's need to test the interpersonal world in an effort to try to find a different outcome (J. Slavin, 1994; M. Slavin and Kriegman, 1992) and the necessity of finding that difference. In order to have a sense of one's own self-esteem and power, the child needs to develop—in a benign seduction (Davies and Frawley, 1994; Searles, 1959)—a sense of having won the parent's love. Similarly, patient and analyst must work through the danger in such feelings if the patient is to be able to establish true intimacy and safety in future relationships.

As Aron and Harris (1993) put it in their discussion of Ferenzci, "The sense in which the analyst has to be a better parent is that, unlike the original traumatizing parent, the analyst can recognize his or her own participation and can discuss it directly with the patient" (p. 18).[3] In the process of the mutual seduction that

[3] The analyst's capacity to recognize his or her participation is assisted by the fact that the hour ends. The analyst can reflect on what has occurred, read, attend symposia, and seek consultation in an effort to maintain a focus on the patient's interests.

inevitably accompanies the treatment of patients who have been abused (as Davies and Frawley discuss)—but in our view, in all treatments—patients learn that someone is capable of *trying* to put his or her real interests ahead of one's own, as best as these can be known. And our struggle to understand our own motives, without ever knowing fully that we can, is a critical component that makes the renegotiation of the patient's experience possible. Dr. S knew at some early point that the feelings engendered in him in relation to L could have led to a destructive and retraumatizing outcome. On some level L knew this too—about her own hungry vulnerability, as well as about Dr. S's feelings for her. "I'm not stupid," she said. Thus, it is not the "heroic reparenting," as Gabbard referred to it, that accounts for analytic progress: it is the ability and the willingness of the analyst to "really" enter an area of the patient's life and to keep the patient's best interests at heart. This is the context in which Davies revealed her own erotic countertransference to her patient, and the context in which Dr. S discussed his feelings with his patient.

In the end, analysts must take responsibility for their own behavior. As Szasz (1963) notes:

> No one, psycho-analysts included, has as yet discovered a method to make people behave with integrity when no one is watching. Yet this is the kind of integrity that analytic work requires of the analyst (p. 442).

In the context of experiences where trusted others who should have been able to place the child's interests foremost but did not, the essential emotional re-creation of earlier relational paradigms, with a different outcome, is a crucial part of the healing process. Can one imagine any other way that individuals whose basic sense of trust and safety in relationships has been violated can regain it? What "really" happened has to be met by something that is really happening and is "really" different. As Freud (1914) noted, "one cannot overcome an enemy who is absent or not within range" (p. 152).

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NEUROPSYCHOLOGICAL DYSFUNCTION AND PSYCHOLOGICAL CONFLICT

BY ARDEN ROTHSTEIN, PH.D.

The author examines the interplay between neuropsychological dysfunction and psychological conflict. Two ideas are emphasized. First, clinicians may overlook or subtly de-emphasize the contribution of neuropsychological dysfunction to patients' difficulties. Second, when neuropsychological difficulties are *diagnosed, there is value in being acquainted with the details of the dysfunction and exploring the* specific *ways in which they are elaborated in fantasy and interwoven in the patient's psychodynamic constellation (including their employment for defensive and superego purposes). This perspective is contrasted with more general formulations concerning the patient's experience of her/himself as damaged. A case serves to illustrate such a clinical process of discovery.*

INTRODUCTION

This paper is intended to demonstrate how an in-depth appreciation of the interplay between neuropsychological dysfunction[1] and psychological conflict enriches psychoanalytic work with se-

[1] "Neuropsychological dysfunction" denotes a neurocortical abnormality or developmental lag. That is, clusters of affected functions correspond to the organization of the brain. I prefer the term "dysfunction" to the commonly used term "deficit" for two reasons. Since "deficit" has come to have psychological meaning in the psychoanalytic literature, ambiguity or confusion may arise when it is employed; therefore, it would be necessary to specify the sense (psychological or neuropsychological) in which it was intended. Secondly, the term "deficit" may discourage the dynamic and nonlinear thinking central to a conflict model. For example, it is generally not helpful in capturing the realities of the clinical situation in which particular types of neuropsy-

lected cases. Despite the proliferation of sophisticated diagnostic methods, the possibility of a neuropsychological contribution to difficulties in learning, achievement, and other presenting problems for analysis may be subtly overlooked or de-emphasized. This is especially common when patients are bright, verbal, and evidence compellingly relevant psychodynamic constellations which appear to explain such problems sufficiently.

When a neuropsychological contribution is considered and if diagnostic assessment reveals the existence of circumscribed cognitive problems, the analytic process will be deepened by exploration of how an individual patient's *specific* cognitive disabilities shape his/her personality and become interwoven in his/her psychodynamic conflicts. This is contrasted with more general formulations and interpretations such as those concerning the patient's experience of her/himself as damaged.

The case of Kate, a young girl with demonstrable neuropsychological dysfunction, is presented to highlight the inevitable interlacing of specific neuropsychological findings with psychological conflict. Diagnostic evaluation, including psychological testing and clinical interviewing, delineated the consequences of neuropsychological difficulties for her learning and their possible effects upon the development of her personality. These data, combined with material concerning her mother's fantasies about Kate's problems as revealed in her mother's subsequent psychoanalysis, foster an understanding of aspects of Kate's psychological development. I will begin by framing this clinical material with several theoretical ideas.

Neuropsychological Dysfunction and Compromise Formation Theory

When we are consulted about a child or an adult who has problems in learning or in carrying out professional responsibilities, we

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chological dysfunction contribute to development in complex and highly individual ways. In the few instances in which I use this term, it will be placed within quotation marks and the sense in which it is employed will be specified.

should try not to overlook the possibility of abnormalities of neuropsychological etiology (e.g., disorders in memory, visual discrimination, visual-motor coordination, or sustaining attention). These abnormalities can be carefully diagnosed for purposes of developing a plan for remedial and/or psychopharmacological intervention. Like any physical illness, they do not derive from psychological conflict and may need to be treated in their own right.

However, when psychoanalytic work is undertaken with such patients their neuropsychological difficulties cannot be conceptualized apart from psychic conflict. Inevitably, the dysfunction and the fantasies which accrue to it contribute to the shaping of psychic structure, psychodynamic conflicts, and the compromise formations which result (see Hartmann, 1950; Weil, 1978).

Several facets of such interrelationships can be delineated. Neuropsychological dysfunction may affect aspects of the development of the ego, object relations, one's self-regard, and one's experience of the external environment. For example, elsewhere I (Rothstein, et al., 1988) have described the multiple neuropsychological features, the intactness of which is assumed in the normal development of object relations. To cite a few, language and fine and gross motor coordination contribute to self-object differentiation just as memory, perceptual processing, and the capacity to integrate these processes contribute to the development of object constancy.

Inevitably, the experience of neuropsychological dysfunction contributes to the genesis of unconscious fantasies. I find it most useful to work with unconscious fantasies from the organizing perspective of compromise formation theory. From this perspective neuropsychological dysfunction is a shaping influence in the development of fantasies which are composed of drive derivatives, affects, and defenses. When employed for defensive purposes, this can assume a *global* form, as in the patient who has the unconscious thought, "I have no aspirations as an oedipal rival. I'm defective and helpless." At the same time, clinical study may re-

veal more *specific* ways in which particular types of dysfunction are especially suited for incorporation in unconscious fantasies, in that there is a convergence between the content of the difficulty and the patient's fantasy. An example is a child who has problems with ocular control or visual processing and who, in the throes of the oedipal phase, imagines that these difficulties are punishments for unacceptable wishes to vanquish his or her rival in order to fulfill erotic desires toward the opposite sex parent. In this sense, neuropsychological dysfunction may become intertwined in superego functioning. The degree to which such dysfunction shapes development will depend upon a "complemental series" (Freud, 1937, p. 73): the severity and/or pervasiveness of the dysfunction and the extent to which it "fits" with the psychodynamic constellations of the patient and his or her parents.

Despite the present climate of sophistication about learning disabilities and Attention Deficit/Hyperactivity Disorders, it is not uncommon to encounter at least subtle favoring of psychodynamic or neuropsychological perspectives.[2] In some respects the chasm between psychoanalytic and neuropsychological perspectives continues to widen. This may be due, in part, to the ever-expanding array of professional subspecialists, with their varied diagnostic techniques and psychopharmacological agents, who are involved in treating patients thought to have problems such as specific learning disabilities and Attention Deficit/Hyperactivity Disorders.

Conclusions about the existence of neuropsychological dysfunction are most accurately based upon a careful diagnostic testing evaluation. This is contrasted with a clinical preconception which shapes what one will find. Even when comprehensive diagnostic

[2] Recently there have been several serious theoretical efforts to integrate neuropsychological and psychoanalytic perspectives (for example, Levin, 1991, 1994; Miller, 1991, 1993; Solms, 1995; Watt, 1990). Some brief clinical cases have also been reported without detailed diagnostic (Kafka, 1984) or psychoanalytic data (Bucholz, 1987; Garber, 1988, 1989, 1991, 1992; Gensler, 1993; Myers, 1989, 1994), with one exception (Rubovits-Seitz, 1988).

study documents the existence of irregularities (or immaturities) in the functioning of the brain, there is no less reason to consider their involvement in the patient's psychological makeup. Put somewhat differently, to say a particular type of learning disability could not have taken shape without certain types of neuropsychological dysfunction is not to say that it fails to become embroiled in conflict or can be considered apart from conflict. Such thinking reflects an insufficient appreciation of the inevitable and inseparable interplay between constitutional and psychological features of the developing child.

Patients who present for neuropsychological evaluation fall into several groups. Many are children whose parents or teachers have questions about the reasons for their academic difficulties. Others are adults who have problems in learning and/or in performing the responsibilities of their chosen professions. Another group comprises adults who, in light of the current awareness of learning disabilities, suspect they had such undiagnosed problems as children. Still others have a more general sense of inadequacy which they believe may derive from as yet undiagnosed neuropsychological sources. On rare occasions a treating analyst[3] refers a patient for diagnostic testing to explore suggestions of neuropsychological dysfunction which appear in the process material or in how the patient relates in the transference.

One encounters many common misdiagnoses which result from imposing on the data preconceived notions of "deficit" (in a psychoanalytic or neuropsychological sense) or evaluations that are insufficient for exploring the range of possible routes to the presenting problems. One broad group of misdiagnoses occurs when specialists in learning problems who are not also general clinicians make suppositions of various cognitive "deficits" (in a neuropsychological sense). An example is the overdiagnosis of "language processing disorders" when a patient has, in reality, a case of what I like to call "average-itis" (average intelligence when

[3] An example is Rubovits-Seitz (1988).

higher potential is presumed) or the patient manifests a major inhibition in functioning related to oedipal conflicts. Another example is reaching the conclusion of limited intelligence in a patient without considering the effects of constriction related to anxiety over the fantasized consequences of aggressive and erotic wishes. Correspondingly, psychoanalysts and psychoanalytically oriented clinicians sometimes erroneously assume that their patients have "deficits" of a purely psychological nature, e.g., inhibitions in learning due to psychological conflict. This is especially true when these patients are extremely intelligent. Such assumptions may result in a failure to consider the possibility of a neuropsychological contribution when psychodynamic explanations seem sufficient in accounting for the psychological phenomena presented. A common example is the underdiagnosis of Attention Deficit/Hyperactivity Disorders.

When psychoanalytic work is undertaken with patients who evidence neuropsychological dysfunction, isolation of the dysfunction may be used for purposes of resistance by the patient or may reflect countertransference problems or other types of oversights on the part of the analyst. Such thinking may also limit the scope of the analyst's interventions, as noted by Willick (1991) in another context. He emphasized

> the importance of maintaining a dynamic point of view in the face of what might appear to be an ego deficit. . . . The danger in conceptualizing this impairment as a defect is that it may lead to the therapist's *reluctance to make interpretations of conflict* . . . (p. 83, italics added).

This is also consonant with Coen's (1986) view that a "sense of defect" is a fantasy that individuals have about themselves, even when there is an actual problem of a physical (and, I would add, of a neuropsychological) nature. A detailed grasp of the nature of the neuropsychological findings will enhance the possibility of more fully appreciating the elements of conflict. This will broaden the scope, as well as the specificity and accuracy, of interpretive possibilities.

CASE EXAMPLE

Kate's parents consulted a colleague, Dr. B, about the appropriateness of their six-and-a-half-year-old daughter's school placement. Dr. B subsequently consulted with me about the diagnostic test data and ultimately referred Kate's mother, Dr. M, to me for consultation about her own treatment.

Kate's evaluation was predominantly at her mother's request; Kate's father went along with it but felt his daughter's main problem was that her mother worried too much. Kate was then in the middle of first grade in an extremely demanding school. At an earlier time Kate's mother raised questions about the advisability of her daughter's progression to first grade. She thought it might be worthwhile for Kate to have another year of kindergarten, given her relatively young age and her lack of proficiency with some of the earliest academic material when compared with most of her peers. However, school personnel felt that there was no reason to have Kate repeat the year. Now, as academic demands were increasing, Kate's mother felt the same concerns about her daughter's readiness for second grade.

Kate and Dr. M (as I observed in the analysis) clearly shared a "sense of defect" (Coen, 1986). No one else in Kate's family or academic environment corroborated her mother's feeling that a consultation was indicated. It would have been entirely possible to dismiss her concerns about her daughter as one manifestation of her fantasy that girls are deficient. Had this been the predominant clinical presumption, the shaping influence of Kate's neuropsychological picture on her experience of herself would not have been appreciated. The complexities of the clinical picture would have been missed in reducing the child's difficulties to her experience of having less than optimal equipment or less than optimally empathic mothering.

This case also illustrates: (1) the possible contribution of particular types of neuropsychological dysfunction to problems with Kate's development; (2) the manner in which such dysfunction inevitably contributed to her psychodynamic conflicts; and (3) the

interplay of her neuropsychological dysfunction and the maternal fantasies which accrued to it.

The Diagnostic Process

When Dr. B met with Kate's parents to elicit their questions and to take a history, several features of their interview were noteworthy. Their first communication reflected their general tendency to define Kate in relation to her older sister, Joan, almost invariably to Kate's detriment. Joan was at the same prestigious and rigorous school where she excelled in everything. Kate's parents reflected, "Given that our first child was outstanding, perhaps there is really nothing wrong with Kate except that she is not Joan." They noted that Kate did not crawl, walk, or talk as early as Joan did and that she was crankier.

Furthermore, Kate's mother expressed the feeling that "what Kate likes, I'm not interested in." Kate liked dolls, jewelry, hair bows, candy, gum, and soda. In contrast, Joan had always expressed interest in more traditionally masculine objects and activities (e.g., cars, trucks, G.I. Joe figures, and baseball), and she eschewed more traditionally feminine ones, as exemplified by her contempt for dolls.

Kate had never been enthusiastic about school. Her mother questioned whether this could have been a result of the "strictness" of Kate's first teacher. Now, in particular, Kate worried that she would not do well in math or reading, subjects in which many of her classmates were proficient.

Kate's parents commented that she was a fearful child who clutched her favorite "blankie" for several hours prior to bedtime. Both parents also expressed some concern about her recent tendency to be "dishonest." As an example, they cited an incident in which her favorite doll was found missing a new dress, a present from Kate's paternal grandmother. Pieces of the garment, in a new configuration, were uncovered under Kate's bed. She denied

being the designer. Her parents seemed to be angry at her, not only for "covering up" her action but for "destroying" the garment in the first place.

Kate's mother was the youngest child of somewhat provincial parents who were not very well educated. Little sense of competition emerged when Dr. M was asked about her feelings toward her three older brothers. Rather, she initially expressed a sense of appreciation that they were there to siphon off some of their mother's irrational critical harangues. It was as if the four siblings' emotional lives were focused upon the need to navigate the waters of their volatile mother. Dr. M described her father as a highly successful, temperamental man who was, nevertheless, equally vulnerable to this woman.

While Dr. M did not spontaneously convey a love for or sense of success in learning, Dr. B's questions nevertheless elicited the information that Dr. M had been an excellent student who went to a fine college and to a very prestigious medical school and surgical residency. These institutional affiliations, as well as the degrees she obtained, made Dr. M objectively more successful than her brothers. She currently practiced as a surgeon in a first-rate medical center. Her husband was her office manager. Despite her apparent success, she conveyed a sense of dissatisfaction and uncertainty about her future. In particular, she had misgivings about continuing to work in what she considered a male-dominated setting.

Mr. M worked long hours as his wife's office manager and was deeply involved in family life. He spoke of Kate with more spontaneity and pleasure than did his wife. Although he contributed little in the consultation interviews, those observations he did make were met with slightly disparaging responses from his wife. In this sense he seemed to assume a denigrated position in relation to his wife (as Kate did vis-à-vis Joan) and to possess a wish to be Kate's advocate. Mr. M was the youngest of three boys born to parents who were college professors. He had formally trained as a nurse after completing his college degree. Although he had evidenced some talent academically, he generally did not achieve

high grades. He expressed great respect for both of his parents, most especially for the importance of his mother's work in her field. It appeared that Mr. M had assumed the same denigrated position in his family of origin as he did in his current family.

In Kate's initial sessions with Dr. B, she presented as an animated, imaginative, and highly verbal six-and-a-half-year-old girl. She disparaged her own productions and preferences, continually comparing herself with her sister whom she deeply admired. In the testing sessions Kate's sense of insufficiency was even more pronounced. She desperately wished to succeed but was almost invariably dubious of her abilities. She also conveyed an assumption that others were far more proficient.

Testing revealed that Kate was a girl of slightly above-average intelligence who manifested several areas of strength alongside a few areas of pronounced weakness. These included weakness in immediate visual sequential memory, in sequential concepts, and in sound blending[4]—abilities central to the earliest academic tasks, e.g., spelling and reading words and numbers. In addition, Kate had a tendency to be distracted both by extraneous stimuli (e.g., sounds and objects) and the flood of thoughts which occurred to her as she endeavored to perform the tasks at hand. The

[4] "Immediate visual sequential memory" refers to the ability to reproduce the sequence of visual material just seen. "Sequential concepts" involve a grasp of "before" and "after" relationships regarding time, number, and space (as in visual stimuli arranged in a horizontal sequence). "Sound blending" is the capacity to weld individual sounds together into a unit, as in initially reading the syllables of an unfamiliar word and then linking them together. It is possible to have a reading and/or spelling disability on this basis; that is, some individuals have solid skills in perceiving and identifying letters and associating them with the proper sounds, but are unable to blend the sound units together to form words. Diagnostic impressions of Kate derived from a comprehensive diagnostic testing battery, which included examination of these specific functions (on tasks such as the Sound Blending and Visual Sequential Memory portions of the Illinois Test of Psycholinguistic Abilities) and observations of the employment of these functions in the context of more complex tasks (e.g., reading). The patterning of test scores was examined neuropsychologically in terms of their correspondence (or the lack thereof) to the organization of the brain. Psychodynamic determinants and meanings of difficulty with these areas were given equal consideration.

former led Dr. B to consider the possibility of an Attention Deficit/Hyperactivity Disorder.

Kate's greatest strengths were in verbal functions, including forming abstract verbal concepts, calling up general factual information, defining words, verbally expressing an understanding of social norms and nuances, and basic oral arithmetic calculation. Tests of expressive and receptive language revealed no difficulties in word finding or in processing the language of others. Nevertheless, there were instances when Kate's approach to what was demanded of her was idiosyncratic, due to the intrusion of personal concerns. For example, when asked to complete the sentence, "A knife and a piece of broken glass both———," she correctly replied, "both cut," but then went on to elaborate, "One time when I was at a hotel I saw a girl fall off her bicycle and cut herself on glass and the police came and she might have been dead."

In the perceptual and perceptual-motor sphere Kate manifested considerable abilities in discerning missing parts of pictures, in analyzing and synthesizing the part-whole concepts necessary for reproducing block designs and in mastering new rote learning. Her solutions of mazes were sometimes problematic. While she usually got off to a good start, there were instances when she seemed to forget the goal by starting at the wrong end or by skipping from one maze to the next.

On academic testing Kate scored below IQ expectations, which in her academic environment was dramatically below the level of her peers. She had at her command only a few sight spelling words. Her automatic reading was even more circumscribed. She was proficient in reciting and writing the alphabet. She accurately named all upper and lower case letters and knew phonic associates for consonants but not vowels. However, her ability to blend sounds together, a skill very important for phonetic reading and spelling, was significantly below age expectations. Thus, for example, when presented with the sounds "c-a-t," she said, "kite" rather than "cat." She was able to recognize most numbers; however, her awareness of sequence was shaky. To illustrate, she was

prone to mistake "16" for "61." Although she correctly counted visually presented materials and was able to determine which was more when given two numbers, her knowledge of simple number facts of addition and subtraction was extremely limited.

Building blocks for these complex skills were examined to further explore the reasons for the above-noted variability of IQ subtest and achievement test scores. With regard to time orientation, Kate was able to name the days of the week, although in scrambled sequence. Assessment of sequential "before" and "after" concepts involving numbers, days of the week, and spatially arranged materials revealed that she was confused about them. In general, her fine and gross motor functions were areas of outstanding strength. She was consistently left dominant. She frequently confused left and right. Tests of sensory processing (tactile, auditory, and visual discrimination) were performed proficiently. Memory findings were inconsistent. Kate's immediate memory for auditory sequential material (number series) was well above chronological age expectations. However, she scored well below her chronological age level on a test of immediate visual sequential memory.

Kate enjoyed projective testing, which seemed to provide her with an opportunity to express her concerns and conflicts creatively. There were moments, however, when she felt overstimulated by her fantasies. This prompted regressive responses, e.g., crawling in imitation of a baby. Central to Kate's experience of the world were the differences between the sexes. Phobic trends were also evident. In diagnostic interviews, her play centered around the activities of an older brother and younger sister who had to cope with frightening noises and threats of intrusion, perhaps foretelling injury, at the hands of unknown creatures. While the brother was by no means fearless, the sister felt entirely incapable of finding safety. Conflicts over aggressive wishes were typically defended against by projecting them onto the outside world. Thus, Kate saw "evil animals" and other manifestations of danger in what was new or unstructured. Such danger was sometimes expressed in relation to the body and threats to its solidity. She

evidenced an uncanny ability to find the "broken parts" of toys (i.e., their irregularities or projections) on which she claimed to "hurt" herself with great frequency. She repeatedly inquired about the functions of these "parts." Also salient were fantasies of needing to sneak around parental or other authority figures to secure what pleased her.

On the basis of these data, Dr. B made several recommendations. Kate should begin psychotherapy as well as remediation. Despite her young age, the latter was important since the circumscribed neuropsychological difficulties from which Kate suffered were crucial to the acquisition of basic reading and arithmetic skills. Her progress should be closely monitored over the next few months to determine the advisability of repeating first grade. Consultation with a psychopharmacologist to consider the possibility of stimulant medication for Kate's distractibility was also suggested, although Dr. B leaned toward considering her intense anxiety as its major determinant. In addition, individual consultations for her mother and father were recommended.

Mr. M regarded psychotherapy and consultation with a psychopharmacologist for Kate and a consultation for himself as "unnecessary." Dr. M was not so sure but conveyed her anxiety that if Kate was offered psychotherapy, she would no doubt become enraged at her mother. Dr. M could not further articulate the nature of this concern. The couple chose to have Kate begin remediation. Dr. M responded that she was not inclined to pursue treatment for herself but needed to think this over.

Months later Dr. M contacted Dr. B to explore some of her reactions to the diagnostic findings and was referred to me. After an extended consultation I recommended psychoanalysis. Despite her objective success in her profession, Dr. M experienced her work life as having come to a standstill years before; she felt directionless and lacking in ability. She worried a great deal about her feeling of disconnection from Kate and her own inability to easily appreciate and love her daughter. At times she felt threatened by what Kate enjoyed. It also became clear that Dr. M felt

quite lonely and unable to form intimate friendships because of her mistrust and envy of others.

Discussion of the Clinical Material

I will now conjecture about some interrelationships between Kate's neuropsychological dysfunction and the psychodynamic constellation which was discernible at the time of consultation. Study of the in-depth data of intensive psychotherapy or psychoanalysis provides the best opportunity for refining initial hypotheses about these relationships. In Kate's case we have only the data of the consultative process with additional data from her mother's subsequent psychoanalysis.

Depending upon the nature of the child's neuropsychological dysfunction, one might conceptualize a child's difficulties either *primarily* as a psychological reaction to the existence of such dysfunction or as an expression of the child's neuropsychological features and his or her psychodynamic conflicts. These are, of course, not mutually exclusive possibilities. An example of the former is a previously well-functioning child's depressive response to the emerging awareness of dysfunction as school work begins to demand those functions which are impaired. An example of the latter is the person who elaborates the existence of some areas of neuropsychological dysfunction as "proof" of fantasies of badness or castration.

In Kate's case I believe she *was* experiencing frustration due to difficulty in the earliest academic tasks she confronted. However, to understand her in a more comprehensive way we must consider the particular types of neuropsychological dysfunction which shaped her development as well as the psychological climate in which she was developing. If we primarily emphasized the nature of the parenting Kate experienced because of her parents' conflicts, without sufficiently exploring the way these conflicts interacted with her particular features and her fantasy elaboration of

both, we would arrive at a far more limited picture of her development and its treatment implications.

The cognitive findings of Kate's testing evaluation—that she was a child of somewhat above-average intelligence with a disorder in sound blending, visual sequential memory and sequencing and was prone to distractibility—were laden with psychological meaning for her and her family. In a general way these features may well have contributed to, as well as reinforced, her underlying sense of defectiveness. The very fact of having less than exceptional intellectual endowment and of having some circumscribed areas of neuropsychological dysfunction in a family of high intelligence and considereable achievement must have been a powerful experience for Kate. Furthermore, Dr. M experienced having such a child as deeply distressing in a number of ways. Mr. M's experience of Kate's cognitive picture was harder to discern because of his guardedness and because he did not pursue his own treatment.

Kate's mother's identification with her daughter and her fantasies about this female child were a significant part of the psychological climate in which Kate was developing even before the diagnostic process revealed the specifics of her cognitive functioning. Dr. M, though clearly very intelligent and a high achiever, suffered from significant self-esteem problems. For Dr. M, Kate's "failure" was one additional manifestation of her failure as a mother, as well as reminding her of her own sense of defect. In her view, she had produced a "defective child."

Dr. M experienced intense conflict over her femininity. In some respects she disparaged traditionally feminine interests and social affiliations. We might view her efforts to discourage Kate's feminine interests as reflecting her intolerance of Kate's oedipal competitive strivings. At the same time, just beneath the surface of Dr. M's denigration was an obvious idealization of the powers of the women she observed at her children's school, since they more overtly permitted themselves to enjoy their femininity in the form of dress, social grace, and coquetry. At moments when Dr. M considered leaving the high-powered profession in which she

worked, she felt extremely anxious. If she left her work, she could be more available to her children and have time for assuming other traditionally feminine roles (e.g., fixing up her home, doing volunteer work, cooking).

As Dr. M's psychoanalysis progressed, multiple sources of conflict over her femininity were identified. One was her emerging realization that she felt her mother regarded boys as superior to girls and favored her brothers over her. A second was her inhibition in competing with a mother whom she experienced as a wrathful, unpredictable, and highly critical person, one who thrived upon declaring her superior knowledge in the areas which she regarded as her domain. In the same way as Dr. M disparaged other mothers whom she unconsciously idealized, she fought with many of her mother's opinions, yet unconsciously regarded them as "correct." For example, Dr. M described herself, using her mother's words, as a "terrible" baby who cried unrelentingly and was excessively demanding. At the same time, she supplied the history that her birth was one month premature and that she had a milk intolerance. Dr. M felt she was experienced, right from the start, as intentionally desirous of giving her mother a hard time.

In a more fundamental way, Dr. M believed that her badness caused things; if there was a family dispute, it was because of *her* actions. This, despite the fact that the data she subsequently presented made it clear that another party was involved in the disputes with many family members. When Kate was born, Dr. M remembered her mother telling her that now *she* would see what it was like to have a daughter; she had somehow escaped this fate with Joan, but with Kate she would certainly have the terrible time all mothers have with daughters. Dr. M thought this was mean and irrational but had nevertheless clearly internalized her mother's prediction. Since Kate's birth she had been on the lookout for her daughter's flaws and impossible behavior. However, Kate had not been a difficult baby. Now, after many years, Dr. M *was* having a hard time with Kate. It was as if the prediction rendered by her mother's crystal ball had come to fruition.

Dr. M blamed herself for all of Kate's difficulties, including her

problems in learning to read and spell. Dr. M's male cousin had a daughter approximately Kate's age who excelled in reading. Thus, according to Dr. M's mother, her cousin had the better child. Presumably, this had come about because her cousin's wife had worked with this child from an early age. However, when Dr. M shared with her mother that she was taking Kate for an evaluation of her possible delay in reading, her mother felt this was too pushy and vociferously criticized her daughter. When psychotherapy was recommended for Kate, this, too, was experienced in a *mea culpa* fashion as the culmination of all of Dr. M's "badness" as a mother.

At one point Dr. M reflected how surprising it was that, although she and her brothers felt overwhelmed by their mother, they had never shared any of these feelings with each other either as children or as adults. After quite a while she considered that if her brothers were to verbalize some of the thoughts and feelings *she* had, it would be even more frightening. In essence, Dr. M would be less able to deny the rageful feelings she had toward her mother. This shed light on her response to the recommendation of psychotherapy for Kate; she was not sure she could tolerate the fury she imagined Kate would feel toward her. This reaction was now understood as a projection of Dr. M's sense of the intolerability of her *own* fury toward her mother. Her feeling that her mother was "correct" and her idealization of other mothers served to buttress her denial of this fury.

As stated before, Dr. M also came to consider her feeling that her mother probably *had* preferred her brothers. In a similar fashion, Dr. M had initially defined Kate in terms of what she was *not* when compared with her more masculine older sister. At an extended family gathering, Dr. M was shocked to observe how her mother paid attention to the only boy present (her grandnephew) and ignored the girls, including her granddaughters, in almost a "bizarre" way. In this context, Dr. M recalled that as a young girl her mother told her she was not as smart as her brothers because she had scored lower on an entrance exam to the private school they all ultimately attended. Kate's insistence upon having mate-

rial things, and typically feminine ones at that, flew in the face of Dr. M's conflicts over her own femininity and her oedipal desires. She demeaned Kate's choices. We came to see that Kate's freedom to want and to ask threatened to unleash Dr. M's tightly held restraints upon her own wishes. She had to reflexively say "no" to Kate, even to attempt to *eradicate* her wishes, lest she feel inundated by them.

A third perspective on Dr. M's conflicts over femininity and her sense of defect emerged in the fifth year of her analysis in the context of the life-threatening illness of a beloved maternal uncle. She wished to be involved in taking care of her uncle and visited him more often than usual, something about which she felt a strange uneasiness that she could not define. Talking alone with this uncle was something she had never done; instead, she had always communicated through her aunt. Upon reflection, Dr. M realized that, in a far more subtle way, the same arrangement existed with her father, to whom she had allowed herself little access; instead she communicated through her mother.

Following a visit to her uncle, she reported a dream in which she went on a car trip alone with her father and another dream the same night in which she was seriously injured. These dreams were meaningless, Dr. M commented, because she had never gone on a trip alone with her father. I pointed out the sequence of her dreams. She was seriously injured after going on a car trip alone with her father. Her associations led to thoughts of how limited she was, how defective, no longer having a career she enjoyed, being unable to do this or to do that. She reflected that her uncle had commented on how excited he was to see her, how beautiful she looked, how terrific, bright, and accomplished she was—all compliments and sentiments of which Dr. M felt underserving. I interpreted that she felt uneasy about her uncle's feelings toward her, as she did about the idea of going on a trip alone with her father in her dream. She associated that as her uncle expressed his excitement about seeing her, she imagined her aunt responding, "Enough already, calm down!" Thus, we came to see how her sense of defectiveness, of the inferiority of females, and her mas-

culine identification also served as defenses against the imagined dangers of positive oedipal wishes. Being successful as a mother and homemaker had similar unconscious resonances. Dr. M believed her mother had failed in many maternal and domestic aspects of life, but nonetheless "owned" them.

For Dr. M, experiencing pleasure in traditionally feminine investments, such as being a mother and taking pride in her home and appearance, was associated with highly conflicted longings for her mother. Being feminine involved a threat of being too close to her own mother and to me in the transference; correspondingly, she experienced anxiety about the pleasure of closeness with her own daughter Kate.

The visibility of Kate's learning difficulties also collided with the secretiveness of Dr. M's family. The existence of problems should be hidden to the greatest extent possible; people would not help but instead judge in a humiliating manner. This fear was a central feature of the transference. In this regard, Dr. M found it startling that Kate was not humiliated upon being told she would go for remediation but was instead rather appreciative of the opportunity.

These are just a few of the psychological resonances of general features of Kate's cognitive picture. It is also worth considering several additional aspects of her particular kinds of neuropsychological dysfunction. Confirmation (or disconfirmation) and further elaboration of these hypotheses would need to take place in the context of Kate's analysis. However, these ideas are offered as illustrations of the value of investigating the specific nature of the patient's cognitive problems. In none of these postulations do I mean to simplistically reduce psychological phenomena to their neuropsychological roots. Rather, I wish to emphasize that our understanding of the components of conflict is enriched by considering how specific neuropsychological difficulties are elaborated in fantasy and are interwoven with the ubiquitous conflicts of psychosexual development.

Kate was able to interpret letters correctly and to associate them with the proper sounds. However, she was unable to blend dis-

crete sounds together to form words. For a child who is preoccupied with fears of things falling apart and with feelings of defectiveness, being unable to put sounds together might be experienced as a form of things falling apart and/or as a defect. Her weakness in visual sequential memory might be one component of the fearfulness that she manifested when presented with new experiences, such as school or day camp. Rather than looking forward to these events, Kate expressed fears of getting lost, of not knowing how to get to the assigned rooms, and of not knowing how to get back to the bus. Difficulties with visual sequential memory might contribute to and/or compound her anxiety about negotiating in space away from familiar others. Similarly, her distractibility by stimuli in her environment would be likely to contribute to her sense of the new as overwhelming and frightening. Kate's other sequencing difficulties (i.e., her failure to grasp "before" and "after" relationships with regard to number, day of the week, and space) may similarly have reduced the reassuring effect of the ability to order experience. Comments such as "I will see you after dinner" or "You will be able to see Dad before you have to leave for the class trip" are not reliably grasped by the child with a sequencing disorder. Likewise, comprehension of the sequence of activities or steps expected, which may be orienting to the anxious child, is compromised by the sequencing disorder.

CONCLUSION

This paper has emphasized the value of being alert to potential oversights in analytic work with patients who present with problems in learning, in carrying out professional responsibilities, and in achievement or cognitive functioning of any sort. A failure to consider the possibility of a neuropsychological contribution is especially common when the patient is intelligent and verbally talented and when we can convincingly formulate a psychodynamic explanation for her or his difficulties. Even when the analyst is convinced of the existence of a neuropsychological substrate for

her/his patient's struggles, there is great value in a comprehensive delineation of the specific nature of the clinical picture. Psychoanalytic work may be enriched as analysts are better able to help their patients appreciate the fantasies which accure to their specific neuropsychological problems, as well as the contribution of these elements to the shaping of their personalities.

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Self Psychology Since Kohut

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SELF PSYCHOLOGY SINCE KOHUT

BY ARNOLD GOLDBERG, M.D.

The changes in psychoanalytic self psychology since its origination by Heinz Kohut are described as differences in three branches: the traditional, the intersubjective, and the relational. Each claims both a distinctiveness and a major influence within self psychology. These are described and contrasted. It is suggested that an effort to integrate all three is premature, and that they will continue to grow separately.

INTRODUCTION

This is in the nature of a historical progress note. For many students of psychoanalytic psychology, the advent of self psychology was an interesting moment in the growth and development of depth psychology, one which began with the publications of Heinz Kohut and which continues on with the adoption of several of his ideas and concepts. Most psychoanalysts do not keep up with the literature of self psychology, and most have only a casual acquaintance with its vocabulary and even less familiarity with its internal struggles. Kohut's original aim for self psychology to have an established place within organized psychoanalysis has given way to its rather surprising emergence embodied in a solid group of clinicians and investigators outside of the psychoanalysis that Kohut knew. This has been accompanied by conflicts, disagreements, and, perhaps predictably, different branches. That a significant partisanship has arisen within the domain of self psychology is one of those inevitable events that plague much of psychoanalysis, but it should not conceal the fact that self psychology, itself, has seemed to travel along distinctly different ideological lines.

It is always difficult to lift out the pure theoretical concepts from the political surround, but there does seem to be a rather clear

clustering of concepts that differ from one another while still claiming an allegiance to self psychology, an origin from self psychology, as well as an advance of and beyond self psychology. Only one of these branches has a definite name, i.e., intersubjectivity, and so one is immediately at a disadvantage in pursuing an effort to single out and describe these other chosen branches without falling into the political pitfalls of organizational controversy. My attempt therefore will be to sketch the separate tributaries of self psychology without, in any way, laying claim to either completeness or correctness. This will necessarily result in certain omissions, such as the role of social constructivism, the concept of motivational systems (of Lichtenberg, 1989), and narrative theory. These are significant and important issues in contemporary psychoanalysis, but they seem to me to be less representative of a movement in self psychology than of general themes in psychoanalysis. Each, however, does play a significant role in the growth of self psychology but has not, as yet, become more of a member of one branch than another, i.e., they are ecumenical.

One often hears of a fantasy involving the return of an originator, like Freud, to consider what has happened to his or her brainchild. One example of this would be to recall the time when the rules for admission to candidacy were so strict that it was claimed that Freud would never have passed muster. Just as that period in time has also passed, so has the question of whether or not Freud would have embraced one or another advance in psychoanalysis, such as ego psychology. The field is too fluid. The same is true of self psychology, since fidelity is often more to persons than to ideas. Beyond the cry of whether or not Kohut might have agreed or disagreed with any idea lies the more powerful plea of whether or not the idea is a worthwhile one. The answer to that remains more with the perspective of history than anything else. Much of the original work of Kohut has found a significant place in psychoanalysis. The significance of the narcissistic transferences, the perception of the maturation of narcissism, the focus upon the phenomenology of narcissistic disorders have all entered into the ordinary discourse of most analysts (Gill, 1994).

The continuing evolution of self psychology has articulated with the emergence of a number of other psychoanalytic excursions such as seen in interpersonal and social constructivist concepts (Hoffman, 1991). Thus the path of self psychology can be seen as a clue to the entire postmodern era for psychoanalysis (Barratt, 1993). Viewing psychoanalysis as an evolving system allows us to see the emergence of a host of ideas that may or may not survive the rigors of clinical experience.

Inasmuch as the varied branches that have emerged in self psychology, perhaps because of their shared origin, have survived in a competitive atmosphere, it is almost impossible to describe them in anything approaching pure form. Each claims a status that seems to depend upon being different from the others, and so any listing or description carries a weight of a value judgment. With the impossible goal of even-handedness, the bibliography will therefore be directed primarily to a few representative works and will aim to avoid as much as possible the spirit of competition that presently exists in and about the students of self psychology. It is selective rather than inclusive.

Following from the excellent book review by Morton and Estelle Shane (1993) which emphasized the differences of opinion about the basic tenets of self psychology, all of which derived from different authors, my essay will be directed toward the trends or movements in self psychology which are crystallizing out without a particular allegiance to a particular person. Just as self psychology is working itself free from an absolute allegiance to Kohut, so, too, will we see these branches survive less on the basis of their fidelity to their founders and more on the basis of what we hope will be essentially pragmatic factors. Although a theory may be inextricably tied to its originator, its destiny depends upon its use over time. And for many it is much too early to judge their staying power.

One unhappy result of any selection of current forces in self psychology, as in any dynamic field, is an arbitrary delineation of exclusion and inclusion. Some people insist that they are not self psychologists although they seem to be. Some insist that they are

but appear otherwise. Probably it does not matter except in an overview such as this which aims to identify trends within the field. Therefore, it seems best to minimize the personal references and to highlight the ideas, and so some omissions are therefore inevitable.

I will exclude some issues that seem closely tied to self psychology but have over time become intergrated into all of psychoanalysis. Prominent among these is the position of empathy which Kohut felt was the basis of all depth psychology but which he insisted had no particular tie or special affinity to self psychology. There is no doubt that there are a number of different emphases on the nature and role of empathy, but, at present, there seem not enough crucial differences in its definition and employment. Its popularity may be ascribed to self psychology but not its utilization. Everyone now seems to include empathy as an essential component within psychoanalysis.

Another notable feature of self psychology has been its altered consideration of aggression as reactive rather than primary. Putting aside the enormous misunderstandings that have grown up outside of self psychology about aggression, there does not seem to be much serious debate within self psychology itself about Kohut's original position (Ornstein, 1993). That position certainly had room for normal assertiveness alongside that of narcissistic rage. The parallel issue that has had only a minority of psychoanalysts preoccupied, i.e., the place of inborn destruction and the death instinct is probably one that self psychology has effectively bypassed. Indeed, the entire consideration of psychoanalysis as posited on drive psychology is not one entertained by self psychology, and is now embraced beyond self psychology (Lichtenberg, 1989).

With these provisos in mind, I will now turn to a brief examination of three main trends in self psychology since Kohut.

Traditional Self Psychology

The major theoretical contribution offered by Kohut in his delineation of psychoanalytic self psychology was that of the selfob-

ject, and the major clinical contribution was the description of the selfobject transferences: their formation, working through, and resolution. The work that followed upon and flowed from these central theses was primarily one of elaboration and variation on these themes. All kinds of forms and types of selfobjects were considered and described. These ranged from non-animate things, such as musical themes, and animals to a further categorization of selfobjects from archaic to mature. As might be expected, the concept became overloaded, with almost anything that seemed to play a role in growth and development quickly and readily being assigned the role of a selfobject. In the evolution of any idea a popular term becomes overpopular and then—usually after a plea to dispense with it entirely—it starts to get a more focused definition. This happened within and outside of self psychology with the overuse of empathy, which still awaits a rescue from its overzealous proponents.

Selfobject was originally intended by Kohut to mean another person who served to perform a function which one could not perform for oneself. He meant this to be thought of as a forerunner for psychic structure, since he described the phase-specific taking over of these functions as resulting in further structuralization. That some selfobjects remain with us throughout life seemed to allow a modification of this theoretical contribution, since it opened the door to a new definition of maturity which seemed to have room for lifelong structural deficiency, i.e., the selfobject was even needed to maintain the self.

Along with the ongoing work on a better definition of selfobject, there has been a continuing debate about whether the selfobject needs to be considered as an inner experience or an actual entity. This struggle over the correct positioning of the psyche in the world is equally waged throughout all of psychoanalysis which has yet to clarify the true nature of objects. Noteworthy, however, is that the selfobject is a theoretical bridge to the controversy that goes on between one-person and two-person psychologies; and self psychology is no stranger to this debate. For some the selfobject is a part of the self and thus is best considered as a one-person

psychology. For others it is a connection to another and is therefore a clear example of a two-person psychology. The concept of the selfobject and its reliance on a theory of self development, however, does serve to differentiate it from most of the other two-person psychologies.

Without too much of an excursion into some knotty philosophic issues, the distinction between one- and two-person psychologies must begin with some agreed upon and accepted definition of a person. From William James on, we have learned not to limit the notion of person to that which is contained within one's skin but to extend it to a larger area involving ownership. Since self psychology regards selfobjects as part of the self, it extends the concept of the person to include those others who function as part of the self. The self is composed of or constituted by its selfobjects. Therefore, the concept of a person seen socially or from the position of an external observer becomes transformed into that of the person seen in a psychological sense, i.e., from within a mind. Two persons in conversation seen by an observer is the social or interpersonal perspective. However, from the vantage point of the inner psychology of one or the other social person there may be only one self with his or her selfobjects; therefore self psychology is now conceptualized as a one-person psychology (Goldberg, 1990, p. 126).

The clinical elaboration of the selfobject transference is also a definite demarcation for self psychology. The literature of self psychology has followed a trend seen in much of psychiatry outside of psychoanalysis in a pursuit of shorter modes of treatment. There seem to be more reports of psychotherapy than psychoanalysis and thus more inferences about the nature of the transference rather than a fully explored and resolved description of its course. Concurrent with the abbreviation of the therapeutic efforts has been the use of what are called principles of self psychology in child therapy, couples therapy, family therapy, and even organizational psychiatry (Goldberg, 1985, 1986-1996). Since this trend too has usually been felt to be a dilution of psychoanalysis, it needs to be carefully studied as to its ultimate value.

One area of inquiry concerns the narcissistic behavior disorders, a diagnostic category of the addictions, delinquencies, and perversions that Kohut felt were a particular form of self disorder. These pathological states have been examined in terms of their self structure, which is characterized by a vertical split, a form of self pathology described by Kohut, There is as well a particular kind of interpretive intervention that seems applicable in the analytic treatment of the disorders. An offshoot of this inquiry has been a significant amount of clinical material that highlights the analyst's enactments during treatment. The change of the position of the analyst from dispassionate observer and interpreter to active participant and performer is being discussed throughout psychoanalysis and psychotherapy, and so it is natural to see its significant emergence in self psychology (Bacal and Thomson, 1996). Perhaps it is most fitting to launch our description of the other trends in self psychology by considering the change in their conceptualization of the place and role of the analyst.

Intersubjectivity

Intersubjective theory is presented as a field or system theory. In one sense all of psychoanalytic theory can be considered an open system, but the original ideas of Kohut were certainly confined and limited to a narrow consideration of the self and its selfobjects. Therefore, one must alter his or her perspective in thinking of "reciprocal interacting worlds of experience" versus intrapsychic structural relations. There certainly must be a gain and loss in each perspective, and one result of a new or different outlook is a new vocabulary. Some critics claim that a retranslation of some of the new words and phrases back into familiar words such as that of "unconscious organizing principles" back into "transference" will show no essential difference between the two lexicons, but that, of course, may rob the new theory of much of its originality and scope (Ornstein, 1995). Therefore, the ideas of intersubjectivity theory ask for a shift from drives to affectivity and a consid-

eration of the psychoanalytic situation as a system with a fluid boundary between patient and analyst. The interplay between patient and analyst is viewed as a situation of conjunction and disjunction. The first characterizes assimilation of experiences into familiar configurations, the second into configurations that alter meanings for the patient. Both patient and analyst make contributions to the therapeutic action.

Intersubjectivists claim few concrete recommendations to style or technique in therapy, since they wish it to be a perspective broad enough to accommodate a range of practice. Indeed, intersubjective ideas are said to be but a call to an increased sensibility (Orange, 1996) or a theory, perhaps like information theory, that can accommodate a number of clinical theories. In order to achieve this position, however, it may be a contradiction to make certain clinical claims, such as those made about transference (Stolorow and Atwood, 1996). These views are not simply another statement about the analyst as growth-promoting versus the analyst as an object of old. The crucial difference between traditional self psychology and the theory of intersubjectivity is that for the latter the transference is felt to have two basic dimensions: the selfobject dimension and the repetitive dimension. The first is said to encompass development enhancing experiences, and the second to illustrate experiences of developmental failure. The essence of transference analysis lies in investigating the dimensions of transference as they take form in the ongoing intersubjective system. This system is formed by the interplay between the transference of the patient and that of the analyst. The focus is ever upon this shared construction and not upon the singular contribution of the patient projected onto the analyst.

At first blush one can hardly take exception to many of the views of intersubjectivity; it must await a test of usefulness to see if it adds much to the traditional approach. However, further difficulties have to do with the recent claim that intersubjectivity is more broad based than the singular concept of the selfobject, has a different definition of empathy, a different view of the curative process, and originated independent of Kohut's contributions

(Trop, 1995). Unfortunately, problems of territoriality seem to contaminate many scientific arguments. It may well be the case that some ideas need to stake out a claim of independence in order to prosper. This does seem to be the present direction of intersubjectivity theory.

From the stance of the selfobject as a component function of the self to that of the analyst as a reciprocal interacting world of experience, we move on to the next category in which the selfobject is a variant of an object relation and in which the analyst necessarily has an impact upon the patient.

Relational Self Psychology

This category is less of an organized movement than is that of intersubjectivity theory, but there is no doubt that a significant number of self psychologists see themselves as concerned with a better delineation of the object as separate and as gratifying. We can loosely call this group relational self psychology (Bacal and Newman, 1990).

Heinz Kohut originally conceived of narcissism as a separate line of development: separate from the known and accepted line attributed to objects of love and hate. Over time he seemed to modify this duality as he moved the study of the self to center stage, and as the self and its selfobjects became the fundamental features of all psychopathology. With his emphasis on oedipal selfobjects, he made these the pivotal issues for this developmental phase, and so relegated the objects of love and hate to a secondary role in the transference neuroses. Thus, the self became central, and the independent objects moved to the periphery. To bring the object as an "independent center of initiative" back to the fore does ask one to develop some scheme of relations between the self and the object. To do so involves either a commitment to the drives, which self psychology has abjured, or a looser use of the term "relations," which is not uncommon in much present-day analytic writing. The insistence on relations between

the self and objects has led some to focus on the need for the person to be aware of the presence, needs, and impact on others and to include these factors in assessing growth and development. It is said that traditional self psychology has simply bypassed this area and that no treatment can make a claim to comprehensiveness without recognizing the status of the other as a separate entity. The affinity to schools of interpersonal analysis is apparent (Mitchell, 1988).

The other area where self psychology differs from the standard view of growth and development of the self has to do with the insistence by Kohut that optimal frustration is the sine qua non for the structuralization of the psyche. His viewing this as a result of interpretation has been challenged by those who claim that optimal gratification is a more felicitous description of what serves to promote change (Shane and Shane, 1996). From this there is but a short step toward concluding that interpretation per se need no longer carry the sole burden in the therapeutic effort for change. The comparison of the child's learning a language is offered as the best example of a major step in growth occurring in a properly gratifying and supportive environment with no need for frustration to serve as impetus or indeed as at all a factor. With a perspective on analytic treatment as a new growth experience, an entry becomes available to parallel the features of analysis with those of optimal development. The knotty problem of "critical periods," those that allow for language acquisition and reading comprehension and others, is yet to be solved, since in this crucial area analysis is clearly not the same as the child's experience of growing up. How can analysis recreate a period of development that has been closed? Language acquisiton seems to occupy a very special place in development and so perhaps is not a valid example of how a gratifying environment can aid in structure formation. For the most part the claims made for an optimal environment suggest that growth takes place both in the life cycle and in the treatment situation without frustration (Shane and Shane, 1996). This, of course, differs from Kohut's original position.

The Place of Unconscious Fantasy

It seems likely that any evolving branch of self psychology will strain against tradition and at some point move on into an independent course. If one considers the role of unconscious fantasy, as an example, it is not difficult to see that both the branches of intersubjectivity and relational self psychology either make little use of it or dispense with it altogether. Rather than concern ourselves with the faithfulness to tradition of the new enterprise, we perhaps can think about the point at which—just as in biological evolution—we decide that a new species has emerged. If we do embark on a new course, much like what may have happened with self psychology and classical analysis, we are justified in reexamining all of the taken-for-granted concepts that constituted the old one. Surely the concept of unconscious fantasy is a legitimate member of that group of tacit assumptions. To the degree that any core concept is eliminated, one can expect a certain ripple effect as others will necessarily be altered or themselves eliminated. No doubt this sort of straightening out of the disorganization that follows from a radical restudy is often left to be done by others at a later time. One needs to be aware, however, that even minor modifications can have significant repercussions and lasting effects.

There is little doubt that Kohut, who was well schooled in psychoanalytic theory and practice, wanted to retain what he felt were the foundations of his own training and beliefs, and that he developed self psychology as a step in the evolution of that theory. Quite aside from the social and political pressures that come from fidelity to a group dogma, he initially believed that self psychology was a natural outgrowth of the tenets of psychoanalysis. He felt that, just as Heinz Hartmann had seen it necessary to expand ego psychology with the elaboration of the concept of neutralized energy, he had to expand the theory of narcissism with the description and elaboration of the fate of unconscious fantasies by way of the deployment of selfobjects. Kohut's development of the foundation for the notion of selfobjects went hand-in-hand with

the modification and transformation of these unconscious fantasies. The fantasy of greatness, which can have a pathological printout in megalomanic visions, can also fuel the mirroring needs and have an adult resolution in the internal feeling of pride. Such fantasies are the underpinning of ambition. The fantasy of connecting with a powerful and benevolent other, which can have pathological deviance in the influencing machine, can fuel the idealizing needs and result in an adult resolution characterized by an internal feeling of enthusiasm. The initial poles of self psychology were posited on the existence of a transformation of a set of unconscious fantasies without which there seemed no psychological sense to their continued existence. The unconscious fantasy appeared to be the motor for ongoing growth, and its fate the measuring rod for the success or failure of this growth. Change could be measured with this yardstick, and pathology could be viewed with this as a background barometer. If it becomes viable to consider new and different selfobjects, such as adversarial selfobjects or twinship transferences, then it seems proper to see if there was a corresponding set of fantasies that can accompany the path for their developmental course.

These minimal considerations about unconscious fantasy must be played out in the future against the further development of the different branches of self psychology. If a patient enters your office and remarks after a bit that she feels you are somewhat preoccupied, the range of options that present themselves for appraisal and scrutiny is quite clearly derived from your own position and stance vis-à-vis these options. You may wonder about your own participation in her view of you and thus see the intersecting subjectivities as forming this present state. However, a stance that reduces your contribution, albeit without eliminating it, might focus upon the patient's struggle with some grandiose fantasy that she fears will not be properly mirrored. A response on your part about her perception of you and your needs, along with the question of whether or not you should aim to correct that perception, would direct the treatment along an entirely different path than a mere interpretation of a grandiose fantasy struggling for recogni-

tion and modification. No one would argue for one position as necessarily exclusive; and most would agree with the absolute necessity for considering and ideally integrating all of the possible perspectives. But any one of them has a certain magnetic pull of its own, as it tends to encourage one approach rather than another. From the concentration upon a possible unconscious fantasy, one is inevitably led toward thinking about the next point in the sequence that asks whether it is from her or from me or from both of us?

The unconscious need not be thought of as a thing or a place. Instead, it is a way of looking at things: we assume that manifest issues have concealed meaning behind them. It is what Kohut called a part of our introspective intentions. One approaches reality only by way of a background of experience, and a part of a psychoanalyst's background is the concept of the unconscious. Every encounter with a patient can be studied within a frame that allows for a major contribution from an unconscious fantasy or for a major contribution from the immediate actions of the participants. The line that we choose to draw determines our varied approach to the patient (Goldberg, 1990, p. 127). Much of present-day self psychology seems to divide along this line.

Intrapsychic versus Interpersonal

Kohut's study of the self was the study of a psychic structure, and he considered the selfobject a component of that structure. He often contrasted his stance with that of interpersonal psychology and usually managed to denigrate the latter in spite of his protest of innocence. His main criticism of the interpersonal was that it was from a third person perspective, but the implicit criticism was that it was superficial. He felt that psychoanalysis studied the makeup of the psyche and that empathy was the tool for such a study, while social interactions were exteroceptive inspections by more distant observers. Gill was one person able to be clear in his view that analysis was interpersonal, and so that we did study the

goings on between persons. He never could quite understand why self psychologists could not see that. It takes no great feat of intellect to see that looking at what you think goes on inside is different from what you think goes on between, and that thinking about what A does to B is different from what B does to A. Putting aside all arguments about methods and models, it seems unlikely that a concentration on an unconscious fantasy will not take precedence over a supportive comment from a therapist if one chooses up sides with Kohut versus if one goes along with Gill. The patient's perception of the analyst's feelings counts more for Gill than does the patient's projection of her own discontent. That is how it should be in our world of heterogeneity; it underlines the differences that exist between the branches without in any way valuing one over the other, save in their ultimate usefulness to both patient and analyst. These three branches do seem to separate out once again when we choose to look for emphasis. The failed parent of Kohut comes necessarily from the patient, is co-constructed with the analyst by Gill, and asks for a new and potentially curative response from our third group. Although such oversimplification does a disservice to all three groups, it does do the service of recognizing that they are not all of a piece. From whatever common core they derive, they are spreading apart, and it seems highly likely that they will continue to do so.

Discussion

Organizations make for easy distinctions, while the distinctions made of a heterogeneous field may seem quite arbitrary. However, a greater problem seems to occur if the non-members of a scientific field assume that it is a static one, and that one need only refer to whatever original works have endured in order to be informed. This is surely the case with psychoanalytic self psychology no less than with any other sector of the psychoanalytic world. One may wonder how Freud would consider the present-day content of a literature in the field about his own brainchild; this is an

equally imaginative exercise for Heinz Kohut, Melanie Klein, Jacques Lacan, and many others.

It may or may not be true that the changes within self psychology are a microcosm of the changes within all of analysis, but there is no doubt that they give hints of general trends. These trends have to do with the recognition of the dialectic exchange that takes place in all of treatment, the more careful study of the different forms that treatment can take, the application of the data and knowledge of the treatment outside of the one-to-one setting, and the incorporation of information from other disciplines into the overall comprehension of therapy. This, of course, is not to mention the enormous changes brought about by the changing place of analytic treatment in our society that ranges from altering training and credentials to modifications in practice. The accompanying social changes that characterize self psychology are, of course, a topic for another discussion.

In conclusion, if we confine ourselves to the clinical and theoretical aspects of self psychology, we see that the central concepts have given birth to a set of separate tributaries, each of which lays some claim to serve as the major voice in the field. The traditional, the intersubjective, and the relational may go on to have distinctive lives of their own or may become reabsorbed in one another or evolved in a totally new form. It may be most important to recognize that efforts to diminish differences or to integrate disparate ideas into some sort of uniformity could turn out not to be in the best interests of the field. That remains to be seen, and it is to be hoped that we shall all continue to look.

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The Complexities and Pitfalls of Working with the Countertransference

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THE COMPLEXITIES AND PITFALLS OF WORKING WITH THE COUNTERTRANSFERENCE

BY STEVEN ROSENBLOOM, M.A.

The author attempts to demonstrate that the usual manner of reporting countertransference experiences does not do justice to the complexity of these phenomena. Clinical illustrations are used to show that the data of countertransferences are partial, often difficult to use immediately in analyses, sometimes ambiguous, and hard to validate. The fate of persistent conflictual residues within each analyst is discussed in the context of the life cycle of psychoanalytic work.

INTRODUCTION

A simple perusal of the current psychoanalytic literature reveals that in recent years no greater shift in clinical theory has occurred than the one in the area of countertransference. This concept, which Thomä and Kächele (1986) once referred to as the Cinderella of psychoanalytic technique, has captured center stage in our discourse and has resulted in a considerable enrichment of our clinical work. The writings of Jacobs (1986, 1991, 1994), Ogden (1994), and Hoffman (1994) are but a few of the contributions being made to our understanding of complex, mainly unconscious communications between analyst and patient in the process of treatment. Countertransference has gone from being a forbidden topic to one of the most frequently discussed issues in scientific meetings and other learning situations (Gabbard, 1995).

A careful examination of the manner in which countertransfer-

ence experiences are addressed in the literature illustrates that many of the complexities and complications involved in using these data in clinical situations are not given adequate attention. Jacobs (1994), for one, notes that the rather cryptic manner of presenting vignettes on this subject does not do justice to the considerable amount of working through required to understand the often long-lasting, subtle interchanges between analyst and analysand.

For purposes of illustration I will construct a stereotyped straw-man image of the way that many countertransference-related experiences are reported in the literature. This is done not in order to criticize past contributors as much as to help provide a context for what is often not emphasized in our literature. My image portrays the psychoanalyst as a plumber. In a typical vignette the clinician becomes aware of an impasse in a particular analysis, he/she engages in self-analytic activity, a revelation arises as to the nature of dyadic interaction, and somehow this gets worked into the analysis via some interpretive efforts. In the reports which most closely match this stereotype, the writers seem to possess "deep psychoanalytic pockets," moving easily from manifest content in the patient's associations to the analyst's own affects and personal conflictual memories, then back to the relationship with the material in the session. The analyst often appears almost as a conduit for the patient's feelings. The clinician has been well enough analyzed so that he/she seems to be bothered largely by signal affects that resonate with the patient's issues. Although this psychoanalyst-as-plumber analogy is good in theory, it does not often work out so well in practice.

First, the amount of information an analyst receives through his or her countertransference feelings at any given point in an analysis will vary widely. The clinician might have fleeting thoughts which disappear, feelings of drowsiness for which he/she cannot account, pronounced anxiety which feels ego-dystonic, or affects involving the patient which lead to insights via self-analysis. I hope to show that, contrary to my stereotype, we are often working with very partial data, and this results in our being unable to use these

experiences effectively in treatment situations. Furthermore, even when such data prove to be useful, considerable delay may be required before the data are applicable to the analysis.

Second, much of what goes on in the intersubjective space created between the members of the analytic dyad occurs unconsciously. Renik (1993) has demonstrated that there is an inherent subjectivity in each analyst, which often leads the analyst to discover only retrospectively what has transpired between him/herself and the patient. The stereotyped image to which I allude presents the analyst as being ahead of the game—or only slightly behind—when in essence countertransference phenomena frequently become conscious only after a complicated series of enactments. As I will illustrate in my first major clinical vignette, some discoveries occur without great analytic fanfare and, instead of becoming the object of interpretive work themselves, may signal that significant analytic progress has been made. This will be addressed in the context of some recent writings on psychoanalytic process.

Third, each analyst in the process of self-analysis is often faced with largely ambiguous information. There is a debate among clinicians about how effective and how consciously controlled our self-analytic activities can be (see Sonnenberg [1991] versus Gomberg [in Panel, 1994]). Some analysts maintain that in certain cases self-analysis is extremely helpful (Silber, 1996); others insist that self-analytic activity is an almost impossible task and that its data are far from trustworthy. We all struggle to determine which ones of our associations comprise valid psychoanalytic data versus those that are defensive rationalizations of our perception of the patient's material. The tendency of the clinician to somehow classify data of self-analysis is addressed in two of my vignettes, particularly in the second one dealing with an elaborate countertransference dream with which I struggled. Both major vignettes highlight the difficulties inherent to self-analytic activity.

Fourth, I will address the complexity of the origins of countertransference affects. I believe that the analyst's experience of being almost a conduit for patients' affects is one subset of the type

of experiences clinicians face in this arena. For example, one area which is important but not given adequate attention in the analytic literature is that of the fate of countertransference issues in the life cycle of psychoanalytic work. By this I mean that there are persistent conflictual residues in each practitioner which reappear in certain situations with particular types of patients. In the current climate of intersubjectivity, less attention has been given to the difficulties which conform more with Freud's original definition of countertransference (1910) or with the writings of Annie Reich (1951). As will be demonstrated, these conflicts arose for me in both of the major vignettes presented in this paper.

Varieties of Countertransference Data

Bouchard and co-authors (1995) offer a classification of countertransference experiences in which the clinician can function in an *objective/rational* mode (relatively objective), a *reactive* mode (corresponding to Freud's original narrow view of countertransference as consisting of the analyst's conflicts), and a *reflective* mode in which the clinician is able to mull over his/her feelings or actions after the fact and achieve some insight into what has transpired. In the same paper these authors go to considerable lengths to demonstrate that our experiences in this domain vary considerably. As alluded to earlier, it is my contention that much of the material published as expository vignettes on this subject is weighted in the direction of Bouchard and co-authors' *reflective* mode. This practice does not adequately portray the complexities of the analytic situation, wherein a particular countertransference experience might reflect a mixture of all three of these authors' categories in varying proportions. In addition, insufficient attention is paid to the all too common phenomenon of the partially useful countertransference experience. I offer the following brief illustration from an earlier paper to make my point.

In a session with an attractive female patient in her late twenties, I found myself distracted as I listened to her associations. We

seemed to be going over old ground, and I was repeating an interpretation which I had given a number of times previously. Suddenly, I had a strong image of myself as the stereotyped analyst that one hears about at cocktail parties. I was going in for the kill with this brilliant interpretation, and this stupid patient would never understand what it meant. This brief experience, in which I saw myself in an abhorrent role, jolted me, but as the session came to an end I forgot about it. In the next session, the patient presented a dream in which a man stood over her while she lay on a couch and continually criticized and berated her. She associated to memories of her father who behaved in this manner throughout her childhood. This led me to believe that I was experiencing what it was like to be her father. However, because of where we were in the analysis, I was unable to make an intervention at this time. I stored this speculation and only later did I use it in tentative interventions as a guide to emerging paternal transference issues (Rosenbloom, 1985). My countertransference experience did help in clarifying the way my patient experienced her father.

Bouchard and co-authors provide a similar example from a previously published paper by Kernberg. The authors explain Kernberg's example as a partially useful countertransference experience. According to them, the analyst is the recipient of a projective identification which he cannot process at the moment, but it later turns out to be of some value in the analysis. Both Kernberg's and my vignette illustrate an all too common phenomenon in working with the countertransference. Data in this area are often weak, unreliable, and not subject to reflection immediately. Hence, we must proceed with caution when we experience unconscious messages of this nature.

Retrospective Understanding of the Meaning of Countertransference Enactments

My first detailed clinical vignette illustrates the difficulty in understanding countertransference enactments or the role-responsiveness behavior of the clinician. It also addresses some of

the issues raised earlier regarding the effectiveness of self-analytic activity.

Clinical Vignette 1

Ms. J is an attractive single woman in her mid-thirties who entered psychoanalysis about eight years ago. Her main complaint was that she was not meeting men, and when she did, something always seemed to go wrong. She admitted to a fear of sexual involvement which often precipitated the end of her short-lived relationships. She is the oldest of three children in a lower middle-class family. Her early years, of which she remembers very little, were punctuated by her mother's being hospitalized for depression on several occasions, and her being shunted around to her grandparents for several months at a time. During these periods of mother's absence, she remembered herself as being Dad's favorite girl, something which she felt produced envy in both her younger brother and sister. One of the reasons for her coming to analysis was that she was considered the "square" of her family.

At the time Ms. J entered analysis, her mother, an attractive woman in her late forties had divorced her alcoholic husband and was living a swinging lifestyle which was totally shocking for Ms. J. A recurring theme in the analysis was that mother was always pushing her out prematurely by encouraging her sexual involvement with boyfriends. What became evident early on in the sessions was that Ms. J was extremely dependent psychologically on her mother and tended via a variety of passive-aggressive maneuvers to keep herself in a tenuous position both at work and in her capacity to manage her daily life. During this period, her relationships with men were very short-lived because of her conviction that these boyfriends only wanted one thing.

Ms. J often presented blatantly sexual dream material, but any attempts on my part to discuss her sexual feelings were met with an ego-alien response, "Well, I sure don't feel that way." During this period a central fantasy emerged in this patient's material

which became the focal point of her analysis. She had what I will call a fallen woman or French Lieutenant's Woman fantasy (from the novel of that title by John Fowles). She saw herself as being "finished" if she ever had sex. She would be abandoned by the man and become a plaything of other men, who would insist upon having sex with her. She might get pregnant out of wedlock and be left with a child. I knew from her history that both she and her mother had been born out of wedlock and that the father had been a philanderer. Attempts on my part to interpret this were greeted with an intellectual understanding of what I was saying, but a firm conviction on her part of the "reality" of this fantasy. Also, any interventions I made dealing with the discrepancy between this fantasy and reality were met with the comment, "You're just like my mother. You just want me to have sex with men so that you can get rid of me."

Ms. J alternated in the transference between seeing me as the mother who was trying to push her out prematurely and the father who never wanted his daughter to leave him. I must add that although this patient continued to bring sexual material via dreams which I attempted to treat transferentially, it did not ring true for her, and I noticed that despite her attractive appearance, I rarely ever had sexual fantasies about her. I understood her central fantasy as being overdetermined. On the one hand she was having difficulty separating from mother, and on the other there was this powerful attraction to father. This produced a considerable amount of guilt and fear. Her sessions often involved descriptions of situations in which she was competing with aggressive women and always deferring to their strength. This theme played itself out both in her dreams and on the squash court.

As we began her fifth year of analysis, I felt more and more as if we were in a stalemate. My patient was not improving and was hanging on to this quasi-delusional fantasy. I experienced her paranoia and felt very distant from her. This led me to speculate that she and I were involved in a series of enactments which I was having difficulty in comprehending. I consulted a colleague on a number of occasions and brought the material to a senior analyst,

all to no avail. Attempts at self-analysis, such as monitoring my dreams on nights after her sessions or observing my daydreams in this situation, seemed to go nowhere. In preparation for a class which I was going to teach to psychiatric residents on the topic of countertransference, I came across Sandler's (1976) paper on role-responsiveness, which I believe to be a classic in the field. It flashed through my mind that there was one thing I did with this patient that I did not do with anyone else: I opened the door for her after every session. I smiled to myself when I first noticed this. Why was I doing it? Was I the chivalrous analyst? Was I trying to be different from the other men in her life whom she saw as scheming and cheap? I did feel somewhat afraid of incurring the wrath of this patient. This must have something to do with her fallen woman fantasy, I reasoned. Maybe I was feeling like a failure and I had to give her something extra. This rang true for me, but then I realized that I had been opening the door for her right from the beginning of the analysis. After some reworking, I settled on my first explanation and put the whole enterprise on the back burner. I realized that I was profoundly reluctant to stop my behavior. It would feel rather silly for me to stop opening the door, just like that. This reminded me of Racker's (1968) term, "countertransference neurosis." I felt like a patient who had a symptom which he could not give up. As also must be evident, these deliberate attempts at self-analysis felt like an intellectual exercise.

About six months later, I finished a session with Ms. J and noticed that I was not getting up from my chair. I felt almost bolted down. In the next session, I had the same experience. After a few more appointments during which I realized that this was a permanent condition, I began to wonder what had changed. I proceeded to examine my notes for sessions several weeks prior to the change and gradually realized what had transpired. I had been vaguely aware that Ms. J started each of her sessions with descriptions of how she couldn't manage this situation and was frightened about that circumstance. Then there would be a pause. What I felt here was always, "So what am I going to do about this?" In her most recent sessions, this had changed. She started with her

usual litany of complaints, but instead of hesitating, she went on to describe realistic solutions which she was applying to her problems. I concluded that somehow Ms. J was signaling to me that she did not need me to be the mother who was supposed to solve all of her problems.

These realizations caused me to reflect upon what had transpired during the impasse. It became evident that the transference-countertransference enactments between Ms. J and me were intersubjective issues which could be examined only retrospectively, and they seemed to indicate that significant progress had taken place in this analysis. Although I realized my role responsiveness in this situation, there was a personal, conflictual element that I had seen time and again with certain patients. My father died when I was twelve years of age, which was traumatic in and of itself. What was worse was that I was left to take care of a frightened, pessimistic mother whose outlook on life can be characterized by a worried look on her face, accompanied by the anxiety-ridden question, "So what will be, Steven? What will be?" I realized that I had felt incredibly guilty about not being able to do anything for my mother, and certainly this had repeated itself with my patient.

What followed in the analysis was a slow but steady change in both the process and in the patient's behavior. Ms. J, several months after my countertransference experience, began a job which has been the longest lasting of her working career, and she is currently dating a man with whom she has made tentative sexual overtures. Most important from the vantage point of the treatment, the ever present "fallen woman fantasy" has become more and more ego-dystonic. Ms. J has been more amenable to accepting interpretations, and I have felt more comfortable working with her. There is an atmosphere of genuine working and therapeutic alliance, which was absent up until recently. Obvious transference references to me as father have become more frequent in her dream material.

This vignette addresses some of the important issues which pertain to countertransference experiences. First, it became evident

that all of my consultations and conscious attempts at self-analysis were to little avail during the period of the impasse. This raises the question to which I alluded earlier about the amount of conscious control we have over our self-analytic efforts. Considerable reflection and work on this subject has led me to favor a more autoanalytic view of countertransference discoveries. That is, I believe that the self-observation functions which are honed in training analyses will often make their appearance, as in this vignette, after considerable struggle and numerous blind alleys. Even more important is that the countertransferences which impede self-analysis are inherently tied to the process in each particular analysis.

Much of what transpired in this analysis is related to the views in a recent work on psychoanalytic process by Boesky (1990). Boesky believes that each analysis produces transference and resistances which "would never, and could never, have developed in the identical manner, form, or sequence with any other analyst" (p. 572). To quote him further, ". . . I have in mind complex and lengthy sequences of interaction which *only gradually become evident to the analyst as a resistance in the patient and to which the analyst in some more or less subtle way contributed by his or her own behavior. The phenomenon to which I refer seems to me to include countertransference but transcends that concept*" (*ibid.*, italics added).

In conjunction with the previously mentioned work by Renik (1993), these ideas tend to encapsulate the phenomena described in my clinical illustration. The confluence of my maternal transference to this patient and her need for me to be the good preoedipal mother combined to produce the type of impasse which arose. In an important sense, my role-responsiveness in this case illustrates a developmental process operating in the analyst, which must inevitably transpire so that creative resolutions of conflict can occur in synchrony with the patient. I have commented in another context on how the development of a unique analytic style, in which the analyst sheds previous identifications and stereotyped behaviors, is probably related to repeated experiences akin to the one in my vignette, in which the clinician works

through personal issues (Rosenbloom, 1997). I believe that what took place between this patient and me occurs more frequently than is reported in the analytic literature and needs more study.

The Ambiguous Nature of Self-Analytic Data

My second vignette illustrates the problems which analysts have in attempting to assess the validity of their own associations when working with a product of their self-analysis, in this instance a countertransference dream. It also demonstrates how the clinician classifies associations, attempts to formulate hypotheses about the data, and ultimately must await the test of more analytic work with the patient before drawing any conclusions.

Clinical Vignette 2

Mr. K is a forty-one-year-old advertising executive who originally came for a consultation two years ago. At that time he was distraught because of an unrequited infatuation which he had for another man at work. I recommended analysis for a variety of reasons which will become evident, but he initially refused. Mr. K contacted me again about a year ago and decided to start an analysis. In brief, this man is deeply conflicted about his homosexuality. He experiences himself as a person who is cursed with homosexual urges. For three years he has been dating a woman who wants to get married. To quote Mr. K, "I'm screwed. I want children, but I would be living a lie if I marry M. I can't love her passionately. On the other hand, I have these urges for men, but I hate the gay lifestyle. I'm condemned to living and dying alone."

This patient is the third child of immigrant parents who moved to Canada from Spain just prior to his birth. His mother became psychotic shortly after he was born, and he was placed in an orphanage at age six months and was not returned to his family for two years. The mother would have intermittent psychotic episodes during which all the children were placed in institutions on three

other occasions until the family was permanently reunited when my patient was twelve years old. Mr. K remembers his mother of childhood as a frightening figure who intimidated her husband and all her children, an explanation which he sometimes proffers for his homosexual tendencies. He remembers wishes, which began in early puberty, to be close to men and to be loved by them. He emphasizes that his wishes even now are less sexual and more related to his desire to have a male as a role model.

Mr. K has not been easy to engage in analytic work. Many of his sessions were spent with his vacillating between believing he has an unalterable genetic disease and attempting to find solutions to his problems in religion and self-help books. He consistently attempted to engage me in conversations about what is normal and what isn't, what does this action of his mean, or what does that one mean. There is a childlike naïveté to this man which makes me feel as if I have to explain the ABC's to him.

As the weeks of sessions went on, I began to feel a considerable discomfort around Mr. K. He often jolted me out of my analytic composure by trying to engage me in comic repartee or by sipping soft drinks in sessions. I found myself developing an inhibition to interpret anything to him. My fantasy was that I was analyzing a Martian. I could imagine a particular look on his face, should I say anything to him about his childhood. It was as if in his mind, I was totally weird. Yet every so often he would bring a dream which we could understand together, and that would cause me to question my own skepticism. I also noticed, as in the first case, a need on my part to be extra nice to this man. I explained my actions in this case as being my personal version of Winnicott's holding environment.

Two months ago, Mr. K's elderly mother became very ill, and he had to arrange for her transport to the hospital. He was horribly frightened that his mother, who had not seen a doctor in over thirty years, would be terrified of the hospital environment. In one session he asked me about ten questions in a staccato fashion about the meaning of his mother's different emotional reactions to her new environment. I found myself sheepishly answering

some of these questions to the best of my ability. As I have written elsewhere, I was suffering at this point from difficulties with my work superego (Rosenbloom, 1992). "What type of analyst answers all these questions?," I was asking myself. In the middle of this session he asked, "Hey, Rosenbloom. Is there any way we can reduce these sessions from four to three times a week? My mother's hospital bills are costing me a lot of money and besides, I'm stable anyway." This was said in the same tone that he used to describe his mother's condition a moment before. I muttered something about how he might be attempting to leave me before his mother leaves him and added that this was not a good time to reduce sessions, given this situation. He said that my first comment made sense but my second one sounded defensive. As the session was coming to an end, I acknowledged to myself that he was probably right. I noticed that with his mother going into the hospital, my feelings of discomfort in sessions had gotten worse. What I was coming to realize was that I had lost my bearings with Mr. K: the uncomfortable atmosphere which pervaded this analysis was more inexplicable now than ever before.

That night I had a dream. I awoke at 2:30 in the morning with the very strong feeling that this was a countertransference dream dealing with my feelings about this patient. I went into my office and proceeded to write it down with all the associations which came to mind. The dream:

> I am at the home of some very religious Jewish people. The walls are covered with beautiful works of art. I am being asked to put masking tape on the art because someone has died recently. This follows the Jewish custom of covering mirrors when in mourning. I absolutely refuse to participate in this. This is going too far. There are some young religious people there, as if I had cousins like this. I reiterate to them, "This is going too far," and refuse to participate. They very begrudgingly agree to let me follow my own dictates, but I am made to feel like an outcast.

My first associations were to the fact that I had visited the shiva house where some family friends were in mourning over the re-

cent death of a close relative. The atmosphere in that house was divided. On one side, you had the immediate family who were somber. On the other, there were husbands and children of the mourners who seemed more cheerful—a getting on with life attitude. This reminded me of the atmosphere in my family when my father died. I didn't cry very much at the funeral, and I had the sense that I wasn't mourning enough. This was followed by a lot of sanctimony in my family. Each relative tried to outdo the other in swearing devotion to my father while he was alive.

At this point in my associations I realized that this related to my patient and his mother. I was aware of having a feeling like "why are you wasting so much time on an old dying lady? What about your analysis and me?" A memory came back from an episode which had happened in the previous summer. Mr. K had told me that he had to be away for two months on business. Half of the time would correspond with my vacation, and the other half he would miss. At the appointed date of his return Mr. K did not show up for his session. He did not reappear for another two weeks, initially saying that he wanted to stop treatment, but after one visit, changing his mind.

I remembered having worried about him for those two weeks. This brought back memories of my sister and me standing at the window every day wondering if our mother would return from work—something which went on for several years after my father died. I now consciously felt the fear of rejection and alienation from my patient. A number of hypotheses began to form in my mind. Was my experience of analyzing a Martian related to this sense of unapproachability?

Another association jumped into my mind. In the second session after returning from his trip abroad, Mr. K said to me, "You know, I looked at your wall with all those degrees, and I said to myself, Is this for real or do you disappear after every session? So I called a colleague of yours who said you are first class." I said, "Oh, you mean you checked up on me last year when we started?" He said, "No, I did that yesterday." I wondered whether I had identified with my patient's feeling of losing his mother. Was he

keeping me at a distance because he was afraid of losing me? I began to see an outline of what might be bothering me. My attempts to do analysis with this patient would be the equivalent of trying to console a depressed mother. My old conflict was back—taking care of my depressed mother and resenting her pessimism. My associations to religion and religious people had to do with psychoanalysis. I was feeling guilty about my inability to help this man change his homosexuality, but really I was feeling paralyzed in attempting to lift his profound sadness. Was Mr. K identifying with his mother and perpetually leaving me before I would leave him? Was he afraid of regression in the transference?

I have tried to impart a flavor of what it felt like in attempting to analyze my countertransference dream. These principal associations and others which I have omitted left me with material of different categories. There were affects about the patient which I trust as being valid. There were memories from my childhood which seemed to fit the dream very well. I became convinced that my old concerns about caring for a depressed mother had been rearoused here. I was and am more circumspect about what all this meant in terms of Mr. K. I believe it is quite possible that we have been replaying something related to his conflicts with mother. Some of these ideas about regression in the transference and identification with the aggressor make some sense, but these are hypotheses which may not be tested for quite a while.

The effect of this experience for me was the equivalent of having brought all this material to a good supervisor. My sense of alienation from Mr. K diminished somewhat after this dream. I felt grounded; I had hooks to hang these ideas on. I noticed as well a greater capacity to empathize with his deep loving feelings for his mother, and my interventions have been less tentative. However, much work remains to be done on these feelings of discomfort. I wonder whether or not these many associations to my patient will bear fruit or whether I have found a more sophisticated way of fooling myself into thinking that I understand him better.

The preceding clinical vignette highlights one of the difficulties

of working with the countertransference. There is considerable uncertainty about the validity of the data. The clinician is never certain about what proportion of his/her associations is due to his/her own personal issues and what proportion is a product of an intersubjective interchange. Hence, more often than not, our conjectures about the intersubjective experience cannot easily be put to the test in the clinical situation.

This methodological problem strikes to the heart of issues currently being discussed in our literature on the validation of psychoanalytic data. In the attempt to define "clinical facts in psychoanalysis," authors have expressed a variety of viewpoints. Some writers argue that the nature of psychoanalytic facts is considerably related to the private theories of each analyst (Gardner, 1994; Sandler and Sandler, 1994). Others, like Beland (1994), view data validation as a combination of self-analytic and group consensual criteria. What becomes evident when perusing the literature in this area is that most criteria for data validation require substantiating material from the patients (Shapiro and Emde, 1995).

As must be evident from my vignette, validation of self-analytic data is more problematic, in that in many instances the analyst must serve as arbiter, classifier, and judge of his or her own associative material without immediate aid from patient input. Some authors who are particularly associated with an interpersonal psychoanalytic approach would argue that engagement of the patient as a partner in the examination of transference-countertransference enactments would be one manner of obtaining validation of the meanings of these events (Ghent, 1992; Mitchell, 1991; Pizer, 1992). Although these writers concur on the uncertainty and complexity of countertransference phenomena, I believe that their patient-as-partner idea is most suitable for psychologically minded analysands who can be engaged in the process without extraordinary difficulty. The two patients I presented were too paranoid and difficult to engage in an exploration of what went on between us.

In general, most analysts would agree that it is not good clinical practice to burden patients with one's own ruminations which

may not immediately connect with what is happening in the analysis. Although what often appears in the current literature on countertransference includes validation from patient material, I would argue that examples like my vignettes occur more often than they are reported. It has been my experience that many hypotheses generated in these countertransference situations are borne out by material from the analysis, but not always. Some of the most convincing self-analytic experiences lead nowhere.

The Fate of Persistent Conflictual Residues in the Life Cycle of Psychoanalytic Work

As mentioned earlier, the current climate of intersubjectivity has tended to de-emphasize the fate of recurrent conflictual residues which surface under particular circumstances. The changes in clinical theory which have resulted in a more inclusive definition, first introduced by authors like Heimann (1950), have placed the contribution of the personal conflicts of each analyst on the back burner. For all the emphasis that has been given to dealing with one's own issues in training analyses or reanalysis, relatively little if anything has been written about how countertransference issues are dealt with in the treatment of analysts. Recent papers by Simon (1993) and Silber (1996) are exceptions to the rule and hold out hope for a more thorough understanding of these often private difficulties facing clinicians.

To this extent, the appearance of the same conflict within me during the treatment of my two patients is instructive. Numerous questions arise as to how analysts deal with these problems. It may well be that analysts and patients self-select so that certain types of therapeutic match-ups do not occur (Baudry, 1991). Similarly, the research on patient-analyst fit and character issues would suggest that stalemates do not occur at random (Kantrowitz, 1992, 1993). I have presented evidence about a developmental process operative within each analyst which potentially allows for a posttraining working through of conflicts that cut across patients (Rosen-

bloom, 1997). Answers to questions about the management of personal conflictual issues in analysts must await the appearance in the literature of more practitioners' reports of the difficulties encountered in the life cycle of psychoanalytic work.

Future Considerations

The recent expansion of the scope of psychoanalysis through the emergence of the intersubjective viewpoint has led to new data which have broadened our horizons. The major contention of this paper is that the current enthusiasm over the importance of countertransference phenomena has promulgated the existence of a long "demonstration" phase around this topic. By this I mean that authors have tended to state again and again that self-analytic activities can indeed be useful for analyses. This had led to the type of reporting which I exaggerate somewhat in my stereotype.

What I believe is missing is a more complex examination of the variety of phenomena we classify as countertransferences. Researchers like Bouchard, et al. (1995) assist in honing our conceptualizations of these phenomena. What must also arise is some manner of externally verifying the effects of intersubjective interchanges on analytic process and outcome. Whether this may come via the study of supervision groups designed to deal with countertransferences and/or the microanalysis of data from individual analyses is difficult to tell. Failure to examine what does not work and where blind alleys exist will reinforce a persistent idealization of the intersubjective enterprise and prevent the development of realistic expectations for what can be accomplished in this area of psychoanalysis.

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Female Genital Anxieties: Views from the Nursery and the Couch

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FEMALE GENITAL ANXIETIES: VIEWS FROM THE NURSERY AND THE COUCH

BY WENDY OLESKER, PH.D.

The author evaluates developmental and clinical data concerning female genital anxieties in an attempt to address the question of its clinical utility. An effort is made to clarify evidence for female genital anxiety as distinct from castration anxiety in females in the clinical situation and in development. This paper examines these concepts from the perspective of the author's detailed observational and clinical data, which are central to this report.

In criticizing Freud's phallocentric view of female sexuality, writers in recent years and in the past stress that a girl's development is affected not only by her awareness of anatomical differences but also by her response to the specific attributes and morphology of her own genitals (see D. Bernstein, 1990; Kestenberg, 1982; Lerner, 1976; Mayer, 1985, in Panel, 1994; Renik, 1992; Richards, 1992; Shaw, in Panel, 1994; Silverman, in Panel, 1994; Tyson, 1990, in Panel, 1994; and Horney, 1924, 1926; Jones, 1927; Klein, 1932). As Mayer (in Panel, 1994) pointed out, "girls struggle with what it means not to have what they *do not* have, [and] they also struggle with what it means to have what they *do* have" (p. 234). In this paper I differentiate female genital anxi-

This paper is Part I of a three-part series discussing the wide range of fears females have about their genitals. Part I covers female genital anxieties and castration anxiety/depressive affect, Part II covers female genital depressive affect (P. Bernstein, 1996), and Part III covers anal contributions to female genital development.

eties from castration anxiety and evaluate developmental and clinical data on female genital anxieties in an attempt to address the clinical utility of the concept.

Many women feel there is something wrong with their bodies, but analytic writing until recently has emphasized the girl's comparison of her body to the male's, the shame of castration, and penis envy and its defensive aspects (Grossman and Stewart, 1976). I address a somewhat neglected area: the girl's response to her own genital morphology and how adequate she feels about her body, not in comparison to males but to other females. Does the concept of castration anxiety cover the range of female experience, or is there a female anxiety about loss of specifically female anatomical features, functions, and sensations? If so, does this argue, as some have suggested, for a separate developmental line of femininity?

Some female fears known as female genital anxieties in the literature result from having genitals that are difficult to see and touch, thereby leading to problems in developing a mental representation of the vagina (D. Bernstein, 1990). Horney (1924) emphasized the disadvantage of the preoedipal girl: in the act of urination the boy can look at, hold, and display his genital and thus satisfy his sexual curiosity about his own body; he may interpret this also as permission to masturbate, gaining greater freedom in his sexual life. Mayer (1985) highlights the girl's fear of the loss of the capacity to be genitally open and her concern that she could be genitally closed as she supposes boys are.

Other writers cite diffuseness of excitement in the female genitalia in contrast to focused sensations in the male, and the narrower wall between the genitals and anal and urinary tracts in females, which fosters anxiety over control of genital, anal, and urinary sensations. Anal displacement appears to play an important role in the girl's attitude toward her genitals. Toilet training issues and fear of aggressive conflict with mother often set the stage for harsh superego attitudes, intense guilt, and inhibition (D. Bernstein, 1983; Burton, 1994; Olesker, 1984, 1990; Shaw, in Panel, 1994). Some suggest that having a genital that cannot be

opened or closed at will leads to penetration anxiety (D. Bernstein, 1990; Horney, 1924; Jones, 1927). Others include fear of loss of pleasure (Jones, 1927) and loss of the procreative function under the rubric of female genital anxieties (Richards, 1996).

Some current writers suggest dropping the term castration anxiety as applied to women and talking only of female genital anxiety (Goldberger, 1993). This is redressing the problem of penis envy with a different form of reductionism, throwing out the baby with the bathwater. My developmental observations show that both castration anxiety and female genital anxieties exist and can be differentiated in development according to the time they appear and by their content. In an adult analysis one rarely hears about female genital anxieties or castration anxiety in isolation. As Shaw (in Panel, 1994) indicates, the problem then is how to differentiate core organizing fantasies from secondary defensive elaborations (p. 237).

I propose to differentiate castration anxiety and castration depressive affect from female genital anxiety. Castration anxiety traditionally refers to fantasies about threats of injury or loss, and castration depressive affect refers to a reaction to injury or loss of the phallus or fantasied phallus (Brenner, 1982). The term female genital anxiety I reserve for fears of loss or damage to the female genitals, which, in my data, appear to develop during the latter part of the third year when certain cognitive and emotional achievements are taking place—the establishment of triangular relationships, further sex role differentiation, newly developed sexual aims, fantasies, and conflicts (Edgecumbe and Burgner, 1975)—although one may discern earlier the precursors of female genital anxieties.

By contrast, castration anxiety, or concerns about damage to or losing a penis, is manifest during the second year and early in the third year of life, before oedipal issues take center stage. These anxieties and affects readily become intertwined. Thus, I see female genital anxiety, and penetration anxiety in particular, as a rung in the ladder of genital anxieties and not as a separate line, or a replacement. While Moore and Fine (1990) include penetra-

tion anxiety under the term castration anxiety and refer to girls' "fear [of] having their genitals penetrated, torn, or otherwise injured" (p. 36), we may gain more by refining and redefining female genital anxieties as distinct and identifiable, and by placing them in a developmental time frame. Thus, I see female genital anxieties as products of specific fantasied dangers tied to particular developmental events and available for transformation by subsequent development.

Fast (1984) believes that both boys and girls understand their own genitals as normative, fear losing what they have, and envy what they perceive or imagine the other sex to have; but observational research finds otherwise. I am for parity, but I must adhere to the child's interpretation of the world of gender. Researchers who conduct observational studies of children between the anal and the oedipal phases highlight the often intense reactions of the little girl to anatomical differences, far more intense than shown by the boy. Galenson and Roiphe (1971) describe a change in mood (to depression), in object relations (increased clinging and stranger anxiety), and in ego functioning (the use of splitting and the distortion of the symbolic function) in some girls in the second year of life.

While many have made assertions about the importance of female genital anxieties throughout the life of the female (D. Bernstein, 1990; Goldberger, 1993; Richards, 1992, 1996; Shaw, in Panel, 1994), conclusions implying childhood roots are based on data from small numbers of adult analytic patients only. Few have actually looked at developmental data to assess the genesis and developmental path of female genital anxieties.

OBSERVATIONAL DATA

I have reviewed the raw data from observational studies of girls in nursery settings for evidence of genital anxieties. In this paper I limit my observations to a focus on the first three years. Ten girls were seen in my observational nursery (Olesker, 1984, 1990) and

eight girls in the Mahler observational nursery (McDevitt and Bergman, 1994[1]; Mahler, Pine, and Bergman, 1975). The data consisted of running accounts of the children's actual behavior in the nursery on a once-a-week, twice-a-week, and sometimes four-times-a-week basis; monthly summaries of these data; videotapes of behavior in the nursery (five to twenty minute segments gathered weekly); interviews with the mother in the nursery and at home; play interviews with the children at home and in the nursery gathered over the first three years of life; yearly psychological testing of some of the children; and periodic psychological testing of the parents. It appeared that female genital anxieties in children three years and younger are like the female genitals: difficult to see, diffuse, and only partially penetrable. I want to make clear that the data I used had not been categorized in any way (no preformed categories), thus providing as true a picture of children's free play in a playground setting as possible.

Feminine behaviors were in evidence before focused awareness of anatomical differences. Starting in the latter third of the first year of life and early in the second year, girls showed early pleasure in their genitals via touching, rubbing, pulling, sticking fingers into, and squeezing as part of general body exploration. Lasting for short moments and usually seen during bathing or diaper changes, these events produced no demonstrable anxiety in their protagonists and often arose in the context of early bodily and affective experiences with both parents. Between sixteen and seventeen months all the girls were coy, flirtatious, showed some interest in babies and dolls, carried themselves differently than boys, and loved to entice others into chasing them. Yet few labeled themselves as girls, were aware of anatomical differences in a focused way, or connected genitals with the concept and verbal label of boy or girl. Many were amused by and laughed at the penis

[1] I want to thank Drs. John McDevitt and Anni Bergman for generously sharing with me their rich observational data on eight girls and their enormously helpful comments on this paper. The original Separation-Individuation Study was under the direction of Drs. Margaret Mahler and John McDevitt and was supported by NIMH Grant MH08238.

without relating it to their own genital, a simple comparison without dynamic significance. By eighteen months a puzzled, confused look at one's own genital, as if searching for a penis, usually yielded no sign of disappointment, self-esteem remained high, and some girls showed new interest in babies.

From twenty-one to twenty-two months on, the girls evinced an increasing number of sexual behaviors such as looking at, showing, and touching their genitals. By twenty-two to twenty-three months the girls studied themselves in the mirror, suggesting that blooming self-awareness now included a sharpened awareness of their genitals as well. A number of girls made a beeline to the bathroom to watch boys urinate or grabbed at boys' penises yet defended against their new knowledge with denial: one claimed that she was growing a penis but it wasn't there yet; two others with unavailable mothers masturbated more often, one of whom inserted her fingers deeply into her vagina. The latter had the most conflicted relationship with mother and used genital stimulation when feeling deprived and angry, not to achieve good self-feeling or as exploration.

Anal issues began to dominate over genital ones. One girl showed off her potty chair. Another became more interested in splashing when in the bath with her brother than in touching his penis which she had done previously. There was a focus on bowel movements and toileting; constipation began to be more common and fear of the toilet began to surface, although only a few girls showed a shift in mood. The increased anal focus suggests the merging and intertwining of genital, anal, and urinary factors at this point in development.

In the period between eighteen and twenty-four months, while the growing awareness of their own genitals and the anatomical difference was one concern among many (including toileting, separation, sibling rivalry, rapprochement issues, and beginning oedipal rivalry), it was diffuse and less organized than the intense reactions seen during the third year in all but a few girls. The sense of genital damage, when it did arise, was ephemeral. One girl claimed her doll was hurt in the genital but showed no sad-

ness, jealousy, or shame. Another masturbated after grabbing her brother's penis but did not seem sad or angry. The fluctuating, somber, negativistic feelings usually seen during this phase and noted in these girls could be attributed to any or all of the challenges cited above.

As comparison with the boys burgeoned, between twenty-five and twenty-nine months, the girls' fleeting manifestations gave way to more focused genital sensations and concerns about hurt, and to more narcissistic defenses, such as masturbation, denial, regression, low-keyed behavior, clinging, and ambivalence toward mother. The feeling of being genitally damaged did not really crystallize in this sample until twenty-nine to thirty-three months, when the girls' reactions were often constriction, inhibition, and depression, reactions suggesting castration depressive affect. Coming through loud and clear were their concerns about lost, damaged, and missing body parts, concerns which appeared quite phase specific. For example, one girl asked mother where her penis was (age twenty-six months) and then explained to her mother it was in her stomach. Another girl wanted a penis for Christmas and was unhappy with her presents (age twenty-seven months). A third girl said, "fix me, I'm broken," and then applied vasoline, the family cure-all, to her genitals claiming she was fixing herself (age twenty-six months). A fourth girl, with a brother named Dan, put a magic marker between her legs and said, "I'm Dan." She told her mother, "Don't call what I have a vagina because you don't call Dan's that." At one point she grabbed Dan's nose and left five deep scratches (age twenty-eight months). Striking out at boys, wanting boys' things, and identifying with boys (i.e., standing to urinate) became commonplace. Hurts were blamed on mother. Thus, by thirty months clear statements emerged about wanting a penis, but no clear wish to be a boy. Rather, the girls wanted it all: a penis and whatever else boys had—bicycle, basketball sneakers, or baseball hat—in addition to being a girl.

By thirty-one months there was also increasing evidence of oedipal concerns, focused sexual desire interspersed with the con-

cern about hurt and fears of loss of control of excitement. One girl, making poisoned soup for a witch, vowed to marry Daddy; another called her father "my daddy" and invited him into bed with her, only to panic later when mother suggested she get into bed with him when she went out (this was followed by nightmares of being eaten by a tiger and fear of breaking apart like Humpty Dumpty). Another girl feared that a man would eat her up after she played that a friend's house was on fire and Daddy saved her; another feared a lion would come into her room at night, bite her, and tear her apart; and still another wanted to lock the doors to keep bad guys out. All the girls acted out anger at mother, and many identified with her by mothering dolls, cooking, cleaning, and shopping. Many became more girlish in appearance, manner, choice of toys and play activities. Those with a more ambivalent relationship with mother increased identification with father if he had been available and pleasurably involved with his daughter. At this point, female genital anxiety—the fear of penetration—was quite evident. The girls were also increasingly competitive with other girls.

One small subgroup of girls was the exception to the observed norm. Three girls articulated early female genital anxiety in the second year of life. These girls had constricted, understimulating, depressed mothers who avoided close, warm body contact, had strong bisexual conflicts, discouraged their daughters from exploring either their own or their mothers' bodies, and generally neglected them. This distance between mother and daughter may have allowed body anxiety, as well as other anxieties, more chance to proliferate and provided a bigger stimulus, if not better opportunity, for the girl to turn to and identify with father. These girls displayed not only some female genital anxiety, but also intense phallic wishes. Upset at the sight of her sister's genitals, one exclaimed, "See the faucet!" and put Playdoh over openings; another was afraid of the toilet opening; a third was uncomfortable with a toy that had no doors.

All three girls maintained strong masculine identifications throughout latency and in follow-up study showed some other

unusual features in common. A sense of separateness was an early and continuous problem. Two girls latched onto babies, not through an active maternal, caretaking identification, but more in an attempt to identify with and be the baby. Each girl, often unable to assert her own individuality, made an intense attachment to a peer who was followed and mirrored. Genital anxiety continued to be of concern. One told the following story: "Someone broke into a room and may jump out and shoot a lady. A guy is going to hurt a woman and she is scared." Most striking was their tendency to develop masochistic solutions by putting themselves in the service of another and a readiness to eroticize aggression. Such a finding is in keeping with Ritvo's view (in Panel, 1989) that aggression toward mother may compromise that object relation and imbue the girl's sexuality with sadomasochistic features (p. 801).

The observational data show that at first girls found pleasure in the female genitals; when genital anxiety first showed itself, there seemed to be little dynamic significance beyond the results of making a simple comparison. Later the girls seemed to feel that something was wrong because they did not have what boys had. Still later, as oedipal issues emerged early in the third year, genital anxiety included the danger of penetration and hurt. The girls' advanced cognitive development and social understanding, in addition to the more sharply focused genital sensations reflected in their behavior and fantasy productions, contributed to the new level of anxiety. They feared not only being torn apart but also passively giving in (falling down a hole, into a well, through a trap door). Anxiety about pregnancy and/or childbirth was notably absent although wishes for a baby were present. Access difficulties did not appear as anxiety but as a difficult developmental task for the girls to master—to mentally represent their genitals as a potential inside space—and not a danger situation; nor did diffuseness appear as a differentiable anxiety at this early age (though it did appear more clearly during latency).

It seems likely that specifically female genital anxieties are developing in the context of burgeoning oedipal conflicts, leading to

the formation of fantasies of genital damage via penetration, and that such fears generally do not arise in an articulated way in the earlier, preoedipal phases. This does not mean that a girl has not developed earlier some sense of herself as female and a sense of her genitals, including a sense of inner space. But such achievements in no way protect her from the conflictual feelings and fantasies aroused by awareness of anatomical difference and its meaning in the context of her family relationships, her sexually exciting and aggressively tinged wishes, her superego prohibitions, her increased cognitive capacities, and her need to ward off danger to her own desiring body with its limitations and vulnerabilities. Thus, by the third year, a girl's lack of a vaginal sphincter that can be opened and closed at will, physical smallness in comparison to a big man, sadomasochistic fantasies tied to aggression from different developmental levels and events, and her castrating wishes and fears of retaliation have all made their relative contributions to the appearance of female genital—or penetration—anxieties.

CLINICAL DATA

My adult analytic cases yielded two patients who provide ample evidence for female genital anxiety, always linked to, intermingled with, at times subordinate or superordinate to themes of oedipal guilt, bisexual conflicts, and castration anxiety/depressive affect. The female genital anxieties I distinguish here are fears of access, diffuseness, and penetration. An understanding of these anxieties was essential to the successful outcomes of both analyses.

Case 1

Kim was a seventeen-year-old college freshman when she sought treatment for anxiety, insomnia, and inability to study. Soon after beginning analysis she developed the idea that she had been a

lesbian from early on. Her fifteen-year-old brother, her only sibling, had died of a rare blood disease after an illness of less than a year. Father was a successful lawyer, preoccupied with his work and son. Mother was described as "spacy," in her own world. When Kim was fifteen, father had an affair with her mother's best friend, leading to the breakup of the marriage.

One manifestation of access difficulties was Kim's wish to be a porn star, analysis of which yielded her idea that this would give her a chance to view her genitals. Another function and determinant of her fantasies was her wish to deny her sense of genital damage (castration depressive affect). In a dream she was repelled by a woman who lost her tongue. A memory followed of her joining with a group of girls at summer camp to encourage a retarded girl to masturbate in front of them; she remembered feeling queasy afterward. She recalled her mother telling her that masturbation was disgusting and that only boys masturbate; she now wished for someone to celebrate her body, not tell her it was disgusting. She saw pornography as a celebration of sexuality. In addition to wanting to see her genitals, she wanted to undo her sense of revulsion about them—the intermingling of castration depressive affect and female genital anxiety. In fact, she grew intolerant of her lover, Sue, who expressed feelings of inadequacy about her own body.

Kim wrote a thesis on prostitutes' rights, using her interviews with prostitutes as a way to learn about sex and femininity. This was also reflective of issues about access. Her turning to women as lovers served multiple functions in that she chose lovers with boyfriends in order to learn about intercourse; she thought her relationship with a woman who did not have a boyfriend was a "dead end." She felt guilty about taking on a woman's ways because it meant that she was taking the woman's man and that she had to become a lover to the woman in order to pay her back for her teaching. Here her conflicts over oedipal wishes seemed more central than the wish to have more access to knowledge about her female genitals although both were clearly present.

Kim's use of anal displacement in her attitude toward men in

general, and her father in particular, reflected diffuseness and fear of loss of control. She turned away from men in fear of her own passion. When her father came to New York to visit, she made him disgusting via excretory images: father sitting on the toilet for hours and making a big smell, the protagonist in the movie *The Color Purple* feeling used like a toilet in sex with her husband, a girl who urinated during sexual excitement. She grew frightened of losing bodily control in her sessions, recalling for the first time that whenever the family traveled together, she shared a bed with father. In fact, she so feared her passion for men that she wanted to practice with women first. Fear of loss of control mixed with oedipal guilt was also seen in a rape enactment with her female lover, in which at first Kim played the victim but later vented her sadistic wishes, realizing she could control her own cruelty toward the woman. After this single episode of sadomasochistic fantasy play with Sue, Kim seemed to feel both safe and bold enough to think about men, and a dream about being father's prostitute followed. The commingling of fears of loss of control, in this case of eroticized aggression, with intense oedipal guilt was striking.

Penetration fears were expressed in her fantasy of a ménage-à-trois with Sue and a man, imagining that Sue would hold her hand during sex. In contrast to Sue, mother cut off anyone who had anything to do with father and announced to a new boyfriend that Kim was gay; Kim took this to mean that mother wanted her to be gay for fear that Kim would steal her man were she not gay. While penetration anxiety may have been one factor determining the ménage-à-trois fantasy, for Kim the meaning was that the woman, by holding her hand, was giving permission for sex with a man. Kim turned to women to avoid her fears of genital damage via childbirth as well as to quell her fears of punishment for oedipal wishes. After a series of interpretations regarding her guilt over feeling that father preferred her to mother (leading to her inhibition in order to appease mother and me), Kim allowed herself to masturbate for the first time with excitement and the thought that "there *is* room for a penis in here." That night she had a dream of having intercourse with a man. In these clinical ex-

amples, we see again the intertwining of female genital anxiety and oedipal guilt.

Adding to Kim's fear of penetration was the role played by her castrating wishes toward men and her fear of retaliation in kind. Kim's fear of her castrating and murderous wishes (her core unconscious fantasy of revenge on her brother and father) emerged graphically via an important dream: "I was with daddy on a trip. I made a toast, 'I love you daddy,' and I hugged his fat belly. My brother was in the water with his clothes on. My tongue fell off. It was alive and shaking, like epilepsy. I tried to reunite or swallow it. I would either die or be o.k." Then, "I was at a hot dog stand about to eat." And, finally, "I was at a mansion. Men with guns and dogs were coming toward me. I was afraid the dogs would mistake me for their prey." She associated to dogs mauling her and chewing her up.

Kim had taken her brother's death as proof that her castrating wishes could really kill, so she was frightened to be near a man. A transference fantasy of me with a male mind, logical, coherent, and able to think in a linear way, and her resulting envy and rage, led her to realize that she could not be with a man because it was too enraging; she felt too jealous. Because she feared her sadistic wishes toward men, she felt she could not be passive with them. Kim's aggressive fantasies were inextricably interwoven with her female genital anxieties.

Case 2

Pat, a married, forty-year-old mother of three latency-age children, presented with frigidity and work inhibition. An archaeology professor, she was unable to apply for tenure. She also felt inhibited in her personal relationships. Both of her parents were frustrated in their business careers, and Pat was left on her own much of the day. Mother, polite and proper, never discussed sex with her, and as early as she could remember, she feared that mother might bring sex into the conversation. She hid her menses

from mother and believed mother did not menstruate. Others could be crudely sexual but not her family or her.

In her anxiety over access, Pat's fear of mother talking about sex covered her intense wish to be educated and guided by a woman. She envied friends who were punished by their mothers for wearing makeup or staying out too late because at least their mothers were engaged with them and acknowledged sexual matters even if only by prohibition. She felt all women knew more about feminine things than she did, and she enjoyed harem fantasies in which the women dressed up, reflected off each other, enjoyed their own company, and shared feminine ways, a fantasy of denial of competition. When she thought we would both be at the same party, she had a dream in which she married me. Rather than win the men and show me up, she should remain attached to me.

As the analysis proceeded, the full intensity of Pat's oedipal longings and guilt came to the fore. Fear of talking to her mother about sex masked the fear that mother would know that Pat knew about sex and would also know about Pat's sexual desire for father. The focus on being seen and exhibiting herself, as well as the defenses against such wishes, seemed linked to an unconscious fantasy of father watching her masturbate—an invitation to father that would provoke mother to fury and desertion. The contributory anxiety over not being able to see her own genitals because of her anatomy seemed less important. Her worry that she had to obey if I asked her to take off her clothes and her view toward father, husband, and me as rapists helped her disown responsibility for her sexual feelings: she was just forced.

Pat's major resistance pattern was the use of masochism. Ecstasy in suffering disguised her awareness of her sexuality. When she fantasized that she was just a fat immigrant mother, I offered the interpretation that the judging part of her was so strong that she had to turn anything exciting or pleasurable into something depressing and painful. Later she had pleasurable sex with her husband with excited arousal for the first time. Her solution to her own voracious needs was that femininity was off limits; she had to remain neuter. The idea that no one would want her and all kinds

of things were wrong with her body—fat, misshapen nipples, too old for sex—helped her avoid her wish to take my men and my rageful retaliation. Here her oedipal conflicts and defenses against oedipal wishes appeared more central than female genital anxiety over access.

Issues of diffuseness, manifested in fear of loss of control, were powerful in Pat. One of her conscious fears about sex with her husband was of getting dirty: she wanted no openings and no wetness; she would rather do to him so that she was in control. She never felt in control of her body. As a young child she suffered from constipation, and mother administered frequent enemas, which no sphincter could withstand. So strong was her reaction that she could not say the word "bottom" for many years. The closer she came to acknowledging her excitement with me, first in relation to mother but later in relation to father (whom she imagined as a seething cauldron waiting to be ignited by her), the more intensely she retreated to her masochistic position. She grew vague, unable to put her feelings into words unless I did so first; thus, she used language defensively to lull, confuse, obscure, and deaden—diffuseness as defense.

Penetration fears could be seen in Pat's wish for a totally smooth body with nothing in it, a person with no openings that could be entered and hurt. A number of experiences contributed to her unconscious fantasy—the fear that penetration leads to a hole from which one's insides will ooze out. These experiences included her fantasy that her clitoris had been damaged by masturbation; the enemas that took feces away; a hernia endured from ages twelve to seventeen but never complained of; and fantasies of a violently passionate man who could puncture her. Her sexual wishes were fused with aggression, not only because of the enemas but because of her anger at both parents for their neglect. Beneath her idealization of father was her sense of a neglecting and rejecting father. She turned her husband into a dirty old man who was not really interested in her. She got revenge on him by lying there but certainly not feeling anything. Her disembodied experience with her husband was also a recapitulation of being alone

and neglected when young. She could do it all for herself now. Her rage at her husband for his moods protected her from her rage at father for wrecking all their lives with his severe obsessions. She had maintained the denial by saying there was nothing with her husband now, unable to let herself know her trauma of past neglect. She had convinced herself she liked being alone. Rage from different developmental levels had made the thought of intercourse and penetration a very frightening, dangerous proposition. Again, female genital anxieties were intertwined with aggressive and sexual fantasies.

DISCUSSION

The line of gender development with its attendant anxieties starts with its preoedipal roots: the subjective experience of anatomy and its pleasures and fears, early identifications with mother (and later some with father), the personality of the parents, the constitution of the child, and the developmental process itself, which gives rise to phase-specific conflicts to be mastered. As the girl grows, awareness of anatomical differences is just one of the several challenges she must face, leading to a range of compromise formations to deal with the knowledge of inherent limits and the immutability of the body. The fact that a girl develops a sense of her body as intact and anatomically female in no way protects her from conflict and fantasy as she struggles to understand what meaning to give the genital difference. Through play, new organizations of fantasy occur. In adulthood the fantasies of early childhood are reorganized in the light of later experience and cognitive development (Dahl, 1993, 1995). Gender is a psychic experience, a set of fantasies, and attitudes rooted in the body and in the archaic matrix of bisexuality; it is constituted from identifications with both parents and shaped by multiple forces, each making its contribution to the form of conflicts and anxieties.

The data presented suggest that the concept of female genital anxieties may prove useful in understanding the complex conflicts with which women struggle. However, such a concept replaces

neither castration anxiety nor castration depressive affect, as is evident in both developmental data and in the lives of adult women. The developmental data show that castration anxiety and castration depressive affect are seen more often in earliest development than female genital anxiety. The latter manifests itself at the same time as burgeoning oedipal conflicts, in part because the young girl does not have a differentiated enough view of her genitals to create focused fantasies until this time.

The adult clinical data show that female genital anxieties, manifest in attempts to master issues of access, diffuseness, and penetration, made their appearance along with oedipal conflicts, bisexual conflicts, and castration depressive affect, with one or the other conflict dominant. Kim and Pat entertained a number of fears and fantasies not only about their female bodies in comparison with other women but about lost, damaged, or missing parts of their bodies and feeling repulsed by or inadequate in comparison to men. Redressing the problem of a phallocentric view with a vaginocentric form of reductionism, or replacing castration anxiety and castration depressive affect with female genital anxiety, does not fit the facts. A separate line for female genital anxiety seems unnecessary; in normal development it emerges slightly later than castration anxiety.

One might even question whether female genital anxieties are specific to the female. In a recent paper Fogel (1994) argues for primary femininity in men. A careful analysis of the developmental data on boys and male analytic patients seems warranted to explore the issue further. This makes perfect sense when we consider that the human mind is capable of any and all possibilities, that these fantasies are organized in the unconscious in complex ways, and that the bedrock of most unconscious fantasies is bisexuality.

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Is Psychoanalysis an Experimental Procedure or a Reflection of Subjective Life?

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IS PSYCHOANALYSIS AN EXPERIMENTAL PROCEDURE OR A REFLECTION OF SUBJECTIVE LIFE?

BY LESTON HAVENS, M.D.

Psychoanalysis fits comfortably into the model of neither an experimental procedure nor a subjective experiencing. Yet it elicits both the deep-running skepticism of science and the passions of everyday life. A structure for incorporating both is suggested.

I have previously suggested that analytic theory generates a concept of authentic selfhood or true self (Havens, 1986a) and that a judgment of such truth functions is necessary for deciding what are transference distortions (Havens, 1993). Today we observe a profound schism within the analytic tradition between those faithful to its original goal of searching for objective truth and those seeking either a frankly empathic or a narrative stance. The present remarks can be read as a brief for both a continuing skepticism toward all symbolic forms and a search for standards of psychological reality that transcend accurate empathy or coherent storytelling. I will argue that the attempt to be objective about the subjective, which is the goal of psychological inquiry, depends upon enlarging our grasp of the nature of language, in keeping with present-day linguistic analysis and the understanding of symbolic forms. More specifically, linguistic analysis yields the concept of performative speech acts that provide a means for shaping discourse toward objective ends; performative speech acts are those ways of talking that determine, simply by being said, states of persons or relationships, as opposed to statements of how things are or seem. The structure of the argument can be seen as reordering the familiar concepts of therapeutic alliance and parameters to the same objective ends.

From the standpoint of responding to modern critics of analytic method, I will be extending McLaughlin's (1991) concept of positive enactments and answering Renik's (1993) challenge to face the pervasive fact of analytic subjectivity. I will also respond to Grünbaum (1984). Emphasis will be shifted from identifying patients' pathology toward making a workable relationship, because only in such a relationship can determinations about pathology be made. Negative enactments are inevitable; what is needed are the positive acts by which workable relationships are established. The concept of performative speech that is relationship-making provides the structure for this achievement.

The study of language has exposed a dual role for most statements, one asserting how things seem, called constantive or assertoric and including interpretations, and a second establishing states of affairs, particularly the relationship between speaker, utterance, and hearer (Austin, 1962), termed performative. Perhaps the most familiar of the latter are the marriage ceremony's "I pronounce you man and wife," the umpire's "safe" or "out," and the doctor's "sick" or "well"; each produces a decisive resymbolization of the persons to whom they are addressed. These are "performative" because once said, the deed is done, words as deeds. The earliest performative statement encountered by almost everyone is being named. (Changing one's name takes another official act.) Henceforth, this is who I am. It has been impressively argued that human mentation is most distinguished by this naming capacity, humans constructing between themselves and things a symbolic world (Cassirer, 1944). Magritte said it succinctly: under a picture of a pipe he wrote, "This is not a pipe." The symbolic world becomes dramatically performative when it emerges as myth, magic, and religion: we are told what the world is and how it works. Even science, which insists that naming is hypothetical and must be tested, never escapes symbolic forms: it only substitutes better tested ones (Popper, 1963). We are again left with a picture of the world. In Cassirer's (1946) words, "All symbolism harbors the curse of mediacy; it is bound to obscure what it seeks to reveal" (p. 7).

Thus, at root, transference and countertransference are not "distortions of reality" (however much they may need correction) but the only way we have of approaching reality. There is no steady, neutral, correct position in which we can take refuge. Not even the most austere science offers that. What we represent to one another, what our perspectives "bring home" to each about the other is a product of our symbolic worlds. Moreover, it is performative of our attitudes and actions toward one another, that is, a statement of one person's perspective immediately establishes a particular relationship to any other perspective. While acknowledging this subjectivity, how do we transcend it?

Many choose to exploit rather than transcend particular symbolisms. Frank and Frank (1991) concluded that all forms of psychotherapy depend upon persuasion and suggestion. The favored rituals and rationales in the setting of a relationship with an understanding and enthusiastic healer restore morale, perhaps most effectively by arousing expectations and guiding patients through experiences of success. Note in this formulation that symbols as rituals and rationales are put directly into the service of healing; they are meant to be believed in. Grünbaum (1984) has given the same description of psychoanalysis. This is the most forthright enemy of the viewpoint put forth here, which, like science itself, proposes to take a reflective, skeptical attitude toward all symbols.

Since our neural apparatus is such that we cannot escape symbolizing—so central to thinking, language, and the organization of feeling life—the need is to acknowledge that dependence, both its usefulness and its dangers. Language, however, has great difficulty achieving this perspective, being heavily freighted with whatever the prevailing views contend (see the jargon of psychoanalysis). In contrast, art forms and mathematics have the potential to be freer, ready to be pressed into the service of whatever visions command the artist or the scientist.

The psychologist and analyst, for the most part using language, are immediately captured by accepted forms. Freud and Rorschach both tried to free language from these fetters. Freud did it

by noting the way speech itself escapes the forms (which he called secondary process), for example by "slips," and then by encouraging that freedom through providing time and imaginary space for its expansion. Rorschach approached the task by using stimuli to prompt imagery and primitive concepts relatively unconstrained by language. In time Freud and Rorschach each accumulated his own baggage of conventions undercutting the actual work, though not the vision. McLaughlin (1993) has also highlighted these two sides of Freud, the liberator and the system-builder.

How do we free ourselves enough from language so that it does not do our thinking for us, which is also to ask, How do we control its performative functions? This is necessary for any analysis or psychotherapy that does not propose to be a form of indoctrination. It is the same problem the patient faces. The two most prestigious accounts of behavior, the instinctive and reflexive, are not here replaced but taken up into the symbolic and performative. What we may instinctively seek, impelled by sexual and aggressive "drives," is formed by the learned meanings, perhaps most dramatically of sexual objects which become fetishistic objects, thereby endowed with performative power. Fetishistic objects immediately establish a relationship of power over anyone for whom they are fetishes. The symbol in one's mind endows the object with its excitement: what would be an object of indifference to one person is immediately created as an object of desire for another. What one person *sees* in the object is the meaning of his or her desire, and here meaning means both what calls up desire and what stands ready in mind to be called up: subject and object united (Mann, 1994). And this is not exceptional but the regular order of things, as is apparent when we move from sexual feelings to other feelings—for example, distaste, dread, or indifference.

So how do the two parties, both in the grip of their respective symbol systems, communicate at all? The answer is by shared conventional meanings that make possible the *appearance* of a therapeutic alliance, just as in ordinary life greetings and thank-you's provide the appearance of meeting. On the other hand, how

would a real therapeutic alliance come into being and how would it be recognized? And how would such an alliance free patient and analyst from the fetters of their languages?

Performative functions affect analysis whether or not we self-consciously recognize them. For example, explanations often have untoward performative results, as when a patient feels objectified or patronized or, as Schafer (1976) demonstrated, when analytic language describes objective, controlling forces that undercut the patient's capacity for responsibility. Applied systematically, however, performatives *stage* the interpretive, that is, set up conditions for exploring and coming to terms with, integrating, sometimes harmonizing whatever psychological elements, including what seems real, are to be "understood." I put understood in quotation marks because it is often ambiguous, meaning at once an intellectual grasp or explanation and an agreement or acceptance.

Such a staging function immediately links performatives with the more familiar "therapeutic alliance." The latter is brought into being by measures owing relatively little to explanations; it comes about instead through attitudes, a climate of acceptance, or simple friendliness. For this reason alliance-building is seen as a "parameter," standing at least a little apart from the interpretive work itself. It is also true that whether I signal my benign concern by a smile or even an accurate interpretation, I am using suggestion, the most suspect of our methods. The relationship between performatives and suggestion must therefore be a crucial concern.

The performative basis of alliance is evident even in an effective neutrality, almost everywhere acknowledged as central to analytic work. An effective neutrality must feel to the patient not only evenhanded but must somehow seem to acknowledge the whole background of beliefs the patient brings to the work. It is not enough to be cool or aloof, since these are often experienced as hostility toward the patient's person, so that what was intended to be a neutrality between psychological elements has a very different overall effect. The creation of both a therapeutic alliance *and* a neutrality between psychological elements requires performative precision simply because friendly or accepting messages may be

pressed into the service of one side or another of a conflict and not be felt toward the patient as a whole, especially if that particular person is consumed by the conflict (for example, in psychoses or near psychotic states).

As in constructing all performatives, it is best to reason back from the effect to be achieved. That is, one goes from deed back to the requisite words or attitudes. For example, to marry someone, if one is so authorized, requires some version of "I pronounce you man and wife." Or if one wishes to create the state of being believed in, one can say "I believe in you." Both these examples belie their simplicity, however, for much besides the utterances is required to achieve the effects sought. Indeed, the utterances *cap* what is in the first case a ceremony of more or less willing celebrants and, in the second, a series of acts in a relationship of significance that makes the utterance itself believable. Nevertheless, these examples should inform us: "more or less willing celebrants" has some features in common with patient and therapist; "a relationship of significance" gets still closer.

The deed an effective neutrality names is the production of a particular state of mind in the patient. It has links to being believed in because experiencing a therapist as evenhanded toward one's psychological parts implies the therapist is also experienced as accepting of one's personhood or at least approaching a sympathetic attitude. What is performative precision here? Marrying requires a penumbra of attitudes, agreements, events that strain even as broad a term as relationship. On the other hand, relationship may imply too much, as in a marriage of convenience or to secure citizenship; then marrying is just marrying. Or consider the umpire's "safe" or "out." This is immediate and decisive. The requisite context is a game of accepted rules, players, and the status of umpire. Note that the umpire is expected to be neutral between one side and the other. However, he or she is not expected to be neutral about the rules or respect for his or her own person or that of the players. We note that "out" can also mean out of the contest! The umpire's call is a guardianship of the game.

We have rules in analysis and psychotherapy. The calls are sel-

dom as decisive as the umpire's but they share other features. We try to practice an evenhandedness toward many of the psychological elements coming into view and a guardianship of the game—we want to keep it going, as the umpire does. Would that we had such a clear means of starting as the umpire's "Play ball!" Therapeutic work begins almost silently, the patient entering an office, sitting or lying down, with only the most perfunctory greetings. Here is the first "call," we might say, this allowing to enter. Sometimes, it is claimed, patient and therapist should indeed "play," following Winnicott (1971). Such an invitation may be made explicitly or by a variant of the more traditional "say whatever comes to mind," the play variant being an effort to bring elements of open mutuality to what may seem an authoritarian command. Play seems to others an inappropriate term for a painful and expensive procedure, which had earlier generated surgical analogies. Midway between is the "piece of work" so often prescribed today, an effort to put the task within manageable limits.

I suggest that whatever the mood (and requisite performative clauses) with which treatment is begun, the sense of an emerging alliance accompanies exposure of what we can call the psychologically real. It is true that a complaint (of possible pathology) may be the first basis of treatment or, better, a joining of therapist and patient around a matter of concern, but this is hardly an alliance, though it may signal a compliance (Gutheil and Havens, 1979), because alliance implies a partnership, an agreement between at least two parties whose earnestness and good faith have somehow been pledged. This is what I meant by exposure of the psychologically real: both parties must feel the other "really means it," is not faking or pretending. Now we move outside the pathological, perhaps toward Sterba's rational ego (Gutheil and Havens, 1979) or a genuineness of feeling, even "true self." Therapist and patient do not utter that familiar performative, "I pledge thee my troth," where troth means both fidelity and truth; again, clinical relationships are established more silently than in either marriage or games. Yet they seem to rest on similar acknowledgments.

One sign that alliances may remain at least incomplete is the

frequent complaint that treatment cannot work because it is not real life; what happens is somehow artificial, a pretend acceptance. The complaint has many forms, for example, that therapists cannot tell patients what they really feel about them, or that therapists' acceptance or respect is a ploy, a technique, restricted to the limited, structured "hour." The difficulty can be doubled when the patients' feelings, too, are seen as unreal in the sense of transferential, belonging elsewhere. What is lost may be compensated for by a scientific, experimental, objective setting that does stand apart from real life: we suspend personal history so that an experiment can be run. The problem is, can treatment be part of an experiment, or does it need to be part of the patient's ongoing history?

What I have seen of the results of treatment as experiment may be described in this way: such patients do change when they take the procedure seriously. Taking it seriously means entering into it and having the procedure enter into them, with the result a change of personality toward the objective and experimental; they become more detached. This can be useful for some people and not so useful for others. What I am implying is that this performative result is a most important one and should guide the wisdom of its application. If we structure treatment as a transferential experiment, it is a different "game" than if we do not, and it has its own effects. If we move the emphasis, however, away from experiments in misconstruing, which may also be dealt with but not so exclusively, how do we meet the objection that treatment by definition cannot be part of real life?

Take the issue of therapists' acceptance of patients and the patients' complaint this is only a "pretend" acceptance. The complaint is important, I contend, because the acceptance may need to be real, for a number of reasons. When pretending, there is little basis for judging what is transference, since the object of transference is itself artificial. Acceptance becomes confusing, in that it is a pose or fixed symbol removed from being safely reflected on; the ground of being together shifts or even vanishes, which is represented by the concrete experience: I cannot put my

foot safely here because I do not know where the other is. And in what sense is a professional relationship a real one if pretending is itself professionalized?

I have argued elsewhere (Havens, 1993) that recognition of the real is necessary because we cannot judge what is transference without a conviction of the real. In what sense can I know I am not your mother unless I know who I really am? It is not enough to say we are all different, because we are all in many respects alike. I am now referring to something beyond our enactments of patients' fantasies or the many contagions of affect smudging any clear boundary between us. It was no foolishness that led the early Greeks to compare the psyche to a butterfly, so elusive is the personal real. While that elusiveness makes recognition difficult, it remains no less necessary.

A pretend acceptance is "countertransferential" in the sense that therapists may be refusing to acknowledge their feelings and diminishing themselves as well as the actual persons they are treating. Therapists are rendered unreal, like patients seen only in transference. I believe I am here stating something obvious, but its implications may be difficult to hear. A fantasy is not simply a fantasy if it corresponds closely to what is happening. Therefore, a context in which what is happening is obscured also obscures what is fantasy. This produces the slippage of ground I alluded to. Therapists' pretending has another result. If one of the goals of therapy is discovering not only the real context of one's life but one's inner reality, perhaps being with a pretender has effects on this second purpose, because it may be that one's personal reality is only discoverable in a felt engagement.

How do the professional and the real stand in relationship to one another? First, the professional is not seen as unreal unless one is an impostor, that is, if it is not one's real vocational role. Second, the professional puts restrictions on personal behavior; these may conflict with what one really feels, loves, hates, whatever. Such may be true of any role we have in relation to one another—friend, spouse, or parent. However, the conflict is particularly intense in those roles that place individuals, as analysis

and family life do, in prolonged and intense contact with one another.

As long as therapy and analysis are seen largely in transferential terms, that is, as eliciting and correcting personal distortions, the conflict is not so intense. If, however, the other side of transference is emphasized, that is, the real upon which the recognition of transference depends, the possibility of conflict increases for the reasons under discussion. Again, it is necessary to say that the familiar analytic purpose of providing a clean slate on which objective reality can be sought encounters the problem of deciding how we know when that reality has been found. Even physical science has difficulty with this problem and in many minds has retreated to an essentially negative position: we can only know when it has *not* been found (Popper, 1963). This makes science interminable, as it does analysis, and such may be the intellectually correct result. But practice, unlike the general scientific enterprise, has more abrupt limits. Is there a reasonable way to work within them? I believe this was not so large a problem for Freud because the judgment of objective reality still stood on earlier grounds, not having been transformed by modern thought, especially thoughts about language (for example, Cassirer, 1944, 1946).

Friedman (1997) has reminded us that analytic method depends on something akin to a seduction, an implicit invitation, accompanied by a stance of patient listening to feelings of the greatest power and their attraction into the treatment. It seems comparable to the modern surgeon's taking the patient's physical heart quite literally into his hands, for the identical purpose of repair. But the result must sometimes be: what is intended to be a *therapeutic* procedure and alliance seems much more and, if not much more, a deception. How is a real therapeutic alliance developed and preserved under these circumstances?

Great passions are also aroused on the ball field and in the courtroom. Yet in both these cases the performative structure has a ceremonial force as well as presiding, empowered figures, umpires and judges, standing apart from the actual contests. In contrast, analysts are themselves the target of the feelings aroused;

they are very much part of the game. What is performative empowerment then?

I am suggesting that analysis and psychotherapy need a structure-generating objectivity, in the face of language use that is inevitably coercive. Such a structure makes at least two demands. First is the familiar scientific practice, to doubt ideas, to treat them as hypothetical—in the analytic instance, acknowledgment of our subjectivity, as represented in the work of Hoffman (1992), Renik (1993), and McLaughlin (1991). A passion for both the possibility and the difficulty of establishing any hypothetical outcome is what unites the search for the real with a deep-running skepticism.

Second is performative means within clinical exchanges that point to objectivity and without presiding umpires or judges. Perhaps surprisingly, the very absence of the latter provides the performative structure, because the involvement of the analyst in the clinical encounter is the most convincing evidence of his or her eventual objectivity; the analyst does not pretend to be aloof. The best possibility of an objective result can emerge only in the fullest exchange, for the analyst is part of the experiment. This is what Habermas (1990, 1992) took from Freud in his construction of an ethical discourse: *the analyst is willing to submit his or her contributions to the judgment of the patient.* The evidence that the actual exchanges function as deeds producing that willingness is the patient's feeling entitled to judge those contributions. The result is that judging is *distributed* in the clinical exchange; the patient is an equal judge.

Any distribution of judging depends upon some approach to equalization of authority in the relationship. The distribution cannot be *ordered,* as free associations have been traditionally commanded in the fundamental rule; to embed a call for freedom in an imperative we can term a performative contradiction. The analyst's language or medium needs to embody the message of equality, for example, by hypothetical constructions ("perhaps what happens is this," or "is this what happens?") as opposed to declarative ones ("it is so" or "it seems so"). Even a hypothetical or questioning language, however, presumes a context of shared

meanings and beliefs by which patients grasp the hypothesis. Lacan argued that something more fundamental must be reached—in Dews's language (1995, p. 275), "the relation of the subject to any symbolic repertoire in general"—as part of the transient nature of subjective existence itself, what I called the butterfly quality of the psyche. Elsewhere (Havens, 1997) I have suggested that the self has not so much a *factual* as an *actual* existence, one dependent on repeated and changing (however slightly) acts of self-assertion and discovery, in frequent danger from suborning relationships. Thus, psychological existence is not so much a settled fact as a series of capturings and recapturings of who we are. For both patients and analysts this appearing and vanishing aspect of psychological reality needs to be acknowledged, as by a modest and sincere tentativeness through which statements about one another are made, however often the tentativeness is lost in moments of strong feeling.

The most obvious conditions coloring free exchange, however, are not these deep-running limitations on the certainty and stability of psychological formulations. The most obvious difficulties are with patients who feel disempowered and, the opposite instance, others only too certain of their perspectives. I have elaborated performative means for balancing such relationships (Haven, 1986b). To illustrate disempowerment: a young woman had seldom felt capable of expressing or even discovering her own point of view. The history of her self-expressive efforts was peppered by what she experienced as demoralizing rejoinders that she increasingly reinforced by covert and sometimes overt agreement. Uncovering these sequences actually added to the self-abnegation; she was now guilty of a fresh failure, to defend herself. Only statements validating her point of view and right to speak gradually liberated both her self-expression and her search for what she felt.

The opposite instance, of countering fixed perspectives, often with paranoid coloring, requires performative statements affirming and enlarging on the fixed perspectives so the patients can feel understood at the same moment they hear what they are implying.

This is an instance of mirroring that I termed counterprojective (Havens, 1986b). Only when, in each of these contrasting instances, the parties gained access to an equality of perspective was it possible to examine historical data in a truly free exchange.

Here, too, is a solution to the problem of how the professional and the real relate. While therapeutic alliances depend on our "really meaning it," the conditions of truth-seeking also depend on professionals' "really meaning it," that is, being willing to submit their contributions to the fullest discussion. For this, there is a special reward: what may feel like the surrender of a necessary authority is, in fact, a transfer of that authority to the process of discussion itself and, by extension, to the fullest possible investigation of the problem. So it is that the authority of science lies not in the scientists themselves but in the processes of science and the community of scientists.

And what protects each party from the coercions of their respective symbol systems, for example, what protects analysands from the coercive properties Grünbaum (1984) identified in psychoanalysis, the covert suggestions? The short answer is performation of the conditions of free exchange. The detailed answer again calls on the comparison with science. In the engagement of the scientific experimenter with the material under investigation there can be no assurance the experiment was in fact objectively carried through. It is only through the community of scientists repeating the experiment and devising further ones that something approaching consensual validation is achieved. It is in the community of analysts exchanging their experiences that consensual validation is also approached, as it is within the treatment itself, patient and analyst contributing their parts to an experiment in the understanding of which the power of judgment is distributed between them both.

The purpose of the present remarks is to restore to psychoanalysis its early passion and love of truth against the force of settled convictions or their substitution by empathy or storytelling. To this end the power of performative functions is added to interpretive ones and the relation between passion and skepticism explored.

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DELUSIONS OF EVERYDAY LIFE. By Leonard Shengold, M.D. New Haven/London: Yale University Press, 1995. 221 pp.

In a recent series of books, *Soul Murder* (1989), *The Boy Will Come to Nothing* (1993), *"Father, Don't You See I'm Burning?"* (1991), and *Halo in the Sky* (1992), Leonard Shengold has offered the psychoanalytic reader a stimulating re-examination of what we have otherwise considered severe pathology and how it can be understood and mastered through psychoanalytic treatment. The current volume continues that exploration, bringing delusions into focus. The title, of course, is an imitation of Freud's volume, *The Psychopathology of Everyday Life.* The author's purpose is similar: to show that the distinction between severe pathology and "normal neurosis" is not great. This trend in psychoanalytic writing corresponds with both the widening scope of psychoanalytic treatment and an attempt to integrate ideas of American ego psychologists with those of Kohutians and Kleinians, particularly on the vicissitudes of aggression. The clarity of ideas in this work is furthered by the author's capacity to relate numerous clinical examples from his practice, as well as many literary examples.

The theme that is repeatedly focused upon is the ubiquity of primitive mental processes. The primal symptoms in these mental processes are delusions; primal defenses include denial, and primal impulses include cannibalistic, murderous, and polymorphous perverse impulses. The author anticipates the complaint of the reader who wants a clearer distinction between delusion and more neurotic phenomena. He tries to address this by referring to such alternate terms as quasi-delusion or fixed convictions. He prefers to stay with "delusion" because it encompasses the strength and persistence of certain primal ideas—such as the tie to the primal parents who are indispensable in our lives—which lead to resistance to change and differentiation in development and in treatment.

The chapters cover delusions in neurotic and narcissistic individuals, delusions defending against malignant envy, and paranoid delusions. Additional chapters are titled "Delusions and Perversions in Love" and "Owning and Warded Off Truths." In a literary vein, there is a chapter devoted to the Victorian novelist, Samuel Butler,

and the delusions seen in his life and writings, which served to ward off malignant envy. In this chapter, the reader feels Shengold's enthusiasm for his literary interests, which makes for exciting reading. There are two brief appendices: one on the purpose of symbolism to defend against primitive processes, and the other a critical review of Randall Jarrell's *Pictures from an Institution* to show how the presentation of eccentricity awakens in the reader delusions that he or she shares in identifying with the characters described.

In "Delusion in a Neurotic Person," through an extended vignette, we can see how a neurotic can disconnect delusional ideas from consciousness. These ideas cluster around the denial of death, loss, and perfection. Shengold spends a great deal of time elaborating these ideas in subsequent chapters. Both conscious and unconscious delusions become difficult resistances to analyze. The author deplores calling this kind of thinking "borderline" because that makes an artificial distinction between neurotic and psychotic. He shows clearly how these patients expose delusions of immortality and omnipotence which are related to identifications with the primal parents. The clinical examples in the chapter, "Narcissistic Delusions," show how it is difficult to distinguish between neurotic and narcissistic delusions. It seems more useful to describe capacities for ego integration and vertical splits in the ego to detail how patients are able to maintain and simultaneously disavow delusions.

In one clinical example (p. 39), Shengold is able to demonstrate how a father and son share a mutual delusion of each other's omnipotence in order to defend against murderous wishes toward one another. Perfection is associated with the idea that only the primal family is important, with all others outside of the family to be rejected. In treating such patients, we have to be able to recognize our own narcissistic investment in the patient, as well as our own weaknesses and mortality. This can be particularly difficult in the termination phase.

In the chapter, "Malignant Envy," we see how envy is part of psychosexual development, stemming from destructive aggression in the earliest period of development, and blending later with greed and sibling rivalry or the wish for the power associated with the other sex. In general, we envy those who can do what we cannot do or have what we do not have. The overwhelming need for the other, such as the

infant's need for the parent, makes aggression or envy directed toward the need-fulfilling object a potentially traumatic situation. We begin to give up envy as we fall in love. The earliest form of love is an idealization of the other. Eventually, with a capacity for mutuality, there is some de-idealization and the capacity to tolerate the re-emergence of envy.

The most malignant form of envy represents the feeling that what belongs to the other has been taken away from oneself. We share an incapacity to escape this envy. (You have everything and I have nothing.) A defensive fantasy of being the only one who exists, or the parents' favorite, results from this envy. The oedipal legend can be seen as a consequence of the child's acting on malignant envy. The killing of the sphinx (the primal parent) and the slaying of the father as well as the mother represent overcoming the sense of being deprived of what rightfully belongs to one. It is a reworking of this myth that permits these strong impulses to be sublimated and eventual gratification to be postponed.

The chapter, "Paranoid Delusions," demonstrates their ubiquity. Projection is always delusional, in that a part of the self is no longer acknowledged. The patients with everyday delusions are suffering from combinations of narcissism, envy, and paranoia. It is significant to note how often this involves experiences or identifications with delusional parents that began in childhood.

In delusions involved in perversions and being in love, there is often a need to escape reality to avoid danger. Transference love is a variety of this delusion. In love, it is only gradually if at all that one can give up the compulsive need for idealization.

Finally, in the chapter, "Owning and Warded Off Truths," Shengold describes teaching the patient to give up delusions and become able to accept the truth. Not owning can range from consciously lying to delusions. "Owning" implies accepting warded-off aspects of one's self which complete a stronger sense of identity. Clinging to delusions is a way of denying the difficult knowledge of separation, loss of one's parents, and the illusion of immortality. In analysis, "owning one's feelings" means giving up old objects and the acknowledgment of unpleasant, hateful feelings.

This book encourages us to face some of the most difficult parts of our clinical work by exposing the mutual delusions of patient and analyst which impede the analytic process. The author spices his ideas

with excellent clinical examples and references to myth and fiction to illustrate his theoretical argument.

ALAN Z. SKOLNIKOFF (SAN FRANCISCO)

BOUNDARIES AND BOUNDARY VIOLATIONS IN PSYCHOANALYSIS. By Glen O. Gabbard, M.D. and Eva P. Lester, M.D. New York: Basic Books, 1995. 223 pp.

While this work is not the first of its kind, it may well turn out to be the most influential and justifiably earn the gratitude of the profession. Partly due to the reputation of its authors, who began publishing papers on this subject in 1989, it is also likely to gain deserved prominence for its comprehensive organization as well as its balance between unflinching documentation and evenhanded exposition. Its extensive bibliography (over 300 citations) draws attention to the sharpening focus in recent years on the topic of psychological boundaries and ethical transgressions resulting in at least seven full-length books since 1986.

Gabbard and Lester offer an eminently understandable text, enabling the reader to follow a smooth, logical sequence from the general subject of boundaries in psychoanalytic theory to an ongoing discussion of boundary violations. While it is likely that the volume will owe its popularity to its later chapters, it deserves credit for the intelligibility of its first four, which occupy about a third of the entire text.

Three phases in the evolution of the concept of boundaries are described: Federn's view of boundaries as functions of the ego gave way to a delineation of self and object consistent with the broadening appeal of object relations theories, followed by Hartmann's neurobiologically based concept of boundaries as mental attributes.

The elusiveness of these concepts finds expression as well in various attempts to define the boundaries within the psychoanalytic process. Moving next to other dimensions of the analytic setting, the authors carefully consider how best to understand the professional or analytic role. The constructs of intrapsychic and external interpersonal boundaries are contrasted. Attention is also paid to the role of gender differences in boundaries. In these chapters, concise clinical vignettes bring illuminating exactness to preceding theoretical discourse.

In its unsparing review of the early history of boundary violations in

psychoanalysis, concentrating on Freud's behavior with Jung, Ferenczi, and Jones, the authors highlight the importance for future generations of this historical legacy and how it "shaped the dimensions of the new profession . . . " (p. 84) but then warn against its misuse: " . . . to blame our analytic parents rather than address basic challenges of the analytic situation that transcend time and place" (p. 86).

Having introduced these delicate issues, the authors resist any temptation to adopt a moralistic stance. There is no hint of such a tone nor the slightest indication of sanctimonious posturing or allusion to traditional pieties. The work is not intended as a handbook containing guidelines for model behavior by analysts, with assured certainties. Yet the authors do not shrink from specifying how violations constitute grave ethical problems with potentially dire consequences. While such descriptions are made with lucid clarity, the authors are careful as well to contrast *boundary violations* with *boundary crossings.*

The chapter, "Nonsexual Boundary Violations," is a good example. It includes a stunning case account, in the patient's own words, verifying "the similarity to the dynamics of sexual boundary violations" and confirming "the soundness of the slippery slope concept" (pp. 142-143). Here again, the authors exclude an absolutist approach exemplified in the following statement: "This discussion shades into that dark nether region known as the art of psychoanalysis, where rigid rules are not particularly useful. Many professional boundaries can be crossed for good reason on occasion" (p. 146).

Considering the rockiness of this terrain, can thoughtful analysts reach discriminating agreement about the margins of crossings and violations? Even murkier perspectives may be noticed in the posttermination period and in psychoanalytic supervision, where consensus invariably withers. For example, if it is a violation for an analyst to have sexual intercourse with a patient in treatment, is it a violation to do so with a patient after termination? Is it a potentially slippery boundary crossing for a supervisor to hug a candidate, to share a bottle of wine during supervision, to attend a dinner dance in the company of supervisees and candidates in training analyses, or to solicit donations for psychoanalytic causes from former patients?

In their closing chapter, Gabbard and Lester bluntly point out that institutional responses have been glacially slow in coming. "There is an irony in the fact that psychoanalytic organizations and training

facilities have done so little about an aspect of the field that has caused devastating damage to the public's opinion of psychoanalysis, to the patients who undertake the treatment, and to the trainees and young practitioners who are disillusioned by the 'clay feet' of their teachers and supervisors" (p. 175). This unambiguous recognition of the problem introduces a sober, compassionate, and practical discussion ranging from ethics complaint management, assessment, rehabilitation of culpable professionals, and prevention.

The chapters of Gabbard and Lester's book on boundary violations may be taken as a version of Freud's admonition about the "dangers of analysis" for its practitioners, inviting "a disagreeable analogy with the effect of X-rays on people who handle them without taking special precautions."[1] Therefore, the importance of this quality update should not be underestimated. It deserves careful attention by trainees, by experienced practitioners, and by teachers at all levels of training. These authors have fashioned an impressive book, most likely to invigorate incentives in most of us, even the least complaisant, to continue scanning within ourselves, for those ubiquitous traces of human temptation likely to emerge unexpectedly and in subtle ways in the form of boundary crossings and unethical behavior.

SAMUEL HOCH (SAN FRANCISCO)

CLINICAL AND SOCIAL REALITIES. By Donald M. Kaplan, M.D. Edited by Louise J. Kaplan, Ph.D. Northvale, NJ/London: Jason Aronson Inc., 1995. 497 pp.

What a great tragedy that we must read posthumously this wonderful set of papers by Donald Kaplan. From the forewords by Mark Grunes and Maynard Solomon through the entire collection of papers we are aware that we are in the presence of an exceptionally literate and broad thinker on psychoanalytic theory and practice.

Kaplan uses involvement in drama, literature, and the arts to broaden our grasp of the infantile contributions to such social issues as morality and its contribution to creative inhibition and gender perception. In doing so, he helps to place psychoanalytic theory on a

[1] Freud, S. (1937): Analysis terminable and interminable. *S.E.*, 23:249.

level playing field with other disciplines so as to facilitate interdisciplinary dialogue and mutual change.

Kaplan opens with a chapter on creative inhibition, "The Unfinished Manuscript in the Drawer." There are moments of quiet brilliance, both theoretically and clinically, in this chapter. Toward the late midphase of her analysis a woman notices a feeling of disappointment at being unable to elicit from her analyst, or from others, responses she can take as disapproval or the coercive authority to which she has been masochistically accustomed. Kaplan notes that something has changed in the signals she sends out. Her ambivalence about this, he says, "is a counterpart of moral masochism in that it employs a manifest compliance with the means of the analysis to maintain a defiance of any of its possible ends. For this to go on, the nature and locus of authority in the analysis must not range too widely. The Analyst must be kept in a place as a benevolent but absolute dictator, well-meaning but morally coercive about the necessities of the analysis" (p. 25). Kaplan describes such creative inhibition in terms of a narcissistically infused moral process rather than as a neurosis involving a particular object.

In his paper, "Transference Love and Generativity," Kaplan opens with the statement that "transference-love is advanced in complexity and is thus made available to modification only to the degree that generativity operates in the therapist" (p. 155). Generativity is a capacity to care and have a "widening concern" for the patient based in love and therapeutic necessity. He quotes Erikson as saying that generativity "overcomes the ambivalence adhering to irreversible obligation" (p. 159). Discipline of method and delay of personal gratification by the therapist can advance transference-love beyond insistence on sameness with archaic objects and can permit the patient to explore the "gains" provided by the generative love of the therapist and to give up the quest for archaic love. "Thus care is distinguished from possessiveness. Lacking generativity, therapists are apt to treat their patients with narcissistic possessiveness, like house pets" (p. 159).

In the third section of the book, "Social Realities," each paper is more appetizing than the next. In "Psychoanalysis and Art" and in "Character and Theatre" Kaplan demonstrates profound appreciation for both psychoanalysis and art. He speaks as scholar, psychoanalyst, and poet on the significance of the meaning of character for

the actor and the part in a theatrical effort. In a broad critique of modern theater he expresses the view that a demand for immediacy in the theater has led to loss of the distance necessary for history and culture to impose a morality—an ethic—and that this has caused a serious dilemma for modern theater. Kaplan goes on to describe the difference between role and character, a difference not always appreciated in contemporary life or in the theater. "Character," he says, "is not a pose but a confirmed plan of action," where "theatricality" (role-playing) leaves off and "authenticity" (identity) begins.

Kaplan refers to Leslie Fiedler's phrase, "New Mutantism." "This new mutantism is an adolescence from which there is no exodus, because the leaders embody no rules for membership requiring an active and sustained psychological effort. Characteristic of adolescence is the hope that you can *be* something without having to *become* it, and with the waning of this myth, a new maturity arises in the life cycle and experience produces not only pleasure but wisdom as well. But to persist in the hope of being without having to become is to remain an *amateur* in a perpetual state of rehearsal for life still waiting to be lived." I see this as pure poetry of the Loewaldian sort. It captures a description of failed versus successful character development, which can be applied to the theater and beyond it. Kaplan concludes with a beautiful description of the tenuous security of character after adolescence that needs to be nurtured in order to develop a professional actor—or a mature human being.

HARVEY L. RICH (WASHINGTON, DC)

BEYOND THE PSYCHOANALYTIC DYAD. DEVELOPMENTAL SEMIOTICS IN FREUD, PEIRCE, AND LACAN. By John P. Muller. New York: Routledge, 1996. 230 pp.

Reading North American psychoanalytic journals in the 1990's, one gets the impression that we have come to an end of theory. While authors pay great attention to "enactments," they appear uneasy about how to conceptualize these nonverbal or paraverbal interactions between the members of the analytic dyad. Concepts such as empathy, mirroring, self-object, and projective identification address interactions of the dyad but do not encompass a theory of "the analytic third," as it has been called by Ogden.

Beyond the Psychoanalytic Dyad expands psychoanalytic theory by suggesting that communications in the dyad can be understood as sign systems needing to be decoded. Muller sees a compatibility between Lacan, the rival of ego psychology, and Charles Sanders Peirce (1839-1914), the American pragmatist philosopher.

Peirce pioneered semiotics as the branch of knowledge that deals with the production of meaning by sign systems. Lacan's "return to Freud" was informed by developments in linguistics and borrowed from Saussure. Muller's book is accessible to those who are intrigued by Lacan but who do not know about his work. Muller elaborates upon Lacan's fundamental frame of reference, the three registers of human experience: the symbolic, the imaginary, and the real. The imaginary is the realm of narcissistic power in which the subject is captured in the thrall of the image's apparent perfection. The symbolic is counterposed to the imaginary and is the world of speech or intersubjective communication, founded on loss and lack. The real is that which cannot be imagined or symbolized and is always potentially traumatic. Our sense of reality is the simultaneous experience of all three registers. Muller links Lacan's real, imaginary, and symbolic to Peirce's conceptions of Firstness, Secondness, and Thirdness.

In Peirce's concept a sign gives rise to something called an interpretant that acts as a sign itself. This is analogous to Lacan's use of Saussure's definition, sign = signifier/signified. Lacan founded the symbolic order on the idea of meaning as arising in "the play of the signifiers." Different modes of signing characterize different registers of experience.

Muller's approach to mirroring illustrates how a Lacanian-semiotic framework yields a more complex view of human development:

> . . . the earliest empathic responses, as well as the affective component of later responses, are automatic, almost coerced in constraining one's subjective state and behaviour to match that of a model. The affective presentation is contagious, captivating, and produces a replica in the other. Recognition on the contrary, is an action that posits difference from self, acknowledging the specific state of the other as other, not as an extension or repetition of oneself (p. 24).

Captivation and fascination by the model, by the icon, is a cardinal feature of the Imaginary. The failure to sustain recognition leads to a collapse of the symbolic, Peirce's Thirdness, and entrapment in the imaginary of the dyad.

> Psychoanalytic treatment aims at engendering semiotic empowerment, the capac-

> ity to sign oneself and to recognize others, as a step towards the assumption of semiotic responsibility, the ability to say what one wants and means and also to reflect on the conditions that prevent one from keeping one's word (p. 25).

As well as developmental semiotics, Muller explores other examples of the conceptual power of the real, imaginary, and symbolic. The phenomenon of psychosis is described as an encounter with the real. Kohut's paper, "The Two Analyses of Mr. Z," is reinterpreted as a shift from the dyadic to the symbolic, and Muller rereads *Studies on Hysteria* as a scandal of language, not of sexuality. There is a tension in pairing Peirce, pragmatist of the conscious, and Lacan, structuralist of the unconscious. Muller's work uses this tension to expand psychoanalytic theory. For North American psychoanalysis, Peirce's semiotics becomes a bridge to Lacan and his return to Freud. I believe such returns, to Peirce and to Freud, are the movements required to build new theory that is truly original.

RICHARD B. SIMPSON (TORONTO)

THE MANY FACES OF EROS. A PSYCHOANALYTIC EXPLORATION OF HUMAN SEXUALITY. By Joyce McDougall. New York/London: W. W. Norton & Company, 1995. 257 pp.

In this book, Joyce McDougall continues her exploration of the archaic conflicts that lie at the core of gender identity, sexual object choice, and human subjectivity. She begins with the provocative statement, "Human sexuality is inherently traumatic" (p. ix), and ends with the conclusion that the fundamental core value of psychoanalysis consists in helping our patients to solidify and ensure their sense of psychic survival (p. 244). In between, in consummate and far-reaching psychoanalytic fashion, she takes her readers through an exploration of the infantile roots of female sexuality ("Femininity and Sexuality"), the relationship between creativity, sexuality, and trauma ("Sexuality and Creativity"), psychosomatic disease ("Sex and the Soma"), sexual deviations, perversions, and addictions ("Deviations of Desire"), and an examination of the value system of psychoanalysis ("Psychoanalysis on the Couch").

As in her previous works, McDougall's subject continues to be the elaboration of archaic conflicts, infantile narcissistic and instinctual vicissitudes, and the opportunities and difficulties for development to which they give rise. The dramatic statement with which she opens

her book reflects her view that "the obligation to come to terms with one's monosexual destiny constitutes one of childhood's most severe narcissistic wounds" (p. xi). This, along with "the recognition of otherness" and the impossibility of sexually possessing either of one's parents or encompassing all of their imagined prerogatives and powers, constitutes an assault on infantile omnipotence and megalomania which can have far-reaching consequences for many patients throughout their lives.

Although McDougall is keenly aware of the importance of mature, phallic-oedipal constellations, it is the vicissitudes of pregenital conflicts to which she is repeatedly drawn. At the deeply unconscious, archaic level of experience of which she writes, libidinal and aggressive aims are barely differentiated; love is equated with catastrophe, castration, and death; the primal scene between parents is dangerous and destructive; and what remains at issue is psychic survival, autonomy of self, and the right to sexual or, indeed, any pleasure.

In elegantly written, detailed case illustrations, McDougall conveys the maelstrom of personal darkness, chaos, and terror with which her patients struggle, as well as the salutary comfort and opportunities for growth that can follow from helping patients to verbalize the primitive desires and archaic terrors by which they are beset. Such verbalization, which occurs as part of an interpretive process that takes full account of the here-and-now transference, but nevertheless rests heavily on reconstruction of the fantastical infantile past, is central to McDougall's implicit theory of cure.

It is through the transforming power of words that McDougall believes love may become freed from archaic and fantastic meanings. When this occurs, the primal scene, which she sees as ubiquitous, the interpretive transformation of which is often decisive for attaining the capacity for creativity, health, and pleasure, ceases to function as a terrifying or persecutory component of one's inner world. Instead, it "becomes a psychic acquistion that gives adult-children the right to *their* place in the family constellation, to *their* bodies, to *their* sexuality" (p. xxi). The emphasis upon the transformative power of language, over and above that of relationship, keeps McDougall in firm theoretical accord with Freud's views[1] on the power that words ("word presentations") and the secondary process have to tame the poten-

[1] Freud, S. (1915): The unconscious. *S.E.*, 14.

tially destructive impact of the drives ("thing presentations") and the conflicts and defenses to which they give rise.

Limitations of space do not allow for an extensive exposition of McDougall's many provocative and stimulating observations. However, a brief reflection on some of what she addresses will alert the reader to the many fascinating areas that this book covers.

In regard to work and creativity, for example, McDougall analyzes numerous instances of work inhibition and the creative process gone awry, emphasizing the extent to which work and creativity may become encumbered by anal conflicts, bisexual wishes, and the need to seek a personal sense of individuality and self-cohesion through what one produces and within the creative work process itself. Her exploration of the many archaic conflicts, meanings, and defenses that beset her patients' work and creativity ranges from fantasies of fusion to the appropriation of the procreative powers, organs, and prerogatives of the parents, to the numerous archaic transference meanings of the imagined public for whom the work is created. Her conclusion "that *violence is an essential element* in all creative production" (p. 55) offers a powerful contribution to the explanation of the vicissitudes of work inhibition and creative stasis.

In regard to the "neosexualities," McDougall continues to plead persuasively that we recognize the ways in which perversions and sexual addictions "serve not only to safeguard the feeling of sexual identity that accompanies sexual pleasure, but frequently reveal themselves to be techniques of psychic survival that are required to preserve the feeling of subjective identity as well" (p. 174).

And few authors take the connection of psychosomatic disorders to archaic psychological phenomena as seriously as does McDougall. She notes the occurrence of somatic illnesses at or shortly after termination of otherwise successful analyses and suggests that these may be partially determined by "unanalyzed archaic fantasies and unacknowledged psychotic anxieties" (p. 112). For McDougall, psychosomatic symptoms express a form of primitive body language, a "*protolanguage,*" which, in earliest life, communicated a message of need to the outer world. As analysis progresses, this protolanguage, with its concrete and immediate "protosymbolism," becomes transformed via interpretation and verbalization into a truly symbolic language. As a result, "the boundaries between 'purely psychosomatic' and 'purely hysterical' manifestations eventually become less distinct" (p. 167).

McDougall's final section deals with psychoanalytic values and the value of psychoanalysis. Her concern is our failure "to examine the extent to which our theory and practice are affected by the value judgments of our theoreticians and practitioners" (p. 219). The latter are not only subject to the pressures of unrecognized social and cultural forces; the very nature of our training structures, in which transmission of knowledge is marked by the strong positive and negative transference affects that exist between analyst and analysand, clinician and supervisor, teacher and student, predisposes us to powerful unconscious investments in the psychoanalytic values, beliefs, and political allegiances of our analytic mentors.

Given that no observation is theory-free and that concepts such as "truth" or "reality" may unconsciously reflect moral, religious, esthetic, or political positions, do core psychoanalytic values exist that are independent of culture and the individual? For McDougall, our greatest good consists in helping patients to discover their own truths and fundamental values (p. 234). To do otherwise, to believe that we hold the key to some "truth" and to use that belief to legislate or impose a system of values, sexual preferences, political opinions, or theoretical convictions upon our patients would be a perversion of psychoanalysis.

HOWARD B. LEVINE (BROOKLINE, MA)

HIDDEN QUESTIONS, CLINICAL MUSINGS. By M. Robert Gardner. Hillsdale, NJ/London: The Analytic Press, 1995. 189 pp.

Gardner's latest book is a collection of papers written over a span of thirty years, both published and unpublished, to which are appended current afterwords. A number were first presented at panels, symposiums, etc., which I think is important as these were words originally spoken and heard rather than read. Words as sounds as well as signifiers and what they evoke about other words, images, and affects are among Gardner's interests in these papers. Language and speech, which is used by him poetically, imaginatively, and metaphorically, is something to which he draws our attention, bringing us closer to words in their sense (as sensory experience) origins. Vision, sounds, feelings are deconstructed and reconstructed via his attentiveness and receptivity to words and images, his own and his patient's. The

convoluted paths to the meaning of experiences are another of his interests. From this we gain in our appreciation of primary and secondary process, unconscious and preconscious mentation and imagery. The two-person relational field aspects of the analytic situation and the contextualization of analytic experience are also highlighted by Gardner. All this for me revives Loewald and his imaginative renderings of mental experience in the analytic situation and process.

Gardner's illuminations of these issues cast light—sometimes new light, other times re-lighting of old lights—upon psychoanalytic therapy. Most brightened is the analyst's mind at work with himself and his patient. The ideas in this book are clearly in line with his other works, *Self-Inquiry* and *On Trying To Teach,* and will be of most interest to working analysts and perhaps to analytic candidates for their helpfulness in freeing and increasing our responsiveness to the spontaneities of one's mental functioning. The usefulness of careful observation and attention to our own and our patients' mental states while at work should strengthen our confidence in the value of the analysis of the experiential aspects of the transactions between patient and analyst. Gardner makes the point that the usefulness of our theoretical constructs occurs when they are serving not as constraints but as structuring and guiding elements.

In these papers, Gardner is interested, as stressed in his afterwords, in delineating his changing views, especially of what he conceptualizes as the nonlinear, nonmechanistic way the mind works—the interstices and hidden questions and meanings that develop out of his random musings and become the focus of his self-inquiries. His perspective is enriching, helping us to use our (and our patients') spontaneous responses by persistently subjecting them to inquiry. In any event, if one has not read Gardner before, one should, as it will serve to enlarge one's analytic perspective.

ROBERT M. CHALFIN (NEW YORK)

THE PSYCHOLOGY AND TREATMENT OF ADDICTIVE BEHAVIOR. Edited by Scott Dowling, M.D. Madison, CT: International Universities Press, Inc., 1995. 225 pp.

This volume offers a rich medley of papers on addiction, its definition expanded to include compulsive sexuality. This monograph is part of

the Workshop Series of the American Psychoanalytic Association and is based on presentations at two seminars for clinicians co-sponsored by the national and local organizations in Washington and Baltimore in 1990. The editor has divided the book into two sections; the first, six clinical and theoretical presentations and the second, four discussions. The book is well written and is an excellent update on the field of addiction from a psychoanalytic perspective, circa the 1990's. It explodes the myth that all that patients with addictive disorders need is treatment that utilizes a disease model and the A. A. philosophy and that psychoanalytic psychotherapy has nothing to offer. Actually, it turns out that all the authors agree that dynamic treatment, in their sampling, is immensely valuable. They agree, too, that addiction is a description rather than a diagnosis, since all character types seem to be represented, each with a segment of personality displaying the addictive character structure, i.e., imperative, dependent, driven to repetitive actions, and self-destructive. The case examples are excellent.

Also, advances in theory and conceptually linked modifications in technique speak eloquently to the maturity of the field, fully incorporating developmental psychoanalytic theory into their undertaking. Most, but not all, utilize varying object relations and self-psychological models that posit early deficiency in the mother-infant bond, from premature symbiotic disruption to the lack of a holding environment. The ensuing helplessness from this overwhelming psychic trauma causes a fixation and longing to return to mother, with consequent longing for an archaic self-object merger transference. The failure in internalization of self-regulating, self-soothing structures, especially regarding affect tolerance, tension regulation, and impulse control, causes a need to escape from intolerable affects and a longing for id gratification, but with fear of closeness and a human connection. This propels them to an "autistic" solution in the form of drugs, excitement, etc.

A number of contrasting views are presented, probably based on their sample and theoretical orientation. Thus, Wurmser's emphasis is on superego pathology underlying the overwhelming shame and guilt which causes the psychic state of helplessness. The burden of this insufferable superego authority is overthrown by the drug. Likewise, according to Dodes, the rage, anhedonia, and powerlessness is overthrown by the assertion of action to obtain drugs to regain mastery and control.

Other fascinating theories are Henry Krystal's hypothesis of alexithymia secondary to affect intolerance from failures in affect development, as well as Khantzian's "self medication hypothesis" in which certain ego defects are chemically corrected for the moment by specific drugs of choice. Thus, the inertia and immobilization of narcissistic, depleted, empty individuals will lead them to seek stimulants like cocaine and amphetamine; inner disharmony and rage from threatening drives and affects are countered by the opiates' calming and muting effect; and, finally, those who seek to wall themselves off from others but who need dependency, nurturance, and contact will seek the warming effects of sedatives and alcohol to relieve some of their feelings of isolation, emptiness, and coldness. Alcohol and sedatives can also aid their attempts at contact by softening their rigid defenses so they can become more sociable. This we are all aware of.

The book is a neat balance of agreement and controversy, well handled and readable, an important book for the clinician wishing to step up to the contemporary theory and treatment of addictions.

MELVIN SINGER (PHILADELPHIA)

ANXIETY AS SYMPTOM AND SIGNAL. Edited by Steven P. Roose and Robert A. Glick. Hillsdale, NJ/London: The Analytic Press, 1995. 182 pp.

Anxiety disorders are now recognized as the largest single group of mental disorders in the United States. According to an NIMH study, 7% of the population is affected.[1] Moreover, in a recent survey of training analysts done by Donovan and Roose, 64% of analysts are now using psychopharmacotherapy conjointly with psychoanalysis.[2] So this reader looked forward with great expectations to this book which promised to approach the far-reaching and crucial topic of anxiety from a variety of perspectives, including psychophysiological, pharmacological, and clinical.

Roose and Glick have assembled an impressive group of thirteen contributors, nine of whom come from their department at Columbia

[1] Pasnau, R. O. & Bystritsky, A. (1990): An overview of anxiety disorders. *Bull. Menning. Clin.*, 54:157-170.

[2] Donovan, S. & Roose, S. P. (1995): Medication use during psychoanalysis: a survey. *J. Clin. Psychiat.*, 56:177-178.

University. Of the eleven chapters in this relatively thin volume, four address the neurobiological perspective and five the clinical perspective, with a general introduction by Glick and a concluding chapter by Morton Reiser.

The introductory chapter by Glick is an excellent review of the history of anxiety within the psychoanalytic movement, as well as a history of neurobiological and developmental research on the subject that nicely sets the stage for the chapters that follow. But the title of the chapter, "Freudian and Post-Freudian Theories of Anxiety," portends the approach that organizes the clinical section, that is, "post-Freudian," with little from the classical approach.

The first section of the book—"Anxiety as Symptom: The Mind and the Brain"—is the most successful part. "An Evolutionary Perspective on Anxiety" by Myron Hofer and "Genetic and Temperamental Variations in Individual Predispositions to Anxiety" by Abby Fyer are fascinating chapters. Hofer, for example, takes up the question of how much of the potential for anxiety is inherited. He states that "animals cannot afford to learn all the possible danger cues: certain signals for danger, particularly in the very young, have to be responded to when the animal first experiences them . . . " (p. 20). He gives numerous examples from animal studies, including newborn mice that are clearly reacting to hitherto unexperienced separations with what looks very much like anxiety responses; these responses are then suppressed by benzodiazopines. The evolutionary perspective offers convincing evidence for the core meaning of anxiety as a behavior state in response to signals of specific dangers that have occurred both in the organism's past and in the evolution of the species. Fyer convincingly uses infant and childhood temperament studies, genetic studies of adult personality traits, and anxiety disorders to demonstrate a genetic component of the tendency to overuse anxiety as a signal. The next paper by Gorman, Papp, and Coplan attempting to establish panic disorders as neurophysiologically and clinically distinct from anxiety disorders left this reader still wanting to be convinced.

The remainder of the book—"Anxiety as Signal: The Treatment Setting"—covers various aspects of anxiety as seen in a clinical setting. Scott Dowling's paper on anxiety in children describes possible pathways to anxiety, such as contagion from mother's anxiety, predisposing physical distress, and traumatic events. Gerald Fogel's paper, "Learning To Be Anxious," is modestly successful in describing

patients who use anxiety as a defense against more primitive affect states. Gloria Stein discusses anxiety as the sequela of disruptions in narcissistic equilibrium. Owen Renik's paper addresses the relationship of the patient's anxiety to that of the analyst, within the intersubjectivity model. Charles Spezzano not only describes the place anxiety has in relational theory, but also seems to be using this paper as a polemic against classical theory in general. It is only in Steven Roose's paper, toward the end of the book, that an integrative approach to anxiety is discussed, as Roose adeptly addresses the use of medication in a psychotherapeutic setting. Nowhere in the book is the classical viewpoint of American psychoanalysis represented.

This is a valiant effort to bring together a wide variety of perspectives on anxiety. The reader is still left wishing the editors had made further attempts at integrating or comparing the various perspectives. Nonetheless, this volume is a valuable addition, probably the best to date on this important subject.

J. SAMUEL CHASE (SAN FRANCISCO)

POSTTRAUMATIC NIGHTMARES. PSYCHODYNAMIC EXPLORATIONS. By Melvin R. Lansky, with Carol R. Bley. Hillsdale, NJ/London: The Analytic Press, 1995. 194 pp.

This volume is based on the author's seven-year study of psychiatric inpatients at a V. A. Medical Center, and I therefore began reading it with low expectations for its relevance to my clinical work. On completing it, however, I believe the book does make a significant contribution to the clinical theory that informs my daily practice of psychotherapy and psychoanalysis. Using data from his research, Lansky makes a convincing case that many posttraumatic nightmares are not—as is often implied—a special type of dream, but are "true" dreams in the psychoanalytic sense—i.e., dreams which have an important latent content and a screening function related to the state of the dreamer's impaired and traumatized psyche.

The author shows how chronic posttraumatic nightmares are instigated by events of the day, and are therefore understandable in a way that goes beyond the need to master a traumatic experience through

dream work. Further, there is immediate clinical relevance in Lansky's emphasis on the important role of shame dynamics and conflicts in the genesis of repetitive posttraumatic dreams. It is the author's contention that only relatively recently in psychoanalysis has shame been recognized as an important element in psychopathology generally, and in the dynamics of posttraumatic states. The data collected by Lansky demonstrate how posttraumatic dreams usually represent the dreamer as in danger but intact, whereas the self experience preceding the dreams "was one of disorganization, disconnectedness, and shame. Thus, the dream work can be seen as . . . accomplishing, in effect, a transformation from shame to fear in the dream scenario" (p. 15). This formulation reflects wish and defense, not simply a mastery of trauma.

Lansky's understanding of the role of both pre-existing and event-related shame conflicts in the pathogenesis of posttraumatic clinical pictures has clear implications for the psychotherapeutic treatment of victims of acute traumatic experiences, and also, I think, for many other patients with chronic exposure to less obvious traumatization in early childhood. A rational treatment approach to severe posttraumatic psychopathology must address these pre-existing, complicating shame dynamics. Furthermore, Lansky's view of posttraumatic nightmares as wish-fulfilling and shame-avoiding mental productions heightens our awareness of the possibility that commonly occurring self-defeating, or self-destructive symptoms that are not identified as "posttraumatic" in the narrow sense might, in a similarly counterintuitive way, conceal and defend against the awareness of painful affects related to shame.

Whereas many of the ideas in the book are not entirely new to psychoanalysis, the author applies them with clarity to the understanding of posttraumatic nightmares. He illustrates with rich clinical material, in a convincing way, his position that psychoanalytic theory has not yet thoroughly addressed posttraumatic nightmares or the shame-related dynamics of trauma victims. Although the data presented here are not psychoanalytic data, they are highly relevant to the theory and practice of psychoanalytic therapies with patients who evidence both severe and more subtle forms of posttraumatic symptomatology.

STEPHEN D. PURCELL (SAN FRANCISCO)

A THING APART. LOVE AND REALITY IN THE THERAPEUTIC PARTNERSHIP. By Irving Steingart. Northvale, NJ/London: Jason Aronson Inc., 1995. 291 pp.

In this book Steingart attempts to ground psychoanalysis, through closely reasoned argument, on the bedrock of the concept of psychic reality. Steingart is a firm believer in the correspondence theory of truth (i.e., that a world exists out there to which we can point) and in the transcendental reality of the human mind (i.e., that a person's psychic reality exists out there independent of our attempts to describe it). In essence, he argues that the psychoanalytic relationship is unique—"a thing apart"—because only in a psychoanalytic relationship do the participants lovingly pursue an ever-evolving understanding about the true nature of one of the participant's—the analysand's—psychic reality.

In the first chapter, "Reality and Truth in the Analytic Relationship," Steingart joins a gathering chorus of psychoanalytic writers who have demonstrated convincingly that all analysts, whatever their avowed theoretical perspectives, utilize some notion of reality and truth in their clinical work. Steingart believes that in a successful psychoanalysis the analysand gains insightful understanding about his or her psychic reality in large part through the interpretive efforts of the analyst. He situates these assertions clinically by asking the following question: How do analyst and analysand decide whether the analysand's perceptions of the analyst are more or less real or more or less transferred from the analysand's unresolved past?

Borrowing from Merton Gill, Steingart says that analyst and analysand must adopt an attitude of "equivocality" toward the latter's beliefs about the analyst—a "let's see what else we can learn" attitude—without taking a position on the truth or falsity of the analysand's perception. In his discussions of Freud, Evelyn Schwaber, Roy Schafer, Gill, Edgar Levenson, and especially Irwin Hoffman, Steingart shows that they all employ some notion of truth in their clinical work. They all help their patients separate fantasy from reality and past from present. He is well aware that several of these writers assert they are doing other things of importance with patients as well as enlarging their understanding of themselves. For Steingart, these other things (e.g., giving advice or opinion, striking a self-consciously empathic stance, or providing a corrective emotional experience

through the disclosure of countertransference) are secondary to the analysand's gaining of insight.

However, already in the first chapter one sees that Steingart, in an effort to have an intellectually coherent psychoanalytic praxis, must simplify certain things. In discussing the issue of disentangling transference from "real" perception, he makes the following statement: "But the psychic reality with which the analysand interprets what the analyst has not observably done has a vastly different significance for the unfolding of the psychoanalytic process than a response to something observably done by the analyst" (p. 5). Most of the time this distinction is not so simply made. Analysands "observe" things continuously about their analysts that may not be immediately observable to the analyst. Who is to decide what the analyst has said or done and what the analyst hasn't said or done? Very quickly these issues move into the uncertain terrain of rhetoric, persuasion, and authority within the psychoanalytic relationship. Steingart's unilateral focus on the decisiveness of the patient's psychic reality—what amounts to a relatively narrow definition of psychic reality—necessitates that he marginalize these issues.

In Chapter 2, "Toward a Comparative Therapeutics," Steingart discusses Hoffman at length. He rightly challenges Hoffman's admonition that the analyst consciously use his or her position as a moral authority to engender a magical environment to effect therapeutic change, and that such actions on the analyst's part should not be "analyzed away." However, because Steingart believes that access to the patient's psychic reality is limited to certain routes, he fails to see, as Hoffman long ago pointed out, that one important route is the analysis of how the patient deals with "real" perceptions of the analyst. Patients often defend themselves against disturbing *realities* they perceive about the analyst. Valuable analytic work can be done around the struggles analysands have with these perceptions.

In Chapter 3, "Love in the Analytic Relationship," Steingart, again beholden to his unilateral focus on the analysand's psychic reality, concludes that the love the analyst feels is not for the analysand as a human person, but for the ever-widening understanding of the workings of his or her mind. This is an extremely narrow view of the nature of love in the analytic relationship. What is the problem with the analyst loving or admiring certain of the analysand's personal

qualities (humor, willingness to work hard, willingness to struggle with difficult issues, etc.)?

In Chapters 4 and 5, Steingart moves to territory that seems unrelated to what has come before. This is his theory of "enacted symbols" and "pathological play" in borderline and narcissistically vulnerable patients. In his theory of enacted symbols, he profitably reworks the concept of acting out. He shows how such patients often use language with a particular kind of omnipotent rigidity—as things or part objects. Steingart sheds new light here. However, it is not clear why he needs to ground his clinical descriptions of enacted symbols in Mahlerian developmental theory. Though intellectually interesting, to this reader it comes across as reductionistic.

Steingart concludes *A Thing Apart* powerfully. In the final chapter, "On the Comprehension of Psychic Reality," he argues, as he did in Chapter 1, for the existence of the mind independent of the observer (what he terms "the transcendentally real human mind" [p. 231]). This time his perspective is more philosophical and literary; his argument is more compelling. To those psychoanalytic writers who have championed social constructivism and the irreducible nature of the analyst's subjectivity, Steingart argues that they have conflated epistemology and ontology—that we cannot be sure of what we know because of our biases (and other constraints on knowledge) does not mean that the nature of psychic reality is up for grabs or does not exist beyond our descriptions of it. As he nears the end, Steingart's language becomes more rhapsodic and passionate. He praises psychoanalysis for its ethic of truth-seeking and proudly places it alongside Michael Polanyi, W. H. Auden, and John Keats as among the best examples of the Western humanistic tradition.

A Thing Apart is by turns challenging, thoughtful, disjointed, and flawed. Steingart strikes an earnest tone; his style is often clunky. His epistemological argument suffers from a formalism that requires him to silence important aspects of the psychoanalytic process that, like an unruly member of the audience, would otherwise disrupt the proceedings. Rhetorical coherence comes, as always, at a price. Though I found myself in disagreement with Steingart much of the time, his integrity, wisdom, and dedication to analytic work came through with admirable clarity.

MITCHELL WILSON (BERKELEY)

LOST PRINCE. THE UNSOLVED MYSTERY OF KASPAR HAUSER. Jeffrey Moussaieff Masson, Translator and Introduction. New York: The Free Press, 1996. 254 pp.

Jeffrey Moussaieff Masson's book offers a number of perspectives on the tragic, intriguing, and celebrated case of Kaspar Hauser. Hauser was said to have been kept in isolation during childhood, imprisoned in his room. His story first came to light when he turned up in Nuremberg in 1828, at the age of sixteen, barely able to walk or talk. Hauser attracted notoriety both during his lifetime and since, inspiring a large literature that Masson cites in his approximately two hundred footnotes.

Lost Prince is divided into three parts. First is Masson's seventy-five-page introduction, which includes his perspective on the case. The second, and central, part of the book is Masson's translation of the work by Paul Johann Anselm Ritter von Feuerbach. Feuerbach was the presiding chief judge in the court that had jurisdiction over Hauser. Feuerbach's book provides a beautiful description of Hauser's mental state and its connection with his past confinement. Masson indicates that his translation is the first *complete* English translation of Feuerbach's book, which is considered to be a masterpiece of German judicial literature. Masson's translation is clear and very readable. The third part of the book contains five appendices, with Masson's translations of additional documents pertaining to the case.

As indicated in the subtitle, the story of Kaspar Hauser is a mystery, or actually a series of mysteries. One such mystery pertains to his unusual state of mind, so clearly described in Feuerbach's work, and how this mental state relates to his severe isolation during childhood. There is also the mystery of Hauser's death, reported to be a murder. Some people claimed that Hauser's death was a suicide and that his whole presentation was a sham. Linked with the mystery of Hauser's death is the question about his identity. Masson marshals evidence to support a theory that Hauser was the Prince of Baden and that he was murdered for political reasons.

These mysteries are linked with the confusion that often surrounds reports of child abuse: Did it really happen? If it did, to what extent are the person's current problems the result of the fact of that abuse? And to what extent can one rely on the accuracy of the individual's memory of abusive experiences?

Masson notes that the latter point has been a continuing focus of his own writings. He repeats his previously published assertion that mental health professionals are overly skeptical and dismissive of reports about child abuse. Masson cites the concept of "false memory syndrome," which he says is currently being used to discredit patients' reports of previously repressed memories of sexual abuse. He states that he is interested in Kasper Hauser's case because it is well documented and because it demonstrates the difficulty in recalling details of abuse during childhood.

Masson reiterates his accusation that Freud, having discovered that repressed memories of child abuse can be recovered during the course of treatment, then "caved in" to societal and personal pressures and abandoned his seduction hypothesis (pp. 55-59). He says that Freud adopted the theory of childhood sexuality as a way of denying the validity of his patients' reports of having been abused during childhood. However, although Masson states that most psychoanalysts disagree with him, he does not acknowledge the point made by Hanly[1] and by Shengold,[2] who emphasize that Freud's theory of unconscious conflict over childhood sexual fantasies provided the opportunity to explore internal factors in addition to, rather than instead of, the effect of life experiences, such as seduction during childhood. Shengold explicitly states that "soul murder should be understood to indicate the actuality of external trauma."[3] Shengold's books as well as his own article on Kaspar Hauser[4] are models for using psychoanalytic theory to explore the effect of abuse on the development of the inner life of a child and the adult that child ultimately becomes.

Masson's book is an interesting contribution to the literature on Kaspar Hauser. However, his use of this work as an additional element in his attacks on Freud, psychoanalysis, and the mental health

[1] Hanly, C. (1986): Review of *The Assault on Truth: Freud's Suppression of the Seduction Theory,* by J. M. Masson. *Int. J. Psychoanal.,* 67:517-519.

[2] Shengold, L. (1989): *Soul Murder: The Effects of Childhood Abuse and Deprivation.* New Haven/ London: Yale Univ. Press, pp. 33, 34, 37-38.

[3] ———(1988): *Halo in the Sky: Observations on Anality and Defense.* New York/ London: Guilford, p. 80.

[4] ———(1978): Kaspar Hauser and soul murder: a study of deprivation. *Int. Rev. Psychoanal.,* 5:457-476.

professions in general is problematic and a distraction from what is otherwise useful and thought-provoking material.

BARRY J. LANDAU (WASHINGTON, DC)

INTRICATE ENGAGEMENTS. THE COLLABORATIVE BASIS OF THERAPEUTIC CHANGE. By Steven A. Frankel, M.D. Northvale, NJ/London: Jason Aronson Inc., 1995. 262 pp.

In this book Frankel attempts to integrate ego psychology, object relations and self psychology, drive theories and deficit theories, and to propose a correspondingly inclusive explanation of psychic change.

Throughout the book, the lines between theory and practice remain tantalizingly unclear. Frankel constructively poses the questions of what constitutes a practice driven by a theory and a theory driven by a practice. Yet one begins to feel uncomfortable with Frankel's notions of theory and practice when he writes: "The therapist lives in a psychoanalytic world without definitive guidance for making choices. There are competing points of view about analytic theory and practice. However, currently there is no method for selecting among approaches" (p. 39). If there is no such "method" at all, what, pray tell, are the thousands of analysts who daily make decisions about interventions and dynamics doing? If the world is reduced to so many points of view in deference to the currents of political correctness, then it would seem that any choice of intervention is arbitrary. The only course to take is to assume that there can be truth in accretion, and that whoever can demonstrate that he or she has taken into account the greatest number of points of view will be the most "right." But this is clearly not the way the world works. And it is not the way Frankel works either, since at the end of the chapter he advocates three ways of making clinical choices.

Frankel valiantly and creatively attempts to demonstrate what happens in his view when practice affects theory and theory, practice. In his discussions there is much to be admired: he appears to be a sensitive, respectful, and flexible clinician. Conveniently for a writer who is attempting to marry object relations with self psychology, his clinical experiences validate both theoretical models. Sometimes, at the outset of the treatment, one model can be held by the patient

(e.g., relationship centered) and the other (drive centered) by the analyst, as in the case of Jim (pp. 46-49). By the end of the treatment, this situation has been altered, producing change in both. Such is the model of change for Frankel: it is necessarily reciprocal.

In speaking of what causes change, Frankel notes, in company with many others, that the analytic relationship is always and necessarily imperfect. Change, then, occurs through a "recurrent process of rupture and repair of rapport within the analytic relationship" (p. 90). Like Ferenczi, who is mysteriously absent from the bibliography, Frankel advocates mutuality: "It is in this process of mutual influence and discovery, and bilateral change, that I locate the most powerful explanation for analytic change" (p. 112). But at times the mutuality that Frankel advocates can be perplexing. For example, what is one to do epistemologically with the statement: "Indeed she (Alison) has progressed. And I will never be the same" (p. 236)? How do we know who is doing what to whom? If I buy a new tie, will she become fashion conscious?

Throughout the book there is an odd but important confusion over what constitutes data or theory, and more fundamentally, over the level of abstraction at which one is speaking: "Some theories of motivation are based on the notion of intrinsic forces, such as drives, that fuel behavior. Others are organized primarily around interpersonal principles" (p. 116). As Freud said, we never know drives directly, we only know drive derivatives. Yet Frankel says quite clearly: "In my view affiliation [as opposed to drives] is the preeminent human motivation" (p. 117). But since he makes no distinction between a motivating force and its derivatives, is he, in fact, comparing apples to apples? Has he not misconstrued Freud's notions of drives by conferring on them an epistemological status which Freud never gave them?

Such a confusion is made more difficult to contend with when Frankel takes a curiously antirational stance, as though to say that the usual criteria for rationality cannot apply to what he does anyway: "I prefer to define psychoanalysis less according to what has been understood formally and more by the depth of engagement which is achieved" (p. 147). But what is he *really* saying here? Is he disagreeing with Freudian principles of understanding unconscious processes? Is he setting Freud up as a straw man in the rationalist tradition in order to knock him down?

Which leads this reader to a fundamental difficulty with many of Frankel's assertions. Consider the following: "In my view, engaging the core self is the final objective of the 'uncovering' process in analysis. Analytic change depends on (a) recognizing core self needs, (b) understanding why and how these needs have been obscured and distorted, and (c) creating a facilitating relationship leading to engagement of the core self" (p. 149). Is all this to be taken on faith? Again, epistemologically, Frankel, like the self psychologists, intersubjectivists, and others, misconstrues or conflates levels of abstraction in the service of oddly deconstructionist or antirationalist postulates. Freud is held up as being limited in his rationalism, while we are supposed to accept assertions which nowhere are adequately demonstrated, presumably because demonstrating them would subject the author to the same criticism they have leveled at Freud. But is this not precisely the kind of thing that needs to happen, so that positions can be articulated, theory and evidence assessed openly and disagreed about?

For instance, when he speaks of the unconscious, Frankel points out that "conceiving of the same 'buried' information as available from the surface through interpersonal engagement conforms to an entirely different psychological model" (than the Freudian one) (p. 165). But, more important still, it also conforms to an entirely different *epistemological* one. And that is the problem. When one is dealing with a different "model," one can easily be relieved of having to articulate one's own position; one simply disagrees with whatever "model" one says one is not using.

There is also a difficulty in how Frankel conceives of psychoanalysis and psychoanalytic psychotherapy. Here I am not disagreeing with the thrust of his argument, but rather wishing that its direction were clearer. He maintains in the first chapter that he has chosen to assess analysis on the basis solely of outcome (p. xxv), which makes it easier for him to assert that there is no difference between psychoanalysis and psychoanalytic psychotherapy. But among the difficulties with such an approach is that it begs the entire matter of analyzability, which cannot easily be evaluated on the *basis* of outcome. And even if it is the case that psychoanalysis and psychoanalytically oriented psychotherapy work the same way, this needs to be demonstrated rather than merely asserted.

In short, while this book is suggestive and full of clinical insight,

missing from it (and in this it is like many contemporary books) is a well-argued position (like that of Freud) from which epistemological distinctions can be made rather than avoided, levels of abstraction can be acknowledged, evidence can be assessed, and differences allowed for. This reader wishes that more effort would be made to present a sound (and necessarily partial) argument which might hold sway, not particularly or not only because its author believes it to be "true," but because he or she has taken the trouble to argue its merits carefully and persuasively.

BENJAMIN KILBORNE (LOS ANGELES)

ULTIMATE INTIMACY. THE PSYCHODYNAMICS OF JEWISH MYSTICISM. By Mortimer Ostow. Madison, CT: International Universities Press, Inc., 1995. 412 pp.

Mysticism as an aspect of religion has occupied the thoughts of many scholars. Mortimer Ostow offers a psychoanalyst's view of the psychodynamics of mysticism. It is a serious contribution to group psychology, particularly with regard to the shared fantasies that serve to create and maintain religious movements. He brings a psychoanalytic perspective derived from work with the mental dynamics of the individual to analyze the similarities in group process; and he has brought together well-regarded contributors from psychoanalysis and religious studies to comment on his observations.

This is not an attempt to examine all aspects of religion. Ostow holds his topic to mysticism in Jewish religion, best known as the Kaballah. All religious movements at some time in their history develop a mystical component: the Kaballists among the Jews, the Sufi among the Moslems, and the evangelical sects among the Christians. All religious fundamentalist groups become mystical. They have "a forceful charismatic leader" and "as they gain following and power, they tend to become politically active and aggressive" (p. 11).

The author's wide experience in psychoanalysis, comparative religion, and Hebraic studies permits him to draw on the parallels between the psychotic fantasies and behavior of individuals and the writings of biblical prophets, apocalyptic revelations, and concerns with the "end of time, world destruction and rebirth of only the good" (e.g., Noah and the Flood). The parallels to any psychoana-

lyst's experiences with depression and psychoses are compelling. Ostow's re-examination of Freud's "Schreber Case" begins to read like the writing of biblical prophets.

The principal themes of the book revolve around depression and fantasies of fusion with God, for which one can read fusion with mother, a return to the womb. Thus, in addition to the phallic-oedipal material, much can be recognized as pregenital oral incorporative wishes. Were all these people psychotic? Trance states, altered states of consciousness, and emotional explosions were frequent among the prophets (as they are among severe depressives and schizophrenics). It may be that leaders of fundamentalist movements were charismatic, visionary psychotics or borderlines who appealed to wretched, helpless, hopeless people.

The Middle East, this land bridge for three continents, was in social and political ferment in the few centuries before and after the beginnings of Christianity. The cultural isolation of the Hebrew kingdoms was destroyed by invasion and conquest. The Assyrians, Persians, Greeks, and Romans arrived with overwhelming armies, their own gods, other moral systems, and different religious practices. The conflicts could not be resolved. To retain Judaism could be punished by death, while the compromise of Judaism threatened the wrath of Jehovah and loss of the afterlife. Within those few centuries, Rabbinic Judaism, gnostic mystics who rejected Jehovah, and various forms of evangelical Christian sects began to grow as pagan nature gods, Zoroastrian and Mithraic religions waned. Many flourished briefly. In a time of suffering everyone looks for a Savior and wishes to join with that Savior's power.

I recommend this volume to those interested in mythopoesis, myths, and the large repository in religious belief and practice of the human being's wish to return to the Garden of Eden, the body of mother.

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Gender Studies

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ABSTRACTS

GENDER STUDIES

Abstracted by Lynne Layton.

The following abstracts include three groups that reflect important contemporary domains of inquiry in women's studies and gender studies. "Queer theory" has complicated understanding of sexuality in important ways, yet it has also had an uneasy relationship with feminism. Postcolonial feminism and the feminism of women of color have complicated understanding of gender and have made it problematic to speak of "women" without referring to race, class, and other identity categories that coexist with gender. And contemporary feminist theories, inspired as they are by "queer theory," postcolonial, and poststructuralist theory, have provided new ways of looking at masculinity/masculinities. Moreover, several of the abstracts reflect tensions between poststructuralist theories that originate in symbolic systems, particularly linguistic systems, and theories that consider themselves materialist and that emanate from the study of lives.

These discussions are relevant for analytic therapists in at least two ways. The psychoanalytic method has much to offer anyone who is exploring gender and sexual ambiguities. At the same time, however, these abstracts reveal that the discipline of psychoanalysis has played a large role in legitimizing certain gender and sexual experiences while pathologizing others.

Reading Freud's Life. Madelon Sprengnether. **American Imago.** LII, 1995. Pp. 9–54.

Sprengnether continues to explore Freud's biography in order to explain why Freud chose to ground psychoanalysis in the oedipus complex. Why have Freud's construction of himself and his self-analysis been so readily accepted by his biographers and the analytic community? Sprengnether examines Freud's letters to his friend Eduard Silberstein and to Martha Bernays during their engagement. In his letters to Silberstein, Freud demands that his friend be totally forthcoming and say everything that is on his mind. The letters to Martha reveal a pattern Sprengnether likens to the fort/da game: instead of mastery, there is a failure to work through the painful feelings surrounding separation and loss. Freud would first provoke a fight with Martha and then reconcile and demand an even greater closeness. Both sets of letters return us to Freud's relationship with his mother, the missing link of psychoanalytic theory. In the letters to Eduard, Freud talks about his closeness to Frau Fluss, who, unlike his own mother, related to him in a non-narcissistic way. Sprengnether believes that Freud enacted a repetition compulsion with Martha, and that he never mourned his separation from and

disappointment in his mother. Freud's oedipal theory bypassed sorrow and mourning. Unable to acknowledge anger toward the mother, Freud created a theory of hostility toward the father and idealization of maternal love.

In Defense of Gender Ambiguity. Jessica Benjamin. **Gender & Psychoanalysis.** I, 1996. Pp. 27-43.

Benjamin adds an important new thread to her argument that bigender and bisexual positions are products of healthy development. Unlike many postmodern theorists who cast off developmental theory because they find it essentially conservative, Benjamin continues to explore development for its potential to produce what she calls postconventional subjects. The author builds on her theory of identificatory love and on Irene Fast's theory of preoedipal gender overinclusiveness (which, according to Benjamin remains a part of the psyche). She argues that, while oedipal gender relations split masculinity and femininity, and split loving another and identifying with another, these polarities can be deconstructed by other developmental gender categories, such as identificatory love (a homoerotic love of one who is like; the wish to be loved as like). In the preoedipal period, identificatory love and object love, being and having, may not be so different. These earlier gender possibilities that remain in tension with oedipal polarities can be reintegrated in postoedipal phases, and here lies the hope for postconventional subjectivity.

Sacrificial Logics. Feminist Theory and the Critique of Identity. Allison Weir. New York/London: Routledge, 1996.

In most accounts of contemporary feminist psychoanalytic theory, the object relations feminism of Chodorow and Benjamin is counterposed to postmodern accounts of gender identity, such as that of Judith Butler. Weir challenges this tradition by focusing on what she perceives to be an underlying similarity: the tendency in all these theories to collapse identity into an oppressive structure of domination, a structure that represses difference. In essays on each of these theorists, as well as on Jacqueline Rose and Luce Irigaray, Weir argues that none of them can derive sociality from their limited concept of the self; at best one gets a paradoxical oscillation between an omnipotent self and a relational self. Weir discredits paradox and urges resolution. She wants to save autonomy and separateness from feminist attack: "This requires a distinction between an understanding of internalization as a form of social domination, and an understanding of internalization as a process (based on identification with others) of learning the norms, principles, and ideals of a society, and of coming to accept them as one's own." Weir's argument is that internalization is a necessary basis of a

capacity for reflection and critique (her definition of autonomy), not a prelude to domination. She draws on a particular reading of Kristeva that grounds a social self in the child's recognition of and identification with her mother's investment in the world, where mother is "unified in division." Kristeva offers a vision of self-identity that develops via acceptance (rather than denial) of nonidentity or difference. Weir's project—to ground a nonrepressive identity—is extremely important; unfortunately, she misreads Benjamin and Chodorow, who both proffer relational theories of internalization that do not lead to domination and who have always distinguished between nonoppressive and oppressive forms of separation and autonomy.

Toward a Model of Self-Identity: Habermas and Kristeva. Allison Weir. In **Feminists Read Habermas,** ed. Johanna Meehan. New York: Routledge, 1995. Pp. 263-282.

This essay would have been appropriate as the last chapter of *Sacrificial Logics*, since Weir sketches her theory of social self-identity more clearly here than in the book. The criticism of Benjamin and Butler is reiterated. It is evident that Weir's central concern is how one develops a capacity for critique. Her model proposes that we do not internalize one conventional and agreed-upon set of norms but rather conflicting norms taken in via the variety of our relationships. From the conflict among these norms comes a capacity to abstract from the particular relationships, to be critical of norms, and to appeal to principles: "The child is forced to individuate through taking positions with respect to given conflicts." Drawing on Mead and Habermas, Weir makes the claim that the learning and use of language guarantee intersubjectivity. Drawing on Kristeva, she argues that love is the motivation for investing in a world of shared meanings rather than only personal meanings. Again, Weir's model of self-identity offers important insights about the sociality of the self, but clinicians may find that her model displays a certain naïveté about how difficult the path to the development of intersubjectivity can be.

Gender and Knowledge. K. Lennon. **Journal of Gender Studies.** IV, 1995. Pp. 133-143.

Feminist epistemologists have challenged hegemonic masculinity by arguing that knowledge reflects "the position of the knowledge producer at a particular historical moment, in a particular culture, of a certain colour, gender and sexuality. . . ." But where does this leave feminist epistemological projects? Lennon reviews criticisms of the search for a female subjectivity (e.g., the diversity of

women, the problem of using the categories masculine/feminine produced by a male symbolic). She believes that we can use the categories masculine/feminine without buying the whole ideological framework of patriarchy. Women's lives are in fact different from men's, and the content of the categories does not remain static. A feminist epistemological standpoint is marked by its acknowledgment of power differences between men and women. Lennon argues that the material reality of the lives of those constructed as "other" challenges those dominant constructions; her vision mediates between deconstructionist and materialist epistemologies. The materiality of lives makes dominant ideologies visible as ideologies. At the same time, each new position can be contested because it inevitably creates its own marginalities. People can theorize from another's position; Sandra Harding, for example, urges men to theorize from women's lives. Epistemological progress occurs as long as space remains open for the marginalized to articulate their experience.

Gender as a Personal and Cultural Construction. Nancy J. Chodorow. **Signs.** XX, 1995. Pp. 516-544.

Chodorow's concern here is that feminists who have turned away from psychoanalysis to focus only on discursive and cultural processes miss something crucial about the nature of gender identity. In the same way, psychoanalysts and psychologists who think that the intrapsychic can be considered apart from culture and its symbolic systems cannot fully account for gender identity. Chodorow's thesis is that "gender cannot be seen as entirely culturally, linguistically, or politically constructed. Rather, there are individual psychological processes in addition to, and in a different register from culture, language, and power relations that construct gender for the individual. Meaning . . . is always psychologically particular to the individual." Because of the personal nature of gender identity, Chodorow contends that there are many individual masculinities and femininities. The processes of emotion, fantasy, and self-construction can be made universal, but not the content.

Was We'Wha a Homosexual? W. Roscoe. **GLQ.** II, 1995. Pp. 103-235.

Roscoe, a cultural historian of the Zuni "two-spirit" We'Wha, was asked if We'Wha was a homosexual. Roscoe's concern is that the constriction of "homosexual" to same-sex love has made contemporaries unable to see links between themselves and these non-Western ancestors who conceived of themselves as third and fourth gender beings. The article examines the cross-influence between "two spirits," European explorers who lived among them and catalogued their exis-

tence, and European discourses that drew on the ethnographies for various purposes (the moral discourse that justified conquest on the basis of inferiority; the discourse that saw the two-spirits as monsters or prodigies; the medical-scientific discourse of the mid- and late nineteenth century that understood them as examples of disease). Roscoe's thesis is that cultural influences between Native Americans and Europeans always go both ways. Thus, those who first used the term "homosexuality" in nineteenth century discourses were not only aware of "two-spirits" but cited and, in some cases, agreed with their self-conceptualizations, which focused on third gender status and not on desiring sex with one's own gender. On reviewing homosexual activism, we see again an expansion of gender categories; therapeutic discourse might this time around refrain from pathologizing and instead allow for a multiplicity that goes beyond male or female.

Against Proper Objects. Judith Butler. **Differences. More Gender Trouble: Feminism Meets Queer Theory.** VI, 2/3, 1994. Pp. 1-26.

In this introduction to a special issue, Butler objects to "queer" theory's way of grounding itself in opposition to feminism. She rejects the claim that feminism's proper object of study is gender and queer theory's is sexuality. By separating sexuality from gender and thus ignoring or repudiating sexual difference, some versions of queer theory risk shoring up the traditional symbolic order in which there is only one sex and it is male. She also protests the Foucaultian turnaway from psychoanalysis, wherein sexuality becomes a regulatory system separate from kinship systems. The bracketing of sexuality from kinship fulfills the fantasy of a "desire to desire beyond the psyche, beyond the traces of kinship that psyches bear." Declaring herself in opposition to the way disciplines found themselves on exclusions and repudiations of other disciplines, Butler reminds us that there are pro-sex feminist positions that laid the groundwork for queer theory (that MacKinnon's theory of sexuality does not exhaust feminist positions), and that the feminism of women of color has shown that genders are no less ambiguous than sexualities. She wants feminism and "queer theory" to focus on the tensions between social practices and the symbolic, the way that particular practices render the symbolic dynamic, unstable, changeable.

Sexual Trauma/Queer Memory. A. Cvetkovich. **GLQ.** II, 1995. Pp. 351-377.

Cvetkovich describes a women's festival in which survivors of sexual abuse were warned against a punk band's performance that included simulations of sexual aggression. She criticizes the fact that lesbian subcultures that focus on healing

from abuse have constructed discourses that are mutually exclusive from those constructed by lesbian subcultures that encourage the exploration of sexuality (by which she often means sadomasochism). She argues that this results in "repeating anew the schism between pleasure and danger, and ignoring the fact that one of the most interesting things about sex is that it so often refuses that distinction." Analyzing two lesbian incest texts, the author makes the case that sex practices and fantasies that resemble abuse scenarios are often ways of breaking silence, claiming agency, and healing. Silence has to do not only with shame about abuse but with shame about the victim's sexuality; the demand usually implicit in abuse literature that the victim be passive, innocent, and desexualized enforces the silence around sexuality. On attempting to explain lesbian culture's possible contribution to the understanding of trauma, the author provides several answers, including the following: lesbianism may be a welcome effect of sexual abuse in that a change of object choice is healing; there are a disproportionate number of lesbians in helping professions, and this presence has an important impact on how healing is practiced and theorized. Rather than worry about linking lesbianism explicitly with sexual abuse, the author argues that the link produces new ways of thinking about and healing trauma.

Experimental Desire. Rethinking Queer Subjectivity. E. Grosz. In **Supposing the Subject,** ed. Joan Copjec. London: Verso, 1994. Pp. 113-157.

Grosz contends, in opposition to Judith Butler, that the critical locus of transgressive inquiry is not the disjunction between a body and its gender but the instabilities of the body itself. For Grosz, "the body is what it is capable of doing, and what anybody is capable of doing is well beyond the tolerance of any given culture." She draws on Deleuze and Guattari to explicate the differences and connections between what a body is and what it can do. Their work offers a way of conceiving the organization of sexuality differently from how it is organized in a heterosexist, phallocentric regime. Grosz turns to the Nietzschean description of active/reactive, affirming/negating forces because she thinks that contemporary psychoanalysis (by which, like most postmodernists, she means Lacan or Freud) is not capable of conceiving alternative libidinal economies or different modes of production and regulation of bodies and pleasures.

Grosz focuses on lesbianism and believes that it is good that lesbianism's sexual practices are undertheorized. This is in contrast to Marilyn Frye, who sees the lack of words available to describe lesbian sexuality as a cultural way of devaluing lesbianism. In Grosz's view, lesbianism has been the most resistant of all sexualities to being subsumed under phallocentric categories. The author concludes that while all oppressions have certain things in common, oppression on the basis of what one does, rather than what one is, is specific to homophobia. In her view, homosexual relations and lifestyles offer the possibility of a different libidinal economy.

The Practice of Love. Lesbian Sexuality and Perverse Desire. T. de Lauretis. Bloomington, IN: Indiana University Press, 1994.

De Lauretis continues to be one of the most exciting of feminist thinkers, always expanding her theoretical framework to accommodate psychoanalysis, strains of postmodern thought, and the concrete reality of women's social practices. She protests the way feminists have appropriated lesbianism as a marker of women's bisexuality or hysteria, or of women's connections to other women; lesbian specificity—same-sex desire and sexual activity—is consistently absorbed into heterosexuality. The appeal of psychoanalysis for feminists is that it was one of the only discourses that posited women as agents with sexual desire; lesbianism currently performs a similar function for heterosexual feminism, but, in so doing, the psychic and social differences of lesbians are elided. She finds in Freud a possibility for a nonpathological view of perversion. In a fascinating reading of Helene Deutsch, De Lauretis argues that Deutsch saw lesbianism not as a regression to the preoedipal and predifferentiation, but as a return to a repressed negative oedipal stage. The analyst as substitute mother gives permission to be sexual with a woman: "The consent to homosexual activity and gratification may be provided by a discourse that permits them, as well as by participation in the activity itself." The author calls for cultural representations of lesbian sexuality that will authorize it, and she analyzes texts and films that attempt such authorization.

Black (W)holes and the Geometry of Black Female Sexuality. E. Hammonds. **Differences.** VI, 1994. Pp. 126-145.

Hammonds is troubled by the silence maintained by both theorists of homosexuality and black and white feminists regarding black lesbian sexuality. Current discussions concerning black female sexuality generally represent it as silenced, simultaneously hypervisible and invisible, an empty void. Historical inquiries speak of a "culture of dissemblance," the tendency of black middle-class women to keep their sexuality to themselves in order not to feed oppressive stereotypes. Thus, no one is talking about the pleasure, exploration, and agency of black female sexuality, let alone black lesbian sexuality. When it is discussed, black lesbian sexuality has been differentiated from white lesbian sexuality; Hammonds argues that it needs to be related to black heterosexuality because of the specific intersections of race, gender, and sexuality. Black lesbians tend to be cast as race traitors. She offers as an example of black-white lesbian difference the possibility that black lesbians may tend also to have sexual relations with men. The author suggests that psychoanalysis may be useful to black women who want to reclaim their bodies and to find a language for expressing desire. She concludes with a discussion of her work on AIDS in the African-American community, where,

again, black women are not heard because of the stigma attached to their sexuality.

The Primitive as Analyst: Postcolonial Feminism's Access to Psychoanalysis. K. Seshadri-Crooks. **Cultural Critique,** 1994. Pp. 175-213.

Seshadri-Crooks reviews the history of psychoanalysis in India. She argues that the scientistic way the analyst has been defined in the West has made it impossible for a non-Westerner to inhabit that position. Psychoanalytic theory opposes the primitive to the civilized, and its definition of the civilized places high value on monotheism, science, and a version of secondary process inimical to such non-Western practices as polytheism. Women, children, and non-Europeans are relegated to the primitive. Thus, Seshadri-Crooks points to the ways in which psychoanalysis is white, European, secular, and middle class.

Nonetheless, this article does not reject psychoanalysis but rather seeks a position for "others" that would still be psychoanalytic. To this end, she examines the work of Indian scholar Gananath Obeyesekere, who theorizes the relation between the unconscious and cultural systems in non-Western societies. The recognition of other modes of self-awareness and self-reflection yields a revised psychoanalysis that accounts for the nature of power relations between the sexes in India and for the psychic violence wrought by colonialism. Such violence includes the emergence of Indians who distance themselves from their culture by occupying the scientific position they believe is valued by Westerners.

On Not Being La Malinche: Border Negotiations of Gender in Sandra Cisneros's "Never Marry a Mexican" and "Woman Hollering Creek." J. Wyatt. **Tulsa Studies in Women's Literature.** XIV, 1995. Pp. 243-271.

Wyatt analyzes three Cisneros stories in which the female protagonists, living on the border between Anglo and Mexican cultures, struggle psychically with three female icons of Mexican culture: "Guadalupe, the virgin mother who has not abandoned us, la *Chingada* (Malinche), the raped mother whom we have abandoned, and la Llorona, the mother who seeks her lost children." In "Never Marry a Mexican," the heroine has not worked through her mother's cultural and sexual self-hatred, which dooms her to sadomasochistic replays and reversals of white/Mexican and conqueror/conquered. In "Woman Hollering Creek," the long-suffering Mexican heroine, trapped in an abusive marriage to a Chicano, comes to identify with her Chicana rescuer, a woman who negotiates freely between Mexican and American gender identities. Wyatt understands the gender negotiations in these stories as two stages of a dialectic completed in a third story, "Little Miracles, Kept Promises," in which the heroine reaches an understanding

of the history of the icons, how they have played into her daughter-mother relations, and how they have affected her psyche. The work produces a psychic freedom that allows communal reinventions and revisions of self and culture. In Cisneros's words, "We accept our culture, but not without adapting [it to] ourselves as women."

Beyond White and Other: Relationality and Narratives of Race in Feminist Discourse. S. S. Friedman. **Signs.** XXI, 1995. Pp. 1-49.

Friedman examines the racial crises that erupted after the acquittal of police in the Rodney King case and argues that we must go beyond the white/black binary if we want to understand race relations in the contemporary world. Feminist theory, she believes has adhered to this binary as exemplified in three different narratives: narratives of denial (white feminists proclaim we are all women; race does not matter); accusation (black feminists accuse whites of ignoring the particularities of black experience); and confession (white feminists take the accusations seriously and confess their racism). All of these narratives maintain whiteness as center, assume a homogeneity of whiteness, obscure other racism beside white, imagine clear boundaries between races, make race the central oppression, obscure contradictory subject positions, and leave no common ground for bonding. Friedman analyzes two films, *Mississippi Masala* and *The Crying Game*, and lists a series of news events, all of which exemplify what she calls narratives of relational positionality. Such narratives recognize that individuals can maintain many group identities, and that identity is defined and constructed according to one's situation. Friedman thinks these narratives better capture both the complexity of identities and the possibilities of cross-group bonding.

Toward Postmodern Masculinities. Barnaby B. Barratt and Barrie Ruth Straus. **American Imago.** LI, 1994. Pp. 37-68.

Arguing that psychoanalysis is both a modernist and a postmodernist discourse, the authors look first at the phallocentric oedipal narrative that positions all male subjects in particular ways. They then seek bodily and discursive practices that would disrupt phallic, homogenizing masculinity. Many feminists have discussed the way oedipal narrative positions man as subject, woman as obstacle/other. Here the authors focus on the father's wish to kill the son and the demand that he repress this wish if the species is to continue. The oedipus narrative represents masculinity as a trajectory from one ineluctable act of violence (repressed infanticide) to the next (repressed patricide). In the authors' Lacanian framework, a key task is to examine why culture routinely obscures the distinction between the penis and the phallus, thus allowing the male subject to deny the reality of

castration. They seek practices in the breakup of patriarchy's own absolutism that might challenge this delusory pretense, and they suggest (1) a renewed experimentation with fatherhood, in which mortality is acknowledged and not defended against; (2) promotion of the eroticization of the whole body; (3) a logic of free association to replace phallocentric logic. Free association is always fluid and promotes a "non-identitarian" subject who is aware of a lack, one not oppressive to others.

Sexual Difference. Masculinity and Psychoanalysis. S. Frosh. New York: Routledge, 1994.

Frosh argues that in psychoanalytic theory, sexual difference is an organizing principle central to personal identity, but its constructed character makes transgression of its categories possible if not likely. Several discussions in the book focus on the gender aspect of psychoanalytic theory. It is no accident that Klein's theory is mother-focused while Freud's and Lacan's theories are father-focused. In a reading of Freud's discussion of the Irma dream, Frosh notes how femininity keeps subverting an attempt to speak in a masculine voice, how Freud keeps slipping into both masculine and feminine positions. In another chapter he explains male violence as the result of the gap between what masculinity is alleged to be (having the phallus) and the actual powerlessness men feel. Sexuality is built around dependence, which challenges the male model of autonomy. Because men feel more dependent and thus less sufficient in sex, violence is a possibility. In a final chapter the author draws on Kristeva to argue that the analyst challenges the basis of sexual difference by intermingling the holding position with the differentiating position. In several chapters, Frosh critiques Lacanian phallocentrism, but he seems to find many of Lacan's categories useful.