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RACE, CULTURE, AND PSYCHOTHERAPY: TRANSFERENCE TO MINORITY THERAPISTS

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We present observations on the use of racial and cultural stereotypes in psychoanalytic psychotherapy with patients from the majority culture and with those from minority backgrounds. Earlier work has centered on black/white patient dyads and has not taken other possible combinations into account. "Race" and "culture" have sometimes been used synonymously. Our clinical experience indicates that there is some overlap in the themes of transferences to us as members of different racial minorities. We note, however, that for the African-American therapist, projections are more often based on racial stereotypes, whereas for the Chinese-American therapist, projections are based more on cultural assumptions. When careful attention is paid to the manifestations of racial and cultural stereotyping, much can be learned about the patient's inner life, to the benefit of the analytic work.

As therapists from minority cultures, we find that our practice of psychotherapy illuminates a number of important issues, especially in the areas of transference, countertransference, and the understanding of resistance. For the purposes of this paper, we are not making a distinction between the treatment modalities of psychoanalysis and psychoanalytic psychotherapy. In our attempt to understand the importance of "racial" and "cultural" influences on the analytic process, significant clarity was gained when we brought our own individual ethnic identities to bear on the process. We found that the "picture" seen and painted by a Chi-

nese-American and an African-American therapist on the same analytic canvas is in some ways quite similar and in other ways very different. An examination of these similarities and differences led to a fuller understanding of the effects of race and culture on psychotherapy.

Although "race" and "culture" are sometimes used interchangeably, we shall differentiate between them for the purposes of our discussion. We use each term to refer to a distinct but not always separate set of influences. While "race" was formerly understood to be a biologically determined factor that encompassed certain distinctive physical traits, it is now seen more as a social construct with its point of origin being identifications based on skin color. Such physical characteristics, which provide a racial identity, can be as dominant a factor in the development of a person as gender. "Culture" is here defined as those values, aspirations, and behaviors that are transmitted by conscious and unconscious processes through teaching, parenting, and modeling. It is reflected in the psychological registers of the ego ideal and self- and object representations, as well as in tradition, institutions, and social organizations. The idea of psychoanalysis without regard to gender is unthinkable, yet racial and cultural factors are often not recognized, understood, or analyzed in the clinical setting. Minority here refers to those in the population who are racial minorities, that is, who are not white.

It is our contention that there is a difference in the power of the relative roles that race and culture exert on the analytic process. For African Americans, we believe race to be the dominant factor, whereas for Chinese Americans, it is the culture that prevails. In our discussions, we were struck by the different qualities in the transferences that we experienced: they seemed related to stereotypes based purely on race for Gardner, but on both race and culture for Tang. Needless to say, socioeconomic status is an important influence, particularly as it overlaps with different races and cultures commonly seen as minorities. When the variables of race, culture, and class are considered along with traditional clinical material, a more helpful and complete therapeutic picture

emerges. We found the use of stereotyping to be an informative reflection of the realities of these variables in the clinical setting.

Obviously, there is a confluence of race and culture in the use of stereotypes, and it is our intention to explore the function of such stereotypes in analysis. It is the nature of stereotyping to mix an identification of a person with a distinctive physical trait (that is, race) with real or imagined personality characteristics. An example would be to see African Americans as athletic, lazy, musical, and aggressive. Racial stereotypes of Chinese Americans would be more likely to include physical weakness, industriousness, talent in mathematics, and sneakiness, whereas cultural stereotypes might encompass passivity, compliance, closeness to family, and money-grubbing. We believe there is much to be gained from the exploration of racially and culturally different patient-therapist dyads. While we observed some similar transference themes that were related to our being identified as members of racial minorities, there were also some significant differences stimulated by the stereotypes that our respective racial identities represented to the patient. It is the functions of these stereotypes, as well as the transference and countertransference themes that arose in various treatment dyads, that will be examined here.

A review of the literature reveals that discussions of race and culture have been limited to a consideration of the difficulties that are introduced into the analytic situation when the therapist and patient do not share the same cultural background. This includes discussions in which a specific clinical phenomenon such as transference, resistance, or countertransference is being examined. Even in this area, there is a prevailing sense that the very fact of cultural difference will become problematic no matter what the particulars may be in terms of the transference or other clinical issues. There are, however, more recent papers (Holmes, 1992; Leary, 1995) that are exceptions to this. Holmes points out that many of the early discussions in the literature focused frequently on an attempt to understand the impact of race on personality development. Though not stated as such, this focus endeavored to explain the pathological impact of race and culture on the per-

sonality, to understand the areas of ego deficit and developmental arrest in the personality due to stresses associated with being a minority person. Underlying assumptions supporting such an investigation presume that cultural experiences or racial identifications are problematic and are unidimensional. In other words, it is taken for granted that being of a particular cultural or racial background results in one kind of identifiable impact on an individual. The influence of this kind of thinking is reflected in the writings of Kardiner and Ovesey (1951) and Karon (1958), who discuss the "Negro personality" with the conclusion that experiences of being black lead to symptomatic accommodations and personality deficits. They write that "the personality functioning of Black people living under segregation and with discrimination was said to be typified by a constellation of traits, including low self-esteem, apathy, fears of relatedness, mistrust, problems with control of aggression, and orientation to pleasure in the moment" (quoted from Leary, 1995, p. 129). Put another way, blacks are treated in ways that result in their being isolated, somewhat paranoid, unable to delay gratification or displace anger — that is, they have little ego.

From such a perspective the analytic endeavor seems irrelevant, indeed almost oppositional to an understanding of people identified as racial minorities. The social and political influences of the 1960's played a significant part in shifting the focus away from this predominantly negative way of viewing the influence of racial identifications and cultural manifestations. Beginning in the late 1960's, articles appeared about the possible enhancing aspects of different cultural experiences (e.g., Schachter and Butts, 1968; Jones, 1985). Writers such as Hoffman (1983) and Renik (1993) began to include the importance of the interactive experience and the relational aspects of coming to understand the meaning of different racial backgrounds. This in turn coincided with the shift in psychoanalysis from the emphasis on the analyst as neutral and a blank screen to an examination of the mutual impact of analyst and patient in the analytic process.

As a result of the influences of the 1960's, other shifts occurred

as well. Racial identifications were no longer seen only as an arena for problems in psychotherapy. There was a greater awareness that being of a particular racial group does not automatically lead to pathology and deficit, but in fact is a fruitful area for exploration and understanding. This is reflected by Schachter and Butts (1968), who suggest that differences in racial background can be not only problematic, but also an asset to the therapy. They state, "If the stereotype and the developing transference are both reflections of the analysand's personal difficulties, this confluence of transference and stereotype will facilitate the analysis" (p. 803). This is consistent with more contemporary observations that when careful attention is paid to realities and fantasies associated with race, particularly in mixed-race therapy dyads or when patient and analyst share minority status, a very successful therapeutic process may be set in motion.

This shift in thinking has continued and now includes cultural differences that are not limited to those based on race or color, but encompasses the notion that white therapists and patients are also from a race and culture. Leary (1995) writes that race and ethnicity are treated as if they are qualities possessed only by people of color, and that when one thinks of the majority culture, one fails to recognize that it is also a definable culture with limitations and parameters just like all other cultures. This point is conspicuously absent in the psychoanalytic literature. Furthermore, in a number of papers by black psychotherapists (Gardner, 1971; Griffith, 1977), there is a tremendous emphasis on the need for black therapists to be comfortable with their own racial identities, especially when treating black patients. The danger in not being secure about one's own racial identity is viewed as a potential threat to the treatment because of highly negative countertransferences, especially if a militant black is in treatment with a passive, compliant one, or vice versa It is interesting that such an expectation does not seem to apply to other groups, for example, a Jewish therapist with a Jewish patient. The description of "Jewish" can refer to culture and its values, to religion, and, mistakenly, to race. Surely there is something to be said for the need for

clarity about one's own identity in patient-therapist dyads such as these as well.

Leary does an elegant job of looking at three cases that clearly demonstrate ways in which both the transference and countertransference, which were related to her being a black therapist, could enhance or impede the course of treatment. Her point, as we understand it, is that the meaning of racial differences as they emerge in the transference and countertransference can be negotiated in such a way as to enrich the therapeutic process, and should be addressed and explored when they arise in the material. This can and should apply equally to any therapeutic dyad.

In this paper, we will examine some of the intrapsychic meanings of both cultural and racial differences, some ways in which the attendant anxiety is defended against, and clinical examples of the impact that this has on the therapy when the therapist is not white. In instances in which the therapist is unfamiliar with certain profound experiences based on racial or cultural identity, and to the degree that anxiety is felt, one common defense is to depend on stereotypical points of view and to rely on more rigid techniques without a true understanding of the dynamics. When such therapists are faced with these experiential differences, value-laden comparisons are often made unconsciously.

The awareness of and coping with being racially different is largely the province of minorities. It is interesting to note that it is minority children who show an earlier awareness of racial differences than do children from the majority group. In a predominantly white culture such as that of the United States, it is not surprising that being a person "of color" is an integral part of one's identity. For whites, it is not the same. "If I am riding my bicycle into the wind, I feel its resistance; but if I ride with the wind, I forget that it's there. The same is true with culture, which must be resisted to be experienced" (quoted in Zaphiropoulos, 1987, p. 459). For a white patient, then, being in treatment with a minority therapist may provide a rare instance of "riding into the wind." It is our contention that psychoanalytic theory represents and is synonymous with Western European

values. We recognize that these values are also dominant in the United States. Here, the cultures of racial minorities are by definition subcultures. Members of a racial minority who enter psychoanalysis are therefore confronted with an unequal relationship, both as seekers of help and as members of a subculture.

In several articles on black-white patient-therapist dyads, a great deal has been made of the quality and content of the transference and countertransference. What is missing from the literature, however, is the intrapsychic meaning of being of a different color. As Erikson (1950) noted, an important part of one's identity formation is the recognition of and identification with one's own group, and the exclusion and often reviling of other groups. Color difference is a concrete symbol of racial difference. Perhaps as a result of the early stage of development at which color differences are thought to be discerned, they can be associated with primitive projections and fantasies. There is general agreement that "black" is associated with depression when it is responded to as a color in the Rorschach. It also carries negative and often scary connotations from an early age, so that at a preschool level, children will associate positive adjectives to white figures and negative ones to black figures (Katz, 1976).

Almost by definition, a minority therapist is already schooled in two cultures—her own and that of the majority culture. She has been trained in a theoretical and developmental framework that is unique to the Western world and that may often differ from her own cultural values and norms. An example of this might be the dependence on one's family which is encouraged in Chinese children, but which is viewed with disapproval in a psychological theory that encourages separation and individuation from the age of two or three. To underscore the value of the family to a Chinese child, it is not unusual for the mother to express her love through meeting the infant's every physical need. The infant sleeps with the parents until another sibling is born, and perhaps even after that. The mother may very well continue to feed the child long after it is capable of doing so itself. In short, if dependence is

valued, then it is the family's job to provide everything that the growing child could possibly need (Tang, 1992).

Another example is the way in which black family members will assume different roles within the family as needed. The flexible exchange of roles where aunt and uncle will often act as parents has been well established within many African-American families. It is not unusual for adult sisters and brothers to live within the same household, or in households that are within close proximity. It is therefore routine for children to spend the night at different houses on different nights of the week, depending on which set of adults is responsible for the children on that particular night. Within the child's world, then, the experience is not one of instability, but rather one in which the child is taken care of by a large, extended family. A clinical example is provided by S who would refer to two different women as "mother," with no apparent need to make a distinction between them. The therapist spent a great deal of time attempting to understand the clinical meaning of this blurring of identities of such a crucial figure in this patient's childhood before understanding that this "blurring" was in fact an accurate account of the patient's experience of "mother" within his extended family.

As a result of the minority therapist's experience of living in two cultures, as it were, the therapist will be more keenly attuned to issues in the transference that are related to cultural differences. As a person of color and of a different culture, the minority therapist is more than just a blank screen, and his or her color will pull forth a rich variety of projections and stereotypes. This is not unlike the kinds of fantasies that male analysts may evoke in their female patients and vice versa. This very use of color to describe people of different racial backgrounds is of interest in and of itself. It is viewed by some (e.g., Curry, 1964) as enhancing certain myths and fantasies associated with a specific color. In Curry's view, black represents "darkness, sleep, death,. . .the Devil and evil" whereas white represents the opposite, namely, "illumination, light, awareness" (pp. 547-548).

In this discussion, we will examine closely two different dyads

and some of the implications these have for the transference, countertransference, and the understanding of resistance. The first is the minority therapist treating a majority patient, and the second is the minority therapist treating other minority patients. We use the terms minority and majority groups to encapsulate the differences between those who are racially identified as being in one or the other in the United States. We are painfully cognizant of the awkwardness of this wording, but it seemed the most convenient shorthand for the purposes of this discussion.

Minority-Therapist Majority-Patient Dyads

When therapist and patient come from similar backgrounds, there are certain shared assumptions by both individuals about their culture. This includes those values and ego ideals that are taught, aspired to, and modeled from early on. It is our contention that the more similar the experience, background, history, and culture of therapist and patient, the fewer challenges there are to shared assumptions about appropriate behaviors and responses to situations. In therapy matches of people of different racial backgrounds, the dissimilarities can threaten the therapeutic process and lead to impasse and premature termination. The therapeutic impasse can occur when the patient holds a particular culture-specific value, and the therapist understands and interprets this as a resistance. The patient is left feeling misunderstood and in conflict between what seems appropriate in her or his own cultural group, and what is clearly in question in the therapy. One of us (Tang) recalled a situation in which a response that was culturally appropriate in a Confucian-based culture was viewed as evidence of self-deprecation, lack of self-esteem, or even false modesty. The occasion was one in which a Caucasian colleague commented on what a nice house I had. True to appropriate form in a Chinese culture, I responded by saying that it was really not such a good house, and I proceeded to point out some of its flaws. Needless to say, I was deeply hurt when my response was under-

stood to be a sign of psychopathology. I would like to stress that it was not until many years later with a more careful examination of what were appropriate forms in my own culture that I understood the problem. Until then, I wondered if indeed there was something wrong with the way I saw and portrayed myself. Although this particular example comes from a social interaction rather than a therapy session, it is reminiscent of a clinical situation in which specific cultural values are not fully understood when they are seen only in terms of defensive functions. It is only when confronted with someone of a different culture who is assumed to have dissimilar experiences that one is forced to confront one's own.

In the case of the minority-therapist majority-patient dyad, a Caucasian patient may see us as knowing what it is like to be disenfranchised, something they have felt all their lives. Just as a female patient may not feel comfortable revealing certain things to a male therapist, but willingly and eagerly shares them with a female therapist, so, too, do our "disenfranchised" majority patients express things to us. A twenty-five-year-old Caucasian woman sought psychotherapy after her graduation from a large public university which she had found tremendously intimidating. In spite of her record of academic success, she was afraid to walk by the administration building for fear that someone would notice her and recognize that she really did not belong. This echoed her own history of never knowing where she fit within her family. Her father's identity was kept secret, and she was aware of being illegitimate. She was shifted back and forth from her mother to her grandmother, depending on the state of her mother's current male relationship. To a great extent, she identified with me as being a "minority" and felt that we shared the experience of being outsiders.

Another such example was presented by a thirty-one-year-old Caucasian lesbian who had sought a change of therapist from one she had met with three times. This other therapist was also Caucasian and a very talented and sensitive clinician. The patient came from the South, from a family of "poor white trash." She

had a hard time feeling that she was accepted at the college that she attended and perceived that other students were from rich and privileged backgrounds. What became explicit in the course of the brief therapy was that she was able to feel understood and accepted by me (Tang) *because* I was from a minority group, and she felt that we shared similar experiences since as a lesbian and as a poor person, she also felt like a minority.

The transference fantasy that occurred in the psychoanalysis of a Caucasian woman with a black female psychoanalyst serves to illuminate further aspects of this phenomenon. In this particular case, the patient fantasized that the therapist was a blues singer, and a very good one at that. The patient was a young woman who acted out her sadomasochistic dynamics in her relationships with men. She saw her therapist as a mature and talented singer, who would teach her how to sing the blues. In fact, the patient became very caught up in this fantasy and took voice lessons quite seriously. This case demonstrates the use to which a racial difference can be put. Being a black, and a blues singer to boot, implies both the experience of suffering and the ability to transcend the position of inferiority and pain by turning passive into active, that is, singing about one's sorrows. The patient's identification with her therapist's racial background allowed her to incorporate aspects of her therapist in a useful and creative way.

Clearly, the role of being a minority member is seen in these three examples as being an inferior one in a stereotypic fashion. It is used as a way to identify with a feeling of suffering and of being an outsider. Schachter and Butts (1968) point out the use to which a Jewish male patient put his stereotype of black men in the transference with his black analyst. His view of the "Negro as a virtual sexual superman" (p. 797) provided a neat entrée to an interpretation about his own sense of inadequacy. Interestingly, in the other case of a black male patient with a white female analyst, it was the patient who presented himself in a stereotyped fashion as highly aggressive, sexually irresponsible, and undependable.

Though not expressed in this way, the use of stereotyping is also evident in a number of cases discussed by Holmes (1992) and

Leary (1995). Not surprisingly, this occurs with both black and white patients. Ms. A, described in Holmes's paper, is a black woman whose self-hatred is reflected in her anger at having been referred to a black female therapist, implying that the therapist must therefore be inferior. Ms. E, a white patient, presumes that Holmes will know what it is like to be poor; that is, blacks stereotypically have experience with poverty. Leary's first case illustration is that of a young white boy who acts out his own sense of helplessness and victimization by treating his black therapist as if she were the slave and he the master. Her second case is of a white man who thinks of her as being "wild and provocative," and, furthermore, that she must be a beneficiary of affirmative action. We believe these are also common stereotypes of black women, namely, needing affirmative action in order to succeed because of a basic inferiority, and of being powerfully sexual and seductive. Her third case reflects the referring white therapist's own assumption that a black woman would, of course, work better with a black therapist, in spite of the lack of evidence in the material.

Clues about some aspects of the transference are provided in the attempts that patients will make to deal with the cultural differences between themselves and the therapist. It is evident at times when the patient vociferously denies that there is any difference or, conversely, greatly exaggerates the difference and makes assumptions based on cultural stereotypes. For example, as a Chinese-American therapist, I was confronted by the concern of a Caucasian patient that I must disapprove of her strained and distant relationships with her own family. Further exploration revealed that she was convinced that as a Chinese, I must come from a close and extended family, and would see her as being irresponsible and somewhat lacking. While on one level, this represented an effort on the patient's part to come to grips with our cultural differences, it is also an example of how in the patient's use of a cultural stereotype—all Chinese have close family relationships—I was an object for a transitory identification, since she herself yearned to create a closer family in her marriage.

We believe that the nature of racial disparity leads to inhibitions

to the development of a negative transference. This can occur when derogatory or angry thoughts about the minority therapist are tinged with racism in a way that makes it uncomfortable for the patient of a different race to express. This is particularly true when the patient is white. Since those of the majority culture, in fact, often have greater power in the social structure, there may be more concern about the capacity to do harm to the therapist. Negative feelings about the minority therapist might stimulate guilt and worry about destroying the therapist.

The understanding that the therapist must always be prepared to do self-analytic work in order to conduct a successful treatment has long been established. "Other innovations in technique relate to the physician himself. We have become aware of the 'counter-transference', which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it" (Freud, 1910, p. 144). We pay close attention to the use of stereotypical points of view and language in reference to minorities. It is as if what might be an even hovering of attention in another clinical situation is shifted into one in which the therapist's minority status assumes a prominent position in the mind of the therapist and in so doing influences the focus of attention. In our observations, the minority therapist pays heed to the reactions of the patient to the minority identity of the therapist. In the case of being matched with a Caucasian patient, the minority therapist has a tendency to be hyperalert to statements that bear possible tones of racism or bigotry. Though this may be a departure from the "ideal" neutral stance, it serves to make available projections based upon race. For example, one of us (Tang) was seeing an older Caucasian female who lamented the marriage of her oldest daughter to an Asian man. Such an attitude might easily reflect a developing negative transference in the therapy. Although the issue was raised by the therapist, the patient denied that her feelings had anything to do with race, but rather with the fact that this man had been previously married and brought two children with him to the marriage. Despite this, the

therapist was alerted to the fact that this attitude might well have an impact on the therapy.

In another example, a Caucasian patient came into my office (Gardner) for an initial consultation. Upon seeing that I am black, he walked directly to the wall where my diplomas hang and inspected them. This dramatic enactment of the patient's concerns about the therapist's professional qualifications may reflect aspects of the patient's character. These may include an obsessional need to know, an inclination to rely on external validation or other clinically significant attributes. However, the black clinician is likely to think first of the possible tones of racism that the act implies, and to be alerted to the potential for a negative transference.

Minority Therapist with Minory Patient

It is especially when a minority patient has the opportunity to see a minority therapist that the therapist's being conversant in two cultures gains particular importance. The culturally "literate" therapist brings with her a set of symbols and myths, not to mention real life experiences that make her more receptive to and understanding of those shared by patients who are of the same or even of a different racial minority group. There is already in place a more flexible and broader way of looking at the possible meanings of a piece of behavior.

When the therapist and patient are from the same cultural background, there is an assumption about shared meaning and experience. As one young Asian woman put it, "You are the first person I have seen who looks like me." Although we came from vastly different geographical locations, she felt that I (Tang) would more readily understand the role of women in a predominantly Chinese family. Many patients express concern that they be understood, often by asking if what they are saying makes sense, or even quite directly if the therapist understands what they mean. It is our experience that when the patient and therapist share a

cultural identity, there is a greater readiness to believe that one is understood, and a positive transference emerges more quickly. In the beginning phase of treatment of Asian patients, for example, I am likely to be sensitive to the difficulty many Asians have in expressing their feelings. In some Asian cultures, to express one's feelings is, in fact, seen as selfish and is highly discouraged. Furthermore, the voicing of "morbid thoughts" is understood to be a contributing factor to becoming mentally ill. Because the relationship is of paramount importance, I am more tolerant of questions that may sound personal to some, since I understand that they represent an attempt to form a relationship and that this requires some sense of connectedness, whether through family ties, or through some common background experience. This may include something as superficial as knowledge of an area in China, or even a special restaurant. At times, this stage may be characterized by a discussion about food, and which dishes are preferred. However, it is also possible to use the perceived similarities in background as a resistance to true exploration. It is not uncommon for a Chinese patient to state confidently, "You know what Chinese families are like," as if this obviates the patient's responsibility to describe his or her own history. On the other hand, I have also consulted with Chinese patients who deliberately chose someone of a different race because they felt that I would be too much like a mother or sister with whom they had highly conflicted relationships. There are also times when I will learn that a Chinese patient opted to go elsewhere because she or he feared that I would share too many of the cultural values from which the patient was trying to escape.

In our experience, this dyad often pulls for particular countertransference issues. In our discussions about working with patients from the same racial background, several things became clear. We noted the sense of relief that each of us would feel at the thought of treating someone who was like ourselves, at least in appearance. Like our patients, we, too, share some stereotypes about cultural backgrounds. Furthermore, we became aware of a somewhat proprietary sense when we would see patients who were African

American or Chinese American with therapists who were white. We had the sense that because of our ability to identify with these patients, we might somehow be more helpful, that there are certain powerful life experiences that can better equip one to be more accurately empathic. These feelings can lead to a sense of responsibility toward the patient that is of a somewhat different nature than the customary role of therapist. It requires that the therapist, in the service of the treatment, draw on her intimate knowledge of her own experience of being a member of a minority. We believe that the minority patient also expects this of the minority therapist, and indeed uses this to establish a positive transference.

Being from the same ethnic group can lead to some countertransference acting out, especially when the therapist identifies closely with the patient's experiences. The therapist may be more tolerant and less confrontational about some instances of acting out. When this identification is strong, the therapist is often tempted to go the extra mile for the patient, for example, calling a patient who has not shown up for an appointment more readily than one might otherwise. It is a temptation to reach out to such patients, in the sense of being somewhat more didactic and helpful about the process itself and about encouraging the patient to return. In trying to explore the possible reasons for this type of countertransference, we felt that it seemed to be related to our own often painful experiences of having been misunderstood, and wanting to protect our patients from similar occurrences. It is with patients from our own or other minority groups that we find ourselves keenly attuned to the possibility of misunderstandings and miscommunications, often readily siding with the patient's view of his or her treatment by the majority authorities. Having been the objects of second-class treatment makes one keenly aware of one's minority status. This, in turn, makes our identification with our patients natural but also a potential problem in the countertransference.

We believe that inherent difficulties may arise out of life histories that are too close. These difficulties take the form of questions

that go unasked because of shared assumptions, and can often lead to a mutual resistance to looking at the material. However, common experiences in patient's and therapist's lives, which can foster a sense of shared meanings, can also enhance the therapeutic relationship. In such cases, the therapist can make the patient feel truly understood and can avoid the pitfalls of misunderstanding communications that have culturally specific meanings.

Conversely, there is the risk of feelings of competition when there is a strong similarity of cultural background and experience. This was brought to our attention when a young Chinese woman decided that she wanted to pursue a degree in psychology that was higher than her therapist's. She was concerned that the therapist would feel threatened by her wish to surpass the therapist in a professional sense. It was, in fact, an issue that demanded close monitoring by the therapist for her own possible feelings of competition. Although competitive feelings can be aroused in any psychotherapy, given the fact that there are still relatively few nonwhite psychotherapists, this issue can be especially acute in minority-minority therapies.

It has also been our experience that as minority members ourselves, we are able to make observations or interpretations that are more acceptable to our minority patients. The case of Mr. S provides an illustration of this point. Mr. S is an African American who came for treatment because of repeated failures to actualize his capabilities. In spite of having completed college, he had only been able to gain employment in a series of unsatisfying temporary positions. He felt that his problems were the result of racism, an inevitable piece of reality for him as a minority person. However, he also acknowledged that he had not taken credentialing courses which would qualify him for more interesting positions. He justified this by explaining that to do so would subject him to racist attitudes and practices in an academic setting. His associations to this discomfort were his fears of eating in public places, particularly "white" restaurants. He felt unable to take in food in such a hostile setting, and thus avoided

both restaurants and academic settings that made him uncomfortable.

One might readily understand this man's difficulties as a resistance to becoming aware of his own inadequacies and offer the interpretation that because it is too painful to think of himself as inadequate, he chooses to think that "others" doubt him, and that it is a response to his being African American. In such an interpretation, it is imperative to incorporate both the reality and fantasy experiences of a minority person and to take into account the fluidity of these experiences. For example, one might include an acknowledgment of the minority person's fears of racism and the dynamic understanding that such fears are often a manifestation of some internal conflict. We would surmise that such an interpretation could be more readily heard and accepted when coming from a fellow minority group member. The point of this discussion is not to promote a specific interpretation but to emphasize that a multicontextual perspective can open up more varied themes and can help avoid a single interpretive thrust such as resistance. In the case of Mr. S it would mean understanding his concerns about racism not only as rationalizations to support a resistance, but also as illuminations of his subjective experience of being a member of a minority and his associations to this.

This point is also implicit in two of the clinical examples discussed by Holmes (1992). In the case of Ms. B, a young black woman, the transference takes the form of the patient's concern that the analyst, like her brother and sister, will envy her professional advancement. In her intervention, the analyst asks, "Do you worry that I, too, would consider you a 'super nigger' if I knew the salary you were promised?" (p. 4). With Mr. C, there is a clear attempt to displace his anger to "all the wrong 'whitey' has done to us." The analyst's response echoes our earlier example of Mr. S, for she responds, "Sure, racism is alive and well, *and,* at the same time, we may have an opportunity to understand how your pain goes beyond racism" (p. 5). It is our contention that such interventions gain their power from the fact that the analyst is

black and that such interpretations would be dangerous ground for a therapist who is not of the same race.

Another aspect of the countertransference with same minority patient-therapist dyads is what we shall term a sense of resonance. By this, we mean more than just common understanding of an experience; we mean the similarity of a psychological resolution of an identical psychic conflict. There are frequent examples from seeing young Chinese women who had either been born in the United States or had emigrated here as adolescents. There were numerous conflicts around their identities as more traditional Chinese (Tang, 1992) or as becoming more American. The solution they chose, at least temporarily, was to select yet a third identity which was neither Chinese nor American. In each of the four cases, the attempted solution resided in learning a (non-English) European language, living and studying in the European country, and identifying for a time as French, German, or any nationality other than Chinese or American.

Some of these questions have been raised with respect to the gender of the therapist with same or different gender patient. To what extent, then, do therapists who are from minority cultures facilitate the work of self-discovery with patients from the same or from different minority cultures? In our observations, therapists who are racially and culturally different have the potential of offering patients a wider range of possibilities for "transient identifications" with the therapist. As has been stated earlier, this is largely a result of having lived in two cultures and being "fluent" in both. Perhaps more important, patients are provided with an opportunity to identify with someone whom they feel has suffered from being a member of a minority, and yet who has overcome hardship and the experience of being an outsider, much as they themselves feel.

REFERENCES

CURRY, A. E. (1964). Myth, transference and the black psychotherapist. *Psychoanal. Rev.*, 51:547-554.

ERIKSON, E. H. (1950). *Childhood and Society.* New York: Norton.

FREUD, S. (1910). The future prospects of psycho-analytic therapy. *S.E.*, 11.

GARDNER, L. (1971). The therapeutic relationship under varying conditions of race. *Psychotherapy*, 8:78-87.

GRIFFITH, M. S. (1977). The influences of race on the psychotherapeutic relationship. *Psychiat.*, 40:27-40.

HOFFMAN, I. Z. (1983). The patient as interpreter of the analyst's experience. *Contemp. Psychoanal.*, 19:389-422.

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

JONES, E. (1985). Psychotherapy and counseling with black clients. In *Handbook of Cross-Cultural Counseling and Therapy*, ed. P. Pederson. Westport, CT: Greenwood, pp. 173-179.

KARDINER, A. & OVESEY, L. (1951). *The Mark of Oppression: A Psychosocial Study of the American Negro.* New York: Norton.

KARON, B. J. (1958). *The Negro Personality: A Rigorous Investigation of the Effect of Culture.* New York: Springer.

KATZ, P. A. (1976). The acquisition of racial attitudes in children. In *Towards the Elimination of Racism*, ed. P. A. Katz. New York: Pergamon, pp. 125-154.

LEARY, K. (1995). "Interpreting in the dark": race and ethnicity in psychoanalytic psychotherapy. *Psychoanal. Psychol.*, 12:127-140.

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

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

TANG, N. M. (1992). Some psychoanalytic implications of Chinese philosophy and child-rearing practices. *Psychoanal. Study Child*, 47:371-389.

ZAPHIROPOULOS, M. L. (1987). Ethnocentricity in psychoanalysis. *Contemp. Psychoanal.*, 23:446-462.

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A CONJOINT PHASE OF TREATMENT INVOLVING A SEVERELY DISTURBED ADOLESCENT BOY AND HIS FATHER

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A phase of father-son conjoint treatment during psychoanalytic psychotherapy of the son is described. The son, who met descriptive criteria for schizophrenia, felt most alive when planning revenge on his father; the father frantically dwelled on the son to the exclusion of virtually everything but work. The conjoint therapy complemented the son's individual therapy and led to a stable, hence analyzable transference. The outcome was generally positive in a case whose prognosis at the outset had appeared dismal. Questions concerning therapeutic change and clinical technique are raised. The author suggests that others in similar clinical circumstances might consider a phase of conjoint treatment.

> Was it a sin to cry when I wanted to feed at the breast? I am too old now to feed on mother's milk, but if I were to cry for the kind of food suited to my age, others would rightly laugh me to scorn and remonstrate with me.
>
> SAINT AUGUSTINE[1]

Psychoanalysis, remarkably thorough when studying most clinical matters, has not systematically investigated conditions under

[1] *Confessions* (c. 400). Translated by R. S. Pine-Coffin. New York/London: Penguin, 1961, p. 27.

which conjoint treatments might be useful. Instead, such therapy has been viewed as a substitute for, rather than a complement to, individual treatments. Individuals unable to sustain the intensity of dyadic involvement are typically thought unanalyzable, but there are more ways than preparatory psychotherapy to bring along a prospective patient. The case I will describe raises the prospect that conjoint work in the treatment of severely disturbed adolescents can complement an individual treatment and can lead to lasting intrapsychic gains not accessible in an exclusively dyadic format. This follows from many of the features unique to the psychoanalytically informed treatment of adolescents, particularly the more disturbed adolescent, which calls for parameters and quite different approaches than are customary in adult analysis (Feldman and Wilson, 1997; Laufer and Laufer, 1989; Panel, 1981; Settlage, 1974).

In the history of psychoanalysis, one sees different lines of evolution with respect to psychoanalysis as a theory of personality as opposed to a theory of therapy (Freud, 1914). Certainly, Freud, in developing his views on personality factors, visited areas beyond the clinical situation and borrowed heavily from mythology, culture, religion, group behavior, literature, the then prevailing life sciences, and so on. The psychoanalytic theory of therapy tends to be less open to crossing the Rubicon of the bounded dyadic clinical situation. Historically, the dyad has been considered the laboratory that psychoanalysis must look to, since this is where clinical efficacy gets tested. It is hard to quarrel with this eminently reasonable view, yet perhaps nondyadic interventions can still be evaluated according to the outcome effects upon the patient within the dyadic system. In this paper, such a case is reported, formulated, and *conducted as much as possible* along the lines of psychoanalytic theory and practice. Since this case terminated, I have conducted several others in like fashion, all but one with promising results.

As far as I am aware, there is no published report in the literature describing this particular treatment configuration with an adolescent and his or her father, although such descriptions can

be found in the literature on the treatment of symbiotic psychotic children (e.g., Bergman, et al., 1983) with their mothers, sometimes called tripartite treatments. In a tripartite model, both mother and child are seen as requiring help, but for the mother it is according to the vicissitudes of her contributions to the child's maturational requirements. Exclusively conjoint treatments with adolescents reported from outside of psychoanalysis, though, are frequent, although not designed to tap the intensity characterizing analysis. Many (perhaps most) clinicians, working within seat-of-the-pants necessities, fall into conjoint treatments with many adolescents, particularly those severely disturbed, dangerous to themselves or others, or those who are locked into rigid and ossified object relations with domineering others, usually family members. Thus, many eating disordered young women, excessively rebellious young men, and others whose families cannot contain their aggression find their way into such therapies. Hence, it follows that some descriptions of conjoint treatments can be found in the generic psychotherapy and family therapy literatures. But one is hard pressed to find family therapy reports that are either admixed with psychoanalytic approaches (cf., Stierlin, 1977) or do more than share a common but loose vocabulary, so interdomain translations are necessary. For example, Doane, Hill, and Diamond (1991) have described how, in what they call the "disconnected family," uninvolved behaviors (object relations!) between parents and symptomatic adolescents can masquerade as intense emotional overinvolvement and connectedness. In order to treat what they term such a "disorder of communication," they warn against a premature separation process and advocate conjoint sessions promoting attachment between parents and the adolescent, followed by subsequent individual meetings with the parents and the adolescent. While they clearly describe dynamics similar to those encountered in the present case, the thoughtful interventions they recommend do not result in an intensive psychoanalytic therapy with the adolescent, which could produce enduring intrapsychic gains rather than strategic ones.

Background of the Case

The case about to be described is most atypical and was characterized by a grim symbiotic[2] struggle. The treatment was initially individual; the patient was the son, eighteen years old at the time of referral. In the middle of individual psychotherapy with the son, circumstances suggested an unusual direction, a once weekly conjoint therapy meeting between father and son which complemented the son's ongoing thrice weekly therapy.

The father—Mr. S—originally came for an appointment a few days before the son—Ken—was due to arrive in New York City. He provided the context for the referral, one that clinicians who work with severely impaired adolescents and young adults will find familiar. He said he was desperate. He was now, for the first time in his life, prepared to dig in his heels and face this dreadful problem, which he had hoped would disappear of its own accord. His son had terrorized everyone in the family with aggressive outbursts and erratic, frightening behavior and had been poised on the threshold of a hospitalizable disturbance for several years. The last time Ken had been home for a visit, he had gotten so angry at his father that he had punched him in the face and given him a black eye. Mr. S said he and his wife also feared for the physical safety of their daughter, Ken's half sister, for Ken recklessly initiated brutal rough-and-tumble games with her that endangered her. These were bald attempts at intimidation and dominance. Mr. S's current wife called me the day after my first appointment with Mr. S to tell me that the return of Ken frankly endangered the marriage as well, for Ken was a source of unresolvable conflict between her and her husband.

Mr. S described how, by junior high school, things had gotten quite bad between him and his son. The year of ninth grade was a disaster for Ken. He battled his father at every turn. With the

[2] Note that I use the term "symbiotic" descriptively; it does not imply an endorsement of the hypothesis that there is such an entity as a symbiotic phase during development.

emotionally damaging birth of his younger sister, Ken had angrily left Mr. S's household to live with his biological mother. After two months he sought to return, but Mr. S would not take him back, offering as an excuse that it would be good for Ken to have continuity in school and finish the year where he was. Actually, Mr. S could not tolerate having Ken return. Ken never forgave his father for this first forced separation, and it became a central organizing dispute between the two. Ever since Ken was in the ninth grade, Mr. S and Ken had been engaged in a run-and-chase game that forced the father to frequently travel around the country to rescue his peripatetic son, who inevitably provoked some new catastrophe wherever he was. After the father's intercession, the enraged son would blame the father for his problems and soon be off again on some new escapade, always expecting to find some Nirvana-like place where he could settle down, but always setting the stage for a new, increasingly dangerous catastrophe. The two were in constant and intimate contact by telephone, negotiating Ken's next fateful step. Most recently, in desperation, Mr. S had, by telephone, placed his son in a peculiar college that was a refuge for disturbed adolescents who had no place else to go. Not surprisingly, Ken avoided classes, was socially isolated, fought with his peers when he came into contact with them, and was forthwith expelled. At the time of referral for treatment, Mr. S was panic stricken at the prospect of his son's return home after expulsion from college, for whenever Ken visited home, he attempted to destroy his father's fragile family life with his reconstituted family, a second wife, and five-year-old daughter.

In our initial meetings, Mr. S also described his and his son's childhoods and the backdrop of the father-son relationship. The case then became less stereotypic. The parents divorced when Ken was six months old, and Mr. S assumed sole custody when twenty-three years of age. Mr. S remarried when Ken was seven years old. As the primary caretaker, Mr. S insisted upon doing and being everything for Ken. He would dress him, comb his hair in the morning, take him everywhere; the two of them were inseparable during Ken's preoedipal, oedipal, and early latency years. It was a

nonstop joint preoccupation with one another that admitted no outsiders. As a child, Ken regularly observed Mr. S injecting himself with amphetamines, and was brought along with him on his many escapades involving severe drug abuse, wild parties, and multiple sexual liaisons with individuals of both sexes.

Even after remarriage, Mr. S had great difficulty allowing the stepmother to break into the father-son symbiosis. Mr. S insisted upon a virtual twenty-four-hour-per-day involvement with Ken, and no one else was allowed to have any sway over Ken's upbringing. Ken signaled for help with a display of symptoms, as adolescents frequently do, but no one spotted it. For example, as an early adolescent, Ken became socially isolated and deeply involved with drugs. He once took one hundred "tabs" of LSD at one time. Although they knew there was profound trouble, both father and son collaborated around a denial of illness and refused to consult professional help.

Mr. S also told me that he felt enormous guilt over what had happened to Ken. He knew something uncanny was going on between them, and he gamely said that it had to do in some way with how his own history affected his role as a father, but he was not at all clear about what specifically was at issue. He then described how his son's psychotic-like disturbance was almost a carbon copy of a similar episode in his own adolescence that began during his first year of college. He had, in fact, been through an eleven-month psychiatric hospitalization and had been diagnosed as schizophrenic (catatonic type). During and after his hospitalization, he refused all psychotherapeutic treatment. He stressed that throughout this hospitalization he could not believe there was anything wrong with him; he believed he was being held illegally by the hospital psychiatrists, who wanted to punish him for his Bohemian counterculture lifestyle. He had the delusion that he was a notorious beatnik poet. Upon discharge from the hospital, his unorthodox lifestyle continued. He preferred to live "on the edge," as he put it. For five years, he was an amphetamine addict, injecting himself three times a day. He consumed an enormous amount of other drugs as well. He was in a

profound struggle at the time with his own tyrannical father, who was soon to die.

By his late twenties, however, he was indefatigable in pursuing his professional interests, and he became quite successful occupationally. Eventually, he worked sixteen hours a day, and neglected the rest of his life and his family for many years in order to get ahead in his career. His second marriage became secondary and almost ended when he admitted to his wife that he was having an affair. Decades after his bout with psychosis, Mr. S was quite occupationally successful, despite continuing drug and alcohol abuse. His relationship with Ken became strained as the symbiotic ties overtly disappeared but without proper resolution, and Ken became a loner, an introverted and brooding late latency child.

Mr. S told me a few things about Ken's biological mother. While out on pass during his hospitalization, Mr. S met the woman he was to marry and who was to bear Ken. He married her when he was twenty-one, and they had Ken a year later. He described her as both anorectic and schizophrenic, demanding care from anyone in her orbit. An early memory Ken had was of his coming home to his father at age five after a visit to his biological mother, crying, pleading to be allowed to go live with his mother so he could take care of her, saying that some day he would be big enough to make sure that she would be well. Presently, during the time of treatment, she lived with her daughter from another marriage in a small Midwestern town and was functionally incapacitated.

Over the years, Ken had periodic but regular telephone contact with his mother. Much of this contact focused on the mother's monitoring what Ken ate, and urging him into a spiritual/religious way of life, preferably Buddhist. During Ken's early adolescence, she competed with him over who had more emotional, financial, and psychiatric difficulties, and intrusively pried into aspects of his burgeoning masculine life that Ken would understandably have wanted to keep private. She was sexually provocative with Ken, and would write him poems in which fantasized sexual contact between them was overtly described. Mr. S said that Ken's mother was and always had been fiercely competitive over

who was the sickest one. A sign of any problem from an intimate would unleash this terrible competitiveness. She would call Ken on the phone, ostensibly to inquire about his life but actually to inflict her problems on him. He would console her but would become immediately physically sick with nausea and diarrhea. This, of course, carried over, and any sense he had that others wanted him to care for them precipitated a chaotic unraveling and murderous rage, although he constantly sought relationships organized in this way.

It was clear from our preliminary meetings that this case was complicated. I had immediately thought of the description of symbiotic psychosis (Mahler and Gosliner, 1955) between mother and young child, except in front of me was a father and his adolescent son. My sense was that Mr. S had tried to be a parent to the best of his abilities. Blos (1984) noted that gender polarity (father-daughter, mother-son) dominates our conception of the oedipus, yet in current psychoanalytic thinking isogendered early object relations are increasingly seen as important for the development of the self. Mr. S's inability to let anyone else into the closeness of the pair, the establishment of what looked like a symbiotic dyad with its attendant vicissitudes, and his subsequent abandonment of Ken in the ninth grade struck me as a unique departure from the classic isogendered father-son relationship, which presumes a mother. Further, symbiosis as an aspect of early object relations is usually conceived as primarily between mother and child. Although in modern times fathering is increasingly studied, rarely are the clinical phenomena related to early object relations and symbiosis viewed as primarily involving the father. Clinically, of course, gradients of father-child symbiotic-like phenomena are seen on a regular basis, but usually in the context of triadic object relations. Father-son symbiotic relationships are much less frequent than such mother-son relationships because of the boy's primal disidentification from mother and subsequent identification with father under various conflicted internal prohibitions. Stoller's (1974) major point was that boys suffer from a natural "symbiosis anxiety" with their mothers, which they must

free themselves from in order to reach the father and masculine identifications—or pay a psychic price.

Beginning of the Individual Treatment

When Ken came to see me, he looked fourteen rather than eighteen. Not surprisingly, when he walked through the door, I found myself speaking to the very image of his father in manner and appearance, albeit a younger version. We arranged for individual psychotherapy, at first four times a week. Shortly thereafter, it became three times a week when he refused the fourth hour because he felt engulfed by the intensity of the therapeutic contact. The early part of the therapy consisted of his determining what possible use I could be to him, since he was less interested in treatment than he was in continuing the life-and-death struggle with his father. He said that he would give therapy a try to propitiate his father so that his father would financially support him. His most immediate problem was New York City. He insisted he needed to be immersed in nature in order to feel peaceful, and he could only do that by moving to the woods of Oregon. I felt futile and useless, and entertained periodic doubts about whether I could be of any help.

It was immediately clear that Ken appeared in or close to the schizophrenic spectrum. He had poor rapport, was extremely circumlocutional, tangential, suspicious, grandiose in his mangled speech, and was struggling to conceal a pervasive thought disorder. It was virtually impossible to understand him when he spoke; long-winded hyperbolic sentences filled with polysyllabic words and neologisms punctuated his dialogue. His object relations were devastatingly primitive. Paranoid projection and its allied defenses were rampant. He had a limited sense of time and place. He had long depersonalized periods, after which he would suddenly snap into a state of alertness with no memory of what had taken place during the last hour or two. His only interests were in Eastern religion, his route to a return to the innocence of nature. He was

visibly disturbed—underweight by thirty pounds, gaunt and disheveled, vigilantly scanning the world about him in an agitated, paranoid fashion.

Nevertheless, I was not convinced he was schizophrenic, even though he met DSM-IIIR criteria. The validity of the diagnosis of schizophrenia in adolescence persevering into adulthood is always open to some question because of the fluidity of the still evolving personality organization. Maturation yet offers the opportunity for a way out of the potentially premorbid straits in which an adolescent may find himself (A. Freud, 1958; Holzman and Grinker, 1977). When I came to understand his history, it became clear that, as is often seen with youngsters struggling with incipient psychotic decompensation, moving from place to place had become a way of averting imminent decompensation. But Ken, like many adolescents, mistook physical distancing for intrapsychic individuation, and so always lived under the threat of cataclysmic object loss. Whenever the inner havoc projected outward threatened him, Ken organized around the task of moving to a new Promised Land (which, we would later come to see, represented his wish to return to a pleasurable father-son symbiosis from which he had felt so violently ejected as a child).

At the beginning of the individual treatment, Ken said that he had to take care of two things—get revenge on his father, and extract his father's fortune so that it all belonged to Ken. Several times a week, Ken would initiate a fierce battle with his father, with the intention of causing him as much distress as he could. After one such episode, Mr. S lost control and screamed at Ken that the only solution was to die himself, that he had felt such relief when his own father had died, and that perhaps he could afford his son similar relief by dying as well. Ken was determined to destroy his father's second marriage, ostensibly for revenge, but also from rageful envy, so that he could have his father all to himself. Over and over again, he raged against his father's present wife, calling her a gold digger, imagining that she had sexual wishes for him and would act on them if he would allow her, and claiming that she now had what was rightly his, Mr. S's fortune and resources. Be-

cause of the tensions between them, it was arranged for Ken to move out of the family domicile into an apartment of his own.

The Father-Son Symbiosis

The similarities between Ken's present life and his father's early one were striking. Indeed, Mr. S had impressed upon me how much Ken's psychiatric disturbance was similar to his when he was at a comparable age. Thus, one early danger for Ken was the threat of a regression to primary identification, with all the attending aggression (which, not surprisingly at the time, was a danger of psychotic proportions). There was an uncanny network of communication between them that could easily remain invisible to an outside observer. Neither of them could live with or without the other. The manner in which they treated one another was characteristic of what can usefully be described as bidirectional projective identification (Zinner and Shapiro, 1972); to wit, they produced in each other states of mind that they evacuated from within, and then fought to maintain in the other so as to feel attached. Although both bitterly complained about the other, each felt compelled to repeatedly produce in the other the very states he consciously detested, yet knew so intimately and felt so familiar with. Ken was terrified that he was like his father and was constantly struggling to disidentify from father's intrapsychic representation, much the way Greenson (1968) described disidentification from mother as a necessary step in male development.

At the same time, Ken became caught in the grip of his father's projections. Mr. S unconsciously encouraged his son to undergo a similar developmental trajectory as he had. In fact, his father told me that the only way he could understand what Ken was experiencing at any one time was by remembering what he himself had gone through under similar circumstances when he was Ken's age; he had no other way of empathically grasping his son's inner life. At other times, he had no confidence that he could understand his son. Of course, one of the reasons he so poorly

understood Ken was that this empathic mode is so ineffective (see Basch, 1983) because it is grounded in a fusion of self and object. Therefore, the object cannot be seen as different from the self but must be forced to be like the self in order for some limited empathic connection to take place. It is no accident, we now see, that Mr. S brought Ken to me when Ken was the same age that Mr. S himself was when hospitalized—for he had then received treatment, and now so too could he endorse Ken's receiving treatment.

In order to develop any workable process with Ken, it was imperative that I not treat his destructive wishes for reparations as a fantasy system, no matter how uncomfortable it became for Mr. S. I earnestly investigated their function and meaning for the conduct of the case. In this way, I earned Ken's trust. He had to know that I did not view him as the only sick one, and that I was his advocate rather than his father's agent. Only by letting him know that I thought his imagination had pockets of sanity could he gradually come to let me know how insane he believed himself to be.

The Phase of Conjoint Therapy

While Mr. S had impressed upon me how disturbed Ken was and had depicted in detail Ken's alarming history, Ken, during therapy hours, kept impressing upon me how disturbed his father was and depicting in detail his father's equally horrifying history. After stormy individual sessions in which Ken would rage against his father and refuse any understanding that might influence his rage, I would repeatedly ask myself how Ken was going to cope with the regressive pull of the protective father of symbiosis: father and son now could openly communicate only hate and fear to one another. How could he understand his feeling of being cast out of Eden into a world of near-psychosis? How could Mr. S ever reach the point where he could fulfill the parental role he longed to have but could not attain?

The individual meetings with Ken continued, but my sense was that I was missing the mark by treating only half of this remarkably intertwined dyad. Mr. S began calling me to ask me about virtually every aspect of his involvement with Ken, such as helping him to recognize and think out the implications of his feelings, providing him with some sense of parental direction, calming his overwhelming anxieties about having any contact with his son, and aiding him in planning how to proceed with Ken. I worked out with him my requirement to maintain the confidentiality of the therapy with his son. However, after consulting with Ken, I did not discourage Mr. S's calls, because I now clearly saw that the only way the case could successfully proceed was if he were treated as well. I did feel overwhelmed by the sheer amount of psychopathology over which I was assuming charge. Mr. S refused any "therapy" with another treater; he preferred my "coaching" him on what to do and say with Ken. By himself, he felt incapable of making proper fatherly decisions; however, a brilliant man, he was a very quick and astute learner. Once he grasped the fatherly function, it entered his future repertoire, although many such functions initially had a stilted and eerily affectless quality, as if they were there for the first time and required polishing before they could be smoothly integrated.

I always told Ken of the calls from his father, described their content, and indicated that I would strive as best I could to keep confidential what was raised in the individual hours. Ken not only eagerly agreed to this (he had no interest in confidentiality at this stage in the treatment; this was later to change) but urged me to convince his father that he too should seek help. It is also true that I was occasionally burdened with pressing secrets from both parties that I had to contain, which at times influenced countertransference reactions I noticed in myself in various ways. I had to work hard not to impress upon this oscillating system any solutions favored by either myself, the father, or Ken, but rather to let the course of events run as they might without the safety of anticipating an outcome. I now regard these countertransference reactions as the most potentially grave problem in the conduct of such

cases. My accepting phone calls from the father, though, was soon to evolve into the conjoint phase of treatment.

I had also initiated a referral for medication, and Ken was prescribed 25 mgs. of Mellaril and 1 mg. Cogentin daily. He responded positively. Mr. S had a more profound reaction than Ken to the question of medication. He developed the fantasy that Ken was being poisoned or would get cancer from the phenothiazine. My concern, of course, was that the taking of the medication would identify Ken as the sick partner of the father-son pair and exculpate the father. Fortunately, this was never an issue.

Actually, it was Ken who suggested to me at about this time that we begin conjoint sessions. He felt that he could only speak to his father with me present, and he thought that I would be able to help him accomplish what he wanted (which at the time was to torture his father and acquire his wealth). I thought the idea of conjoint sessions a good one, although my agenda did not overlap with Ken's, and so Ken proposed to Mr. S a weekly meeting among the three of us. Individual therapy with Ken was not enough—insights Ken acquired dissipated in the emotional volcano that erupted when he and his father were together, apart from me.

The Induction Phase

We began the conjoint sessions one hour a week, while I continued to see Ken three times weekly, and I saw again and again what the nature of their relationship was like. They were obsessed with each other. No conversation could be civil for thirty seconds without escalating into a bitter fight. Aside from their preoccupation with one another, the rest of Mr. S's and Ken's lives were characterized by isolation, avoidance of people, fearfulness, and depression. Despite the paucity of actual contact between the two of them, each was the most significant person in the world to the other. This was reflected in Ken's concurrent fantasy life. For example, later in his sessions with me, Ken's continuous fantasy

was that he was so "devastated" because when he was young, his father would inject him with drugs so that he would only feel the same things that his father felt.

When Mr. S spoke to his son in a parental way, I winced at the silent violence of his comments, their intrusiveness, their imperiousness, their insensitivity, their controlling quality. For example, he would echo comments I had made to him privately but use them in a piercing and condescending way—such as that Ken's requests for money at times symbolized his wish for nurturance and at other times revenge. Ken could make no use of what was ostensibly insight, but which he experienced as accusations. He would boil over with rage, unable to clearly identify the toxicity of the comments or the source of his rage. He would explode and berate his father, but for entirely displaced reasons, and it was unclear to me who was more violent, father or son, although the son was the one labeled as "violent." One of my clinical tasks was to point out how harmful such comments were, to make plain that their lack of emotional sensitivity was hurtful and worthy of attention. Specifically, I pointed out how Mr. S talked down to his son, and I sought to "lend" Ken enough ego strength to feel he could speak and be heard without fear and without finding it necessary to retreat to a near-psychotic confusion.

It soon came out that behind his rage, Ken was terrified of object loss. He would test this fear by initiating a violent quarrel, then immediately make his form of reparations by phoning his father and pretending that nothing had happened, thereby ensuring that his father was still available. I sought to put into words in our sessions, to the degree that both people could tolerate it, this and other such maneuvers that constituted their communicative system. In individual sessions with Ken, I gently interpreted to him over and over again and in many different ways the masochism implicit in his revenge—that he wanted to hurt himself on so many occasions in order to hurt his father, and that hurting himself was a high price to pay for the satisfaction of getting back at his father.

One question that was settled early on was my relative neutrality in the conjoint sessions. At first, Ken wanted me to join him in attacking his father. I refused, and told him that I could best help by lending him what it took to be able to take advantage of certain opportunities—for safe discussions he could have nowhere else or for the strength to raise anxious and fearful issues and try to overcome his rage and settle them. However, I added that if he wanted to attack his father, he was, of course, entitled to do so; I simply would not join him. The early stages were indeed characterized by multiple attacks of this sort, but soon these waned as the more important uses of the conjoint sessions emerged with clarity.

Moving the Symbiosis Forward

After both had accomplished a great deal during the conjoint sessions, I came to see that the time had come for a structural reorganization. Ken had a powerful reaction to ending each of the conjoint sessions, because he had to physically leave my office with his father to walk to the street, and he could not stand the transformation in their relationship that took place—from the "honesty" of the therapy to the "hypocrisy" of walking down the halls with him and chatting about nothing in particular. He wanted a more satisfying relationship, and he complained that he never saw his father, stepmother, and sister at their apartment because they seemed afraid of him. In this and in other ways Ken signaled me that he was ready for a new beginning with his father. Just as the individuating child requires a "gentle push" (Mahler, Pine, and Bergman, 1975), so, too, did Ken require an external push toward structural reorganization at a critical moment when he and his father were structurally prepared but unable to initiate the move on their own.

So, I called a meeting with just Mr. and Mrs. S. I reiterated to Mr. S that it was time for him to get into his own individual treatment, now more so than ever. I told him that for everybody's sake the next step in Ken's treatment was for Mr. S to overcome

his avoidance of and anxiety about Ken away from my office. I suggested to both Mr. and Mrs. S that by avoiding Ken, they were trying to make me into Ken's father, and that providing money for Ken may seem virtuous by way of guilt atonement but was a pale excuse for fatherliness. Mr. S readily agreed that he had passed Ken on to me ("passing the buck," he called it) and said that, though this made him feel guilty, he simply had no time to see Ken. I suggested that he was hiding behind his schedule and that he might try to understand his fear of his son, which he could best realize in his own treatment. Further, I told them that the problem was no longer best thought of as Ken's but rather had evolved on its way to resolution into one between Ken and his father. Mr. S's immediate reaction was to panic; at first he said he would think about it, but rather than go into therapy, he stopped drinking instead and started going to a gym four mornings a week. He also began seeing his son for dinner once a week, and tried to reintegrate Ken into the family.

This was not so much new as a new edition; they had refound each other, rekindling their early symbiotic ties, but now with the possibility of letting factors on the side of progressive maturation be internalized. What was in impasse was thus bathed in the stream of development, thereby modulating what had been unresolvable, fanatical mutual preoccupation. The more contact they had now, the more the old wounds receded and were healed. Concomitantly, Mr. S began providing Ken with more money, supporting the idea that money symbolized much more than financial currency. This casts new light on Freud's depiction of the finding of a love object, as he notes, "There are thus good reasons why a child sucking at his mother's breast has become the prototype of every relation of love. The finding of an object is in fact a refinding of it" (1905, p. 222). In this case, even amidst the hatred, there was a prototype of love. There had been no breast, no suckling, only a perplexed but devoted father, himself little more than a child, barely discharged from a psychiatric hospitalization, yet within whom a prototype of love could still be refound.

Through the interventions of this period, tensions were re-

duced, and gradually father and son were able to take steps toward being able to talk with each other, share their perceptions of their past, quarrel on more equal terms, and dread each other less. As this developed, Ken began less and less to dwell on leaving New York City. He alluded to not wanting to be that far from his father in the years to come. It ought not to come as a surprise that he began to appear more conventional. He seemed much clearer in his thinking, judgment, and planning. He began paying attention to how he looked and no longer appeared patently schizophrenic; he cut his hair and took pride in his grooming, stopped wearing bizarre purple clothing that was many sizes too big, and gained some much needed weight. He spoke of studying subjects in school such as anthropology and computer science. He signed up for an abnormal psychology course at the university where I was a professor. He also began exploring his numerous sexual anxieties in his individual sessions. He spoke of his wish to have a girlfriend, although his anxiety made this beyond his means at that time.

Ken began more reasonable planning for his future. He said he wanted to go to a college where there was "a lot of structure" and where other kids did not "party on drugs" all the time. He was much better related to me as well as to his father, and he began to see some peers as friends. He got his first job, as a clerk in a candy store, although he lost it after a short period because of a fight with his female boss. With my assent, he decided to stop the psychotropic medication. We worked out a plan whereby he would have access to medication when he wished, and any resumption was entirely under his control, if and when he chose. He has never resumed them. He boldly told me that he trusted me and spoke of his need to see me when he left New York to go to college. He planned to visit me at least monthly for psychotherapy no matter where he lived. He began showing up at my office once or twice a week without an appointment when overtaken by some anxiety in order to work out the problem. I accommodated him whenever I could, even if only during the five-minute break I take between patients.

Ken sought to understand his relationship with his biological

mother, the hidden figure in all this tumult. During the hours spent struggling to understand his relationship with his mother, he would almost burst with overwhelming rage and anxiety, yet he grasped the importance of insight into this terribly difficult and painful relationship and valiantly stayed with it despite the pain. In pursuing insight into this relationship, he realized that his preoccupation with taking care of her daughter was a new edition of how he had felt when he was a child visiting his mother on weekends and she would rush upstairs to bed, cry, and threaten him with her suicide unless he took care of her. The feelings this evoked were now displaced onto his sister. Together, we worked on how he might build an emotional "wall" so that he would not be so devastated by her phone calls, and how he would not enter into her competition with him over who was sicker.

Perhaps as important, Mr. S had tasted and embraced fatherliness. He, as much as Ken, was changed by the conjoint therapy. He developed confidence and understood how to step outside the characteristic struggles that initially defined their relationship and to turn them into dialogue rather than escalating rage situations. He invited Ken to accompany him on a four-day vacation alone, thereby offering to recapitulate the early blissful symbiotic state when each had only the other. (Ken delayed accepting this invitation, with the idea of puzzling out with me why it meant so much to him. Finally, he agreed to go, but only on condition that they not mention his biological mother while on the trip.) Shortly thereafter, Mr. S and Ken spent one week together overseas, and Ken returned as integrated as I had yet seen him. Mr. S had made great strides in dealing with the conflicted nature of his wishes toward his son. He was able to acknowledge to Ken openly that he did in fact abuse and abandon him; that in Ken's ninth-grade year he sent him away with the hope that he would disappear—but he did this when his own life was a mess, and now he would do anything to rectify what a mess he had made of Ken's life. As his fear abated, he was able to express affection in a way that did not make Ken recoil and was not suffused with what Ken experienced as hypocrisy. He bought Ken some gear for camping, and it was my

impression that they were given as true gifts, were gratefully received, and neither experienced them as blackmail, reparation, or a bribe. Mr. S was much calmer, and I stopped receiving so many panicky phone calls about emergencies with Ken that another parent would see as pedestrian occurrences.

Termination Phase of the Conjoint Treatment

After about one year of weekly conjoint meetings, Ken announced to me one day in an individual session that he no longer felt the need for the father-son sessions. As he had initiated these sessions, so, too, did he conclude them. The changes in him during the interim were remarkable. The only echo of his desire for the conjoint treatments occurred during Ken's first hour after my summer vacation. He strode into my office, and without even saying hello, immediately demanded a conjoint session. Sensing an extraordinary amount of anxiety and fear, I gave him the phone, and he called his father and scheduled a meeting for a forthcoming free hour. From the start of this conjoint hour, it was clear that Ken called the meeting because he wanted the confidence of knowing that these meetings might still be available to him. He was also panicked about my going away and his father's accessibility, and he sought reassurance that both of us were still available. There were no further joint sessions after this one. Their purposes had been served, and Ken, Mr. S, and I knew the time had come to shift to the concerns of an individual therapy.

At this time, Ken was a moody, confused, but accessible young man. As the father-son symbiosis was worked through, much of the psychotic symptomatology receded. He could no longer be confused for a schizophrenic adolescent. He was preoccupied with getting a job, finding friends, meeting girls, and overcoming his inhibitions, not with getting revenge on his father, destroying himself and his father's family, and extracting his father's fortune. He did indeed find his first girlfriend that fall. He was thrilled that she was a person who kept running off to San Francisco whenever

she had a conflict with her father, and he could counsel her to stay in New York City and squarely face her conflicts. He looked back on the previous five years as a grim nightmare that he had fought his way out of.

Transference and Subsequent Psychoanalytic Therapy

The conjoint weekly meeting had facilitated Ken's individual psychotherapy. To illustrate, some of the individual hours would take up key questions first raised in the conjoint sessions, and we would pursue them in more depth. At other times, Ken wanted to use the individual therapy to plan for the conjoint meetings. What might be raised, how he might respond, and how to reasonably pursue an inquiry with his father were all issues in the individual therapy but actually at the interface of the individual and conjoint meetings. In some important ways, Ken learned how individual therapy functioned through the conjoint sessions. He came to appreciate the importance of psychological causes and explanations in a way he could not prior to embarking on the conjoint sessions.

The individual psychotherapy continued for a number of years after the conjoint sessions ended. During this period, I no longer had regular contact with the father and continued to treat Ken thrice weekly. After the conjoint treatment phase closed down, the dynamic issues clustered around the "invasion" of others into his burgeoning autonomy, his anxieties over letting down his guard, which were made manifest in pseudograndiosity and avoidance, entering a world where he might indeed fail at tasks he set himself, his wish to be passive and controlled, and idealization and perfectionism as a defense against aggression. These conflicts quickly made their way into the transference, and were usefully handled once accompanied by the analytic leverage necessary for the systematic observations required for transference resolution.

During the course of psychoanalysis, there is rarely material so consistently alive and heated up as that which stems from the

transference. Nevertheless, with adolescents, there are times during which transference concerns are put to the side, since other dynamics heat up and come to occupy the patient's attention. Anna Freud particularly disagreed with the view championed by Strachey (1934) that only the interpretation of the transference is mutative (see Couch, 1995). Arlow consistently (e.g., 1987) puts forward the view that the psychoanalyst is pre-emptively concerned with interpreting unconscious fantasies, and to the extent that the analyst is enveloped in them by way of the transference, so much the better. Thus, in the pluralistic community of contemporary psychoanalysis, there is some recognition that the transference interpretation is key, but is not all.

This case demonstrates that with severely disturbed adolescents, interpretation of the transference must await its proper arrival on the analytic stage. Transference is, of course, ubiquitous, as Brenner (1982) has properly noted, and Ken's transference certainly played a significant role early on. How, then, does this period of conjoint therapy intertwine with the all-important role of transference in an analytic treatment? It did not interfere with the unfolding of the transference, nor was the transference "contaminated" by the actual realities that intruded into the therapy. The dynamics of the transference constantly served as a guide to where the crucial dynamics lay, but interpretation of the transference proceeded in a zig-zag fashion.

At first, transference material was meaningless to Ken; this disinterest is not an unusual start in adolescent treatment or with narcissistic or borderline patients of any age. Thus, it was not systematically gathered as in the analysis of an adult in order to be interpreted, because its intensity was not ripe for amplification. It would have endangered rather than furthered the treatment. It was at first interpreted when its volatility frankly endangered the continuity of the treatment. Then, the conjoint phase breathed life into the transference material, while in the individual sessions we investigated Ken's sense of the processes in front of our eyes and tied this together with how he dealt with a multitude of other people and places, both real and imaginary.

This served to capture his unfolding interest in learning more about himself and his mind, rather than simply having his way with others. Much of the conjoint work was on a kind of in vivo transference constellation; after all, it involved one who had been a primary infantile object, and this later made interpretation of the transference more meaningful to Ken. This work thus deeply sharpened his sense of transference mindedness. The intrapsychic gains of the conjoint phase (insight and maturation) allowed for the liberation of the therapeutic value of examining and even intensifying the transference, which was to serve as a focus during the individual treatment that followed the termination of the conjoint work. Setting the stage for the analysis of the transference *so that it is a useful undertaking* is a tricky yet necessary prestage with many adolescents (Wilson and Weinstein, 1996).

By no means was Ken fully recovered at the time of the termination of the conjoint phase. Rather, the critical therapy marker was that the changes undergone qualified him to embark upon an intensive psychoanalytic psychotherapy, which became of greater importance than the conjoint meetings. The essential point is that the transference could be dealt with analytically, whereas when the case began, it could not. The conjoint phase had allowed for the creation of an analyzable transference, which in turn accelerated the motion of the mutative power of the psychoanalytic procedure.

Some Implications for the Theory of Therapeutic Change in Adolescents

There are many competing views on the contemporary psychoanalytic scene concerning what constitutes mutative analytic factors. These range from the acquisition of insight, to remediating deficits, to promoting authenticity as one of several relationship factors, and to freeing up developmental processes that were not in synchrony with age-specific maturational expectations. Whereas discussions concerning these respective positions used to be

framed in either/or terms (e.g., relationship factors versus insight), recently there is movement toward more ecumenical, nondichotomized sets of arguments. Supportive factors are now found in places where analysts had previously not looked for them (Werman, 1984), including the act of interpretation itself (Pine, 1993), and are found especially mutative with more disturbed patients (Wallerstein, 1986). Apart from the supportive factors in analysis proper, there is even the proposition that supportive psychoanalytic therapy, as a distinct technical set of interventions, aims for the same structural changes as psychoanalysis (De Jonghe, Rijnierse, and Janssen, 1992). Old embattled positions are being transcended as interactions between mutative factors embedded in the organic processes of treatment are being unpacked (Renik, 1993).

In considering the clinical evidence presented in this paper, it is scientifically presumptuous to generalize with confidence from this case to all other analytic cases in the abstract. Perhaps the data are germane to the treatment of a small subset of seriously disturbed adolescents. Perhaps the data speak more to some quite limited constellation of clinical factors common to all—or some—adolescents and/or adults. There are other possibilities as well. Whatever the nature of the generalizability may indeed be, the evidence from this case does lend support to putting forward for further general consideration a particular aspect of—or perhaps prerequisite for—therapeutic change: therapeutic benefit is in some way related to the facilitation of structural growth where there had been some form of fixation or developmental impediment. Clinical interventions, i.e., taking such a structural organization into account within one's goals for treatment, can be analogically guided by renditions of mental models pictured in psychoanalytic developmental psychology. These structural factors have, as some of their features, an indivisibly blended intrapsychic/interpersonal cast, in which objects are recruited so an individual can accomplish intrapsychic tasks unaccomplishable by oneself. These tasks, though, are not isomorphic with the typical tasks of childhood; they are better understood analogi-

cally, each requiring careful and individualized diagnostic appraisal. Mr. S and Ken accomplished something crucial through the conjoint treatment, related to what one might reasonably expect ought to have been successfully navigated many years earlier. What Ken acquired, largely through the conjoint meetings, is characterized by astonishing complexity (Wilson, Passik, and Faude, 1990). Inevitably intertwined with the compromise formations observed in intrapsychic conflict, the successful consolidation of these structural factors in most clinical work can be taken for granted. Their firm presence becomes an assumption of interpretive clinical work. If these issues flare up with such adolescents or others, it will tax the creative powers of the analyst to work effectively, because they must be carefully parsed out from the compromise formations of intrapsychic conflict and their technical implications.

What is also highlighted is how the ability to use insight is different from merely having insight. For Ken, it was necessary to first potentiate a capacity for using insight before he could assay the burden of bringing self-understanding to bear on his life. Having insight is a stilted substitute; it means little unless it can be internalized, integrated, and, hence, used. In this case, the ability to use insight rested on a preverbal structural organization that I found could be facilitated in the unusual manner of these conjoint meetings. If this structural organization was not present, insight and its brethren, conflict resolution, would not have emerged as a salient mutative factor. Speaking more generally, the translation from these shadowy processes to the verbal and paraverbal interventions of the analytic office is an important inductive undertaking in contemporary psychoanalytic theory construction.

What evidence from this case leads to these proposals? Certainly, at the point when the conjoint work was concluded, there had not been sufficient interpretation of intrapsychic conflict provided to make insight a clinical priority, as in the analysis of a neurotic patient or as would later become available for Ken. Nor did relationship factors in the transference particularly spur Ken's recovery during this time, since I was by no means a "new" object

whose newness was the subject of identification (father, in fact, was far more important to Ken than I was at the time)—nor was I one who ushered him into novel experience that provided him with a working model from which to learn about himself (that occurred later). Rather, something took place first in a series of processes between Ken and his father and only later within Ken, and it provided a foundation upon which higher-level treatment factors, such as insight, could rest. What took place was at first simultaneously intrapsychic and interpersonal, but the intrapsychic was far less accessible than the interpersonal. This is true in human development, when the intrapsychic splits off from the interpersonal and then takes on a course of its own. It was only through father and son working out their suffocating interaction that the intrapsychic world of the son could become accessible to me as a treatment factor. The intrapsychic required a set of interpersonal experiences for its accessibility, suggesting a hierarchically organized and mutually potentiating continuum between interpersonal and intrapsychic that collapses any effort at dichotomization (Wilson, 1995).

It is no accident that many of the theorists who champion the view of liberating a heretofore thwarted growth potential in analysis with adults (e.g., Loewald, 1960) cite evidence from infant research to bolster their clinical proposals. The analogue is of *developing* as distinct from *learning* about oneself; this sets up a set of linkages with child analysis and brings what is known from child analysis (especially the contributions of Anna Freud [1965], to whom being optimally positioned in the ongoing stream of expectable developmental/maturational processes was the criterion for determining mental health) into a useful conjunction with what can occur with adults. Others (e.g., Pine, 1990) who see maturation as an analytic goal, and generalize from the analogue of the developing child, note that such growth is far more visible—and more dramatic—in the treatments of severely disturbed patients. Further specification of commonalities among adaptive psychic structures and how through treatment they can be potentiated—among children, neurotic adults, and severely

disturbed adults—thus emerges as a useful topic for deeper scrutiny.

Whereas Laufer and Laufer (1989) suggest that, using their approach, an analytic process is possible with severely disturbed adolescents, my finding (in other cases similarly conducted as well) is that the conjoint therapy enabled Ken to become a candidate for making use of intensive psychoanalytically informed therapy, but not for psychoanalysis proper. This may be a semantic rather than an actual difference.

In conducting a conjoint phase, a certain kind of competence is called for, one different from the typical interpretive competence of individual treatment. The clinical demands of the conjoint phase did not require me to be especially nice, or soothing, only clinically competent in a particular manner; my role was often akin to that of a diagnostician/facilitator. I had to keep alive an optimal level of tension between them, thereby enabling Ken and his father a) to avoid slipping into near-delusional and hence unresolvable issues; b) not to precipitously lose empathic sight of one another because of the rage and unpleasantness involved; and c) to move toward a new equilibrium between engagement and disengagement needs.

Once the conjoint work took place, there was a dramatically increased accessibility to many other intrapsychic issues which the engagement-disengagement issues had held in check. Such psychological processes are what Loewald was referring to when he first described a "sliding balance" (Loewald, 1952). This involves co-existing multiple levels of integration and differentiation in the child and the parent, and the way the distinction between inner and outer, social and intrapsychic, collapses when the pair navigate the task of constructing such levels—at first between them, and then, close behind, in the structural organization of the child's enduring intrapsychic life. Related issues will undoubtedly swim more into focus in the near future of psychoanalytic research. There is a sore need for more published case studies that report technical innovations and experiments in this and related genres. The fact that the conjoint phase did not take place upon

a couch (which is always a judgment call with adolescents) and through the medium of free association ought not to obscure an important proposition which can be empirically tested: that perhaps many more seriously disturbed adolescents can be treated with such a psychoanalytically informed approach than has heretofore been recognized.

Postscript

At the time of the writing of this paper, it is ten years since the individual work was terminated. Ken at that time had left New York City in order to attend college in a distant city. Mr. S recently called to request an appointment in which he asked me to consult with Ken, to help Ken sort out some ambivalence about attending art school. He told me that Ken had dropped out of school, but had held a job and maintained most of the gains obtained through treatment. While meeting with Mr. S, it became clear that something else was troubling him. It soon emerged that Mr. S's wife was pregnant, and he was frightened that there would be a repeat of Ken's ninth-grade year when his sister was born and he fled his father's home to move in with his biological mother, which hastened his precipitous downhill slide. The raw materials for another symbiotic crisis were present. I agreed to do an extended consultation with Ken, who flew into New York City for a week to meet.

Only one session was necessary. Ken maintains close and blustery relations with his father, whom he now sees twice a year, but only on the condition that Mr. S journey out to his city to visit him. The consultation was successful. We cut to the chase, explored some of Ken's ambivalence about the birth of his new sibling, identified how it was reactivating some of the old symbiotic yearnings, including his wish to extract supplies and obtain revenge, and we planned how to handle these difficult feelings of abandonment and sibling displacement. It was clear that there would be no damaging repetition, nor was the situation nearly as dire as Mr. S feared.

I took the opportunity to ask Ken his memories and sense of the value of the conjoint phase. His response was telling. He paused, struggled to find the correct words, and emphatically told me that he had no memory of any of the particulars that were said during any of those hours, just something that he felt and which had never changed since. The words he found, and which he kept repeating, were that "there was a change of polarities inside of me and between me and my father." He was communicating something quite important, and the words he had available did not map well onto what he was remembering (Wilson and Weinstein, 1992). The spatial metaphor of "change of polarities" (here I am condensing) expressed his sense that the structural changes taking place, simultaneously inside of him and between him and his father, strengthened him and, in doing so, loosened his need to be so preoccupied with his father. This development set the table for the dramatic and more visible changes to come—including the insights obtained in the psychodynamic therapy proper, which themselves became worth remembering, but which required for their mutative impact the girding of the structural changes that evolved out of the conjoint phase of the overall treatment.

REFERENCES

ARLOW, J. A. (1987). The dynamics of interpretation. *Psychoanal. Q.*, 61:68-87.

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

BERGMAN, A., SCHWARTZMAN, M., SLOATE, P. & WILSON, A. (1983). The oral deadlock: treatment of a psychotic child. *J. Amer. Psychoanal. Assn.*, 31:443-465.

BLOS, P. (1984). Son and father. *J. Amer. Psychoanal. Assn.*, 32:301-324.

BRENNER, C. (1982). *The Mind in Conflict.* New York: Int. Univ. Press.

COUCH, A. S. (1995). Anna Freud's adult psychoanalytic technique: a defence of classical analysis. *Int. J. Psychoanal.*, 76:153-171.

DE JONGHE, F., RIJNIERSE, P. & JANSSEN, R. (1992). The role of support in psychoanalysis. *J. Amer. Psychoanal. Assn.*, 40:475-499.

DOANE, J., HILL, W. L. & DIAMOND, D. (1991). A developmental view of therapeutic bonding in the family: treatment of the disconnected family. *Family Process*, 30:155-176.

FELDMAN, M. & WILSON, A. (1997). Adolescent suicidality in urban minorities and

its relationship to conduct disorders, depression, and separation anxiety. *J. Amer. Acad. Child & Adolescent Psychiat.*, 36:75-84.

FREUD, A. (1958). Adolescence. *Psychoanal. Study Child*, 13:255-278.

——— (1965). *Normality and Pathology in Childhood: Assessments of Development.* New York: Int. Univ. Press.

FREUD, S. (1905). Three essays on the theory of sexuality. *S.E.*, 7.

——— (1914). On the history of the psycho-analytic movement. *S.E.*, 14.

GREENSON, R. R. (1968). Disidentifying from mother: its special importance for the boy. *Int. J. Psychoanal.*, 49:370-374.

HOLZMAN, P. S. & GRINKER, R. R., SR. (1977). Schizophrenia in adolescence. *Adolescent Psychiat.*, 5:276-292.

LAUFER, M. & LAUFER, M. E. (1989). *Developmental Breakdown and Psychoanalytic Treatment in Adolescence: Clinical Studies.* New Haven/London: Yale Univ. Press.

LOEWALD, H. W. (1952). The problem of defence and the neurotic interpretation of reality. *Int. J. Psychoanal.*, 33:444-449.

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

MAHLER, M. S. & GOSLINER, B. J. (1955). On symbiotic child psychosis. *Psychoanal. Study Child*, 10:195-212.

——— PINE, F. & BERGMAN, A. (1975). *The Psychological Birth of the Human Infant: Symbiosis and Individuation.* New York: Basic Books.

PANEL (1981). Psychoanalytic perspectives on the "more disturbed" adolescent. M. Shane, Reporter. *J. Amer. Psychoanal. Assn.*, 29:161-175.

PINE, F. (1990). The concept of ego defect. In *Drive, Ego, Object, and Self: A Synthesis for Clinical Work.* New York: Basic Books, pp. 198-231.

——— (1993). A contribution to the analysis of the psychoanalytic process. *Psychoanal. Q.*, 62:185-205.

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

SETTLAGE, C. F. (1974). The technique of defense analysis in the psychoanalysis of an early adolescent. In *The Analyst and the Adolescent at Work*, ed. M. Harley. New York: Quadrangle/The New York Times Book Co., pp. 3-39.

STIERLIN, H. (1977). *Psychoanalysis and Family Therapy.* New York: Aronson.

STOLLER, R. J. (1974). Symbiosis anxiety and the development of masculinity. *Arch. Gen. Psychiat.*, 30:164-172.

STRACHEY, J. (1934). The nature of the therapeutic action of psycho-analysis. *Int. J. Psychoanal.*, 15:127-159.

WALLERSTEIN, R. S. (1986). *Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy.* New York: Guilford.

WERMAN, D. S. (1984). *The Practice of Supportive Psychotherapy.* New York: Brunner/Mazel.

WILSON, A. (1995). Mapping the mind in relational psychoanalysis: some critiques, questions, and conjectures. *Psychoanal. Psychol.*, 12:9-29.

——— PASSIK, S. D. & FAUDE, J. P. (1990). Self-regulation and its failures. In *Empirical Studies in Psychoanalytic Theory, Vol. 3*, ed. J. Masling. Hillsdale, NJ/London: Analytic Press, pp. 149-211.

——— & WEINSTEIN, L. (1992). Language and the clinical process: psychoanalysis and Vygotskian psychology, part II. *J. Amer. Psychoanal. Assn.*, 40:725-759.

——— ——— (1996). The transference and the zone of proximal development. *J. Amer. Psychoanal. Assn.*, 44:167-200.

ZINNER, J. & SHAPIRO, R. (1972). Projective identification as a mode of perception and behavior in families of adolescents. *Int. J. Psychoanal.*, 53:523-530.

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THE DEVELOPMENT OF TIME SENSE IN MIDDLE ADULTHOOD

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The focus of this paper is on the normal, intrapsychic, subjective experience of time in a developmental context. Time sense in middle age is determined less by the chronological age markers of forty or sixty and more by powerful, complex dynamic factors. Issues such as physical aging and illness, relationship to spouse and children, death of parents, and retirement will be explored in terms of how time is experienced.

This is the fifth in a series of papers (Colarusso, 1979, 1987, 1988, 1991) describing a psychoanalytic developmental line of time sense throughout the life cycle. As in the four prior efforts, the focus is on the normal, intrapsychic, subjective experience of time in a developmental context. The developmental framework utilized is based on Spitz's (1965) definition: "The emergence of forms, of function, and of behavior which are the outcome of exchanges between the organism on the one hand, the inner and outer environment on the other" (p. 5). Thus, I will repeatedly refer to the body and biological variables; to the intrapsychic world, i.e., the mind as it exists and changes in middle adulthood; and to the external environment.

I understand the developmental process to be lifelong and in a constant state of dynamic flux and transition (Colarusso and Nemiroff, 1981). Subjective time sense, which is immersed in and shaped by the primary forces that forge development, is, at any point in the lifecycle, an amalgam of past temporal conceptualizations, current developmental tasks and themes, and environmental influences. The subject of this paper is the examination of these influences in midlife.

Erikson (1950) included adulthood in his well-known "eight stages of man." Building on this pioneering division of adulthood into young adult, adulthood, and maturity, Robert Nemiroff and I (1981) divided adulthood into the following developmental phases: young adulthood (ages twenty to forty), middle adulthood (ages forty to sixty), and late adulthood (ages sixty and beyond). This paper will focus on the years beyond age forty. Although stage theory and a chronological framework are useful in conceptualizing experience in adulthood, they are not entirely satisfactory because each phase covers a period of time as long as all of childhood, and basic developmental themes are experienced across phases and decades. With this dilemma in mind, Nemiroff and I introduced the concepts of adult developmental tasks and adult developmental lines (after Anna Freud, 1965). For similar reasons, Settlage, et al. (1988) formulated the notion of developmental process. These conceptualizations allow universal experiences—such as the effect of the aging process, the awareness of time limitation and personal death, parenthood and grandparenthood, and the developmental line of time sense in particular—to be described within a broader temporal framework.

Following a brief summary of temporal experience in childhood, adolescence, and young adulthood, I will begin a detailed discussion of the evolution of time sense in middle adulthood.

THE DEVELOPMENT OF TIME SENSE IN CHILDHOOD AND ADOLESCENCE

The subjective experience of time changes continually and dramatically as an individual moves from infancy to old age.

In earliest infancy, because of the undifferentiated state of the ego, there is little, if any, differentiation of past, present, and future. However, there are precursors such as homeostatic regulatory mechanisms, alternating sensations of frustration and gratification (Seton, 1974), and physiological rhythms such as pulse

and breathing which, through kinesthetic sensations, convey intervals and thus the concept of time (Fenichel, 1945). By the third week of life the normal infant begins to differentiate between day and night. This beginning responsiveness to the twenty-four-hour day/night cycle is intimately related to maternal responsiveness (Gifford, 1960). What was biological becomes psychological and is experienced by the infantile ego as part of the relationship to the emerging object. In addition to the innate biological rhythm, the infant repeatedly reacts to the alternating experiences of frustration and gratification, called by Rapaport (1951) the "cradle" of time sense. With each experience of relief from unpleasure, a rudimentary orientation to the space-time continuum begins (Spitz, 1972).

The sensitivity of the mouth and the gastrointestinal tract and the frequent repetition of the hunger-satiation cycle combine to make feeding the major time-related instinctual experience of early infancy. Through her repetitive associations with hunger and feeding, the mother becomes identified as the source of both frustration, with its heightened painful sense of time, and satiation, with its soothing sense of timelessness. With her power to relieve hunger and painful time, she gives and controls time. *She becomes Mother Time* (Colarusso, 1979).

Freud (1909), Abraham (1921), and Jones (1913) all noted the relationship between time and anality as they studied the obsessive neurosis with its compulsive rhythms and unconscious equations among castration anxiety, time, and death. As the toddler gains some appreciation of the processes of urination and defecation and begins to control the sensations involved, he or she manipulates the associated intervals of time. Here is power over one's body and over time. Surely, our persistent feeling that we can conquer time and death has its roots in the toddler's irrational, magical sense of dominance.

But when toilet training begins, the preoedipal mother (Brunswick, 1940) demands that the highly pleasurable control of elimination processes and the accompanying sense of domination of time be surrendered to her. As toilet training progresses and

the toddler begins to identify with mother's power, he or she gradually realizes that time can be used to manipulate the environment.

During the anal phase the development of language adds a powerful conceptual dimension to time sense as time words such as soon, tomorrow, yesterday, now, and when appear between the ages of eighteen and thirty-six months. This cognitive development results in a differentiation of past, present, and future, and of the id and the ego (Hartocollis, 1974).

At the end of the anal phase, the achievement of object constancy (Mahler, 1974) produces several important changes in the way a child experiences time. Time sense becomes more internalized and less dependent on external objects. In addition, the time modes of past, present, and future, only vaguely conceptualized earlier, begin to have identifiable continuity as psychic experience. With the establishment of object constancy, the capacity for a sense of duration—the connectedness of events over time—is established (Seton, 1974).

From Object Constancy to Adolescence

The oedipal conflict significantly alters the development of time sense as the child gradually realizes that his or her desire to possess the parent of the opposite sex and assume the power and position of the parent of the same sex cannot be fulfilled because of the immaturity of his or her body. Realizing that the immature body is an insurmountable handicap in this quest, the oedipal youngster longs for the time in the future when physical maturity will occur. If only the loved one would *wait* until the child possessed a sexually mature body and the strength to vanquish the oedipal rival! Arlow (Panel, 1972) described the incest barrier as an actual barrier imposed by time.

Parental influence on time sense is effected primarily through attitudes toward the child's impulses. The concept of Father Time, the oedipal castrator, who controls time through his power

over life and death was introduced by Meerloo (1948) a half century ago. To this conceptualization I added Father Time, the *gratifier* (Colarusso, 1987)—the source of real and fantasied pleasure for his daughter in the midst of her positive oedipus complex and for his son as the object of his negative oedipal sexuality.

In my formulation on time sense during the preoedipal years I described mother as the primary external influence. During the preoedipal years Mother Time played a similar role for both sexes, but during the oedipal years her influence is increasingly gender related and analogous to father's role as she acts as both gratifier and frustrator, as both lover and competitor, to her son or daughter (Colarusso, 1987).

Latency is the phase of development in which children learn to "tell time." The changes in brain anatomy, physiology, and chemistry, which make this perceptual and cognitive leap possible at approximately age seven, are still poorly understood (Shapiro and Perry, 1976).

However, these events are no less significant than the temporal effects of normative changes in psychic structure which are occurring at the same time. Loewald (1962) emphasized that psychic structures exist and develop in a temporal context. For example, the creation and re-creation of presence is a temporal aspect of the synthetic function of the ego while the id and the unconscious are reflected in memorial activity and a sense of the past. The superego is related primarily to future sense.

As it reacts strongly against the blatant conscious expression of oedipal fantasies, the superego stimulates repression of many preoedipal and oedipal experiences and memories and produces a new attitude toward the past, which becomes vague and inaccessible. For the first time the present is associated with an internally organized quality of expectation, deprivation, and judgment as the superego exerts its influence over fantasy, object relationships, "work," and play. For example, in some games time is limited; it runs out, resulting in victory or defeat. In regard to the future, "Conscience speaks to us from the viewpoint of an inner future,

whether it tells us what we should do or how we should behave in the future, or whether it judges past and present deeds, thoughts, and feelings" (Loewald, 1962, p. 265).

Puberty is a major demarcator of time sense, a significant psychobiological change which divides life into a physically/sexually immature past and a physically/sexually mature present. This is particularly true for girls because the menstrual cycle is described in temporal terms.

Bonaparte and Erikson relate puberty to the adolescent phenomenon of *time diffusion.* It occurs because "too many instincts are in ferment" (Bonaparte, 1940, p. 429), consisting of "a sense of great urgency and yet also of a loss of consideration for time as a dimension of living. The young person may feel simultaneously very young, and in fact baby-like, and old beyond rejuvenation" (Erikson, 1956, p. 82).

During adolescence there is a major intrapsychic reorganization of the way in which the three temporal moods are understood and experienced. Childhood's body and activity become synonymous with the past. The adolescent body, as it continues to mature, imbues the present with powerful sexual affect, urgency, and anticipation of new experiences of all kinds. Because of the emergence of new cognitive capabilities "the adolescent is capable of projects for the future . . . of nonpresent interests, and of a passion for ideas, ideals or ideologies" (Piaget, 1969, p. 105).

This newly emerging cognitive capacity becomes fused with the equally significant changes which are occurring in the superego-ego ideal as concepts concerning the ideal use of time in the adolescent and adult future clash with the urgent wishes for immediate instinctual gratification.

By late adolescence, "the future is dominatingly active as a reality in the objective present." As the adolescent struggles with issues of career, lifestyle, and intimacy, "the past dims in significance and time seems to begin anew" (Seton, 1974, p. 807). From the above, it is clear, as Arlow (1986) pointed out, that the self is a time-bound concept.

TIME SENSE IN YOUNG ADULTHOOD

Time sense in the twenties rests on psychic structures built in childhood and adolescence. In the early twenties the consignment of childhood to the past can produce a brief, latency-like temporal calm which is built upon the resonance between conscious aspirations and the unconscious expectations of the ego ideal, and upon the realization that the future is long enough to postpone some decisions, undo mistakes in career or object choice, and start again if necessary. But by the mid-twenties time sense is increasingly influenced by the search for adult structure and new objects—career, friends, lovers, and spouse and children—to replace the temporal organizers of childhood, Mother and Father Time (Colarusso, 1979, 1987).

Subjective time sense in the thirties is qualitatively different from that of the twenties because it is the decade in which midlife issues emerge and gradually become dominant. For example, as signs of physical aging become more apparent, the phenomenon of loss in relation to the body is translated into a growing awareness of personal time limitation. This is particularly true for women who confront the approaching loss of procreative function which has an impact upon subjective time sense in as dramatic a manner as the onset of puberty did in early adolescence (Colarusso, 1988). The "thirty-something" individual must also assess object ties and work achievement differently. Significant progress toward the establishment of a family to replace the family of origin is expected by the ego ideal, as is achievement in the workplace. The time required to meet the expectations of the intrapsychic standard-bearer leads to the development of a strong sense of urgency.

Object relationships significantly influence subjective time sense in young adulthood. The relationship to the *spouse,* the one to whom time is committed "until death do us part," is one of the most important intrapsychic organizers of time sense in adulthood. Like no other mutually consensual relationship in life, mar-

riage defines the expectation of how time will be used as well as how it is conceptualized consciously and unconsciously. Over time, a long-lasting, mature love relationship becomes as significant an organizer of time sense in adulthood as was the relationship between parent and child in childhood.

In my opinion, however, *becoming a biological parent* is the quintessential temporal experience of young adulthood. As I expressed it in 1991:

> The ability to reproduce provides humans with their only immortality; through genetic transmission a part will live on after death. The event of biological parenthood, when coupled with the capacity to love and remain invested in one's offspring, leads to major psychic and, more specifically, temporal reorganization. Future sense is expanded, and the past is extensively reworked as the parent consciously and unconsciously relives each developmental stage with the child. In middle adulthood this ongoing comparison between parent and child, and grandparent and grandchild, is intensified because of normative mid-life preoccupation with time (p. 134).

Expectations from the past of the *parent* are deeply embedded in the offspring's intrapsychic repository of future sense, the ego ideal (Loewald, 1962); there they influence how the young adult evaluates his or her own progress.

The intrapsychic power of Mother and Father Time is gradually reduced by the inability of the real parents to control their own aging or to protect their children from a similar fate. Should a parent die during these years, the inner sense of immortality, which was based on an identification with Mother and Father Time, is shattered. Infantile narcissism loses its power to protect against the dawning realization that someday in the increasingly diminishing future the "child" must follow the parent to the grave.

Normal temporal functioning at the end of young adulthood implies that as one approaches forty, he or she has accepted the aging process in the body, integrated the use of time with pro-

ductivity, separated psychologically from Mother and Father Time, begun to deal with the notion of personal death, and forged new ties with contemporaries and children who give new meaning to the present and the future. So equipped, the young adult approaches middle age ready to engage, master, and integrate the monumental temporal challenges that lie just ahead.

TIME SENSE IN MIDDLE ADULTHOOD

"In early childhood *every* birthday is a momentous occasion signifying the unambivalent wish to grow, to mature, to be older. As childhood passes into adolescence, certain birthdays take on more meaning than others, but all still signify the attainment of new privilege and status. Sixteen—'and never been kissed,' 18—'I'm an adult now: I can vote and go to war, ha!' and 21—'No more faked I.D. cards, I can drink, legally.'

"As the 20s—'Twenty five, God, that's a quarter of a century!'—pass into the 30s—'Thirty, I guess I can't even pretend to be a kid anymore. Is it true that you can't trust anyone over 30?' Birthdays become a source of ambivalence because they mark the passage of time that no longer signifies growth and the attainment of privilege but now demarcates aging and loss of the endless future of youth.

"And then comes 40, the watershed birthday, the unequivocal indicator of middle age. 'I never thought I'd be 40, now that's really old' " (Nemiroff and Colarusso, 1985, p. 117).

As previously described, stage theory—the concept of the occurrence of developmental themes at concise chronological ages—is less meaningful in adulthood because as people live longer, life events tend to leapfrog decades. For example, consider the sixty-year-old college student-grandmother or the ninety-year-old businessman. Nevertheless, there are certain universal themes that influence the manner in which time is experienced intrapsychically in midlife and old age. Thus, the subjective sense

of time in middle age is determined less by the chronological age markers of forty or sixty and more by complex *dynamic* factors, such as physical aging and illness, relationship to spouse and children, death of parents, and retirement.

One of the most profound influences on development in adulthood is the increasing awareness that personal time is limited and that one will die (Colarusso and Nemiroff, 1981). This painful realization is both a source of conflict and psychopathology and a developmental stimulus which forces a new appreciation of the preciousness of time and a reordering of priorities.

As Pollock (1971) expressed it: "The acceptance of time is the acceptance of change and therefore of death, but it is also the acceptance of multiplicity, growth, and future development" (p. 445). Or to quote Neugarten (1979), "Time becomes restructured in terms of time left to live instead of time since birth. It is not that 50 or 60 years have passed, but the question, how many years lie ahead? What is yet to be accomplished, and what might best be abandoned?" (p. 890). Indeed "it might be ventured that the central psychological task for middle age relates to the use of time, and the essential polarity is between time mastery and capitulation" (Neugarten and Datan, 1980, p. 594).

My detailed consideration of time sense in middle age is based on the hypothesis that *coming to terms with time and, in particular, time limitation, is indeed the central psychological task of middle age. Implicit in this statement is the conviction that temporal awareness and management in midlife have a greater impact on development, healthy and pathologic, than at any other point in the life cycle!*

The intrapsychic conflict over the acceptance of time limitation and personal death is illuminated by the philosophical and the psychoanalytic literature.

As Kermode (1968) expressed it: "Time is that without which we cannot be human, and that which denies us the eternality we feel we were meant for, but can experience only in the unconscious, where it is a trouble to our dreams. As Heidegger remarked, 'We perceive time only because we know we have to die' " (p. 379).

The realization that we must die has led to the poignant, childish wish that time could be stopped, a wish that comes crashing down (only to arise again) under the bittersweet weight of the reasoning capacity of the mature ego.

"The freezing of contemporary culture forever would . . . make for stability, but since we have no way of freezing it, it would appear to be more prudent to adjust ourselves to the brute fact of change. And since the change cannot come about without death, it will be necessary also to learn how to unloosen our grasp on what we have and build a philosophy of life upon the premise that nothing whatsoever is immortal" (Boas, 1950, p. 262).

The human need to deny the fact of personal time limitation is responsible for the cross-cultural need to conceptualize time without end—immortality! According to Pollock (1971):

> Among some people, a new era begins not only with every new year but with every new reign, every consummation of marriage, the birth of every child. These are all times of regeneration with the same end: to annul past time, to abolish death, to begin creation (p. 443).

> Thus the notion of immortality is a way of arresting or reversing the irreversible flow of time toward death. . . . In some religions, resurrection, salvation, and eternal life include the eventuality of bodily restoration; however, this optimistic hope of a world to come, where time has stopped and there is reunion and everlasting continuity, is a defense against the total helplessness associated with the 'nothingness' of nonlife, be it death or the earliest states of infancy. The various death, burial, mourning, and anniversary rituals evolved in order to functionally handle this basic anxiety through public, private, and mystical means (pp. 441-442).

But these efforts at immortality inevitably fail because

> from childhood through early adulthood the leading cause of death is accidents, but for the age range 45 to 64, for both men and women, malignant neoplasms and heart disease account for nearly two-thirds of all deaths. To put this another way, in early

> life death is exceptional and accidental; but in middle age not only does death strike frequently, but it strikes from within (Neugarten and Datan, 1980, p. 600).

It was this realization that led Nemiroff and me to address this theme in our first paper on adult development. There we stated, *"A central, phase-specific theme of adult development is the normative crisis precipitated by the recognition and acceptance of the finiteness of time and the inevitability of personal death"* (Colarusso and Nemiroff, 1979, p. 68).

A Developmental Line of the Passage of Time and Death Awareness

Freud (1915) observed that we show an unmistakable tendency to put death aside, to eliminate it from life. Our instincts do not respond to a belief in death, and in the timelessness of our unconscious we are convinced of our immortality. But an understanding of a developmental line of time sense from childhood and young adulthood will help explain how experience counters this unconscious (and conscious) wish and false belief in immortality and culminates in midlife in a poignant, painful conflict between irrationality and reason.

Childhood is characterized by a tendency to deny the inevitability of personal death because of the immaturity of the psychic apparatus, the forward thrust of maturation, and the limited understanding of the concept of time. There is little in the anabolic thrust of the developmental process to indicate a personal end.

Then in late adolescence, because of the loosening of intrapsychic ties to the parents, a sense of history emerges which includes the realization that a part of the self and an entire epoch of life, childhood, is in the past and irretrievably lost. But this dawning recognition is quickly defended against by the optimism and idealization of youth—a semi-successful attempt, according to Jaques (1965), to deny the "two fundamental features of human life—the inevitableness of eventual death, and the existence of hate and destructive impulses inside each person" (p. 505). Gradually, a

"more contemplative pessimism" (p. 504) replaces the youthful belief that the power of stasis, the status quo, and catabolism can be overcome.

With youth behind them, normal midlife adults are forced to confront their finiteness as the defenses against the acceptance of time limitation and personal death crumble before the power of new physical, psychological, and environmental experience. All vestiges of the processes of physical maturation and the promise of new capabilities in an abundant future vanish as the vice-like grip of the aging process—so apparent in the presence of grey hair, wrinkles, diminished sexual drive, and the menopause and male climacteric—tightens.

Then, too, parents, friends, and contemporaries die. The death of a parent, in particular, undercuts the childhood sense of unending continuance and safety which was provided by the good-enough parent. *One is left alone, unprotected by the infantile notion of parental omnipotence, with the staggering realization that the "child" must die, just as the parent did.* At the same time that the older generation disappears from the scene, the younger generation approaches adulthood. The transformation of children into physically and sexually mature adults also shatters the parent's sense of perpetual youth as they become bigger and stronger than their progenitors.

The realization that time is running out is painfully thrust into consciousness by the growing awareness that many cherished ambitions will never be realized—and that there is not enough time left to achieve new ones of equal importance. A personal end is forcefully brought into focus by the loss of power and prestige in the workplace or the realization that the highest level of achievement possible has been reached. Power belongs to the young, who have the time to begin new ventures and bring them to fruition in the distant future. As one analytic patient, a highly successful professional, put it: "I've become redundant. The heir apparent can do everything I can and a lot that I can't. My time in the spotlight is just about over. Soon it will be lights out!"

The quintessential temporal task of midlife produces powerful

responses, both normal and pathologic. Regressive and pathologic responses can range from excessive physical activity to inattention to bodily care to competitive envy of the next generation to neglect or abandonment of aged parents. Or there may be the onset of a full-blown midlife crisis, in which life structures that took decades to build, such as stable marriages and successful careers, are thrown away in a frenzied attempt to ward off death awareness and to reverse the passage of time.

Confronting this adult temporal experience can also stimulate healthy development and produce a profound awareness of what it means to be human. The gradual acceptance of time limitation and personal death can result in a midlife redefinition of goals and the channeling of energy and resources into obtainable objectives that gratify self and loved ones. Impulses once held in check when time was thought to be plentiful can find an outlet in new activities and pleasures which are consistent with a realistic assessment of physical competence.

And what of the future if the self is no longer seen as omnipotent and everlasting? Those who have successfully integrated the concept of a temporal end may use Eriksonian psychology (1950) to reach across the temporal barrier imposed by death. They may approach old age with "a post-narcissistic love of the human ego—not of the self—as an experience which conveys some world order and spiritual sense . . . the acceptance of one's one and only life cycle as something that has to be . . . it is a comradeship with the ordering ways of distant times and different pursuits" (p. 268).

Relationships with family members are at the core of human experience in midlife. One's interactions with spouse, children, parents, and grandchildren affect every aspect of being, including time sense.

As expressed by Kernberg (1989),

> Intimately related to these issues is a patient's capacity to experience himself as part of an "older" generation, to accept, for example, that there is a younger generation at work . . . and a still older generation to which he can in turn relate. A lack of this

> normal broadening of the time span of ego identity is one of the most frequent symptoms of severe character pathology in this age group. A middle-aged patient who gives the impression of standing alone in the world rather than actually experiencing a sense of loneliness as he projects his life span into the past and the future is another manifestation of this same problem (p. 218).

As one becomes middle-aged and accepts the notion of a personal end, there is a growing identification with elderly parents. In addition to influencing one's time sense, this identification leads to a redefinition of the self. This perception is repeatedly confirmed by younger colleagues deferentially using the title "Sir" or ticket vendors volunteering senior citizen tickets or women becoming aware that they have become "sexually invisible."

In young adulthood, individuals reworked the concepts of Mother and Father Time. As their parents aged and lost the power to control their offspring's time, the internal perception of the parents as the omnipotent originators and arbitrators of time was weakened. Lost, too, was the ability of Mother and Father Time to protect their children from the notion of personal death.

The shattering of the power of Mother and Father Time is brought to an inevitable conclusion in midlife when parents die. Like soldiers in formation marching into battle, the older generation in the front row is relentlessly mowed down; suddenly there is no one between oneself and the grave. Not only are we and our contemporaries unprotected against the relentless onslaught of time, but there are children and grandchildren in the rows behind whom we would like to protect in the fruitless never-ending battle against the grim reaper.

The death of a parent at any age produces an increased awareness of the fragility of life, but the effect is uniquely more powerful in middle age because it is intensified by, and fused with, the phase-specific preoccupation with time limitation and personal death which is intrapsychically consuming, regardless of parental health. Because of this fusion of developmental tasks, the intra-

psychic experience of *mourning* is altered. One mourns not only for the dead progenitor but also for the mortal self.

Conversely, and paradoxically, the continued life of parents, particularly if they are ill and dependent, has a significant effect on the temporal experience of middle-aged persons. Freed of the time-consuming responsibility of raising children and sometimes from the burden of work, middle-aged individuals yearn for years filled with time for themselves — satisfying time enhanced by continued physical health and mental capability, precious time reserved for narcissistic pursuits. Time "stolen away from me," as one woman patient in her early sixties put it, "by the responsibility of caring for my father [aged eighty-seven]. Oh, I do things that I want to but if I'm not actually taking care of him, I'm worrying about him. When I wish him dead, I feel awful. He has so little time left. But so do I. So do I. Will there ever be time for me?"

In my paper on time sense in young adulthood (1991), I said:

> *Over time, the mature love relationship is as significant an organizer of time sense in adulthood as was the relationship between parent and child in childhood.* . . . By midlife it becomes difficult to conceive of time apart from its relationship to spouse and children, so complete is the internalization of these objects, yet that will be precisely the developmental task of middle and late adulthood when separation from children and eventual loss of the spouse force another reorganization, a late adulthood individuation in preparation for death (p. 132).

Although some spouses die in the years between forty and sixty, the issues facing most partners which affect time relate to the aging process in the spouse and changes in sexual functioning. Excess weight, sagging breasts, unreliable erections, pot bellies, wrinkles, and grey hair are just some of the constant reminders of aging in spouses. In addition to forcing a restructuring of the object representation of the spouse, physical aging has a continuous effect on time sense. For some individuals, mostly men, the experience is so painful that they abandon this constant reminder of their own inner temporal conflict and seek a younger partner

who bolsters their defenses against awareness of time limitation and personal death.

Sexual relations between husband and wife in young adulthood are a temporarily gratifying experience because of the possibility of creating new life—of literally creating time in a new being. But sexual relations in midlife, particularly after menopause, are a reminder of a procreative perspective which is now in the past. This sense of aging and time limitation is also heightened by the awareness of gradually diminishing sexual capacity. Sexual relations, which can continue to be a source of great pleasure and intimacy throughout the middle years, can also be a constant reminder of a greatly esteemed capacity which has been diminished (at least physically) by the passage of time.

The death of a spouse in middle age, particularly in a marriage of considerable longevity, shatters the infantile sense of temporal control and immortality in a manner similar to that experienced upon the death of a parent. The two may occur in close proximity to each other. Very often the death of a spouse of twenty or thirty years produces a much greater disturbance of temporal equilibrium than the death of a parent because the temporal associations to the spousal representation have a greater emotional valence than those associated with Mother and Father Time. Further, the death of a spouse in middle age threatens the defenses to a greater degree than the death of a parent because it is not as expected, not as integrated a component of ego and superego awareness. Accepting the death of friends, acquaintances, and loved ones as a "naturally" occurring experience of increasing frequency is a central developmental task of middle and late adulthood.[1]

The differences between parents and their adolescent or young adult "children" comprise a major factor which forces a redefinition of time sense in middle age. For example, sexual feelings

[1] Although the subject is outside the scope of this paper, it is a fact that many middle-aged men and women are not living in long-term relationships. How do divorce, remarriage, stepparenthood, and stepgrandparenthood affect time sense in middle age? These questions await psychoanalytic exploration.

toward a young man or woman whom a son or daughter is dating, or toward a son or daughter-in-law, are reminders of the passage of time and of one's position in the older generation. This sense of difference is heightened by the sharp distinction between the cultural content of the middle-aged parents' past (popular music, movies, automobiles, etc.) and that of their children. The difficulty in relating to the popular culture experienced by one's children is a constant reminder of one's middle-aged present.

While middle-aged time sense is partly shaped by the contrast between the procreative sexuality of young adult offspring and the nonreproductive sex of middle age, reproductive science and the culture of divorce are diminishing the distinction between the generations—but not the temporal consequences. The difficulties and dangers of childbearing in the late thirties and forties are experienced intrapsychically in temporal terms. For males, the experience of fatherhood in the late forties and fifties is accompanied by the painful awareness that time may run out before one's child has reached self-sufficient adulthood.

For some middle-aged new fathers, the experience of parenthood is often closely related in time with grandparenthood. The consequences of such an interaction are both gratifying and conflictual. As one recently remarried man in his late fifties, whose son had also just married, put it: "I'm sure Dave will become a father soon. Well, I just might, too—maybe before he does. I've still got what it takes. But that thought of competing with him bothers me. This should be *his* time to make me a grandfather. I shouldn't diminish that."

Through genetic extension, through the process of identification of parent-child-grandchild, middle-aged grandparents, for the second time in their lives, participate in the creation of new life; in the creation of time. *Through genetic continuity children and grandchildren provide the only form of physical immortality which exists. The dynamic relationship between grandparents and grandchildren cannot be fully understood without comprehending the temporal bonds which define their relationship.* Grandchildren draw grandparents toward

the beginning of life, toward tender years when time itself seemed to exist in unlimited supply—and away from the painful awareness of old age, time limitation, and death.

The intense joy and pure love which grandparents feel for their grandchildren is based on the mechanisms of projection and identification. The idealized self, the luxuriant, time-rich self of early childhood, with its unlimited future potential, lives again in this third generation as it did in the second: but now the need to identify with the child is particularly powerful because of closeness to the end of life.

By giving one's ideas and physical possessions to the young with whom the self is identified, the middle-aged grandparent uses Erikson's generativity to diminish the sting of the loss of the self through death. Making the best of an unresolvable dilemma, the individual creates a limited form of immortality by living on through the surrogate selves who reside in the minds of the young as long as one is remembered.

Grandparenthood, possibly as much as any other experience in life, stimulates a major intrapsychic reorganization of time sense. Nowhere is this more eloquently expressed than in the words of Cath (1989) as he describes how grandparenthood stimulates an interest in both past and future:

> From the ancient, ghostly halls of family introjects, as many as five generations may be exhumed in an active, longitudinal inventory of intrapsychic roots, characteristics, and determinants . . . a screening of their own parenting characteristics, memories of their parents' and grandparents' behavior, family attitudes, habits, and tendencies are likely to cover several generations of affectively laden memories consisting of a mixture of reality and myth. . . . In all likelihood, this process begins silently in the mid-years and gradually sets in motion a challenge to the balance between narcissism and altruism. This leads to new interpretations of the past and an internal redefinition of "time remaining." This Janus-faced reconsideration is usually accompanied by various degrees of regretful reevaluation of self (p. 100).

TURNING FORTY IN ANALYSIS

The following analytic material, from an analysis conducted by John Hassler and published in *The Race against Time* (Nemiroff and Colarusso, 1985), illustrates the intrapsychic power of subjective time sense at middle age and its relationship to current conflicts, particularly with the patient's wife.

Mr. B turned forty after two years and 335 hours of analysis. He was a highly intelligent professional who entered analysis because of symptoms of depression and conflicts about sexuality and work. He was ending an affair with a younger woman as his birthday approached.

One Week Prior to the Birthday

Mr. B.: Heck of a day yesterday . . . I talked with a new junior associate who began working for me . . . she's only 25 . . . a lot younger than I thought . . . I am feeling older and older, oh well.

In the final session of the week, the last before his birthday, he mentions the following for the first time:

Mr. B.: My birthday is coming up . . . I don't want a cake . . . (*later in the session he comments*) I think I want to take a vacation for a day or two . . . the senior partner has been out all week; I wish there were more sunny days . . . I wish it were September and I could ride a bike around with the sun in my face.

In retrospect, he might be wishing to deny the opportunities of manhood and the dreads of aging and preserve some of the childhood fantasies of basking in love, "the sun."

First Week after the Birthday

He . . . described his indifference to a surprise 40th birthday party attended by six couples that his partner had organized for him.

Mr. B.: Forty candles on a cake are too many . . . but they were a nice group of people . . . one of the ladies was crying.

Analyst: Why do you feel she cried?

Mr. B.: A sad affair, birthdays . . . (*after a long silence he added*). . . . I have been irritated with everyone . . . and myself since I have the feeling I don't do the things I want to do with my life. . . .

The following day he started reviewing how sick and weak he felt. This was the only time in the analysis that he complained of a cold, although he had colds at other times. He then went on:

Mr. B.: I'm frosted at my parents for putting me in school a year early . . . I was smart enough but I just wasn't ready emotionally . . . (*later*) . . . my partner has been a real disappointment in my life . . . maybe I put him in a role he didn't fit . . . (*later still*) Maybe I have confused my girlfriend in the same way . . . she is a burden . . . I find it difficult to remember that she is only 26 . . . there is quite a disparity between 26 and 40 . . . the needs are different . . . I don't want to start all over again . . . I don't seem to be getting anywhere . . . maybe tomorrow I'll feel better . . . (*silence*) . . . I'm also irritated at turning 40 . . . it beats the alternatives, but I'm tired of all the problems; I spend my whole life learning how to grow up.

In the third session of the week following his birthday, after complaining about his cold, Mr. B. presented this dream.

Mr. B. (*dream*): At the stadium, quarterbacking a professional football team, crowded stands . . . I was on the better team but couldn't pass to save my ass; it was halftime and I was talking with Ed . . . he had a lot of money bet on the point spread, and I was going to try to increase the lead so he could win . . . I wasn't starting in the second half so I was walking over to the other side of the field . . . but then I had to get back to the game, and I threw a touchdown pass even though all the men in front of me were taller.

Mr. B. (*associations*): I am putting myself on the winning team . . . not the biggest but the best man . . . I'm about average height . . . even though I am bigger than my father now, of course I wasn't as a boy . . . used to be self-conscious about being short as a kid . . . in fact, I still have difficulty seeing myself as big . . . inferiority complex, keeps me thinking small.

Analyst: I wonder if your dream doesn't help us understand your conflict over accepting height, prowess, success.

Mr. B.: And I can perform for others too . . . going to make Ed a winner . . . you may have met him, he runs the gas station around the corner . . . in reality, for him I don't need to be successful or a winner . . . just a hell of a nice guy . . . trying to repay a friendship.

Analyst: Am I involved in this move toward success and friendship?

Mr. B.: You do care about my growth.

Although there are other sections of the dream that relate to working through a variety of conflicts, what is crucial for a review of analysis at the 40th birthday is Mr. B.'s assumption of manly prerogative now that he is at "halftime" and his move toward a more loving image of adult males, that is, the owner of the gas station as the analyst/father through displacement. In the last session of this first week following his birthday, Mr. B. reported a dream of oedipal success.

Mr. B. (*dream*): At work with the partners, around a table at the cafeteria . . . discussing applications for new men . . . I was advocating certain people . . . but the senior partner had only trivial bullshit cut downs and then I walked off for lunch with his wife.

Mr. B. (*associations*): Actually, it has occurred to me recently that I'll be a senior partner when he retires in 3 or 4 years . . . it is the part of me that is still sorting out manhood . . . it doesn't come from my father's wife . . . although in the dream I'm confident

enough to have her . . . (*later in the session*) . . . I don't think I am looking to replace my wife anymore . . . I used to be . . . I enjoy life more with her (pp. 108-110).

TIME SENSE IN MIDDLE-AGED WOMEN

With the beginning of menstruation, a woman's sense of time is influenced by her "monthly." Pregnancy produces another sexually defined cycle for the female. This psychobiological event, which spans nine calendar months, is divided into temporal phases—early, middle, and late.

In middle adulthood gender differences continue to manifest themselves, most notably in women in the loss of the procreative function. The running down of the biological clock leads to menopause, ending a reproductive interval of approximately thirty years. The menopause produces two paradoxical effects on time sense in middle-aged women. The cessation of menstruation is a temporal watershed, sometimes leading to a mourning reaction related to the loss of the awesome ability to create time through the creation of new life. The inability to master this mourning process is a significant factor in the problematic responses to the menopause seen in some women.

When the mourning process related to the menopause is successfully worked through, however, a major developmental transformation in subjective time sense occurs. No longer dominated by the timetable of the monthly menstrual cycle or by the possibility of pregnancy, women are free to use time in new egocentric ways. The sense of liberation is one of the dynamic factors supporting the contention that a problematic reaction to menopause is not usual or normal (Nemiroff and Colarusso, 1985).

A significant developmental task of middle adulthood is the ability, free of significant conflict and guilt, to use increasing quantities of time for egocentric purposes. In both men and women, the newly found temporal freedom and the sense of ex-

hilaration that accompanies it become quickly fused with generative activities. In other words, the self is aggrandized by giving to and caring for younger generations and identifying with their abundant future. When this fusion occurs, a pattern that began with parenthood becomes driven by different dynamics, namely, the need to react to the confrontation with the awareness of time limitation and personal death.

WORK AND TIME

The nineteenth-century author George Sand noted that work is not man's punishment; it is his reward, strength, glory, and pleasure. Earlier in this century Freud (1930) stated that human life has "a two-fold foundation: the compulsion to work, which was created by external necessity, and the power of love. . . " (p. 101). Although work has come to be seen as a means of consolidating identity and self-image in adulthood, little has been written on its effect on temporal attitudes and development.

Developmental Antecedents

The capacity for work begins to develop in the second and third years of life when parents introduce toilet training and other limit-setting experiences. As parents regularly frustrate the toddler's wish for total freedom and impose routines and restrictions, they help the child to begin to tolerate frustration, delay gratification, and establish the capacity to control mind and body—components of temporal adaptation and a mature capacity to work. In gently insisting on adherence to societal demands for bowel and bladder control and cleanliness, parents facilitate the emergence of a core strength which forms the basis on which the ability to work is built (A. Freud, 1965).

During the oedipal years, ambition and initiative directed toward parental competitors are integrated into the future worker's armamentarium. Success in the workplace is predicated on the

ability to face potential rivals and challenges and to work with and learn from those with superior knowledge and capability. The child who successfully traverses the oedipal stage and its developmental tasks internalizes the characteristics required for future success in the workplace.

With the internalization of the superego in early latency, the child begins to possess the moral values, ability to control impulses, and self-generated expectations for achievement that are indispensable for the successful worker. A successful worker is self-motivated and goal-oriented, continually responding to a powerful inner gyroscope that directs him or her toward higher levels of achievement.

Adolescence is the phase when many individuals enter the work force for the first time. Their desire to partake of the pleasures of adult life (and parental insistence) pushes adolescents into the work force, where they earn small sums of money and learn about the demands connected with work.

Sometimes the power of adolescent drives and the failure to master work-related tasks from earlier phases of development accentuate the adolescent preoccupation with the present and immediate gratification and diminish the emergence of a sense of future awareness.

For example, Sarah was an exceptionally bright, seventeen-year-old analytic patient whose character pathology and predilection for immediate gratification were seriously undermining the development of the intellectual tools and academic credentials necessary for success in the workplace. She was a fine student in elementary school, but her grades deteriorated in adolescence when intense involvement with friends and dating and a neglect of homework produced a C- average and an 810 SAT score.

"I wish I could whisk you twenty years into the future so you could see how important these high school grades are," I said in a moment of frustration. "But you can't," she smiled sadistically. "I guess I'll have to learn it for myself the hard way. But I'm going to take my time doing it."

Thus, equipped with varying degrees of capability and conflict,

adolescents become young adults and enter the adult work force, there to experience the powerful influence of work on subjective time sense and temporal development.

The transition from childhood learning and play to young adulthood learning and work involves a subjective temporal shift that takes place at some point in the late teens or early twenties. This shift produces a significant change in the way time is experienced. As Hartocollis (1976) put it:

> . . .time becomes less important as an immediate experience and more important as a commodity, as a goal, rather than as a means to an end. Time acquires the value of a product, becomes literally money, productive thinking, opportunity for more planning, more meetings, more sales, more profits, more accomplishments (p. 367).

Just as parental introjects form the nucleus of the superego/ego ideal in latency and adolescence, mentor/protégé relationships are the source of identifications that influence the choice of career and determine internal perceptions of time and work in young adulthood. Through the young adult's interactions with colleagues and mentors in the workplace, time becomes increasingly identified with work—almost a tangible commodity which is assigned an economic value as described by Hartocollis.

WORK AND TIME SENSE IN MIDDLE ADULTHOOD

For most men and an increasing number of women in Western society, work is an activity of major importance. It organizes the use of time and directs the activity in which most waking hours are spent. Capable, accomplished, and powerful, at the top of the labor pyramid, midlife workers control their own time. But like Mother Time and Father Time during childhood, they also control the time of their time-rich younger employees and protégés, thus consciously and unconsciously compensating for the sense of time loss generated by growing awareness of time limitation and

personal death. For some, the comfortable, predictable routine of time and the domination of the time of others become so narcissistically gratifying in counteracting the injurious responses to time limitation that work becomes the *primary* source of emotional sustenance and temporal stability.

Such investment in work may block the engagement of a related, temporally driven, developmental task: planning for retirement and replacement by the next generation. The awkward juxtaposition of maximum achievement and power in the workplace and the simultaneous realization of time limitation and inevitable loss of power is at the core of the midlife worker's intrapsychic and real predicament.

Aspects of the conflict are expressed by sociologist Judith Bardwick (1990):

> Forty is a symbolically powerful age for Americans. In addition to the stress of aging, the forties is a decade when almost all will reach their plateaus at work. For the majority, work will be mastered, promotions will end and, the responsibilities of child rearing will be over. Thus the commitments made to the past no longer provide satisfaction in the present or guidelines for the future. . . . The future is shortening. One may have spent twenty years in an occupation and may face spending the next twenty doing the same thing (p. 202).

According to Bardwick most men in their fifties and beyond have "organized their lives around a self-oriented commitment to work and that is all they can imagine. As long as they continue to work hard, they can avoid thinking about aging and retirement" (p. 208).

As middle age progresses, a growing realization that one's abilities and ideas are being nudged aside or replaced leads to a growing sense of redundancy. A new world is emerging which can never be completely yours because you do not have the energy or the ability to absorb its ideas; you do not have the skills to be a significant player or the time to participate in its development. An example of the sweeping cultural changes that stimulate the

awareness of redundancy is the reluctance of many middle-aged individuals to embrace the computer age. Another example is the struggle to maintain a psychoanalytic identity in a field in which biological psychiatry under managed care has replaced psychoanalysis as the dominant theory and method of treatment. A growing identification with the past, when one's generation was the heir apparent and then the prime mover, forces a reorganization of the time modes of past, present, and future and is a significant factor precipitating the phase-appropriate developmental conflict over retirement.

Retirement is not a universal experience. In third world countries and for many individuals in the developed world it is neither an important consideration nor a choice. These individuals must work until they are no longer able.

For the millions of men and women in the Western world who do retire, the cessation of work with its regulation of time produces a variety of psychological and temporal consequences. I will group these consequences into two greatly oversimplified categories.

For the many individuals who did not love their work and had little or no narcissistic investment in it, retirement results in an increase in the amount of time available for more pleasurable activities and a liberation from the tryanny of time which had to be devoted to a necessary, nongratifying activity. Subjective time sense becomes infused with a sense of liberation, exhilaration, and abundance which counters the phase-specific, midlife preoccupation with time limitation. As one retired patient put it, "I'm retired. I can do whatever I want, for as long as I want."

For those who love their work and receive pleasure from the comforting regulation of time and an activity which enhances self-esteem and generativity, the loss of work through forced retirement, redundancy, or illness produces a significant temporal disruption. In this instance time is experienced as empty and unproductive ("I've got too much time on my hands"), and the sense of awareness of and anxiety related to personal time limita-

tion and aging is often replaced by depression, despair, and premature death.

A Summation of Healthy Time Sense in Middle Adulthood

The ability to conceptualize the experience of time is most highly developed in emotionally intact, mature individuals at this, the zenith of the human life cycle. But even at the peak of human understanding, the experience of time remains inscrutable and somewhat beyond human comprehension. There are, however, certain aspects of psychotemporal adaptation at midlife which are definable. Among the most important are the following:

(1) An understanding of the complex interrelationships among past, present, and future in the human psyche. This concept is clearly illustrated by Loewald (1972):

> Past, present, and future present themselves in psychic life not primarily as one preceding or following the other, but as modes of time which determine and shape each other, which differentiate out of and articulate a pure now. There is no irreversibility on a linear continuum, as in the common concept of time as succession, but a reciprocal relationship whereby one time mode cannot be experienced or thought without the other and whereby they continually modify each other (p. 407).

(2) A recognition of the finite nature of personal time and the inevitability of personal death. This most central developmental task of midlife, possibly of all life, defines the human condition more than any other. Acceptance of a personal end is an indispensable component of mature psychic functioning in midlife. It prepares the way toward engagement of the central developmental issue of late adulthood: not *if* one will die, but *how*—to paraphrase Erikson, with integrity or despair.

(3) A complex understanding and acceptance of two contradictory trends in human experience: the inevitable predictability of the linear temporal progression from present to future, from the beginning to the end of personal time; and the inevitable unpre-

dictability of loss and change in human experience. The mature individual at midlife uses this understanding and integration to experience life fully, with serenity, pleasure, excitement, and fulfillment, as illustrated in this quotation from Pollock (1980):

> In dealing with aging issues, I have found the focus on the mourning-liberation process to be of great importance. The basic insight is that parts of self that once were, or that one hoped might be, are no longer possible. With the working out of the mourning for a changed self, lost others, unfulfilled hopes and aspirations, as well as feelings about other reality losses and changes, there is an increasing ability to face reality as it is and as it can be. "Liberation" from the past and the unattainable occurs. New sublimations, interests, and activities appear. There can be new relationships with old "objects" as well as new "objects." Past truly can become past, distinguished from present and future. Affects of serenity, joy, pleasure, and excitement come into being (p. 576).

REFERENCES

ABRAHAM, K. (1921). Contributions to the theory of the anal character. In *Selected Papers of Karl Abraham, M.D.* New York: Basic Books, 1953, pp. 370-392.

ARLOW, J. A. (1986). Psychoanalysis and time. *J. Amer. Psychoanal. Assn.*, 34:507-528.

BARDWICK, J. (1990). Where we are and what we want: a psychological model. In *New Dimensions in Adult Development*, ed. R. A. Nemiroff & C. A. Colarusso. New York: Basic Books, pp. 186-213.

BOAS, G. (1950). The acceptance of time. Berkeley: Univ. of Calif. Publications in Philosophy, XVI, pp. 246-270.

BONAPARTE, M. (1940). Time and the unconscious. *Int. J. Psychoanal.*, 21:427-468.

BRUNSWICK, R. M. (1940). The preoedipal phase of the libido development. *Psychoanal. Q.*, 9:293-319.

CATH, S. H. (1989). Readiness for grandfatherhood and the shifting tide. In *Fathers and Their Families*, ed. S. H. Cath, A. Gurwitt & L. Gunsberg. Hillsdale, NJ: Analytic Press, pp. 99-118.

COLARUSSO, C. A. (1979). The development of time sense—from birth to object constancy. *Int. J. Psychoanal.*, 60:243-251.

——— (1987). The development of time sense: from object constancy to adolescence. *J. Amer. Psychoanal. Assn.*, 35:119-144.

——— (1988). The development of time sense in adolescence. *Psychoanal. Study Child*, 43:179-197.

——— (1991). The development of time sense in young adulthood. *Psychoanal. Study Child*, 46:125-143.

——— & NEMIROFF, R. A. (1979). Some observations and hypotheses about the psychoanalytic theory of adult development. *Int. J. Psychoanal.*, 60:59-71.

——— ——— (1981). *Adult Development: A New Dimension in Psychodynamic Theory and Practice.* New York: Plenum.

ERIKSON, E. H. (1950). *Childhood and Society.* Second edition. New York: Norton, 1963.

——— (1956). The problem of ego identity. *J. Amer. Psychoanal. Assn.*, 4:56-121.

FENICHEL, O. (1945). *The Psychoanalytic Theory of Neurosis.* New York: Norton.

FREUD, A. (1965). *Normality and Pathology in Childhood: Assessments of Development.* New York: Int. Univ. Press.

FREUD, S. (1909). Notes upon a case of obsessional neurosis. *S.E.*, 10.

——— (1915). Thoughts for the times on war and death. *S.E.*, 14.

——— (1930). Civilization and its discontents. *S.E.*, 21.

GIFFORD, S. (1960). Sleep, time and the early ego: comments on the development of the 24-hour sleep-wakefulness pattern as a precursor of ego functioning. *J. Amer. Psychoanal. Assn.*, 8:5-42.

HARTOCOLLIS, P. (1974). Origins of time: a reconstruction of the ontogenetic development of the sense of time based on object-relations theory. *Psychoanal. Q.*, 43:243-261.

——— (1976). On the experience of time and its dynamics, with special reference to affects. *J. Amer. Psychoanal. Assn.*, 24:363-375.

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

JONES, E. (1913). Hate and anal eroticism in the obsessional neurosis. In *Papers on Psycho-Analysis.* Third edition. New York: William Wood, 1925, pp. 553-561.

KERMODE, F. (1968). Doing time. *The Listener*, March 21.

KERNBERG, O. F. (1989). The interaction of middle age and character pathology. In *The Middle Years: New Psychoanalytic Perspectives*, ed. J. M. Oldham & R. S. Liebert. New Haven/London: Yale Univ. Press, pp. 209-223.

LOEWALD, H. W. (1962). The superego and the ego-ideal. II. Superego and time. *Int. J. Psychoanal.*, 43:264-268.

——— (1972). The experience of time. *Psychoanal. Study Child*, 27:401-410.

MAHLER, M. S. (1974). Symbiosis and individuation: the psychological birth of the human infant. *Psychoanal. Study Child*, 29:89-106.

MEERLOO, J. A. M. (1948). Father time: an analysis of subjective conceptions of time. *Psychiat. Q.*, 22:587-608.

NEMIROFF, R. A. & COLARUSSO, C. A. (1985). *The Race Against Time: Psychotherapy and Psychoanalysis in the Second Half of Life.* New York: Plenum.

NEUGARTEN, B. L. (1979). Time, age, and the life cycle. *Amer. J. Psychiat.*, 136: 887-894.

——— & DATAN, N. (1980). The middle years. In *The Course of Life: Psychoanalytic*

Contributions toward Understanding Personality Development. Vol. III: Adulthood and the Aging Process, ed. S. I. Greenspan & G. H. Pollock. Washington, DC: National Institute of Mental Health, pp. 592-608.

PANEL (1972). The experience of time. J. S. Kafka, Reporter. *J. Amer. Psychoanal. Assn.*, 20:650-667.

PIAGET, J. (1969). The intellectual development of the adolescent. In *The Psychology of Adolescence: Essential Readings*, ed. A. H. Esman. New York: Int. Univ. Press, 1975, pp. 104-108.

POLLOCK, G. H. (1971). On time, death, and immortality. *Psychoanal. Q.*, 40:435-446.

——— (1980). Aging or aged: development or pathology. In *The Course of Life: Psychoanalytic Contributions toward Understanding Personality Development. Vol. III: Adulthood and the Aging Process*, ed. S. I. Greenspan & G. H. Pollock. Washington, DC: National Institute of Mental Health, pp. 549-585.

RAPAPORT, D. (1951). *Organization and Pathology of Thought: Selected Sources.* New York: Columbia Univ. Press.

SETON, P. H. (1974). The psychotemporal adaptation of late adolescence. *J. Amer. Psychoanal. Assn.*, 22:795-819.

SETTLAGE, C. F., CURTIS, J. & LOZOFF, M. (1988). Conceptualizing adult development. *J. Amer. Psychoanal. Assn.*, 36:347-369.

SHAPIRO, T. & PERRY, R. (1976). Latency revisited: the age 7 plus or minus 1. *Psychoanal. Study Child*, 31:79-105.

SPITZ, R. A. (1965). *The First Year of Life: A Psychoanalytic Study of Normal and Deviant Development of Object Relations.* New York: Int. Univ. Press.

——— (1972). Bridges: on anticipation, duration, and meaning. *J. Amer. Psychoanal. Assn.*, 20:721-735.

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WHAT THE ANALYST DOES NOT HEAR

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In the clinical situation, the analyst fails to hear more than he or she hears and spends much time working in the dark. The author raises questions about how we can take cognizance of that state of affairs in our thinking about analytic work. A clinical example illustrates how, in an analytic atmosphere, a patient will correct an analyst's failure to hear. Some ideas are offered about how to maximize the patient's participation in that effort. The author suggests that the problem may not fall precisely under the heading of technique so much as reflecting the analyst's attitude.

At a recent American Psychoanalytic Association workshop on analytic listening, Arnold Goldberg posed a key question to the presenters: how do you know when you are wrong? I would like to offer some musings on that question, and then raise a subsidiary question: can we incorporate the fact that we are wrong much (if not most) of the time into our thinking about analytic work? To put the question somewhat differently: how can we best understand the role of what we do not hear in the analytic process as we listen to our patients and ourselves? Renik (1993) recently proposed a conception of psychoanalytic technique that took into account the analyst's "irreducible subjectivity"; in what follows, my emphasis will be on the related problem of how to take account of the analyst's ignorance. Let me say at the outset that I have no satisfactory answer; my ambition for this contribution is limited to bringing the question into sharper relief.

I would like to begin the discussion with a brief clinical illustration to highlight the difficulty of accounting for what we do not hear.

A woman writer came to analysis because of a series of unsatis-

fying romantic involvements with men. Despite being sought after by many men, and despite many satisfying casual friendships with bright and talented people, she harbored the conviction that she could not be too choosy in her romantic life. Repeatedly she seemed to find herself with men with whom she felt little or no connection, emotionally or intellectually.

She was the only child of a father who was an artist and critic, and a mother of limited education and ambition. As her father became more celebrated, her mother became increasingly isolated and withdrawn. Finally, as the patient was entering adolescence, her parents split up. The patient was devoted to her mother, whom she felt had been wronged by her father, but it gradually emerged that she also felt convinced that she had been a more suitable companion to her father than her mother had been. She shared his interests in a way the mother was unable to do, and as might be expected, she struggled with a sense of responsibility for the divorce.

Much of the early work centered around the ways in which she sold herself short, and how they seemed to calm certain anxieties. She had chosen me over many better known analysts because she had never heard of me; she did not feel it right for her to take one of the "stars" from someone else. As the work progressed, she became less anxious, and freer in her enjoyment of the company of men. Her opinion of me improved as well; it soon became clear that she found our interaction stimulating and enjoyable.

Well into the analysis, she complained about an insensitive remark made by the man she was dating at the time. She then shrugged it off as not typical of him. I heard her readiness to dismiss her complaint as another example of selling herself short, and I commented that she seemed to be saying she did not deserve better. This remark was met with a brief but noticeable silence, after which the patient made it clear that I was mistaken. I had not heard that she was serious about the man she was seeing, whom she found exciting and admirable. She then said, "You know, you've been making that same interpretation for a long time. I get the feeling that you think the only person good enough

for me is you." She was quick to add that she guessed it was "just wishful thinking" on her part. We were familiar with some versions of the wishes in question, which had been explored profitably in the past, and to which she now returned.

After some time, I commented on her use of the word "just," and suggested that she was more comfortable seeing the issue as purely her doing than she was considering the implications of what she saw in me. She realized that was so. She found it unsettling. It was flattering, exciting, but I was not supposed to be interested in her that way. It also felt like a burden. She wanted to get on with her life, not spend it in analysis. I said she seemed to be fighting the feeling that she had to accommodate me by not getting on with her life.

As she thought about that over the next several sessions, a variety of issues opened up. She experienced the dilemma of being caught between two people she loved, and she felt that she was being asked to choose, as she had felt about the divorce. She reviewed this experience of me alternately as my needing her to take care of me and as my being excited by her. The former brought up thoughts of her concerns for her mother at the time of the divorce. The latter reminded her of an incident in which she had noticed that her father was sexually aroused in her presence. At first she had condemned him for it. Subsequently, she became aware of a sense of guilt for her presumed role in the incident. She could now recall that she had also felt excited at the discovery that she was capable of arousing him, and she realized that nothing untoward had happened. As she turned back to her experience with me, she began to consider the possibility that she and I could enjoy a mutual excitement that did not constitute a claim on her or stop her from loving someone else.

I would like to review this example in terms of how I listened and what I did and did not hear, in several stages. What I heard, first, was that the patient was selling herself short with her choice of men, in order to lessen her anxiety about being capable of attracting a more suitable man. I had not heard that she was happy and excited about the new man she was seeing. I will comment

later on how I heard her response to my interpretation and how it affected my subsequent listening, but first I will describe some possible readings of the events.

From one perspective, the patient responded to my remark by hearing it as evidence for the transference fantasy that I wanted to keep her for myself. I invited her to elaborate, and two transference configurations emerged, corresponding to her perceptions of her mother and father, that I was competing with other men for her. I believe this is a reasonable description, as far as it goes. It conveys some important movement in the analytic work. From one listening perspective, it might be the end of the description: the patient construed the analyst's meaning in accordance with her preformed transference expectations, which she then elaborated. From this standpoint, the analyst's motives are irrelevant, and it is taken for granted that his actions are in the service of the analysis—i.e., all the analyst did was interpret; the interpretation could be inaccurate, ill-timed, or incomplete, but anything the patient experiences other than the analyst's analytic intent is so powerfully determined by the patient's transference that one can safely treat the outcome as the patient's creation.

Another reading of the events might add another dimension, namely, that my countertransference contributed to what I heard and how I listened. According to this view, we might consider the "contamination of the field" by the intrusion of the analyst's unconscious processes: my own unconscious motives compromised what I heard and how I listened *in this instance.* This view presumes that there are times when the analyst's unconscious motives do not contribute in an important way to the patient's experience. If that was how I listened to myself listening, I could consider my intervention to be a mistake and relegate its understanding to my self-analysis. The significance for the analysis of the patient would be limited to attention to the impact of my mistake, advantageous or otherwise. Since (from this perspective) it was a departure from an analytic stance, it is part of the analysis only as a breach. In other words, it need not be incorporated into a theory of technique.

An alternative formulation taking countertransference considerations into account would look to my experience as information about the patient's activity, e.g., via projective identification. Here let me add something of my actual experience to the report. When the patient told me she heard me as saying the only person good enough for her was me, my immediate (and disturbing) reaction was to see that there was some truth in what she was saying. I had been feeling that "someday" she would be ready to leave analysis, but I realized that I so enjoyed her that I was reluctant to think that "someday" would actually come.

From the perspective of countertransference as information about the patient, I could have listened to my reaction as one stimulated by her projected wishes. It was not a great leap to recognize that the view of me as wanting to keep her, or the view of her father as being aroused by her, or the view of her mother as being nothing without her, all had wishful elements; she subsequently confirmed as much. This view makes the same epistemological assumptions as the first description, in which the patient's preformed transferences eclipse any other concern. Both construe the analyst's listening as a primarily passive, receptive process. Countertransference, in this usage, is a reaction to transference. (Note, by the way, how often we refer to "countertransference" and how rarely we refer to the analyst's transference to the patient [Bird, 1972; Grossman, 1996; McLaughlin, 1981].)

The striking feature of all these views is the implication that the rules governing the analyst's psychology are different from those governing the patient's (Henry Smith in Workshop, 1995). We do not expect our patients' perceptions to be free of unconscious determinants; indeed, we insist that this is never so. But certain listening perspectives implicitly depend on the implausable assumption that the analyst can suspend his or her unconscious motives in analytic listening. This is true whether we see ourselves as detached, objective, mirrorlike observers (Freud, 1912) or as empathic receivers of the patient's projected experience (Ogden, 1979).

I would like to return to the example to try to take the fact of the analyst's psychology into account in two ways: first, to show how I actually listened in the clinical moment (which I think will be consistent with a view that is reflected in much of the current literature); and second, to begin to address the problem of how to approach what we do not hear as part of the process.

When my patient responded to my interpretation, she made her own interpretation of one unconscious meaning of my actions. My reaction confirmed (at least to my satisfaction) that she was onto something, which I understood as far as I have described above. Although I was not very comfortable with what she said, I did not suggest that her perception was mistaken. Moreover, at the time I felt that by virtue of her external perspective, she had inferred one of my unconscious motives about which I knew very little. This experience affected my subsequent listening in many ways, two of which I would like to highlight. First, it brought to the forefront of my attention what I accept in principle but do not always bear in mind: that my own unconscious activity was playing a role in the interaction. Second, it forced me to realize that I was operating on a theory about the patient that needed reconsideration. The patient had told me I was wrong. That did not mean the patient was right, but it did remind me not to assume that I was right.

By interpreting the patient's effort to dismiss her perception of me as "*just* wishful thinking," I tried to keep the subject on the table between us. At the time I was not sure of the extent of my contribution, but I tried to be sure that it was available for our discussion by addressing her effort to disavow it, and by trying to avoid any suggestion that would covertly challenge her perception. I did not confirm its accuracy; it was, after all, her own version of something I actually did, and so it was neither strictly accurate, nor strictly a distortion. Furthermore, she had considered only one of my motives; there were others of which I was aware, and doubtless still others of which I was not. But neither did I refer to her interpretation of my actions as her "fantasy" or even as her "wish"—which I think would have implied that I

would have preferred that we ignore whatever it was that I did to stir it up.

I believe that proceeding this way had a useful impact, which was to help the patient see that this very human exchange of feelings did not necessarily compromise our work or her life choices (it was useful to me for the same reason, although that was not what she was paying me for). In the larger scheme of things, it was useful because it confronted the patient with the fact that my unconscious activity was a part of the interaction for which we could both listen. Patients often seek to disavow or discredit their perceptions of the analyst, and it is all too tempting for the analyst to let that happen.

In describing the vignette as I just did, I believe it will be familiar to readers as representative of a particular trend in contemporary analytic literature. Many analysts have become increasingly interested in their own unconscious contribution to the process. Jacobs (1986), for example, has contributed many elegant instances of his involvement in subtle unconscious enactments. In each case he described how his own self-scrutiny undid an impasse and ultimately moved the work forward. Gill (1982) has emphasized the connection of all transference to the actual analytic situation. Boesky (1990) has offered a view of the process which emphasizes a reconceptualization of resistance as a joint creation. Renik (1993) has suggested that without transference-countertransference enactment, analysis might be impossible. Hoffman (1983) has written about the patient as interpreter of the analyst's experience. The recent literature has been enriched by many such contributions, of which this is only the merest sampling. I share with most of those authors the impression that the analytic process consists of the retrospective study of complex interactions, of which the analyst is co-author, with the goal of helping the patient toward useful self-awareness. My way of thinking about what I did owes much to the above contributors, although I am slightly more uneasy than some of my colleagues about making technical recommendations, for reasons I will explain in due course.

The best of these contributions is built on clinical material that

shows how the analyst, by listening to the patient, by listening to the patient listening to the analyst, and by listening to him or herself listening to the patient, can bring much that was previously unnoticed into the discussion. In my example, my patient's comment made me listen to how I had been listening, and provided the opportunity for me to enlist her participation in noticing how she listened to me. In many of the cases in the literature, we come away with a respect, sometimes bordering on awe, for what the analyst is eventually able to hear. But there is an implication in all of these writings, one that is certainly not what the various authors intended: that by the end of the vignette, the situation will have been understood.

These vignettes are publishable because they are exemplary moments of understanding. But most of the analysis takes place in long stretches between those moments when we feel we understand. Furthermore, it is my impression that, even at those moments, what we do not know far outweighs what we know. In this sense, even the best of the analytic literature does not reflect the actual experience of analytic work. That is, of course, an artifact of writing: we write about what we know and not about what we do not know. My example is, after all, an example of what I finally came to hear; it does not, and could not, deal explicitly with what I never heard.

We spend far more of our time mired in uncertainty than otherwise. In my experience at least, the state in which I spend the most analytic time is one of feeling that *something* is going on but I do not know what it is, other than to notice some almost ineffable tension between my patient and me. Periodically, we learn something, but never everything, about it. Even those moments that feel like an epiphany usually prove in retrospect to be something more than what I thought had been happening. It is often the case that what we feel the most sure of turns out to be a misleading partial truth. Gradually, our understanding comes into clearer resolution, and we have a sense of the work moving forward; but at any given moment, what we do not understand far outweighs what we do understand.

It should be clear by now how complex and profound a question Goldberg posed when he asked how we know when we are wrong. Often we do not know. It is tempting to quip that the one time we are sure to be wrong is when we feel certain we are right. The patient's agreement with our ideas is no guarantee of correctness; we often discover collusions and compliance, although I suspect that in every analysis they remain undetected far more often than not.

In my clinical example, it was easy to suspect that I might have been wrong. The patient told me so, and she told me her ideas about why I was wrong. Those situations may be challenging, but they are not the main difficulty. In the instance cited, I did not have to speculate about the silent operation of my unconscious processes, because my patient slapped me in the face with them. One inference I draw from the clinical example is that, for every instance in which a patient is able to alert me to the possibility that I might be wrong, there must be countless examples in which I never notice I am wrong.

So the question arises, how do we take our struggling in the dark into account in our thinking about analytic technique? Our published clinical vignettes almost always show us reaching a satisfying understanding, even if it follows a protracted struggle. But this skews our picture of the analytic process toward an idealization, and may make us embarrassed by the confusion, tension, and relative ignorance that is (or in my view, should be!) our day-to-day state.

Clinical vignettes do not easily demonstrate the more typically muddy analytic situation. Perhaps it would be useful to imagine an "anti-vignette" that would encompass the volume of clinical material that does not get reported because we never understand it, or never even notice that there is anything to understand. For example, an "anti-vignette" true to analytic experience would consist of all that I do not remember or do not notice about what went on in each hour of a given day. Here is what I could say about my participation in those unrecorded moments: I know that I did something with each patient, motivated by something

I did not understand, which was in some measure a response to the patient (and therefore includes some contribution on his or her part), and which was also an expression of my own psychology. I do not know my unconscious motives for what I did; I do not know how to separate my contribution from the patient's; I do not know what will turn out to be important to the patient and what will not. And I do not know if I will ever find out.

I certainly expect that I will learn a great deal about *some* of the overlooked interactions, as clinical events bring them to my mind or to the patient's mind. So some of my ignorance is an artifact of my choice to restrict my example to one day. But I suspect that much, if not most, of what goes on in my office will remain undiscovered. That is a limitation of the clinical art that we live with. When circumstances bring something previously unconscious to awareness, we have a clinical vignette; when they do not, we do not. We do not know what we do not know; what is unconscious is unconscious, and that applies to the analyst as well as to the patient.

What implications does this fact have for clinical work? It means, among other things, that we need to allow that the patient is often in a better position to notice the manifestations of the analyst's unconscious processes than the analyst is (Hoffman, 1983). The analyst has a valuable and different perspective on the patient largely (though not exclusively) because it is a view from the outside; the same may be said for the patient's perspective on the analyst. Neither view is free of subjective bias; neither party can ever be certain. These facts lead me to number myself among those who view the analytic task as a collaborative effort to understand the interpersonal events of analysis as they happen, with neither party having special access to truth (Renik, 1993; Smith, 1995). The goal of such a view is to try to help the patient maximize not only the capacity to observe him or herself, but also the capacity to observe the analyst, in order to make optimal use of the analyst in the service of helpful self-awareness.

It is not obvious how that goal is to be achieved, and I have only the most tentative and general suggestions to make as to how to

think about it. Certain contemporary views are efforts to move in that direction, but each has its associated pitfalls. For example, Hoffman's (1983) advocacy of willful self-disclosure is designed to facilitate collaborative work, including giving the patient the opportunity to interpret the analyst's experience; but Hoffman (1994) also suggests the need to leave undisturbed certain of the patient's magical illusions about the analyst. Thus, the analyst chooses to self-disclose at some times and not at others. If this is a technical problem, what principle can we teach our students to guide the choice?

In any case, the least the analyst can do is strive not to make the collaborative task of the patient and the analyst observing each other and themselves together any harder than it need be. A particular maneuver such as willful self-disclosure may not succeed as a universal prescription for making the analyst's unconscious activity available to the participants in the analysis; but as we have seen, certain *attitudes* can serve as obstacles to the full accounting of the analyst's contribution. The analyst's *conviction* that he or she is merely an observer will certainly convey to the patient the analyst's wish that the two of them need not take the patient's perceptions of the analyst seriously. Whether the patient tacitly agrees, or subtly complies to protect the analyst, the outcome is that an important segment of the patient's experience is summarily excluded from analytic consideration. The same reasoning applies to the analyst who has the conviction that everything he or she feels in the hour has been "put into" him or her by the patient. In fact, the same may be said of the analyst who insists on a more "egalitarian" stance—if, for example, the analyst is unwilling to consider the possibility that the patient's perception of the analyst as authoritarian might have some basis in the analyst's behavior.

Renik (1995) has made many of these same observations. At the same time that he warns against the analyst cultivating unearned authority by adhering to a counterproductive ideal of anonymity (p. 494), he also points out that any doctrine, no matter how humble or egalitarian in theory, can be used in the ser-

vice of authoritarian or other anti-analytic goals (p. 484). He argues for the need for an "*ethic*[1] of candor" (p. 494, italics added).

This brings me to my uneasiness about technical recommendations. Although I am in substantial agreement with what Renik has to say, I am not sure that the matter properly falls under the rubric of technique at all. When he refers to analysts using an ideal of anonymity to cultivate unearned authority, I believe that the main problem he is identifying is that analysts may use their theories of technique to rationalize aspects of their character. And as he suggests, no theoretical position is immune from that use. When he then recommends an *ethic* of candor, he is recommending not a technical device, but an *attitude*—again, one that (I believe) cuts across particular technical approaches. In the discussion of my clinical example, I tried to show how analysts of various persuasions might have listened to the patient and what they would have heard, in accordance with their theoretical ideas. But I suspect that both our way of listening and our preference for theories are primarily consequences of our way of seeing ourselves. It is true that theory shapes technique, but to a far greater extent, character shapes theoretical preference. Of course, that applies to me as well, and to my emphasis in this paper on aspects of the clinical situation that I think we might be inclined to neglect. But no technical approach has a monopoly on candor or honesty or empathy; nor, as Renik suggested, is any technical approach a guarantee against defensive or exploitative use. I believe that we are inclined to confuse our character traits (e.g., activity or passivity) with our technique, because we are stuck with our character traits. But I will leave the further elaboration of this position for a future communication.

In a sense, the villain in the piece is the analyst's certainty—a character trait, not a technical device. The analyst's realization of the limits of knowledge, of both him or herself and of the patient,

[1] I would prefer the word "ethos" to underscore the creation of a certain atmosphere, but Renik may have chosen "ethic" to emphasize the sense of a value.

helps set a collaborative tone in the work and makes it possible to address the patient's idealization of the analyst as omniscient. On the other hand, if we subscribe to a view of ourselves that says we *should always* know, or to a position that says we can translate anything we feel into a *fact* about the patient, we are in danger of colluding with the patient's passivity and idealization of the analyst, and of discouraging the patient from questioning the analyst's authority in favor of his or her own.

The analyst's unconscious personal (or professional) myths are no less tenacious than the patient's. We know it is a valuable practice to attempt an ongoing "self-analysis" in the course of our work; but beyond that, we need to give full weight to the fact that we are governed by unconscious forces just as our patients are. And we need to modify our attitudes to take that into account. At a minimum, that means not only being aware of the limits of our understanding of ourselves with our patients, but also insisting that our patients do not avoid awareness of those limits. Our interpretations are hypotheses, filtered through our own perceptions; if our patients treat them as other than our personal impressions, we must explore their efforts to hear them the way they do.

These observations imply the endless nature of the quest to understand the patient, and the limits of the *analyst's* capacity to provide such understanding. This shifts more of the responsibility for the ongoing work onto the patient. Analytic listening is still listening *for* the patient, but it must be listening *to both* parties in the interaction (Smith in Workshop, 1995); and it must become listening *by both* parties. This means that somehow the patient's participation as a listener to both parties must be actively sought, and the patient's efforts to evade that responsibility must be actively confronted. Analytic listening is not something the analyst does to the patient. No matter how enlightened a listener, the analyst will hear only what he or she can hear in accordance with his or her own unconscious motives. Therefore, there must be two listeners, attending to two actors, striving toward a shared perspective about the patient. And as I suggested, I am more inclined to

think of this effort as establishing an attitude, an ethos, rather than as exercising a technique.

How do we know when we are wrong? Ultimately, we do not know. Perhaps, after all, it is the wrong question. A more practical question may be in order: how do we know if we are helping the patient with the problems that brought him or her into the office? We must look for practical results. The approach of analysis is to use the dialogue with the analyst to open up the patient's internal dialogue. To do so means to try to prevent the foreclosure of any thought or feeling, but that runs counter to human nature, ours and the patient's. We have no guarantee against failure. If the patient's life is not changing for the better, we have to reassess our work. Our best chance of success is to enlist the patient as a collaborator in the listening task as fully as possible.

REFERENCES

BIRD, B. (1972). Notes on transference: universal phenomenon and hardest part of analysis. *J. Amer. Psychoanal. Assn.*, 20:267-301.

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

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

GILL, M. M. (1982). *Analysis of Transference. Vol. 1. Theory and Technique.* New York: Int. Univ. Press.

GROSSMAN, L. (1996). A note on empathy and the analyst's transference. *Psychoanal. Q.*, 65:372-375.

HOFFMAN, I. Z. (1983). The patient as interpreter of the analyst's experience. *Contemp. Psychoanal.*, 19:389-422.

——— (1994). Dialectical thinking and therapeutic action in the psychoanalytic process. *Psychoanal. Q.*, 63:187-218.

JACOBS, T. J. (1986). On countertransference enactments. *J. Amer. Psychoanal. Assn.*, 34:289-307.

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

OGDEN, T. H. (1979). On projective identification. *Int. J. Psychoanal.*, 60:357-373.

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

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

SMITH, H. F. (1995). Analytic listening and the experience of surprise. *Int. J. Psychoanal.*, 76:67-78.

WORKSHOP (1995). How does the analyst listen? What does the analyst hear? Sponsored by the American Psychoanalytic Association, San Francisco, October.

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SLEEPING AND DREAMING ON THE COUCH VIEWED FROM THE PERSPECTIVE OF COMPROMISE FORMATION THEORY

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The purpose of this brief communication is to emphasize that sleeping and dreaming on the couch are best understood (as are any other data) as enactments motivated by complexes of conscious and unconscious fantasies conceptualized as compromise formations. This theoretical perspective counters an unnecessarily limiting tendency to view these phenomena primarily as resistance or acting out in the transference with predominantly preoedipal determinants—the emphasis of most existing contributions to this subject (for example, Alexander, 1976; Roark, 1970; Robinson, 1974). My clinical experiences with sleeping and dreaming on the couch in two cases revealed prominent erotic transference manifestations; the analytic work was also in keeping with Hurst's (1976) and Inderbitzin's (1988) "multidimensional analysis" of sleep in their patients,[1] for whom it embodied "complex, multiply determined compromises with many changing meanings" (Inderbitzin, p. 674).

After several years of analysis, two of my male patients began repeatedly to precipitously fall asleep and dream on the couch. Analysis of their experience of sleeping and dreaming in my presence revealed that the revival of specific aspects of erotic transference wishes was most salient. The act of sleeping had assumed a central place in their histories, which contributed to the prominence of this symptom at particular points in their analyses. Sleep-

[1] There is also a related multidimensional literature on hypnoid defenses by Dickes (1965), Dickes and Papernik (1977), Shengold (1989), and Silber (1970).

ing was a venue for their mothers' overstimulating and disavowed seductive exhibitionistic behavior. It came to be associated with highly conflicted and sometimes overwhelming sadomasochistic urges to take vengeance on the teaser, as well as a crushing sense of disappointment and humiliation about her lack of responsiveness. This complex of wishes and feelings, which were sometimes of traumatic proportions, also predisposed these men to rely upon a defense which involved alteration of consciousness.

The symptom of sleeping and dreaming on the couch arose in the analytic hours when these patients began to re-experience me in the transference as a powerful seductress who used them exploitatively. The knowledge that they served as training cases for me became incorporated in this experience; on the one hand, they regarded themselves as special narcissistic objects whom I desperately needed, while on the other imagined that I might promptly reject them when they no longer served my purposes. Prior to this, each patient had defended against such feelings by extolling me for my special investment in him as a male patient whom he fantasized I preferred to all others. At times, each one further believed himself to be my one and only male analysand.

My patients' disappointment in the transference coincided with analysis of the denial inherent in their fantasies of being mother's one and only. This gradually gave way to a dawning awareness of mother's tendency to use her son for self-gratification in a seductive and possessive manner, while distancing herself when she no longer needed him in these ways and neglecting him in other important respects. Despite her apparent devotion, she was ready to drop her excited, expectant son in favor of the rival at a moment's notice. Each man cherished the defensive belief that he had been the central focus of his mother's emotional life, preferred even to his father. Prolonged periods of paternal absence contributed to these ideas. As the analysis proceeded, even a fleeting recognition that their mothers were disappointing in general, and self-involved (indeed exploitative) in particular, was associated with intense depressive feelings. It became increasingly evi-

dent in the transference and in childhood memories that, in fact, others were important to mother. This awareness evoked frightening vengeful sadomasochistic wishes toward mother who was experienced as a siren and sexual teaser.

In this context—the dawning of these feelings in the transference—these two men became intensely drowsy and (usually unsuccessfully) fought off the urge to sleep. This symptom, as well as the dreams which emerged during these periods of sleep, expressed a panoply of warded-off ideas. Sleeping in my presence was associated with gratifying fantasies of sleeping with mother. These patients also identified with mother's unacknowledged pleasure in being observed by her son as she exhibited herself in various states of undress. Upon awakening from sleep during the sessions, each of these patients reported feeling "naked" in front of me. Excitement in the transference, experienced as overwhelming, was also expressed and defended against in this manner. Wishes to touch the exposed sleeping mother were enacted in reverse. These patients fantasized that I would feel tempted to touch them as they slept, physically or with my voice, in order to awaken them. Simultaneously, I was experienced as someone who would either prohibit or give my patient permission to sustain the many gratifications of sleeping. At the same time, not awakening my sleeping patient (which is what I chose to do) was experienced in the maternal transference as an expression of insufficient interest on my part, a wish to get rid of him and a form of not taking him seriously.

In both of my patients there were a number of other contexts in which the symptom of sleeping repeatedly appeared. These included a combination of intense anxiety and depressive affect involving the re-evocation of memories of their fathers. Both patients frequently observed their fathers asleep for prolonged periods of time in favorite living room chairs. At times when these patients (as young boys) had hoped to gain their fathers' attention, they were disappointed; their fathers were actually inaccessible, while apparently accessible. Furthermore, not awakening

the sleeping father, which would permit easier access to mother, was fraught with anxiety. "Let sleeping dogs lie" was a favorite expression of both of these men.

Case 1

Mr. Stern, a single freelance writer, sought analysis because he experienced great difficulty proceeding with his professional goals, and he worried that he might be unable to marry. Any sort of personal or professional success ("forays into the adult world") was followed by bouts of regressive undoing in the form of self-defeating activities. These were also attempts to get others "hot and bothered" in criticizing him for being irresponsible.

This trend was vividly expressed in the transference as well. Having experienced himself as actively engaged in understanding himself, and having found a piece of analytic work valuable, Mr. Stern embarked upon various types of self-sabotage. Most pronounced was the compulsive perverse, exhibitionistic, and voyeuristic behavior in which he could become absorbed for many hours, oblivious to the passage of time. Central to these activities was an attempt to "captivate" a woman's attention as she marveled at his physique, most particularly the astonishing size of his erect penis. Mr. Stern attempted to dull his excitement and sense of being captivated by a particularly good analytic hour (which often made him feel like crying) by inducing excitement in me. He did so by dramatically describing his attempts to rivet the attention of the woman who served as the object of his perverse behavior. However, in the end, *he* typically felt "captive" to both of us.

It was significant that during the height of Mr. Stern's oedipal period, his father had been transferred to a remote area on a top secret work assignment. Given the nature of the setting, it was not practical for Mr. Stern and his mother to go along. Thus, with the exception of brief visits, mother and son were effectively separated from husband and father for one and a half years. For the first

years of the analysis, Mr. Stern luxuriated in memories of his specialness for mother. He vividly recalled sleeping with her, accompanying her to communal dressing rooms when she shopped, and seeing her "cleavage." However, after several years of analysis, Mr. Stern began to describe other, more deflating experiences. He felt "dismay" when, upon his father's permanent return, Mr. Stern noticed that his mother let go of his "pint-size" hand to embrace her husband at the airport; it dawned on Mr. Stern that he was merely an onlooker. For the first years of the analysis Mr. Stern remembered his father as a tempestuous man who was extremely frustrated with his life. He was prone to nap in his favorite living room chair in the afternoons, during which Mr. Stern felt a sense of relief; he tiptoed past his father lest he awaken "the beast." Over time, Mr. Stern became far more aware of the disappointment he simultaneously experienced about his father's unavailability.

In an analytic hour, as Mr. Stern tried to picture my excitement while watching a television show about Freud, which he had made special arrangements to videotape, he noted that he hesitated to admit this because it "sounded romantic." Remarking that "it's getting dangerous," Mr. Stern found himself intensely drowsy and momentarily dozed off on the couch. He awakened from "a little dream" which conveyed his regression from oedipal wishes, which had become so evident in the analysis:

> I only remember a fragment of it. I remember feeling tiny, like a child, a boy next to a woman who's protecting me, in the jungle somewhere. I had the thought as I was coming out of it that this woman was my real mother. I actually had been adopted by my parents. Shit! I think it would have been meaningful, sort of preverbal, at such a preconscious level. I can't remember anymore. It was as if this woman was protecting me from bad people, the enemy. Hmm [Mr. Stern began to laugh]. It strikes me that might be my father, when he was away for that year and a half when I was four . . . also in this little dream here I just seem to remember I was prone, this person, the woman, was next to me.

> There was some bare skin somewhere. I don't know if it was on me or her. I can't help but think of this time when I was alone with my mother and we slept in the same bed.

I interpreted that his dream expressed just what prompted him to fall asleep: exciting feelings about me, next to whom he was lying prone, which he experienced as dangerous.

Mr. Stern responded by being twenty minutes late to his next session, apparently unmoved by the previous one, while at the same time having undeniably continued to struggle with its meanings on his own. He spoke of

> feelings about you, toward you, transcending sexual feelings, or actually not transcending but kind of an indeterminate sort of urge, attraction. I suppose, given all the things I've been talking about the last couple of days, it's like a child might feel toward his mother. They're sort of wrapped up together, I think, and thus will it ever be, I suppose.

Mr. Stern further associated to rage at "tantalizing, teasing" women. He recalled previous interpretations I had made concerning his perverse behavior as expressions of his wish to retaliate against women he experienced as teasing him. He also experienced my interpretations as teasing; he wanted much more.

Case 2

Mr. Kay, a divorced, moderately successful investment banker, sought analysis because of dissatisfaction with his chosen field of work and his inability to "get excited" about future directions. He claimed his personal life needed no attention. He was living with a woman whom he would probably marry. They had a "titillating" sexual relationship in which "anything was possible." He was especially excited by her breasts and her alluring, teasing style. Only months after the analysis began, it became apparent that his woman friend was repeatedly absent until late at night without revealing her whereabouts. When she ultimately announced that

she was pregnant, without specifying by whom, Mr. Kay became "frothed up" to an unmanageable degree and ended the relationship. Staying one step ahead of his anxious and depressive feelings was extremely important to Mr. Kay. As erotic transference feelings rapidly emerged, and in the context of my first vacation, he met another woman whom he quickly married. The intensity of his wishes toward me was not understandable to Mr. Kay at that time, despite my attempts to explore this with him.

Early on in the analysis, Mr. Kay portrayed his family of origin as a wealthier and more sophisticated version of the idealized Brady Bunch. With time, a different picture emerged, one extremely distressing to Mr. Kay. He was the third of five children born to a couple who battled eternally, episodically separated, and then spent nearly a decade dissolving their marriage in a mutually abusive manner. Mr. Kay's mother came from an extraordinarily wealthy and unhappy family. Mr. Kay came to believe, through the course of the analysis, that his father had married his mother for her money, and that his mother had married to escape her parents. Although Mr. Kay's reports were highly suggestive of infidelities on the parts of both his father and mother, he disavowed this for many years in the analysis.

Mr. Kay had several especially charged memories of his mother. As a child he had difficulty separating to go to school. However, he recalled special times with his mother upon his return in the afternoon as he reclined on the living room couch and recounted the day's events. He felt his mother was highly attentive, supporting him in whatever he experienced or wished; at such times, he felt "anything was possible." Mr. Kay mused over how, given such validation, he had ended up "unexcited" and dissatisfied with his work. He eventually came to feel that his mother's apparent "unconditional support" was an expression of her lack of investment in what he did. Over time, other more conflictual memories emerged. Mr. Kay's mother characteristically stayed up until the wee hours of the morning reading, smoking, and drinking; she dozed on and off in bed until late in the morning, long after her children had gone off to school and her husband had left for

work. Mr. Kay reported memories of his "disgust" when, upon going into his mother's room to "say goodbye," he saw her sleeping. Her "fat" body was only partially covered, her breasts or genitals frequently at least partially exposed.

In the sixth year of the analysis, Mr. Kay began to ponder for the first time, with intense sadness and "panic," that his analysis might not continue forever, that I might actually be willing to let him go. He became angrily preoccupied with my "secret closet" (a room within a room in my office which serves as a playroom). In the first hour of the week (a Tuesday hour following a canceled Monday hour), Mr. Kay ragefully confronted me with his fantasy that I had been surreptitiously videotaping our sessions with equipment in the "secret closet." He demanded that I answer "yes or no." He would not accept merely exploring this matter. Recently he had "transgressed" in the analysis in many ways hitherto unimaginable to him. For example, he talked to me sitting up, looking squarely at me for five minutes, paid me over a month late, and looked at books about analysis; he imagined I had forbidden him to engage in this activity.

Mr. Kay's fantasy about the "secret closet" was a later version of an idea he expressed from the beginning of the analysis: that I regularly reported his material to the male analyst who originally referred him to me. Alternatively, he believed that I paid a commission to this analyst for each hour of earnings. In this fantasy Mr. Kay was merely barter in the relationship I had with this man. In a related vein, Monday hours had always been painful for Mr. Kay. He "had to start all over again" to regain his sense of comfort with me, as if he had been forgotten. He had little access to the nature of his fantasies about where and with whom I had been during the weekend interruption.

In the third hour of the week Mr. Kay shared his resentment and disappointment that analysis would never "fix" him; he was "broken" in ways which were permanent. All he could hope for was that in becoming aware of them, he might diminish their impact. Why had I not told him this? He had expected to emerge "great," "perfect," and I had never "set him straight." In fact, I

had implicitly supported him in his mistaken idea with my silence. Mr. Kay imagined that I had considered, "if I tell him 'the truth,' I will be unable to 'keep him there.' " I commented that he felt I had led him on to ensure that he would serve purposes of my own, Mr. Kay associated, "That is a sexual remark. This is dishonest of you. All you think about lately is sex. I'm not sure this is coming from me." Mr. Kay reflected that he had not yet brought up the secret closet today. With an air of "Isn't this ridiculous? We know I do not really mean what I am about to say," Mr. Kay offered an analogy: "If I began analysis thinking at the end I would marry you and you did not set me straight, that would be misleading me." He further associated that, so far, the analysis had been a one-way relationship. This would not go on forever. It was very exciting to think that maybe someday I would need his help with something and call him up. This probably would not happen, he thought with sadness.

In this context, Mr. Kay became noticeably drowsy. In an effort to fight off sleep, he sat up on the couch sideways. This position enabled him to "transgress" by looking at me. He reported a dream from the night before in which he and a high school friend drove to the North. They shared a whole salmon they had hooked and learned they did not like each other. Mr. Kay associated to two Harvard girls who were murdered or, he reconsidered, had they committed suicide? (Mr. Kay had recently reported a series of dreams in which suicide by older "overweight" women was a prominent element. These had arisen in the context of his nascent thoughts that at some point "this [the analysis] would end.")

Apparently refusing to offer any further associations, Mr. Kay aggressively challenged me, "What are we doing here, Arden? Let's break some new ground. Show me what you got babe." I repeated his words. Resentfully noting, "that sounds sexual again," Mr. Kay berated me for having agreed to change too many appointments of late to accommodate his requests. I interpreted that he felt I had "shown him too much and been seductive." With this, sleep overcame Mr. Kay. After five minutes he awakened

with a start, reporting a dream of knives and murder. He could not remember who was involved, but associated to the rich wife of his cousin whom he had unexpectedly encountered the week before; "I'd like to stab my stupid cousin who married the rich bitch and is father to her child!" He was saddened and infuriated that his cousin did not include him in his life. Mr. Kay then associated to his mother, "the rich bitch!," and to me: "You still have not answered my questions about your secret room. You got away again." "Unlike the salmon you hooked in your dream," I interpreted.

In conclusion, I have emphasized the advantages of compromise formation theory in analyzing the phenomena of sleeping and dreaming on the couch. In two cases this perspective facilitated exploration of the manifold meanings and functions of sleeping and dreaming during the analytic hours. I have highlighted these symptoms as expressions of and defenses against my patients' positive oedipal wishes. Their overwhelming rage at and depressive responses to frustration of these wishes were prominent aspects of their personalities. The associated anxiety was sometimes of traumatic proportions, culminating in an alteration of consciousness. These patients' histories of sleeping with a parent and viewing sleeping parents no doubt also contributed to the choice of sleeping as a symptom. Rather than posing an interference, analysis of this symptom in the transference greatly enriched the analytic process.

REFERENCES

ALEXANDER, R. P. (1976). On patient's sleep during the psychoanalytic session. *Contemp. Psychoanal.*, 12:277-299.

DICKES, R. (1965). The defensive function of an altered state of consciousness: a hypnoid state. *J. Amer. Psychoanal. Assn.*, 13:356-403.

——— & PAPERNIK, D. S. (1977). Defensive alterations of consciousness: hypnoid states, sleep and the dream. *J. Amer. Psychoanal. Assn.*, 25:635-654.

HURST, D. M. (1976). Sleep on the analytic couch as a symptom of the transference neurosis. Presented at the meeting of the American Psychoanalytic Association, December.

INDERBITZIN, L. B. (1988). Patient's sleep on the analytic couch. *J. Amer. Psychoanal. Assn.*, 36:673-695.

ROARK, G. (1970). A clinical and theoretical study of the patient falling asleep during the psychoanalytic hours. *Bull. Phila. Assn. Psychoanal.*, 20:161-165.

ROBINSON, L. H. (1974). Sleep and dreams in the analytic hour: the analysis of an obsessional patient. *Psychoanal. Rev.*, 61:115-131.

SHENGOLD, L. (1989). Autohypnosis and soul murder. In *The Psychoanalytic Core: Essays in Honor of Leo Rangell, M.D.*, ed. H. P. Blum, E. M. Weinshel & F. R. Rodman. Madison, CT: Int. Univ. Press, pp. 187-206.

SILBER, A. (1970). Functional phenomenon: historical concept, contemporary defense. *J. Amer. Psychoanal. Assn.*, 18:519-538.

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SECRET WEAPON

BY PAOLA MIELI

The waiting room opens onto a vestibule. The main door to the analyst's office is to the right on the near end of this vestibule, whose far end is created by a curtained-off doorway. Behind this doorway is the analyst's study. From his office, the analyst is able to enter this study directly, thanks to a second private office door which opens into it.

Taking advantage of a free hour that day, he busies himself in his office doing "I don't know what." When he hears someone calling his name from the study, through the private half-opened door separating his office from it, he encounters the big smile of one of his patients, almost an hour early for his appointment. The smile is met with surprise. Nevertheless, the analyst receives the analysand who begins to recount in detail one of his recent projects. A cartographer by profession, he has just finished plotting the geographical features of the territory of the foreign country he is mapping. It is a rural area bisected by mountainous terrain and adjacent, in part, to the sea.

The countryside and the animals that live there remind him of the story of a bet he recently made during a visit to one of his friends who owns a restaurant. At lunchtime his friend invites him to order anything he likes. Studying the menu, he selects the most expensive entrée: pheasant. The friend, who is treating him to the meal, seems irritated by this expensive choice. The conversation becomes a bit tense, but the analysand continues to laugh and joke around. Before leaving the restaurant he tells his friend, "I'll

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This is the English version of the article, "L'arme de fond," published in *IO, Revue Internationale de Psychanalyse,* Paris 1992. Translation by Jacques Houis and Paola Mieli.

bet that before the end of today you are going to invite me back and serve me pheasant again." Half annoyed, half amused, the friend replies, "Well, I'll take that bet, because I'm sure I won't invite you back for pheasant."

The patient then goes to a gourmet shop and buys three pheasants. Later, he returns to his friend and offers him two of them, keeping the third in his bag. His friend, who really appreciates this gift, is warm and affectionate again. Just then the analysand takes the third pheasant out of his bag and says, "This one is my pheasant, and I would like you to cook it for me for tonight's dinner." Indeed, the story ends with a big pheasant dinner. To his analyst (who, as he tells me, listens to him somewhat helplessly), he triumphantly points out that he won his bet.

If you bet, it is precisely because you know you can win, but the other side of this possible gain, of course, is a possible loss. Risk itself is at stake here. What do we make, then, of a bet from which loss has been excluded?

This pheasant story is a hunting story; it concludes with a dinner which, to me, immediately evokes the image of a sacrificial or totemic banquet. The analyst responds to my remark by telling me that, indeed, it was as the result of a hunting accident in a foreign country that his patient had lost his son. This was the third death which had deeply marked his life, the first being his father's death when he was only a child, and the second being his paternal uncle's when he was an adolescent. For him, the only son of a family whose name he carries, the dead embody the destiny of lineage.

I remark to the analyst that there are four pheasants involved, three plus the *one* that caused the bet. Indeed, it was because of unwarranted depression and sudden anxieties that the patient had decided to contact his analyst, having told him from the outset, with a sense of relief, that, anyhow, he knew he didn't have long to live: although perfectly healthy, he would die on such-and-such a date, in such-and-such a year, in the relatively near future.

If the bet is a wager with death, a sure way of winning is to know exactly when to expect it. Along with chance, such knowledge

eliminates the unknown and cancels risk. Albeit not the fact that one dies anyway.

In the pheasant bet, victory entails paying a price, specifically the cost of the three pheasants. The analyst responds to my comment with a sudden association: he remembers another of the patient's bets. As a child, during one of his father's illnesses, he was playing with a friend when his mother took him aside to tell him that his father had just died. After a long silence, he had gone back to his game, to bet with his friend who was ignorant of what had just happened, that his father had just died.

What had they wagered? Nothing, answers the analyst, but he had "won" anyway.

To place a bet whose outcome is known is swindling. However, we can wonder who, in our example, is the dupe. While knowledge is the precondition for swindling, it must be noted that the knowledge involved in our example strikes the subject in the form of a sudden fatality, of an external event to which the subject must submit.

Are betting to another's detriment and swindling him out of the "nothing" achieved through a symbolic victory one and the same? It is worth noting that whereas in the first case, the other is reduced, through his exploitation, to the status of the object stolen from him, in the second the challenge bolsters a symbolic gain whose stakes are pure prestige. However, in the three wagers just mentioned, the one with the playmate, the one with the friend from the restaurant, and the one with death itself, the acquisition of prestige on the winner's part sanctions his own loss, and victory takes its toll. If the price to pay is indeed death—the father's, the son's, the family name's, his own—the bet in question seems like a ruse seeking to compensate the subject with a certain symbolic mastery when confronted with the eruption of the real. By means of his victories the subject re-establishes the coordinates of his field of action; he redefines the limits of his hold on reality. The victory does not counterbalance the loss, however. Rather it *returns the subject's loss to him, repeated and confirmed,* thanks to a change of level which, by making the person master of the game he is subject

to, transforms the inescapable, incorporating it in the form of a law.

What, then, in these "innocent" bets, is the function of the other, of the one who, duped through the challenge, loses only some nothing? If a bet is made in bad faith, if it is a perverse undertaking, the other, exploited, manipulated, and eventually ruined by the swindle, is recast in the role of waste product. On the contrary, in the case of the innocent bet/trick, the other from whom some nothing is stolen is there to represent or embody the position of the *Loser.* He is there so that, thanks to the ruse of a bet whose outcome is known in advance, the role of dupe can be transferred onto him. A hostage in the hands of the victor, he becomes a metaphor of the former's destiny. He thereby frees the author of the ruse, by shouldering his truth. His function, unlike that of the waste product object for the pervert, is reminiscent of the function of the third party in wit as illustrated by Freud. This third party is "indispensable" if the witticism is to occur (Freud, 1905a, p. 155). He functions as the medium through which the author of the witticism can discharge "*par ricochet* [on the rebound]" (p. 156) the pleasure accumulated in the very technique of the word work, the pleasure taken in play (*Spiellust*) or in lifting inhibitions (*Aufhebunglust*), which derives from the economy of a psychic effort heretofore expended by reason, critical judgment, repression.

This bet/innocent trick resembles a *Scherz.* Freud considers *Scherz* to be an intermediate category between play and jokes (1905a, p. 144).[1] Its characteristic, he stresses, is that it is not yet

[1] Strachey translates the word *Scherz* as *jest* (Freud, 1905a, p. 129). We choose to keep the German, for the noun *jest* does not convey the meanings of the original. *Scherz* (from the Longobard *skerzon*) is a commonly used German word which encompasses various meanings: puns, spoonerisms, practical jokes, dirty tricks, etc., which have in common a playful, nonsensical quality. As Freud points out, unlike witticisms, they are not "intellectually successful," and do not necessarily provoke laughter. Freud's examples of *Scherz* in *Jokes and Their Relation to the Unconscious* are puns. Yet we prefer not to translate *Scherz* as *pun* because what characterizes the notion of *Scherz* is precisely the fact that it can be both a practical and a linguistic joke. It is also worth noting, once again, that Strachey's translation of *jokes* for *Witz* is inappropriate. In this case there exist better English terms, *witticism* and *wit.*

wholly suited and effective in its content, which is evidence that its substance derives from the gratuitous and pointless quality of play. The fact that the bet of the father's death, inscribed as it is in a childish game, resembles a *Scherz* made in bad taste does not detract from its enigmatic nature, from that aspect of surprise which also characterizes the *Scherz* involving the pheasants. Indeed, this incomprehensible quality, this absurdity which leaves us amazed, points to how, here, something "tightens," to use Lacan's expression (1975), in the sphere of the symbolic, entailing the abolition of meaning. This contraction, this "no-sense," is precisely what turns the *Scherz* into a kind of interpretation.

The third party of the witticism benefits from his position as essential medium. To use Freud's expression, he "buys" his pleasure without spending. He receives it "as a present" (1905a, p. 148). In the bet/innocent trick, on the contrary, the gift the other finds himself holding is an absence of harm, the advantage of having engaged in a confrontation strictly limited to prestige, where he lost without having to pay a price. Having embodied the being of the loser, his profit amounts to the subtraction of a supposed real loss, which produces the relief required by the *Scherz*. This pheasant banquet is a relaxed banquet where reestablished friendship is celebrated in laughter. Because he can symbolically confirm his loser's dignity without having anything real to lose, the other in the innocent bet, although aware of being tricked, is nevertheless able to maintain his narcissistic integrity in the face of the attack.

Although this type of harmless *Scherz* is less likely to provoke laughter than surprise, its author derives from it a satisfaction which verges on irony. This half laugh or internal smile of victory is a response, through a ruse, to the discovery of the inescapable. Faced with the inconceivable quality of the event, his father's death, or his son's, faced with the groundswell which suddenly undermines him, he finds a way to stem the tidal wave of the real and regain his footing on firm ground, so to speak. Like a good magician, he transforms tears into smiles; he turns a sudden, un-

bearable knowledge, something impossible to contemplate, into the very wellspring of his accomplishment as a bettor.

This art of symbolic appropriation, this technique of the good magician, brings to mind little Hans's laughter when he sees his sister's genitals, a laugh which spares the speaking being, as Claude Rabant has noted, "from choking with emotion" (1990, p. 116). In this sudden abeyance, in this contraction of thought, the laugh signals the actual "crash" of knowledge in the face of the inconceivable—in this case inconceivable sexual difference. Laughter is tantamount to a "naturally false" response—"*ist natürlich eine falsche,*" as Freud puts it (1908, p. 257)—but which, nevertheless, shows, for the first time in Hans's life, "the recognition of sexual difference."

Hans, proponent of infantile sexual theories, theoretician of the difference between the animate and the inanimate, Hans, philosopher of compromise at the time of his sister's birth ("her widdler will get bigger," he asserts) ends up laughing. This laughter, this emptying of meaning, punctuates the appearance of the antinomy, of the *gap* separating experience and theory. This laughter sanctions the momentary surrender of theory, the oscillation of the myth, of the boundary needed by the subject to protect himself in the face of the unthinkable. If, as Freud claims, laughter signals a recognition, it is because it reveals, in the antinomy, the affirmation of the law—the assumption, as it were, of sexual difference, of the prohibition against incest. The subject needs this law, which sanctions loss, to grant status to his desire, since, as Lacan points out, one can only desire according to the law (Lacan, 1959-1960).

Laughter concludes a chapter in Hans's story. The following chapter introduces phobia. A construct, a barricade now becomes needed to re-establish the boundary threatened by the antinomy, by the appearance of a gap. According to the assumption of the law, a barrier is drawn to separate the subject from the object of desire, to make the phobic object that signifier which compensates for the "lack in the Other" (Lacan, 1966, p. 610). But if

laughter, in Hans's story, punctuates the transition to phobia, it is because, in a certain sense, it trumpets the arrival of phobia: it already contains it. As a bulwark in the event of the real, as a technique of tightening the symbolic, this laughter demonstrates its congruence with the phobic strategy.

Faced with the unthinkable, laughter or the innocent bet is triggered in order to wrest from anxiety what Lacan calls its "horrible certainty" (1962-1963). It is so that there may be a *transfer of certainty* that thought and action invent their ruses within a field riven by the emergence of anxiety. Through trickery the harmless bet restores the subject's knowledge in the form of a confirmation which displaces the unbearable quality of certainty. This confirmation, moreover, is the *re-establishment* of a theory, *of the very theory of the bet*; it is the re-establishment of a boundary which acts as a barrier against the real. In the ultimate bet, the one with death, theory creates a boundary in time and space—on such-and-such a day, in such-and-such a year. Theory becomes the very boundary of life. It is thus that the laugh, the secret smile of symbolic appropriation demonstrates, along with the recognition of the law, the very possibility of its repression.

One can therefore see how, in the innocent bet, this knowledge which avoids chance and sustains the myth of a knowledge that fully knows itself, by recasting the limits of the possible, designs a strategy analogous to phobia's. Whereas perverts would accept along with the bet, honest or not, chance and the risk of losing, convinced as they are of winning *in any event*, phobics find themselves *forced to trick*—their reply is naturally false, Freud says. They find themselves forced to *maintain the falseness* of theory in order to border the real, to circumscribe with their thought the scope of reality and establish an ethic through their fear.

To return to our initial example: the analyst is doing "I don't know what" when he is surprised by his patient's arrival one hour in advance of his appointment, surprised by the smile that greets him through the back door of his office. The big smile which stifles a laugh punctuates the *Scherz*, the ruse with which he "catches" the analyst by overturning the rules of the game in

which he is engaged, those grou nd rules which require that he respect the ritual of analysis This time it is the analyst who embodies the loser, a position he confirms, moreover, by neglecting to make his patient pay for the following session, the appointed one, canceled by this premature appearance.

A loss, then, takes place, makes place. The smile punctuates the presence of a threshold inside the analytic space, the wall, the door which separates the office from the study. Once again, the ruse signals the weight of knowledge, this time of the cartographer's knowledge as he ventures into the other's territory. In fact nothing prevented him, no sign forbade this exploration, other than the ritual of the analyst's route and that implicit convention which makes us respect the privacy of others. But, after he had stepped through the curtained door and entered the study—that domain of the Other's knowledge—after he had discovered the topographical features of the place, the weight of a transgression crystallizes within the bared frame. It is then that the dividing line between the office and the study reveals the consistency of a barrier cutting across the space of analysis. While the ruse restores to the subject the fruit of his transgression in the form of an innocent *Scherz*, it nonetheless marks the emergence of an obstacle bearing witness to prohibition itself. By giving a symbolic status to this imaginary threshold which borders the real, the joking smile sanctions the event of a loss. It is evident that the appearance of this boundary actualizes the restoration of the "site of phobia" within the analytic space (Finzi Ghisi, 1981, p. 26), the restoration of the barrier that separates the subject from the object of his desire. This is a line of defense, I might add, with which the subject does not respond to anxiety, but *with* anxiety, to the event of the real.

I shall conclude with an anecdote about a phobic five-year-old girl. During one of her visits to the analyst, she invents the following game. She is fond of red and golden glass beads. She asks the analyst to close his eyes while she hides them. He will later have to look for them. She places the beads under the analyst's chair, but when he opens his eyes, she tells him, "Look under the sofa

cushions, I hid the beads there." She runs to the sofa, lifts the cushions and shows him this "absence" as she laughs. That is when she adds, "Don't look under your chair, because there's something very, very dangerous under there."

Everything is known in this game where the analyst is the dupe of the little girl who cannot help but be insincere, in this game, which, in turn, is the very metaphor of the certainty it tries to grasp, to displace. Not only does the wished for object become an object fraught with danger; it is also manifested in proximity to the analyst's body. Thus is the frame bared to show the symptom's design. By staging the law of desire, the game shifts the weight of desire onto the analyst, and laughter signals, along with the confirmation of this law, the very possibility of its being forgotten.

REFERENCES

FINZI GHISI, V. (1981). La barriera delle tasse: l'apparato psichico e la sua rappresentazione nella storia di una fobia. *Il Piccolo Hans*, No. 31, Milano: Dedalo.

FREUD, S. (1905a). Jokes and their relation to the unconscious. *S.E.*, 8.

——— (1905b). Der Witz and seine Beziehung zum Unbewussten. In *Gesammelte Werke, VI.* Frankfurt am Main: S. Fischer Verlag, 1940.

——— (1908). Analyse der Phobie eines fünfjährigen Knaben. In *Gesammelte Werke, VII.* Frankfurt am Main: S. Fischer Verlag, 1941.

LACAN, J. (1959-1960). *Le Séminaire, Livre VII: L'éthique de la psychanalyse.* Paris: Éditions du Seuil, 1986.

——— (1962-1963). *Le Séminaire, Livre X: L'angoisse.* Unpublished.

——— (1966). *Écrits. Le champ freudien. Collection dirigée par Jacques Lacan.* Paris: Éditions du Seuil.

——— (1975). Le Troisième. Lettre de l'EFP, No. 16.

RABANT, C. (1990). L'orient, le sexe. In *Espaces*, No. 17. Paris: Interligne.

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TERMS OF ENDEARMENT IN CLINICAL ANALYSIS

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There seems to be increasing concensus that selective intentional disclosure by an analyst of his or her personal thoughts and feelings can be a useful feature of clinical technique and that we need to develop ways of thinking systematically about when and how such disclosure is best made (Cooper, 1998; Rosenbloom, 1998). Particularly problematic is the matter of an analyst's sexual and loving feelings toward his or her patient. It has been argued that such self-disclosure can be helpful (Davies, 1994), but the dangers of the analyst's disclosure of sexual and loving feelings and the problem of the slippery slope are well known (Gabbard, 1995). Under what circumstances and in what way are these fundamental feelings most usefully expressed in a well-conducted analysis (Davies, 1994; Gabbard, 1995; Slavin, 1998)? With these considerations in mind, I would like to offer the following vignette.

Clinical Material

George is a thirty-five-year-old obstetrician in analysis for severe depression. Although he is married and the father of three, he feels he has no satisfying relationship in his life. Over the past two years, we have explored the ways that his religious upbringing resulted in a judgmental and moralistic overlay to his sexual feelings and fantasies, about which he is riddled with shame. Neglect by his distracted, concrete, intermittently seductive mother and ridicule from his successful businessman father were experienced in an emotional vacuum, as a result of which George developed profound self-loathing.

He comes to a session worried about having sexual feelings toward a female patient earlier in the day. He imagined her exercising and being sweaty and then having sex with him. He felt ashamed of having these "inappropriate" thoughts, and found himself wondering what I did with my sexual feelings toward patients. Then he decided that was just a "weird way of wondering if you have sexual feelings toward me—of course you couldn't because I'm disgusting." That idea makes George even more ashamed because he assumes I always put my patients' needs first and don't get distracted by such things. He begins to wonder if I am secretly laughing at him.

I find myself in a very familiar, very delicate, even precarious place with George. I have obtained multiple consultations on how to handle the erotic transference presented by this profoundly vulnerable man, who is filled with self-hatred but has an urgent clinical as well as personal need to find new and less dangerous ways to conceptualize sexuality. Nonetheless, my repeated efforts to focus on his fantasies about and experiences with me have not been helpful: we keep coming back to the same tight circle of his self-criticism in which we now find ourselves.

With some anxiety, I decide to try a new approach that speaks from my own, necessarily subjective experience. I say, "I don't separate my mind from my body to think about myself or patients. It seems so obvious to me that there's been a rapport between us from the beginning that we both enjoy, that I can't help thinking that your worry and self-criticism about having sexual feelings and about your own attractiveness have to do with something you bring to our relationship. I have in mind the traumatic experience of your mother's lack of desire for you—which may well have resulted from her discomfort with her desire for your bodily self. And the idea that I'm laughing at you reminds me of your having said that you think your father had contempt for you."

"That makes sense," he said, "and it's a better way to think about what I'm experiencing. While you were talking, I was remembering falling down when I was playing football with my father, and him laughing at me while I was in pain. And you're right

about my mother. I never felt like she even wanted me around, much less that she enjoyed my physical presence."

A few sessions later, George says, "I know you have a kindness and a caring for me, but there are times when I confuse it with a tender love." And I say, "I think it *is* a tender love. What's the confusion?" He says, "Well, I think I make it into more than it can be—a kind of nurturing that I need so desperately."

I say, "It *is* a kind of nurturing that you need so desperately. The problem, I think, is that this is the only place you've ever gotten it, and there are times when you want this relationship to be the sole source for you. You need more than I have available to give to you, and it may be hard for you to believe that other satisfying relationships are possible." He says, "I think that's true. I think the novelty of this is so profound—feeling understood and cared about—that I turn the fact that it's new in my experience into a conviction that it's unique to this relationship. The feeling of closeness I have with you is so deep at times that it's like I'm coming to you with an aching tooth, and when I feel connected with you, the pain just goes away. It's really something, and I'm able to hold onto that feeling for a while, sometimes for days."

Then he thinks about his wife and how she pressures him by asking how much she is on his mind. He continues, "One of the times I felt closest to you and when I thought you were the tenderest is when I asked you about how much I was in your mind, and you said, 'No matter how much you're in my mind, it's not as much as a mother carries an infant in her mind.' " He adds, "And I understood what I was really asking for from you and how sad it was that I didn't have it when I needed it as a child. And you didn't make me feel ashamed for asking you for it. And it makes me understand what my wife is really asking of me."

A few days later, George reports that he has signed up to go to a national professional meeting because he knows that he needs other relationships, and now he feels like it's time to get them. He feels hopeful about it. For the first time, too, he notices that he doesn't feel resentful when he gives me a check.

Discussion

There are times in the course of an analysis when the dangers of too little restraint in the analyst's expression of charged feelings toward the patient are balanced by the dangers of too much restraint. On many previous occasions George had presented me with his sexual feelings and coexistent feelings of shame and self-loathing. I doubted that questioning him once again about the origins of his discomfort would be fruitful. I thought that we were immobilized by his assumption that I experienced him in the same way that he had always experienced himself, and his shame about my presumed disgust with his body and contempt for his sexuality seemed to foreclose further self-investigation.

Until this point in the treatment, George had no direct way of knowing that I did not share his feelings of disgust about himself. I had repeatedly expressed curiosity about his assumptions about my point of view, but questioning his assumptions had not proved sufficient to overthrow them. My feelings about him were different from his feelings about himself, and it seemed to me that it would be useful—even necessary—for him to have not just some hypothetical alternative perspective to which we had alluded many times before, but my own particular perspective on him as a man and on the place of sexual feelings in a treatment relationship. I thought George needed not just more questions about his ideas about my experience of him, but information about the effect he had on me.

At the same time, I was concerned about opening the door to such a discussion with George. He had spoken at length previously about his intense sexual feelings for me, admittedly trying to arouse me. I wanted him to know that I did not find him disgusting and that I did experience him as a sexual man, but that the sexual aspect of our relationship was something that could be acknowledged without derailing the considerable work we had to do together. I hoped by my own example to show him that sexuality could be put in a workable perspective in a relationship in which the sexual element was neither denied nor exaggerated.

Furthermore, I thought it was extremely important not to be provocative. George had told me about how his mother would repeatedly undress with the door open and then shame him for looking at her body. He felt that she would excite him, deny her part in exciting him, and then shame him for being excited. He imagines this same mother would put him down in the midst of a feeding in infancy to do household chores. It seemed crucially important for me to be matter of fact, not titillating.

Therefore, rather than make a direct statement that might misleadingly spotlight my sexual feelings toward him, I made reference to them by mentioning the obvious rapport between us. I hoped that the way I referred to the feelings would communicate the place they had for me in our relationship: present, acceptable, and enjoyable, but not dominant or disruptive. My comment was calming to him. He became relaxed and was able to proceed with memories of the origins of his self-loathing and fear of ridicule.

When George later raised the subject of my loving feelings, I decided to take the same approach I had with the sexual ones. I had been impressed with the degree to which an acknowledgment of my side of the relationship had freed him to pursue further self-investigation in the earlier session. I also knew well how the absence of loving feelings and disavowal of sexual feelings in his family of origin had been catastrophic for him.

When he presented his struggle with finding the appropriate terms for the kind of care he was feeling from me, I responded frankly and without hesitation that his experience of my "tender love" for him matched my own. Once again, I hoped that the manner of my response would convey my attitude toward what I was saying and that my comfort with my feelings would help him clarify his own confusion. By being explicit and straightforward about my feelings, I hoped to avoid the seductiveness and confusion inherent in allowing the subject of my feelings to remain taboo.

He was then able to describe his desperate need for nurturing. When I agreed that I was nurturing to him, we were able to sort out his very real experience of being nurtured by me, the newness

of that experience in his life, and his sadness over not having had what he needed of it in childhood.

Knowing where I stood in my feelings for him allowed George to make a stepwise progress. He was able to separate the novelty of being loved in a nurturing way from his belief that I was the only possible source of a loving and nurturing experience. He was then able to reflect on how soothing the experience of intimacy can be to him in the present, which, in turn, allowed him to reflect further on his sadness about the lack of intimacy in his childhood. Instead of feeling self-critical and confused about his wish to be loved by me, he was able to appreciate the transference aspect of his wish. Soon thereafter he reported taking steps toward finding other types of potentially satisfying relationships. At the same time, he stopped feeling resentful about having to pay me.

While dangers of exploitation and overstimulation from excessive disclosure of sexual and loving feelings by the analyst are well known, they may be counterposed by less obvious but equally strong dangers of confusion and seductiveness when the subject of the analyst's feelings remains taboo. We need a way of discussing these vital responses to our patients that will be neither exploitive nor withholding, but clarifying. I agree with Renik (1995) that an ethic of candor serves to demystify the power of the analyst, including the analyst's power to love the patient. I am also respectful of the destructive potential that Gabbard (1995) alludes to in his discussion of the slippery slope. I believe there is a middle ground for candid but careful discussion of the loving and sexual relationship between analyst and patient that allows the patient to make sense of the experience of being loved in analysis in a way that illuminates the past and opens the future.

REFERENCES

COOPER, S. H. (1998). Countertransference disclosure and the conceptualization of analytic technique. *Psychoanal. Q.*, 67:128-154.

DAVIES, J. M. (1994). Love in the afternoon: a relational reconsideration of desire and dread in the countertransference. *Psychoanal. Dialogues*, 4:153-170.

GABBARD, G. O. (1995). Countertransference: the emerging common ground. *Int. J. Psychoanal.*, 76:475-485.

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

ROSENBLOOM, S. (1998). The complexities and pitfalls of working with the countertransference. *Psychoanal. Q.*, 67:256:275.

SLAVIN, J. H. (1998). The innocence of sexuality. Presented at the Spring Meeting of Division 39, Boston, April.

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BOOK REVIEWS

TRADITION AND CHANGE IN PSYCHOANALYSIS. By Roy Schafer. Madison, CT: International Universities Press, Inc., 1997. 271 pp.

The relation of change to tradition is a central concern of psychoanalysis, and Schafer's essays on diverse subjects collected in this volume represent his continuing participation in these debates. He sees change as a matter of transformation and accurately sees himself "as engaged in the study of transformation in theory and practice rather than radical discontinuities" (p. x). Schafer's discussion of the writings of other analysts from Freud on to the present time is guided by the premise that there can be no *value-free* exploration and exposition of psychoanalytic assumptions, concepts, methods, and apparently purely objective, empirical reports (p. 2).

In his overview of Hartmann's contributions, he defends him from critics who claim that, for Hartmann, adaptation meant "conformity," "compliance," or "superficial adjustment" to societal values. These critics neglect Hartmann's fundamental point that adaptation includes "fitting in" as only one among several possibilities. Hartmann's writings on adaptation include making efforts to change one's situation or even leaving a personally unsatisfactory social environment.

Although Schafer extols many of Hartmann's contributions to ego psychology, he mounts a devastating critique of Hartmann's notion of clinical psychoanalysis as a *technology*. For Schafer, "technology" is a trope with a set of mechanical connotations that, on the face of it, is chilling and points to a serious flaw in Hartmann's argument. In Hartmann's view of psychoanalysis, the analyst is expected to be a detached and thoroughly objective observer and technician, thoroughly impersonal and purely rational. Psychoanalysis is a process of dialogue, and all of its so-called facts are the products of multiple interactions between analysand and analyst. Hartmann incorrectly assumed one could separate facts and values.

Schafer astutely recognizes and discusses how much the organizing ideas of *dialogue* and *intersubjectivity* have been moving to the center of psychoanalytic interest in contemporary writings on both the theory and the practice. In his view, "dialogue" conveys the idea that the understanding and the changes that take place in an analysis can only

come about through an evolving dialogue between analyst and analysand. For him, the concept of intersubjectivity "conveys the embeddedness of each person's cognitive and emotional position and his or her dialogic orientation in so-called real or imagined relations with others" (p. 9).

Schafer views psychoanalysis from a postmodernist perspective in which

> no one approach can provide a complete clinical and theoretical approach all by itself. It is the nature of each and every systematic approach that it sets limits on what is available to it. Each approach equips us with instruments of thought that bring both light and darkness to its subject matter (pp. 12-13).

The postmodern world rejects the idea of one grand metanarrative that will take account of all questions and problems within a discipline. This contemporary and future world of psychoanalytic thought and practice is a world in which theory has lost the "grandeur, majesty and mythic proportions" (p. 21) it had for the earlier theorists, such as Freud and Hartmann.

Schafer's excellent and illuminating chapter, "Gendered Discourse and Discourse on Gender," summarizes the themes developed in recent years by feminist scholars. In Schafer's enlightened opinion, "Gender should not be approached as an immutable, irreducible fact of nature. Instead, it should be approached as a construction" (p. 36). He criticizes Freud for his condescending remarks about women, which unfortunately were consistent with his own and his culture's patriarchal view of women.

The second part of the book shows how deeply Schafer's clinical understanding and approach have been influenced by the contemporary Kleinians of London. His readable clinical studies also demonstrate his shift toward object relations thinking, a shift he claims has been well under way throughout psychoanalysis. He does not view contemporary Kleinian approaches and standard Freudian ego psychology approaches as either alien or antagonistic; in fact, his clinical vignettes show a beneficial melding of the Kleinian and ego psychological sets of influences.

According to Schafer, Betty Joseph and other contemporary Kleinians are hyperalert to the insidious forms of destructiveness some patients direct at the analyst and the analytic process. Contemporary Kleinians are especially sensitive to issues concerning analysts' not adequately engaging the patient's destructiveness. As a result of this common shortcoming, there is often an unwitting collusion between the destructive patient and the analyst. This unconscious collusion creates continuing impasses, misunderstandings, and repetitive enactments instead of opening up possibilities to develop insight and change.

Schafer provides a balanced and hopeful overview of the topic of authoritarianism in psychoanalysis, and he accurately points out both the antiauthoritarian side of Freud as well as his authoritarian side, linked with his patriarchal orientation. Although Schafer claims that there is a growing number of women analysts who are resisting the still prevalent patriarchal orientation and that these enlightened women are reinforcing the antiauthoritarianism that has been developing among men, my observations indicate there are still many analysts who maintain an authoritarian attitude. This authoritarian attitude and the use of indoctrination methods are most often linked with an analyst's denial of their existence and/or their harmful effects on the analysand and the analytic process.[1]

This book is highly recommended for those clinicians who can respect tradition and value change at the same time.

THEO L. DORPAT (SEATTLE)

JACQUES LACAN. By Elisabeth Roudinesco. Translated by Barbara Bray. New York: Columbia University Press, 1997. 574 pp.

For those who admire or revile Lacan there is much to ponder in Elisabeth Roudinesco's *Jacques Lacan.*

Roudinesco's presentation of Jacques-Marie Émile Lacan, human being, and Lacan, originator of psychoanalytic thought, put me in

[1] Dorpat, T. L. (1996): *Gaslighting, the Double Whammy, Interrogation and Other Methods of Covert Control in Psychotherapy and Analysis.* New York: Aronson.

mind of Ray Monk's *Ludwig Wittgenstein: The Duty of Genius.* Both books achieve the complex task of weaving together the story of a man's life and his intellectual voyage. Roudinesco brings the reader a rich panorama of facts, anecdotes, interviews, and analysis, both psychoanalytic and historical, from her perspectives as a Lacanian trained analyst and a historian. Lacan's capacity to engage, albeit on his own terms, with the likes of Plato, Augustine, Spinoza, Hegel, Heidegger, and Sartre gave a strong voice to psychoanalysis among the philosophers. He was involved in the major intellectual movements of the twentieth century: Freudianism, surrealism, existentialism, structuralism, and poststructuralism.

Born into a conservative bourgeois Catholic family, Lacan always walked a line between conservatism and radicalism. Roudinesco believes Lacan's concern about the "father" in his theories was in part a response to his cold, austere mother and his warm but intellectual father. She gives a vivid portrait of the young Lacan:

> His hunger for fame and knowledge made him insatiably curious, assailing with question after question anyone whose learning he might hope to absorb. He looked at people so intently they often took him for some sort of diabolical being, possessed himself and trying to possess them. Yet there was nothing diabolical about him. The fascination he exercised on others came from the extreme swiftness with which his mind worked, combined with the extreme slowness of his bodily movements. Always deep in thought he was at once tyrannical and attractive, inquisitorial and anxious, a show-off and a man haunted by the truth . . . (p. 137).

If one reads Lacan's seminars, it is amazing to see the depth and breadth of his reading of a myriad of authors. Notwithstanding this immersion in Western thought, fathoming the depths of clinical experience in psychoanalysis always remained the center of Lacan's concern, whether he was interpreting Sophocles' Antigone as a personification of pure desire or viewing the Borromean knot as a map to depict the complex interrelations of the real, the symbolic, and the imaginary.

Lacan was a figure of paradox. He longed to be understood but presented his ideas in ways that even his friends, such as Lévi-

Strauss, had difficulty understanding. He defied the forces of the IPA in his technical practice of the short sessions but was surprised and deeply hurt when he was "excommunicated." At that point in his life the philosopher Louis Althusser came to his aid. At the same time, Lacan came in contact with—some would say under the influence of—one of Althusser's students, the twenty-year-old Jacques-Alain Miller. Roudinesco's description of this crisis gave me a sense of the forces at play between Lacan and Miller. It was as if Miller were the one Lacan had been looking for—the interlocutor who could speak to Lacan in his own register. Miller went on to marry Lacan's beloved daughter, Judith, and became the executor of his intellectual estate.

Lacan's decline from the late 1970's until his death in 1981 has the form of a Shakespearean tragedy. He was like King Lear: having handed over his kingdom to Miller and Judith, he wandered in a state of decline, bordering on madness. Maud Mannoni observed:

> His people had brought him as a sort of fetish to celebrate the dissolution of his own school. He sat at a table on his own with Gloria (his secretary) mothering him. He didn't recognize anyone. His eyes were blank; his hand just lay idle. For a year after that, his entourage dragged him around to lots of meetings so that his presence might legitimize what was being done in his name. . . . Lacan had become completely silent, but the impact of his legend was such that suggestible people heard him speak through his silence (p. 403).

Roudinesco's *Jacques Lacan* is an achievement of impressive scholarship and vivacious style. The size of the cast of characters is daunting, and some of the same ground was covered in her previous history of psychoanalysis in France; nevertheless, for those who are drawn to Lacan, Roudinesco's book helps to put the man and his work into context. Lacan was similar to Wittgenstein: his way of thinking was unconventional, and he felt a tortured alienation about the place of his ideas in history. Perhaps such a price must be paid by those who work at the edge.

RICHARD B. SIMPSON (TORONTO)

THE TALKING CURE. THE SCIENCE BEHIND PSYCHOTHERAPY. By Susan C. Vaughan, M.D. New York: G. P. Putnam's Sons, 1997. 208 pp.

We are, most of us, ready for our field to move beyond pitting psychodynamics versus the biologic—the old debates now seem stale and trivial. We have always known that the two were joined; how could it be otherwise? Moreover, modern clinicians, like it or not, must live in both worlds, each with different jargon and philosophical assumptions. De facto, each clinician, then, will arrive at his or her own integration, knowing that there will be contradictions and gaps of knowledge. Nevertheless, I was not prepared to like this book so much: at this juncture to explain the science behind psychotherapy seems not only a tall order but one likely to be filled by a tall tale. Approaching my reviewer's task I mused that such a book might nonetheless be a signpost, reflecting a contemporary attitudinal shift rather than describing actual scientific underpinnings to psychodynamics. Ultimately though, I got more than I anticipated—indeed, I was won over. Vaughan's sheer enthusiasm and her marshaling of extensive, relevant knowledge are like a breath of fresh air.

Vaughan herself is a bright, engaging author who, we learn, is on the verge of graduating from her analytic training. She is of a new generation of psychoanalysts, one grown up with computers and the Internet; neurobiology and Prozac; classical psychoanalysis, self psychology, and relational models. Accordingly, the synthesis she arrives at is not a shotgun marriage, but that of an engaged academic practitioner immersed in the issues and culture of her time. Her associations range from neural nets to Disney to Saab commercials. This, though, is what we would hope for—not a polemic, but an embracing of many positions at once in her attempt to integrate modern practice. She is surefooted and sprightly as an author; in keeping with her intended general audience, her writing is breezy, informational, and spunky.

Vaughan's primary integrative approach is a mapping strategy: she is looking for correspondences, consistency, and coherence among different domains. Each chapter, then, implicitly reflects such a program, beginning with a clinical moment (often a dream) and then a clever interweaving of clinical story, biological hypotheses, psychotherapy and child development research, psychoanalytic theory, and

integrative speculation. By interweaving domains the reader, too, ends up mapping one field to another in a rich tapestry. Such a mapping in itself is, of course, not proof, but rather a philosophic reflection, a way of bringing an overall coordination and unity to areas that we assume a priori *must* come together. And so we are reassured—though in a somewhat circular, self-fulfilling fashion—that everything fits, just as we knew it must. Nevertheless, the sheer mass of correspondence and interesting juxtapositons of experiment and analogy is compelling, and we are ripe for it. It is also how we tend to live in the world: as practitioners we must make decisions in pluralistic fashion, even in the absence of grand syntheses, and so we always already have our tacit and ragged mappings among domains, with their inevitable gaps, faultlines, and deficiencies, as we leap in our assumptions from one plane to another. It's nice, though—aesthetically pleasing—when someone like Vaughan does it so well.

Of course, there are quibbles: Vaughan's conception of a "story synthesizer," for example, is too facile for my taste, a kind of homunculus dressed up in computer-eze. Sometimes her clinical explanations seem too easily settled: for example, does the author "find" links in her patients' neural nets, does she create them, are the mixed metaphors getting the better of us? The sheer piling up of so many metaphors from so many disparate domains, juxtaposing such different degrees of speculation and "facts"—a very consequence of her mapping program—can be dizzying. Are we here bewitched by language?

Ultimately, though, I was charmed. Vaughn has written a helpful, straightforward, comprehensive, and up-to-date book that bridges the increasing divide in academia between the psychodynamic and the biologic. I will enjoy recommending it to medical students and residents—I want to get their reactions as they struggle toward their own integration. More experienced practitioners will enjoy her book as well—I learned a lot, underlining research I was unfamiliar with (and yet relieved to learn was there). This is an enjoyable, informative, ultimately touching and convincing account of a modern practitioner's coming to grips with her sprawling field, a synthesis that is competent and appealing, told simply and well.

ALFRED MARGULIES (NEWTON, MA)

PSYCHOANALYSIS AND COGNITIVE SCIENCE. A MULTIPLE CODE THEORY. By Wilma Bucci. New York/London: The Guilford Press, 1997. 362 pp.

Psychoanalysts have recognized that our theory of mind is untenable. Attempts have been made to forsake the scientific aspirations of metapsychology by basing psychoanalysis on social/interpersonal or hermeneutic foundations. Such projects have helped rid clinical practice of destructive influences of outmoded theory. Yet we have not been able to replace metapsychology, for no alternative theory conforms as well to the reality of internal conflict and defense. The result of this impasse has been internal conflict and defensiveness within the psychoanalytic community, reflecting hopelessness about the possibilities of grounding psychoanalytic work on objective knowlege.

Meanwhile, from neurophysiology, cognitive science, and developmental research, elements of a scientific model of the mind have begun to converge. In this important monograph, Wilma Bucci integrates these elements into a theory that is both compatible with the clinical observations of psychoanalysis and accessible to objective investigation and modification.

The brain appears to be modular, composed of semiautonomous information processors dedicated to particular tasks. The result is "an imperfect device; the new and powerful representational system of language has been overlaid on a set of other representational systems that were previously in place, but without adequate mechanisms for integration of the systems having been developed" (p. 321). The various modes of functioning of these diverse representational systems constitute the "multiple codes" of the book's title. Bucci divides these systems into two distinct types: symbolic and subsymbolic (perhaps an unfortunate term). Language is the preeminent symbolic system. It utilizes discrete entities (words), with arbitrary referents and logically structured interrelations, and processes them sequentially. Symbolic processing also occurs in nonverbal systems, particularly in visual thinking, where sensory images can serve as the discrete symbolic entities. In computers, the symbolic processing mode corresponds to traditional algorithmic programming.

Subsymbolic representational systems operate in a continuous, infinitely graded, global fashion, rather than by manipulating discrete

symbols. They function like massively parallel distributed processing computers. Such systems are intimately connected with sensory and motor systems. Each functions in a unique, modality-specific manner. Readily comprehended examples may be found in the systems that control bodily position and movement. They automatically and continuously adjust muscle tensions, performing even the simplest physical tasks in ways we could never adequately specify with symbolic algorithms.

Bucci proposes that subsymbolic processing connects with language via "the referential process." First, continuously varying subsymbolic representations are "chunked" into equivalency classes. (Think of the way the brain divides up the continuous visual spectrum into discrete colors.) A prototype is constructed, representing the class. (Imagine "apple." You summon an image that somehow represents the class of apple varieties you know.) The prototype can then be associated with a word. Importantly, the process is bidirectional; words evoke nonverbal, subsymbolic representations.

Emotion systems are subsymbolic. They chunk their contents, in Bucci's model, into "emotion schemas. . .prototypic representations of the self in relation to others, built up through repetitions of episodes with shared affective states" (p. 195). Emotional processing may connect to language via the referential process. Thanks to bidirectionality, the referential process also permits symbolic thinking to modify emotion schemas. However, the referential process is inherently imperfect and is subject to defensive disruption. Pathology resides in such disruption, and psychoanalysis seeks to repair the disruptions and modify emotion schemas.

The elements of metapsychology with most enduring value are easily discernible in Bucci's model, but in a viable scientific form. The model is scientific in two senses: it is consistent with current data from other branches of brain science, and it generates predictions that can be empirically tested. Psychoanalytic process research is a major concern of Bucci and her colleagues, and of this book. The concept of the referential process proves to be amenable to surprisingly simple operational measurements. Bucci applies these to verbatim transcripts of analytic treatment, with interesting results that are of clinical significance.

The book, of course, does have shortcomings. The most important,

but inevitable one, is the incompleteness of the model at this point. The central concept of clinical relevance, defensive disruption of the referential process, needs clearer definition. Bucci speaks of the "individual turn[ing] against the symbolizing process itself" (p. 208), an evocative phrase, but beset by the well-known logical problems of homunculi within the mind. More explicit modeling of this concept may have to wait for neurophysiologic data about how painful affects modify communicative function between different brain areas (e.g., in neocortex-amygdala pathways). Also, just as repression proved incomplete as a model of defense, disruption of the referential process will need to be elaborated and supplemented if it is to supply a sufficiently broad base for clinical work. And, as has been true of previous cognitive formulations of analysis, the passionate power of motivation needs to be more fully integrated into the model.

Some scholarly omissions are notable. Bucci connects her ideas to neuroscience, cognitive science, and psychoanalytic research. She does not, however, acknowledge voices within psychoanalysis that have proposed similar ideas. Consider dream theory. Bucci views the manifest dream as an attempted translation into symbolic imagery of subsymbolic emotional processing with current-life, adaptive significance. She is at pains to link her theory to the findings and contentious views of Hobson and McCarley. However, she does not seem to recognize that conclusions essentially identical to hers have already been well established through an impressive corpus of clinical, neurophysiologic, and sleep-lab research.[1] Similarly, Bucci does not credit those writers, except for her fellow process researchers, who have previously attempted to refashion psychoanalytic theory upon the cognitive/Piagetian concept of emotion schemas.

This volume is cogent, informed, and clearly written. It is a powerful antidote to the prevalent skepticism regarding the possibility of establishing psychoanalytic theory upon a scientific model of the mind.

ALAN POLLACK (NEWTON, MA)

[1] For example, see R. Greenberg, et al. (1992): A research-based reconsideration of the psychoanalytic theory of dreaming. *J. Amer. Psychoanal. Assn.*, 40:531-550.

L'ENFANT ET LE PSYCHANALYSTE. LA QUESTION DE LA TECHNIQUE DANS LA PSYCHANALYSE DES ENFANTS. (THE CHILD AND THE PSYCHOANALYST. THE QUESTION OF TECHNIQUE IN CHILD PSYCHOANALYSIS.) By Antonino Ferro. Translated from Italian by Patrick and Danièle Faugeras. Ramonville Saint-Agne: Editions Erès, 1997. 248 pp.

This book, a translation into French of the work of an Italian child analyst, introduces a new variation on the understanding of the analytic couple. In the work itself, this understanding is applied mainly to the analysis of children, but does not need to be restricted to it. It addresses what the author calls *"le champ,"* the field, created in the interaction between the two participants. The concept derives much of its power from the projective identification which Ferro sees in most interactions, especially in cases of severe pathology.

This work is most impressive and convincing; the author has all the modesty and integrity one hopes for in an analyst; and the illustrations are vivid to the point of giving the reader a sense of participation in a fascinating search for establishing or re-establishing contact within the psychoanalytic couple. What Ferro describes is, of course, what troubles us most: the knotting and the unknotting of the threads within the therapeutic relationship. He implicates himself and his internal processes at the same time as he attempts to understand the patient. If this sounds familiar, it is because of the resemblance of this approach to others using projective identification and the notion of the evacuation of parts of the psyche into the other. Yet Ferro believes that he goes one step further when he suggests that "it is not only the patient who influences the analyst, with all the problems of countertransference which derive from it, but for the most diverse reasons, it is also the analyst who influences the patient" (p. 213). The influences Ferro describes consist in projective identifications, literal evacuations into the patient of affective components which the analyst is unable to symbolize and therefore experience as part of him or herself.

Ferro contrasts his approach with those of other analysts by demonstrating how his successful interpretations are "non-saturated and weak" and remain within the field of the analytic couple without attempting to go outside it. Emotions are experienced in the present;

Ferro therefore takes into consideration "the simultaneous presence of two living texts. . .which interact continuously by transforming themselves" (p. 11). According to the author, these ideas are an outgrowth of a development starting with Freud, who made frequent references to history in his interpretations, going on to Klein, who introduced external reality as a contrast to the unconscious fantasies which she interpreted, then to Bion, who was interested in the thinking apparatus within the bipersonal field. To this evolution, Ferro proposes to add the analyst's role and task within that field which he also calls poetically "the shared nuptial bed of analysis" which engenders "a new history inscribed by the two participants" (p. 225). "It concerns a symmetrical relation, the expression of the vicissitudes of the psychoanalytic dialogue, bearing in mind that 'what one does', in the transaction of affects, goes far beyond 'what one says' " (p. 225).

The following is an illustration of his method: "If, after a session which appeared to the analyst as intense, a young patient tells that his little sister, having ingested much risotto in no time at all, had indigestion and lost consciousness, this will indicate to the analyst that the overly intense and excessively condensed emotional charge of the 'function' little sister caused loss of consciousness (faint/losing contact), and that the interpretive and relational diet must be reduced so as to prevent 'loss of significations' " (pp. 74-75).

The outstanding experience for me in reading this book was the sense of its honesty. It towered high above those others in which the authors display their access to their own unconscious and leave the reader prey to their doubts about their own ability to accomplish these great feats of introspection. Ferro makes no attempt to take himself out of the group of constantly struggling analysts who try to make sense of the process in which they are profoundly implicated. Nor does he portray the patients as victims of analytic fumbling. He discusses seriously an episode during which his own family problems derailed his emotional contact with the patient, but Ferro's respect for himself, for the reader, and for the patients toward whom he tries to be the best he can be, shine through this beautiful and moving book.

MARION M. OLINER (NEW YORK)

RECOVERED MEMORIES OF TRAUMA: TRANSFERRING THE PRESENT TO THE PAST. By C. Brooks Brenneis. Madison, CT: International Universities Press, Inc., 1997. 204 pp.

Brenneis's book is a timely and thoughtful contribution to the ongoing controversy regarding memories of sexual abuse. He intentionally keeps his focus on the appearance of previously unremembered trauma during the course of psychotherapy and psychoanalysis and takes a reasoned, serious approach to this vital matter. Adopting an attitude of "informed skepticism," Brenneis surveys both the clinical and relevant research literature to arrive at his sobering conclusions that debunk many widely held beliefs.

Brenneis brings under careful scrutiny the "symptoms" that may lead the clinician to question the existence of unrecovered memories of trauma: traumatic dreams, dissociation, flashbacks, and repetitive behavioral enactments. In particular, he cautions against one-to-one correlations between dream elements, for example, and actual traumatic events in the past. To infer from the manifest content of a dream specific occurrences from the past is to ignore the complex processes of dream work in the symbolic transportation of events into dream images. Furthermore, Brenneis reminds us that repetitive dreams (and recurrent behavioral enactments) occur in a variety of clinical situations that are unrelated to unremembered memories of trauma. He also challenges the notion of a special form of memory for trauma, as advocated by van der Kolk, in which specific elements of past trauma are remembered in an undistorted manner. Brenneis reviews the cognitive research that shows little support for a special form of memory for trauma and also seriously questions whether any memory escapes distortion by the social context in which it is recalled.

This brings us to the heart of Brenneis's volume: the inquiry into whether reports of memories of trauma recovered during psychotherapy are actual or whether they are reactions to the clinician's technique. He does not deny the existence of recovered traumatic memories, but questions the therapeutic circumstances under which they are remembered. The clinical reports, some by psychoanalysts, that describe the emergence of recovered traumatic memories during treatment frequently demonstrate the active, sometimes invasive,

work of the therapist to "assist" the patient in overcoming "resistances" to remembering. Brenneis astutely observes that the patient's alleged "traumatic memory" actually may be a metaphor for her experience in the here-and-now of an assaultive technique. He cites a published account of a woman hospitalized for multiple personality disorder in which she was restrained and "assisted" in recovering a memory of past abuse. Not surprisingly, she remembered being raped while tied down to an altar.

Brenneis's caveat is for us to be respectfully doubtful of our patients' productions and to be mindful of the possible dilemma of having to choose "between bearing false witness or failing to bear true witness, without knowing with any certainty which we are doing" (pp. 59-60). The combination of an overzealous therapist looking for confirmation of his/her assumption of abuse and an anxious patient who may be fantasy prone and extremely susceptible to influence is the fertile soil in which recovered memories of trauma may suddenly sprout. Brenneis discusses the inevitability of influence in psychotherapy and analysis, elaborating on the mutual unconscious influences of patient and clinician that may contribute to the unquestioned surfacing of previously unremembered traumatic memories.

I felt anxious reading this book that Brenneis's carefully reasoned arguments, in the wrong hands, could be used as ammunition to discredit all recovered memories of trauma. But this is a thoughtful book for practicing clinicians that teaches us, in the best psychoanalytic tradition, to maintain an attitude of questioning inquiry toward our data. Brenneis also takes a more contemporary approach to technique in his exploration of the subtle mutual influences of patient and analyst upon each other and how we may ascribe to the past what is occurring in the here-and-now. Indeed, my main dissatisfaction with this book is that Brenneis could have more fully discussed the issues of mutual influence within a psychoanalytic framework. For example, he describes the subtle "demand characteristics" (an experimental psychology term) of the therapist for the patient to produce traumatic material; however, a more thoroughgoing review of the current psychoanalytic literature on influence, intersubjectivity, and enactments would have further enriched this already valuable book.

LAWRENCE J. BROWN (NEWTON CENTRE, MA)

THE SEED OF MADNESS. CONSTITUTION, ENVIRONMENT, AND FANTASY IN THE ORGANIZATION OF THE PSYCHOTIC CORE. Edited by Vamik D. Volkan and Salman Akhtar. Madison, CT: International Universities Press, Inc., 1997. 213 pp.

This book brings new life to a topic seemingly put to death by "the decade of the brain." It focuses on primitively fixated and regressed patients who are mad, but not crazy, not schizophrenic, due to failure of development of early structure. This refers to the psychotic core that lies at the dawn of the psyche when the continuity of raw, primordial experience is fractured by overwhelming and uncontainable tension states of displeasure.

Volkan's introductory chapter sets the stage by positing the book's thesis: that the basis of madness is a disturbance in the undifferentiated mother-infant matrix. He describes five fates of this infantile psychotic self. An interesting midrange category is described as a healthier self encapsulating the infantile psychotic one just enough to allow its voice to be heard in cracks experienced as focalized bizarre traits.

Kehtonen's remarkable chapter deals with the primordial psyche, Freud's body ego, "the psychic projection of the body surface." It is represented by simultaneous fusion of self with object and the affect of pleasure, and with sense impressions of the body surface and of internal somatic processes. This is the coenesthetic psyche-and-soma experience of oral instinctual gratification.

The dream screen and the Isakower phenomenon in adults infer these noncognitive, perceptual-affective experiences of pure feeling awareness. The boundaries of the body ego, argues Kehtonen, are based more on this psychic satisfaction than on actual physical boundaries. With traumatic overstimulation from hunger, etc., the continuity of the body ego is disrupted. This results in a loss of libidinal dominance, and a defensive union of pleasure with death, in a wish for sleep, rather than with drive objects. Sleep (death) is now the only release from tension.

An important distinction is made between vital and categorical affects (following Stern), in which the former relates to the solidification of the body ego and the complex experience of aliveness while the latter relates to the more discriminatory affects connected with more evolved object relations. The use of primal repression, experi-

enced as a blank state and the loss of vital affects in which psychophysiological satiety in fusion with mother, leading to sleep, is not only a supportive structure for well-being but also a protection of the self against internal and external impingements that should properly be sought and savored. Treatment, he feels, must return the patient to this basic body ego state, within the transference-countertransference in order to provide an opportunity for restoration of the fundamental bonds between self, object, affect, and perceptions.

Salonen traces the roots of dignity back through integrity to integration of the personality. Since the original unity experience with mother (wholeness) is the driving force behind the later wish to unite with the ego ideal, the pleasure principle drives us toward identification with our ego ideal. Success in this requires both autonomy and integration of conscience. Being whole is therefore a requisite for the capacity for dignity.

Salonen describes the need for psychic representation in order to feel alive. He posits that the therapeutic vehicle necessary to acquire this representation is overcoming splits and enactments that preclude aliveness. I feel he must differentiate between unconscious and preconscious representation and address the concept of decathexis. Otherwise, I am in agreement.

Boyer advocates the use of transference-countertransference as the best method of treatment of the primitive psychotic self, within the consistency of the psychoanalytic frame. Utilizing Ogden's felicitous term "analytic third," Boyer stresses the point that seemingly stray, unrelated thoughts and feelings within the analyst are not idle preoccupations distracting us from free-floating attention but are central to it. He uses the transference-countertransference interaction of the previous session as a day residue for a state of reverie that becomes a potential space for creative play in which each is the subjective-object for the other. The verbal associations of each act upon those of the other in a verbal version of Winnicott's "squiggle game." He feels that this provides powerful access to the patient's dissociated states in which interpretation can be made not only with but "through" the countertransference.

Akhtar, in his usual lucid and comprehensive style, offers a summarizing statement comparing the dialectics between the constitutional and the environmental and between the unconscious fantasy life of the child and his/her parents and the dynamic unconscious

interactions between them that require treatment. He quotes Pao[1] on the failure of reciprocal feedback in the mother-infant attempts at mutual cuing that lead to what Freud called pain in separation. Pao added that this leads to pain in being held as well as in being laid down. Subsequent inconsolability produces mindless states of withdrawal, automatism, and depersonalization. Grotstein[2] called this state, psychic black holes. Winnicott referred to this state as both the failure of going on being and psychosomatic indwelling that leads to hypochondriasis. Singer[3] has written of the phenomenologic states of emptiness and nonhumanness, associated with fears of closeness and of distance, which Burnham, et al.,[4] referred to as the need-fear dilemma.

Akhtar coins the term affective turbulence to refer to an ego fractured from too heavy a dose of stimuli, from within and from without, unprotected by a maternal shield so that there is a breakdown of boundaries and a need for projective techniques. Rampant self-hatred and attacks on linking, especially between thoughts and undifferentiated affects, are the consequence of the progression from organismic distress to menacing terror and then to reactive rage, which, when blocked from outward expression because of parental vulnerability, leads to turning against the self. Learning is also contaminated by association with the threat of abandonment; parental attitudes of disinterest and neglect are conveyed by a push to the child to "get on with it," i.e., learn so you can leave.

I recommend this book enthusiastically for those analysts who work with seriously disturbed patients. It affirms, if one had any doubt, that psychoanalytic theory continues to have a great deal to say about psychotic states.

MELVIN SINGER (PHILADELPHIA)

[1] Pao, Ping-Nie (1979): *Schizophrenic Disorders: Theory and Treatment from a Psychodynamic Point of View.* New York: Int. Univ. Press.

[2] Grotstein, J. S. (1996): Nothingness, meaninglessness, chaos and the "black hole." III, Self-regulation and the background presence of primary identification. *Contemp. Psychoanal.*, 27:1-33.

[3] Singer, M. (1977): The experience of emptiness in narcissistic and borderline states. I, Deficiency and ego defect versus dynamic-defensive models. II, The struggle for a sense of self and the potential for suicide. *Int. Rev. Psychoanal.*, 4:459-479.

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

THE INWARD EYE. PSYCHOANALYSTS REFLECT ON THEIR LIVES AND WORK. Edited by Laurie W. Raymond and Susan Rosbrow-Reich. Hillsdale, NJ/London: The Analytic Press, 1997. 478 pp.

The Wordsworthian origins of this book are made quite explicit not only in the couplet that provides its title—"That inward eye/Which is the bliss of solitude"—but in the editors' avowed belief concerning the intersubjectivity of analysis. They have embraced the poet's credo of subject and object acting and reacting upon each other in "an infinite complexity of pain and pleasure." They proceed to find an antidote, at one remove, to the deprivation and frustration they experienced in their training analyses concerning their lack of knowledge about their analysts' private experience with them. In their introduction, the editors are refreshingly candid in acknowledging how the vicissitudes of their training analyses and their complex emotional relationships with their institute motivated their desire to penetrate into the intersubjective heart of analysis. Through the medium of these provocative interviews with prominent contemporary practitioners they have achieved this aim.

Significantly, their sixteen subjects are almost exclusively "classical" clinicians who ostensibly view analysis as a one-person psychology. A subtext of this book is thus to debunk that premise, even though Hans Loewald effectively accomplished this in his theoretical work over twenty years ago. His conviction of the two-person nature of analysis is aptly summarized by his Socratic question: "Are we justified in simply equating the psychic life with the intrapsychic?" Example after example abounds of the interviewed analysts' recognition of the intersubjective two-person nature of psychoanalysis; e.g., Jacob Arlow: "Like the creative writer, the analyst is influenced by the evocative power of the experience with other people" (p. 61). André Green on the analytic situation, quoting Sartre: "En soi, pour soi, pour autroi" ("In itself, for oneself, for someone else") (p. 92); Leo Stone on repeat analyses: "One of the things that struck me most was how little people remember of interpretive material. . . .the basic affective relationship between the two as persons so dominated the actual responses that this other (interpretive process) seemed unimportant to them" (p. 124).

Thanks to the editors' ability to also elicit revealing commentary on the nature of what catalyzes the choice of career as a psychoanalyst,

we can see the parallel to what Wordsworth said about the poet's art: "It is a homage paid to the native and naked dignity of man, to the grand elementary principle of pleasure, by which he knows, and feels and lives, and moves. We have no sympathy but what is propagated by pleasure; I would not be misunderstood, but wherever we sympathize with pain, it will be found that the sympathy is produced and carried on by subtle combinations with pleasure."

PETER BUCKLEY (NEW YORK)

EROS OF THE IMPOSSIBLE. THE HISTORY OF PSYCHOANALYSIS IN RUSSIA. By Alexander Etkind. Translated by Noah and Maria Rubins. Boulder, CO: Westview Press, 1997. 408 pp.

This book, which first appeared in Russian (1993) and subsequently in French, has been eagerly awaited. While high expectations might well threaten disappointment, *Eros of the Impossible* makes for an exciting if demanding read. Etkind is a sophisticated author who has produced a series of remarkable essays which succeed in fleshing out the story of the reception of Freud's work in Russia.

One chapter deals with Lou Andreas-Salomé, her psychoanalytic contributions as well as her relationship with her native land. The next deals with the symbolist movement and its similarities to psychoanalysis, helping to account for Russian responsiveness to Freud. The third chapter is devoted to the Wolf Man. The next section is on psychoanalytic activity before World War I, which was active enough to overshadow how Freud was being received in most other countries. Sabina Spielrein (Jung's first analytic patient) is important enough to justify a chapter of her own; Etkind succeeded in interviewing some of her surviving relatives.

In 1923 the thirty members of the Russian Society comprised an eighth of the membership of the IPA. An analytic pediatric facility (attended by Stalin's son) was attempted, and Etkind comes up with findings about not only how positively Trotsky viewed analysis, but the ways in which he encouraged the movement. Human nature was supposedly capable of being transformed, which partly explains why analysis flourished (until 1930) in the land of the Bolsheviks. The Russians tried to make a special study of childhood as part of applied education.

By the early 1930's analytic thinking was denounced as a deviation from the Party line. Totalitarianism ultimately destroyed analysis in Russia, although today once again there is a resurgence of Russian interest in Freud. Those interested in the history of ideas will relish Etkind's book; among other points he examines whether Max Eitingon may have been a NKVD agent, and points out how one chapter in Bulgakov's *The Master and Margarita* was modeled on William C. Bullitt. Etkind has made a memorable contribution to the growing literature on the comparative national receptions of Freud.

PAUL ROAZEN (CAMBRIDGE, MA)

ABSTRACTS

Revista de Psicoanálisis. (Argentina) Special International Issue, 1995: The Body

Abstracted by Irene Cairo Chiarandini.

Body, Signification, and Language. Jorge L. Ahumada. Pp. 9-30.

Ahumada refers to two currents in contemporary psychoanalysis, one empirical, anchored in Freud, the other linguistic-narrative, hermeneutical. Blackburn said that any investigation should study the relationship of its subject to language. Feyerabend, however, warned against the excesses of the linguistic current. Ahumada asks: Which approach leads to increased knowledge of contents? Referring to Freud's famous metaphor, he observes that there has been a gradual abandonment of the "*via di levare*" (or Charcot's "let the facts speak").

Basing his views on Freud's statement that the ego is fundamentally a body ego, and on the idea of drives, Ahumada affirms that object ties are expressed through the body in a primary emotionality. Melanie Klein related symbolization to weaning. Representation passes from primary identification of the object to visual representation and then to representation by words.

For Freud, there were two interpenetrating levels: one, the motivational—a process which corresponds to drives and the object representation, a level which underlies the basic signification of the subject; the other, a layering of meaning in conscious memory and in language. In contrast, in the narrative hermeneutic currents, signification resides in language; therefore, speech itself is viewed as susceptible to motion, an act, something we do, and do to someone. Ahumada cites the surprise we experience when we have access to the peculiar world of primary links and their particular signification: two children are talking, a five-year-old and a two-year-old. The older child asks, "Where is that plane going?" And the younger one answers, "To look for its mommy." This illustrates the different logic of Freudian references at the level of impulses, of object representation, and of emotions, in contrast to the representational level of the linguistic current.

For philosophers of language, meaning has to be created: they sever the connection of the links body-sex-object tie, and meaning has to be created from and by speech. Some of these authors reduce individual psychology to elucidating how the individual understands language. Contrasted with the representational theories of knowledge (that come to us from Aristotle and Locke) are the idealistic notions (illustrated by Berkeley) that we do not have assurance that ideas correspond to the outside world. Therefore, the world that is knowable is restricted to our private, hidden, personal ideas: our speech refers to that world of ideas. Some believe that facts are pseudo-entities, that the idea of attention to facts is a useless

notion. In fact, Ahumada argues, the survival of all living organisms rests on meaning: for both fox and hare, what they mean for each other stimulates the hunt for the first and evasion for the latter. The meanings of the nipple to the baby and the baby to the mother assure survival. Insight evolves from a pragmatic paradox: the analyst's neutrality allows him or her to grasp the patient's unconscious flow, and it permits the analysand to become aware of the emerging meanings recognized as his or her own.

Analysis of associations and interpretation results in the emergence of the primary unity of act, image, and object, through the action of speaking and listening to the analyst. The concrete aspect of symbols, heretofore repressed, is made conscious, and verbal images acquire emotion and meaning. Psychoanalytic work then allows lifting of repression and re-establishment of meaning. Ahumada recognizes that some current linguistic thinking maintains that to account for language and speech, we must understand how mind-brain links the subject to reality. Infants and animals do not have language, but they have intentional states, and the logical relationship of dependence goes from them to language, and not in reverse.

Does the Body Speak? Teresa Bolaños. Pp. 41-58.

Reflecting on the way the body is presented in analysis, Bolaños reviews her clinical caseload. Bodily expression transcends the spoken word, yet only the latter implies development, both biological and mental, of certain psychic structures. In some situations the body acts as the only means of expression; is this intentional? Libido is transformed into somatic innervation. In other cases, the soma manifests an inhibition in development; sensations never make it into the psychic world, the world of meaning. Is there a phase-specific—oral, anal, genital—language for the body? The author refers to McDougall, Anzieu, Liberman, Green, and the views of Marty, de M'Uzan, and David, who all converge on the notion of deficiency in symbolization in the psychosomatic patient who cannot insert affective experiences of the body into the linguistic code.

A six-year clinical case is described in great detail: an adult woman in whose analysis an autistic nucleus was revealed. Once analyzed, this encapsulated area of the mind revealed itself in the development of a new musical talent that allowed the patient to work musically with autistic children. Through analysis of the somatic symptoms that surfaced in the session, and their associations, she began a process of enriched symbolization.

Body expression can be read as "noncommunication" or as a message. Referring to Milner and the idea that fusion and identification are precursors of symbolism, the author discusses the meaning of worldlessness within the analytic process, forms of primitive expression which, in some cases, can be put into words by the analyst.

Somatization: A Pathology of Attachment and Influence. Marie Claire Célérier. Pp. 59-73.

The author reviews the psychic functioning of patients who somatize: every problem leads to action; intense wishes are gratified without psychic working through; affects are expressed only in regard to medical tests and procedures, to the particular illness, to the restrictions such illness creates. Free association is impossible. These patients dismiss the idea of having a problem. They reveal an "as if" personality, a "false self." They use primitive defenses. Neither the sexes nor the generational boundaries are clearly distinguished. Indeed, the most severe pathology relates to issues of separation and difference. Dependence is either denied or experienced as being influenced, which is opposed. In the childhood of such patients, the family usually offered the illusion of an ideal group, an illusion that often hid family secrets. Negation and splitting prevail, as in psychoses.

The author thinks that death drive nearly submerges life instinct in these patients. However, looking at meaning, it seems that the body reactualizes something from early object relations. The regression caused by physical dependence plays a role. Attachment drive (Bowlby) and influence drive (Dorey) have unusual intensity in these patients.

The analyst must at first serve a containing function. Then affects and representation can be given words. Following Bion's ideas, the author thinks that in the beginning the analyst should not interpret, only return to the patient, in a "detoxified" state, the experiences the patient cannot verbalize.

The Body in Psychoanalysis. Rodolfo A. D'Alvia. Pp. 119-127.

The relationship of psyche and soma is a preoccupation of current psychoanalytic theory. Some models conceptualize a unity in which there is no differentiation. The somatic area is the psychic unconscious, devoid of meaning. In other words, Bios refers to the physiological body of needs, and Eros to the psychological body of desire. D'Alvia describes three levels of body image: conversion, hypochondriasis, and psychosomatic illness.

Three levels of representation are possible. One is connected with the exteroceptive world, that of the senses. A second is connected to proprioceptive sensations: balance, movement, hunger, cold, and the vicissitudes of pain. The third level belongs to erogenous zones.

The ideal integration between psyche and soma results from the use of external and internal perceptions, affects, desire, fantasy, words, and the adequate experience of the object. In pathology, however, one sees different articulation of these developments. In conversion, repression of conflict and identification are used; at any rate, the symptom is a symbolic message. In hypochondria, the symptom is linked to misperception and misinterpretation. Libido is narcissistic, and "doctor shopping" leads to iatrogenic situations. Primary narcissistic identi-

fication results in internalization of a persecuting object. In psychosomatic disease there is poor connection with the body, incapacity for affective expression, yet the body, subject to overdemands, is neglected and subordinated to certain cultural ideas. There is impoverished psychical processing. Words do not communicate. In Bion's terms, alpha function is deficient.

Therapeutic efforts should differentiate (1) the area of discourse (how the patient includes body metaphors to express feelings, the misinterpretations of sensations, etc.); (2) the area of expression where direct signs can be observed (blushing, tremors, etc.); and (3) the area of signification. The physical symptom becomes the linguistic expression of a body that now has meaning.

Body and Somatic Event. Prehistory and Potential for Repetition. José E. Fischbein. Pp. 131-151.

The concept of the body underscores the limitations of psychoanalysis. First experiences are somatic: their emotional register is part of the prehistory and protohistory of mental organization. Psychoanalytic theory is organized around body metaphors. In *Studies on Hysteria* the body is placed in front of the scene it hides. Only the acquiring of representations permits the body access to consciousness.

Various levels of psychopathology emerge from the distinction between somatic body and erogenous body. The body, with its needs, presents to the psychic apparatus as an object against which to defend. Considering the body as a concrete, asymbolic vertex in psychosomatic pathology, psychoanalytic treatment attempts to create a system of meaning that gives the subject a form of mental expression. Fischbein illustrates his ideas about the role of psychoanalytic treatment in psychosomatic disorder with a highly detailed, rich clinical case: a thirty-two-year-old man facing a gastrectomy for chronic ulcer who begins an analysis that will last seventeen years. For the author, the main instrument in the psychoanalytic approach is the creation of constructions about early object relations and the analysis of their repetitions in the form of the somatic event in the transference. A discussion of "mental anatomy" follows. The breast, which does not make demands, is the nucleus of the ideal object. The body begins to be felt as belonging to the space "not-me." The peremptory demands of that body not only threaten the baby, but also the mother. The early ego, the "I" of that moment, is a shared "I," which faces the massively imposing soma. The mother of this kind of patient demands an early adaptation at the psychic level that is based on splitting and alienation from the child's own affective states. Some of these mothers demand precocious regulation of self-esteem.

Signal anxiety is deficient and the preconscious system is inhibited, both factors that favor acting-out. The somatic event in analysis is an imperative search for the lost object of the past which cannot be found in the present and which exchanges the love with the primary object, a love which did not exist, for a compulsive

manipulation of the soma in the present. Regression to primitive, undiscriminating states predominates. The organic syndrome is anchored in the wordless history of the subject. The recurrence of those experiences that preceded words allows the psychoanalytic construction; that is the moment when the object is a dangerous one. The irruption of the symbol breaks the fusion with the primary object. In the past the subject would protect the mother, severing the connection with his/her own body. Now the demands of the body act as facilitators of new object relations.

The analytic constructions are an instrument for change from concreteness, lack of discrimination, and alexithymia. Analyses of countertransference and of universal symbolism have a main role.

American Imago. LII, 1995.

Abstracted by Thomas Acklin.

The Affirmation of Primary Repression Rethought: Reflections on the State of the Self in Its Unconscious Relational World. Anthony Elliott. Pp. 55-79.

Reviewing the contributions to the Freudian notion of primary repression which have been made by object relations theory (Sandler and Benjamin), by Lacanian theory, and by Lacan's commentators (Laplanche and Pontalis, Castoriadis and Kristeva), Elliott offers his own contribution. Kristeva and Laplanche posit an elementary form of subjectivity created when the small infant enters an identification with signifiers in the preoedipal phase binding unconscious drives through primal repression and constituting the intervention of the Other into psychic interiority. Elliott himself suggests that we must speak of pre-object relations in the constitution of primary intersubjectivity, which is less a phenomenon of the Other breaking in from the outside than of the ordering of psychic interiority within intersubjective boundaries of shared unconscious experience. From the representational flux of the unconscious, "rolling identifications" provide for the insertion of subjectivity into an interplay between self-as-object and pre-object relations, spilling across libidinal space in pre-self experience before the differentiation of self and other. This emergent relation to the pre-object internally splits the infant's subjectivity, and the experience of loss is felt as a result of the preliminary disillusion of basic representational self-sufficiency. The loss of self-referential representation fulfillment substitutes a relation to pre-objects and to self-as-object, with an imaginary anchor in parental significations. Representational wrappings of the self and other spiral in and out of the intersubjective life ordering and reordering the psychical imagination and the social process. This allows the subject to negotiate the imaginary tribulations of potential space as the individual, through representational wrappings, establishes the imaginary and sociosymbolic forms through which human beings can establish a psychical relation to the self, to others, to received social meanings, to society, and to culture.

An appreciation of this process of primary repression and primary identification allows us to see how social significations are unconsciously organized within the matrix of former preoedipal experience and thus that there is a wealth of fantasies, images, and feelings available in the creative engagement of the subject in culture. These early fantasies, images, and feelings support not only identity but also the identificatory process of re-imagining our world, the power of radical imagination allowing us to imagine the self society, politics, and ethics anew.

Lacan and the Ostrich: Desire and Narration in Buñuel's *Le Fantôme de la Liberté*. Reynold Humphries. Pp. 191-203.

Humphries explores how cinema sometimes challenges codes of narration and representation in a reversal of expectation so that the narration as a production of meaning has constantly to be renegotiated. Themes and characters can be introduced with a seeming irrelevance, challenging the whole concept of character. Sometimes accepted codes are used, not in the form of reversal but as standard clichés which disrupt the miscognition where the subject believes that it controls words, though really the subject is an effect of the signifier. Thus, the ideology of the self-centered individual is overthrown by virtue of unconscious sources as the subject of enunciation is dethroned in favor of a message that is always already there of its own accord. Cause and effect are reversed to show the unconscious cause. Behind all this there is a loss which is repressed, as in fetishism where an absence is passed off as a presence. The technique of Buñuel introduces such elements as the ostrich, which returns suddenly like the repressed and in which the subject recognizes the "truth" (in the Lacanian sense) lying behind the discourse emanating from the place of the Other.

***Innerspace:* A Spectacular Voyage to the Heart of Identity.** Robert Lang. Pp. 205-235.

Robert Lang explores the American "buddy film," considering the movie *Innerspace*. This movie is an elaborate anal incorporation fantasy of Tuck into Jack. The film asserts, even as it undercuts the assertion, that healthy masculinity involves the repression of homosexuality and of women. At the end of the movie Jack is cured of his unmasculine fears through identification with Tuck, even after Tuck has left his body re-enlarged. Until Tuck gains a sense of the body he is inhabiting, he does not exist as a subject. As Jack comes to realize that Tuck has been injected into him, he becomes the divided subject of psychoanalysis as described by Lacan. In the imaginative fantasy Tuck briefly enters into the body of a woman from which he must return, indicating the mediation of the female body as a receptacle, not by identity. The film departs from the genre of the American buddy film by no longer denying that male homosocial desire is a continuum including homosexuality.

The Jewish and German Roots of Psychoanalysis and the Impact of the Holocaust. Martin S. Bergmann. Pp. 243-259.

Bergmann concludes that Freud absorbed ideas from many writers, though he learned most from Friedrich Nietzsche. Heinrich Heine had the greatest influence on Freud's personality. Bergmann makes the point that style is an expression of personality, and in Freud, German and Jewish roots intermingled as they did in Heine.

Psychoanalysis emerged at the crossroads of the Enlightenment and German Romanticism, a rational methodology trying to understand the irrational. According to Bergmann, the fact that the International Psychoanalytical Association was willing to allow the German Psychoanalytical Society to maintain membership only if its Jewish members voluntarily resigned shows that psychoanalysis shared in the spirit of accommodation to Hitler.

The Internalization of Nazism and Its Effects on German Psychoanalysts and Their Patients. Volker Friedrich. Pp. 261-279.

According to Friedrich, it is difficult for us to recognize the Hitler in ourselves, and it has been especially difficult for German psychoanalysis to take historical responsibility for what happened under the Nazis. During the 1950's and 1960's, psychoanalysis in Germany fled the past by moving forward and promoting psychoanalysis in extremely rigid and orthodox forms. Only in the 1980's were voices heard calling for analyzing together the unconscious identifications with the Nazi introject. According to Friedrich, it is necessary for psychoanalysis to analyze countertransference, to accept openly all projections onto one another, and to expand our tolerance for pain and anxiety in order to deepen the understanding of the second and third generations of both survivors and perpetrators of the Holocaust.

The Intergenerational Taboo of Nazism: A Response and Elaboration of Volker Friedrich's Paper, "Internalization of Nazism and Its Effects on German Psychoanalysts and Their Patients." Harold P. Blum. Pp. 281-289.

Blum does not agree that silence is the worst crime, pointing out that, while it is not the same as murder, torture, and starvation, it does compound the crime, avoiding its exposure and understanding. He explores the function of identification in reference to the Holocaust, namely, identification with the aggressor, identification with the victim, identification with the paranoid, omnipotent leader, and the role of identification in superego corruption and regression, all under the shadow of the Holocaust.

In the Aftermath of Nazi-Germany: Alexander Mitscherlich and Psychoanalysis—Legend and Legacy. Karen Brecht. Pp. 291-312.

Brecht asserts that Alexander Mitscherlich obstructed the attempt to go back and understand the true history of psychoanalysis and minimized the involvement

of German psychoanalysts with the Nazis. She indicates that, despite the role Mitscherlich claimed for himself in the revival of German psychoanalysis, he did not differentiate between psychosomatics and psychoanalysis, never underwent a personal psychoanalytic formation, and analyzed social and historical phenomena rather than undertaking day-to-day psychoanalytic practice. Brecht does acknowledge that in later years Mitscherlich became a legitimate representative of psychoanalysis. In particular, Brecht criticizes the transfer of knowledge of psychic processes of individuals to groups and large groups without making a specific consideration of group dynamics.

The Presence of the Past—Xenophobia and Right-Wing Extremism in the Federal Republic of Germany: Psychoanalytic Reflections. Werner Bohleber. Pp. 329-344.

Referring to the wave of violence against foreigners and asylum-seekers in the Federal Republic of Germany in the 1990's, Bohleber explores the phenomenon of right-wing parties and other extremist groups, along with the re-emergence of anti-Semitism. It is the extremist attempt to enforce a reinterpretation of history, the loudly proclaimed wish for a clean break from the past, which furthers the denial of the Nazi past with a deep-seated memory blockage. One's own hatefulness is located in a stranger, and one tries to destroy it there because of an unstable inner equilibrium and an uncertain self-identity which can be traced to the poor quality of maternal relationship and the suspicion of one's own siblings. The fantasy of the extremist group is of a unitary entity representing the mother's body, a function which the fatherland also assumes as a purely homogeneous community. For this to be achieved, everything that impairs an absolute state of purity has to be eliminated, and, thus, some of the very ideals of Nazism return in these extremist groups.

H.D.'s Post-Freudian Cultural Analysis: Nike versus Oedipus. Katherine Arens. Pp. 359-404.

Reviewing the autobiographical memoir of H.D.'s (Hilda Doolittle) analysis with Freud during the 1930's, Arens argues that this record of her analysis is a refashioning of Freudian discourse and modernistic poetics through which H.D. moves her own legend and Freudianism into the post-Second World War world. Her second level of analysis is a self-analysis in which she interrogates her relationship with Freud and her analytic experience of reclaiming her childhood. Her self-analysis moves in the direction of re-creating her memory of spaces as domains of control of various powers—male/female, public/private—thus recognizing herself as analyst, not just student or analysand. She recognizes an unconscious resistance to Freud and to those around him, and that she did not give him either the satisfaction of curing her or of having her behave like all his other patients and colleagues. She describes Freud's impotence in the hands of his

students and his loss of personal agency in the face of protective, domestic women. Her ultimate evaluation of psychoanalysis is that it is a science feeding off the unrecognized needs of women, which had become part of the world of male politics. She ends by realizing that she, in the end, did give him something: the tribute of her ability to self-analyze.

"Desire Pronounced and/Punctuated": Lacan and the Fate of the Poetic Subject. David Kellogg. Pp. 405-437.

On the subject of contemporary poetics, Kellogg discusses desire in the works of Jacques Lacan and Sigmund Freud. Unlike Lacan, Freud never uses desire as a central theoretical concept. Lacan's *desir* substitutes for the Freudian *Wunsch*, that is, a desire for what can never be known, what Lacan calls "the Other." This Hegelian influence upon Lacan sees desire directed toward recognition, and self-consciousness achieving its satisfaction only in another self. Since one recognizes oneself through an intersubjective relationship with the other, the Other is the negative space of misrecognition. While the subject enters the signifying chain through recognition of and by the Other, the subject is forever barred from knowledge of the Other. Juliet Flower MacCannell sees the Lacanian notion of desire as recognition, as maintaining the history of the oppression of women because it is still phallocentric. Jorie Graham's poetry deploys the effects of this desire.

Recasting Moses: Narrative and Drama in the Dumbshow of Freud's "The Moses of Michelangelo." David Wagenknecht. Pp. 439-461.

Wagenknecht places Freud's essay, "The Moses of Michelangelo," alongside his other work, *Moses and Monotheism.* He observes an inability in Freud to choose between two different cultural identifications, that of Jew or of Gentile, between two different countries, two versions of parent, and two different emphases in sexual theory: bisexualism or patriarchalism. Studying the dramatics of gesture in "The Moses of Michelangelo," Wagenknecht notes that he whose wrath is directed at the makers of graven images is represented in Freud's essay as a graven image, in the effort to drive paranoid decomposition in the direction of oedipal idealization. Wagenknecht notes several stages: a first stage in which Freud's alter ego associates himself with the mob Moses is about to chastise, a second stage of conflict in which Moses remains quiescent and is no longer about to leap up, and a third phase in which the interpretation shifts to Moses' lap where his hand counteracts his violent impulse and is dallying with his beard.

Guys and Dolls: Exploratory Repetition and Maternal Subjectivity in the Fort/Da Game. Jay Watson. Pp. 463-503.

For Watson, Freud's discussion of the "Fort/Da Game" in *Beyond the Pleasure Principle* is really an interpretation in which Freud and his infant subject are in a

conspiracy to render the mother into a manipulable object. It is a story of the mother's power and desire, in that little Ernst is not playing the role of his more masterful self, powerful over his mother, but is assuming the more complex role of being his mother's subjective presence and assuming her power over him. The Fort/Da Game thus presents the mother's language in her own right, and it is the mother's desire rather than the father which splits the original dyadic fusion. Not only the loss of the mother but death itself is insinuated in this splitting. The Fort/Da Game is a "guy's" version of playing with dolls, playing at mothering by playing around with his beginnings and reproductive possibilities. Beyond mastery of the mother there can be the achievement by the child of a mutually ennobling relationship of identification and love, like a psychoanalytic interpretation which forgoes mastery.