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ON THE QUESTION OF SELF-DISCLOSURE BY THE ANALYST: ERROR OR ADVANCE IN TECHNIQUE?

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The question of self-disclosure by the analyst and its uses in treatment is an issue widely debated today. In this paper, the author reviews this controversial technique from historical and contemporary points of view, delineates several forms of self-disclosure, and, by means of several clinical examples, discusses the effects on the patient and the analytic process of utilizing one or another kind of self-disclosure in these particular situations.

My purpose in this paper is to discuss an issue in psychoanalytic work which arises with some frequency and which has been the focus of much interest and considerable controversy in recent years: self-disclosure on the part of the analyst.

Self-disclosure is a broad and nonspecific term which encompasses a wide variety of the analyst's self-revelatory behaviors. The behaviors, which can range from a one-word response to a question to extensive revelations about the personal life of the analyst, cannot be spoken of as belonging to a homogeneous group. Each instance of self-disclosure must be evaluated on its own terms in light of the clinical situation in which it occurs and its effect on the analytic process.

This paper, in somewhat different form, was originally presented as part of the panel, *Self-Disclosure – Analyst to Patient*, at the New York Psychoanalytic Institute, March 11, 1995.

In this paper, I will focus on three types of self-disclosure. The first, little discussed in the literature but one that constitutes a frequently utilized pathway for self-revelations, concerns disclosures that occur outside of the analyst's awareness through slips, errors, and other, often nonverbal, means. I will offer an example of a disclosure of this kind which had a significant impact on an analysis and which threw light on important transference-countertransference interactions taking place at the time.

The second and third types of disclosure involve deliberate acts on the part of the analyst: sharing with patients certain subjective experiences and answering particular types of questions. In the former instance, the kind of disclosure that I discuss in this paper is limited to the sharing of phenomena that arise in the analyst's mind in the course of an hour – an image, a fantasy, a memory, an affect, and the like. To illustrate this type of disclosure, I will cite two clinical examples. In one case, the disclosure had a surprising and quite positive effect, leading to the opening up of a previously stalemated treatment. In the other, the result was more problematic. While the latter disclosure fostered the gaining of a new and valuable insight, it became clear later on that it had also frightened the patient and had led to increased resistance and the unconscious concealment of certain transference responses.

With regard to the issue of answering questions, the kinds of queries that I refer to involve curiosity about such matters as books I have read, films I have seen, and my whereabouts when I am away from the office. As I discuss below, with certain patients the analytic work may be advanced rather than compromised by the analyst's answering such questions and then exploring their meaning, rather than deflecting them and seeking directly to uncover the thoughts and fantasies that gave rise to them.

It will be apparent that the self-revelation involved in the clinical examples I cite in this paper is of a limited sort; it is confined to the disclosure of the kind of information just mentioned. For some colleagues, however (Rothstein, 1997), any self-disclosure constitutes an error and always represents the unwarranted enactment of a countertransference response – behavior that has no place in proper analytic technique.

This restrictive attitude toward revelation by the analyst of his or her inner experiences, an attitude that in essence constitutes an unspoken taboo, has its roots in the early history of psychoanalysis.

The behavior of several of Freud's contemporaries, most notably Ferenczi's (1933) experiments with mutual analysis and his difficulty in maintaining clear boundaries in certain cases (behavior that constituted a threat to the public image of psychoanalysis), gave the notion of self-disclosure a bad name. In the minds of many traditional analysts, self-disclosure became linked with improprieties, with confessions of love and sexual passion, with acting out, and with misuse of the transference.

Partly in response to this situation, partly in reaction to his growing recognition of the powerful countertransference feelings inevitably stirred up by doing analytic work, and partly because there was a clear need among practitioners for technical guidelines, Freud (1912) formulated certain principles of technique. Emphasizing the importance of neutrality, abstinence, and analytic anonymity and invoking the model of the surgeon at work, these initial formulations set forth an approach that was quite stringent – more stringent, in fact, than Freud himself employed or that he believed applicable in all cases. From his later writings on technique (Freud, 1933, 1940), in fact, it became clear that Freud intended the principles he had enunciated to be regarded not as absolute rules, but as guidelines to be used flexibly as the clinical situation dictated.

Despite this caveat, for many years analysts adhered more or less closely not to the spirit of Freud's intent, but to the letter of the precepts that he articulated. Accepting with little question the blank screen model of the analyst, generations of colleagues operated on the belief that the analyst's sole task, in fact his or her only legitimate role, was to understand, clarify, and interpret the patient's material.

Interventions that were not strictly interpretive – spontaneous comments, for instance, that contained hints of suggestion, guidance, or opinion, or that reflected aspects of the analyst's personality – were denigrated as not the stuff of true analysis. Rarely, however, were the transactions that evoked such interventions or their effects on the analytic process further explored.

Although long recognized as an ever-present and inevitable as-

pect of the analytic situation, the analyst's subjectivity, and especially his or her countertransference reactions, were regarded primarily as sources of difficulty, as interferences with correct understanding and technique that were to be dealt with privately, either through personal analysis or self-analytic efforts.

This, at any rate, was the official stance embodied in classical technique. In practice, things were often otherwise. Many patients who were in treatment with the generation of analysts following Freud reported that their analyses were conducted in a far less formal way than the theories of the time dictated. In fact, the analyses were conducted in a manner closer to the way that Freud worked; spontaneous comments on the part of the analyst, the use of humor, and the offering of opinions or suggestions more or less thinly veiled as interpretations were not at all uncommon. Responding to the discrepancies that often existed between theory and practice and seeking to encompass the realities of the clinical situation under the umbrella of traditional theory, Eissler (1953) used the term "parameters" to designate those techniques that departed from the classical approach. Assigned to this category were many of the interventions just described, as well as those that involved the analyst's sharing a thought, an image, an affect, or a bit of personal history with the patient.

It was only in the 1980's, when the notion of analysis as an enterprise involving the interplay of two psychologies gained acceptance among a group of classically trained American analysts (Chused, 1991; McLaughlin, 1981, 1987, 1991; Poland, 1986; Renik, 1993a, 1993b; Schwaber, 1983, 1992), that study of the analyst's subjective experiences, including, but not limited to, countertransference reactions became a legitimate topic for investigation in this country. Elsewhere the Kleinian and British object relations schools had long regarded countertransference, in the broad sense of the analyst's subjective reactions, as an indispensable pathway for understanding projected and split-off aspects of the patient's psychology.

As interest in the intersubjective aspects of analysis grew – a development that took place with explosive speed in the United States – certain colleagues (Aron, 1991, 1996; Ehrenberg, 1992, 1995; Hoffman, 1991; Renik, 1995) began to pursue what, for them, seemed a natural extension of the intersubjective point of view. Given the

fact, now increasingly accepted, that the analyst's inner reactions properly used can be a source of valuable data, they reasoned, would it not follow that selective sharing of these experiences with patients could also prove to be a technique of great value, one that had the potential to enlarge an individual's understanding of his or her unconscious communications?

On the surface, the answer seemed to be yes, of course, that must be so. Clinical experience, however, has shown that the issue is far from a simple or straightforward one. In practice, the act of self-disclosure has turned out to be something quite different from the concept of it, as formulated theoretically. Fueled by motivations that often represent needs of the analyst as well as of the patient, and often having unforeseeable consequences, self-disclosure has proven to be a technique that requires the most careful and thoughtful evaluation.

From Freud's own personal experiences – he is said to have acknowledged that on several occasions he had come close to acting on his attraction to a female patient – he knew well the temptations faced by every analyst who is truly engaged in the analytic encounter. Powerful feelings of love and hate, of neediness, of anxiety, of sadness, and, though rarely discussed, of desire arise within us in response to the needs and passions of our patients. The work is arduous and at times we may find ourselves wishing for relief from the tensions that build up in the course of our working days. One way of doing this is to share some of our subjective experiences with patients. Though motivated in these situations by the analyst's needs, such behavior can easily be rationalized as a technique that serves the interests of the patient. Self-disclosure always carries this danger. In fact, until quite recently, concern about just such countertransference acting out on the part of the analyst, as well as adherence to the principle of analytic anonymity, has led to the view that self-disclosure of any kind constitutes a serious error. As a consequence, objective study of self-disclosure in its several forms and the efforts to evaluate its impact on patients and the analytic process has not yet been undertaken.

There is good reason, however, for the caution with which the field has approached the question of self-disclosure. For the patient, the analyst's words carry great weight. Because the patient is in a state

of regression and filters the analyst's comments through the prism of his or her own perceptions and conflicts, the patient often hears interventions in ways that are quite different from what the analyst intended. This disparity between what is sent and what is received, always a phenomenon that requires attention in analytic work, is of particular importance when, in an effort to foster insight into aspects of the patient's character of which the patient is unaware, the analyst discloses how she or he is experiencing these traits. Disclosures of this kind may unwittingly cause much pain and precipitate reactions that act not as spurs to the analytic work, but as powerful and enduring blocks to further progress.

It is also true, as we know, that certain revelations on the part of the analyst can limit or inhibit aspects of the patient's imagination and the free flow of fantasy. Since we are interested in the patient's creations, and since, in some instances, these are stimulated by nondisclosure and analytic anonymity, the use of self-revelation may work against our aims. If a patient knows, for instance, that I skied in Vermont during this past winter, it is unlikely that she or he will imagine me tanning myself on the beaches of Oahu. Clearly, this is the kind of limitation that traditional analysts cite as a technically important reason for avoiding self-disclosure of any kind. Such revelations, they maintain, inevitably muddy the waters, and, insofar as the patient's freedom to imagine and create is compromised, the analysis is impoverished.

While in theory this is true, in practice the situation is often otherwise. Nondisclosure and analytic anonymity, especially if rigidly and automatically applied, do not always serve patients' interests. In certain individuals – for instance, those who have had long experience with secretive, non-responsive parents or whose self-esteem is particularly fragile – the traditional analytic attitude with regard to self-disclosure may be experienced as hostile and may have an inhibiting effect rather than being liberating. Instead of functioning to open up communications and to free up the mind, it can shut it down. It is important to remember, too, that if, for a particular reason, I choose to reveal where I have been on a brief vacation, that surely does not put an end to my patients' fantasies. It may, in fact, prove to be a powerful stimulus to them. There remains much room for my

patient to fantasize, much to explore in his or her inner world. The patient, for instance, is quite free to imagine me, as often happens, as a tanglefoot novice on the slopes, nearly breaking my neck on the beginner's hill, or, less frequently, and regrettably a good deal less accurately, as completing the giant slalom in record time.

If self-disclosure, then, does have a place in our technique, what role does it play and how can it be effectively used? These are difficult questions to which no general answers can yet be given. We are dealing here with a clinical decision that depends entirely on the kind of patient we are working with, on the phase of the analysis, and on the nature of the transference-countertransference interactions that are in the ascendancy at the moment. For many analysts, the matter of self-disclosure is a new and comparatively untried aspect of technique. Cognizant of the opportunities for achieving fresh and emotionally meaningful insights that it offers, they are also aware of the pitfalls that can await them in its use.

When we discuss the issue of self-disclosure and seek to evaluate its place in our technique, it is important to remember that it is not a single, well-defined entity. As I have noted, it is many things with many faces, ranging from the sharing of a fleeting image to the revelation of complex attitudes and feelings. There is also the kind of self-disclosure that, although meaningful in the treatment, is carried out by means of an unconscious act on the part of the analyst. Some authors (Levenson, 1996) refer to this phenomenon as self-revelation, reserving the term self-disclosure for the conscious and deliberate sharing of information with patients. While useful for heuristic purposes, this distinction is not one usually adhered to in clinical work. For most colleagues, the idea of self-disclosure covers both aspects of the analyst's revelatory behavior – deliberate actions and those unconsciously enacted.

The latter route, however, is often neglected in discussions of self-disclosure. This omission has led in turn to the underestimation of the importance of this pathway for the transmission of countertransference and other unconscious communications on the part of the analyst. Such was the case in the following clinical example.

Some years ago, I was working with a gifted and attractive woman whom I liked and admired, but who found much to criticize in her

analyst. In fact, there was little about me, from my voice and appearance to my way of working, that she did not pick apart.

Surprisingly, however, her attitude toward me underwent a sudden change. For reasons that were quite mysterious, she began one hour to speak about me in a different way. All at once she admired my approach, the incisiveness of my comments, and what she regarded as my unflappable manner. She had nothing but sterling things to say about me, going so far as to suggest that despite our differences, we might turn out to be soul mates after all. Surprised by this turn of events, I had no explanation for it. Then, well into the session, a memory arose in my mind. It is a hot day in July, one of those scorchers that cause wise folk to take shelter in a movie theater or under a cold shower. I am sitting in the living room of our apartment wearing my bright yellow high school basketball team warm-up jacket. Sweat has soaked through my shirt and has begun to stain the jacket. Coming in and out of the room are my sister and one of her friends, an unusually attractive girl whom I want more than anything to impress. After passing me a few times, she pauses and speaks to me in a tone of obvious amusement.

"I couldn't help noticing that you are on the basketball team," she says in a not unkind voice. "That's terrific. I'll bet that you are good, too. But I don't think it's fair for the coach to insist that you wear your jackets in such hot weather just to advertise what terrific players he has on the team. I'll bet it would be all right if you took it off now."

Had the patient turned around then, she would have seen that my face was flushed with embarrassment at this unbidden memory. Where had it come from, I wondered, and what had it to do with the material of the hour? Pondering this question and coming up with no answer, I found myself glancing around the room, searching for a clue. Then my gaze fell on my desk. There in plain view was a recent copy of my college alumni magazine. It so happened that this is the same school that the patient's first and greatest love had attended and of which she had the most exalted opinion. I had no recollection whatever of this fact when I left the magazine on my desk, but now my motive – one not dissimilar to that of the sixteen-year-old sweltering in a warm-up jacket on a hot summer day – became painfully clear.

For reasons that I could now grasp, I had a need to alter the patient's perception of me, to impress her, and to deflect her criticism. These countertransference responses were so troublesome that they were expressed not directly through the usual channels of affect and fantasy, but through an enactment, a slip that threw a good deal of light on the kinds of transactions that were taking place between Ms. C and myself. This kind of unintentional revelation, I believe, often exerts a significant influence on the analytic material. Patients' perceptions of it, sometimes conscious, but often registered subliminally, find their way into their associations and dreams, and by detecting them there and bringing them to light, we can assess their influence.

With regard to the issue of intentional self-disclosure, there is one clinical problem with which all analysts must contend: the matter of answering questions. In traditional technique, questions are viewed as associations, elements in the patient's train of thought, and are rarely answered directly. Rather, an effort is made to uncover the thoughts and fantasies that gave rise to the question and, from the viewpoints of transference and resistance, to determine just how and why the question arose at the time that it did.

While in many – perhaps most – cases this is a useful technique, there are times when it is not. In some situations, for reasons peculiar to the patient's psychology and life history, it proves fruitless and counterproductive. Even under such circumstances, however, many analysts are reluctant to alter their way of working. Holding fast to the technique that they have learned, they continue not to answer questions and to pursue an exploratory approach. Not infrequently, this leads to increased resistance, which then becomes the focus of analytic scrutiny. The result, all too often, is a standoff, a treatment stalemated by intransigence on both sides of the couch. And unless this battle of wills can be correctly identified and effectively dealt with, either by means of interpretation or, as is often required, by a change in the analyst's approach, the analysis may become ensnared in an unresolvable impasse.

In such situations, interpretation alone may not suffice to resolve the impasse. The analyst may have to utilize other options that may involve not only responding directly to certain questions, but at times sharing information about his or her attitudes, reactions, or thinking

processes.

Recently, a patient asked if I had seen the documentary film, *Hoop Dreams*. To this question, I could have responded in one of several ways. I could have remained silent and awaited further associations; I could have pointed out just when in the hour the question arose and focused on the meaning of this shift in associations; or I could have attempted to grasp the underlying motive for the question and, by passing the manifest content, speak directly to that issue.

I did none of these things, and the reason was simple. Repeatedly, if not doggedly, I had employed all of these techniques in the course of the analysis. At no time did they prove useful in fostering associations, in leading to the emergence of more material, or in otherwise promoting the analytic process. On the contrary, for reasons that had to do with the patient's early history of having lived in a traumatically unresponsive environment, they were continually misinterpreted and were responded to by reactions of withdrawal and shutting down that were automatic, hard-wired, and deeply entrenched. On the basis of this experience, then, I realized that a change of approach was mandatory if I had any hope of reaching this patient and preventing the development of an unresolvable impasse. Accordingly, when Mr. G inquired whether I had seen *Hoop Dreams*, I responded forthrightly. I confirmed that I had, and then, unexpectedly, I heard myself adding, "I found parts of it very moving."

"Which parts?" Mr. G wanted to know. At this question, a scene from the film arose in memory. This issue focused on the cruel expulsion of a black youth from a private school for nonpayment of tuition fees. This was a youngster who had been recruited by the school because of his talent as a basketball player. When the boy did not live up to his promise, his scholarship was withdrawn. Unable to pay the fees, he was forced to withdraw. Clearly depicted in this scene is the shame and humiliation experienced by the student and his family at being dropped in this fashion. I told Mr. G that it was this scene that I found so moving.

"I thought that was the one that you had in mind," he replied. "I could barely stand it myself. I nearly walked out."

As my patient spoke, it became clear to me what this exchange was all about. Mr. G had lost his job in the past month, a job that he'd

had for twenty years and that was his only source of income. Although he had some savings, he was very worried that they would not be sufficient to cover the cost of analysis, as well as his living expenses. Then he would be forced to drop his treatment.

A prideful man, Mr. G had hinted at, but had not actually articulated, this fear. It was in the air, however, and the scene in the film that I have described mobilized my patient's anxiety about it. By asking whether I had seen the film and wanting to know what it was that had touched me, Mr. G was indirectly asking what my response was to his situation. If he could no longer afford my fee, he wanted to know, how would I handle this crisis.

In this way, we could get into matters that were of the greatest importance and that Mr. G had long avoided: his emotional investment in the analysis and our relationship, his fantasies about what our work meant to me, and his unspoken ideas about what sacrifices both of us would have to make to sustain it.

Of course, I was not consciously aware of all of this when my patient posed his question. Having seen the film, however, whose central theme was the collapse and drying up of dreams, in retrospect it seems likely that I sensed that Mr. G's concerns about being dropped from treatment had prompted his query. Whether or not this was the case, however, I would have answered Mr. G's question for reasons that I have noted. Although on the conscious level he understood why, earlier in the treatment, I sought to explore the meaning of his questions rather than answer them directly, he experienced my failure to do so as a harsh rejection, a slap in the face, and evidence that I did not respect him. As a result of prolonged analytic work focused on this issue, he was ultimately able to come in touch with the childhood roots of this extreme sensitivity. Useful as it was in giving him some perspective on reactions that troubled and bewildered him, however, this insight did not appreciably change the way he felt. As a consequence, I recognized that further efforts to employ our usual techniques would not be productive. Far more effective, I realized, was to respond directly to Mr. G's queries, to exchange thoughts, ideas, and opinions with him, and through that kind of engagement, approach the underlying issues that gave rise to his questions.

This is what took place in the example that I have cited. Although

I did not know what might develop as a result of my answering Mr. G's question about the film, I imagined that something both interesting and pertinent to Mr. G's conflicts would arise as a result of our discussing it. This had been my experience with this patient, just as it had been my experience that not answering his questions provoked a state of withdrawal, covert hostility, and increased resistance.

Quite different is my approach to Mr. F, a man who regularly – and relentlessly – bombards me with questions. Although to give myself a breather from his ceaseless onslaught, I sometimes find myself answering a question directly, usually I refrain from doing so. Instead, I focus on Mr. F's behavior in relation to me. I've learned that his behavior often expresses covert rage as well as an ongoing effort to avoid self-understanding through action and the projection of inner conflicts. When it seems appropriate to do so, I interpret the defensive maneuver involved – Mr. F's need to turn the tables on those who persecuted him and, in the transference, to make me suffer as he suffered. At the same time, he is identified with me as the helpless, overwhelmed child.

In Mr. F's case, in other words, the content of the question is far less important than its place in his associations and the tone and manner with which it is asked. The central issue with which we must grapple is Mr. F's aggression: his wish to hurt and defeat me, and to render me confused and helpless. To answer his questions, to deal directly with their manifest content, in other words, would, in this instance, be to enter into a collusion with my patient – a collusion aimed at avoiding the hard and painful confrontations with Mr. F, as well as the feelings that he evokes in me: issues that are at the heart of Mr. F's psychology and of his treatment.

When the question that the patient asks is a personal one, the issue becomes more complicated. "Where are you going on vacation?" Mr. L wants to know. In addition to containing important subtexts, such a question intrudes on our personal domain. For these and other reasons, including the strong influences on us of our theory and our training, we are usually quick in deflecting this kind of question, focusing instead on the motives that prompt it. While, again, this can be a useful approach, it, too, can become routinized and unproductive. Only occasionally, in my experience, has the approach

favored by many colleagues of asking, "What comes to mind?" in response to such a question yielded something truly useful. Not infrequently, I find, the patient's thoughts turn to a kind of intellectualized speculation which is of limited value in understanding his or her inner world. While no doubt some underlying fantasies fuel these speculations, these are often so heavily encased in intellectualization, so removed from affect, that they lack life and authenticity. Used primarily in the service of defense, these speculations often protect against the emergence of more genuine responses.

Consider another approach. In the case of Mr. L, a man who, like Mr. G, has not responded productively to efforts to explore the meanings of his questions, I reply to his query "Where are you going on vacation?" with the direct response, "Colorado, where I'll be doing some skiing."

Intrigued by this reply, Mr. L responds with a bit of irony, "No doubt on double black diamonds," he says in a tone of obvious amusement.

"Naturally," I agree, in tongue-in-cheek fashion, "I'm strictly a black diamond man."

"What is this, some kind of comic routine?" he persists. "Theodore Reik on skis? Give me a break. The only black diamonds you know are in a deck of cards, and I doubt if you've ever opened one."

What is going on here? What is this banter all about? Why have I entered into it? It is my effort, quite spontaneous, to pursue a theme that has recently developed in treatment: Mr. L's intense competition with me. Relating to his envy of, and fierce competitive feelings toward, an older brother, this issue is one that Mr. L has not been able to approach directly in the transference. Nor has he been able to speak of it when it arises in displaced form in extratransference settings. It has been too threatening for him to do so. He can, however, express his fantasies when they are cloaked in the guise of banter and playfulness. This vehicle allows Mr. L to use humor as an agent that leavens his hostility (Bader, 1993).

I have observed this, and without consciously planning to do so, have made some alterations in my technique so as to be able to find a way of talking with Mr. L about this centrally important issue. Thus, in recent months, I have found myself engaging in repartee and ban-

ter with him, attempting, I believe, to take advantage of a comparatively new pathway that has opened up in treatment.

A reader might say that this is an enactment on my part, that I am playing into my patient's resistance and am living something out with him; that countertransference issues must be involved in my engaging Mr. L in this way. And she would have a point. As a younger brother, Mr. L quite readily stimulates competitive feelings in me, as older brother, and I am aware that in employing the technique that I have adopted, I run the risk of enacting old scenarios from my own history. Nonetheless, I've found that offering something of myself for Mr. L to latch onto as a target area, so to speak, has proven to be an extremely useful approach. As with Mr. G, I have discovered that responding directly to questions and using the exchanges between Mr. L and myself as a wedge to open up other more basic issues are far more fruitful than the standard techniques of parrying questions, attempting to explore their roots, or focusing on their place in the patient's associations.

What this tells us, I believe, is an old but important truth. Analytic technique, which is the form that we employ in our art, must follow function. To be effective in analysis, we must frequently adjust our approach to the material at hand. In a number of cases, this means responding to patients with a directness that may include the disclosure of a piece of personal information or the sharing of a subjective experience. This is a directness of response, however, whose aim is indirect, whose purpose is to discover new and sometimes untried routes to the inner worlds of our patients.

When it comes to the use of our subjective reactions to patients, however, the problem is a particularly difficult and challenging one. Is it useful for patients to know how they are affecting others, including their analysts? I believe that in selected cases, such knowledge can constitute an important aspect of insight and self-understanding. Too often patients deny the effect that they have on others, project their impulses onto their objects, and split off and disown certain unacceptable parts of themselves. Interpretations that employ such phrases as "your aggression," "your sexual feelings," and the like, often become absorbed into a network of intellectual and obsessional defenses and are rendered ineffectual. Thus, although much is talked

about and much understood, the patients do not truly confront the force of their impulses and the impact of their actions on those around them. Yet sharing with a patient how one reacts to that person is a tricky business. Potentially helpful, it is also fraught with snares and traps into which the unwary analyst can easily fall. As I mentioned before, the analyst's words carry great weight, and if we choose to share our reactions to patients with them, we must be aware that what we say may have an enduring effect on those individuals. It is partly for this reason that, traditionally, analysts have kept their subjective reactions to themselves, seeking to utilize them in the service of understanding their patients, but not otherwise disclosing them.

I have found that while selective sharing of one's reactions to patients can be extremely useful, a price is often paid for doing so, a price that may not surface for some time. Here is a brief example of what I mean.

About ten years ago, I began work with a woman who had become an aggressive individual as the result of profound traumas suffered in early childhood. Her aggression, however, was always expressed indirectly, through provocative questions, intellectual disagreements, quotations from one's detractors, and the like. For some time, Ms. K had been attacking me in this manner, subtly but forcefully putting me down, undermining my efforts to help her, and failing to respond positively to anything that I offered. In response to these indirect attacks, I would often feel my guts tighten up, and I would find myself becoming tense.

One day, when Ms. K's assault on me was particularly strong and unnerving, I must have responded by looking troubled. She asked me what was wrong. Before I knew what was happening, I found myself sharing some of my feelings with her. I told her that I felt my guts tightening up as I listened to her and that I thought this was in reaction to what was happening between us. I told her that I felt attacked, that she was expressing a great deal of aggression toward me in a concealed way, and that I believed that my physiological reaction was a response to the anger I felt over her veiled criticisms. Did she have any awareness, I asked, of what was happening between us?

Ms. K was silent for a while. She looked upset. Then, after a minute or two, she spoke. "I wasn't aware of that," she said. "I guess I

don't know what I'm doing or how I affect people. What you said just now is what my husband says. He claims that I'm always attacking him. I'm not aware of this. He has so many problems himself and is so ready to fight that I've dismissed what he says. I didn't believe it. But if you say it, you who know me so well and whom I trust to be honest, I've got to believe it's true."

While this unplanned and uncontrolled intervention was not a particularly skilled one – it would have been far better to have shown Ms. K how, in indirect and subtle ways, she was attempting to induce in me the very feelings of impotence, despair, and rage that she regularly experienced in relation to men – it proved useful in some respects. The patient came in touch with her underlying rage and the covert way that she expressed it in a manner that had not happened before. But this insight came at a price.

Some years later, Ms. K returned to that incident and revealed that my response to her had shocked and frightened her. She hadn't realized that she could really have an impact on me, that she had the power to upset me and cause me pain. She had always thought that she could say whatever she liked in analysis without worrying about the consequences. Wasn't that what was supposed to happen? When she realized that she could, in fact, upset me and make me angry, she became frightened of her own power. From that time on, she said, she thought that she had become somewhat inhibited, somewhat more cautious in what she said. Was my intervention worth the price? I am not sure. I leave it to the reader to think about.

Finally, I will describe another clinical example which involved my sharing of certain inner experiences with a patient. In this case, I am more confident that my act of self-disclosure, which involved revealing the way that I experienced the patient's behavior, helped him to truly understand an important aspect of his character for the first time.

For some years, I worked with a man whose father had been maimed in a serious accident during his son's adolescence. A moody, irascible, and depressed man, the father would often withdraw into a state of total isolation. For days on end, he would wander about the house chain-smoking cigarettes, mute and unapproachable, a solitary figure lost in memories.

My patient, Mr. D, would often withdraw in similar ways, especially when he was angry with me for missing sessions. He, too, became silent, remote, and unapproachable. For my part, I interpreted the various elements that contributed to this behavior, including his rage at me for abandoning him, his wish to strike back through withdrawal, and, most prominently, his identification with the father whom he longed to please but whom he also experienced as hurtful and rejecting.

These interpretations seemed to have little effect. Although Mr. D understood them and would often acknowledge their accuracy, they seemed not to touch him. They registered intellectually and induced intellectual assent, but that was all. They did not reach him emotionally, nor did they seem in any way to influence his behavior.

In the face of this reaction, I lost no opportunity to confront my patient's resistances and the motivations that fed them. All of the factors involved, from Mr. D's fear of passive acceptance of my interpretations to his covert aggression in dismissing them, were interpreted ad nauseam. Still nothing happened. No lessening of his resistances was apparent.

Following a brief vacation of mine, Mr. D went into one of his withdrawn states that was even deeper this time, more entrenched and more sustained than its predecessors. Sitting there, I felt totally shut out, totally helpless, unable by any means to reach this man. For some time I remained quiet. There was silence in the room. Then, unconsciously propelled by what I was experiencing, I found myself speaking, saying things that I had not said before.

I told Mr. D that I thought I knew from my own feelings of the moment what he must have experienced as a child, trying to make contact with a father who was utterly unreachable. I said that when he went into one of his periods of withdrawal, as he was doing now, I felt shut out and helpless. I experienced myself as completely cut off from him, as though a wall of steel had come between us. And I told him that I knew that no matter what I said or did, there was no way that I could reach him. He had become, I said, the father sitting in darkness, the father who, in his hurt and anger, shut out the world.

Mr. D's response took me by surprise. He broke into tears and wept for several minutes, unable to stop, unable to stem the tide. When

finally he could speak, he said simply, "I never thought that you really understood. Now I feel that you do. I've heard what you've said before, but you seemed to be speaking words – something abstract and analytic, not felt and genuine."

In substance, my interpretation on that occasion was no different from the ones that I had offered many times before. To Mr. D, though, the difference was enormous. He experienced me as conveying a sense of authenticity that had not previously been there. In particular, the fact of my having spoken of my own feelings had a great deal of meaning for him. In the weeks following my intervention, he returned frequently to this idea.

"There really wasn't anything new in what you said to me about how I shut you out the way my father shut me out of his life. You've said the same thing before. But I heard it differently this time. The fact that you made it personal and told me how I was affecting you had a big impact on me. It made the whole thing real to me. Your feelings spoke in a way that your words didn't. I can believe people when I know they have experienced what I have experienced. That's important to me."

In time, as we explored my intervention and Mr. D's response to it, certain meanings that it had for him became clear. He felt that at last he had reached me. He had managed to penetrate my defenses and had caused me to feel as excluded, frustrated, and helpless as he had been. He wanted me to know first-hand what he had to contend with, not only as a means of understanding his pain, but because sadistic impulses involving a wish to cause me similar pain also motivated his behavior. He came to recognize these factors in himself, just as in adolescence he had recognized them in his father. This realization took him a long way toward modifying his behavior. Could this level of insight have been achieved if I had simply utilized standard technique and continued interpreting as I had done before? I don't know the answer to that question. Possibly it could have. My own private hunch, though, is that the analytic work would have remained at the intellectualized and rather unproductive level at which it had been operating for some time.

Clearly, disclosing what I was experiencing functioned in a number of ways and on a number of levels for both patient and analyst.

Our transaction both mobilized and was mobilized by important changes taking place in both of us. For reasons that had much to do with feelings of frustration and despair – feelings that must have disrupted my usual analyst-at-work defenses, I spoke to Mr. D in a way that I had not done before. Not only did I disclose some of what I was experiencing, but I did so with much feeling. This new way of speaking, intense and personal, had a powerful effect on Mr. D. Like his father before him, this man had built a solid wall around himself that protected him against feelings, his own and those of others. For him, feelings were disruptive. He imagined that they could destroy the fragile equilibrium he had constructed.

Somehow my words pierced that shell. Altering his defenses, they worked on my patient in a way that scores of interpretations similar in content had not. Why was this so? I cannot say. Possibly Mr. D knew that he had reached me and that my feelings spoke in a way that my words could not. Perhaps he was touched by the fact that I spoke personally; that at that moment I was no longer the doctor-father whom he feared and had to hide from – not the same transference figure whose presence evoked in him a set of old, instantaneous, and seemingly unalterable responses. Or perhaps it was simply that by the way I spoke, Mr. D knew that I cared about him and his welfare, knowledge that is not always conveyed in the style and manner of our interpretations. Although we have a number of theories of therapeutic action, instances of this kind highlight how little we actually know and how much we have yet to learn about how the mind shifts and changes in response to unconscious communications between patient and analyst.

In seeking better understanding of the complex communicative processes that take place between patient and analyst in the analytic situation and how these processes can be turned to therapeutic advantage, a number of colleagues, particularly those trained in the Kleinian tradition, have focused on the phenomenon of projective identification as a key explanatory concept. These colleagues argue that in analysis, warded-off and split-off parts of the self-representation, as well as internalized negative object representations, are regularly projected and experienced as coming from the analyst, whose reactions must then be contained and controlled. They maintain that

selective self-disclosure allows the patient to grasp these unconscious defensive maneuvers in a clear, direct, and nonintellectual way. It is through the analyst's self-disclosures, in other words, that the patient is able to come in touch with disavowed and unacknowledged parts of him/herself.

Bollas (1987) puts the matter this way.

> If such interpreting [of the analyst's subjectivity] is developed responsibly and judiciously, the analysis is enhanced because the analyst is able to release certain countertransference states for elaboration and, in so doing, he makes certain split-off elements of the patient available for knowing and analyzing. Since so much of the psychic life in the clinical setting is within the analyst, one of our emerging technical difficulties is how either to give back to the patient what he has lost, or bring to his attention those parts of himself that he may never have known (p. 207).

In addition to underlining the importance of this process of reclaiming aspects of the self-representation and the role that the analyst's sharing his or her subjectivity plays in it, Bollas points to another value of self-disclosure. Emphasizing the importance of the analyst's viewing his or her own thoughts in the manner that Winnicott did – that is, as objects to be put before the patient so that they can be "played with, kicked around, mulled over, torn to pieces" (p. 206) – rather than as the official version of the truth, Bollas suggests that by sharing their thoughts, analysts facilitate the analytic process and help patients come in touch with their inner experiences.

> If the psychoanalyst has a particular kind of relation to his own interpretations as possible truth-bearing objects, and so possesses a capacity to release the patient for new self experiences, then it is possible to disclose his subjective states of mind to the analysand. The aim of releasing the subjective state of mind into play is to reach the patient and provide him with a scrap of material that facilitates the cumulative elaboration of his own internal states of being (p. 206).

Reiser (1997), too, has suggested that the analyst's sharing of certain inner experiences can advance the analytic experience. His neurophysiologic research indicates that memory banks in the analyst's brain are regularly activated by the patient's material, producing thoughts, images, and memories in the analyst that link with that material. This finding, he goes on to say, supports one of Isakower's (1963) original ideas: that the technique of selectively sharing certain images that arise in the mind of the analyst during an hour can have the effect of stimulating associations, raising preconscious thoughts and imaginations to the conscious level, and aiding the analytic process. Reiser's work, then, provides both neurophysiologic and clinical evidence to support the notion that selective sharing of the analyst's inner experiences can advance the analytic work.

One effect of self-disclosure that is alluded to but not sufficiently explored in some recent writings relates to the quality of the patient's experience when the analyst chooses to share subjective experiences. As Mr. D pointed out, while the content of the interpretations made may not differ in any substantial way from those offered before, the way that the patient experiences them is often quite different. And for some patients this difference carries a great deal of meaning. Patients often report a change in the atmosphere of the session to one of greater immediacy, intimacy, warmth, and connectedness. Resonating with centrally important fantasies and wishes in the patient that require careful analysis, this change may in turn have significant impact on the transference-countertransference alignment, the defensive systems of patient and analyst, and the access of each to preconscious material. As yet, however, the effects of self-disclosure on the analytic process have not been adequately studied. While some colleagues (Aron, 1996) describe alterations in the behavior of the patient, in the quality of the working alliance, and in the general movement of the analysis, evidence from careful clinical research is lacking. Such evidence could throw light on intrapsychic changes in both patient and analyst, as well as changes in the analytic process that may accompany the use of self-disclosure as a technique.

Research of another kind, however, may be relevant to the question of self-disclosure and its place in analytic technique. I am referring to the field of infant observation.

In recent years, the work of Fonagy and Target (1996), Main (1993), Stern (1985), and others has demonstrated how the young child's developing self representation relies on the mother's view of the child. Moreover, the child's ability to appreciate her own and another's mental life and to develop the capacity to understand how ideas and moods affect behavior is dependent on the self-reflective capacities of the mother. When these are lacking in mothers or are insufficiently developed, children frequently have difficulty in developing these essential functions; they often experience the world in so self-referential a way as to be continually wounded in relations with others.

It is possible – and this would seem to be an idea worth exploring – that in such cases analysts' abilities to demonstrate their self-reflective capacities and to share some of their thoughts and feelings with patients may play an important role in fostering and enhancing development. For certain individuals, work of this kind, along with interpretation and the gaining of insight, constitutes a valuable part of the treatment.

While this is most apparent in the case of the more disturbed patient whose self-representations are fluid, poorly formed, and highly subject to external influences, problems of a similar kind may be found in some neurotic individuals. In these cases, dynamic factors undoubtedly play an important role, but not an exclusive one. Some patients who rely a great deal on the views of others for their sense of self may be suffering not only from neurotic problems but also from a developmental problem that is not insignificant, although not as severe or pervasive as that with which the more troubled patient must contend. In such patients, difficulties in the mother-child relationship may have led to deficiencies in the building of a stable self-representation due to impairment in the child's ability to internalize the mother's perception of him or her or to identify with her self-reflective capacities. In these situations, insight and the working through of conflicts alone may not prove sufficient to achieve change. In addition to the interpretation of conflict, these patients, theoretically at least, may benefit from – and perhaps need to experience – a kind of neodevelopmental process in which their internalization of the analyst's view of them, as selectively disclosed in the course of the analytic work, aids in the

development of a more realistic self-representation. Whether or not disclosures of this kind on the part of the analyst actually contribute to such alterations in the patient's view of him/herself, however, remains to be seen.

For the present, then, we are left to grapple with the question of whether or not self-disclosure has a legitimate place in analytic technique. Many, if not most, analysts retain the traditional view that self-disclosure is a questionable technique fraught with potential problems, one that, if utilized at all, must be carried out selectively and with careful assessment of its impact on the patient.

In the case of Mr. D, this effort was far from a thoughtful, well-planned, or well-executed one. Occurring as a spontaneous, if not impulsive, action that was born of long frustration in reaching my patient, it nevertheless had a strong impact on the analytic process. Altering the atmosphere in sessions, it had the effect of shifting Mr. D's perception of his analyst, modifying his defenses, and contributing to the resolutions of a longstanding impasse. Clearly, these were important changes, and the analysis of them occupied a good deal of time in Mr. D's treatment. The fact, however, that they occurred in response to my sharing certain feelings with him and had not taken place before despite my repeated, and I believe essentially correct, interpretations of his behavior, has, along with other experiences of this kind, caused me to want to take a second look at the question of self-disclosure and its uses in certain cases.

It is possible that Freud's original views of the issue, based in large measure on early instinct theory and the blank screen model of the analyst and, in part, influenced by the excesses of his colleagues, are in need of some revision. I would not be surprised if, after we have studied the matter more thoroughly, we find a place in our technique for selective and creative disclosure by the analyst of certain of his or her inner experiences. If that method, in fact, is found to have value and comes into wider use, it will be important to remember that self-disclosure cannot be prescribed as a general technique. It is a delicate matter, one that can cause harm as well as prove beneficial. Whether to utilize it and in what way are not easy matters to decide. Such decisions can only be made at a given moment in the clinical situation. Used correctly, however, selective self-disclosure may sur-

prise us and prove to be an effective tool in our work, a tool that advances, rather than impedes, analytic progress.

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GETTING COLD FEET, DEFINING "SAFE-ENOUGH" BORDERS: DISSOCIATION, MULTIPLICITY, AND INTEGRATION IN THE ANALYST'S EXPERIENCE

BY JODY MESSLER DAVIES, PH.D.

This paper attempts to explore the fate of the analyst's multiple self/other organizations during times of heightened countertransferential enactment. It is suggested that such countertransference activity involves the "de-homogenization" of otherwise indecipherably integrated self/other constellations, evoked independently or in response to, but always in interaction with, the patient's own unique organization of multiple centers of psychic awareness and unconscious receptivity. An extended clinical example is used to illustrate the theoretical conceptualization.

Back in the "olden days" of psychoanalysis when analysts really believed that they knew what they knew, and meaning was something that one looked up in a dictionary rather than negotiated interpersonally, the one thing that analysts of all persuasions spoke about with even greater certainty than anything else was their ability to analyze and resolve transferences and to understand their own occasional, conflictually based countertransferences. Our current psychoanalytic

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milieu recognizes the simple naïveté of this statement and, one hopes, appreciates the nuances and complexities of real working through and psychic change with a steadily growing sophistication and subtlety.

We now recognize the transference-countertransference process as intrinsically and irreducibly interactive. "An interactive matrix," as Greenberg (1995) has termed it; "irreducibly subjective" as Renik (1993) has described it. Transferences are not distortions but competing, oftentimes conflicting, organizing schemas or interpersonal fantasies lying at the foundation of each participant's unique striving toward self-integration. They are sets of expectations which nourish the essential illusion that we live in a predictable world populated by knowable people. Transferences are not necessarily displacements from the past. Although they begin in our earliest formative relationships, such meaning schemas reorganize and reconfigure themselves throughout the life span in accord with ongoing interpersonal experience. As organizing schemas, transferences are not resolvable. Perhaps expandable, perhaps malleable to a certain extent, renegotiable in new contexts, but at the same time, entrenched in their devotion to old object ties and familiar outcomes. We therefore no longer emerge from our treatments "cured." We seek, rather, to familiarize ourselves with our conscious and unconscious preconceptions, thereby opening the door to new experience; to expand and enhance our familiarity with aspects of self previously unknown or unformed; and to seek and find others who will depart from the expected, those who will know us and touch us in a myriad of previously unimaginable ways.

Implicit within this conceptualization of the transference-countertransference process is a model of mind which I have articulated at greater length elsewhere (Davies, 1996, 1998; see also Bromberg, 1996; Mitchell, 1993; Pizer, 1996) but will repeat here briefly in order to put the present discussion into context. It is a model of mind which replaces the more linear, topographically organized, repression-based structures of classical analysis with a dissociative-integrative continuum along which mind, indeed the individual's experience of self at any given instance, reconfigures itself in accord with the present interpersonal moment. This model of mind involves viewing psychical processes as a kind of confederation of multiple, dynami-

cally interacting, but otherwise autonomous sub-organizations of internalized self and object representations which move in and out of conscious prominence depending upon the evocative potential of the current interpersonal moment. Within such a model, analysis of the transference involves allowing the interpersonal present, as it exists between patient and analyst to fill the moment, to invite a suspension of integrative processes and a temporary, iatrogenic intensification and exaggeration of particular constellations of self/other organization within the therapeutic dyad. The goal of such an analytic agenda is to invite into interpersonal enactment those dissociated aspects of self/other experience that have been rendered unconscious by dint of the individual's striving toward a state of equilibrium and integration. By making them conscious within the analytic relationship, patient and analyst potentiate a more inclusive redefinition of particular aspects of self/other interaction.

If we hypothesize the regular occurrence of such heightened dissociative process within the transference – the "de-homogenization" and intensification of particular self/other dyads – then it stands to reason that the analyst will be as swept up into the disorienting vortex of such potentially fragmenting forces as will the patient. An intermingling of disentangled, highly evocative patient/therapist self states will seek out alliances and misalliances in the ever more complex arena of transference-countertransference enactment. Such an analytic process requires that the analyst maintain an awareness of the multiplicity of self/other organizations that may infuse the treatment relationship, as well as an openness to the emergence of her own partially dissociated self experiences in relationship with or in response to the patient's shifting transference experiences.

Given the intricately choreographed intermingling of multiple self states, the multitudinous intersecting points of patient/therapist strength and vulnerability, which call to each other within intensely evocative and highly interactive relational analyses, it is indeed surprising that so little has been written about the analyst's increased vulnerability to disorganizing and potentially fragmenting dissociative processes within the transference-countertransference space. Indeed, it is the aim of this paper to pursue just such a project: to explore via an extended clinical vignette and some preliminary theo-

retical musings the fate of the analyst's areas of pain and vulnerability within the clinical encounter. How do we manage our own shifting self states within the analytic work? How do we maintain an awareness of multiplicity as a backdrop against which iatrogenically intensified countertransferential states will emerge and temporarily assume center stage? What form of safety, of holding, and potential space do we ourselves require in order to manage our vulnerabilities and fears in this most intimate of encounters? Can we keep our vulnerabilities out of our work? Indeed, should we? Does the analyst's safety-seeking affect or even implicitly guide her clinical choices? Does the patient assume any responsibility for the analyst's unconscious psychic safety?

I hope that there are few among us who still hold any illusions about their reasons for doing analytic work. The old notion that the analyst, by dint of training analysis, now holds some privileged access to superior mental health seems a form of rather arrogant self-protection and denial. We are who we are, most of us would now agree, in order to repair our ailing internal objects and heal ourselves and keep healing ourselves, over and over again. In a paper which seeks to deconstruct the myth of the invulnerable analyst, McLaughlin (1995) states:

> …what each of us needs from the other, whether on the couch or behind it, is at depth pretty much the same. We need to find in the other an affirming witness to the best that we hope we are, as well as an accepting and durable respondent to those worst aspects of ourselves that we fear we are (p. 434).
> Traditionally, we have expected this to be true for the patient. We have come to find it to be true for the analyst as well. Acknowledging this, we can be more ready to see how our needs suffuse all that we are and do in the work, and how we must endlessly be self-observing to discipline and optimize these tendencies that are both our strength and our liability (p. 461).

In discussing the analyst's vulnerabilities to countertransferential self state dissociation, I will make several assumptions. First, that as practitioners doing analytic work we seek to create not only a safe haven for our patients, but strive, also, to create a transitional space in which we ourselves have the most optimal access to our own unconscious process. I refer to "safety" here not in the regressive sense of avoiding

painful places but in the more Winnicottian ideal of holding, containment, and non-retaliatory expectations. Indeed, I will suggest that out of the myriad of possible directions at any given point involving clinical choice, we will often be unconsciously directed in pursuing aspects of the clinical encounter that we hope will optimize our own sense of safety, creativity, and the rich efflorescence of unconscious process and play.

Finally, I will suggest that rather than coming into the analytic endeavor eschewing our own need states and personal self-interests (see also Slavin and Kriegman, 1998), we must evolve a theory of clinical technique for relational analysis that recognizes the analytic encounter as one in which there are two participants coming together, attempting to create an optimal space in which to experience and process multiple aspects of who they both were, are, and might yet hope to become. We seek ways of reaching and touching each other, of nurturing, exciting, soothing, arousing, and ultimately healing the places that hurt. Within this intersubjective space, the analyst, too, wants to be reached, known, and recognized.

Of course, I realize that the clinical responsibilities to reach, recognize, and know are by no means symmetrical. The patient's feelings, needs, and conflicts over both are almost always in the foreground of the analytic work, and the most essential responsibility is the analyst's to help the patient. However, I will maintain, at least for myself at this point, that the most meaningful and potentially mutative psychoanalytic work proceeds on an unconscious trajectory toward a place in which the analyst's unconscious processes, the destabilization of her more integrated "professional self" (see Mitchell, 1997), the creative use of self-state shifts and temporary intensifications, can occur without the threat of overwhelming, potentially fragmenting anxiety, humiliation, or retaliatory expectation.

CLINICAL EXAMPLE

Consider the following series of clinical vignettes involving a patient I will call Daniel. Daniel was twenty-seven years old when he first came seeking psychotherapy with the vague sense that he needed some help

"putting things together." Indeed, my first impression of him was of a young man for whom nothing quite went together: clothes somewhat wrinkled and mismatched, long arms and legs that didn't quite work together in coordinated motion, thoughts that seemed scattered and undirected. He came for the first time on a bitterly cold day, and some of the first things that struck me were the thin socks and sandals he wore on his feet. Though I asked him about this, he simply replied offhandedly, "Oh, I never, ever get cold." Daniel was exceedingly bright, remarkably well read, and potentially attractive under his somewhat rumpled, ragged, and disorganized exterior: an interesting combination of creative genius and neglected little boy. I entertained both fantasies.

Daniel took to analysis as if he had been waiting for this moment all his life. Within the first month he was coming three and then four times a week, a schedule he has maintained to this day. However, despite the manifest eagerness, there was an odd, disconnected quality to the story of his life as it emerged in the first months of working together. In telling his story, Daniel seemed to be relaying a series of separate, unrelated events – well remembered, even emotionally full, but oddly disjointed from other occurrences or from any overriding attributions of meaning that would enable him to draw conclusions or construct any patterns of motivation and significance. There was a kind of intermediate dissociative process between the awareness of certain events and the attribution of meaning to those events. For example, Daniel told of coming home from school one day, around the age of fifteen, to find his mother lying on the kitchen floor with the gas on, all the windows closed, and a towel stuffed into the doorjamb. "You mean she had attempted suicide?" I naïvely asked. The patient looked shocked and then tearful. "Do you really think that's what she was doing?" He was incredulous.

And so, much of the early work involved weaving together the disparate, dissociated pieces of Daniel's story. Mother was episodically severely depressed, hospitalized intermittently, and given shock treatments when all else seemed to fail. The prevailing images were of mother lying in a darkened bedroom, heavily sedated, completely unavailable; of Daniel, himself sitting outside her bedroom door listening to her crying, feeling simultaneously enraged and utterly in-

ept; of a sadness and despair that was too heavy, too large for him to begin to comprehend, let alone manage. Occasionally, mother would emerge from her internal hell and swoop down upon Daniel in a feverish, desperate, frenetic attempt at some compensatory mothering. Here he remembered a physical stiffening of his body, a terrified attempt at "keeping her out," of managing his yearning and desire. He came to understand through the analytic work that fending her off was more than his badness, more, even, than his rage at her. It was also a self-protective awareness that taking her in would only lead to another abandonment, another heartbreak. And he already felt himself to be on the edge. He remembered the despair that would inevitably follow his inability to "be nourished" by mother during her episodic appearances, and he began to speculate about the connection between such moments and his current bouts of depression and interpersonal withdrawal. Daniel expressed frustration at the time constraints of analytic hours, my coming and going like his mother – "swooping down upon me with so many goodies, only to disappear again at the end of the hour!" We watched with a growing mutual interest the intricate dance of desire, yearning, dependency, humiliation, and withdrawal that defined the borders of our analytic relationship.

Daniel rarely spoke about his father, but when he did, he sketched the image of a man who was often away from home, avoiding contact with his depressed, mentally ill wife, drinking too much, highly critical and emotionally unavailable to his needy young son. "My job was to take care of mother so that he didn't have to," Daniel would explain. "I was expected to do her bidding, to do all of the things my father refused to, to be compassionate and understanding where he could be outraged and disgusted." I was troubled by Daniel's description of his relationship with father, for although his words were insightful, he would become somewhat dissociated whenever he spoke of him. His eyes would become heavily veiled and opaque, a look I have become used to referring to in my own mind (coined originally by a patient of mine) as "dead eyes." "Dead eyes" look inward only; they see only internal spaces, as if transfixed by some kind of horror. "Dead eyes" always make me worry, in a now familiar way, that somewhere a child has been betrayed. But Daniel spoke only of neglect

and loneliness.

My relationship with Daniel became very intense very quickly. From the outset there seemed a meeting of metaphor and of mind that led to the creation of an imagistically and affectively fertile analytic space. He seemed to take in everything I said with appreciation and gratitude, often commenting on how remarkable it was that I knew "exactly" what to say and how to say it, so that he could use pieces of his emotional life that had before seemed overwhelming. Indeed, he had learned well how to breathe life into a needy and depressed mother, but unlike his mother, Daniel's appreciation affected me. If Daniel's "father eyes" were "dead eyes," his "transference eyes" bespoke an intensity of desire and faith that began to make me feel both deeply nourished and decidedly uncomfortable. Was I promising too much? Were my comments too deep and penetrating? Could this kind of idealization be worked through slowly or was it destined to splinter and shatter irrevocably? Indeed, would the whole thing become eroticized in a way that would spiral out of control? Had that happened already?

Although I worried about the atmosphere of mutual seduction that seemed to be going on between us and the almost manic fervor with which Daniel embraced his unconscious, the analysis, and me, I was also aware that something deeply and mutually enriching and emotionally resonant lay at the heart of this analytic process. I tried to move between these two experiences, one of deep immersion and faith in our ability to work through what would come and the other of impending transference-countertransference catastrophe, with at least a modicum of equanimity, but this state of mind was often illusive.

As the facts of Daniel's story deepened within the context of our particular analytic relationship, some of the clues which had eluded understanding emerged more clearly. With time, I was allowed to peer into Daniel's "dead father eyes" to a relationship of truly profound neglect and sadistic emotional abuse. It appeared that Daniel's father would disappear for weeks at a time, even when his wife was most depressed, leaving his son in an essentially empty house, with a mother utterly incapable of caring for him. Even this barren environment was, however, to be preferred to times when father ruled absolutely

and vindictively through the intoxicated haze of alcohol-induced psychotic rages. Father's raison d'être at these times became the relentlessly sadistic humiliation of his young son. Daniel described with excruciating attention to psychic twists and turns the consummate skill of his father's cruelty and his own childhood victimization. Here at last was a place of some emotional intensity and intrapsychic concordance between Daniel and me, for such childhood experiences of burning humiliation and inexpressible rage were not unfamiliar pieces of my own growing up years. Not identical, to be sure, but close enough in their affective harmonies to resonate deeply and to open intricate intrapsychic passageways between us. Such shared areas of what Elkind (1992) has termed "primary vulnerability" must, it seems to me, unconsciously guide the analyst's sense of direction even before it can be articulated consciously. When such points of unconsciously resonating psychic vulnerability are brought to the fore, I believe that we can retrospectively see how they become nodal organizing lynchpins in the organization of transference-countertransference processes and clinical decision making.

In looking backward from this point, I could see how I had always tended to deal first with Daniel's basic proclivity to experience need and desire as profoundly humiliating. In the past I had intellectually explained this by believing that as long as need and humiliation were so intricately intertwined, everything he took in from me would be internalized with a commensurate sense of shame and defeat. It was a repeated attempt to climb out from under the paranoid-schizoid position to a place of some enhanced mutuality where the profound neglect that marked this patient's inner world could find nourishment outside the borders of shame. I believed myself, at this point, to be in touch with the multiple voices in which Daniel could speak and with which I could respond. Again in retrospect, I believe I was more in concordant touch (Racker, 1968) with the patient's experiences of shame and humiliation than with the potential for a complementary countertransferential reaction; that where such experiences have been inflicted, there lies in wait an identification with the aggressor that could make him the object of my own wish to humiliate and shame, and could also make me the victim of his rageful need to do unto others precisely what had been done to him.

My own experience of a kind of dissociated countertransference response came one afternoon when Daniel was relaying in gut-wrenching, affectively nuanced detail the extent of his father's sadism. He began to recall an incident which had been unavailable to him before, and as he spoke, he began to shake rather violently and uncontrollably. He seemed frightened by this unexpected reaction, and I tried to reassure him by suggesting that the shaking might be intimately involved in some way with the memory he was trying to articulate. Indeed, what Daniel was about to describe was an incident that occurred when he was about seven or eight years old. His father returned home one night, particularly drunk and particularly enraged, only to find his wife again sedated and unavailable. Daniel remembered crying because he was tired and hungry, and there had been no one home to feed him or put him to bed. Father flew into a rage and began beating his son, calling him a sissy and a weakling, saying that he needed a man to toughen him up, to teach him how hard life could really be. At that point, Daniel recalled how his father had ordered him to remove all of his clothing, including his shoes and socks, and had locked him on the family's back porch for what he remembered as an interminable length of time. It was the middle of winter and the porch was covered with ice encrusted snow. Daniel was still trembling. "It was so cold," he whispered.

Now, although I have heard many such horrific stories from my patients over the years, many in their concrete manifestations far worse, this story, coming from this patient, in the context of our particular relationship, was among the hardest to listen to. The next thing I knew, I was standing next to Daniel's chair wrapping a blanket around his shoulders, not quite sure how I had ended up there. I did remember reaching with a disembodied arm into the cabinet where I kept the blanket for my own occasional use, and then getting up out of my chair, but these were not considered actions. For me this was the most striking aspect of this countertransference enactment. Not that it occurred – for I could easily imagine thinking about doing something like this and then deciding that it was or was not the best course of action at the particular moment. (This could be debated at another point in a discussion of action and interpretation. Did the action open up or close off exploration?) But for the purposes of this paper, it was

the lack of just this kind of thoughtful consideration, the lack of conscious awareness that several alternatives might be open to me, the inability to consider the multiple meanings that such a gesture would have to my patient, that seemed remarkably inconsistent with the way my work usually goes. This was clearly an action that had proceeded from one naked, exposed, and humiliated child to another. It was an action that occurred from well within one particular transference-countertransference constellation and not, as we prefer to work, from an ever-moving point amidst several simultaneously interacting perspectives.

But Daniel was no slouch. As he left the session he stared at me intensely. "You know this place," he said. I nodded. "It explains a lot about the way we can talk to each other," he continued. "Yeah, I think it does," I responded. I then asked him if he had a blanket at home in case the shaking came back. "No, you forget," he said with his usual sense of irony, "I'm the guy who never gets cold." "I didn't forget," I replied, "I was just thinking that if our work goes well, you may find yourself needing one."

It would be hard to communicate how recognized and known I felt by my patient in this session, particularly in the last few moments; how healing this exchange felt for me, both in what I took from Daniel's understanding of my countertransference and in what I felt able to give to him. The problem lay in the fact that it was one-dimensional and in my lack of preparedness for what came in the session that followed. My total immersion in this one transference-countertransference paradigm left me blind to the other unattended-to places within this particular intrapsychic landscape, places more clearly discernible from outside the transference-countertransference enactment of the moment.

From the minute Daniel entered his next session, it became apparent that the mutuality and intimacy of the day before had been transformed. He stared at me with icy rage. "You're pitiful," he began. "You think you're so self-aware...all of you analysts...that you can be so giving and caring...Well I know it's all a crock of shit...You do what you do so that you can feel good about yourself...it has nothing to do with me...You must have been feeling pretty good about yourself last night...did you bother to think how I was feeling?"

As it was difficult to capture the power of the day before, it would be equally difficult in this paper to capture my shock, my hurt, the visceral sense of being deeply wounded that I felt in this moment. Daniel, of course, had no way of knowing that he was no longer speaking to his analyst, but had reduced her in his outrage to a humiliated young girl, not only caught feeling secretly good about herself, but arrogantly confusing a generous and caring gesture with the basest and most self-serving of motives. My patient had no way of knowing that he was treading dangerously close to troubled waters, and I was destabilized enough to be of little help in making this apparent or using it constructively. Struggling mightily to emerge from the role of victim to this sadistic humiliator, I, unfortunately, turned the tables again, retreating to that purely interpretive position on high, available to all of us at our most vulnerable moments. "Well," I countered (in what was surely one of my worst clinical moments), "it would appear that you've had some difficulty holding on to the intimacy that we were able to create here yesterday. I suppose that it's something we'll have to keep working on."

It was quite a mess, and it stayed that way for some time. I did much thinking, talking, dreaming, and remembering in my efforts to help the two of us out of the place into which our work had descended. Daniel, for his part, was fighting, too, to rediscover the trust and balance that had been so reliable a part of our work before these events transpired. Once past the hurt, we were both able to acknowledge how broadened a picture of what it meant to be a humiliated child had been provided by our mutual enactments; how both of us could see and respond to the hurt child within the other, but how each of us, too, had demonstrated an ability to turn this victimization into a finely honed weapon of assault. What did it mean to take pleasure in giving to another? To what extent was it generous, to what extent self-serving? Were these two mutually exclusive? Did they cancel each other out? The different self states which marked different transference-countertransference constellations each took their place in the foreground to be explored, felt to the fullest, fantasized and imagined about with a freeness that had not been possible before. Having already enacted the best and the worst that we could be with each other, there seemed so much less reason to hide in our attempts to under-

stand the multiple meanings of our interaction.

Ultimately, Daniel and I were able to reconstruct his internal experience on the night I had reached out to him with the blanket. Although he recalled feeling seen and touched and nourished, he also described a parallel experience of being too quickly penetrated and then exposed in his inability to reject my offer of warmth. He could acknowledge having seen through to a vulnerable place within me; how angry this made him, probably because of his mother's depression; and how frightened he had been of seeing me, of feeling himself to be an equal, of feeling himself to be a man, of feeling his own potential to touch, penetrate, hurt, or overwhelm. Ultimately, what he could not see through the haze of his humiliation, and what I had been unable to help him to see through the haze of my own, was how touched and nourished I had felt by his understanding of my experience in that session and in the broader context of our work as reflected in that session. It was, in the end, this insight, the ability to hear and truly apprehend his effect on me, that seemed to carry the greatest potential to change what had transpired between us from an experience of penetrating exposure and vulnerability, a paranoid-schizoid flip-flopping of only one needer and only one giver, to a moment of true mutuality and intersubjective recognition in which Daniel and I both felt held and nourished.

I cannot provide any closure to this story. Daniel's is still a treatment in progress. But I will close with an exchange we had toward the beginning of this winter. Daniel was talking about something I could not quite attend to when suddenly I blurted out, "You're wearing boots!" Gone were the socks and the sandals. He grinned broadly. "I've been waiting to see how long it would take you to notice." "Has it been very long?" I felt a moment of concern. "Oh, I think I'll let you worry about that," he said, reaching for a healthier, more playful, even flirtatious version of his sadism. "So tell me about the boots," I continued. "I don't know. My feet have been getting cold lately," he shrugged. "That's amazing," I said, probably grinning too broadly. For Daniel countered much too quickly, "But don't get too excited. It's only the toes!" "Toes are good," I told him, "I'll take the toes, and we'll work from there."

DISCUSSION

The psychoanalytic milieu in which I grew up and was trained would require that I look carefully at Daniel's response to my clinical intervention and ask honestly how this reaction speaks to the "rightness" or "wrongness" of what transpired between us. Did the emotional attunement of that night, Daniel's ability to speak openly and directly about parts of me that he had not allowed himself to engage before, his sense of being held and warmed – did these reactions imply that the transference-countertransference enactment between us had been a therapeutic one? Conversely, did his rage, contempt, and assaultiveness on the following day suggest an action that had been too penetrating, too affectively overwhelming, either incorrect or at the very least premature?

The difficulty here is not in articulating an answer, but with the question as so formed. For it rests upon a model of mind that I believe to be no longer compatible with contemporary psychoanalytic theory in general and our understanding of the transference-countertransference matrix in particular. The question presumes a linearly organized mind in which we address ourselves as analysts to the outermost layer of preconscious material primarily. From this place, the patient can respond in a more or less integrated way to both the affective attunement and the psychodynamic accuracy of the analyst's intervention. As clinicians working with this model, we look for a well-modulated emotional response and an enhancement of associative material in order to feel confident that we are on the right track.

My own clinical experience would suggest, however, that no intervention and no patient response are ever so immediate or so clearly tied to the patient's subsequent response. Though we construct our clinical interventions with certain conflicts in mind, we have, in fact, little control over where they ultimately land. Much like the seeds of a wind-blown dandelion that scatter and take root in places unknown, that which emanates in interpretive form from the analyst's particular intervention, her own construction of conscious, preconscious, and unconscious experience with the patient, seeds the patient's conscious, preconscious, and unconscious places in myriad ways that may

not become fully knowable (to the extent that they are ever fully knowable) for years to come. Likewise, the patient's response resonates with so many different parts of us that we are never in a position to objectively evaluate any one particular intervention from any one point in the treatment situation. We are confronted with a model of mind based on a loose organization of multiple experiencing and reacting centers, and a new psychoanalytic humility born of the need to acknowledge that we can never be quite sure, at any given moment, who within the patient is listening and who within the analyst is speaking.

So my own answer to the question of whether this particular intervention with Daniel was right or wrong would be to suggest that it was *neither* right *nor* wrong but *both* right *and* wrong to each of those parts touched by the moment. It emanated from multiple parts of my own being and immediately reorganized, like the turn of a child's kaleidoscope, the operative organizing relational matrices which gathered themselves around it. The analytic function, to my way of thinking, does not involve constructing the precisely accurate intervention at any one clinical juncture, but, rather, the holding within the analytic space of multiple patient/analyst levels of reaction and meaning, separating those reactions out from reactions wedded to the past, and thereby creating a new, more openly creative space for constructing emergent levels of emotional reactivity and meaning.

Daniel, the seven-year-old boy, provided me with a unique opportunity to forever change the way in which he would remember that horrible night of such traumatic overstimulation and psychic desolation. He opened a psychic doorway between us to a new kind of maternal experience that could nourish and warm him, an experience that would ultimately carry the potential to enliven both his body and spirit. I am convinced that Daniel, the boy, will never again remember that night with his father with quite the same affective despair, for it will always be associated in memory with another night, between us, in which his terror and need were more fully apprehended and responded to. For Daniel the seven-year-old and me as mother, that particular clinical moment could not have been more "right."

However, Daniel also saw a frightened and humiliated young girl who responded out of her own need to be rescued and warmed, a girl

who was too young and too frightened herself to be of much use in taking care of him. He was left with the frightening perception that we were children together, and still no one was at home to be a parent, to care for him. Perhaps no one was "running" the analysis. He did not want a sibling or another damaged adult whose needs he would have to worry about. Daniel with another damaged child and Daniel with his damaged, depressed mother were two other relational paradigms that organized themselves around this clinical moment and informed the emotional response to it. In holding these relational experiences, we were able to understand more deeply those aspects of his current interpersonal world that resonated with these transference-countertransference paradigms. We came to understand his attraction to and contempt for "needy" others, the way in which the stimulation of "neediness" within him was always ensconced within a passive feminine identification and accompanied by a profound sense of shame and mortification.

Daniel the seven-year-old also saw me as the sadistic, self-serving father, exploitive and cruel, stripping him of his defenses and reducing him to a shivering shell. He fought with me, competed with me, wanted nothing to do with me. At times he viewed the analysis itself as a trap in which to ensnare and humiliate him. He attributed to me the basest of Machiavellian motives; he raged at me and at times withdrew out of fear that he might do me real damage. Indeed, where I felt humiliated by his rage, my contemptuous response was not completely dissimilar to his father's, and where my agenda was to be a nurturing mother, it was clear that my needs as well as his were being served. Here we were able to explore his episodic rage reactions, as well as the tremendous difficulties with authority that had plagued Daniel's professional and academic lives. Equally important was Daniel's ability to begin to apprehend the aggressor inside of himself, that part of him who could be brutally contemptuous and penetratingly perceptive in his reactions when threatened.

But Daniel was not a seven-year-old boy. And Daniel as adult man experienced my "too accurate" perception of his terror and despair as intensely humiliating – its stimulation of years and years of unmet preoedipal yearning as penetrating in a way that threatened his very organization of self, particularly with regard to male gender. In re-

sponse to his emotionally absent mother and his abusive, sadistic, out-of-control father, Daniel had fashioned a male gender identity based on an omnipotent denial of all need states, a form of complete control and mastery of his destiny and desire. Any crack or fissure in this fortress automatically reduced Daniel to the shivering little boy on the back porch, and there was sorrowfully little middle ground between the success of his omnipotence and the dissolution of his experience of a masculine self. To want the blanket, to want me as giver of warmth, was incompatible with being and feeling like a man. These were the present interpersonal issues which emerged in Daniel as adult man in relation to an emotionally responsive mother. However, where Daniel's need to reject such nurturance became overwhelming, I believe that I resorted to the position of the little boy, who couldn't stop trying to reach out and heal his depressed mother. I could feel an almost frantic need to get through and sense some emotional responsiveness on his part. I could feel anxious and alternately despondent and enraged when these efforts failed. Where my efforts to heal became too penetrating, I believe that this was the operative transference-countertransference paradigm.

As Daniel is not a little boy, so I am not his mother. We therefore struggle as well with the relationship between adult man and adult woman as separate centers of mature desire and agency. Daniel is convinced, and remains convinced as I write, that for me to have seen him so often reduced to states of humiliation and terror, to have witnessed his inability to cure his mother and to control and ultimately defeat his raging father renders him, in my mind, an eternally defeated, whining, and hopelessly pitiful child. He believes that I will never see him as an attractive and sexually potent man. Likewise, to desire me as a woman he will never have immediately sends him back to the frigid porch, defeated, humiliated, and castrated. On my part, as adult woman within this analytic relationship, I search for ways that are neither too stimulating nor too possessive in which to let Daniel know that the defeated little boy is only one small part of my overall vision of him. I struggle with how to let him know that I admire the courage which he has brought to our analytic project and with which he has faced such devastating childhood terrors; that I am touched and not repelled by the vulnerability I have been permitted to see;

and that I feel honored rather than burdened by being chosen to accompany him on this most extraordinary internal journey. I believe that it is part of my job as his analyst to let him know that these things enhance rather than reduce his potency and attractiveness as a man. But I must do this in a way that does not bind him to me in incestuous re-enactment, but rather sets him free to express his desires where they can be more fully met.

These are only a few of the many, many relational matrices that organized themselves around this one particular clinical moment between Daniel and me, and this was only one out of countless moments that have transpired and continue to transpire between us. The clinical work which emerged from these interactions involved the full participation of the entire "cast of characters" I have described. The bereft little boy, the humiliated little girl, the mortified little boy, the depressed mother, the "swooping down" overwhelming mother, the available nurturing mother, the absent father, the sadistic and abusive father, etc., all became an improvisational troupe of players whose active participation in the analysis of different transference-countertransference processes enabled the clinical material to live itself out in the room, in a sense bringing the unconscious to life in what transpired between us. Each participant took his or her turn in the foreground of the clinical work and was afforded the opportunity via this kind of "therapeutic dissociation" (Davies, 1996) of remembering the past, experiencing the present, and imagining the future, unencumbered by the need to create an illusion of integration and linearity. I have tried to use this clinical material to demonstrate the constant breaking apart, reorganization, and reinterpretation of self/other states that become the basis of any relational analysis: the dissociation, multiplicity, and reintegration that create the emergence of new modes of emotional reactivity and meaning schemes for both patient and analyst alike.

CONCLUSIONS

I am aware that the clinical material I have chosen for this paper raises the important question of how much control the analyst

can and should maintain over her own unconscious process within the intersubjective domain and over the ultimate direction of the psychoanalytic process in general. As I stated at the outset of this paper, I believe unequivocally in the analyst's responsibility for the fate of the psychoanalytic endeavor with each patient. But where we must become immersed in our own and our patients' internal processes simultaneously, where we must live and breathe there in order to know those places more fully, temporary suspensions of intellectual, verbal, fully conscious processes will occur for the analyst as well as for the patient. As Freud (1915) stated so long ago,

> It is a very remarkable thing that the *Ucs.* of one human being can react upon that of another, without passing through the *Cs.* This deserves closer investigation, especially with a view to finding out whether preconscious activity can be excluded as playing a part in it; but, descriptively speaking, the fact is incontestable (p. 194)

It is not my intention to suggest that such experiences of relatively unmediated responsiveness become a reified aspect of psychoanalytic technique, that they are to be actively sought after or mimicked in the analytic situation. My point, rather, is to suggest that they are endemic to the analytic situation and will indeed occur regardless of one's theoretical orientation, model of mind, or years of personal analysis. They are, I believe, intrinsic to the mutual deep immersion in intrapsychic and intersubjective spaces potentiated by psychoanalytic work at the deepest levels of experience. My point is to suggest that they will occur whether we pay attention to them or not, and, in line with our psychoanalytic values, I believe that where prospective control and decision making over the direction of the analytic process temporarily eludes us, a scrupulous retrospective attempt at understanding and integration becomes part of our professional task.

Our new psychoanalytic milieu has ceased to value verbal insight and understanding above all else. Though we continue to rely on such processes, we have finally come to understand and accept the ineluctably interactive nature of psychoanalytic work. We seek a level of emotional resonance and empathic attunement that will facilitate

the emergence of intense, deeply moving affect states and interpersonal fantasies. Where I have offered some deeply personal clinical material, I have done so, in part, in order to demonstrate the inextricably intertwined presence of the intrapsychic and the interactive throughout the analysis of transference-countertransference processes, the constant infusion of unconscious fantasy into the therapeutic relationship by both participants in the analytic process.

As any treatment progresses, the analyst's immersion in her own internal psychic process must deepen and more freely engage in a fanciful and creative play with that of the patient. This is not a way of thinking more accurately about the nature of the particular analytic process, but rather a completely different manner of experiencing, a way of being with the patient and with oneself that brings into enhanced focus those aspects of unconscious or unformulated experience (see Stern, 1983) which could not otherwise be psychically represented and elaborated. The creation of such a "psychic dreamspace" (Davies, 1997) recognizes the limits and borders of rationality and form, the constraints of language and definition. Though we no longer hold to the unconscious as a fixed psychic structure containing the archives of the patient's historical past, we do seek the creative efflorescence of unconscious fantasy that retains a kind of primary process sensibility, as first described by Freud (1915). In this sense such a dreamspace of mutual unconscious participation and influence involves a sense of timelessness, a multiplicity born of the absence of internal contradiction, an emphasis on the processes of displacement, condensation, projection, and introjection, and the preeminence of psychic over external realities. In short this is a place in which fantasy rules, omnipotence survives, and boundaries fade. The impossible, the unimaginable, and the irreconcilable reign freely.

Like the explorers of old, we travel with our patients across this great and hazardous divide, from conscious to unconscious, from secondary to primary process modes of experience, in order to bring back the riches of far-off, fanciful places that we could not otherwise begin to imagine. We avail ourselves of what is beautiful, exotic, and enriching. We bring back such riches, integrating them into too old and too familiar ways of life, creating new schemas, emergent modes of being and being with, of construing experience and imbuing it

with fresh meaning.

As analysts we become, with time, more seasoned travelers, familiarizing ourselves with the terrain of conscious and unconscious spaces and with all of the intermediary stops along the way. We recognize that the quality, shape, and texture of each journey, the relative success with which we are able to traverse potential space, to reconfigure conscious and unconscious experience, to bring rationality to chaos and fanciful imaginings to our thought, all rest on the unique pairing of each particular patient/analyst dyad. As fellow psychoanalytic travelers on this highly personal and perilous journey, patient and analyst together come to realize with some trepidation and dread that we are oftentimes dependent upon each other for safe passage through these transformational straits. We must therefore negotiate in ever more effective and reliable ways how we will confront conflict and survive dangerous encounters. With each successful negotiation, the patient becomes less afraid of all that is new. However, the analyst grows safer too and becomes able to rely upon the developing analytic skills of the patient. Here I believe the analyst becomes a more hearty explorer, willing to take greater risks, to confront more intense dangers in order to enrich and enliven the quality of the overall journey. She comes to understand via a finely tuned unconscious communication that the patient has become able to provide certain critical holding functions for her, and she thus becomes capable of undertaking forays into the deeper recesses of her own unknown and irrational places.

It is not my intention to suggest that we burden our patients with such a responsibility for our well-being, that we communicate to them as a formal part of psychoanalytic technique that such is their responsibility. This would be unconscionable. Rather, I am suggesting that the analyst will often unconsciously make clinical choices which are designed to heighten her sense of safety. As I was inclined to focus my work with Daniel around issues of shame and humiliation even before the full unconscious meaning of these issues became clear to both of us, I believe that analysts are often able to understand only in retrospect how they have chosen to emphasize certain clinical issues over others in order to pave the way for the more emotionally intense countertransference issues that they unconsciously recognize as lying ahead. Here, the analyst unconsciously maximizes her own ability to

rely upon the patient's analytic skills when the psychoanalytic terrain becomes individually impassable. She may seek, first, to work through patient issues which touch upon her own areas of conflict and vulnerability, so that she can more effectively immerse herself in a deepening and intensifying analytic process. Surely we must recognize that it is not the patient's job to care for her analyst, to make her feel safe when the going gets rough. However, it is our job to recognize that as the therapeutic relationship deepens, taking a turn at caring for the analyst is precisely what the patient wants to do, and needs to be able to do in order to survive otherwise impassable hurdles (Searles, 1979). I often tell my patients that there are some life experiences which are simply too traumatizing and too overwhelming to be experienced and processed alone. We do not seek to become dependent upon each other; at these moments we simply are. The nature of the journey renders us inextricably intertwined for its duration. We create a place of such mutuality and interdependence, for only within such an interdependent place can we truly articulate and define the borders of our own agency and desire. Perhaps the recognition that such mutuality lies at the heart of a deepening analytic process is what we have always meant by the evolution of a therapeutic alliance.

Loewald (1979) describes his vision of the analytic relationship:

> As a special form of psychotherapy, psychoanalysis constitutes a unique mode of personal relationship. It shares certain aspects with other kinds of personal relationships, for instance with those between child and parent, patient and physician, student and teacher, between friends, and between lovers (p. 372).
> The psychoanalytic method of treatment requires simultaneously unusual restraints and endurance of frustration together with an uncommon quality and degree of spontaneity and freedom – and all this, although in different ways, from both partners (p. 373).

Perhaps, as presaged by Loewald, the question which most consumes contemporary analysts is how often and how far we may allow ourselves to wander on any given analytic journey, with any given analytic patient, without becoming dangerously lost along the way. Given our emphasis on mutuality (Aron, 1996), on the intrinsically interactive influence of patient and analyst upon each other (Mitchell, 1997),

on the qualities of unconscious immersion, playfulness, and spontaneity, how do we define the "safe-enough" borders that mark the appropriate limits of this most unusual relationship?

"Safe-enough" analyses are not easily defined. They depend in large measure upon the particular dyad involved. However, the effort to formulate the question and the commitment to ask it of ourselves on a regular basis becomes, for me, more essential than the impossible task of articulating a precise and theoretically reified answer. What answer we can begin to frame as a working model of both possibilities and limits in the psychoanalytic relationship will, it seems to me, be composed of an oscillating rhythm of points and counterpoints, a balance between moments of adventure and risk that enhance one's sense of mastery and competence and the moments of necessary retreat to safe havens in which we regroup and refuel in preparation for the next challenge. Hoffman (1998) has referred to this as the dialectical interplay between ritual and spontaneity in psychoanalytic work.

Any analysis consists of infinite moments, some remarkable, most not, in which conscious controls are temporarily loosened and suspended, in which new constellations of self/other experience emerge into consciousness, followed by attempts at defining, naming, and integrating these previously unconscious schemas into an enhanced understanding of our current interpersonal experience. I become concerned when I read about "mutual analyses," "mutual regressions," or "analyst surrenders" that do not make clear that although we lose ourselves again and again in our own unconscious vulnerabilities, the regression in psychoanalysis is primarily (though not exclusively) the patient's, and the focus must keep returning (though it will and must wander) to the patient's unconscious process. This is the only way I know to ensure that the analytic work we do will involve a full affective, cognitive, physiological integration of previously dissociated relational experience, and not a downwardly spiraling, out-of-control regression, more consistent with dissociated re-enactments and retraumatizations.

Such a psychoanalytic journey, from self state to self state, between past and present, from unconscious to conscious modes of experience, oscillating in focus between self and other, is a dizzying, destabilizing, and occasionally overwhelming project. As analysts we

strive to keep our itinerary in mind, to maintain our orientation, to know more or less in what direction we are heading. We attempt to strike the optimal balance between the reliable and trustworthy main highways that will clearly get us where we are going and the scenically enriching back roads that will determine the beauty and quality which we will ultimately remember about the experience. I believe that the analyst must be prepared, given the complexity of what she is about, to feel lost and out of control, to sometimes "wander" in an effort to find herself again. Indeed, if we do not lose ourselves along the way, we will conduct a trip in which we see only the known and familiar spots; we will never happen upon those special moments of unexpected delight hidden off the beaten track. All of us who have traveled can remember with unequaled delight those moments of meandering, somewhat lost, of turning an unfamiliar corner to be amply rewarded for our momentary anxieties by the breathtaking vision of exquisite and completely unanticipated vistas. For me, my psychoanalytic work with a patient never feels quite right unless our journey has included at least several such moments, experienced and shared together.

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SELF-ENVY AND INTRAPSYCHIC INTERPRETATION

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Self-envy is described as the consequence of an early split between different part objects which form the structure of the oedipus complex. This takes place between an excluded destructive child part and another part usually modeled on a harmonic parental couple or on a creative and successful adult. The former will attack, paralyze, or destroy the latter, out of envy within the self. There are three main advantages in using an intrapsychic interpretation: (a) avoiding possible transference collusion in paranoid or perverse borderline structures; (b) eliminating possible persecutory anxiety from superego part objects projected into the analyst; and (c) putting the conflict in the right place, inasmuch as transference is a projection of internal conflicts. Clinical material is presented.

In 1949, Ludwig Binswanger, the existential psychiatrist, conceived of the human being as immersed in three different kinds of interacting worlds: *umwelt,* or environmental; *mitwelt,* defining the individual's continuous relation with other people; and *eigenwelt,* representing each one's own inner and intimate world. "Classical psychoanalysis," said Binswanger (1947) "has only a shadowy, epiphenomenal concept of *mitwelt* and no real concept of *eigenwelt*" (p. 49). If I were to extrapolate these notions and compare them with the different forms of interpretation as they are known today, *umwelt* and *mitwelt* could correspond to extratransference and transference interpretations respectively. *Eigenwelt* seems to be left out of this picture, at least concerning the metapsychology of the interpretation, as if Binswanger's assumption

were still appropriate, and interaction of inner elements within the self were not yet provided with a necessary relevance.

By *intrapsychic* I am not referring only to a concept synonymous to "inner world" or "reality structure," but also to the complex and dynamic interaction of inner part objects within the self, in a manner similar to Freud's expression – although never elaborated further by him – that "all the interplay between an external object and the ego as a whole…may possibly be repeated upon this *new scene of action within the ego"* (1921, p. 130, italics added).

Melanie Klein's (1946) subsequent understanding of the convoluted organization of the inner self, including splitting of the ego, part and total object relationships, and primitive mechanisms of defense, such as projective and introjective identification, has undoubtedly provided a better perspective for understanding the interaction between inner part objects and its powerful effect on the outcome of the analysis. These concepts have been further elaborated by other authors, such as Paula Heimann, who in 1952 referred to "intrapsychic projection," while describing the dynamics of paranoid states. She stated:

> ...but I did not understand how such intra-psychic projection took place, until I came to appreciate the part played by the splitting mechanisms...I realized that intra-psychic projection is preceded by a split in the ego (p. 210).

Heimann described the presence of mechanisms of introjection, dissociation, and intrapsychic projection as a consequence of the incorporation of a hated object that would eventually give way to an interaction between the ego and a dissociated aspect of itself containing the introjected hated object. Rosenfeld (1971) has described the existence of a complex destructive mechanism of different part objects which function similarly to a "gang mafioso." Joseph (1975) referred to patients "difficult to reach," in whom splitting of the personality induced a resistance to the analysis, because one part tries to keep another, more needed aspect away from treatment. Greenberg (1975) described the existence of intrapsychic projective identification directed toward internal objects as a way to explain Freud's dynam-

ics of the lost object in "Mourning and Melancholia." Meltzer (1973) has referred to destructive narcissism as a part of the self that presents itself to another suffering good part, "as a protector from pain, as a servant to its sensuality and vanity and covertly as a brute and torturer" (p. 97). Steiner (1982) speaks of a "perverse relationship between different parts of the self," in patients in whom a narcissistic aspect of the personality could acquire an exaggerated power and control over healthy parts, inducing them to form a kind of perverse alliance. When the intricacy of these inner relationships are taken into account, "intrapsychic interpretation" of the interaction between each of them is absolutely necessary.

At least from a theoretical point of view, we could conclude that if the aim of extratransference interpretation would be to move toward transference interpretation, the purpose of the latter should be toward the understanding of intrapsychic interactions, i.e., to clarify the complex relationship between different part objects within the self, because, after all, transference is not the real fact, the final truth; it is only a fatalistic complication of continuous repetition of derivatives projected into the analyst. Intrapsychic, on the other hand, the interaction of part and total self-object representations, would be the end of the quest, the legitimate situation where all the interactions have been and are continuously taking place. Following this line, I have defined projective identification as a *defense that requires a specific form of narcissistic communication between two self objects, one inside the self and the other placed inside another person's self, representing an anonymous bystander, who almost always will suffer the consequence of its effects.* As we well know, introjection of projected objects and resolution of transference are important signals to be taken into account once termination of analysis has been considered.

The importance of intrapsychic interpretation became obvious to me while researching the dynamic of "self-envy" in borderline structures and has led me to attempt a brief description of self-envy at this time. The condition of self-envy results from, among other things, the interaction of different elements forming the oedipus complex (López-Corvo, 1992, 1994) – for instance, in cases in which a serious increment of envy has taken place during childhood between a child, who felt excluded, and the parental couple. This is an envy usually

related to different aspects of parental harmony, power, control, creativity, capacity to reproduce, and so on. Those envious feelings experienced by children toward their parents will remain inside as foreign and active objects, without ever being assimilated within the ego. When these children grow and become adults like their parents, they will then envy in themselves their own capacity to establish a harmonious relationship, as well as to create, or to exercise control, etc., just as they envied their own parents in the past. Because of the severity of the splitting, these feelings are not experienced as one's own, and it is this impression of extraneousness that allows envy to take place. I believe that self-envy is a more common conflict than we have thought.

Although I have in the past (López-Corvo, 1992, 1994) referred to clinical material about the dynamics of self-envy in more detail, I would like now to examine a case briefly. A twenty-four-year-old, Gregory, the older of two boys, has been in analysis for the last three years because of depressive bouts and other difficulties related to his studies. There was also a great envy of and rivalry with his younger brother, who the patient felt was favored by his parents, and, according to the patient, was just the opposite of himself: easygoing, with a lot of friends and very successful with women. However, it was pointed out to him what a poor academic achiever his brother was, in comparison with the patient's successful university accomplishments. Lately he has been working at a hospital in order to write his thesis and expects to graduate six months from now. Also, different from before, he has been missing sessions and is one month behind in his payments. He explained that lately he felt rather confused, was not functioning properly or working well on his thesis or in his job at the hospital, and his attendance record at the university was poor. It became clear that his graduation was causing a great deal of anxiety at that particular moment, inducing intense feelings of unconscious envy against the "graduating aspect" of himself, understood as a subtle but continuous attempt to undermine his desire to achieve. And this is exactly what I pointed out to him, his own inner difficulty between one aspect that wished to succeed and another that continuously and simultaneously spoiled his chances for success.

During the previous session, Gregory had talked about joining a volleyball team at the university, and as usual feared that he would unconsciously sabotage the games and make the team lose. He remem-

bered when he was in primary school and there had been a writing and spelling contest. Because he knew more English than the other students, he was asked to be the last one to compete. However, when his turn came, "I made the stupidest mistake you could think of, and my team, which was ahead, lost." He continued explaining that he has always been afraid of winning. Then I told him that he envied winners so much that he has to make sure he is not one of them.

At the next session, the last in November, he handed over a check with the payment from the month of October, already overdue. I made the comment that November was not included. He answered that lately he was very confused, that he was not doing anything right, and that he continued with the intention of repeating the same pattern of punishing himself before he was punished. After a silence, he remembered a dream:

> I was driving my car at night, but my vision was significantly blurred. Suddenly, I hit a man who was cutting the grass at one side of the highway. There was blood all over, and the car was badly dented. A lot of people started to walk toward me saying, "Now you are really in trouble. Look what you have done. You cannot continue driving if you cannot see right." But I continued driving, and further on I hit a woman on the sidewalk who was holding a child, killing them both and repeating the previous gory scene. Likewise, the people approached me insisting that I should not continue driving, but I persisted and the situation was repeated perhaps once again. I woke up sweating, very anxious and feeling very pleased that it was just a dream.

After a short silence and his giving no associations, I said that there were three main elements in the dream. A blind killer, several victims, and an accusing chorus. He added that it was like a Greek tragedy, like *Antigone* or some other tragedy where the chorus was always pointing out the truth. This "killer" aspect was attacking the working part in himself, as well as the possibility of becoming – after graduating – his mother's favored child (the woman with a child), attacking as well my "working patient" by missing sessions and the analyst also by not paying on time. "Blind" with envy, an excluded part object now introjected was destroying idealized aspects – of himself and of the others – that were also

introjected objects as part of his inner drama within the self.

There are at least two other situations, besides the dynamic of self-envy, in which intrapsychic interpretation can be very useful. I am thinking, in the first place, about the danger of a transference collusion in patients suffering from important perverse or paranoid psychopathology; second, about cases in which there is the possibility of projections of superego aspects into the analyst, and, as a consequence, the danger of the patient's experiencing most of the interpretations as accusations.

* * * * * * * * *

Let us look at a case in which intrapsychic interpretation is preferred in order to avoid a perverse homosexual collusion from a twenty-seven-year-old male, Ray, in his second year of analysis, who originally complained of difficulties with penile erection. Lately, we have observed a certain tendency that he has to repeat my interpretations, pursuing further whatever I might have expressed, adding to my hypothesis other interests of his own, or corroborating what I might have said. At one point, I had the impression that we were two analysts discussing the case of a patient who was not there. Afterwards, this changed into his tendency to complain continuously about not being able to accomplish what his parents expected of him: not working while studying, not having friends or dating several girls. His unfair accusations induced the countertransference feeling that he, like his parents, was also complaining that I was not helping him to achieve these goals. The unfairness of this demand also induced a desire to defend myself, and I recognized in the countertransference the presence of a certain anger, also acted out by him whenever he decided not to do what he felt his parents wanted. As I interpreted these aspects he started to remain silent for several minutes at the beginning of each session, complaining that he found it difficult to say exactly what he was thinking. The session I will now present was the first one after the Easter holiday. As usual, he remained silent for the first ten minutes.

> PATIENT: I always feel that I remain silent and that I waste my time. Sometimes I think before I come here about some things that I consider very important, and I say, I will say this to the doctor. But then I arrive here and I remain silent and say noth-

ing, and I start to think about other things, many things that go through my mind very rapidly, and whatever I was thinking before I don't think about any more, and then I say nothing, I become mute. And I remember what you once said, that I was preparing the sessions.

ANALYST: [I wish to interpret his resistance, his dissociation.] It seems as if there is one Ray who wishes to hide another Ray.

PATIENT: Well, I feel as if there is a part of me that is only mine, something very intimate, that it is only my own business. And I think, how could it be of any importance to the doctor if I tell him that the battery of my car died because I didn't use my car during the holidays, and that I have to recharge it, or that I have to go to the supermarket to get food because my parents are not here now?

ANALYST: [I think that I have to insist on overcoming the resistance, the dissociation, but also help him see that what he is leaving out is perhaps very important.] Perhaps you're afraid to let yourself know that I could be very important to you and that you might need me; that while I was away, you felt uncharged and empty and that now you are coming back here to recharge yourself. Perhaps you also feel angry because you had to feed yourself alone.

PATIENT: [Silent for a few minutes.] In the religious books like the Torah, the Rabbi searches for all sorts of words in order to find all kinds of meanings. For instance, if such a word is repeated several times in a paragraph, that would mean that a war against Iraq was going to take place in 1990, as if something that was said so many years ago, could have something to do with the present time, as if they already knew what was going to happen. And if I were to ask, "Well, Rabbi, prove to me that what you are saying is true," I feel that it would be an impudence, that I would be disrespectful of him. Here I feel the same way, that when you say that the battery is uncharged, I wonder what in the heck has this to do with me. I feel like

saying also, "Well, Doctor, prove it to me," but I feel that it will be disrespectful of you also.

ANALYST: [I feel the power of a projective identification, the danger of a transference collusion. I feel that he wishes to get involved in a discussion with me as a homosexual resistance in order to protect himself against the anxiety induced by his ambivalence over a homosexual need to be possessed. There is the presence of a needy, helpless, and envious element that feels that whatever the Other might have to say is the absolute truth. I feel at this moment that the best strategy would be to show the conflict between the parts, to provide an intrapsychic interpretation.] It seems as if you feel trapped between a Ray who needs so much to please and to feel wanted – and this need makes you feel very angry, as if you have no will power – and another hidden Ray, who you fear to let go of, to share, and who questions everything, regardless of whether it is important for you or not.

PATIENT: The problem is that I always accept whatever the others say, my father, the Rabbi, you. And you are right, there is this little me inside, and whenever you or my father or the Rabbi says something, this little me says, "Why should I accept anything?" But then I feel frightened, I feel as if I am bad, that I am bad if I say something against it or if I question it.

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Finally there is the use of intrapsychic interpretation for the purpose of dealing with superego projections which usually induce persecution and guilt in patients with important melancholic features. Amelia is a twenty-eight-year-old housewife, in analysis for the last eight months, who consulted because of marital problems in her second marriage. She was the oldest of four sisters, and there was a history of resentment and sibling rivalry because she felt she always received the worst in her family. From very early she was considered a "problem child" and was seen by a school psychologist around her fourth grade because she was accused of being verbally as well as physically

abusive toward other children. Her adolescence was not easy either: she was rebellious, acted out frequently, had poor grades, and for a while, used marijuana. When she was eighteen she had to get married because she was pregnant, getting divorced shortly after giving birth to a girl who is now ten years of age. At this time she is giving great importance to her decision to go back to the university. She is taking a course in economics and feels very happy about it "because it's different from before. Now I am studying for myself instead of doing it to please my parents, as I used to do before." Two years ago she married again. Everything was going well until they started to have problems because "he is too jealous and I am too aggressive. We have too many discussions, and I don't want to get a divorce again."

Amelia is a very attractive, coquettish, seductive, and intelligent young woman, always dressing in very short skirts and very low-necked dresses, as well as using a generous amount of makeup. There was a dissociation in the transference between her exhibitionism, on one hand, and a feeling of low self-esteem on the other. She was afraid of frequently being scolded and thought that she had nothing good to offer or to say, which resulted in a difficulty to free associate. Countertransferentially, I was aware of her attractiveness, although her exhibitionism did not elicit any erotic feeling. But I felt that I should be cautious about falling into the temptation of being part of an exhibitionistic-voyeuristic couple. I would like now to refer to a session, the first one of her four weekly sessions.

She said: "This weekend I had a fight with my husband. Things had improved for a while, perhaps because I am less aggressive than before. This Saturday I was back from the university where I am taking a course in administration. He was watching TV. He was watching it the whole morning. Lately I try not to say anything about it, but I get very irritated when I see him like that, only watching TV, because he pays no attention to anything. The world could collapse and he wouldn't move. At the beginning, to catch his attention, I used to undress myself in front of the television. All that he does is watch TV and TV and nothing else. Yesterday, I said that he looks like an idiot, with his mouth open and drooling, watching that stupid TV all day. I told him that he was going to become an imbecile, but he didn't answer me. Then I threw a mango I was eating and hit him on the head. He got

furious and started to scream at me, and then we insulted each other." She paused.

At this moment I decided to interpret, but was aware of the danger of inducing resistances, of increasing the superego sadism. I might be throwing a "mango" at her head instead of helping her to gain insight, were I to say, for instance, that she felt like a TV herself, that she wanted to compete with television because what she really wanted was for all of us to drool while watching her, and that she felt very angry when this didn't happen. I decided to interpret in a different form: "Perhaps some anger that you feel against your husband is also against yourself, or better, against a powerful part inside you, which creates for you a real trap and great confusion, not knowing exactly what is more important for you, either 'imbecilizing' yourself and changing into a TV, while changing all of us into 'imbeciles,' drooling while watching you, or using your head and your intelligence instead, which you are also trying to educate by bringing it to the university. Angry with being trapped, confused for not really knowing what is more important for you, your body or your head." She was silent for a short while and then she said: "I have never seen things in this way before."

By interpreting in this manner, I was attempting to place the conflict inside, because her anger was not only about her husband preferring the TV to herself, but also against herself, because of her need to compete with a television. Placing the conflict between two different parts of her self, I was also avoiding the danger of eliciting further superego sadism by inducing self-accusation, as I would have if I had identified only her unconscious exhibitionistic transferential wish of competing with a TV. After all, this was not completely true either, because there was ambivalence in her: it was certain that a very important part of her was interested in a voyeuristic-exhibitionistic interaction, but there were other interests in her, too. At the same time, this interpretation attempted to provide the ego with a better perspective of the conflict, meaning that the problem at the end was the consequence of disparate and opposite interests continuously present within the self, trapping the ego between two different possibilities: either (a) the conviction that being a TV and having everybody drooling over herself was the real core of her oedipal need, i.e., winning over her mother for her father's complete attention; or (b) discovering other

possibilities of obtaining pleasure by focusing her full energy on developing other interests.

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ENACTMENTS: AN INTERSUBJECTIVE PERSPECTIVE

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We offer a critique and synthesis of classical and interpersonal views of enactment. From an intersubjective standpoint, the study of enactment leads to a reconsideration of the nature of the psychoanalytic process. And enactment becomes virtually synonymous with the psychoanalytic process. Enactments are interactions of analysand and analyst with communicative and resistive meanings that lead to valuable insight and can constitute corrective emotional experiences. Enactments that are recognized and defined become valuable dramatizing moments that have condensing, clarifying, and intensifying effects upon consciousness. The inevitable participation by the analyst in enactment is compatible with appropriate analytic discipline. A case will demonstrate these points.

THEORETICAL CONCEPTS OF ENACTMENTS

Chused, as paraphrased by Johan (in Panel, 1992), exemplifies the mainstream view:

> During analysis, a symbolic action that generates a corresponding impulse for action in the analyst can provide substantial information about unconscious forces and affects within a patient. In the best of all possible worlds, an analyst is sensitive to his patients' transference as expressed in ei-

> ther word or action, but he does not act. Instead, he contains his impulses, examines them, and uses the information gained to enrich his interpretative work. The best of all possible worlds is an ideal, something we all strive for, but often fail to achieve. In the second best possible world, where most of us dwell, the analyst reacts to the patient, but catches himself in the act, so to speak. He then regains his analytic stance, observes himself and the patient, and in so doing increases his understanding of his unconscious fantasies and conflicts and those of the patient which have prompted him to action (pp. 828-829).

Chused's (1991) view of enactment usefully articulates a prevailing traditional model of the human psyche. Chused says that analysts of course have subjective responses to their patients. She advances beyond the earlier classical model which she describes as one in which the analyst is "so constricted that he is never stimulated or so defended that he is not aware of his behavior" (p. 616). However, ideally, the analyst does not *react,* but rather contains and analyzes his or her subjective experience. It is not the analyst's subjectivity she denies. She apparently believes that the analyst's subjectivity can be and should be excluded from the therapeutic transaction. She regrets its interactional expression even though she recognizes that "the potential for enactments is omnipresent throughout an analysis…" (p. 617). Chused seems to say: to be human is to be subjective, analysts are human, therefore they are subjective. However, she attributes to the analyst an ability to "catch himself" (p. 616) in the act and curb it. She obviously assumes that it is both desirable and possible for the analytic process to proceed with the patient's subjective experience relatively isolated from that of the analyst. This point of view would also seem to regard the analyst's interpretation as a cool experience for the analyst, gaining its power only from the compelling logic of its content.

In contrast, we hold that the analytic relationship is an intense, continuously changing process. It is not a cool experience for either the analysand or the analyst. The two involved parties in the analysis live the experience together, and a merging of their subjectivities occurs. The analyst's silences, reflections, and fantasies, as well as his or

her interpretations, are both reciprocally induced and influential. We agree that the patient and analyst are different psychological entities, and we do not feel that either party loses his or her individuality in the analytic process. But we are convinced that each party brings his or her fantasies, goals, values, and needs, that is, his or her world view, to the experience. And in the complex interaction of these, analytic change occurs.

Renik (1993) has said, apropos of such a position as Chused articulates, "Thus, the fundamental conception we hold is of psychoanalysis as an interaction between two complete psyches, *but regrettably so:* our theory of technique directs the analyst to eliminate personally motivated action as much as he or she can" (p. 555). We agree with Renik that although analyst and patient are separate psychological entities, they are incomplete, and they, like all people, need to complete themselves in their relationships, including the analytic relationship.

Roughton (1993) quotes Jacobs, who originated the term enactment, as stating that an enactment is "the transformation of a wish or an idea into a performance." Roughton writes, *"Enactment,* as a general term, means simply putting into behavior that which one is experiencing internally" (p. 457). These general definitions neither espouse nor deny the intersubjective meaning of enactment. As the term has evolved in analytic usage, its interactive meaning is increasingly emphasized. Poland (1988) views the analyst as reactively involved. He stresses that enactments are generally precipitated by the patient's actions or by silent communications in his or her words. McLaughlin (1981), in his view of the inevitability of transference reactions by analyst and analysand, seems to be describing a two-person interactional state that would now be called enactment. However, later (1991) he emphasizes that enactment is a defensive and mutually regressive interaction. Similarly, Boesky (1982) sees enactments as behaviors brought about by either the analyst or the analysand which are meant to actualize transference wishes rather than analyze them. McLaughlin and Boesky both emphasize the resistive aspect of enactment. Chused (1991) similarly regards enactment as mutual resistance on the part of analyst and analysand. She writes that the patient wishes to actualize a transference fantasy, and the analyst, instead of bringing the

behavior into the domain of language, suffers a countertransference reaction and joins in the activity.

Roughton (1993) advances the mainstream view by acknowledging the communicative and corrective emotional experience qualities of enactment. He contends: "There seems to be an evolving consensus that 'enactment' is a relationship phenomenon initiated by either one of the analytic dyad which at least potentially evokes the participation of the other" (p. 458). And he adds, after presenting a case in which he subtly joins in a patient's seductive behavior, "It is my conjecture that the attenuated symbolic seduction, which proved both acceptable and safe, had a positive effect simply as an actualizing experience" (p. 462).

Hoffman, Greenberg, Hirsch, Stolorow and Atwood, Mitchell, and Aron are cogent discussants of enactment. Hoffman (1983) argues against an "asocial" space for the analyst. The concept of continual interaction is captured in Hoffman's term "co-construction." Greenberg (1986) also postulates that the analyst cannot avoid participation. Hirsch (1987, 1996) introduces the term "observing participant," truly accentuating the analyst's continuous subjective involvement. Stolorow and Atwood (1992) persuasively argue that the concept of the "isolated mind" alienates a person from nature, from social life, and from subjectivity. They employ the phrase "the unbearable imbeddedness of being" to capture the pain of vulnerability which accompanies immersion in an interactive field. Mitchell's (1988) view is that the patient's intrapsychic life emerges only as the affectively involved analyst lives out new editions of old internalized relations with the patient.

Aron (1996), a relationist, rejects the validity of the concept of enactment. He acknowledges that terms such as enactment "create a conceptual space within which to house interactional concepts" (p. 190) within psychoanalytic theory. But he also objects to these terms as follows: "On the other hand, these terms have been used precisely to contain and constrain the interactional dimension of psychoanalysis. By giving interactional concepts a limited place under the rubric of enactments or projective identification, these traditional theories have sealed off interaction, limiting the recognition of the centrality of the interactional dimension and obscuring the continual

and unending role of interaction, in effect, keeping it in its place and hence setting limits on the interpersonalization of psychoanalysis" (p. 190).

Aron's warning about the ever-present tendency to retreat from the "unending role of interaction" deserves careful study. For example, Ogden (1994) coined the helpful term "analytic third" to describe intersubjectivity. He states: "I believe that...one can no longer simply speak of the analyst and the analysand as separate subjects who take one another as objects. The idea of the analyst as a neutral blank screen for the patient's projections is occupying a position of steadily diminishing importance in current conceptions of the analytic process" (p. 3). Ogden uses the intersubjective perspective to describe graphically the power it brings to interpretations. He notes: "I view my 'choice' of imagery as a reflection of the way in which I was 'speaking from' the unconscious experience of the analytic third (the unconscious intersubjectivity being created by Mr. L and myself)" (pp. 10-11). Unfortunately, Ogden allows the analyst a position outside of the intersubjective field by stating: "At the same time, I was speaking *about* the analytic third from a position (as analyst) outside of it" (p. 11). In doing so, he allows each party a place outside an interactional process. But Ogden appears ambivalent, for he later emphasizes that there "is no analyst, no analysand, and no analysis in the absence of the third" (p. 17).

While we support Aron's cautionary stance, we disagree with his wholesale repudiation of the term enactment. We will show that the use of the term enactment does not necessarily invalidate the notion that the psychoanalytic process is continuously interactive. We will demonstrate that the term enactment enables us to understand the value of dramatization in analysis. We will also show through clinical example the two types of enactment that may be discerned.

ENACTMENTS AS INTERSUBJECTIVE INEVITABILITIES

Analysts agree that one of their major goals is to help the patient develop insight that will improve the quality of his or her life. Tradi-

tionally, it has been held that the analyst's input ideally should be limited to verbal interpretations generated and conveyed dispassionately, minimizing subjective input from the analyst.

Alternatively, we maintain that the fundamental therapeutic process (and the basic origin of psychoanalytic data) is the living situation of patient and analyst. The subjective input of the analyst can never be minimized. As analyst and analysand live coequally but asymmetrically in the analytic space, their respective subjectivities are always involved. The analyst is a participant observer who constructs the analytic process with the patient. The personal history and fantasy life of each are among the varied experiences that each party contributes and shares. Thus every interpretation not only speaks to the patient about his or her life and times, but also conveys the values, goals, and world view of the analyst. Similarly, Levine (1994) states that *"the fundamental data of the analysis is [sic] a continual stream of jointly-created events..."* (p. 669).

We believe that when resistance occurs in analysis it is produced by both parties and therefore is an aspect of enactment. Boesky (1990) hints at a similar view when he states that *"the manifest form of a resistance is even sometimes unconsciously negotiated by both patient and analyst"* (p. 572). Nevertheless, analysts usually find it useful to discuss resistance with the patient as if it were the patient's solitary creation, thereby utilizing an illusory concept. Thus, an intersubjective perspective is essentially compatible with standard psychoanalytic terms and techniques. Just as we assume that interpretation involves the analyst's silent subjectivity, the same is true of resistance.

Free association has been traditionally assumed to be an autonomous process. We suggest that the autonomy of the patient's and the analyst's free associations is more illusory than real. The intersubjective process generates the associations of both parties. While it is useful to free associate and to interpret the meaning of the associations, it is also very important to bear in mind that the associations, the interpretations, and the insights that arise all occur as part of an enactment.

Analytic change occurs through the experience of a relationship which results in increased insight. Change also develops when insight

produces new qualities of relationship. Insight and relationship have the same connection as have chicken and egg. The two are always interdependent and reciprocally influential – no matter how obscure their dynamic connection may be.

In one sense, then, we would state that enactments are continuous in analysis and are *essentially just another way of describing the analytic process*. Enactments are based on the continuous living out of important and mostly unconscious fantasy in the analytic relationship, and both analysand and analyst are coequal participants. Each party is relating to the other simultaneously as to parent, sibling, mate, offspring, or other figure. The case of Bob (below) illustrates this point. In the interplay of fantasy, each fantasy is also continuously changing.

Although it is convenient to discuss enactments as though a single fantasy in each participant produces an enactment, the facts are probably quite different. It is more likely that multiple fantasies of varying quality and intensity are active at any time in both parties and are continuously interactive, producing a web of interpenetrating interactions. It is a web whose configuration is constantly changing due to the continuous interplay of the constitutive fantasies.

CASE ILLUSTRATION

Here we present a week's work from a smoothly progressing analysis, which the analyst felt was heading toward termination. Immediately after each session, process notes of the analytic dialogue, as well as the analyst's subjective experience, were recorded. We present these data in order to illustrate our thesis that the analytic process consists of an endless series of multiply interacting enactments. Some of these enactments are brief and time limited. Others are overarching and may extend through the entire analysis. Therefore, we propose two categories: 1) brief enactments and 2) extended enactments.

Before presenting the week of analytic work, we wish to jump ahead to another hour which occurred six weeks later. Our hope is

that this later Session V will provide perspective on where the analytic couple was heading in Sessions I-IV. Also, initially we will present portions of the patient's past and a brief history of the analysis, followed by information about the analyst's past. Finally, the four sessions will be presented.

Session V

Bob ended the session saying, "It's amazing, I've been in analysis for six years." He was celebrating how much we had accomplished, but his words also carried an angry reproach as though he were asking me, "Why did you take so long? Why didn't you just tell me that I was a scared little boy?" This insight he had gained was so powerful, simple, and clear that I too pondered his question.

This session began with the following dream: "I was vacationing in Hawaii with Dick, an old business partner. When it was time to leave, I pleaded with him, saying, 'Oh, please! Can't we stay a few more days?'" Dick was identified as "the only one I've partnered with who had a doctorate degree," and we agreed that Dick represented me. Since age five or six (when Bob was reunited with his father after the parents had been separated for a year), he always associated a tropical climate with the calmness derived from the reunion with his father. Bob was soberly impressed by "how much I really felt like a five-year-old, pleading with a father." Pictures of his four-year-old grandson acting similarly led him to identify a feeling of fear about returning home from vacation. Bob recalled a feeling of apprehension after a frustrating afternoon at the office the day before the dream. The pace of his new business project was not meeting his expectations.

I felt a great sense of excitement and relief. Bob had finally felt himself to be a little boy. He could now "feel" me as the father. This affective state, which Bob and I had painstakingly co-constructed, was like the critical missing piece of a jigsaw puzzle. (We, the authors, assume that in the process of co-construction, patient and analyst include their respective personal histories, as well as their current feel-

ings, thoughts, and attitudes.) Bob rapidly used this regressed feeling to clarify for himself that today's dangers, for example the problems at work, were different from the terrors he experienced in childhood. Now, he recognized that he was a talented adult who could solve problems. Insight coupled with feeling allowed him to separate the present from the past.

Bob recalled a recent difficult business trip. He had previously reported that thoughts of closeness with me and with his wife, Judy, had buffered him against fear and loneliness. He next reported, in considerable detail, a recent rebuff by his mother. His picture of her, as usual, reminded me of how fearfully my own mother viewed life. But I thought to myself that, unlike my mother, Bob's had nothing left to give him. Instead, she fearfully withdrew, accusing him of wanting too much from her. Bob then recalled for the first time a picture of himself at age three or four calling endlessly for his mother, who never came. We agreed that this was the earliest memory (or version) of a state of pain we knew quite well from his later childhood and adolescence, one which led him to lie on his bed by the hour in a confused helpless agony.

We linked his pain to mother's unavailability. In his next association, Bob proclaimed that he did not need to run back to her any more, and he surprised and puzzled me when he said, "I did so well on that recent business trip." He proceeded to describe his recreational activities and other means of occupying himself during his scant free moments. I tried to hide my irritability by gingerly remarking, "Bob, this may sound funny to you, but I'm struck by what a different picture you're painting of how you felt during the trip." I then reminded him that he had first talked of fear and loneliness, as well as his need and appreciation for me and Judy. With curiosity in his voice, he said, "Yes, that's true." I told him I thought that remembering his mother's desertion, which we talked about, caused so much pain that he had to get away from it by creating a picture of himself as completely self-sustaining. To my delight (since it had been a subject I had not yet found a way to interpret to him), he used the word "grandiose" to describe this sense of himself. We spent the remainder of the hour talking about his grandiose adolescent fantasies.

HISTORY OF THE PATIENT AND OF THE ANALYSIS

As I write, I think about Bob's closing celebratory amazement and his lament over having to spend six long years in analysis. At the beginning, we met two to three times per week for two months before starting a four-times-per-week analysis. Bob is now fifty-seven and I am fifty-four years old. He came to me asking for help in deciding whether to marry Judy. His two prior failed marriages haunted him, and he did not want to marry another self-absorbed woman. As Bob recounted his life story, I learned that a previous analytically-oriented psychotherapy had helped him overcome panicky anxiety attacks and a number of phobias. Only a fear of heights remained when we began. The prior therapy foundered when his therapist seemed to "lose interest in me" and when he simultaneously asked to invest in one of Bob's business ventures. I also learned that Bob suffered a traumatic childhood and adolescence that produced such high levels of anxiety that he was unable to concentrate in the classroom or participate in organized sports, which he loved. He compulsively ate candy. His mother was episodically depressed, chronically terrified, and self-absorbed. She clung to Bob to soothe her and to replace her husband, who withdrew emotionally from her and Bob. This withdrawal began when Bob was six or seven, one year after the parents reconciled following a year-long separation. Also, this correlated with the move back to their home town. When Bob was nine, a brother was born. Father then withdrew further from Bob and gave the younger brother what little love and attention he could muster.

Bob's adolescence reminds me of a house divided. His parents withdrew, feeling silent recrimination toward each other. When Bob's father was nine years old, he had been sent to work and was thus emotionally abandoned by his own father. He revisited this trauma on Bob. By Bob's thirteenth birthday, father was telling him he should be self-supporting. By the time Bob was fifteen or sixteen, his father wanted him out of the house. Mother, on the other hand, wanted just the opposite. She barred the door when Bob would attempt to go out for the evening. Hysterical fights ensued. Bob was labeled as the "bad

one" in the family and taken to several authority figures for lectures to shock him into submission. Among these authority figures was a psychiatrist. To Bob, psychiatric contact at age fourteen felt as though he had reached the promised land. Unfortunately, after four sessions father ended the treatment because the psychiatrist asked for a family session.

As Bob described his business career to me, I commented on what seemed to me an obvious pattern. I pointed out that he successfully built a business, generated wealth, and even more successfully found creative ways to undo his success. Bob was dumbfounded by my observation. He picked up my lead and analyzed this pattern in business affairs dating back to age twenty. He became upset with his first therapist for never having noticed. The analysis started on the basis of Bob's conviction that without further help he was doomed to repeat this pattern to his grave.

During Bob's first hour on the couch, I felt as if he were a frightened child clutching at me for safety. He repeatedly arched his neck toward me and said "Right?" after he reached any conclusion. A chasm existed between us. On the one hand, I experienced him as a terrified little boy desperately clinging to my pants legs and begging for reassurance. On the other hand, I felt powerless to discuss this picture in our dialogue. It took six years to bridge the gap. I can only artificially pretend to trace a path between then and now. The early work cleared away a thick underbrush of distrust. The middle of the road was obstructed by Bob's incredulity over any mention of him as neurotically frightened or dependent. I believe that over time, I taught him to slow down by helping him to learn to analyze problems instead of developing hysterical anxiety and running from his thoughts and feelings. I, through the analytic process, drew him to look at his thoughts and fantasies. For the first time in his life, he learned to take on problems one step at a time. It was easy to see why he had never succeeded academically. We then began to elucidate his massive underlying anxiety and to identify the presence of constant catastrophe fantasies which haunted his daily life and his dreams. Further down the road, Bob told me that when we first discussed how scared he was, he believed I was incredibly naïve because I did not agree with his view that he was in mortal danger from exter-

nal forces.

We, the authors, submit that Bob's father transference to me was partly determined by my need to father and be fathered. Recall that he came for treatment regarding issues with women. I brought up his problems associated with masculine strivings, which shocked him and led to the analysis. The father/son transference-countertransference constitutes an *extended* enactment. By this term we mean that a father/son transference-countertransference relationship has continuously contributed to the course of the analysis. We insist that the analyst's basic attitude consistently helps to shape the analysis throughout its entirety. We believe the reader's knowledge of my history will permit a deeper understanding of this analysis. However deeply analyzed I strive to become, my subjective input is invariably unconsciously determined by my past. I mainly become aware of its influence in retrospect. We also want to make it very clear that we are referring to initiating motives in the analyst that are not just responses to the patient's desires. The term "countertransference" is too narrow to cover the breadth of the issues we envision.

My father lost his business when I was twelve. He was in his early sixties, just a few years older than Bob. To a minor degree, I was enlisted to help save the business during its two years of death throes. I was deeply disappointed by my father, and my mother's criticism of him augmented this feeling. I could not see him as depressed, and I mainly viewed him lacking the strength to forge ahead and find new work. My feelings toward him were simultaneously sorrow and angry impatience. This state of affairs dragged on for two years until my mother asked for a divorce. When my father left, I was so mad at him that I planned never to see him again. I felt blindsided when my mother and grandparents insisted that I not only avoid an angry confrontation, but that I also submit to weekly visits with my father. I gradually repressed my anger and formed an obligatory relationship with my dad. He was not strongly interested in me, but he did the best he could, always taking pleasure in reports of my academic, athletic, and artistic achievements. Unlike Bob's father, he was never antagonistic to me. But like Bob, I did lose a father figure in early adolescence. Through my analysis, I recovered my anger and

learned that the easy oedipal victory I imagined I had won actually deprived me of a growth-promoting father figure. However well analyzed that need (and the need for submission to undo victory) is in me, I am continually surprised at how I unconsciously join together with men such as Bob to co-construct the presence of a father/son relationship.

PROCESS MATERIAL

Session I (Third Hour of Week One)

In the month before these sessions, Bob had launched a new business venture. In retrospect, I now believe we mutually and unconsciously developed, i.e., co-constructed, a silent belief that his life and analysis were on hold until he succeeded. Hindsight leads me to conclude that I intensely identified with Bob's singular focus on the business's outcome and that we constructed an unarticulated belief that this business's success was equivalent to maturation from boyhood to manhood. Throughout the analysis I had been aware of feeling like a good father to Bob. I especially enjoyed multiple occasions when we could acknowledge and celebrate his growth. This is another aspect of an extended enactment. The occasion of Bob's uncertain new business venture resonated with my pain over my father's failure. It activated feelings in me of being the disappointed son to Bob as the disappointing father. This single incident is an example of a brief enactment. It should be emphasized that the brief and the extended enactments were occurring simultaneously and were interpenetrating.

Bob's recent attempt to resurrect himself mimicked my father's situation sufficiently to interact with my oedipal competitiveness. Bob's stance as the needy son, and mine as the supportive father, can also be regarded as a brief enactment of a bilateral defensive state of noncompetition.

I now recognize two parallel subjective streams. On the one hand, I maintained a breathless, coaching attitude to Bob, as he went from one business challenge to the next. Bob and I were co-constructing

discrete, serial, acute enactments. Simultaneously, at a more fundamental level, I appreciated, in a silent and sustained way, his needs for broader dimensions of success, including enhanced insight and improved intimate relationships. Thus, we see the two types of enactments: those that are brief and those that are extended.

As the hour began, Bob's thoughts turned to his visit to the dentist two days ago. He was told his blood pressure was elevated, which shocked and surprised him. He told me that his blood pressure was 160/95 at the dentist's office. He then told me that he could control his hypertension himself through a program of weight loss and exercise. He seemed to be seeking my approval. He commented that in recent years when his weight increased, his blood pressure also tended to rise, but apparently not to this level. He asked me if I thought this plan to proceed with his treatment approach before seeking medical attention was satisfactory. I wondered whether, since the dentist had agreed to his plan, he was seeking my fatherly as well as medical approval.

I did agree with his plan of action, but shortly thereafter, as he was describing his new diet, he commented that when he took his blood pressure at home, the diastolic reading was 110. I waited to see if he would register any overt alarm about this reading. He did not, but he wondered if he should see his internist regarding use of medication until his exercise and diet took effect. I agreed. Immediately after my agreement, Bob began associating to scenes from adolescence in which he was harshly criticized. I then interpreted that my agreement may have been experienced as a hurtful criticism. However, he seemed impervious, and he claimed that he was not upset with me. The hour ended and I thought no more about our interchange as my day proceeded (subsequently I have decided that my advice was both helpful and devaluing, inasmuch as he had ample extra-analytic resources on which to rely). This is an example of a brief enactment. Several components can be identified: Bob was seeking a father who would be so supportive that he would magically sweep aside any realistic problems. Perhaps he was also seeking the oppressive father from me. I was attempting to bolster my father's sagging business efforts and could not tolerate inattention to "realistic" difficulties.

Session II (Fourth Hour of Week One)

Bob started by boasting about his new business. I was perplexed when he stated that he believed he had created a new industry. He sounded like an exuberant adolescent. His next set of associations centered on fears of attack, which he labeled as catastrophe fantasies. At first he felt these fears were precipitated the preceding day by his rejection of a business associate's offer of partnership. Bob noted that he was now on his own without a partner for the first time. In retrospect, I believe the catastrophe fantasy was also related to a feeling of estrangement from me, his primary partner.

So far, I had remained silent. Bob proceeded to describe his yoga session of this morning. In a meditative state, he pictured dragons fighting. He reported seeing two huge dragons locked in a death struggle. He wanted to kill them, but he felt powerless to do so because of their overwhelming size. Then the scene switched to his parents' apartment. He pictured himself carrying a gun with sixteen bullets, and then he watched himself empty the cartridge into each parent. The scene was morbidly vivid in his mind. He took pains to tell me that he actually saw the bullets enter their bodies. He saw blood and body parts all over the room. First, he shot his father. He felt good about that. Then he turned to his mother and with special pleasure and relish said, "And now, for you!"

His associations indicated to me that to him assertiveness was equated with the murder of his parents, whom he viewed as thwarting his independent aggressive adolescent strivings. We talked at length about the implied guilt over self-assertiveness, and he commented, "How could I have imagined that I could have ever succeeded if this was the consequence?"

After pausing, Bob somewhat reluctantly said that my advice the preceding day to see his internist had caused him to be more aggressive in business and then to have the murder fantasy during yoga. After yesterday's session, he finally did feel hurt and angry, because he believed that I did not think he had the ability, the knowledge, and the fortitude to take care of his blood pressure problem by himself. He added that he also felt I had lost faith in his capacity to analyze the issues in his life causing the elevation of the blood pressure. I

acknowledged that I had spoken to him as his dad did. Not only had I denied his abilities, but also from his standpoint, I had broken our most sacred bond – the analytic one. I assured him that he had experienced it as a complete rejection by me. We discussed the connection between my rejection and his father's rejection (and, he added, his mother's as well) during adolescence, which stimulated the murderous fantasy.

As the hour closed, he repeated that it was very painful to feel that I doubted his ability to analyze the causes of his hypertension. This was so because it undermined his hard-won belief that he could trust the power of analysis (i.e., rationality and thought). This belief in analysis had subdued the old feeling of being trapped in an overwhelmed hysterical state (identified with his mother). I was aware here of issues of grandiosity and omnipotence in Bob's view of himself, of me, and of the analytic process. However, I deferred interpretation of these issues because I believed that such an interpretation at this time would inflict further narcissistic wounding.

Session III (First Hour of Week Two)

Bob spent the first half of the hour reattaching to me after the separation by boasting about how well he had done over the weekend and by seeking my reassurance that he was okay. I responded with evenly balanced reassurance and interpretation. This balance had been established earlier in the analysis.

As Bob settled into the session and no longer seemed to be seeking reassurance and reattachment, he began to articulate the neurotic issues that we had recently been dealing with. He concluded this discussion by stating that because he was less engaged in "regressive-compensatory" actions, he was now free to be more aggressive. When I heard this comment, I bristled and felt that our analytic work was being devalued. I recognize now that this reaction was my defense against unacknowledged painful feelings. I believe I then attributed to Bob my own fear and inhibition of aggression. Had I been less defensive, I would have agreed with his statement. Instead, I subtly negated him by adding that I pictured him as fearing assertiveness

and hiding out because of anxiety. My schoolteacher-ish lesson (as I now see it) was that until he understood the anxiety more, he could not escape the regression and become effectively assertive.

So, in effect, I threw cold water on his assertion. I believe he felt immediately rebuffed, for he reported that he had just had a quick flash of a prison scene. He could not tell whether it was the jail that his parents took him to see when he was fourteen, or whether it was the prison to which the district attorney would have sent him if he were to be arrested for his fantasied wrongdoings.

I next reviewed this sequence of events with Bob, and he became aware of feeling chastised by me. He believed my statement about anxiety challenged his belief about aggression versus regression. He thought that he had lost my affirmation, and he definitely felt deflated. I asked whether he had any fantasies about why I would do this to him. In reply, he seemed to defend me by saying that he was inflating a mild rebuff by me because of the severe "put-downs" during his adolescence. We ended in the midst of this discussion. This incident exemplifies another brief enactment.

Session IV (Second Hour of Week Two)

By the middle of the session, Bob felt to me like a happy, enthusiastic adolescent who needed to report how well he was doing to a parental figure. He talked of the burst of creative energy he had experienced since retrieving the murderous fantasies. He noted that he was experiencing a peaceful underlying feeling instead of his usual anxiety. The future seemed open to him and "not like a mine field with disaster waiting." He then brought up the subject of his constant worries about short-term cash problems, and we discussed this at some length. We finally reached the conclusion that he was using these worries, which never did materialize, as a form of punishment for his aggressiveness, which he believed he had equated with murderousness toward his parents. He next brought up the subject of his fear of arrest by the district attorney, and we worked through this issue, first noting that his fantasies were baseless and then by concluding that this too represented a form of punishment. He pictured himself be-

ing arrested, tortured, and locked in solitary confinement for life. For him, this was equivalent to the state of pain from his childhood and adolescence. The prison cell was his childhood bedroom.

I said that this elaborate fantasy of retribution sounded like a form of punishment for his murderous fantasies. Bob then laughed and said that he had been thinking that if he had actually killed his parents when he was fourteen, he would have been acquitted because he acted in self-defense secondary to their abuse. I once again felt irritated and uncomfortable, and had the urge to say, "Do you really believe you would have gotten off scot-free – that you wouldn't have been in prison for a few years or at least psychiatrically hospitalized?" Instead, I proclaimed that the issue was not guilt or innocence about murder itself, but was about murderous desires. I immediately felt I had erred and, as is obvious, my thoughts and words were quite garbled. My comments produced an immediate flash of shame in Bob, who announced that when he was fourteen, he was not aware of his murderousness and guilt. His reference to age fourteen alerted me to the probability that he felt chastised and criticized, and I suggested that my comment had shamed him and that he was displacing his anger to times past. Bob acknowledged that he did not understand my comment and felt mildly derailed and devalued by what I had said, although he could not tell why. However, the hurt generated by my comments passed, and Bob ended the hour on a note of youthful enthusiasm. He talked about the intellectually exciting and challenging quality of his present business and how lucky he felt to be doing work that was so interesting. He remarked that there is more work than anyone can do in a day. We agreed that he seemed less tied to his parents' view of the world as boring and unexciting. I noticed that I felt calmer as we talked about his guilty identification with his parents. I also felt freer to be more aggressive, and I had a series of memories of my own adolescence and the feelings of inhibition I experienced then.

Even in this final segment of the hour, I now see that I very subtly sidetracked his youthful enthusiasm. While discussing how full life was, he mentioned that by choosing one area of interest, namely business, he foreclosed his interest in other areas. When I agreed about the inevitable limitations of choice in life, he quickly responded like

an omnipotent-feeling adolescent: "But I'm interested in business!" It was as if I had said to him that he should do other things or not be so aggressive in one area. And perhaps that is exactly what I had said in a metacommunicative way. Here are two more enactments in which we relate as the critical father and the son who cannot get it quite right.

DISCUSSION OF CLINICAL MATERIAL

Enactments express aspects of the past and present life of each participant. The clinical material (from both sides of the couch) illustrates that the analyst, as participant observer, cannot leave the interactional field composed of two "intrapsychic" organizations. There are no blank screens, empty containers, neutral analysts, or third spaces present. During the years of analysis, the analyst and Bob struggled with a complex father/son set of issues, which they constructed in the analytic relationship out of their respective pre-existing father/son conflicts and needs. During the week of this case material, they constructed the presence of an aggressively carping, deflating father similar but not identical to Bob's.

This analytic fragment demonstrates how easily but prematurely one could dismiss the analyst's participation as simply a countertransference reaction that interfered with the natural unfolding of a predominantly positive father transference. In the same vein one could argue that the enactments could have been avoided, thus allowing us directly to observe Bob's wishes uncontaminated by the analyst's subjectivity. The analyst's activity could be conceptualized as *only* an empathic failure, that is, the failure to mirror Bob's adolescent grandiosity, causing anxiety and fragmentation (here the reader should recall Bob's steady stream of associations to feeling overwhelmed at age fourteen after the analyst's deflating comments). To some degree these critical views have value. Nevertheless, we insist that the analyst's aggressiveness was an aspect of his "irreducible subjectivity" (Renik, 1993) that inevitably was operative in this analysis at this time.

The analyst and Bob worked diligently on Bob's analysis. In doing so, both lived out powerful personal agendas in the form of a

continuous stream of enactments out of which the analytic dialogue emerged.

Bob and the analyst unconsciously decided that a large and overt part of the analytic work would center on a father/son relationship. In the months preceding the analytic material just presented, there was sustained discussion about Bob's submission to the therapist as a powerful father. The analyst, for his own theoretical reasons, wanted Bob to feel his need for the analyst as a supportive father. The analyst also wanted Bob to realize that he had this need in order to defend himself from his competitive feelings. Bob, on the other hand, believed that he needed the analyst as a guiding, benevolent father only because he had not experienced a normal developmental interchange with his dad. Probably the analyst actively disillusioned Bob in order to help him make contact with his competitive feelings. The analyst was expressing his protest against Bob's implicit demand that the analyst submit to his belief that he could treat his own high blood pressure.

During the months after this vignette, Bob agreed that he had an "overripe" need for the analyst to be a perfectly attuned, validating father figure. This change enabled Bob to recognize his competitive strivings toward the analyst. However, by agreeing with the analyst, Bob was subtly continuing his submission and idealization of the analyst.

The analyst's awkward disillusionment of Bob arose from at least two sets of motives in the analyst. First, as father, the analyst wanted Bob to grow up, be competitive, and to gain insight into the fantasies obstructing healthy assertiveness. After all, that was the analyst's own life story and therefore his favorite theory for these particular clinical situations.

Second, as son to Bob as father, the analyst wanted Bob to succeed in his new business venture in order to represent to the analyst the analyst's own father, who had failed to resurrect his business. The analyst wanted to redeem his father and save him from the analyst's rage and competitiveness. Bob's success would show the analyst that he too could become successful and strong. Bob's adolescent grandiose belief that he could manage his elevated blood pressure on his own angered the analyst. At this moment, the analyst needed a ma-

ture father, not a naïve adolescent. In this way, Bob disappointed the analyst, who was yearning for a successful father. Simultaneously, the analyst unconsciously gratified two oedipal wishes. By attacking Bob, the analyst was unconsciously attacking his own father and was also depriving Bob of a good father.

The analyst became more aware of his murderous desires toward his own parents as a result of Bob's fantasies of getting away with murder. When Bob said he could have murdered his parents without punishment, the analyst's murderous wishes were stimulated. The analyst envied Bob's experience of a good father in the analyst, to whom he could express these murderous desires. Therefore, the analyst attacked Bob to spoil the envied relationship. The complex maze of dynamics emanating from both participants illustrates a fundamental point, which is that enactments are continuous and unavoidable events in analysis. Each analytic pair will create its own unique stream of enactments.

We believe these details from a long, complex, and successful analysis demonstrate that every moment of the analytic experience is produced by the continuous interactions of the two participants. The transactions show how the analysand and the analyst are continuously influencing and being influenced by one another. The events could have been reported in a more conventional and convenient manner, and thus the account could have been purified of the analyst's "tainting" influence. Such a report ultimately would be false and misleading.

The multiple enactments identified in the case material represent only those enactments that became evident to the analyst either through conscious experience or through inference. But what about those enactments that do not become known? They exist in the vast unconscious realm, always exerting powerful but mysterious influence.

THE COMPLEXITY OF ENACTMENTS

In previous publications (Natterson, 1991; Natterson and Friedman, 1995), we have emphasized the ambiguity and complexity of the analytic situation as it reflects the ambiguity and complexity of human

life embedded in the universe. Analysts need to be aware that the "recognition of co-responsibility is the enabling event for understanding and for constructive outcome" (Natterson, 1991, p. 12). In the case of Bob, the analyst's awareness of his role in the enactments raised the level of authenticity of his interpretations. The richness and depth of the patient's insight corresponds to the analyst's intuitive and/or explicit awareness of his/her co-responsibility.

Recognition of the therapist's subjective input does not create a shallow interpersonalism that pulls attention away from the inner world of the patient – the "intrapsychic." Instead, it renders the "intrapsychic" more accessible. Witness how the analyst's lumbering progress toward realizing his own murderous fantasies facilitated Bob's emotional understanding and working through of his own homicidal urges. An analyst's private acknowledgment and analysis of his or her own neurotic and non-neurotic input renders the analyst much more able to perceive the counterpart contribution of the patient. In turn, there develops a powerfully facilitating mutual sense of reciprocity about the therapeutic process, with both parties now more able to appreciate their own contributions to the process. Deliberate self-disclosure by the analyst is not an obligatory component of these events. However, at times it is helpful. In the case of Bob, deliberate self-disclosure by the analyst did not occur.

Enactments occur multiply and continuously. They interpenetrate and interact, and they are therefore unstable in some, but not all, respects. Thus patient and analyst are engaged in action at all times, even when they are unaware of such activity (Gill, 1994). Furthermore, it is incorrect to regard action and thought as existing in sequential relation. Thought and action are intimately intertwined and cannot ultimately be disentangled.

Renik (1993) states, "Everything I know about my own work and that of my colleagues leads me to the conclusion that an analyst's awareness of his or her emotional responses as they arise in the course of an analysis *necessarily* follows translation of those responses into action – i.e., awareness of countertransference is always retrospective, preceded by countertransference enactment" (p. 556). And he adds, "It seems to me that when we can look closely enough we always see that an analyst's awareness of a personal motivation in the clinical

situation has its origins in self-observation of a behavioral manifestation, in some form or other, of that motivation" (p. 557). Certainly, the case of Bob supports Renik's assertion. However, it is also true that thought often precedes action. For example, in the case of Bob, when the analyst gained new insight into his lethal fury, his subsequent analytic behavior changed. This inconsistency teaches us that it is impossible to separate action and thought. Action always accompanies thought, and thought (of some kind) always accompanies action. They are inseparable. This principle, then, invalidates Chused's (1991) notion that one can prevent action and retain only the thought in mind.

ENACTMENT AS DRAMA

One important benefit of defining the concept of enactment is its potential dramatic impact upon consciousness, leading to further developments based upon this changed consciousness. It may be that the dramatic perspective in analysis has been underestimated. A therapeutic process is a continuum of unformulated, shared experience punctuated by intense moments of increased consciousness, articulation, and rapid change. These moments could be considered as dramatic events and as enactments. As used here, drama condenses, clarifies, and intensifies. Thus, drama functions as a valuable part, but only a part, of a broader spectrum of psychological events that are continuously occurring between and within each of the two persons who constitute the analytic dyad.

So the dramatizing aspect of the formulated enactment plays a crucial role in the reduction of the ineffably complex circumstance of analysis to the manageable simplicity of verbal communication. This helps achieve a sharper focus for both participants on the crucial current emotional emphases than would otherwise be possible. Aron's abolitionist stance regarding enactments would sacrifice this value. When the analyst formulates a specific enactment (using the term in its most popular version today), the analyst is defining the focus and the limits of the immediate and manifest analytic dialogue. Thereby the analyst is also giving direction to how the dialogue will

proceed in the future. This is what most people currently mean by the term *enactment*. However, at all times, beyond the formulated enactment there lies the entire dyadic universe, of which the specific enactment provides only a slight but valuable hint. The dramatic quality of enactment renders the concept an exceptionally useful one for teaching the clinical value of an intersubjective perspective to the less experienced clinician.

These serial dramatic interludes called enactments reveal the available, conscious, or near-conscious aspects of the total analytic experience. This awareness sustains the freshness of the analytic dialogue and provides satisfaction and stimulation to both participants. When the idea of enactment is focused upon, the analyst is more inclined to wonder what enactment he or she is participating in at the moment. In turn, this leads to more basic questions: What are my wishes and hopes, what values am I communicating, how am I conveying them, am I reacting only to the patient or am I presenting a separate agenda of my own that is not somehow related to the patient?

The point here is that although much of this questioning cannot be answered, the active inquiring stance of the analyst regarding his or her subjectivity and its enactments facilitates the conscious formulation of enactments – and this actively questioning attitude is itself a form of enactment. This questioning stance invariably enhances appreciation by the analyst of subtle but powerful forces at work in the analytic field, leading to improved interpretations.

ENACTMENT AND THERAPEUTIC DISCIPLINE

The concept of formulated enactment, as used here, indicates the intersubjectively derived dramatic event occurring between patient and analyst. This drama may be manifest, it may have to be inferred, it may be perceived as it is occurring, or it may be recognized only in retrospect. Whatever dramatic form the enactment assumes, it always entails involvement of the analyst's subjective life.

Does this acknowledgment of the analyst's subjective participation imply then that an analysis is by nature wild and disordered? The

answer is: not at all. Analysts constitute a subgroup of the broad category of care-providing professionals. A long tradition of explicit and implicit guidelines for appropriate behavior exists. These rules govern analysts to the same extent that they apply to other professional groups. In fact, sensitive and ethical behavior by the analyst should be enhanced rather than jeopardized by an intersubjective orientation. The fuller awareness by the analyst of his or her subjectivity should help minimize egregious acting out by virtue of a more complete awareness of inner motivations.

Restraint is a crucial practice for the analyst. It derives partly from the common-sense realization that relative but encouraging silence on the analyst's part invites verbalization by the patient. Also, effective restraint is a product of the analyst's sustained attention to his or her own subjectivity, with a consequent softening of guilt-based self-judgments by the analyst. The analyst implicitly conveys this attitude of self-acceptance based on the unflinching search for self-knowledge to the patient, who then is also able to develop greater self-acceptance and greater expressive freedom and fluency in the analysis. Overall, the mutual growth of spontaneity and acceptance – without relinquishment of the analyst's restraint and discipline – leads to higher levels of creativity, playfulness, and ingenuity in the expressive/interpretive process.

The analyst listens more powerfully and profoundly when his or her subjectivity is included as a legitimate part of the experience. This impression opposes the view of others, such as Schwaber (1981, 1983), who assert that elimination of the analyst's countertransference needs allows the analyst to view the patient's "true self."

Acceptance of intersubjectively-based enactments reduces defensiveness about the analyst's personality entering the analytic field. Sandler (1976) suggested that the analyst's spontaneous subjective reactions, when not battled against, permit what Sandler called free-floating role responsiveness. He proposed that the analyst continuously and unconsciously enters into reciprocal role relationships with his patients. He distinguished these role relationships from projective identification, insisted that they were not simply resistances, and demonstrated that they serve richly communicative purposes, promoting the achievement of otherwise absent understanding. Freud

stated that the analyst listens with free-floating ideational attention. Sandler adds that the analyst also participates with free-floating role responsiveness.

Analysis consists of an endless series of enactments. Some of these enactments constitute spontaneous corrective emotional experiences. Renik (1993) addresses this issue as follows, "…*unconscious* personal motivations expressed in action by the analyst are not only unavoidable, but *necessary to the analytic process*… it is precisely because of the analyst's capacity for self-deception, the analyst's *willingness to be self-deceived,* that he or she is able to enter spontaneously and sincerely into corrective emotional experiences with the patient without the presumption and hypocrisy of deliberate role-playing. These interactions provide a crucial series of gratifications and frustrations to the analysand that form the basis for a successful analytic process" (p. 564). Similarly, Roughton (1993) states, "It is in this positive sense of actualizing the transference that we need to reclaim 'corrective emotional experience' as a useful term, untainted by historical implications of intentional, tactical manipulation of the analysand by the analyst" (p. 463). The case illustration in this paper shows how corrective emotional experience (Alexander and French, 1946) is a precursor to the current concept of enactment. Bob and the analyst productively functioned as father and son to each other, thereby generating progressive change.

CONCLUSIONS

Recognition of the interactional nature of psychoanalysis as epitomized by the concept of enactment increases the analyst's sensitivity to the intrapsychic processes occurring in the analysis. This new emphasis on enactment, we believe, retains the best of the traditional focus on intrapsychic processes while incorporating the essential contributions of the interpersonalists. Our approach constitutes a contribution to the ultimate development of a newer, richer theoretical model.

Enactments that are identified and discussed in the analysis serve a peculiarly valuable dramatizing function. Specific and identified

enactments can be regarded as drama. They thereby provide a crispness and freshness to the analytic process. They help fix blatant and subtle meanings in the consciousness of both analytic participants. This enhanced consciousness is not momentary and isolated; rather, it then pervades and influences the immediate and subsequent analytic events. Consciousness of a brief or acute dramatizing enactment enables both parties to survey prior and subsequent analytic events as containing similar implicit enactments. It is useful to identify some enactments as brief and others as having an extended or overarching quality. This distinction is relative rather than absolute. The clinical example demonstrates these points.

Intersubjectivity is the overarching theoretical model. Enactment is the intersubjective process in action. Insight is the conscious recognition of the meanings of the enactment. Resistance is the inner opposition to the awareness of the enactment and its meanings. Interpretation is the verbal communication of the consciousness of the enactment and its meanings. Free association is based upon the silent, internal aspects of the enactment. Transference-countertransference is essentially a synonym for the phenomenon of enactment.

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BOUNDARIES AS PRE-CONDITIONS

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Boundaries in psychoanalysis and psychotherapy can be considered either as indicators of moral transgressions or as guidelines for therapeutic intervention. This paper suggests that these categories be better delineated in the hope that less attention be paid to that of moral mistakes and more to that of treatment effectiveness.

The intent of this paper is to distinguish between the view of boundaries as loci of transgression or moral issues from the concept of boundaries as practical points of treatment or ethical considerations.

It is not always clear just how we distinguish between the definitions of the moral and the ethical. If we borrow from Ricoeur (1992), we may highlight the difference as being between that of norms and that of aims. The moral is to be considered as what is felt to be good and normal, and so it lays claim to a universal status. It consists of the rules of correct behavior. The ethical has to do with the aim or goal being pursued, and so it directs us to the proper way to live. Ricoeur feels that ethics therefore encompasses morality.

To transpose this distinction to psychological treatment, we might say that we have a variety of moral standards or norms in dealing with patients, while having a goal in mind as to what we consider best for an individual patient. We behave in a certain way that we consider moral, but beyond that, we impose other standards in order to promote our goal of treatment. It may not be wrong in and of itself to tell our patients personal matters about ourselves or to have a cup of coffee with them, but it may not promote the treatment to do so. In this case, it is clear that ethics includes and determines morality. On the other hand, some may say that certain (for some) morally offensive

or repugnant behavior is truly in the patient's best interests. These, of course, become arenas for argument and disagreement, as first occurred between Freud and Ferenczi.

Putting those possibilities momentarily to the side, it seems prudent to consider our concern with boundaries as more properly belonging to our ethical behavior. As such, boundaries are the allowable constraints for achieving our goals and are not so much our moral norms. This is quite familiar to some analysts who recognize that certain perfectly normal forms of behavior, such as sharing a cup of coffee, are considered breaches of proper technique. It is less familiar to some therapists who feel that sharing a cup of coffee is so natural as to make us seem foolish to decline. The difference is a product of a plan: a plan of doing good. Therefore, it may be more profitable to see boundaries as the conditions that allow for the plan to proceed, and so they may be termed pre-conditions. With this in mind, one can begin to examine and clarify just what are the proper pre-conditions that are necessary for just what therapeutic action. Mistakes in the recognition of boundaries are not necessarily moral failings, although they well may be, but rather are more often technical errors. A reconsideration of boundaries as pre-conditions for effective therapeutic action moves them from the area of morality to that of pursuing an optimal treatment process: an ethical aim.

What may at first seem a fairly easy delineation of boundaries, i.e., the analytic claim of neutrality, has had a recent re-examination (Renik, 1996) and is held by some to be untenable, even unusable. However, it seems more to the point that supposed neutrality is, for some, but a synonym for the respect of boundaries. Little is gained by the substitution of phrases until we spell out just what is ethically demanded of us.

The usual image of neutrality (or what has been an acceptable substitute definition: staying equidistant from id, ego, and superego) is an image of immobility, of the analyst's refraining from making a difference. The usual image of boundaries is one of allowing action or sometimes even encouraging action up to a point. Therapeutic action makes a difference. The difference between neutrality and operating within a boundary represents a shift in our thinking about

the requisite action of analysts and therapists, i.e., what needs to be done in order to accomplish one's goals. Therapeutic alliance, rapport, empathy, a host of recommended stances all speak to our doing or being something that is needed, rather than to our being nothing that gets in the way. It is in the areas of doing too much or too little, or making mistakes, that the issue of boundaries arises. Perhaps one should therefore focus upon the allowable and necessary actions of analysts and therapists rather than on the usual concern devoted to errors of commission. To return to ethics, we can say that we need to operate within an arena that allows us to accomplish our aims of treatment. This arena of operation assumes a recognition of norms and standards, but these do not determine the boundaries of the arena. Rather it is bounded by what is needed to achieve the best interests of the patient.

It seems fair to say that most discussions about boundaries in psychotherapy and psychoanalysis have to do with violations and transgressions. As such, they focus upon both of the moral considerations of the concept: the standards of propriety and the breaches of good conduct. Within these discussions (Gabbard, 1994, 1995), there lies a clear message about the impact of such violations upon the treatment process, but there is no clear-cut delineation of the nature of the boundary. To be sure, the discussions of boundary problems are inevitably linked to investigations of transference-countertransference problems that lie with the therapist or analyst, but there remains a lack of clarity about just what is the status of this entity. For example, a recent list of recommendations (Day, 1994) for practicing psychiatry in rural communities was directed toward points of caution in maintaining what could only be described as an aloof and diplomatic stance in order to (once again) avoid boundary violations. Yet it would seem to be obvious that one needs more than such a series of constraints to properly position oneself vis-à-vis a patient. What one *should* do is therefore more a matter of describing the conduct that becomes a caring and interested professional. None of these guidelines seem to define a boundary as part of a treatment process rather than as a signpost of a moral failing. My effort here is to consider the simple and perhaps obvious view of boundaries as pre-conditions.

What Is a Pre-Condition?

A pre-condition is the sum of factors that allow one to effect a therapeutic intervention. It can be thought of as the stance of a therapist or analyst that should exist in order to proceed with whatever action is being considered. The ensuing action may then breach the boundary. There is no absolute point of effective intervention, and naturally the kind of intervention planned will determine the particular pre-conditions. There is surely an ideal pre-condition for certain forms of interpretation as well as for particular moments of optimal frustration or gratification, etc. We need to study and define these ideal conditions in order to better define just what a boundary does and how it functions. Before one can possibly detail the violations, it seems a wise course to describe the proper dimensions of a boundary, and these would seem to vary with the nature of the intervention being entertained. A therapist who, for example, believes in optimal gratification of a patient might well assume a different position than one who supports optimal frustration. A therapist who is planning to teach something to a patient will surely have a different set of preconditions than one who eschews that position. Without in any way supporting or discouraging these particular stances, we must examine them more carefully before we can consider any particular action as a violation of a boundary. In this sense, one distinguishes between boundary crossings and boundary violations (Gabbard and Lester, 1996), in that one necessarily crosses boundaries in treatment but need not thereby commit a violation.

Do Pre-Conditions Differ?

A perhaps apocryphal and unreferenced story told about Freud describes his ending an analytic hour with Helene Deutsch and having her sit up. Freud is then said to have explained to her just what had transpired during the previous analytic hour. This rapid transition from analyst to teacher illustrates the altered conditions required for his being the one rather than the other. His function as an analyst demanded of Freud a commitment to his own definition of neutrality

(which may have been a liberal one) while his performance as an instructor could be said to take advantage of a certain transference element that would lend strength to his educative efforts. Each of these positions lived within a set of boundary conditions that, while having some similarities, clearly differ from each other. As we consider the varieties of actions attributed to analysts, it is difficult to insist upon a single set of pre-conditions for what is now felt to be a range of activities that go beyond the single and most familiar one of interpretation. We call them pre-conditions because they are the necessary pre-existing conditions that allow for the ensuing activity, which, for some, may have interpretation as a final common pathway, but, for others, a whole series of activities ranging from trial identification to instruction to more active involvement.

One Example

Arlow (1979) lists the nature of an analyst's experience as going from passive listening to a change involving introspection of some material that intrudes into the analyst's consciousness. That change speaks of an identification with the patient and the taking on of the role of observer-interpreter. This is followed by intuition which consists of a silent and effortless organization of data. A third process, according to Arlow, is that of empathy, which is said to make intuition possible. These three components form the first part of the interpretive work. The second part is based upon cognition and the exercise of reason. Side by side, these two parts allow for interpretation to take place.

There seems to be no set position for an analyst or therapist to allow all of the above to proceed. The boundary for passive listening, if such a thing exists, seems not to coincide with that of trial identification or active interpretation. We are surely in different places at these different times. As Rangell (1979) says, "the analyst roams." He or she moves between transference and non-transference and avoids fixation points. Rangell refers to his and Fenichel's "necessary activity" and even goes on to note the emotional experiences that are corrective or therapeutic in all analytic procedures.

At the point of this "necessary activity," one sees the step beyond the concept of a boundary as a pre-condition and enters the arena of actions that are held to be therapeutic in themselves. It is often the case that boundary violations are rationalized as being in the patient's best interests, and so it may follow that a particular act can, in that way, be rescued from the category of misbehavior. However, this should better be thought of not so much as a boundary that demarcates a place of therapeutic action as a proposal for the supposed violation taking its place as a part of the therapy. One does or does not do something to a patient for the patient's benefit. There are a host of such maneuvers that have been offered over time – from yelling at patients to hugging them, from scolding them to applauding them, from the giving of gifts to accepting them. All of these actions become anointed as part of the treatment rather than as violations of a boundary. And, as such, they are not moral mistakes but rather are incorporated into one's ethical aim. Such actions lay claim to a status equal to that of analytic interpretation and so are defended as necessary. This, of course, is the major refuge for therapeutic misbehavior. It is therefore the crucial area for distinguishing the ethical from the moral viewpoint.

For the most part, analysts take refuge in the principle of abstinence. This stems from the theoretical assumption that one must frustrate the instinctual drives in order to develop an interpretable transference. Brenner (1979), in espousing this principle, agrees that some gratification is inescapable, but he takes issue with Stone's statement that there are occasions when an analyst should give advice to a patient or offer condolences when a patient suffers a catastrophe. Brenner feels these are not in accord with good analytic practice. But surely the failure to take these actions could be just as "gratifying of an unconscious infantile wish" as would the acts themselves. Neither position is a guarantor of an ensuing successful interpretation. Brenner rightly says, for example, that to express sympathy for a patient's loss of a loved one may make it more difficult for the patient to express pleasure over the loss. But to withhold it seems equally to run a risk of a different sort. Indeed, there is no sure way of knowing what your action or inaction will lead to, especially since much of what is communicated remains unconscious. Is it possible for one to feel sympa-

thetic, withhold sympathy, and still remain within the bounds of effective interpretive work? Is it equally possible to feel unsympathetic, yet offer sympathy and then proceed to analyze the patient's reaction to the loss? It seems more likely that each position runs the risk of going outside of the boundary required for effective interpretation.

Abstinence is no longer the insulated position for the conveying of insight, since the word may have lost its original meaning. Silence, all forms of withholding, all standards of anonymity, carry a powerful message, one that may convey more information than does talking, advising, and exposing. One must be very cautious in attributing a virtue to what is essentially a kind of negative behavior. Not answering a question can be creating a condition that inhibits interpretation just as much as does a prompt response. Abstinence as a form of the frustration of gratification can readily be seen, on occasion, as gratifying, just as action of many sorts is liable to be frustrating. Offering a tissue to a crying patient or refusing to do so speaks primarily to the therapist rather than to the theory of technique. There is no easy way to predict the effects of our involvement, and yet we are always involved.

What seems true of most analysts and therapists is the construction of one's own particular boundary within which one lives and operates. This may be termed one's style, but here it refers to one's conditions for therapeutic action. Given the usual moral norms, we all try to develop the optimal pre-conditions that allow us to be effective and efficient. Just as the taking of notes seems to work for some and to impede others, so too an entire system develops that becomes the most agreeable setting for the individual to function. Indeed, the interesting work on matching of analyst and patient (Kantrowitz, 1996) seems to support the notion that a host of factors come together that allow for a workable dialogue. This leads to the conclusion that not every patient will realize every transference with every analyst. It also suggests another conclusion that all sorts of behavior are allowable without any danger of indulging or conspiring with the patient or complying with the patient's distortions (Rangell, 1979, p. 93). To consider that question, I turn to another example.

Non-Interpretive Interventions

It is important at the outset to try to separate the customary behavior of a therapist – what some would call his or her basic style – from those actions of the therapist which are felt to be particularly directed toward an individual patient. To be sure, some actions are felt to impinge of necessity on any patient, and so there remain a large fuzzy area that defies easy categorization. One would suppose that if one hugs every single patient, it could become a matter of style, just as never uttering a word could be seen as the same. But let us proceed to examine interventions that can be seen as involving moving out of the established set of conditions or boundaries to effect a change just as an interpretation might optimally do.

Interventions that are felt to be therapeutic yet do not rely upon insight usually fall under the broad category of the "relationship" or perhaps the "therapeutic relationship." That term is an umbrella for the various kinds of connections of persons. There are different theoretical explanations for the ways that people connect or relate to one another. Object relations theory may posit the relationship as gratifying a drive while other theories may see a relationship as offering a psychic structure. The benefits derived from these relationships encompass a range of psychological terms, from holding to nurturing to growth enhancing. Most, if not all, of the benefits attributed to these relationships are posited on some scheme of development. Thus, a growth relationship may substitute for a failed development or may enhance a defective development or may allow for an arrested development to proceed. Inasmuch as there are variations in these concepts of development, there seems to be no agreed-upon set of explanations as to just why relationships are ameliorative. However, in the broadest sense, relationships are seen as functioning as supports or substitutes that are needed as a result of pathological development. A problem arises when one attempts to explain how a therapeutic relationship can lead to a long-lasting improvement once the relationship has ended and has done so without the benefit of interpretive work. That problem has bearing upon the issue of boundaries as preconditions, since we assume that the relationship is some sort of vehicle for therapeutic change and so is or should be both clearly delin-

eated and necessarily limited. Otherwise, it runs the risk of being an unending relationship, a form of addiction. Or else it must have a mystical component that defies explanation. On the other hand, the cessation of the relationship accompanied or followed by interpretive work is very much like the analytic situation of a bounded posture which allows for interpretation: it is just a different set of limits.

Relationships can thus be seen as extended boundaries that can be effective and are capable of being terminated. The ending of these relationships can then be interpreted with hope for insight, or terminated in such a way that development proceeds, as is posited in the formation of psychic structure. The crucial variable would seem to be that the cessation of the relationship leads to a positive change: something felt to be offered by the relationship can have a long-lasting effect. With this in mind, one can re-examine the issue of boundaries as pre-conditions, i.e., what sort of a relationship allows for a reasonable termination that results either in insight or in increased psychic structure? This serves to distinguish this category from transference cures and never-ending relationships. These last two, though not necessarily to be condemned, are variants of psychotherapy that call into question the very point of an ethical determination of what one considers best for a patient. However, the clearer category of a limited relationship returns us to the notion of an individual boundary for an analyst or therapist from which he or she can operate *and* which can be terminated to the patient's benefit. Relationships must therefore be seen as temporary way stations which, when interrupted, can be utilized by the patient. Unless a relationship can be dissipated by discussion, it tends to bind the patient to the therapist and the therapist to the patient. Therefore, for example, not offering condolences requires a discussion about what fantasies this evoked in the patient, just as does having a cup of coffee with the patient. Nothing can escape the need for metacomments, i.e., talking about what we just did. This scenario, which says that it matters not so much what you do but rather that it must be examined, both redefines neutrality and gives us a powerful tool to better delineate our concept of boundaries.

Transference and Boundaries

If boundaries are to be seen as the pre-condition for analysis and/or psychotherapy, then the entrance into the area of therapeutic work, either interpretive or non-interpretive, is an entrance into transference issues. Perhaps best emphasized by Gill (1979), the most reliable guide to the transference is what is actually going on in the analytic situation. Resolution of the transference can be seen as parallel to the resolution of the therapeutic relationship: the first by interpretation, the second by whatever developmental considerations may be entertained by the therapist. Persistence of the transference, though recognized as ubiquitous by all analysts, is reluctantly accepted with the hope for its ultimate diminution. Persistence of a therapeutic relationship falls under the category of the kind of maneuver encouraged by Basch (1995) in certain forms of psychotherapy, or else is to be otherwise explained. More often than not, this becomes the site of a host of boundary violations that are not in the best interests of the patient, primarily because they reflect a wide variety of unacknowledged, unspoken, and unresolved transference issues.

Relationships that are not interpreted can surely be vehicles for patient improvement, but it would seem to be critical to the improvement that they be the focus of the treatment. For example, if a patient improves in treatment partially because of the imposition of the regular event of treatment times in the patient's life, then the therapist must consider whether such regularity is now an added part of the patient's psychology and can be readily transposed to his or her life outside of treatment. I believe this to be a common occurrence in some non-interpretive treatments, although it may at times be a minor factor in itself. However, that example is one that primarily flows from the needs of the patient. When we examine aspects of therapeutic relationships that are products of mixed therapist/patient needs, we begin to see how difficult these may be to resolve, if indeed they demand resolution.

Once a commitment is made to an examination of all aspects of the analytic or therapeutic relationship, then no one part can be ignored. If a patient and a therapist have a cup of coffee together, it must be made the center of inquiry. There may be little difference in

an analyst's asking a patient how she felt about his failure to offer condolences and a therapist's asking what the patient's fantasies were during the coffee period. In each of these cases, one attends to the actual reality of the analytic or therapeutic encounter and studies it for its transference implications. An inquiry such as suggested by Brenner – to allow a patient to express his or her feelings about a recent loss – is essentially one that removes the analyst from the equation. The transference is therefore not the focus of this exchange; instead, the focus is on an outside commentary about the patient. The same may occur with a variety of interactions in many therapeutic relations. A shared cup of coffee is not a moment outside of the treatment, and so it can be neither condemned nor promoted, but rather must be made a part of the treatment.

Unfortunately, many aspects of these relationships that are not interpreted or otherwise resolved fall into the category of being unresolvable or, better, are never discussed. Every such discussion of an event or encounter places a bracket around the event and so segregates it from the ongoing relationship. It essentially says, "Let us step to the side to see just what transpired," and so in its own way, it destroys the moment. It also re-creates a boundary, one of inquiry and investigation, and in this manner, it undoes the relationship. It thus seems obvious that this is often the reason these issues remain undiscussed. Times of physical contact, of self-revelation, of gift-giving and gift-receiving, of emotional outbursts, all tend to evolve into conspiracies of silence, of awkward efforts to erase or rationalize the possible misstep. Analysts who yell at their patients insist that this is for the patient's benefit. Therapists who accept gifts from their patients claim it to be a natural part of the relationship. In either case, the event does not actively participate in the treatment either by its being understood or supported by a reason outside of the therapist's own needs. Once again it must be noted that each of these supposed missteps has a right to be brought in as a natural part of an ongoing treatment as long as one can demonstrate it as both needed and temporary. And no one can easily distinguish between a defense of any such behavior as either well planned or rationalized after the fact. The struggles of Ferenczi are an interesting study of that very uncertainty (Jones, 1957, p. 164).

Two Examples

Kohut (1984) tells of allowing a patient not to pay his analytic fee for several months in order to make a later purchase (p. 73). He states that the reason for the request and the meaning of the response only became clear much later in the treatment. He took a chance and perhaps was correct, but it was done in the process of the examination of the act.

At one time I saw a female patient who told of being in analysis with her husband's analyst during the same period of time. She insisted that this analyst never revealed to her anything that her husband said, but she said that she could not help but feel and even see that he knew a great deal more than she told him. It is difficult to see just how this could be claimed to be in the patient's best interest, but I have no doubt that such a claim would be made. It is only by keeping in mind the dual point of "temporary" and "necessary" that we can properly claim such probable boundary crossing as justifiable.

The Problem of Relationships

A review of a rather provocative book entitled *When Boundaries Betray Us: Beyond Illusions of What Is Ethical in Therapy and Life,* by Carter Heyward, an Episcopal priest, is a fascinating examination of what seems to be a confusion about boundaries, morals, and ethics. In the book, Heyward tells her own story about her encounter with a psychiatrist who, while agreeing to treat her, refused her request that they be friends. She goes on to say that this refusal was unethical and also a betrayal. The book reviewer disagrees and claims that the psychiatrist's error lay in her not setting boundaries clearly and early. This reviewer, Marie Fortune (1994), herself a minister and therapist, writes of the patient's mistaking a "healing" relationship for a peer relationship and assumes that the psychiatrist did not feel that a mutually intimate friendship was in Heyward's best interest.

The published review article is followed by a response from Heyward, who claims that she had indeed found just what she was looking for in her therapist who, at one point, agreed that only her

professionalism was an obstacle to this mutually intimate relationship desired by the patient. Heyward goes on to say that this allows pre-set rules and codes to dictate what may not be in the best interests of these participants. Inasmuch as this particular psychiatrist said that she would have liked to have been her patient's friend, one may feel that the issue is clouded by countertransference, but in its own way, it is clarified by this frank admission of the therapist. Before discussing this, mention should be made of Fortune's reply to Heyward. This last is a review of what is felt to be the respect of boundaries and a clear call to distinguish between professional relationships and those of intimacy. The plea is supported by an unarguable claim against exploitation of patients.

At first blush, one might quickly side with the reviewer who feels that this psychiatrist and her patient simply did not stick to the rules. However, an analyst might well wonder just why and how the need for this particular kind of relationship was understood and interpreted. As long as the wish to be a friend is taken as a potential violation rather than as a symptom, it remains a part of the struggle between patient and therapist. And sadly, with no mention of the unconscious determinants of this particular wish, our reviewer seems to join in by mistakenly considering this as a possible or potential boundary violation. However, one soon begins to side with the forsaken patient, who is never shown that relationships need not be either indulged or frustrated but rather must be understood.

The reason for the psychiatrist's refusal to be Heyward's future friend should not be seen in terms of potential transgressions, but rather as an impediment to her understanding what it means to the patient. The failure to adequately explain how one relationship differs from another, i.e., "healing" from "mutually intimate," stems from a barely concealed failure to understand what relationships are all about. This can only be solved by some sort of theoretical stance that squarely sees the relationship as a temporary place for a specific task. Regrettably, the word has itself gained a mystical aura that allows some therapists to claim an inherent "healing power" that relationships offer. With this claim, boundary problems seem inevitable, since some relationships seem morally correct while others are felt to be beyond moral norms. However, this misplaced judgment fails to say if the

relationship is a part of the treatment, i.e., is ethically correct. Being a friend is not immoral, but seeing it as a boundary violation blinds the reviewer as well as the psychiatrist from seeing it primarily as demanding an explanation rather than as a warning sign.

Discussion

To revisit the intent of this paper is to see that boundaries can be viewed either as practical roads to an end or as moral injunctions. We need to take a long-term view as to whether or not what is done will facilitate or impede the treatment, all the while knowing that some effects may not be predictable.

Boundaries may be seen as launching pads for treatment. Their supposed violations are both inevitable and invaluable. When we step across a boundary, an enactment takes place, and we thereby change our relationship with our patient. If the enactment is one of interpretation, then it may either lead to insight or to a different position for both patient and therapist. We are unable to move from a neutral bounded place to interpret and then jump back to a safe neutrality, since the conditions have now been reset: sometimes a little, sometimes a lot. These new conditions become the boundary for the ensuing work. And just as every interpretation calls for re-examining our position, so does every other sort of action or inaction. It is only the failure to recognize these resettings that allows for the prolonged realization of unresolved transference configurations and persistent untherapeutic relationships. Just as Sigmund Freud moved from analyst to teacher with Helene Deutsch, so too do we all inevitably modify our boundaries, and therefore we need to be aware of these ever-changing positions. It might even have been suggested to Freud that his mini-lecture to Deutsch be the focus of the next analytic hour. Nothing goes away, and everything counts. With this in mind, we may see that the attention that one must pay to boundaries is better seen as an ethical consideration – what is the best way to accomplish what this patient needs? – rather than a moral one – what have I done wrong?

The monitoring of one's boundaries can be burdensome as well

as painful. That would make clear, from an ethical point of view, why such things as physical contact, financial arrangements, and social interactions are the ruination of analysis and therapy: they are much too complex for any one person to scrutinize and interpret. Only one's personal unresolved megalomania would allow one to have dinner with an analysand: this is not a moral issue, but rather one that requires understanding that the general difficulty of this complicated state of affairs makes it nearly impossible to be handled in a treatment. Certainly, one cannot stay alert to all of the unconscious enactments (Hoffman, 1991) and the shifting boundaries of an analysis or psychotherapy, but the clues to those relationships that remain unexamined and unexplained become available for study as one's own grandiosity is subjected to personal scrutiny and questioning. Therefore, the effort to rationalize a boundary transgression is usually designed to avoid the proper inquiry as to what it meant to the treatment process. Thus, we should not so much limit our actions on the basis of the violation of moral norms as on the very practical point of our own very limited capacity to understand all that goes on between ourselves and our patients: events that should mainly accrue to the benefit of the patient.

I began this paper with the hope that a reconsideration of boundaries as the pre-condition for effective therapeutic action will move them from the arena of morality to that of ethics, i.e., pursuing an optimal treatment process. In this light, interpretations as well as various forms of relationships that aim to help patients can be seen as actions that cross and modify boundaries. New boundary configurations depend upon the recognition and, often, the discussion of what has transpired between the analyst or therapist and the patient. Without the examination of just what happens following an interpretation and/or an enactment, the newly formed boundary can unfortunately cease to be a pre-condition for further therapeutic activity and can thus become an uninterpreted or a not understood lasting situation. The continual scrutiny of the existing boundary configuration is a powerful antidote to the grandiose fantasy of being able to be more than just an analyst or a therapist. That should once again place us on a proper ethical path.

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COUNTERIDENTIFICATION, COMPREHENSIVE COUNTER-TRANSFERENCE, AND THERAPEUTIC ACTION: TOWARD RESOLVING THE INTRAPSYCHIC-INTERACTIONAL DICHOTOMY

BY DAVID B. FEINSILVER, M.D.

Two dichotomous trends in thinking about countertransference and therapeutic action can be delineated historically as well as in clinical practice: the intrapsychic and the interactional. The author proposes a new usage of the concepts of counteridentification and comprehensive countertransference to help transform these dichotomizing tendencies into more useful, integrative therapeutic action across the broad spectrum of psychoanalytic treatment for patients from the neurotic to the most severely disturbed.

The editors of *The Psychoanalytic Quarterly* note with sadness that this is a posthumous publication. David Feinsilver died of cancer at the age of 59 on February 23, 1999. For an account of his analytic work in the context of his struggle with his illness, see Feinsilver, 1998.

A previous version of this paper was presented at the conference "Countertransference and Therapeutic Action," Washington, D.C., December 4-5, 1992, under the auspices of the Advanced Psychotherapy Training Program of the Washington School of Psychiatry. In addition, another version of this paper was the 1997 winner of the Gary O. Morris Research Award, given by the Washington Psychoanalytic Society.

INTRODUCTION

The concept of countertransference has evolved in the context of two trends which tend to be viewed in the field of psychoanalysis as antagonistic and divergent: the first, with a narrower scope, has been termed the "intrapsychic" or "classical" view, and the second, having a broader scope, has been called the "interactional" or, alternatively, "relational" or "interpersonal" or "totalistic."[1] This paper will delineate how these divergent trends have arisen historically, how they occur in daily clinical practice, and how they can be more usefully integrated by using the concepts of counteridentification and comprehensive countertransference. A delineation of several of the key ingredients of therapeutic action emphasizing the role of the therapist[2] as a person will show how this integration can operate not only in classical analysis but also in psychoanalytic psychotherapeutic work across the entire spectrum of psychopathology. To this end, I will present a literature review, case examples, and discussion.

HISTORICAL REVIEW

In this review I hope to show how tendencies toward a dichotomization of the "intrapsychic" and the "interactional" points of view has had an unnecessarily fragmenting influence on psychoanalysis and has served as a stumbling block to integrative efforts for using psychoanalytic understanding in treating patients across the broad range of psychopathology. I will trace the evolution of these trends, focusing particularly on those contributions on the subject of countertransference, which, although furthering dichotomization, also develop new concepts that point the way toward its ultimate resolution. Note particu-

[1]This designation is somewhat reductionistic, but for purposes of simplification in this paper, I will try to stick to the terms "intrapsychic" *vs.* "interactional." Occasionally I will use the other, more inclusive terms when they seem warranted.

[2] In this paper the terms analyst, therapist and analyst-therapist will be used interchangeably depending on which aspect of functioning is being emphasized.

larly the central role of conceptualizations of empathic processes and the vicissitudes of processes of identification.

Freud's View

As Freud developed the basic principles of psychoanalytic technique, he discovered that the route to resolving the patient's *intrapsychic* conflicts was by interpreting the manifestations of these conflicts through the *interactional* effects of the patient's transference (Freud, 1912a). In fact, we might say that the technique we call psychoanalysis was born when Freud discovered that, for patients undergoing the hypnotic method, resistances to the cathartic flow of repressed memories were resolved by interpretation of the transference.

Moreover, although he gave very little explicit attention to the concept of countertransference, it is not too difficult to see, if we read between the lines, that the development of the concept of countertransference paralleled that of transference and was seen implicitly as crucial to working with it. For instance, through Freud's (1905) now famous postscript to the Dora case, apparently written "through the retrospectroscope" after his self-analysis, we can deduce it was Freud's discovery of what he himself would later call "countertransference" that enabled him to realize that Dora's love for him led to her premature termination. He only mentions this missed observation in passing and emphasizes instead his profound discovery of the role of transference resistance:

> Transference, which seems ordained to be the greatest obstacle to psycho-analysis, becomes its most powerful ally, if its presence can be detected each time and explained to the patient (p. 117).

Nevertheless we can easily deduce the unmistakable role of the analysis of his countertransference participation from his letters to Fliess. In these letters he details the belated recognition of his blindness to Dora's erotic attachment to him (see Bird, 1972).

Freud (1910) first defined the term countertransference in the "classical" sense, almost as an afterthought rather separate from techni-

cal considerations, in an attempt to purify the interactional field from contaminations arising from the patient's resistances and to maintain the intrapsychic focus on the patient:

> We have become aware of the 'counter-transference,' which arises in him [the analyst] 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...and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations about his patients (pp. 144-145).

In "Recommendations to Physicians Practising Psychoanalysis," Freud (1912b) does not explicitly use the term "countertransference," but he seems to be implying what we now consider the broader, interactional definition. Focusing on the importance of harnessing a wide range of personality factors, he describes the analyst tuning in to the unconscious of the patient, as with a telephone, as the basis for empathic communication. In what became known as his "telephone model," Freud seemed to be implying that the analyst somehow uses his total personality as a "receiver and transmitter." Although he leaves it for others to articulate later more precisely how this happens, this image vividly conveys how the combined empathic processes of the analyst's total personality can serve as a voice transmitting messages from an unseen source. He emphasizes, as he enumerates his rules of technique, that these principles are what he finds useful given his own personality. Although he does not go into the specifics of how his total personality is operating, he states that these are rules "suited to my individuality" (1912b, p. 111) for the purpose of harnessing the analyzing instrument to listen properly, with evenly hovering attention, to the free associations of the patient. He adds, "I do not venture to deny that a physician quite differently constituted might find himself driven to adopt a different attitude to his patients and to the task before him" *(ibid.)*. Nevertheless, Freud excludes from consideration an explicit accounting of the interactive implications of personality as he gives more explicit definition to his narrower focus on classical countertransference. Although still not using the term

countertransference, he states that the resistances must be overcome in order for the analyzing instrument to function properly. He says the analyst must undergo a "psycho-analytic purification" (p. 116) to make this happen. It has been suggested that Freud's exclusion of the interactive component from his view of the intrapsychic dimension in the interaction of transference and countertransference probably resulted from his own analysis being a self-analysis which did not involve interactive working through with another analyst (see Bird, 1972). Thus, seeing the analyst's transference this way as a counter to the patient's transference formed the basis for what came to be called the narrower "classical definition," or Freud's definition, of countertransference. It seems important to note, however, that in actual clinical practice Freud himself was probably not so "Freudian" and was very much trying to take into account the broader focus without including it in his formulations (see Lipton, 1977).

Freud focuses explicitly on the narrow aspect of what he means by countertransference in "Observations on Transference Love" (1915), when he states that one of the main problems in management of the transference occurs when the patient falls in love with the doctor. The analyst must not give in to a "tendency to a counter-transference" (p. 160) and see this as due to the reality of his own charms. And while he makes it clear that the physician "should deny to the patient who is craving for love the satisfaction she demands," and that "[t]he treatment must be carried out in abstinence," he also leaves room for the broader, as yet uncharted, definition when he states that, obviously, he does not mean "the deprivation of everything that the patient desires, for perhaps no sick person could tolerate this." He goes on, "Instead I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes..." (p. 165). In addition, toward the end of the paper he emphasizes how much difficulty he knows this can create for the analyst. He points out that basically, except for taking place in the context of the analytic situation, "transference-love" is pretty indistinguishable from "'genuine' love" (p. 168) and urges the analyst nevertheless to be like the chemist who knows that he is dealing with "highly explosive forces" but must proceed anyway with "much

caution and conscientiousness," and be "not afraid to handle the most dangerous mental impulses and to obtain mastery over them for the benefit of the patient" (pp. 170-171). He does not, however, tell us how to best balance the necessary gratification with abstinence to achieve optimal persistence of "need and longing;" nor does he specify any parameters. He very vividly and poetically gives us the metaphor of the chemist handling dangerous impulses, but he does not give any clues as to how to achieve this. As anyone who has dealt with patients under such influences knows well, Freud is pointing to, but not fully articulating, a broad area of still uncharted countertransference issues.

Heimann and Reich

For the next forty years there was very little written on countertransference that has had any significant impact on the field. In the 1950's, however, a spate of articles began to delineate areas of controversy and take up different sides.

Heimann (1950) criticized what she felt had become a caricature of Freud's "classical" view of countertransference which was being defined in terms which she felt were too mechanistic, "unfeeling and 'detached'" (p. 81). In her groundbreaking article she noted that analysts tended to misunderstand Freud's emphasis on paying exclusive attention to one's thoughts in "evenly hovering attention." She argued that even though he did not emphasize it, Freud meant to include in his telephone model that in addition to paying attention to one's thoughts, paying attention to the "freely roused emotional sensibility" (p. 82) of his interaction with the patient was also at the center of how the analyst's unconscious will understand that of the patient. She argued that the analyst's reactive feelings contained useful information about what the patient was resisting. She was among the first to emphasize that countertransference could be *a path to understanding the patient*, as well as an interference, and among the first to argue for a broad, interactional definition of countertransference which she specified as "all the feelings which the analyst experiences towards his patient" (p. 81). She contended that when

analysts misunderstand Freud's focus on evenly hovering attention and try to eliminate their own transferential feelings that are aroused in response to the patient's transference, they are excluding important information about the patient. Heimann pointed the direction for the future when she closed her article with a plea for the field "to work out more fully the way in which the character of the counter-transference corresponds to the nature of the patient's unconscious impulses and defences operative at the actual time" (p. 84).

Partly in response to Heimann's views and partly because of the need to provide a long overdue explanation of what Freud had in mind in the telephone model, Reich (1951) articulated more fully the narrower, classical view of countertransference which she defined as "the effects of the analyst's own unconscious needs and conflicts on his understanding or technique...[because]…the patient represents for the analyst an object of the past on to whom past feelings and wishes are projected…" (p. 26). The analyst's technique, as she saw it, centered on the experience of insight coming as a sudden gestalt based on a partial identification with the patient. She was, therefore, picking up on Fliess's (1942) core concept for understanding the workings of the telephone model called a "trial identification." What interferes with this process of partial identification, she noted, was the analyst's countertransference. The analyst might (a) identify too much with something intolerable in the patient's *self* experience, or (b) identify too much with something intolerable in the patient's *object* experience (the clear division into self and object is my emphasis). Although she was clearly making a plea for the narrower view of countertransference, Reich (1951) also made some important contributions to the broader view. In the close of her article, for example, she argued:

> Counter-transference is a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest is lacking. But it has to remain shadowy and in the background (p. 31).

Applications to Sicker Patients and the Concept of "the Corrective Emotional Experience"

During this prolific period, Little (1957) focused particularly on the interactive aspects of working with sicker patients. She extended the telephone model beyond "free floating emotional responsiveness" (Heimann, 1950) to *"the analyst's total response to his patient's needs, whatever the needs, and whatever the response"* (Little, 1957, p. 241). She called this the "R" response. She noted that before analytic work could progress to the point where transference interpretations might be meaningfully heard by the patient, the analyst had to involve her/himself as a total person with regard to several dimensions: a) commitment to the patient, b) responsibility for the patient, and c) feelings for the patient. At the same time she emphasized that this had to be done within realistic limits as to what the therapist could and could not accept.

Tracing its origins to earlier work of people such as Ferenczi (1933), a major development in the interactive school during this period was the evolution of the concept of expressive participation of the analyst as a reparative object. Some, such as Balint (1952), emphasized the value of a positive object, and others, such as Winnicott (1949), emphasized the value of objective hate. But this trend can be seen to reach its culmination in the work of Alexander (1956) and the notion of "the corrective emotional experience." He argued for the central importance of the therapist's behaving in actuality in ways that are different from the transference objects of the patient's past.

During this same prolific period of the 1950's there were several key figures associated with Chestnut Lodge Hospital, such as Weigert (1954), Cohen (1952) and Searles (1973a, 1973b), whose efforts to apply psychoanalytic principles to sicker patients led them to articulate further aspects of the intrapsychic and interactive perspectives. Particularly influential was Searles, whose contributions centering on processes of identification extend to the present day. Combining both classical and interactive perspectives, he emphasized many different aspects of countertransference in his model of therapeutic action, which he termed "therapeutic symbiosis" (1973a). He emphasized particularly the reparative value of the patient and therapist working through phases of a mutually dependent, "symbiotic" relationship.

He noted that one aspect of the interaction that needs to be resolved is the role reversal that forms in the tendency of the patient to heal and be "therapist to his analyst" (1973b). Searles was also the first to note the tendency of the therapist to repeat, in supervision and other settings, a parallel to what the patient was doing to him. He called it a "reflection phenomenon" (1955), and the phenomenon has come to be included in what has been more broadly called "parallel process" (Gediman and Wolkenfeld, 1980).

Projective Identification and Role Responsiveness

This brings us to the contributions of the object relations theorists in the 1950's, 1960's, and 1970's, such as those of Bion (1967), Grinberg (1962), Kernberg (1965), and Sandler (1976). Trying to explain countertransference phenomena using Klein's concept of projective identification, they focused on trying to explain the interaction of intrapsychic and interactive phenomena on the basis of combining projective and introjective mechanisms into a single process. A prime example is Grinberg (1962). He articulated the concept of projective counteridentification as a particular type of countertransference in which the analyst inappropriately accepts as his/her own a projective identification from the patient (unknowingly identifies with what is being projected). Grinberg says that once having counteridentified with the patient's projection, the analyst can react by either fighting against it, passively accepting it, or beginning to react more therapeutically to it by understanding and metabolizing his/her involvement, a process Bion called "containment" (1967).

Because of the confusion in the literature that tends to surround the usage of projective identification (see Feinsilver, 1983, particularly the discussion around blame-throwing). Sandler (1976) tried to characterize the phenomenon in other, more classical, terms by defining what he called "role responsiveness." Sandler saw this as an update of Heimann's concept of "free floating emotional responsiveness," which was in itself an attempt to update Freud's concept of "free floating attention." Without articulating the details of the process, Sandler advises the analyst to focus on the kind of role he or she

tends to adopt in the interaction with the patient. Then through self-analysis, paying particular attention to patient and analyst contributions which create the role, the analyst can deduce what the intolerable situation is that the patient is trying to ward off.

Kernberg (1965), in his landmark article during this period, noted two developing trends. He called the more narrowly based focus on the analyst's intrapsychic conflicts, used primarily by classical analysts working with neurotics, "classical countertransference," and the broader approach focusing on interactive phenomena, used primarily by analysts working with sicker patients, "totalistic countertransference."

Racker

In his 1957 overview article entitled "The Meanings and Uses of Countertransference," Racker made the most profound contributions to date, still insufficiently appreciated, toward integrating interactional concepts with the intrapsychic (see Hoffman, 1983). I will summarize these contributions and then show how the terms "comprehensive countertransference" and "counteridentification" derive from his conceptualizations.

Racker emphasized that transference and countertransference are mutually influential and interactive, such that, for instance, the patient's transference could be understood as a reaction to the analyst's transference. Countertransference, like transference, he said, was the result of several double-barreled influences: past and present interaction, fantasy and reality, and unconscious and conscious processes. In criticizing what he called "the myth of the analytic situation," he emphasized that the analytic relationship had to be understood as a relationship between two personalities, and that it needed to encompass everything that can happen between two persons.

Racker stressed that countertransference could be a source of interference as well as a valuable ally. But he also saw its potential for re-creating the past in a new, growth-promoting way. Management of the countertransference was a central tool in the work. His view of countertransference was analogous to Freud's comprehensive view of transference. In short, Racker took an all-encompassing point of

view as he tried to take into account the totality of influences on the analyst's reaction to the patient. This indeed seemed to be the first major step in the direction of bridging the gap between the intrapsychic and interactional points of view.

In an effort to straighten out much of the confusing terminology surrounding the concept of countertransference, Racker made the sensible suggestion that one should be sure to use specific modifying terms to make clear which aspect of countertransference was being considered. The term "countertransference" alone would be used only when talking in a nonspecific way, while terms such as "negative countertransference," "positive countertransference," "erotic countertransference," etc. would be utilized to emphasize specific aspects of countertransference; terms such as "neurotic countertransference" or "classical countertransference" would be used when referring to Freud's original definition and the term "total countertransference" when referring to the broad area comprising any reaction of the therapist. Therefore, for the sake of clarity, I propose that adjectives always be used to emphasize the category or subcategory we are considering. The adjective "comprehensive" should be used when referring to the all-inclusive, overarching sense of the term "countertransference." Thus, "comprehensive countertransference" can be seen as a general category of countertransference containing such subcategories as "intrapsychic" and "interactional" countertransference, as well as all the other specific ways in which the concept is used.

Racker focused on two specific types of countertransference: "concordant" countertransference and "complementary" countertransference. As I understand them, concordant countertransference refers to ways in which the analyst's *self* representations, using an updated telephone model, become identified through empathy with different aspects of the patient's *self* representations, while complementary countertransference refers to ways in which the analyst's *self* representations become identified with the patient's *object* representations. It is important to be clear that concordant and complementary countertransference identifications coexist and have an interdependent, dialectical relationship with each other, growing out of the empathic bond that arises when one person attempts to give care to another. Whether or not one type or the other becomes dominant, as I un-

derstand it, depends on the vicissitudes of the analyst's experience of frustration with the patient in the transference-countertransference interaction as the patient and analyst come increasingly under the sway of the patient's evolving transference resistance.

The tendency of the analyst to create new, concrete identifications with the patient as part of the concordant countertransference experience determines the nature of the analyst's self and object experience as he or she tends to project what is intolerable and introject what is compatible. Borrowing from Grinberg's concept of projective counteridentification, I propose that we refer to these newly created, concrete identifications simply as counteridentifications. The projective aspect is dealt with as a separate process (following Sandler, 1976, and Feinsilver, 1990). The analyst's tendency to create these concrete counteridentifications is driven by the inclination to do back to the patient what the analyst feels is being done to him/her. The governing principle, according to Racker, comes from the biblical injunction, "an eye for an eye and a tooth for a tooth," or the biblical prescription for its antidote, "Do unto others as you would have them do unto you." The positive and the negative can be seen to go hand in hand, as bad objects beget bad and good objects beget good. Therapists form an unconscious identification with the aggressor as they tend to hit back in the same way while projecting externally the most conscious negative aspects of their aggression and maintaining internally what is good. The counteridentification thus expresses one's frustration while emotionally disconnecting from the external source of blame for the frustration. Racker gives the recognizable example of the suicidal patient for whom we feel to blame for failing to help. We feel like quitting out of a sense of helplessness and hopelessness, or in the extreme, we feel like killing ourselves. The therapist needs to recognize that the wish to blame either her/himself or the patient is part of a vicious cycle of blame-throwing that is set off by the wish to kill one's self originating in the patient – a concordant identification with the patient's self-destructive tendencies. It is important to note that although Racker is clearly using, and is greatly influenced by, Kleinian concepts such as projective identification, he does not use Kleinian terms. He integrates these concepts into classical terminology, into concepts of projection and introjection. This is

particularly useful, I believe, because it helps the analyst realize that his/her concepts of origination and causality come from his/her participating in a projection, and this helps the analyst to tease out the elements leading to a tendency to put interpretations into a framework (such as projective identification) which only perpetuates the blame-throwing. (For further discussion of blame-throwing, see also Sandler, 1976, and Feinsilver, 1983.) Determining whose frustration is coming from whom resolves the tendency towards perpetuating a vicious cycle.

Racker also notes that tendencies to express transference in action rather than in thoughts give rise to what he called countertransference positions rather than countertransference thoughts. These positions are due to "the strength" of the transference disposition being dealt with. If one takes the strength of the transference disposition to mean the strength of the basic need-satisfying transference that is mobilized, then the degree to which the holding environment is threatened will determine the degree to which action will replace thoughts in the countertransference in parallel to the transference. In other words, whether the patient is healthier or sicker, there will be a tendency for the analyst to encounter action in him/herself rather than thoughts, solely on the basis of how threatened the holding environment is at that moment in the interaction between analyst and patient.

Racker closes his landmark article by talking about the need to establish parameters for "countertransference disclosure" (sharing of personal reactions) and warning against overestimating countertransference feelings as an "oracle" or "the answer." Referring back to Freud's telephone model for understanding transference-countertransference interaction as a receiver and transmitter of the unconscious, Racker wisely states that our unconscious countertransference feelings are to be understood as no more and no less than "the best [receiver and transmitter] we have of its kind" (p. 354). To my mind, Racker was pointing here to a need to de-idealize and demystify the classical model and establish the parameters for bringing into the relationship the reality of the personal interaction between analyst and patient, thus pointing the way toward the whole new dimension of the analyst as a person.

Current Trends in the Interpersonal and Relational Schools

Emphasizing a "two person psychology" derived from the interpersonal school of Sullivan (1940) and the object relations school of Fairbairn and Klein, many writers in the 1980's and 1990's have aimed toward a more integrative approach while emphasizing various interactive aspects of countertransference.

Gill and Hoffman (1982) emphasized that the analysis of transference is a relational experience. Hoffman (1983) described a new paradigm which he called a "social-constructivist" approach: it emphasized the co-creation of both repetition (via enactment) and new experience by patient and analyst. He has articulated further aspects of the analyst's countertransference experience and has advocated a perspective in which the analyst's "expressive participation" is in a dialectical relationship with "analytic discipline." That perspective reflects Hoffman's (1992, 1994) increasing emphasis on dialectical thinking in general. Ehrenberg (1992), defining what she calls an "intimate edge," delineates various aspects of countertransference, such as reality, authenticity, spontaneity, and disclosure, which are important in the creation of a mutative, relational experience. Levenson (1991), focusing on some of the same issues, places emphasis on the creation of a new, plausible story, a process he calls "deconstruction," borrowing a popular term from literary criticism. Mitchell (1988) has developed a model of therapeutic action in which he focuses on a "relational matrix" which transforms old "bad object" experiences into new relational experiences and, more recently (1997a), has focused on the importance of the analyst's authority and the dialectical interplay between influence and autonomy.

Other major authors writing from this perspective are: Aron (1991), focusing on the patient's experience of the analyst's resistance; Bromberg (1979), on the importance of regression; Davies and Frawley (1994), on the reparative experience of victims of sexual abuse; and Stern (1997), on unformulated experience. In addition, the pros and cons of countertransference disclosure have been debated by many (Cooper, 1998; Mitchell, 1997b; Pizer, 1997). Also growing out of this perspective is an "intersubjective school" which focuses on the transference-countertransference interaction as a rela-

tionship between two subjectivities (Natterson and Friedman, 1995; Stolorow and Atwood, 1992).

Taking an anti-integrationist stand, Greenberg and Mitchell (1983) developed the thesis that a "relational/structure" model has evolved as distinctly different from, and incompatible with, the traditional "drive/structure" model. In contrast, others have begun to emphasize common ground (Gabbard, 1997; Hirsch, 1998). Nevertheless, controversy about the relative importance of interactional *vs.* intrapsychic aspects persists.

The Move to Abolish the Concept of Countertransference

In response to the increasingly complex and confusing use of concepts and terms, several authors, such as McLaughlin (1981), have argued for doing away entirely with the concept of countertransference and encompassing the phenomena of transference-countertransference simply in terms of the analyst's transference and the patient's transference. It is argued that by taking the broad view of transference as a mental function which enables analyst and patient to relive the past and reshape the present and future (see Bird, 1972), the "work ego" for both analyst and patient is promoted, and the concept of countertransference becomes superfluous. While this trend has the advantage of promoting the need to distinguish between the two transferences and fostering a healthy, well-functioning alliance between two "analytic work egos," it assumes that each ego is clearly separate. But more important, in insisting that we precisely distinguish between the analyst's transference and the patient's transference, we cannot encompass confusing situations, such as counteridentification, in which the analyst's transference becomes an integrated expression of the patient's transference as well as his or her own.

Current Efforts to Bridge the Gap as Exemplified by Jacobs and Renik

Following from work in the 1970's and 1980's in both the intrapsychic and interactional schools, current writings on countertransfer-

ence and therapeutic action can be seen as continuing to demonstrate how the best integrative efforts still result in unnecessary dichotomization as they struggle to bridge the gap between the two approaches. I will take as examples the work of Jacobs, coming from an intrapsychic point of view, and Renik, coming from an interactional one. I will review their writings, including examples in which each of them takes issue with the other's perspective. Then, using a case vignette from each, I will show how insufficient use of the concept of the counteridentification process produces an unnecessary dichotomization.

Trying to stay within the classical model, Jacobs has articulated, in a series of papers over the past two decades (1973, 1983, 1987, 1990, 1991, 1997), how hidden aspects of the here-and-now relationship with the patient can be illuminated by careful attention to aspects of the analyst's countertransference experience. Greatly influenced by work in kinesics, the study of communication through bodily movements, he noted (1973), for instance, that the analyst's posture and gesture could provide a signal awareness of his own transference revivals (classical countertransference), thereby revealing empathic cues to how the patient is experiencing him. And this was something that neither he nor the patient could previously see. He describes how he sees his own body position as an unconscious response to an unconscious communication from the patient's body position, although he does not articulate clearly how this communication occurs (as Freud did not in his telephone model). He sees this discovery, however, as enabling the analyst to tune in and interpret the patient's unconscious resistance.

In a paper entitled "Notes on the Unknowable" (1987), Jacobs begins to characterize more specifically how he sees his countertransference as preparing the pathway for interpretation. He notes his own transference reasons for repressing and keeping secret certain intolerable areas of concern. He sees the clarification of his own transference, which has been responsible for enacting an interfering collusion with the patient, as the important aspect of his countertransference that frees him to see his patient more clearly. This then leads, as he sees it, to a full analytic exploration, interpretation, and resolution of the relevant issues for the patient.

Jacobs (1990), however, also begins to move in an interactional direction in a paper revisiting Alexander's concept entitled "The Cor-

rective Emotional Experience." Here he advocates promoting the expression of certain kinds of countertransference feelings, particularly with sicker patients, for the expressed purpose of correcting certain negative transference dispositions. He notes that, rather than interfering with the analytic process, such activity can be most facilitating to insight and therapeutic action. Although Jacobs moves toward an integration of the classical and the relational perspectives, he maintains a definite classical focus. The therapeutic action of psychoanalytic work centers on analyzing the interplay of intrapsychically based transference reactions of himself and his patient and is probably best exemplified in his paper, "The Interplay of Enactments" (1991).

In a series of recent papers, Renik (1993a, 1993b, 1995, 1996) has been developing a more interactional model, systematically attacking some of the major tenets of the classical model while maintaining others. Central to his critique of the classical model presented in his paper, "The Ideal of the Anonymous Analyst and the Problem of Self-Disclosure" (1995), Renik sees the blank screen model and the anonymity of the analyst as unnecessarily fostering a self-perpetuating, idealized view of the analyst's authority (what Racker warned against). Accordingly, this screen model fosters the patient's idealized view at the expense of his or her negative views; thus the bottom line: transference resistance is enhanced. For Renik, the antidote is to demystify the analyst by paying attention to the patient's interpretation of the analyst's experience (see Aron, 1991; Hoffman, 1983). Together with judicious use of self-disclosure to make explicit the *analyst's* thinking, one aims for exploration and interpretation in the context of the interaction of subjectivities (see Natterson and Friedman, 1995; Stolorow and Atwood, 1992).

Another major feature of Renik's critique, taken up in his paper, "Countertransference Enactment and the Psychoanalytic Process" (1993a), is that he takes issue with the classical concept of enactment in general and Jacobs's ideas in particular. Jacobs views enactment as an error of technique which will inevitably happen and can be seen as part of a useful learning experience for the analyst. Renik argues instead for seeing enactment from the outset as a positive, necessary part of the therapist's basic subjective participation. Rather than something to be prohibited, Renik sees enactment as something which naturally occurs as a constant dimension of analytic events, to be allowed and

accounted for within limits (not intentionally arranged), and then analyzed afterward. He emphasizes that this allowance does not amount to a license for wild analysis and "anything goes," but argues instead that any inclination toward exploitation of the patient by the analyst under these circumstances is naturally governed by (a) general ethical considerations, as with any professional, and (b) the anti-authoritarianism of the demystifying, non-anonymous "uncertainty of subjectivity." Thus, according to Renik, the concept of countertransference, even totalistic countertransference, is replaced by the concept of total intersubjectivity. The focus of therapeutic action goes from an authoritative therapist interpreting the patient's unconscious roots, to a therapist engaging the patient in a kind of corrective emotional experience, involving a mutual resolution and discovery of unconscious interferences in both therapist and patient.

For Renik, neutrality, anonymity, and the "blank screen model," for instance, have been dropped in favor of the notion of "the interaction of subjectivities." Freud's telephone model and "evenly hovering attention" as the focus of therapeutic action have evolved beyond Heimann's "free floating emotional responsiveness," beyond Sandler's concept of "role responsiveness," to "evenly hovering subjectivity" (my term). Analysis and interpretation of transference resistance as the tools of therapeutic action have evolved into exploration and interpretation of mutual enactment of transference and countertransference resistance in the context of a corrective emotional experience.

While Jacobs and Renik emphasize the importance of both major aspects of comprehensive countertransference, the intrapsychic and the interactional, they have clear differences. In contrast to Jacobs, Renik's primary focus is on the therapist's joining the patient in creating a meaningful healing experience in the "here and now" (interactional). Interpreting the past both in himself and in the patient (intrapsychic) is important only insofar as it serves this end. For Jacobs, it is the other way around. Although Jacobs, too, acknowledges the importance of corrective experience, his main use for the here and now is for insight in interpreting the present in terms of the past.

In looking at the clinical material that these authors use, it seems clear that the views of Jacobs and Renik would be less divergent and dichotomous if each took into better account how the role of the analyst's

counteridentification can integrate both intrapsychic and interactional perspectives. In Jacobs's focus on the vicissitudes of the analyst's transference reactions and Renik's focus on the interaction of subjectivities, each, without realizing it, emphasizes one aspect of the counteridentification process to the exclusion of the other. Clearly, a more integrative position is needed.

For instance, in an example from a recent paper (1997), Jacobs describes how, at a moment of silent frustration with Mr. S, he was overcome by an inexplicable sadness, and his associations were taken over by the following three images: (a) a visual memory of being rejected by his ill father at a time when he wanted him to appreciate his accomplishments in a game of catch, (b) a six-year-old patient hitting a rubber ball with a paddle regularly without a miss, and (c) a boy sitting alone on a park bench. Although not able to do much with this spontaneously, after much self-analysis, Jacobs was able to understand for possible later interpretation the following: Mr. S. was probably experiencing an underlying sadness because of feeling rejected and lonely in the interaction with Jacobs that had just preceded the silence, in much the same way, for much the same reasons, that the people in Jacobs's images did, including particularly the way he had felt with his father. Eventually, in this case he does come to appreciate the here-and-now, interactional aspect that has been eluding him.

In this vignette one sees that Jacobs is utilizing his counteridentification with the patient to clarify how his own intrapsychic past is resonating with what his patient is experiencing. But he does not take into account the fact that this counteridentification is a product of the battle with his patient, of which he is unaware, over the fact that his patient is frustrating him in much the same way that the patient feels frustrated by him in the transference at that moment. I would argue that if Jacobs accepted the importance of the interactional aspect, he would be more easily aware of how his counteridentification was functioning as an identification with the aggressor in his here-and-now battle with his patient. In addition, being more aware of how this here-and-now battle was being warded off by both patient and analyst would have put Jacobs into a better position to address his patient's frustration of the moment with an interpretation that was part of a more integrative, corrective emotional expe-

rience.

In another example, Renik (1996) describes how his patient begins to recall memories of the ways in which she was both neglected and sexually stimulated by her parents, but does this only after Renik interacted with her by taking sides and arguing with her. Renik acknowledges that his arguing was stimulated in large part by angry-critical memories from his own past family situation, but that he was initially unaware of this. Eventually, after he "engaged dialectically" (interpretively and interactionally) with his patient, the basic transference-countertransference situation emerged more clearly. He was then able to recognize that his outrage and criticism of his patient's plight were due to counteridentifications (he does not use this term) with situations in his own personal life which engendered outrage and criticism. While emphasizing interaction, he becomes caught up in arguing about the way his patient was frustrating him at the moment and does not realize his own neurotic contribution. Renik tries to argue for the value of intuitively letting himself get caught up in arguing with his patient and analyzing it afterward.

In this vignette, it seems to me, Renik is showing that if he had been more aware earlier of how his counteridentification was being influenced by his own intrapsychic past, he might not have been so argumentative for so long. Perhaps then he would have been in a better position to address "interpretively" and in a "corrective emotional" way the intrapsychic roots of his patient's frustration of the moment. While I would certainly agree that it may be necessary and useful for Renik to interact with his patient the way he does, I would simply argue that his experience would be more integrative and less argumentative if he were more aware of how much his own anger was being generated by the counteridentifications from his own intrapsychic past, as well as the multiple here-and-now realities from the battle with his patient. In my view, this would enhance, not preclude, the usefulness of an intersubjective, corrective emotional experience. Both interpretive as well as corrective-emotional aspects would be present all along.

Thus, due to insufficient use of the counteridentification process, both Jacobs and Renik, coming from opposite poles of the intrapsychic and interactional dichotomy, can be seen as emphasizing one aspect

while missing the integrative aspects of the other side that would contribute to a better treatment.

BRIEF CASE VIGNETTES

The following vignettes from my own work will elaborate how careful attention to the counteridentification process promotes integration of the intrapsychic and the interpersonal. The case material will show how this particular use of counteridentification process elements, which is part of the analyst's comprehensive countertransference, fosters the therapeutic action of analytic work across the diagnostic spectrum. Furthermore, this is an attempt to extend the historical evolution described to include a more integrative view of the intrapsychic and the interactional perspectives.

Recognizing the counteridentification process will provide a specific, uniquely targeted, empathic view of what is frustrating the patient at a particular moment in the interaction with the analyst. In an effort to convey the everyday usage of this tool and its many variations, I have chosen arbitrarily the following three vignettes.

Case 1: Ms. Triple Play (DSM IV = Depressive Neurosis with Dissociative Features). Ms. TP is a middle-aged mental health professional who keeps finding that in her efforts to achieve her analytic goal of being able to "communicate meaningfully," she is being thwarted by an "angry-pleasing" way of relating that overtakes her and from which she feels emotionally disconnected. Her frustration causes her to thrash the couch angrily at these moments. I call this patient Ms. "TP" or "Triple Play" because previous analysis revealed that this behavior was expressing anger in a threefold way: against the minister father who sexually abused her as an adolescent, against the busy socialite mother who emotionally abandoned her, and against her guilt-ridden self that she feels keeps bringing such tragedies upon her. Her "depression" about feeling "haunted" by these issues brought her to treatment (see earlier vignette in Feinsilver, 1990).

In today's session, she begins to hit the couch, saying that she is angry at herself because she can't tell when she started to do "it," refer-

ring to her passive-aggressive "angry-pleasing" way of relating. I notice that I, too, am becoming furious with myself because I did not realize when she started to do "it." In fact, I thought she was talking quite meaningfully, and it was not until she mentioned it that I realized I had let myself get drawn into falsely thinking that she was expressing herself genuinely. At this point I noted that I was muttering angrily at myself for getting caught up in it, in much the same way that Ms. TP does to herself. But then it struck me in a flash that I was being angry at myself instead of at Ms. TP, and in so doing I was failing her just as she was doing to me. That is, I was counteridentifying with her way of unknowingly expressing retaliatory angers against her bad object in the transference.

Thus it became clear to me (I had a sense of fogginess being lifted) that it was her anger at being sucked into being "had" by me that she was defending at this moment by turning it against herself. With the image of my own anger at recognizing my own "getting sucked in" as a model, I began to supportively explore with her whether a big part of what was setting off her frustrated hitting of the couch was that she was having difficulty being aware of the feeling of being sucked into something. She said, "Exactly," and added quickly that she keeps recognizing how she gets sucked in all the time, but, she emphasizes, she ends up hitting the couch because she feels she gets disconnected from the impulse to please me that seduces her in the first place. She was then reminded of the anger she felt about trying to maintain the lost "hero image" of her father after the abuse incident. She recalled being in boarding school, where she was sent after the sexual abuse incident, and how angry she felt about having to submit to the authority of the teachers there, who knew her father as a former teaching colleague whom they greatly admired for his high moral principles. She began weeping profusely as she expressed particular bitterness about getting sucked into having to keep the secret of his abuse to herself and go along with maintaining the hero image of him.

I felt that specific repressed memories were being released which were associated with an aspect of Ms. TP's bad object experience of me as an abusing parent. She was trying to preserve my good image as she turned her anger on herself (and the couch) while also dissociat-

ing it from its object (me as a sucking-in object). My counteridentification (as a victim who gets sucked in and gets angry at himself) was serving me as an intrapsychic guide to interpreting empathically Ms. TP's interactional experience of me at that moment.

Case 2: Mr. Uncommitted (DSM IV = Narcissistic Personality Disorder with Depressive Features). Mr. U is a married lawyer in his early thirties who came to treatment because he was depressed over not being able to feel committed to any career. As part of our initial evaluation I told him that his experience at age five or six of having his father divorce his mother and abandon the family seemed related to his problem in making commitments, and I would recommend that we continue exploring these issues in an analytic treatment. Since he refused to accept the possibility of an indefinite commitment to formal psychoanalysis on the couch, or to fully accept the idea that he really needed any treatment at all, we agreed to proceed in a three-times-per-week, face-to-face, psychoanalytic treatment. From the beginning, the issue of commitment played itself out in his reluctance to accept a policy of "renting time." Although he very much appreciated the principle of my "committing" hours that he could count on and was willing to accept my policy up to a point, he made it clear that he did not like the idea of paying for missed hours that he felt were not his fault. I therefore agreed to go along with his request for me to "be flexible" and to try within certain limits to reschedule hours that he could not make, as long as he agreed to consider the possibility that these concerns might have something to do with his fears of making commitments in life.

This system worked fine for several years, and Mr. U became increasingly involved and committed to our work. He and I gradually learned that the malaise that would overtake him in life, often reaching suicidal proportions and leaving him feeling unable to get himself motivated to pursue commitments, was related to fears of angry eruptions at people who were slighting him in the same way he felt his father did. In addition, we clarified that it was the eruption of these concerns about being slighted by me, or the opposite in passive homosexual surrender, that had as its core the fears of being abandoned. As this became clarified, Mr. U declared that he was finding our work very helpful and would often announce proudly that he

was feeling increasingly committed to it. At the same time, he would make clear that he was unwilling to make a full commitment to seeing the treatment through; in fact, he was beginning to feel that he had gotten enough from it to begin making plans to move with his wife back to their country of origin in order to settle down and begin a new life together. He said this even though he recognized this might be considered a premature conclusion of the treatment.

At this point, just prior to the time of a scheduled hour, Mr. U called to say that, due to a snowstorm that had left the roads somewhat icy, he wondered whether I might be able to reschedule our early morning hour for a time later that day. When I told him this would not be possible, he persisted in asking about several alternative times before finally leaving off, saying, "Well, I still think I don't want to try coming in. It's just too icy."

In the next hour, Mr. U was in a rage, saying that it would be unfair for me to charge him for this time. He said he could tell from my voice that I was blaming him and demanding that he risk his life to come to the hour. I said I would be happy to reconsider if he could explain to me why my holding the time that he was renting should constitute a demand or an accusation of anything, although I could certainly see that the icy conditions required that he make a judgment about whether or not he wanted to try to drive in. He then shifted his argument by saying that I should be willing to accept his word about whether or not he could make it because over several years I had gotten to know him as someone who was committed to the work. I said it was very interesting that he should say that after just telling me that he did not think he wanted to see the work through. He insisted that one thing had nothing to do with the other and became very argumentative and legalistic, completely obfuscating our discussion.

At the next hour, though I had previously agreed to begin fifteen minutes early in order to accommodate his wish to catch a plane, I completely forgot our agreement and came at the usual time. When I suddenly realized what I had done as I came to greet him, I apologized profusely for having forgotten our agreement. He laughed and jumped into a reversal of roles as he teasingly asked me what my self-analysis would suggest was the reason I forgot. I sensed that I was

counteridentified with his usual role and, playing along with the role reversal, I confessed that at that moment I was feeling quite dumbfounded and asked if he could offer any possible interpretations. He then confessed he was afraid it was my anger at his angry legalistic arguments in the last hour. He was also having the fantasy that I was going to come in today and tell him that I could not work with him anymore. I said that was a very interesting fantasy. He might also be interested to know, I added, that although his legalistic arguments were certainly annoying, at this moment I was most conscious of how much his anger in the last hour was a welcome sign to me that we were finally engaging and talking about this issue of commitment. That struck him as interesting, he said, because indeed he had been thinking more about commitment since the last hour, when he realized how much he was having trouble being as open and honest with me as he wanted. This disturbed him very much. He noticed how much his legalistic arguing was part of a reluctance to tell me that he felt I was right about linking his fight over the time to his fears about making a commitment. In fact, he was noticing right then a reluctance to admit that to me. He was not sure why, but it seems to have to do with a fear of having to present himself in a position of helpless surrender – the way he always feels with his father, no choice but surrender. The hour then ended with his having to excuse himself early to catch his plane. But before leaving, he acknowledged that his unwillingness to make a commitment was a central problem and that he certainly couldn't feel finished until we addressed it.

After the hour, it further occurred to me that my forgetting my commitment to him was probably the result of my losing track of the anger I felt at being subjected by him to the same kind of overpowering demand for passive surrender that he felt subjected to by me. I also thought about how this had echoes for me of my own problems with surrendering to authority. As a result of my empathic counteridentification, having both interactional and intrapsychic aspects, what became clear to me was not only what was frustrating Mr. U and why, but how he (and I in the counteridentification) felt too embattled to really hear and integrate what the other was talking about. Over the next few hours, a major breakthrough seemed to occur as I delivered in piecemeal fashion the following interpretation: Could it

be that your wish to control my policy over missed hours – like your wish to impose your own "premature deadline" on the treatment to avoid an open-ended commitment and like your problem in making a commitment in life – is part of your wish to gain control over a situation in which you feel you are being forced by me into a hurtful surrender, which is what you feel your father did to you when he abandoned the family and indeed keeps doing when he criticizes your interests?

Case 3: Mr. Takit (DSM IV - Bipolar Disorder, Manic type, with diffuse cortical brain damage, primarily affecting word recognition). Mr. T is a middle-aged, divorced man who, despite a history of bipolar illness which has kept him in and out of hospitals since his early twenties, was managing to function at high levels with a wife, family, and job until he was discovered to have developed an organic brain deficit. In two years under my care (with the help of Depakote, Prolixin, and regular meetings with a rehabilitative treatment team) he has stabilized, progressed to a point where he is now living out in the community, and beginning to train for a remunerative clerical job.

Mr. T begins the hour by lapsing into his usual silence after his usual complaint, "Dr. Feinsilver, I am feeling tense and depressed today." At this point, struck by the repetitious nature of this complaint, I find my thoughts going to the famous advice of that great "philosopher," Yogi Berra (a baseball folk-hero): "When you come to the fork in the road, take it." When I wonder what, if anything, this might have to do with my patient, I recall that Mr. T and I had left off the previous hour talking about how he certainly does not like to be aware of the angry-frustrated feelings he experiences when he tries to talk to people and his brain deficit prevents him from following the conversation. He concluded by saying, with his characteristic way of denying and forging ahead, that he didn't understand why he just can't forget about his problems and "relax and relate" anyway. It then becomes clear to me that Mr. T's complaint and silence were probably due to his trying once again to forget about his problems in recognizing words, thus meeting his "fork in the road:" that is, whether he should acknowledge or ignore the humiliating and frustrating word-recognition deficit by forcing himself to "take it" (try communicating) anyway, with his usual manic-denial way of both facing and ignoring. Keeping in mind how Mr. T was dealing with his conflict in a way that just made his deficits

worse, I ask him if he had any sense that he was banging his head against a wall and making himself more tense and depressed than he needed to be by forcing himself to take the road of conversing and communicating. "Yes, exactly. And that reminds me of what we were saying about how I try to deal in general with negative feelings by covering them over with positive." We then close the hour with Mr. T suddenly becoming fluently communicative with me and poignantly sharing the angry, depressed feelings he gets as he contemplates the holiday season and struggles with efforts to hide his loneliness and tendency to isolate himself beneath a "Yogi Berra-like" manic denial.

DISCUSSION

In this discussion I will focus on the following: (a) why it is important to have concepts that can truly integrate the intrapsychic and interactional dimensions of therapeutic action; (b) why the concept of counteridentification, as part of comprehensive countertransference, is uniquely situated to perform that task; (c) how the concept can help to guide many other dichotomized issues into useful therapeutic dialectics, and, finally, (d) how the concept helps to guide the analyst to function in an overarching, integrative way as a "therapeutic mentsh."

Importance of Integration of the Intrapsychic and Interactional

The literature review demonstrates clearly how from the earliest beginnings of psychoanalysis both the intrapsychic and interactional dimensions of therapeutic action were recognized as essential components. At the birth of psychoanalysis, Freud discovered that, in order to overcome resistances in his hypnotic patients to the cathartic expression of *intrapsychic* repressed memories, he also had to address the *interactional* aspects of the caregiving relationship that had become established between patient and analyst. His attention, however, remained centered on the patient's intrapsychic conflicts while maintaining the interactional aspect in the secondary role of "interference." This "interference" then had to be "harnessed" and minimized

through an application of technical "rules" and a "psychoanalytic purification" of the analyst's intrapsychic "countertransference."

We can see in the historical evolution of notions about the relationship between therapeutic action and countertransference that one writer after the other, from Reich and Heimann to Jacobs and Renik, aims at integrating the intrapsychic and the interactional but tends to emphasize one aspect to the virtual exclusion of the other. At best, each writer gives only grudging lip service to the other dimension.

I believe my detailed comparison of Jacobs and Renik demonstrates how, despite each taking great strides toward integration, each ends up falling short by coming down on one side at the expense of the other. Thus, everyone agrees that both aspects are important, but all find it difficult to get away from taking an either/or position. Clearly, concepts are needed that can resolve the tendency to dichotomize and that can truly integrate.

In addition, the crucial importance of both aspects has been the bedrock of our accepted notions of the essential "curative" or "mutative" factors of therapeutic action (Freud, 1925; Loewald, 1960; and Strachey, 1934).

The Role of Counteridentification and Comprehensive Countertransference

I believe the clinical material of my three case examples, as well as those of Jacobs and Renik, demonstrate how attention to the analyst's counteridentification as part of his/her comprehensive countertransference can help to maintain an integrative dialectical interplay between otherwise dichotomized, fragmented aspects of the therapeutic process.

Let us examine my three cases more closely. I become counteridentified with each patient's frustrated self: Ms. TP's "getting sucked in, angry-pleasing" self, Mr. U's "subjugated and subjugating, uncommitted" self, and Mr. T's "taking the fork in the road" self. I recognize this by first focusing on my comprehensive countertransference (my total subjective experience in the interaction) and then teasing out from this multifaceted self experience several different aspects of

what frustrates me. The key is defining first what habitually frustrates me (intrapsychic countertransference) and then defining what aspects of this are like what frustrates my patient (interactional countertransference). The junction of these two component identifications (the patient's self experience in relation to me and mine apart from him or her) is the therapist's counteridentification with the patient's frustrated experience of him or her in the transference at the moment, as will be delineated below.

The counteridentification process has been previously elaborated by me (Feinsilver, 1990), but the specifics can be summarized essentially as follows. The analyst unknowingly ends up with an identification with the self of the patient that is frustrating him/her (an identification with the aggressor) which the analyst psychologically makes into his/her own affair and carries out of the relationship with the patient into his/her own life. (Please note that positive, loving experiences can be part of what is frustrating overall.) With Ms. TP, I find myself "getting sucked in, in an angry-pleasing way," and with Mr. U, I find myself getting involved in a power struggle over who is going to subjugate whom under threat of noncommitment and abandonment, as if these are problems of my own and have nothing to do precisely with what the patient is doing to me. With Mr. T, my identification is carried away by "free associations" to the joking philosophical comment of Yogi Berra, "When you come to the fork in the road, take it."

The tendency to ward off or split the frustrating aspect of the experience occurs because, to begin with, the patient's frustration with the analyst (transference resistance) becomes something the patient wishes to ward off, although also wishing unconsciously to express by hitting back at the analyst with the same kind of thing he/she feels he/she is being hit with in the transference (identification with the aggressor). The analyst, as part of his/her own tendency to avoid the transference resistance (countertransference resistance) because it involves matters that frustrate (intrapsychically and interactionally), joins with the patient's wishes to avoid it while expressing it. The analyst expresses frustration unconsciously by identifying with the patient's mechanism of identification with the aggressor and divorcing it from the relationship with the patient by carrying it into matters that have to do with his/her own life and seeing it as his/

her own problem. The analyst thus ends up with an experience in his/her own life (part of comprehensive countertransference) that parallels what is frustrating the patient in the transference situation of the moment (as in the above examples), and this needs to be sorted out and recognized.

It is important to note that the analyst's experience is parallel to, but not equivalent to, the experience of the patient. It is important for the analyst to differentiate within the total comprehensive countertransference experience the components which comprise the resulting counteridentification, particularly the classical countertransference aspects and the relational aspects. This is crucial in transforming confusing countertransferential resistance into meaningful therapeutic action.

Although the process of sorting out the relevant counteridentification sounds very complicated (and indeed is), I have found clinically that often by simply asking the question of whether a particular experience that I am having is at all like what frustrates my patient, the relevant transference resistance will emerge as if being illuminated by a lighthouse beacon in the fog – or to use Freud's analogy, like the voice of a familiar friend coming from an unseen source at the other end of a telephone.

I believe the concept of counteridentification can be seen historically as a further articulation of the role of identification processes. This historical line starts with Freud's description of the tuning-in processes of the telephone model, then progresses to the development of the concept of trial identification by Fliess and Reich, through the conceptualizations of projective identification by the object relationists, to the multidimensional role delineated by Racker and the contemporary formulations of the analyst's self by Jacobs and the analyst's subjectivity by Renik.

Counteridentification and Transforming Other Fragmenting Dichotomies into Therapeutic Dialectics

I believe the clinical material can also be seen to demonstrate how an appreciation of the counteridentification process can help trans-

form, into integrative, therapeutic dialectics, many of the other fragmenting, dichotomizing tendencies that can plague clinical work, particularly the conflict *vs.* deficiency polarity and the internal *vs.* external reality polarity.

For instance, with Ms. TP, my experience of discovering how lost and dissociated I had become in being angry at myself for not realizing how I was "getting sucked in" and "being had" by her helped me realize how lost and dissociated she was as she kept "getting sucked in" and "being had" by me. This enabled me to be particularly empathic to her experience of feeling lost and dissociated, and then I was able to be both supportive to it and precise about the conflicts as I interpreted to her (in a questioning, exploratory way) that she was feeling "sucked in" and "had."

With Mr. U, my recognizing the counteridentification in the experience of finding myself forgetting my commitment to him initiated the process of putting things into perspective. This occurred in the midst of getting totally lost and embattled with him during his argumentative assault aimed at controlling the hour, but this recognition of the counteridentification process, while I was not yet clear about the details, enabled me to maintain a supportive, role-playing position while working out the specifics. The interpretive aspects were delivered as they became clear later along the way. It is worth emphasizing also that my being able to maintain both these supportive and interpretive dimensions led to Mr. U's becoming more allied with me and himself, supplying both interpretive and supportive aspects himself.

With Mr. T, my counteridentification involving Yogi Berra's "When you come to the fork in the road, take it" gave me a particularly empathic appreciation of Mr. T's crazy, manic approach to his conflict over whether to face or ignore his communication deficit. This enabled me to ask a particularly well-targeted, supportive-interpretive question about whether he was frustratingly "banging his head against a wall" by trying to forget about his deficit and then communicating anyway, which brought out his underlying depression.

Thus, the analyst's appreciation of the patient's plight, arrived at through his/her counteridentification, provides information about both the conflicts being warded off and about the deficit which initiates

the experience of frustration. The analyst arrives at the right combination of supportive care and insight that the patient needs through a two-step empathic process generally experienced as intuitive and automatic: first, he/she recognizes in his/her counteridentification what the patient would need by seeing him/herself in the patient's shoes, and then takes into account how the patient may be, in fact, somewhat different. The counteridentification provides a first-hand, metaphorical experience of what the patient needs. Creative fusion of elements in the counteridentification (sometimes very creative and dream-like) when teased apart, helps to clarify just what is frustrating the patient. Recognizing the parallel between what appears to be the analyst's own plight and that of the patient, including both similarities and differences, enables the analytic therapist to be clear about the proper balance of support and insight the patient needs at that moment. (For further details of differences across the diagnostic spectrum, see Feinsilver, 1990.)

It seems to me that some degree of the combination of both support and interpretation will always be necessary in the healthiest as well as the sickest of patients. In my experience, patients will be receptive to interpretation only if they feel supported – at least to some extent; the holding environment must be secure. Without the supportive dimension there can be no interpretive dimension. Thus, it may be a general principle (to be integrated dialectically with the principle of abstinence) that interpretive interventions are only possible to the extent that (and because) adequate support has taken place. In addition, the dichotomy between classical psychoanalysis and analytic psychotherapy may be more usefully thought of as part of a continuum of psychoanalytic treatment applicable to patients across the broad range of conditions, varying only in the degree of focus on support or interpretation, but always requiring both.

Also looking at the dichotomy of external and internal reality, the clinical material demonstrates how this is integrated and resolved through my appreciating both the supportive (external) and the intrapsychic (internal) aspects of the counteridentification with Ms. TP's "getting sucked in," Mr. U's feeling "subjugated and abandoned," and Mr. T's "taking the fork in the road." The counteridentification process guides the therapeutic transformation of internal and external

realities essentially as follows. To begin with, what frustrates the patient intrapsychically, i.e., his/her internal, psychic reality, is transformed into transference resistance, i.e., his/her external, objective reality. The therapist then transforms the transference resistance through counteridentification and comprehensive countertransference – involving a sophisticated teasing out of the interplay of external and internal realities – into new external and internal realities for the patient through a felicitous combination of supportive care and insight.

I believe this can be seen as an elaboration of the therapeutic processes Freud had in mind when he stated in his classic paper, "Negation" (1925), "The first and immediate aim...of reality-testing is, not to *find* an object in real perception which corresponds to the one presented, but to *refind* such an object, to convince oneself that it still is there" (pp. 237-238). The therapist and patient must first create in mutually perceived external reality a negative object situation (the object of frustration that has become lost) that convinces the patient that he/she has finally found the "son of a gun" that first did him/her in, and then transform this perception of external reality and its corresponding internal reality through a precise combination of the external support and internal insight dictated by the therapist's sorting out his/her counteridentification process. Also, I believe this can be seen as an extension of what Strachey (1934) had in mind when he developed the concept of the here-and-now interpretation of the externalized frustrating superego as the basis of his mutative interpretation, as well as of Loewald's (1960) concept of the development of a new object. Thus, transforming this dichotomy into therapeutic dialectical interplay can be seen as part of an overarching dimension of therapeutic action which, while recognized for a long time in our field, has been insufficiently emphasized and articulated (see Hoffman, 1994, and Mitchell, 1997a).

Counteridentification, Being a "Therapeutic Mentsh," and the Role of the Therapist as a Person

Articulating how the counteridentification mediates the interplay between internal and external reality also emphasizes the importance

of the therapist as a person in an overarching dimension of therapeutic action. Although this has been addressed to some extent in the literature (Bibring, 1954; Gabbard, 1997; Gerson, 1996; Greenson, 1967; Hoffman, 1994; Lipton, 1977; Viederman, 1991), I believe that the role of the so-called "real relationship" in therapeutic action has not yet been sufficiently articulated. Appreciating how the counteridentification functions as part of comprehensive countertransference to help the therapist zero in on the patient's plight of the moment exemplifies how the totality of the therapist's functioning as a real person must be taken into account.

This topic has been generally covered (in a dismissing way) under the heading of the emotional maturity of the therapist as a person – encompassing how he/she handles the vicissitudes of his/her own transference reaction to the patient (McLaughlin, 1981; Stone, 1961). To my mind, the counteridentification process articulates this dimension in a way that is probably best captured by the word "mentsh," a word which has crept into English usage in recent years. I would define it as follows: a person who confronts, clarifies, and overcomes what frustrates him/her, internally and externally, to do morally and ethically, with compassion, what the situation calls for; in essence, a person who rises to the occasion in difficult situations to do "the right thing"[3] (see Feinsilver, 1997, 1998).

Being a "therapeutic mentsh" describes the essentials of counteridentification and therapeutic action as follows: first, the analytic therapist must be a mentsh and recognize interactionally and intrapsychically as part of his/her comprehensive countertransfer-

[3]The word mentsh comes from Yiddish or German and is also often spelled mensch, mensche, or mensh. The best dictionary definition I could find is: "A decent, upright, mature, and responsible person" *(Random House Unabridged Dictionary,* Second Edition, New York, 1993). A somewhat better definition was found in *The Joys of Yinglish* by Leo Rosten (New York: McGraw-Hill Publishing Company, 1989): "A man with character, rectitude, dignity, and a sense of what is right or ethically imperative. Many a poor man, even an ignoramus, conducts himself in the luminous manner of a mensh." But finding these definitions somewhat lacking of the connotations which have struck me, I offer my own synthesis of these definitions.

ence that he or she is having a frustrating experience; second, the therapist must be a mentsh within and clarify and confront intrapsychically the parallel in his/her counteridentification between what is frustrating him/her and what is frustrating the patient; and third, the therapist must rise to the occasion and be a mentsh interactionally by providing the full range of caregiving and analytic interventions necessary to enable the patient to overcome frustration. Finally, the patient rises to the occasion to overcome frustration in order to be a mentsh.

Although the role of the therapist as a person requires further elucidation, I believe that the concept of "therapeutic mentsh" helps to articulate an aspect of this overarching integrative dimension. This demonstrates further the integrative power of the concept of counteridentification.

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BOOK REVIEWS

MELTING THE DARKNESS. THE DYAD AND PRINCIPLES OF CLINICAL PRACTICE. By Warren S. Poland, M.D. Northvale, NJ: Jason Aronson Inc., 1996. 296 pp.

As we approach the upcoming centennial celebration of our discipline, we find the hounds of criticism braying at our institution doors, threatening to turn the festivities into a wake. The common ground that Wallerstein (1990)[1] attempted to stake out for us was beginning to seem like a rather elusive piece of territory. Nonetheless, psychoanalysis continues to evolve and manage the strain rather nicely, thank you.

A significant contributor to this burgeoning spirit of ecumenism has been Warren Poland. *Melting The Darkness* is on the cutting edge of controversy in that it considers the analyst's authority and the place of subjectivity within the consulting room. No debate in our recent history has generated more heat – our journals and meeting rooms are straining to accommodate the changes that are occurring in technique and in deciding in which ways, if any, technique is informed by theory.

Poland is in a unique position to write on this subject, having emerged as an independent representative within contemporary psychoanalysis. His is a paradoxical unity of what one usually understands as alternatives. Poland's vision is always in the direction of preserving the truth of human existence in all its complexity, steadfastly resisting the lure of a parochial allegiance to partial visions. The reader is in the privileged position of peering over his shoulder as he weaves together papers he has written, modified, and created anew, devoid of the disfluencies that plague such volumes. Presented as a lyrical and personal reading, conversational in tone, informed by the force of his intellect and breadth of his knowledge, the book is a

[1] Wallerstein, R. (1990): Psychoanalysis: the common ground. *Int. J. Psychoanal.*, 71:20.

poetically inspirational work, at times thought-provoking, although at other times frustratingly repetitious. We are taken on a journey between an explanation of the patient and an understanding in terms of phenomenology. Psychoanalysis as created by Freud and practiced by Poland refuses to participate in such a disjunction. Throughout, it is recognized that patient and analyst exert constraints, or more generally, influence on one another, along with a sense that each has an independent existence as well.

This is not a book to be read as a systematic treatise, but as a tracing-out of Poland's thoughts on how the mind of the analyst registers and resonates with the unconscious communications of the patient. It is a book that stretches beyond discourse intent on communicating ideas to that of recreating it as a self-giving and self-evidential image in the mind of the reader. The virtue of following Poland in his musings lies in the book's ability to disturb habitual modes of thinking. The danger rests in its potential to substitute effect for substance.

Poland begins by enunciating his guiding principles, most prominent of which may be his "regard for otherness, the analyst's profound and genuine respect for the authenticity of the patient's self as a unique other, an other's self as valid as the analyst's own…" (p. 7). He then goes on to share with his reader the principles that inform his technique. The next section of the book sharpens the focus from the broad strokes of the analytic encounter to more specific issues that play a part in the treatment situation for him. Prominent among these would be his classic understanding of analytic tact. Our journey with the author continues with an examination of the place of the other in self-analysis and leads us finally to sitting in with Poland as he works with his patients and demonstrates the dyadic vitality of the psychoanalytic situation.

For Poland, the analytic dyad is an ontological reality that cannot be reduced to what takes place within each of its members. This is intrinsic to his thinking, as it was to Martin Buber as he conceptualized the I-Thou relationship. This feeling into the patient's subjective state, with its respect for the mutuality and presence of the other, seems to have found a comfortable resting place in current psychoanalytic practice. With it, though, comes the heightened potential to blur the real and the analytic relationship and to permit the actualiza-

tion of latent scotomata[2] in the analyst. So how does the analyst behave?

Could we not legitimately wonder why our recent interest in understanding how the unconscious mind expresses itself in relation to the mind of the other, in what is occurring in the participants' subjectivity, in questioning the role of analytic authority, and in the increasing disinclination for analysts to believe that they are in a privileged position to know what is in the patient's mind, might lead us to take a position of greater rather than lesser restraint? The legitimate technical consideration of the co-created transference and the roles of the intersubjective and interactive dimensions of analysis and of the use of the analyst's inner experience are powerful lures to an exclusive emphasis on the here and now. It does not have to be at the expense of devaluating the importance of the past in our theories of pathogenesis or of demonstrating to patients how their minds work and where and why they falter.

In an era when it has become less fashionable to quote our intellectual ancestors, let us not fail to mark the contributions that have allowed us to understand the importance of language and its instrumental role in constructing the mind. George Herbert Mead laboriously demonstrated in the isolation of the language mechanism the process by which the mind is socially constituted and through which the self that is conscious of itself as an object appears and develops. Perhaps even closer to our analytic home is the curiously neglected paper by Bernfeld[3] that ever so clearly and elegantly demonstrated how mutual understanding derives from the evocative power of human speech and discourse and creates states of mind in the listener akin to those of the speaker. We have learned from him that the often-assumed background information necessary for understanding the subject, object, or predicate is often (usually?) not mutually available.

Melting The Darkness is a book that lends an excitement and authenticity to the psychoanalytic enterprise, and it speaks to what is intriguing about our work and helps it to continue. Poland's fertile ideas place him among the creative thinkers in psychoanalysis, and they give every

[2] See Gabbard, G.O. & Lester, E.P. (1995): *Boundaries and Boundary Violations in Psychoanalysis*. New York: Basic Books.

[3] Bernfeld, S. (1941): The facts of observation in psychoanalysis. *Int. Rev. Psychoanal.*, 1985, 12:342-351.

indication of having the power to enrich the concepts within our field by suggesting avenues of investigation and opening new horizons for interpretation. Only future research can answer the question of whether analyses conducted as Poland counsels us can produce more efficacious outcomes. What is clear is that he has ever so poignantly reminded us that it is the analyst, like Aristotle's "unmoved mover," around whom the treatment is ordered and connected and who helps the analysand to construct more adaptive compromise formations.

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A MEETING OF MINDS. MUTUALITY IN PSYCHOANALYSIS. By Lewis Aron, Ph.D. Hillsdale, NJ/London: The Analytic Press, 1996. 292 pp.

The title of this book draws from a statement made by Hans Loewald: "Understanding [the patient] would seem to be an act that involves some sort of mutual engagement, a particular form of the meeting of minds."[1] Choosing Loewald's citation for an epigraph, the author presents a book about "relational" theory, a model incorporating a variety of theoretical persuasions in keeping with the delineation made by Greenberg and Mitchell[2] and distinguished fundamentally from drive theory. Aron describes this distinction as reflecting two basically incompatible views of human nature – Man as an essentially individual animal versus Man as a social being. He writes:

> Relational theory is based on the shift from the classical idea that it is the patient's mind that is being studied (where mind is thought to exist independently and autonomously within the boundaries of the individual) to the relational notion that mind is inherently dyadic, social, interactional, and interpersonal (p. x).

Aron argues strongly, and rather repetitively, in the course of

[1] Leowald, H. (1980): *Papers on Psychoanalysis.* New Haven, CT: Yale Univ. Press, p. 382.

[2] Greenberg, J.R. & Mitchell, S.A. (1983): *Object Relations in Psychoanalytic Theory.* Cambridge, MA: Harvard Univ. Press.

eight chapters (a number of which are based on or excerpted from earlier publications) and a coda, for his preference for the latter. He sees the roots of the shift from a "one-person" to a "two-person" psychology as going back to the work of Ferenczi and Rank (described in interesting and balanced detail), and in more recent years propelled by the cultural and intellectual trends of feminism and postmodernism.

This book makes for informative reading, particularly in sketching the historical, political, and institutional developments influencing the evolution of a discretely labeled "relational" model. The author shares his own training background at the Postdoctoral Program at New York University, recounting the multifaceted history and some familiar-sounding polarizations in the formation and changes within this program. While the reader can have much to learn about the historical underpinnings of the current active debates in our field from this richly presented work, a number of concerns abound.

There is a strong political or strategic aspect to the arguments made, even, in fact, to the evolution of the relational model. Consider, for example, the following statement:

> What are the benefits and risks of emphasizing the similarities of relational theories versus the differences between them? My own feeling is that it is *strategically useful* to emphasize their similarities. By doing so, we have created *a movement* within psychoanalysis that allows analysts of very diverse schools of thought to recognize that they have something in common, namely, the shift away from a focus on drive theory and toward more relational considerations (p. 41, italics added).

I find the notions of strategy and movement troubling. Aside from the straw-man problem (which is to some extent acknowledged) in that many of the arguments posed draw upon a "drive" model without fairly taking into account its own continuing evolution and conceptual shifts, there is insufficient illustration of specific clinical dilemmas necessitating a change in model. (See too Richards' review, making a similar point.[3]) Posing primarily a philosophical position,

[3] Richards, A. (1997): Book Review. *PANY Bulletin,* 35:9-11.

Aron does not offer a convincing effort toward a scientific, *data-grounded basis* for such a change.

As we know, central questions about incorporating the nature of the surround within our psychoanalytic understanding have dogged our field, as a science of inner life, nearly from its beginnings. Fantasy versus seduction was an observational and conceptual dilemma which has become engraved within the history of psychoanalysis. The relational theorists, with Aron among their distinguished contributors, have been significant catalysts in vitalizing our dialogue on these matters, for which we are indebted. Yet, while Aron argues cogently, I believe, for the importance of including the subjectivity of the analyst in our clinical stance, fundamental epistemological issues remain clouded. He uses such descriptions as "real" or "actual," in some places seemingly rather casually, suggesting an objectivity determined by the analyst and without indication of how he arrives at these distinctions. In his paraphrase of a comment to his patient, "You seem to have the mistaken belief that, if you have any negative thoughts or feelings toward someone, then that means you don't really love them" (p. 226), we hear no consideration of how, within his schema, the analyst can assess a patient's internal belief as "mistaken."

I agree with Aron's salient reminder that the patient may observe dimensions of the analyst's subjectivity prior to the analyst's own awareness of them (I would add that they may lie outside the patient's conscious awareness as well) – that is, that the patient's perception warrants nonjudgmental attendance. There is, however, inadequate discussion of the historical-developmental complexity of perceptual experience, of its early neurophysiologic and psychologic registrations as influencing and organizing future perceptions and of yet unconscious fantasy and conflictual experience. Similarly, the understanding of transference seems reduced to the question of whether or not it is viewed as a distortion, with the classical position seen as inherently linked with such a view, without consideration of the more profound complexities of this concept – serving as bridge between past and present, inner and outer realities, one-person and two-person psychologies. I have expressed the view, noting its representation of the observer's impact on the observed, that the concept of transference marked the entry of depth-psychological observation into the scientific

era of relativity.[4] (In terms of my own position as described in Aron's book, I would add a correction: I see myself as a Freudian, or "classical" analyst, recognizing the continuing evolution of the classical position.)

Essentially, beyond the question of alternative theoretical models, Aron presents a philosophical outlook about the psychoanalytic enterprise. Interpretation, he writes, is "a mutual meaning-making process" (p. 94); "meaning is arrived at through a meeting of minds" (p. 263). Meaning, in other words, is constructed, rather than to be discovered. Wherever one stands on the salient matters raised here, this engagingly written book will sharpen our awareness and deepen consideration of central dialectic tensions enlivening our field.

EVELYNE ALBRECHT SCHWABER (BROOKLINE, MA)

[4] Schwaber, E.A., Editor (1985): *The Transference in Psychotherapy: Clinical Management*. New York: Int. Univ. Press.

INTIMATE ATTACHMENTS. TOWARD A NEW SELF PSYCHOLOGY. By Morton Shane, M.D.; Estelle Shane, Ph.D.; and Mary Gales, M.D. New York/London: The Guilford Press, 1997. 242 pp.

Psychoanalysis, as it manifests in both its clinical and its theoretical elaboration, is such a complex phenomenon that I can discuss the latest form, *Intimate Attachments,* only by putting it into the context of psychoanalytic history. In that connection, it is fitting that the developmental psychology that was created by Sigmund Freud and that is known all over the world as *psychoanalysis* is celebrating its one-hundredth birthday. It is worth noting that starting from a few narrowly defined clinical cases of what was then called hysteria and conceptualized on the basis of a few new basic principles, such as unconscious drives and unconscious defenses, psychoanalysis as a new and original field of knowledge has had its own growth and development during its first century.

The growth and development of psychoanalysis was guided by Freud, its inventor, for about forty years, until his death in 1939. It is often forgotten that Freud continually changed and revised his

theoretical formulations on the basis of new clinical observations. As a true scientist, he did not present his conclusions and speculations as final but as constantly evolving, and the same was true for his early students and followers. While he insisted on the acceptance of his fundamental principles, he was at the same time supportive of free discussion of divergent views and tolerant of different and often contradictory theoretical speculations by his disciples. Inevitably, a number of psychoanalytic schools of thought emerged and competed for recognition. The vigor and richness of these various ideas, which arose from the original Freudian vision, and their remarkable impact outside of psychology on the arts and humanities, testify to the soundness of that vision. This process of development of psychoanalytic thought into various directions is as alive today as it was in Freud's time. We should not fear the heat, and sometimes light, of controversy but regard it as proof of vitality.

Intimate Attachments: Toward a New Self Psychology is the latest manifestation of specific, clinico-theoretical modifications of Freud's original conceptualizations. They represent, in my judgment, a forward movement at the frontier of psychoanalytic thought, a movement that gradually has been altering the face of psychoanalysis for many decades. It is at the leading edge of a number of evolutions that are refining and elaborating specific psychoanalytic concepts without sacrifice of basic psychoanalytic principles. As an illustrative example, Freud's fundamental motivational inference of an unconscious quasi-biological, instinctual drive has been refined into an inference of biologically-based unconscious drivenness to organize all experience into a meaningful order, of which a sense of self and other are fundamental constituents. It follows that much of psychoanalytic attention is shifting – and, indeed, has shifted – from a primary focus on sexuality and aggression to a focus on the experiential vicissitudes of crucially significant relationships and their impact on the experience of self and self-with-other. Hand in hand with this attentional shift goes an additional alteration in perspective from a unidirectional concern primarily with the analysand to an interest in more bi-directional analyst-analysand interactions. Such an attentional shift, however, does not imply that sexuality or aggression are ignored or neglected. Rather, they are examined in the context of the significant relationships that give them their intense experiential

meaning.

All these shifts under the label *psychoanalytic self psychology* were already detectable in the 1971 volume *The Analysis of the Self,* as first published by Heinz Kohut. In *Intimate Attachments,* Shane, Shane, and Gales further develop the Kohutian paradigm. A developmental process stands at the center of their conceptualization of the self and its vicissitudes. This bi-directional, dual process brings the self into being as well as simultaneously the self's being in connection with others. Anything that impedes this process causes damage to the self and its relationships. The self uses various self-protective measures as coping mechanisms in response to threats to this development, i.e., threatened or actual disruption. These protective measures, the equivalent of what are commonly designated as defenses, are adaptive and not pathological per se. However, they may interfere with self consolidation and thus may have a deleterious effect on the self and its relationships, with symptomatic and/or behavioral manifestations. Psychoanalysis has the potential to provide new and positive experiences that will undo, at least partially, what has been impeded and thus can revitalize the developmental process.

In conceptualizing their psychoanalytic thinking, the authors have abandoned the structural paradigm in favor of poststructural and postmodern formulations for their models. Their models are from nonlinear dynamic systems, that is, models used to demonstrate that complex and apparently disorderly (i.e., chaotic) phenomena exhibit underlying patterns that, while not necessarily predictive, can be regular, lasting, and regulatory. The authors' metapsychology integrates a number of theories that underlie their positions, and they discuss the theories they have tried to incorporate. In addition to many aspects of Kohut's self psychology, these include a definition of development as the integration of nonlinear dynamic systems, aspects of Bowlby's attachment theory to illuminate enduring self-other patterns of interaction, brain research, studies in infant development, and a theory of psychopathology based on trauma derailing the developmental process.

The authors' elaboration of developmental systems self psychology entails a trajectory of developmental progression. They define relational configurations as persisting patterns of relatedness between

self and other that describe the influence of the past on the organization of present-day lived experience. They distinguish three kinds of configurations: (1) Old-old, which is old traumatized self with old traumatogenic other. Here the patient experiences both self and analyst in a repetition of patterns categorized predominantly on the basis of past traumatic experience. (2) Old-new, which is old self with new other. Here the patient continues to categorize the self in old traumatized ways, but is beginning to be able to categorize the analyst as a novel, positive other. Intimacy between them now becomes possible. (3) New-new, which is new self with new other. Here the patient categorizes both self and analyst predominantly in novel, positive ways, not based on the traumatic past. Intimacy between them is firmly established.

Intimate Attachments is a clinically useful guide to the psychoanalytic treatment of many disorders of the self. However, I would add one word of caution. While the authors certainly do not advocate that the mere provision of positive experiences is all that is needed for cure, they may easily be misunderstood to be suggesting just that, with their emphasis on providing non-traumatic, positive experiences as a condition for a curative strengthening of the self. A dynamic elaboration of how the new positive experiences result in change is not spelled out. Therefore, I could easily imagine a most regrettable misunderstanding and misinterpretation of their valuable extension and elaboration of psychoanalytic thinking.

ERNEST S. WOLF (CHICAGO)

UNFORMULATED EXPERIENCE. FROM DISSOCIATION TO IMAGINATION IN PSYCHOANALYSIS. By Donnel B. Stern. Hillsdale, NJ/ London: The Analytic Press, 1997. 293 pp.

Unformulated Experience is a profound and provocative examination of psychoanalytic epistemology: the "mystery at the heart of knowing" (p. 221). In this beautifully written book, Stern explores the implications "of what clinical psychoanalysis might be in an interpretive, constructivist, hermeneutically conceived world" (p. xiii). His views are rooted in the propositions that (1) existence is indeterminate by reasons of its funda-

mental structure (Merleau-Ponty); and (2) there is a reality that exists beyond words, but it is not one that we will ever be able to sense directly (Gadamer). Only through the creative and imaginative act of language can we grasp, as we give shape to, the inherently ambiguous contents of "reality."

For Stern, reality is neither simple nor objective. It is never "uncovered," but must be constituted (constructed) by an act of speech and imagination that is creative, dialectical, dialogical, and limited by the very language used to describe what is felt to be known. "Language is not merely a set of tags or labels for experience but actually plays a role" (p. xi) in the construction of what we come to feel and call experience. In so doing, language simultaneously allows and limits the extent to which reality or experience can be grasped.

Stern's thinking is rooted in the works of philosophers such as Foucault, Gadamer, Habermas, Merleau-Ponty, Ricoeur, and Saussure. Therefore, the epistemological assumptions from which he begins are radically different from those of the nineteenth-century scientific materialism in which traditional classical psychoanalysis is grounded and have profound implications for psychoanalytic theory and practice. If there is no objectively determinable, unambiguous, unconscious reality covered up in the mind of the patient, if the contents of the unconscious are not fully formed, hidden by defense and awaiting discovery, then what do we mean when we talk of unconscious experience or say that we know something about the patient or our experience of the patient? What is the nature of the material we are trying to understand in analysis or of an interpretation? What qualifies as truth in the analytic setting? How can we recognize it? And who determines when we have reached it?

Stern's attempts to answer these and related questions make for fascinating, provocative, and informative reading that has far-ranging implications for our view of psychoanalytic theory and practice. For example, in Stern's view, unconscious material, rather than being already "there" in a disguised or covered-over way in the mind of the patient prior to the interpretation, is seen as a potential experience that remains to be articulated. Hence it is designated as *"unformulated* experience," and Stern prefers dissociation rather than repression as the archetypal example of psychic defense.

Stern's preference for dissociation, which he describes as "the refusal to formulate – to think through – for defensive reasons" (p. 76) and "the refusal to allow prereflective experience to attain the full-bodied reflective meaning it might have if we left it alone and simply observed the results of our own capacity to create it…the deletion of imagination" (p. 98), has the effect of turning traditional psychoanalytic thinking on its head. In contrast to Freud, who believed that the mind required effort (repression) to keep experience out of awareness, Stern is suggesting that the natural tendency of our minds is *not* to experience; that we let potential experience remain unformulated outside of awareness for defensive reasons, and it is only when action and effort are applied that we bring some aspect of potential experience into being and into consciousness.

This change of perspective inevitably alters our understanding of the analytic task – "Psychoanalysis is not a search for the hidden truth about the patient's life, but the emergence, through curiosity and the acceptance of uncertainty, of constructions that may never have been thought before" (p. 78) – and of the analytic process and relationship. "Patient and analyst cocreate the environment in which it becomes possible to think certain thoughts and not others, to have certain feelings, perceptions and experiences" (p. 101).

In terms of the theory of technique, this means that for the analyst the primary and most central problem is not how to select the correct interpretation, but how to sense that there is something there to interpret. "Interpretation can be merely wrong, but experience itself can be absent and absence is the greater difficulty" (p. 187). Rather than uncovering the single, pre-existing unconscious meaning, the analyst instead offers the patient a construction that the patient can find "interesting" or "useful" according to some inner, felt, subjective sense of usefulness or suitability of fit.

From the patient's perspective, the "good enough interpretation" looks like this: "In response to a successful interpretation, the patient working in a relatively safe-feeling atmosphere senses (i.e., is *willing* to sense, is *interested* in sensing) a 'place,' a kind of empty meaning-mold of the same shape as the interpretation, a 'place' that, despite its not having been felt before by the patient, may nevertheless feel, in the very moment of its appearance, as if it has been waiting for

the interpretation to fill it. This 'place' is not just a manifestation of the patient's acceptance of new meaning; it is the simultaneous recognition of this meaning and the absence that is now suddenly understood to have preceded it" (pp. 175-176). Such a fit need only be "recognizable," or "useful," not "perfect."

When all goes well in analysis, a collaborative relationship develops that is marked by a freer, more imaginative and creative capacity for thought in both patient and analyst. Under such circumstances, therapeutic progress may be measured by the patient's gradual acquisition of a new curiosity and freedom of thought as he or she begins "to think effectively, for the first time, about parts of life that had heretofore remained outside the range of reflection" (p. 180). When it does not go well, experience remains unformulated (dissociated) and patient and analyst remain mired in the constrictions of stale and familiar perspectives.

Defensive dissociation "can be understood as the restriction or stifling of imagination, accomplished by the stereotyped or empirical use of language. *What* is dissociated in this way can range from the entire experience (so that it is never allowed to occur in the first place or so that it seems as if it never happened) to much more subtle emotional resonances that leave the perceptual part of the experience intact, but make it feel unalive (p. 115). For Stern, it is the openness of the imagination to knowing and to the fullness of experience that is crucial. "Language is always interpretive; the question is only whether the interpretation is hackneyed or from the heart" (p. 114).

Simply stated, *Unformulated Experience* is a major contribution to our field. It should be required reading for anyone who wishes to understand the clinical and theoretical implications of those movements in contemporary psychoanalytic theory, such as hermeneutics, phenomenology, constructivism, and intersubjectivity, that have been gathered under the broad banner of postmodernism. It is contemporary psychoanalytic thinking at its best.

HOWARD B. LEVINE (BROOKLINE, MA)

DEPTH-PSYCHOLOGICAL UNDERSTANDING. THE METHODOLOGIC GROUNDING OF CLINICAL INTERPRETATIONS. By Philip F.D. Rubovits-Seitz. Hillsdale, NJ/London: The Analytic Press, 1998. 464 pp.

Our clinical interpretations depend heavily on our understanding of the meaning of what is transpiring in our patient's mind, our own mind, and in the interaction between the two. How we arrive at this understanding (its methodological grounding, that is) has always been of crucial interest to psychoanalysts. In a broader sense, interpretation means the derivation of underlying meaning in any human pursuit and, as such, has been a central philosophical question in all of the human and social sciences. There is perhaps no psychoanalyst who has studied this methodology as deeply, as broadly, or as wisely as Rubovits-Seitz. This book is his *magnum opus*, and it is truly magnificent.

The author begins with a historical overview, describing "Freud's Methodological Conflict" between "his positivist ideals...and his clinical need for flexible, nonpositivist interpretive methods," and the lingering impact this has had upon our current thinking as we, perhaps somewhat hesitantly, turn away from positivism. He proceeds, in an encyclopedic tour de force, to compare our contemporary thinking to the approach of other fields. In the course of this, we are treated to summaries of both language-based models of interpretive methodology (primarily the work of Lacan, Edelson, Schafer, Labov and Fanshel, Clippinger, and various narrative theorists) and nonclinical methods (the pattern model approach, gestalt psychology, systems theory, hermeneutics, structuralism, psycholinguistics, communication theory, semiotics, literary theory and criticism, archaeological decipherment, and the various approaches of the cognitive sciences). All of this is done so concisely and clearly that I found, to my amazement, that I could understand it with relatively little intellectual sweat. After a chapter defending the placement of psychoanalysis as a commonplace psychology, the author turns to the problem of "justifying" our interpretations, that is, of showing that they are indeed susceptible to scientific proof, Grünbaum notwithstanding. He details methods of doing this, including an illustrative case, and concludes with a lovely summary of

the progress we have made and the problems we have still to face.

I found this to be a remarkable book. The breadth of the author's knowledge is astounding, as illustrated, for example, by the fact that there are nearly 1,000 references. If you have written anything related to your attempts to understand your patients, the odds are that your work will be cited. The author achieves readability by sticking closely to his main points and relegating excursions into less pertinent details to an extensive compilation of notes at the end of the main text. However, contrary to a claim on the dust jacket, you will not read it "enraptured as by a detective thriller." Rather, it is (delightfully) dense. There is no padding. Almost every sentence contains a new thought and needs to be read with care. Each note (and there are hundreds of them) can, if you are interested, lead to an excursion into the literature which could preoccupy you for days. If you have any interest at all in the theory of how psychoanalysts understand their patients, this book is required reading.

SYDNEY E. PULVER (PHILADELPHIA)

THE ARTIST AND THE EMOTIONAL WORLD. CREATIVITY AND PERSONALITY. By John E. Gedo. New York: Columbia University Press, 1996. 255 pp.

A great many efforts have been made to study creativity from a psychoanalytic point of view. Most often in such studies, either the artistic product is subjected to analytic scrutiny or the life of the artist is examined analytically in an effort to explicate the conflicts and the psychopathology that gave rise to the work of art.

Often neglected in such studies is an examination of the total personality of the artist. This includes such matters as genetic endowment, unusual sensitivities and predilections that affect personality development and adaptation, and the unique fit that exists between character traits and the environment in which the future artist is raised. Frequently neglected, too, are the complex effects that artistic activity – and the cessation of such activity – have on the personality and the critical role often played by key figures who support the young person's artistic development. In not a few instances, input by such models

and mentors at critical times in an individual's childhood or adolescence has played a decisive role in setting the person on the path toward an artistic career.

In this valuable and much needed book, John Gedo corrects this omission by focusing on the question of personality and its relationship to the creative process. Drawing on material from creative individuals whom he had seen in practice over the past three decades, as well as on biographies of major artists, Gedo has put together a comprehensive picture of the roles played by personality factors and the environment in the development of creativity.

Gedo's book is not only comprehensive (he deals with more than fifty individuals in the course of his study), but in its elucidation of the interplay between nature and nurture, character and environment, internal forces and the external world, it is both original and persuasive.

Among the great delights of this book are the short but fascinating portraits of artists and writers that it contains. No more than biographical sketches, these brief studies of such figures as Delacroix, Cézanne, Goya, Tolstoy, and Trollope, are not only informative and insightful, but richly illustrative of the author's central thesis. Here the reader can see in specific detail the interplay between heredity, innate talent, childhood experiences, and core conflicts that enter into the formation of personality. Gedo then demonstrates in a convincing way the impact that the personality has on the artist's development.

If there is any defect in this important book, it is only that it contains so much information and deals with so many personalities that the reader may feel rather inundated by the wealth of material here. Such an exhaustive study also tends, at times, toward the repetitive. These, however, are minor flaws in what must stand as a major achievement in the analytic study of creative individuals. Illuminating, informative, and entertaining, this book is essential reading for anyone interested in the field of creativity.

THEODORE J. JACOBS (NEW YORK)

THE SHAME RESPONSE TO REJECTION. By Herbert Thomas, M.D. Sewickley, PA: Albanel Publishers, 1997. 55 pp.

In this concise volume, Herbert Thomas opens to us a very important moment in the dynamic of shame: the shame response. According to Thomas, the shame response is a physiological response to rejection of oneself by another. This can be reflected in intense physical pain or by a barely noticeable response. Behind the shame response is a hurt causing great pain. While this hurt can cause anger which may be directed outward against another or inward against oneself, the aggression or depression should not be misunderstood as the problem. Instead, it is important to enter into the moment of the shame response in order to seek to resolve the hurt behind the anger or depression. The intensity of the shame response is related to the significance of the other who rejects or by the significance of the witnesses to the rejection, as well as to vulnerability of the one rejected, whether the rejection is of the total self or of an aspect of the self. Whether or not the rejection comes as a surprise is also a factor. In its most intense and painful forms, the shame response may include a tightness of the throat, nausea, stomach pain, and a sense in one's chest and abdomen of collapsing, exploding or imploding. Thomas also examines the relationship of violence to the shame response, when the experience of rejection is so painful that violence is the reaction.

Among many valuable insights, Thomas's book allows us to see the profound meaning of the shame response, how difficult it can be to detect, and how necessary it is for one to return to this shame response in order to really be able to deal with the hurt. To react to the anger or to simply try to reassure the patient that there is no need to be upset fails to address the deepest core of the problem and to touch into the profound hurt.

In numerous clinical vignettes, Thomas illustrates how this takes place. In one account, he tells about an inmate who begins to serve tea in the cafeteria of a prison which is against the policies and regulations. When the inmate is rebuffed by one of the administrators, he reacts by beginning to attack another person. The stares of the administrators only succeed in aggravating the shame response. But when the psychiatrist simply responds with a broad smile, the bond of trust

between himself and the inmate is re-established and disengages the need for a violent reaction.

One area in Thomas's book that left me looking for more has to do with the relationship between shame and guilt. He comments that in many societies there is a culture of shame, but in America there is a culture of guilt. This statement, which also appeared in his article on shame and violence in the 1995 *Bulletin of the American Academy of Psychiatry and Law,* is not elaborated by him in this article or in his book. For example, in the well-known work of Gerhart Piers and Milton Singer, *Shame and Guilt,*[1] shame is differentiated from guilt, in that shame arises out of a tension between the ego and the ego ideal, not between the ego and the superego as in guilt. In *The Ego and the Id,* Freud defined three functions of the superego: the function of observation, the ego ideal, and conscience. Piers and Singer note that guilt is generated when a superego boundary is touched or transgressed, while shame occurs when a goal presented by the ego ideal is not being reached through some shortfall of the ideal. The unconscious threat in shame anxiety is abandonment, whereas in guilt it is fear of a punitive mutilation (castration.)

Whatever nuances are necessary in the theory of Piers and Singer, it certainly is important to appreciate that the phenomenon of shame does seem to have more to do with falling short of the ideal, whereas what we mean by guilt usually has to do with crossing over a boundary. In Thomas's discussion of shame, he notes how the repression or isolation of the experience of rejection triggers the shame response until such time as these can be dealt with and can reach an experience of separateness and acceptance in place of rejection. While Thomas locates the physiological ground of the shame response in the base of the brain, he recognizes that the actual experiences of rejection or difficulties in the process of separating psychologically from significant others greatly determine one's vulnerability to experience the shame response. The healing and relief come in being able to objectify the experience of rejection, thus objectifying the objectification which originally produced the shame response. This involves

[1] Piers, G. & Singer, M.B. (1953): *Shame and Guilt: A Psychoanalytic and a Cultural Study.* New York: Norton, 1971.

moving beyond the secrecy which maintains the isolation and repression of the painful hurt. Only then, according to Thomas, is acceptance possible, culminating in an experience of equality.

But what happens to shame in the process of this healing? It seems to me that shame must be seen not merely in the shame response so dramatically experienced in the "kindling" discussed by Thomas. Shame must also be the context of the process he describes as a growing separateness. Shame must be understood as the very means whereby an individual can come to experience acceptance. If shame has to do particularly with the ideal, the ideal must be seen not simply as the "paradise lost" of rejection, but as the experience of acceptance within the shame found in the reality of separateness and individuality. Likewise, with regard to the phenomenon of guilt and its transgression of boundaries established by the superego, should we not instead see these boundaries as a horizon of possibility where guilt can be incorporated within an experience of acceptance and forgiveness?

Thomas has opened us to these and many other questions by his profoundly sensitive treatment of the shame response, which enkindles in us the re-experiencing of shame in our personal lives, as well as a heightened attunement to this response in those with whom we are engaged in therapy. Thomas has observed that it is difficult for shame to remain above the surface, and even for us to remain engaged in our discussions about shame. His contribution has been such a sensitive treatment that upon reading his book one feels already that the secrecy and isolation have been lifted.

THOMAS ACKLIN, PH.D. (LATROBE, PA)

TRANSFORMATIONS. COUNTERTRANSFERENCE DURING THE PSYCHOANALYTIC TREATMENT OF INCEST REAL AND IMAGINED. By Elaine V. Siegel. Hillsdale, NJ/London: The Analytic Press, 1996. 193 pp.

In *Transformations,* Elaine V. Siegel presents several case histories which revolve around the uncovering of patients' repressed memories of sexual abuse by one or more close family members. Siegel reports

that, each time an analysand came close to reporting such memories, Siegel herself experienced certain physical sensations: heart pounding, breathlessness, and a feeling of constriction in her stomach. She calls these physical sensations "somatic counter-transferences," which she came to regard as valuable guides in the treatment of this group of patients. Siegel considers her own physical sensations, occurring as her analytic inquiry led her patients to recall their past experiences of incest, to be repetitions of feelings that she first experienced as a young child. At that earlier time, Siegel had innocently asked her family about some neighborhood children and was made to feel frightened and guilty because those children were thought to be "mating" with other members of their families.

Siegel's formulation brings together a number of issues in an interesting and thought-provoking way. Particularly impressive is the consistency and predictability of the sequence of the patients' reports of incestuous experiences, following Siegel's experience of her own physical reactions.

Siegel's inclusion of her personal notes about her emotional and physical reactions, recorded shortly after the sessions, is helpful. However, the complexity of the material, and especially the central role of the analyst's use of her subjectivity, is such that readers will inevitably react to this book on the basis of their own psychoanalytic orientations and personal experiences. For this reason, it would have been useful for Siegel to have included some detailed process material, particularly her observations of what it was in her patients' verbalizations and behavior within the sessions that provoked her reactions.

In a number of passages from Siegel's notes, what stands out about her reactions is not only the "palpitations, breathlessness," etc., that characterized her childhood memories, but also her feelings of boredom, impatience, and anger toward the patients. It certainly is plausible, as Siegel suggests, that her intense affects were inherently a part of engaging the patient's nonverbal communications as memories of incest began to surface. But other hypotheses are also possible. Siegel herself highlights some of the critical questions, such as a possible difficulty in dealing with these patients' hostility (p. 178); her intellectualizing in order to ward off her anger at the patients (p. 86); and/or a difficulty with their tendency to sexualize the transference (p.

135). Thus, it seems possible that Siegel's tendency to focus on deeply buried issues from the past may have relieved, and thus bypassed, some of the more immediate tensions developing within the analytic situation.

In addition, Siegel's experiences of boredom and frustration may also have been, in part, reactions to the patients' strongly maintained defensive positions. Although Siegel mentions having sought supervisory consultation about these experiences, it would have been useful to have further discussion about any modifications of her technical approach that she may have considered and/or ruled out.

In conclusion, this book is an interesting and original approach to dealing with important and complex issues. Because of the complex and emotion-laden nature of her subject matter, it would have been helpful if Siegel had presented more detailed process material and had addressed more fully the issues pertaining to the immediate clinical interaction. I think that such additional data would help readers to be better able to consider and assess Siegel's contribution to the literature pertaining to transference and countertransference in the treatment of incest victims.

BARRY J. LANDAU (WASHINGTON, DC)

THE ADOLESCENT PSYCHE. By Richard Frankel. New York: Routledge, 1998. 243 pp.

In *The Adolescent Psyche,* Richard Frankel offers a unique perspective into the impact of contemporary culture on the adolescent psyche and provides guidelines for those working with adolescents. Frankel advocates a new orientation to the theory and practice of adolescent psychotherapy using a conglomeration of Jungian and Winnicottian ideology. Although Jung rarely wrote about adolescents, his concept of individuation, or striving toward self-actualization, constitutes the crux of Frankel's approach. With his focus on the teleological significance of adolescent development, Frankel seeks to erode the common reductionistic approach often used to understand and treat adolescents

In the first section of the book, Frankel describes three primary directions of orientation for formulating a psychological theory of

adolescence. The first looks to the past as the cause of what is happening in the present. He describes the psychoanalytic theories of puberty of Sigmund Freud, Ernest Jones, Anna Freud, and Peter Blos. A recurring theme throughout this chapter is the theory of recapitulation, or the resurfacing of infantile sexual wishes. Frankel argues that the psychoanalytic theory of recapitulation negates the phenomenological view of adolescence and fails to take into account the major differences between children and adolescents. He criticizes recapitulation theory as being too narrow, missing other, nonsexual aspects of the adolescent process.

Frankel delineates one branch of analytical psychology, termed developmental analytical psychology, in the second chapter. It involves a "conceptual shift away from the emphasis on the ego...toward an analysis of the transformations of what Jung terms the 'self' (the totality of conscious and unconscious personality in which the ego is contained)" (p. 37). The idea is that archetypal material that arises during adolescence is a reactivation of the adolescent's preoedipal past. The themes of deintegration and integration are prevalent throughout this chapter. They refer to the shutting-down and opening-up process the psyche undergoes en route to psychological maturity. This chapter formulates some important aspects of Jungian theory that are necessary for Frankel to lay the groundwork of his theory; however, the language is convoluted and difficult to follow.

In the second section of the book, "Adolescence, Initiation, and the Dying Process," Frankel explores adolescent initiation rituals and links the human drive for ritual to events in modern culture. In the third chapter, he explores the archetype of initiation. He describes historical accounts of ceremonial rites and rituals at the time of puberty, and he notes that outside of certain religious practices, no formalized rites or rituals exist in current culture. He suggests that ancestral rituals have become fodder for archetypal material and are inherited in each subsequent generation. Furthermore, adolescents have an instinctual drive for initiation rites, and they will consequently seek to enact these initiation rituals of their own accord. For example, modern day gang-related activity and drug experimentation may be the adolescent's attempt to satisfy the biological need for initiation. Modern society's lack of a formalized initiation ritual, coupled with the

adolescent's need for it, may contribute to some of today's social epidemics, such as substance abuse and teen pregnancy.

Other issues often foremost in the adolescent's mind include death and the meaning of life. Frankel suggests that the pervasiveness of suicidal imagery in adolescence is the result of an impulse toward suicide as a metaphorical urge. He hypothesizes that a part of the self must die in order to make room for the integration of the psyche, which may actually fulfill an urge for new life. Frankel links the metaphorical suicide urge to the human need for ritual as an outlet for enacting metaphoric suicide. He suggests that the high rate of adolescent suicide may be the result of a failure to acknowledge the need for the literal enactment of metaphoric death via initiation rituals. Frankel presents some interesting ideas in these chapters; however, his descriptions are heavily laden with baffling jargon. More case examples in these two chapters might have enabled the reader to gain a clearer understanding of Frankel's conceptualizations.

In contrast to death imagery, Frankel presents another aspect of the evolving feelings and imagery inherent in the adolescent psyche, namely adolescent sexuality, idealistic yearnings, and ideational processes. In Chapter Five, he contrasts the psychoanalytic and phenomenological approaches to addressing these areas of adolescent experience. In contrast to the psychoanalytic philosophy of the life force (libido) being primarily sexual in nature, he suggests that libido should be equated with life energy. This philosophy allows for flexibility, and life energy encompasses the adolescent's sexuality, yearning for knowledge, and idealism. Interestingly, Frankel suggests that the diversity of American culture leaves the adolescent psyche vulnerable to fragmentation. This lack of cultural cohesion may contribute to the adolescent's sense of isolation. He reproaches modern psychological theorists for failing to consider the adolescent's cultural milieu.

The third section of the book, "Jung and Adolescence: A New Synthesis," is the essence of the book. In the chapters leading up to this section, Frankel has laid the foundation for his orientation. Section Three integrates the concepts from the second part of the book into a viable analytical approach to understanding adolescent development. More specifically, Frankel reveals how he applies Jungian concepts to his psychology of adolescence, and he sprinkles thoughts from Winnicott

liberally throughout this section.

In Chapter Six, Frankel delineates the individuation tasks of adolescence. He begins by examining the "here-and-now" impact of the parent-adolescent relationship. First, parents must also undergo major changes as their child enters puberty. That is, the parent must adjust to his or her changing role in the adolescent's life. Second, the parent's unconscious is a major influence on the adolescent child. For example, the parent may unconsciously attempt to keep the adolescent in a dependent role by imposing strict curfews and curtailing much of the adolescent's freedom. In contrast, the parent may unconsciously wish to retain his or her own youthfulness by becoming overly involved in the adolescent's life. The parents' behavior gives rise to unconscious resentment in the adolescent. According to Jung, an unconscious portion of the adolescent's personality carries the role of the child's mother and father. Until the adolescent recognizes that he or she is reacting to an aspect of his or her own personality, rather than to those of the parents per se, the adolescent cannot truly begin to grow psychologically.

The second part of Chapter Six is devoted to describing specific events that allow the adolescent to uncover his or her own personal uniqueness. The first event he describes is adolescent friendship and first love. He defines this two-part event as a manifestation of how the adolescent's need for intimacy moves beyond the familial realm.

The experience of betrayal follows closely on the heels of adolescent friendship and first love. According to Frankel, the experience of betrayal is necessary in order for the adolescent to gain knowledge about safeguarding the self. He also explores the experiences of suicidal ideation, obsessive behavior, religious and philosophical explorations, and political and social awareness in the adolescent. Throughout this chapter, he uses excerpts from the works of Salinger and Dostoyevsky that are very helpful and highlight his main points.

As a final theme in Chapter Six, Frankel cites Winnicott's unique perspective of the adolescent as an isolate. Winnicott felt that some aspects of the adolescent need to remain hidden and should not be drawn out through psychological testing. Although Winnicott's per-

spective is sensitive and enlightening, it seems abrupt appearing at the end of this chapter. It might have been helpful to present this perspective before describing the specific events leading to the adolescent's uncovering of his or her personal uniqueness.

The seventh chapter applies Jung's concepts of the persona and the shadow to the adolescent psyche. This chapter was the most readable in the book, largely because of Frankel's use of case examples and literary vignettes. In discussing the persona, Frankel describes the different cliques in high school and the different "masks" the adolescent wears when interacting with each clique. Frankel draws from Jungian theory as he states that the persona mediates between the individual and the collective. He expresses the view that the adolescent's struggle for individuality appears with the adolescent's expression of persona. In an attempt to achieve individuality, the adolescent may assume a persona that challenges societal norms. For example, the adolescent may wear a number of piercings or tattoos. Frankel states that it is important to allow the adolescent to explore the outer limits of his or her identity in order to have a strong and stable sense of self as an adult.

In the latter part of Chapter Seven, Frankel addresses the adolescent personal shadow. He discusses the importance of integrating the shadow with the psyche and describes shadow integration as a central task in adolescence. Rather than using dry descriptions and definitions, Frankel uses several vignettes from a Jamaica Kincaid novel to define his main points. These vignettes are the most interesting and readable aspect of the entire book. The vignettes provide a description of Frankel's conceptualization of the adolescent personal shadow in an easy-to-understand format. The use of this technique in other chapters might have been helpful in clarifying some of his main points.

In conclusion to Chapter Seven, Frankel relates the mythological figure of Hermes to the adolescent persona and shadow. Hermes is the trickster god whose unstable nature closely parallels the changing, unstable nature of adolescence. In this concluding section, he describes Winnicott's conceptualization of the "lying, thieving" adolescent. Winnicott believes that it is a developmental necessity for adolescents to lie because lying allows them to gain their own sense of morality. This brief Winnicottian afterthought is useful, but it might

have been better integrated with the rest of the chapter.

The eighth chapter focuses on the development of the adolescent conscience. He advises that prohibiting the adolescent does not work because no outside authority can constantly monitor the adolescent's behavior. He advocates a gradual withdrawal of authority in order for the adolescent to begin to sort through his or her own responses versus societal and parental values. Frankel urges the therapist to assist the adolescent in uncovering his or her potential for self-navigation.

The fourth and final section of the book describes the actual therapeutic process of Frankel's approach. He admonishes the therapist to beware of projecting his or her own painful material onto the adolescent or of overidentifying with the adolescent. Frankel acknowledges the challenge of striking the delicate balance between respecting the adolescent as "other" and moving in to make a connection with the adolescent.

As a final note, Frankel describes specific clinical considerations such as substance abuse. Again, he advises against a flat prohibition against drugs. Instead, he recommends the process of inhibition whereby the therapist questions adolescents about whether their substance use is meeting their expectations. The goal of inhibition is to make the adolescent aware of the gulf between what the adolescent yearns for in his or her urge to use drugs and what he or she is actually getting. Frankel closes by addressing the mixed message society sends to adolescents. According to Frankel, society has no tolerance for the psychic energy of the adolescent and attempts to squelch this energy through prohibitive tactics. As society suppresses the adolescent's individuation process by imposing rules that counteract the adolescent's growth, the adolescent is driven to release his or her energy via unhealthy channels.

Although this book is touted as a useful guide for anyone who works with adolescents, it was very difficult to follow, and the author's use of cloying rhetoric seemed almost self-indulgent at times. *The Adolescent Psyche* was targeted at an audience well-versed in psychoanalytic theory, and other readers may be left grappling for a life preserver in Frankel's sea of complex rhetoric.

MARYELIZABETH FORMAN (HATTIESBURG, MS)

UNAUTHORIZED FREUD. DOUBTERS CONFRONT A LEGEND. Edited by Frederick C. Crews. New York: Viking, 1998. 331 pp.

There is much that usefully stimulates thought in Crews's selection of brief statements by a number of critical Freud students who make points Crews agrees with and aims to promote.

In a necessarily brief review, it would be impossible to summarize and do justice to all that Crews presents here and all that he omits. He argues that Freud was a liar, seducer, bully, schemer, doer of vast harm, and all-around scoundrel who adopted a method he could use hypnotically and suggestively to impose his logically and scientifically unsupportable ideas on patients, whom he claimed to cure but failed to help. He plagiarized others' ideas. He was a bribing, threatening paternalist who created a squabbling, infantilized collection of damaged followers, who have failed, as Freud failed, to acknowledge their errors, apologize, and abandon their useless beliefs and practices. He created a false, self-aggrandizing personal myth of himself as a lonely, put-upon, unappreciated prophet. And he harmfully interfered in the lives of his patients; sometimes, as with Frink, the results were dire.

We can agree with Crews's list of some of Freud's more important errors. These include: (1) Freud claimed that he discovered that infantile seduction is the cause of neurosis and that he discovered the secret of dreams. Freud did not discover the source of the psychic Nile as he wished to. The Nile, in fact, has more than one source, and so do psychological phenomena.

(2) The idea that recovery of the repressed memory of early traumatization brings about abreaction and cure is largely incorrect. To discuss traumatic experiences with another person, sometimes using hypnosis or drugs as an aid, can be very helpful, but a simple trauma-abreaction idea is insufficient.

(3) That cure takes place through interpretation by an objective analyst who discovers important hidden contents simply by listening to the patient's free associations is not accurate. In fact, the analyst pushes, interrupts, and educates patients by indicating what he wants to hear. Cure implies disease, and generally, analysts do not seek to cure diseases. This criticism is largely correct, though the effort to take this into account in the current practice of analytic work is omitted by Crews.

(4) Freud's views that the oedipus complex is universal and psychologically central, and that penis envy is the main issue for women, are highly questionable. If, as Crews does, one depends on a narrow definition of the oedipus complex, if repressed patricidal-sexual appropriation of the mother is defined as the oedipus complex, the idea is wrong. If that was Freud's idea, it was wrong. If neurosis is ascribed to this version of oedipus, that is wrong. The same goes for centrality of penis envy, which, incidentally, occurs in men as well as women. But Freud had a much more subtle view. He posited multiple (active, receptive, positive, negative, etc.) oedipal complexes.

(5) That women are morally defective is clearly wrong.

(6) That a patient's improvement demonstrates the correctness of the analyst's theory of cure is wrong. If two events coincide in time, one cannot logically be said to cause the other.

(7) Freud did not always help his patients. But what alternative treatments were available? Those that were, when tried, hadn't helped.

(8) Freud did at times behave unethically with patients. He failed to satisfy his, as well as our, standards.

(9) The analytic method is imperfect and flawed since its propositions are not falsifiable. This is Grünbaum's, Popper's and Sidney Hook's argument, and it is true that no one can construct an experiment that will make falsifiability possible when it comes to psychoanalytic ideas. I once had dinner with Sidney Hook. When Hook learned I was an analyst, he asked me why and said that since analysts cannot imagine a person without an oedipus complex, one should not accept that there is such a thing. To know something requires seeing what would be there if the something were absent. I asked if Hook had a son. He did. Did he and the son have an amicable relationship? Not always, said Hook; they also competed with each other. Was Hook's relationship with this son quite like Mrs. Hook's relationship with him? No, the relationship between mother and son was different, more affectionate, and less competitive. Did Hook know any family where these things were absent? No, said Hook. That is an oedipus complex, said I. He'd have to think about it, said Hook. Nobody had put it just that way to him before.

Then this book criticizes contemporary psychoanalysis. "Contemporary analysts possess no reliable means, internal to 'clinical evi-

dence,' of locating or correcting their own misconceptions" (p. x). True, but not entirely relevant. Analysts do not rely only on internal clinical evidence in arriving at or changing their conceptions and misconceptions. They also have other sources of information available to them. Clinical experiences, their own and those of others, child development observations, reports from parents in child analyses, clinical discussions with colleagues who may be treating relatives and friends of patients, reports from patients about the events and behavior of important people in their current lives, critiques of their work (as by Crews, et al.), all can enter into analysts' thinking. In addition, there is also the possibility that analysts learn something about their own tendencies toward certain misconceptions from their own analyses and from patients, readings, case discussions, and so on. Finally, psychoanalysis is the situation in which the interacting, wish- fear-influenced participants' interrelationship is an important subject for study.

We are told that "the emergence of latter day psychoanalytic incest inquisitors constitutes the most dramatic sign that the present book is neither antiquarian nor superfluous but urgently practical…every feature of recovered memory therapy, even the crudest, was pioneered by Freud, and nearly all those features were retained in his practice of psychoanalysis proper" (p. xi). Are incest inquisitors really psychoanalytic? Yes, says Borch-Jacobsen. He writes, "Are we much more advanced now that a hundred years have passed… Apparently not, to judge by the spectacular comeback of the traumatic-dissociative etiology of neurosis…" (p. 13). Are we analysts responsible for the practices of misusers, misstaters, and misunder-standers of "analytic" ideas? Are Borch-Jacobsen or Crews's colleagues responsible for such misstatements?

We also read that "free association proved every bit as contaminated as hypnosis had been…" (p. 5). Every bit?

Also, "Freud's Promethean self-analysis…was nothing more than a sequence of contradictory dreams and hallucinations that he entertained and elaborated with cocaine-enhanced feverishness…" (p. 7). Has Crews really read the Freud-Fliess letters? And what about the Signorelli Paraparaxis, the Disturbance of Memory paper, and the Screen Memory paper, which together give a quite complicated picture of Freud's data and thinking about his psychology?

We are told that "Freudian dream theory has undergone little

alteration in nearly a century…REM sleep is universal among our fellow mammals…none of whom is likely to be suffering from repressed childhood memories or castration complexes…" (p. 73). Actually, much has changed in regard to dream theory. By and large, most psychoanalysts treat dreams like other psychological phenomena, as examples of mental functioning to be understood in terms of all that is known about the particular patient, including what we know is not known, from the many available observations of people in general. Dreams are probably not seen as the royal road to the unconscious by most analysts. We do not use the topographic model, with its important emphasis on the barriers between conscious and unconscious and between latent and manifest much these days. REM sleep may be universal among our fellow mammals, but highly enlarged and developed cerebral cortexes, and their modifying influences on subcortical activity, are not.

What Crews shows in this book is not only what he intends to show about Freud and his faults, that analysts make questionable, arguable assumptions, and that analysis is not an experimental or mathematical study. He shows that good things can be misused, as Freud and other analysts can misuse their patients and their method and as Crews and some of his included authors do, in purveying misinformation, prejudices, and hostility under the guise of presenting logical, historically accurate, supposedly factual information.

There are better and worse psychoanalysts, and better and worse critics and historians. Crews shows something important by example as well as by demonstration and argument. That is, in the study of complex systems, like the functioning of a particular mind, the interrelationships between people, or the history of personal or societal development, no available methodology can eliminate the fact that logic, observation, and the selection of data can be used and, probably inevitably, are used to serve the wishes, defenses, moralities, and adaptational possibilities of authors. No method can entirely eliminate the possibility of people causing harm in their writings and teachings.

This volume provides a guided tour, a Crews-led cruise, through the ideascapes of writings of eighteen Freud critics, whose views he shares. These are some well-known figures, like Peter J. Swales, Frank J. Sulloway, Adolf Grünbaum, Joseph Wolpe, Stanley Fish, some less

well known writers and, most importantly, Crews himself, who uses the selections to speak for him, and tells us what they say. If taking Freud and his work seriously and as important enough to consider critically is a compliment, then this book is complimentary to that extent. Because critical views of ideas expressed by intelligent authors give those holding the criticized ideas a possibility of rethinking and then of modifying or abandoning their ideas, this book presents psychoanalysts with an unusual, concise opportunity to reconsider those ideas.

The book presents interesting views in a trenchant, relentless, stylish, and often amusing manner. Less positively, the tone is often outrageously provocative or exaggerated, and the critiques can be smugly insistent, as though there is nothing else to be said. This quality lessens the force of some arguments, especially when what is being criticized about Freud is his un-self-questioning infatuation with his own ideas, his lack of respect for others' views, and his hectoring, bullying manner. Of course, this take-no-prisoners, polemic approach also provides an amusing read.

More negatively, there are important instances when a seeming absence of scholarship, knowledge, and understanding is evident, and this permits oversimplified or plainly wrong conclusions to be proposed. Arguments that Freud failed to do his homework, as in the Leonardo paper, and that he impulsively jumped to conclusions are weakened when the critics misbehave similarly. Further still into negative territory are some patently false statements. All in all, however, we and our patients owe Crews a vote of thanks for this presentation.

ERNEST KAFKA (NEW YORK)

FREUD AND THE BOLSHEVIKS. PSYCHOANALYSIS IN IMPERIAL RUSSIA AND THE SOVIET UNION. By Martin A. Miller. New Haven/London: Yale University Press, 1998. 237 pp.

This is the third book on Russian psychoanalysis to have recently appeared. Alexander Etkind's *Eros of the Impossible* (1997) and James Rice's *Freud's Russia* (1993) were both different and yet wholly fascinating; Martin Miller's new book is distinguished by the fact that as a profes-

sional historian he provides a smooth narrative account, whereas the two earlier texts were both primarily thematic rather than chronological. While the first two books on Freud in Russia interestingly explored special topics on the subject that particularly interested the authors, this new study by Miller undertakes to cover the entire sweep of the story of psychoanalysis in Russia, and he does so in less than 200 pages.

It is often forgotten that before the Russian Revolution there were psychiatrists and intellectuals in the Romanov Empire who took great interest in Freud's work. The 1904 Russian translation of *The Interpretation of Dreams* was the first to be made into any language. Other Russian translations of Freud soon followed. Although Miller does not choose to dwell on the way nineteenth-century Russian literature prepared the way for Freud, it is clear that in no country was the national response more immediate than in imperial Russia. And Russian-born analysts (like Lou Andreas-Salomé, Sabina Spielrein, and Max Eitingon) played a notable part in the international movement of Freud's followers.

Once the Revolution took place, even more interest in Freud's work grew in Bolshevik Russia; the Russian Psychoanalytic Institute, with about thirty members in 1922-1923, then made up about an eighth of the entire membership of the IPA. And the Soviet state officially supported the work of the analysts. An experimental school for small children was founded along psychoanalytic lines, and one of Stalin's children attended.

Miller sensitively explores the issue of how ambivalent about psychoanalysis Lenin might have been, and he touches on Trotsky's endorsement of Freudian objectives. By the mid-1920's, there was a full-scale debate about the difficulties of reconciling Marxism with psychoanalysis, a topic which interested some important Western thinkers as well. Trotsky's support was to prove a fatal sort of backing, and by the end of the 1920's psychoanalytic studies were considered heretical and the practice of Freudian therapy seems to have ceased. Regulatory legislation on marriage, divorce, and other such areas was pursued in an unenlightened spirit at the same time that a Stalinist witch hunt was undertaken against psychoanalysis.

A thaw started after Stalin's death and accelerated throughout the

1960's. By the time of the collapse of the old Soviet Union in 1991, Freud had become a popular subject in Russia, even though easily confused with tea-readers and old-fashioned mediums. Even if Miller does not take the subject quite up to the present day, it is the case that psychoanalysis is now, as in the early 1920's, supported by the Russian state, and Boris Yeltsin's 1996 decree made it a legitimate part of university education. So Freud is once again fashionable in Russia, and if only that tragic country has a bit of good luck, it should have a secure future in the history of psychoanalysis over the coming century.

PAUL ROAZEN (CAMBRIDGE, MA)

SEXUAL ORIENTATION. TOWARD BIOLOGICAL UNDERSTANDING. Edited by Lee Ellis and Linda Ebertz. Westport, CT/London: Praeger, 1997. 276 pp.

This book is a collection of papers based on presentations at the *First International Behavioral Developmental Symposium: The Biological Basis of Sexual Orientation and Sex-Typical Behavior,* which took place in 1995 in Minot, North Dakota. It is an effort to ferret out the biological influences that bear on sexual object choice. It is off the beaten track for the usual psychoanalytic reader, although certainly not outside of his/her grasp. It is quite readable, with introductory explanatory paragraphs and clear, concise conclusions. Terms are clarified and jargon is kept to a minimum. At the same time, it is difficult to judge the validity of the studies, as the research is not presented in depth and the researchers themselves claim a lack of substantiation of previous studies as well as a need for replication of their own studies.

A wide range of topics is covered, with attempts to generalize and to substantiate the generalizations from other mammals to human sexual preference. The emphasis is on the biological, with an effort to distinguish genetic from hormonal influences as the sexually dimorphic brain is formed. A nod is given to psychosocial and cognitive influences, although they are often appreciated only as an indication of sexually determined (genetic and/or hormonal) brain lateralization. Stress is appreciated as a powerful hormonal influence, especially as it affects the critical development of the fetal brain.

The book is divided into two sections. The first deals with genetic and perinatal influences on sexual orientation, the second with neurological and physiological aspects of sexual orientation.

The bluehead wrasse (fish) was studied because of its male-female flexibility as well as its sexual partner preference flexibility. Variations in sexuality and sexual behavior were noted to result from stress and environmental factors, resulting in hormonal, neurochemical, and anatomical changes. Reorganization of the brain results in a sexual transformation. A similarity to the human brain is suggested, with a focus on the importance of the neuroendocrine system and the social environment in the regulation of sexuality. It is suggested that in both fish and humans, social hierarchy and stress are important regulators of the expression of sexuality. In fish, this expresses itself as initial phase or terminal phase males, and in humans, as homosexual or heterosexual males.

The bluehead wrasse has two phenotypes of interest: the initial and the terminal phase male. Removal of the terminal phase male from the population results in the largest initial phase male becoming more aggressive and increasing its courtship behavior. There is a rapid behavioral shift, which is followed by neuroanatomical changes (increase in size of the hypothalamic, preoptic gonadotropin-releasing hormone cells) and ultimately by a change in gonadal anatomy and physiology. Anatomical change follows the behavioral change which follows the change in milieu. It is postulated that social cues, i.e., the presence of the terminal phase male, inhibit both behavioral and anatomical sexual development in subordinate initial phase males.

Studies were run on testosterone levels, 11-Keto-testosterone levels, aromatose levels, and size of preoptic gonadotropin-releasing hormone cells. The first hypothesis is that sex change is a result of sensory input. The second is that stress, i.e., the presence of the dominant male, increases circulating corticosteroids; this affects the brain, inhibiting gonadotropin-releasing hormone secretion, the pituitary by blocking gonadotropin production, and the gonad, maintaining initial phase maleness in subordinate males.

Subsequent chapters in this section deal with prenatal stress as it affects masculinization of the brain, and there are attempts to correlate this with human experience. Evidence is given of the higher inci-

dence of homosexuality in men born to women living in Germany during the most stressful period of World War II. There is also reference to studies indicating that stress, especially during the second trimester of pregnancy, is reported by mothers of homosexual sons. This was information acquired through extensive interviews and questionnaires. There is an inference here that male homosexuality is an indication of a less masculinized brain, an idea that underlies much of this book.

Permanent changes in neuroanatomy as the result of neurochemical influences are postulated. Much of this is not adequately replicated, but some of the findings are of interest. The preoptic area is larger in males than in females. Stress diminishes its size in males but not in females. Other male-female differences are noted and are found to be similarly affected by stress, e.g., in the spinal nucleus cavernosus and the dorsolateral nucleus as well as in fiber tracts connecting the two hemispheres. It is postulated that these sexually dimorphic structures are especially vulnerable to neurochemical disruption produced by prenatal stress, resulting in development in a female direction. Evidence for stress resulting in a more feminine behavioral repertoire is noted in rats' copulatory and parental behavior. The chapter on the sexual differentiation of the human hypothalamus is most thought-provoking, suggesting arenas for further exploration.

Chapters in the second part of the book on the neurological and physiological aspects of sexual orientation, such as those on sexual orientation and handedness, transsexuality and adextrality, and sex, sexual orientation, and cognition, are filled with studies that have been contradicted by other studies or not evident in replications done by other researchers. The focus is on the diminished lateralization of the human brain and the correlation with male homosexuality.

There are many problems with this book: the jumps made from non-human to human functioning, the lack of definitive confirmation of tests conducted, and the lack of adequate appreciation of the environmental, i.e., sociopsychological impact. Its chief asset is that it turns our attention to biological factors in sexuality and points the way toward new avenues for exploration. Doing research in this arena is necessary, but the complexities are great. For the psychoanalytic reader, the complexities are greater than appreciated here. The need for many more stringently conducted studies, to confirm or negate those already

conducted and to lead us into new arenas, is clear. One closes this book with an appreciation of the importance of the environment as well as with a realization that there is much to be learned about the biological underpinnings of sexuality.

RUTH S. FISCHER (BRYN MAWR, PA)

ABSTRACTS

THE PSYCHOHISTORY REVIEW. XXIV, 1995/96.

Abstracted by Thomas Acklin.

Consuming Freud in Consumer Culture: Historicizing the Empty Self. John E. Toews. Pp. 13-26.

In Philip Cushman's book, *Constructing the Self, Constructing America,* Freud's writings are viewed as a cultural text in which autonomy becomes linked to the domination of the irrational. The struggle to find human meaning increasingly came to be defined as primarily internal to the self, a process of self-definition, self-discipline, and self-control. On the other hand, the American understanding of the interior self viewed the self as inherently good and as capable of controlling the external world spiritually, an optimistic faith in secular salvation, strongly in contrast with Freud's "hermeneutics of suspicion."

Following in the tradition of Michel Foucault, Christopher Lasch, and Elizabeth Lubeck, Cushman describes the search for the true or essential self which focuses on the individual and criticizes the way in which unconscious psychic desires can be manipulated, producing an apathetic conformity and willing normalization which legitimates the culture of professional soul healers and personality adjusters.

Psychotherapy, according to Cushman, is grounded in an unquestioning affirmation of a bounded, isolated, self-contained, and empty self, which fits into a culture of consumption because it defines healing as a filling up of the empty self. Cushman argues that there never was a real encounter between American therapies and Freud, because Freud was never allowed to speak with his own historical voice and from within his own culture. Indeed, even in Europe, opposing positions emerged rapidly, including such disciples of Freud as Adler, Jung, Reich, and Rank. Unconscious individual interiority was liberated, manifesting itself as an infinite desire for wholeness, recognition, and meaning.

Cushman points out the disturbing homogeneity between this mission statement and consumer capitalism. Psychotherapy has assumed an even more important role because of the collapse of the former mediating power of religious and ethnic traditions. It is necessary for us to reimagine and rethink the ways in which individual autonomy and community identity can be bridged.

The Problem of the Relation of "Self" and "Society" in Writing the History of Psychotherapy. Eli Zaretsky. Pp. 35-42.

Arguing against Philip Cushman, Eli Zaretsky asserts that Freud transcended Cartesian dualisms of mind and body, idealism and materialism, subject and object, and psychology and history. Freud's Darwinian perspective freed him from such dualism in his psychological theories since Freud thought in terms of an environmental field, while pre-Darwinian psychology focused on associationism and heredity. As a Lamarckian, he viewed characteristics as inherited and serving adaptive needs, and he considered evolution in terms of an interplay between inner and outer. Neither Freud's cultural works nor even his instinct theory counterpoises the mind and the environment. The social was not missing from psychoanalysis from its establishment but was subtracted from it in the process of creating modern psychotherapy, which has focused on the self to the exclusion of society and has viewed the psychological as entirely inside the individual. The sense of emptiness that ensued was not caused by the history of industrial capitalism but flowed from within it. Cushman's preference for the interpersonal theory of Sullivan and his critique of Melanie Klein are also challenged.

From the Empty Self to the Communal Self: Reactions to the Journey. Jacqueline W. Ray. Pp. 43-51.

Philip Cushman's critique of twelve-step programs and his passionate advocacy for a psychotherapeutic paradigm beyond narrow and sterile confines of "two-person" psychological theories calls for a hermeneutical terminology. We refer to horizons of understanding in interpreting ourselves and others. Such horizons of understanding are critical in the psychotherapeutic process in which both therapist and patient are challenged to expand their horizons by moving away from the known and the comfortable. While various psychotherapies can be seen as commodities which can be obtained to fix what is wrong, Cushman insists that a psychotherapist cannot dismiss the sometimes disquieting impact of political and cultural happenings upon the patient or upon the therapist.

Psychotherapy, Confessional Technology, and the Reproduction of Capitalism. Suzanne Barnard. Pp. 61-75.

The production of a self-referential discourse requires the labor of free association, being therefore akin to the phenomenon of capitalism. Confessional technology is discussed outside the religious sphere in the way in which it has served as a scientific tool. Within psychoanalysis the confessional structure is a revelation of a confession with an authoritative interpretation of the latent truth contained within. Nonetheless, Philip Cushman notes that this psychoanalytic attempt to find within the unconscious a deep interiority has

only produced more territory to be exploited by the corporation or capitalist entrepreneur. Cushman warns that the analysis of the transference-countertransference relationship provides a powerful tool to deconstruct the power relationship between therapist and patient when the countertransference is recognized and dealt with during the therapy hour.

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Abstracted by Thomas Acklin.

The Framework of the Psychoanalytic Situation. Jürgen Körner. Pp. 15-26.

The rule of free association makes it possible for the analysand to reshape his or her relationship to the analyst continuously while speaking. The analyst, on the other hand, gains the analysand's sympathy by sharing in his or her unconscious relationship fantasies, that is to say, in the context of what he or she is saying. Both parties get into an uncertain relationship situation and are confronted with the task of joining forces to look for a new framework in which both feel comfortable. In this work the analyst is supported by the broader framework made up of his or her own convictions about the professional tasks of a psychoanalyst at this time.

On the Early Development of Neurosis and Its Implications for Psychology. Martin Dornes. Pp. 27-49.

A short overview of results stemming from infant research serves as a starting point for the following reflections. (1) Parents' fantasies about their children are a powerful – helpful or detrimental – developmental force. The capacity for symbolization as it expresses itself in fantasies is therefore the "ultimate" specifically human foundation for neurosis or healthy development. (2) The affects of the infant are of short duration and situationally variable. They gain durability only later through linkage with fantasies. Aggression is not a problem because it is a drive; instead, it is a problem because of its propensity for derailment. This occurs when aggression, being in itself an adaptive disposition, becomes connected to destructive fantasies. (3) An interactional revision of the concept of projective identification is proposed. (4) The author argues for an interactional supplement to the theory of neurosis which has hitherto primarily focused on the analysis of intrapsychic mechanisms. (5) Observed interactions between depressive parents and their infants support clinically obtained suppositions regarding the

genesis of depressive disorders. The author also comments on the diversity of modalities serving to express and communicate states of mind.

The Psychodynamics of the Borderline Personality Disorder as a Sequel to Trauma. An Outline (or a Proposal). Ulrich Sachsse. Pp. 50-61.

The clinical and empirical results presented by various authors within the last ten years have supported the conjecture that many borderline patients, especially women, have suffered from real traumata: deprivation, loss of a parent, physical and sexual abuse, and incest. These traumas temporarily destroy the individual's ego functions and the "good" object associated with them. Through personification the trauma can be defined as only a "bad" object or can be further processed by fantasy, games, and dreams. The strictly "good" object, formed as a response to the trauma, contains the restructured, fantasy-like paradisiacal time prior to the trauma and the hope for a livable future. Depersonalization can be induced as a splitting of the physical experience during abuse, while derealization can be induced as a metamorphosis of the traumatic experience into fantasy. The ability to repress can be hindered or destroyed, thereby preventing traumata from becoming psychological "abscesses." Levels of fearful recollections up to and including hyperamnesia remain as an "open wound" on the emotional surface, employing the defenses of acting out, self-mutilation, or substance abuse. All of the essential mechanisms and symptom formations of borderline personality disorder are therefore understandable as sequelae to trauma.

Reticularization: A Parameter in the Psychoanalytic Treatment of Psychotic Patients. Georg Bruns. Pp. 84-94.

The psychoanalytic treatment of psychotic patients requires some technical variations. The author describes a variation which he terms reticularization *("Vernetzung").* It is a parameter which psychotic patients often tend to install. Reticularization is the tendency to involve the analyst with other relationships of the patient. The psychoanalyst should not interpret this as a way of acting out or try to stop it or strengthen it. It should be considered to be a helpful method for the patient to sustain the therapeutic alliance and to protect him/herself from symbiosis or unbearable dependency. The psychoanalyst profits by it, too: in times of aggravated illness of the patient, the analyst finds some relief and in his/her fantasy becomes part of a network releasing him/her from strong and threatening countertransference affects. For the patient the capacity of the analyst to integrate diverse connections sets an example for overcoming his or her own tendency of fragmentation and splitting. If treatment is continued long

enough, the patient gives up reticularization, indicating the transition from a psychotic to a neurotic stage of functioning and an increased capacity for symbolizing.

A Critique of the Concept of "Primitive Defense" in the Concept of Splitting as an Original Mechanism of Defense. Günter Reich. Pp. 99-118.

The author portrays the development of the descriptive term *splitting* as generated by Freud and the explanatory concept of splitting in the object relations theory of Melanie Klein and Kernberg. The explanatory use of the concept is critically reviewed from the viewpoint of recent infant research with respect to the underlying concept of regression and with respect to the implicit equation of "deep" with early psychic processes. The author discusses the question of the continuity of psychic processes, the relationship between primary and secondary process, and the relationship of the development of the self to early infantile development. After an examination of the underlying concept of reconstruction, the author presents a critique of the concept of splitting from the clinical point of view. Splitting is understood as a result of a combination of denial and/or repression with other defensive processes. Reich suggests looking upon the phenomenon of splitting as a screen process, as Greenson described it.

Nonverbal Communication in the Therapeutic Dialogue. Eckard Daser. Pp. 119-132.

Action and coaction in therapy are seen as dialogue following Klüwer's concept of "action dialogue." Moreover, dialogue is understood as recognizing elements of oneself in someone else. On the basis of some examples, the article demonstrates that nonverbal interactions can be described as integral parts of such a dialogue directed toward recognizing elements of oneself in someone else. It is with this conceptualization that the creative effects such nonverbal actions can have become intelligible and explicable. Seen against this background, acting appears not only as resistance against remembering but also as moving toward insight-oriented understanding.

Technical Problems in the Treatment of Schizophrenic Psychosis. Günter Lempa. Pp. 133-149.

The author gives a general view of different concepts of schizophrenia, the common denominator being the schizophrenic's incapacity to differentiate clearly between the definition of oneself and that of others. The central schizophrenic conflict is not reenacted in the therapeutic situation as a transference reaction proper, i.e., as a symbolically represented relation, but as a presymbolic pattern of affective behavior. The author suggests a therapeutic technique as an essential prerequisite to analytic technique itself. At first the

analyst has to avoid the repetition of pathologic psychosocial arrangements between therapist and patient on a body-ego level. By means of a "therapeutic symbolization," in the course of which the analyst and the patient negotiate the schizophrenic's basic problem, the building up of representations of the former presymbolic problem becomes possible. Only on this basis can interpretations and reconstructions be useful. Lempa refers to the paradigm of contingency and compares his method of treatment with that of others.

"One Body for Two" Observations on Chronically Ill Adolescents and Their Mothers. Annette Boeger; Inge Seiffge-Krenke; Carina Schmidt. Pp. 150-159.

Concepts of psychoanalytic object relations theory, in particular McDougall's concept of "one body for two," are described and analyzed using clinical case material. The mother-child relationship in cases of young people afflicted with diabetes mellitus is examined. Special attention is given to any inability of the mother in supporting the child's requirement for autonomy as described by McDougall in her analysis of psychosomatically ill patients. A case study shows how the occurrence of a chronic, somatic illness in adolescence can initiate or regressively reactivate previous pathological mother-child relationship patterns.

Primal Scene Fantasies within the Analytic Relationship. Christian Maier. Pp. 201-220.

In the course of a psychoanalytic treatment, primal scene fantasies are integrated within the analytic process and gain the signification of transference. The relevant experience of the analysand is characterized by feelings of exclusion and aloneness. Primal scene fantasies are regularly connected with a constellation within the analytic relationship which is suitable for provoking an experience of feeling left out and excluded. It is a well-known phenomenon that patients with primal scene experience tend to act out primal scene fantasies. Within the analytic relationship this may also have the function of putting to the test the developing capabilities for being alone. Social structures may foster certain character traits by the ideologically favored way of dealing with the primal scene.

Abstinence or: From "Necessity to Virtue." Historical Background and Current Meaning of the Concept of Treatment Technique. Manfred Klemann. Pp. 221-238.

Talking to analysts about their perception of the "analytic rule of abstinence" may easily give rise to the impression that it is a kind of taboo regulation rather than a rational concept of analytic technique. Actually, the term "abstinence" outlines a canon of rules that delineates the frame for relations

with patients in the specific treatment situation of psychoanalysis. If you consider this in union with the recent gleefully spread press reports on sexual relations between patients and psychotherapists, you will become painfully aware of how great is the need for discussing analytic abstinence. This holds both for the definition of its content and its translation into the practice of analytic technique. Against this background, Klemann first outlines the genesis of the analytic concept of abstinence: born of the necessity to provide the difficult analytic relationship with a moral framework, abstinence grows into a prerequisite of treatment technique. The underlying metapsychological and clinical implications are shown. In conclusion, some thoughts on the present ethical and practical meaning of the analytic concept of abstinence are presented.

The Body and the Ego Boundaries. A Case Study in the Psychoanalytic Therapy of Psychosomatic Patients. Joachim Küchenhoff. Pp. 239-249.

Psychosomatic diseases have been described by a variety of psychoanalytic theories. No single concept can cover the whole range of psychodynamic processes in psychosomatic patients. Some of them are able and motivated to have a psychoanalysis, but they are "borderline cases" with respect to psychoanalytic technique. Within the last decade a considerable amount of conceptual work has been done that may be helpful in the psychoanalysis of these psychosomatic patients. A few concepts are summarized: Green's model of the psychodynamics of borderline cases, McDougall's psychosomatic theories concerning foreclosure and archaic hysteria, and, finally, Anzieu's work on the "skin ego." To exemplify the fruitfulness of these concepts, the author presents a case history of the psychoanalysis of a patient suffering from bronchial asthma and colitis.

Learning from Experience and the Experience of Learning. Reflections on Psychoanalytic Training. Franz Wellendorf. Pp. 250-265.

The author investigates the vicissitudes of learning processes within the psychoanalytic systems of training. The emotional experiences of students and teachers have a decisive impact on learning the technique of psychoanalysis. Following Bion, Wellendorf presents the concept of learning from experience. He discusses the multiple and conflictual experiences of the participants in the training system. The dialectic of fragmentation, on the one hand, and internal and external integration, on the other, are discussed in detail. Some factors are identified which impede finding ways of linking the diverse learning processes of psychoanalytic training in a clear and differentiated way.