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OEDIPUS, DARWIN, AND FREUD: ONE BIG, HAPPY FAMILY?

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The author reviews recent sociobiological and psychoanalytic literature relevant to sexual aspects of the male Oedipus complex. Sociobiological discussions of incest and incest avoidance frequently contrast Freud's Oedipus complex with the Westermarck hypothesis. Westermarck argued that children who grow up in close association are averse to sex with each other as adults. Human and animal evidence supports the Westermarck hypothesis, and sociobiologically oriented writers have argued that it contradicts Freud's oedipal notion of an early incestuous sexual interest. However, two additional lines of evidence are relevant to such discussions. First, recent analytic theory on the Oedipus complex does not require the existence of a central, powerful, incestuous sexual drive. Second, both oedipal and sociobiological theory suggest that early familial experience forms a model for adult sexual mate choice and establishes patterns of adult sexual relationships. In these instances, sociobiological understandings of early development correspond well to oedipal theory.

Sigmund Freud was no stranger to controversy, and his theory of the Oedipus complex was among his most controversial (Freud 1916-1917; Simon, 1991). Encapsulating his ideas on infantile sexuality and unconscious conflict, the Oedipus complex was the centerpiece of psychosexual development and neurosis formation. It was also an out-

rage to many of Freud's opponents, and thus an admirable instrument for distinguishing the true adherents of psychoanalysis from its enemies (Freud 1905).

The century that followed Freud's proposal of the Oedipus complex has transformed, but not resolved, the controversy surrounding the theory. Recent critics have held that his oedipal theory is undermined by a lack of empirical support and thus is no more scientifically valid than the theory of the Loch Ness monster (Torrey 1992). But judgment of Freud's theory of the Oedipus complex goes well beyond mere scientific dispute. Freud's critics now blame him for a failure of courage in allegedly interpreting reports of childhood sexual abuse as fantasy. Although he initially took such reports literally, Freud subsequently attributed many of them to unconscious incestuous wishes that may never have been fulfilled. In creating the Oedipus complex, Freud is guilty of fashioning the "perfect instrument for explaining away allegations of sexual abuse" and of doing "untold harm" to society in the process (Webster 1995, p. 513; see also Masson 1984).

The sociobiologists among Freud's critics have been more sober and have taken him more seriously. They recognize his work as an early attempt to ground psychology in notions of evolution and instinct, and to apply principles of evolutionary biology to human behavior. They find Freud's approach congenial to sociobiology, which constitutes the study of ways that natural selection has shaped behavior in humans and other animals. But they also accuse Freud of having a poor understanding of evolutionary theory and of holding to principles of Lamarckian evolution that have since been thoroughly discredited (Sulloway 1979). And they have not been persuaded by Freud's oedipal account of early childhood development, an account that requires a powerful sexual drive which finds an early incestuous object. Instead, they generally hold to the Westermarck hypothesis and assert that humans and other animals possess an innate aversion to incest triggered by frequent and intimate association during childhood (Westermarck 1894; Wolf 1993). Freud could perhaps be forgiven for believing that children experienced powerful incestuous urges, since incest was believed to be common among animals. But sociobiologists now hold that humans and other animals possess an

incest avoidance mechanism, and they regard Freud's oedipal ideas as clearly erroneous (Bower 1991; Daly and Wilson 1990; Trivers 1985). Most would agree with Sulloway (1997) that Freud's ideas on the subject constitute a "fundamental misreading of family experience" (p. 146).

There is significant evidence that supports the Westermarck hypothesis against drive-oriented accounts of infantile incestuous wishes. But debate in this area has generally underemphasized two important factors. First, contemporary oedipal accounts are not oriented to drive theory. Both classically and relationally oriented theorists now conceptualize oedipal development as a complex interplay of triadic object relations, cognitive development, and gender identity consolidation in which sexual elements are present. Oedipal development is not seen as the simple manifestation of a primary, barely controllable incestuous sexual drive. Second, other relevant sociobiological data have been underemphasized. Sociobiological theories of mate choice propose that in many animals, the opposite-sex parent functions as a model or template for a later choice of sexual partner. Such sexual imprinting occurs early in development, even though mate choice must await a significant interval of maturation. And there are also sociobiological hypotheses suggesting that early family experience forms a model for adult family life through the formation of sexual strategies**,** evolved patterns of reproductive and parental behavior. In this sense, sociobiological understandings of early childhood correspond well to theories of oedipal development: both posit that early experience with parents (attachment) forms a model for later mate choice and family relations.

The analysis that follows will review evidence for this thesis, as well as briefly review the course of the sociobiological-psychoanalytic debate on incest avoidance. The focus will remain on sexual aspects of the Oedipus complex. In both sociobiological and psychoanalytic theory, female and male sexual development and behavior differ markedly. Because psychoanalytic theory of female oedipal development is "in a state of considerable flux" (Simon 1991, p. 653), only heterosexual male oedipal development will be examined here.

PSYCHOANALYSIS I: FREUD AND INCEST

Sigmund Freud did not assert that infantile sexual drives are incestuous per se. In his account (Freud 1905), they are not initially directed toward any particular object. The early sexual drives are oriented toward the sensual pleasure that results from the stimulation of particularly sensitive areas of skin and mucous membrane. Such erotogenic zones are discovered more or less indirectly in the course of normal somatic functioning. Any part of the body may come to function as an erotogenic zone, but the normal course of development predisposes the infant to find sensual satisfaction in particular areas: the lips initially, through sucking, then the anal area through increasing sphincter control, and finally the genitals through micturition and chance manipulation. Even if early experience can direct sexual motivation in almost any conceivable direction, sexual satisfaction normally comes to focus on the genitals, which are uniquely suited to fulfill sexual desire.

The "finding of an object" (Freud 1905, p. 272) of sexual desire begins in early infancy, but is completed in the oedipal period. Anyone involved in the infant boy's care is likely to become "an unending source of sexual excitation and satisfaction" (Freud 1905, p. 223). Because they are usually caretakers, the infant's blood relatives, especially his sister and mother, become the objects of sexual desire. And from his early encounters with his mother's breast, the infant boy has taken his mother as his first and primary sexual object. As his sexuality finds a loose genital focus, he comes to recognize his mother as a fitting object of sexual desire. Here, in love for his mother and in fear of a dangerous competition with his father, the oedipal drama begins.

In "Three Essays on the Theory of Sexuality," Freud (1905) did not posit a rigid, deterministic sequence of psychosexual development. Rather, he elegantly described a sequential unfolding of the sexual instinct. The experience of pleasure usually comes to focus on the genitals because they are especially fitted to provide such pleasure. And genital sexual desire will come to focus on the boy's mother, because her caretaking arouses his sexual instinct, and because he comes to recognize her as an object of sexual satisfaction. When he

fixes on her as an object, he will inevitably come to fear his father as a powerful competitor.

Freud was aware of the complexities of oedipal development, and he did not maintain that they were an exclusive function of the sexual drive. But this account is compelling in part because it flows so neatly from his drive theory. Each step in psychosexual development follows logically from the preceding one. Drives constitute the demand for the repetition of pleasure, which comes to be found internally in the genitals and externally in the mother. And "to this choice of his mother as a love object, everything becomes attached" (Freud 1916-1917, p. 329) in the formation of the Oedipus complex. Thus the sexual drive becomes the "motor" (Greenberg 1991, p. 14) of oedipal development.

Freud was familiar with other hypotheses regarding incestuous desire. He argued that psychoanalysis had proven the Westermarck hypothesis "totally untenable" (Freud 1913, p. 123) by showing how intensely people struggle with incestuous wishes. He held that there would be no need for a strong prohibition of incest if no one desired to commit it. And he felt that the Westermarck's mechanism of incest avoidance, early and close social contact, was too nonspecific to efficiently serve its purpose. This mechanism would inevitably go far astray of its object of incest prevention and would inhibit sexual activity with any "totally innocuous" person who happened to share the same childhood home (Freud 1913, p. 123).

SOCIOBIOLOGY I: FREUD AND WESTERMARCK

Freud was probably correct in so characterizing his disagreements with Westermarck. He held that early and intimate association was likely to arouse sexual desire, while Westermarck asserted that it would prevent sexual interest. And the question of whether "innocuous" nonrelatives could become objects of incest aversion would provide a fruitful line of sociobiological research. Certainly, the assertion that humans and other animals are averse to incest would

remain controversial long after Freud's time.

Incest among animals has since been shown to be relatively rare. Long-term studies of a variety of bird and mammal species show a rate of sibling or parent–offspring incest of usually less than 2 percent (Harvey and Ralls 1986). Studies of a number of primate species, including chimpanzees (Goodall 1986; Pusey 1980), rhesus monkeys (Sade 1968), and macaques (Murray and Smith 1983), have shown that sexual activity is uncommon between siblings or mothers and sons. Such incest avoidance has been observed both in experimental and natural settings.

Evidence regarding humans is necessarily less direct. Since the incest taboo is held to be universal, avoidance of incest among humans could be attributed to almost any combination of cultural and biological factors. But two prominent test cases of the Westermarck hypothesis have emerged. The first involved children raised together in Israeli Kibbutzim. These children were socialized together in unrelated, similarly aged peer groups. They slept, ate, and played together throughout childhood. Several investigators were unable to find any instances of marriage between those raised in the same peer group from early childhood, although such marriages were not discouraged (Shepher 1971; Talmon 1964). In a survey of approximately 2,800 marriages of Kibbutz members, Shepher (1971) concluded that a negative sexual imprinting had occurred between children raised in close association during the first six years of life, so that they did not experience sexual attraction to each other as adults.

The second test case concerned a "minor" form of Chinese marriage (sim pua) in which mothers reared nonrelated girls as wives for their sons. Wolf (1993, 1995) examined a sample of 14,000 sim pua marriages and found that fertility was more than 25 percent lower and divorce was 2.5 times more likely than in other forms of marriage. He has argued in extensive detail (Wolf 1995) that these data are not explained by other proposed social or psychological factors. He has proposed that the Westermarck effect is one aspect of attachment as described by Bowlby, and that the first two to three years of life constitute a critical period in which early attachment and incest aversion are formed.

There is other, less direct evidence that humans reared together in intimate association experience markedly decreased sexual attraction (Bixler 1981; Brown 1992; Thornhill 1991; van den Berghe 1983, 1987). Several authors have undertaken reviews of this evidence (Erickson 1989, 1993; van den Berghe 1983; Wolf 1995). Erickson (1989, 1993) has proposed that these data support the distinction of two evolved types of social attraction, familial and sexual. Sexual attraction may occur in the absence of early intimacy, normally between unrelated or distantly related individuals. Familial attraction forms in response to close contact in early childhood, includes attachment or family bonding, and occurs almost exclusively between immediate kin. Familial attraction is associated with altruistic behavior and sexual avoidance. Erickson argues that a strong, nurturant familial bond inhibits sexual desire, and that incest is likely to occur only in the absence of secure familial attachment. He cites animal evidence that siblings who normally avoid incest are highly incestuous when separated early in development. And he notes that there is generally a history of disrupted attachment in the lives of both perpetrators and victims of sexual abuse. For instance, Parker and Parker (1986) compared a sample of fathers convicted of incestuous sexual abuse to a normal control group. Except for a history of abuse in the parents of perpetrators, they found only one other variable that predicted sexual abuse: fathers and stepfathers intimately involved in the early socialization of their daughters (birth to age 3) were far less likely to perpetrate incestuous abuse.

In summary, sociobiologists argue as follows: because of adverse genetic effects of inbreeding (Bittles and Makov 1988; Frankham 1995), the offspring of incestuous mating are less likely to survive and reproduce. For birds and mammals, incest is usually maladaptive and is therefore unlikely to result from natural selection. A mechanism for incest avoidance is required. In many species of birds and mammals, early exposure promotes attachment and inhibits incest. There is evidence that a similar mechanism exists in humans. Freud, who postulated early incestuous attraction, was simply mistaken (Bower 1991; Daly and Wilson 1990).

SYNTHESIS I: FREUD VERSUS WESTERMARCK

Sociobiological proponents of the Westermarck hypothesis frequently contrast this proposal with Freud's Oedipus complex (Bower 1991; Thornhill 1991; Wolf 1995). And several psychoanalytically oriented authors have replied on Freud's behalf, holding that there is no contradiction between Freud and sociobiological theory (Badcock 1990a, 1990b; Rancour-Laferriere 1985; Spain 1988). Both groups have concerned themselves with the Oedipus complex as presented by Freud and other early analysts, assuming that incestuous wishes lie at the core of the Oedipus complex. In casting the debate in terms of Freud versus Westermarck, they attain the benefit of clarity, not to mention the dramatic contrast of two towering turn-of-the-century intellectuals. But focus on the Freud–Westermarck debate has been associated with the underemphasis of two relevant factors. First, discussions have overlooked more recent psychoanalytic thought on oedipal development and have forfeited the advantages of the half-century of analytic inquiry after Freud. Second, the focus on incestuous drive in regard to the Oedipus complex has obscured other areas of overlap between sociobiological data and oedipal theory. Many writers have referred to such data (Erickson 1989; Rancour-Laferriere 1985; Slavin and Kriegman 1992; Daly and Wilson 1990), but a detailed review regarding oedipal development has not been undertaken.

PSYCHOANALYSIS II: CLASSICAL AND RELATIONAL OEDIPAL ACCOUNTS

Sociobiologists have been understandably reluctant to engage the complexities of recent analytic theory, finding the various psychoanalytic versions of the Oedipus complex "too numerous to review" (Daly and Wilson 1990, p. 164). There is no current consensus regarding even male heterosexual oedipal development, and no comprehensive historical account of the development of oedipal theory. The Oedipus complex, which constitutes a complex of ideas with fluid

and difficult-to-define boundaries, has made its way through psychoanalytic history as something of a "moving target" (Simon 1991, p. 647). Therefore no general account of recent developments can be given here. But several prominent examples may illustrate recent lines of thought on male oedipal sexuality.

Greenberg and Mitchell (1983) have conceptualized psychoanalytic history as the development of two broad theoretical models, the drive/structure model (including classical psychoanalysis and ego psychology) and the relational/structure model (including object relations theory and self psychology). Recent oedipal theorizing may not be so neatly divisible, but it can be conceptualized along a spectrum from drive-oriented to relationally oriented oedipal accounts. While some have maintained a drive-reductionistic perspective (Green 1996), some classically oriented theorists have proposed models in which other primary motivational systems are present (Pine 1990; Sandler 1981, 1983; also Lichtenberg 1988; Stern 1985). At least two such models have emerged in regard to the Oedipus complex. The first takes the Oedipus complex as the product of multiple, distinct lines of development, and the second attempts to show how oedipal dynamics emerge from preoedipal development.

The first model has been most clearly articulated by Phyllis Tyson (1986, 1988, 1989). Drawing on the work of Anna Freud (1963), Tyson holds that there are a number of developmental lines in addition to sexuality. The development of object relations, gender identity and gender role, object choice, sexuality, and aggression all meet in the oedipal period. Sexuality alone does not account for oedipal development—self psychology, object relations, and other psychoanalytic theories must also be utilized.

> [Freud's] earlier ideas are incomplete and inaccurate because of their overemphasis on sexuality and sexual anatomy *per se,* and also because of their relative neglect of the roles of object relations, ego and superego functioning, and aggression in personality development, conflict and character formation....Sexual development as proposed by Freud is only one among a number of developmental lines. [Tyson 1989, pp. 1051-1052]

Other theorists (Blanck 1984; Modell and Sacks 1985; van Dam 1980) have argued along similar lines. In this scenario, separate functional and motivational systems develop in parallel, "vertical" fashion. Their complex interaction and interpenetration result in the oedipal convergence, in which the basic oedipal drama of conflicted, triadic parental relationships still takes place. Sexual interest in the opposite-sex parent continues to play a critical role but is not in itself the fundamental, driving force of development.

The second model also attempts to integrate relational theories with drive and ego psychology. Here, there is a "horizontal" layering of classical and relational accounts. Earlier, preoedipal development is characterized in terms of attachment and other relational conceptions, while later, oedipal development proceeds along classical lines (Mitchell 1988). Robert Tyson (1991) has pictured preoedipal development as the "coarse tapestry" upon which the "finer and more complex threads" (p. 41) of oedipal development are woven. Theorists have attempted to explicate the way in which oedipal experience emerges from the preoedipal weave, to show fundamental continuity between the qualitatively distinct dyadic mother–child relationship and triadic oedipal relationships (Chasseguet-Smirgel 1988; also Ogden 1989). Loewald (1979), for instance, argues that the "original intimate unity" of mother–infant is "anterior" (p. 765) to sexuality and is the source of the child's emerging sexuality. As sexual and object relations development proceeds, sexual elements and desires enter the boy's relationship to his mother. When she becomes the object of his libidinal interest, the sacred innocence of the mother–infant unity is violated, and not merely by the presence of sexuality. The mother has become an object for her son, disrupting their preoedipal sacred unity. Thus incest is felt to be fundamentally evil and is resisted.

In this and similar accounts, the sexual drive is no longer the "motor" of oedipal development. Sexuality enters as an important element in relational life during preoedipal development. Sexuality is an indispensable element in the oedipal drama, but it is not the simple unfolding of sexuality that characterizes this development. Rather, oedipal development proceeds on the basis of preoedipal attachment, the dual unity of mother and son.

Relationally oriented theorists have been more daring in their reevaluation of oedipal sexuality. Two examples may suffice here, from object relations theory and self psychology. Fairbairn (1952) famously characterized libido as object seeking rather than as pleasure seeking. He offered a complicated oedipal account in which the ambivalence of the oedipal situation—positive, excited feelings toward mother and negative feelings toward father—grows directly out of ambivalence toward the mother alone. The oedipal phase derives from the earlier, more fundamental attachment of infant to mother. And the oedipal phase itself is distinguished more by a new level of object relations rather than by an incestuous sexuality. The "chief novelty" (p. 121) of the oedipal situation is the transition from dyadic to triadic object relations. This transition may include a "heightened genital awareness and sexual need" (p. 122). However, sexuality in the oedipal situation is not primary, but comes from "a desperate attempt to make emotional contact with the object" (p. 37). The oedipal boy's sexuality becomes prominent when parental love seems unavailable, and varies "in inverse proportion to the satisfaction of his emotional needs" (p. 122). Since these needs are never fully satisfied, some sexual/genital component remains.

Kohut also formulated an analytic psychology in which relational needs are primary to sexual drives. In its final form (Kohut 1984), sexuality is no longer necessary to oedipal development. Kohut distinguishes between the developmental oedipal stage and the pathological Oedipus complex. The oedipal stage is characterized by age-appropriate nonsexual affection and nondestructive assertiveness. In the presence of adequate parental mirroring, the oedipal-stage boy experiences affectionate acceptance from his maternal selfobject. Only in the event of empathic failure does the pathological Oedipus complex develop. In such cases, the oedipal self becomes fragmented and disharmonious, and nonsexual affection becomes grossly sexual. A pathological, neurotic development results.

Few analytic theorists have gone as far as Fairbairn or Kohut in deemphasizing sexuality in oedipal development. But most relational theorists have implicitly deemphasized the role of the Oedipus complex and sexuality in development. Greenberg (1991) has countered this trend by undertaking a reexamination of oedipal and drive theory.

He claims that there is a "burgeoning consensus" (p. 62) in psychoanalysis that all wishes can no longer be derived from the sexual and aggressive drives. But he asserts that adherence to the dual-drive theory has been unnecessarily tied to the Oedipus complex, so that those who reject drive theory tend to reject the Oedipus complex as well. He calls for the construction of a new Oedipus complex, one that fits more closely with the complexities of clinical experience, and one that is not directly derived from the dual-instinct theory. Greenberg proposes his own sort of drive theory, but his reconstructed Oedipus complex is rooted in relational development. He holds that the Oedipus complex is not unique due to the presence of sexuality, which is already present in earlier phases of development. It is the cognitive capacity to represent triadic object relations that is new. This new capacity brings the boy to the awareness that his sexual interest in his mother affects his relationship with his father, as well as his parents' relationship with each other. This complexity makes oedipal relations conflicted and ambivalent, as each player in the oedipal drama may experience a range of positive and negative affective responses. The outcome of the oedipal situation is not predetermined, but results from the oedipal boy's attempts to cope with the reactions of his parents, his own fantasies, and his conflicted desires.

Greenberg's treatment of the Oedipus complex is ambitious, but it is typical of relational theorists in one sense: he does not attempt to derive the Oedipus complex from the development of the sexual drive. Rather, there is a critical shift from dyadic to triadic object relations, which is associated with a fundamental transformation in cognitive and social functioning. The presence of sexual interest in this setting complicates the boy's already ambivalent relationship with his mother and father, and the oedipal boy is faced with negotiating a path through a veritable forest of desires, fantasies, and relationships. He must do so, and he will do so in a way that becomes paradigmatic for his later relationships, especially his sexual relationships.

There is obviously no single analytic account of the Oedipus complex. But both classical and relational theorists no longer give exclusive drive-reductionistic explanations of oedipal development. Both usually see sexuality as playing a role in a broader developmental scheme.

Two other areas of analytic agreement are relevant here: adult mate choice and adult patterns of sexual relationships. Since Freud, analysts have held that infantile object choice forms the prototype for mature object choice. "There can be no doubt that every object-choice whatever is based...on these prototypes. A man, especially, looks for someone who can represent his picture of his mother" (Freud 1905, p. 228).

The adult male seeks not only the image of his mother, but also a repetition of relationships formed during oedipal and preoedipal development (Dicks 1963; Scharff 1982). As David Scharff (1990) has summarized:

> All development takes place within the family context. Attempts to establish a relationship sexually and otherwise involve attempts to match external objects to existing internal object relations, both with the purpose of reestablishing what has been familiar and good and of repairing what has been painful....In later relationships...the history of previous relations, as carried forward by internal object relations, determines the way relationships are understood and modifies them. [p. 449]

SOCIOBIOLOGY II: MATE CHOICE AND SEXUAL STRATEGIES

Sociobiologists have also taken an interest in mate choice and patterns of sexual relationships. Since Darwin's work on sexual selection, it has been clear that evolutionary development does not merely proceed through survival of the fittest. Sexual competition between members of the same species also shapes the evolutionary process. Success in the evolutionary game means producing the greatest number of surviving offspring. This requires the selection of a mate whose genes and behavior will best enhance the offspring's ability to survive and reproduce. It also leads to the adoption of sexual strategies, alternative patterns of mating and parenting that enhance reproductive fitness. Sociobiological models of mate selection and sexual strategies occupy an overlapping conceptual domain with psychoanalytic

thought, and are relevant to sociobiological approaches to the Oedipus complex.

Mate Choice

The development of the capacity for nonrandom mate choice has been the object of intense sociobiological interest (Buss 1986; Dawkins 1989). Three sociobiological ideas appear relevant to the Oedipus complex and mate selection: optimal outbreeding, sexual imprinting, and positive assortative mating.

Optimal Outbreeding. Incest avoidance is one important aspect of sociobiological theories of mate choice. Close relatives are not likely to be chosen as mates because of adverse genetic consequences to offspring. But the avoidance of inbreeding is balanced by other, opposing evolutionary forces. Just as there are disadvantages of inbreeding, there may be costs to outbreeding as well (Frankham 1995; Read and Harvey 1988). For instance, coadapted groups of genes are likely to be broken up by outbreeding, so that their advantages are lost. Or genes adapted to local conditions might be suppressed by outbreeding. Bateson (1983) proposed a theory of optimal outbreeding. Animals are likely to choose a mate with an intermediate degree of relatedness, so that the costs of inbreeding and outbreeding are balanced and minimized. In experiments with Japanese quail (*Coturnix coturnix*), Bateson (1982) found that quail preferred members of the opposite sex who were first cousins to those who were third cousins, siblings, or unrelated. He hypothesized that the animals sought mates who were similar but not identical to those with whom they were reared. This selection of optimally discrepant mates leads to an optimal balance between inbreeding and outbreeding. Subsequent investigation has not settled the question of whether optimal outbreeding is an important factor in mate choice (Frankham 1995; Read and Harvey 1988). But there is experimental evidence from other bird and rodent species suggesting that these animals avoid mating with close kin but choose mates who are similar in appearance (Barnard and Fitzsimons 1988; Bateson 1983; D'Udine and Alleva 1983).

Sexual Imprinting. Bateson has proposed that sexual imprinting is at least one of the mechanisms for optimal outbreeding. Imprinting has been most clearly demonstrated in birds, where sexual imprinting and filial imprinting are distinguished as separate processes (Bolhuis 1991). Filial imprinting is the narrowing of social preference that occurs early in the chick's life. Chicks quickly learn to follow the object of filial imprinting (usually the mother) and avoid novel objects, including other animals. Sexual imprinting occurs later, but well before sexual maturity. During a "sensitive period" (Bateson 1979), the bird forms an internal image or template of a parent and, possibly, of siblings. At sexual maturity, the bird uses the template to select a mate that is "different, but not too different" (Bateson 1979, p. 477) from the object of sexual imprinting. Thus birds do not appear to possess an innate, species-specific image for mate choice. Instead, they are preprogrammed to form such an image in early development, and to select a similar but not identical mate.

Sexual imprinting in birds has been shown to be a complex, flexible process. It has been demonstrated in several avian species, but most extensively studied in the zebra finch (*Taenopygia guttata*). Zebra finches raised by foster parents prefer birds of the foster species as mates. There is evidence that an image of the opposite-sex parent is formed early in development, and then either consolidated or modified by sexual experience at maturity (Bischof 1994; Vos 1995). Increased early social interaction with a given parent can cause the chick to imprint either one of the "parents" when it is raised by birds of two different species (Clayton 1994). The presence of siblings may also affect the process (Ten Cate 1994). Clearly, sexual imprinting is not a simple, rigid, or exclusively genetically controlled process.

Imprinting is a complex process in birds, and it is likely to be even more difficult to decipher in mammals. For mammals as well as other animals, the concept of kin recognition includes behaviors associated with imprinting. Several mammalian species show analogues of filial imprinting, where early recognition of, and preference for, mother appears to be based on olfactory and other sensory cues (Chalmers 1983). In humans, mother–infant bonding develops rapidly (Daly and Wilson 1981; Wells 1987) and is associated with auditory, olfactory, and visual discrimination (Porter 1991). When this

bonding occurs, it is associated with such kin-directed behaviors as food sharing, altruism, grooming, and nepotism (preferential care of offspring) (Porter 1987; Wilson 1987). It is also associated with subsequent mate selection.

The data regarding mate choice are much more ambiguous in mammals than in birds. As noted, there is considerable evidence that many mammals avoid mating with the animals who fostered them, whether or not they are genetically related (see also Blaustein 1987). Rodents have frequently been the object of study in this regard. Many rodent species have been shown to avoid mating with litter mates (Dewsbury, 1988). This appears related to an early period of sensitization, for males will attempt to mate with genetically identical females if they are raised apart (Boyse et al. 1991). In this case, the appearance of the relative (distinguished primarily by odor) is the standard for negative imprinting, or incest avoidance. But there is evidence for positive sexual imprinting as well, where rodent offspring seek mates similar to their parents. Rodents cross-fostered to other rodent species show decreased sexual interest in their own species and markedly increased sexual interest in the species of foster parents (D'Udine and Alleva 1983). Other evidence suggests that mice, like Bateson's quail, may show greatest sexual interest in mates of intermediate relatedness, often second cousins (Barnard and Aldhous 1991; Barnard and Fitzsimons 1988). The evidence is far from conclusive, however, and likely to reflect complex underlying mechanisms. Yet several reviewers have held that results so far are consistent with Bateson's optimal outbreeding hypothesis (Blaustein 1987; Dewsbury 1988; D'Udine 1983) and reflect mate choice mechanisms that balance inbreeding and outbreeding, in part on the basis of family experience.

Little is known of the relationships between kin recognition and mating in nonhuman primates, except that close kin are usually avoided as mates (Walters 1987). There are very few studies regarding humans. As noted, humans also appear to avoid mating with those whom they knew intimately in childhood. On the other hand, there is little available evidence on whether parental appearance functions as a positive model for mate choice. Jedlicka (1980) examined subjects who had parents from different ethnic groups. He obtained a sample

of 980 twice-married subjects who had married into either their father's or their mother's ethnic group. In approximately 60 percent of both their first and second marriages, male subjects married a partner of their mother's ethnicity and female subjects married according to their father's ethnicity. Jedlicka (1984) found a similar pattern when he examined more than 7,000 marital couples in Hawaii. All had parents of mixed ethnicity, and all were in their first marriage. Although the mother's ethnicity was more influential overall, men again tended to marry a bride from their mother's ethnic group and women tended to choose the ethnic group of their father. Other studies have examined the role of fathers in daughters' mate choice, and found positive correlations (Epstein and Guttman 1984; Miller 1969; Wilson and Barrett 1987; Zei et al. 1981). However, these studies have suffered methodological difficulties, and results have been difficult to interpret.

Positive Assortative Mating. One other possible example of optimal outbreeding and positive sexual imprinting in humans has been proposed. "Positive assortative mating" refers to the tendency of humans and other animals to mate nonrandomly with those who are phenotypically similar. Positive assortative mating is well documented among humans, who tend to marry according to a host of physical, psychological, and social similarities. These include height, weight, facial features, age, intelligence, educational level, ethnicity, religion, and various personality traits, including extroversion and neuroticism (Buss 1984; Epstein and Guttman 1984; Mascie-Taylor 1988; Susanne and Lapage 1988; Thiessen and Gregg 1980). Positive assortative mating has been documented across a wide array of social groups, and is "one of the most well replicated findings in the psychology and biology of human mating" (Buss and Barnes 1986, p. 560).

Numerous explanations for positive assortative mating have been proposed (Epstein and Guttman 1984), but the phenomenon has not been fully explained. Social factors account for some, but not all, of positive assortment (Mascie-Taylor and Vanderberg 1988; Phillips et al. 1988). Factors related to individual selection of mates are also involved.

Thiessen and Gregg (1980) have offered a sociobiological explanation of positive assortative mating, noting that it has been demon-

strated in numerous nonhuman species, including insects, fish, and birds. They hold that natural selection has resulted in a genetic propensity to choose a similar mate, in these species and in humans. They cite evidence that similar mates show increased levels of fertility and longer, more stable relationships. Both Thiessen and Gregg (1980) and Bateson (1979) have suggested that positive assortative mating is an instance of optimal outbreeding that has evolved to balance the advantages and disadvantages of inbreeding and outbreeding. Both note that human mating is the result of a complex biopsychosocial process, but they hold that early experience or imprinting is one likely mechanism of this pattern of mate choice.

In summary, the sociobiological evidence regarding patterns of human mate selection is fragmentary at best. But an array of sociobiological data and theory suggest that humans and many other animals seek mates who are similar in appearance to their early associates. Human children, like other offspring, may form a template or model for a later sexual mate choice. This appears to occur after early familial attachments form, but well before sexual maturity, as the result of frequent, close social and physical interaction. For sociobiology, as for psychoanalysis, the opposite-sex parent is likely to be especially important in the formation of such a template.

Sexual Strategies

Broadly defined, sexual strategies have received more interest from sociobiologists than have the fine distinctions of individual mate choice. Sexual strategies are evolved patterns of forming and maintaining sexual relationships, and include involvement (or lack thereof) in raising offspring (Buss and Schmitt 1993). Sexual strategies are the products of natural selection, because they are critical factors in an organism's ability to produce surviving offspring. These patterns of behavior have been identified in diverse animal species (Dawkins 1989). Sexual and life history strategies have been classified along a continuum of possible strategies. On one end of the continuum, the r-strategy involves the production of many offspring, early sexual activity, and relatively low levels of parental investment in offspring. The

other extreme, the K-strategy, constitutes an effort to maximize parental investment to ensure the survival of offspring, who are produced in smaller numbers. The r-strategy involves the production of the greatest number of offspring with a variety of mates, at the cost of lessened parental investment in those offspring. It is associated with earlier maturation, early sexual reproduction, high levels of sexual activity, larger litter size, and shorter life span. The K-strategy typically involves a large investment in a small number of offspring with a more carefully chosen mate or mates, at the cost of producing fewer offspring. It is associated with slower development, later onset of sexual activity, small litter size or singleton births, lower infant mortality, and longer life (Rushton 1990; Wilson 1975). K- and r-strategies vary between species, and mammals are more K-selected than birds or reptiles. Humans are highly K-selected.

Reproductive strategies vary within species as well. When females must nurture offspring for their survival, they are frequently more K-selected than males, who can sometimes reproduce without other parental investment (Dawkins 1989). Individuals of any species and sex are likely to vary in the character of sexual strategy. Rushton (1985) has proposed a differential K theory, in which humans vary in the extent to which they acquire an r- or a K-strategy. Draper and Harpending (1982) have outlined a developmental model for humans in which sexual strategy is variable and determined on the basis of early experience during a sensitive period of childhood. Noting some parallels among other animal species, they have synthesized social, psychological, and anthropological research on mature sexual behavior as a function of father presence or absence during early childhood. When the father is absent, males later demonstrate a pattern of transient, unstable sexual relationships. They are likely to show low parental investment and higher levels of aggression and competition toward other males. Females are likely to engage in earlier sexual interest and activity, pursue short-term relationships with males, and hold a more negative attitude toward males. Males from father-present homes, in contrast, have shown decreased interest in social dominance with other men. Both males and females from father-present homes show a later onset of sexual activity and greater interest in forming stable pair bonds. Draper and Harpending found these patterns in

both Western and non-Western societies. They have argued that either reproductive strategy may be adaptive, depending on local conditions. For instance, females waiting for "Mr. Right" in a culture characterized by promiscuous masculinity are likely to enjoy little reproductive success of any kind. In societies where male parental investment is low, the male's reproductive success depends primarily on his ability to negotiate the hierarchy of male dominance.

In most studies they reviewed, Draper and Harpending (1982) found that the critical period for father absence was early childhood, ages 1-5 years. They hypothesize that this is a sensitive period in which children begin a developmental track oriented to the social conditions in which they find themselves. This early tracking allows for a period of "selective observation and practice of the kind of skills they perceive will lead to reproductive success" (p. 460). Children orient themselves to their father's presence, their mother's relations with men, and other relevant social and economic conditions. This early experience leads to the development of the more adaptive reproductive strategy. Draper and Belsky (1990) have since proposed that the security of the child's attachment style is the proximal mechanism that mediates early experience and later reproductive strategy.

A sociobiological notion that early childhood experience leads to the development of adult social patterns or strategies is not unique to Draper and Harpending. In bird species, sexual imprinting and bird song learning are examples of critical, early learning in the development of mature adult functioning (Clayton 1994; Slater 1983). Early mother–infant bonding is another such phenomenon in mammals. In humans and primates, the quality of early mother–infant attachment has been shown to have lasting effects (Chalmers 1983). For humans, there is evidence that patterns of attachment learned early in life are likely to be repeated in adult and later family relationships (Fonagy et al. 1993; Rossi and Rossi 1990). Low (1989) has argued that cross-cultural patterns of child training are oriented toward, and vary with, the needs of adult reproductive strategies. In addition, Sulloway (1997) has presented detailed historical arguments for the hypothesis that children develop lasting patterns of personality and relationships as a result of negotiating their niche in the sibling birth order. Thus sociobiologists should find a congenial hypoth-

esis in the relational oedipal model, which asserts that patterns of sexual and other relationships form early in childhood.

SYNTHESIS II: DISCUSSION AND CONCLUSIONS

Oedipus and Sociobiology

In both psychoanalytic and many sociobiological theories, early experience is critical for the development of adult sexual relations. For both theories, mate choice results in part from childhood experience with early familial and other social relationships. A template or internal image of early associates, primarily the opposite-sex parent, is formed early in development and is later used as a guide for the selection of a similar mate. And for both psychoanalysis and sociobiology, childhood familial experience may set the developmental course for adult sexual bonding. Patterns formed through observation of, and interaction with, parents are carried into adult sexual and familial relationships and repeated there. Clearly, there are fundamental differences between sociobiological and oedipal accounts, but there does not appear to be a contradiction in these areas of overlapping content.

Psychoanalysis, Sociobiology, and Sex

What, then, of sociobiologically oriented criticisms of the Oedipus complex based on the rejection of incestuous sexuality? On the one hand, recent oedipal accounts are not drive reductionistic. The Oedipus complex does not develop simply because powerful sexual desire is suddenly turned on the parent. Rather, sexuality is one element of early familial relationships, which become oedipal—triadic and conflicted—as development proceeds. On the other hand, sociobiological theory does not posit that early attachment leads to incest avoidance alone (negative imprinting). Early attachment also leads to later sexual relationships with those who resemble parents or early

caretakers (positive imprinting). In Erickson's terms, familial attraction may inhibit sexual attraction, but familial attraction (or attachment) initiates the development of sexual attraction. Sexuality and early bonding are not divorced, but linked. On these grounds, it would make little sense to argue that there are no conscious or unconscious elements of sexuality in early attachment. The opposite may well apply.

Daly and Wilson (1990) have placed the heavy onus of proof on those who assert that the oedipal child lusts after the opposite-sex parent. But analytic theorists do not need to prove that the oedipal boy would have sex with his mother, if only he could, nor do they need to show that sexuality is the prime motivator of all the oedipal boy's wishes. They need only demonstrate the presence of sexual elements in early attachments. And there have been some observations of mounting or sexual play between infant male monkeys and their mothers and siblings (Hanby and Brown 1974; Missakian 1973). There are also reports of sex play among human children who later avoid incest with each other (van den Berghe 1987). Shepher (1971) states that Kibbutzim educators did not interfere with the sexual play of children in peer groups, who were "exposed to each other constantly.... This sexual play begins in infancy, is very intensive during early childhood, and is somewhat less intensive in the first school years" (p. 244). Although these reports hardly constitute evidence, they raise the question of whether early, playful sexual interest is a component of the early bonding that leads to incest avoidance.

Sociobiology, Psychoanalysis, and Early Development

The theory of the Oedipus complex would explain some of the data of sociobiological developmental theory cited previously. But the relationship between the two may amount to more than alternative explanations of the same evidence. They may prove to be alternative descriptions of the same developmental process. Sociobiology and modern psychoanalytic thought constitute opposing approaches to psychology: sociobiology, with roots in ethology, attends to concrete behavioral patterns explained by distal evolutionary mechanisms; psy-

choanalysis, with roots in clinical practice, attends to subjective experience, fantasies, and the subtleties of possible unconscious experience. Yet both posit a similar broad scheme of development. Early preoedipal bonding takes place between mother and infant and forms the basis of later attachments. This bonding forms the basis of incest avoidance, and incest is much more likely when early familial attachment is disrupted. But before the onset of sexual maturation, an oedipal, sensitive period of sexual imprinting (or its mammalian equivalent) occurs. During this time, a template for later mate choice is formed, and patterns of future sexual relatedness begin to develop.

Clearly, this developmental scheme has not been fully explicated or tested from a sociobiological point of view, and therefore remains speculative. Moreover, because of their unique methods and perspectives, neither sociobiology nor psychoanalysis can be reduced to the terms of the other. But attempts to form an evolutionary psychoanalysis (Slavin and Kriegman 1992) are not inherently flawed. Their overlapping content and shared intellectual history suggest that Freud's desire to ground psychoanalytic theory in an evolutionary account may yet be gratified.

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KNOWING ANOTHER FROM A DYNAMIC SYSTEMS POINT OF VIEW: THE NEED FOR A MULTIMODAL CONCEPT OF EMPATHY *

BY GEORGE GANICK FISHMAN, M.D.

This paper explores the concept of empathy within the context of current debate regarding the advantages of an intersubjective versus an intrapsychic focus on the treatment process. The author explores the way in which dynamic systems theory, the parent of intersubjectivity, can potentially embrace the wisdom of both relational psychoanalysis and ego psychology. The ongoing analytic discourse is represented in two modes, by schematic and symbolic representations, which roughly correspond to the intersubjective and the intrapsychic record. Empathy is redefined as the enactive, imaginal, and interpretive efforts an analyst makes toward understanding both the schematic and symbolic discourse with her patient.

INTRODUCTION

Empathy was once the reigning definition in psychoanalysis of how one person comes to know what is on the mind of another. Relational and intersubjective approaches have gradually and, for some of us, convincingly ensconced transference-countertransference en-

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actments as a rival means of knowledge. The confusion over the primacy of empathy or enactment could be seen as emblematic of the larger, often acrimonious debate between contemporary ego psychologists and relational theorists. From one side, the ascendancy of enactment and its even more controversial companion, self disclosure, has been feared as signifying the demise of a belief in the dominant influence of the patient's unconscious and the analyst's traditional role in pursuing understanding of this influence. From the other side, the focus on empathy has been suspiciously viewed as a means of preserving the illusion of the analyst's privileged(in the sense of direct and objective) access to the patient's state of mind.

In the face of this debate, it is useful to remember that empathy has traditionally served as one of the bellwethers of changes in our field. A periodic flurry of interest in revisiting this pivotal concept usually signals some wrenching movement in the tectonic plates of psychoanalytic theory. For example, Fliess (1953) described empathy as a trial identification that could be actively and accurately pursued. In hindsight, "trial" may have been chosen less as an accurate description of the empathic process and more an embedded caution lest an analyst mimic Breuer and let himself fall too far into the inner world of his patient. There was good reason for worry.

Analysts have undergone a hard-earned acceptance of the fact that knowing one's patient affectively poses inevitable but necessary risk. Relational theory has made a virtue of this necessity by espousing the view that the analyst arrives at understanding by a series of inadvertent collisions between his and the patient's irreducible subjectivities (Renik 1993, 1996). As a result it has earned an unfair reputation from its critics of having abandoned the foundational belief in the power of the patient's unconscious in favor of a superficial, feel-good interpersonalism. The culprit in this current decentering of empathy is the idea of mutual influence implicit in the concept of intersubjectivity and dynamic systems theory. There can be no feeling into or with another person without being intimately affected. To empathize is to court being significantly changed.

There is no possibility of restoring to the concept of empathy the

illusory idea of privileged, objective, and uncontaminated access into the inner world of another person. However, freed from a connotation of omniscience and recognized as a construction, I believe that empathy can be uniquely redefined to serve as a key operational term within the various dynamic systems perspectives that developmentalists (cf. Beebe and Lachmann 1992, 1994, 1996; Lyons-Ruth 1998; Sander 1985, 1991; Stern 1995; Stern et al. 1998; Stolorow et al. 1994; Thelen and Smith 1995) have been suggesting as overarching models of the treatment process. More will be said shortly, but in a nutshell, dynamic systems theory fully recognizes both the intrapsychic and interpersonal determinants of a person's mental life. The intrapsychic or self-organizing aspects of subjective life are in a continuous dialectical relationship with those aspects that are organized from within key interactions. Although clear and absolute distinctions cannot be made, roughly speaking, ongoing interactions are encoded procedurally as schematic representations; self-organizing elaborations of ongoing experience are encoded declaratively as symbolic representations (cf. Bucci 1993, 1997; Fishman 1998). In accord with modern neuroscience, we can regard both forms of representation as being continually processed in parallel, i.e., as exerting mutual influence upon one another. In order to empathize, the analyst must attempt to imagine the intersection of these multiple channels of actual discourse and inner representation. In this sense, empathy is a multimodal concept.

I will now elaborate on these themes via the following steps:

1. I will present a case example that will provide illustration for the other parts of my discussion.
2. I will expand upon the manifest idea that empathy is an innate human capacity that orients one person toward the inner life of another. Beneath the surface, a complex network of latent innuendoes and connotations surrounds any particular use of the term that manages to keep alive an unconscious belief that empathy can afford privileged access to the patient's mind. I will review recent debate of the empirical evidence that one person can have direct access to the mental state of another. The discussion will hopefully shed light not

only on the concept of empathy but also on the current intellectual climate and the state of modern practice.

3. I will describe and discuss the schematic and symbolic modes which comprise the analytic dialogue and its inner representation within a dynamic systems approach. Both the schematic and the symbolic modes are the objects, or "targets" of the analyst's empathy.[1]
4. I will then suggest a new incarnation for empathy as the name for the enactive, imaginal, and interpretive efforts an analyst makes toward understanding both the schematic and the symbolic discourse with his patient.
5. I will reiterate my version of the modern mantra that this fuller recognition of the patient cannot occur unless the analyst immerses herself in full-bodied affective participation and risks the inevitable collusions, collisions, and dysjunctions (cf. Beebe and Lachmann 1996; Renik 1993a; Stern et al. 1998) that will occur between two irreducible subjectivities. However, I will stress that the participation and the collision need not be as noisy as it is sometimes represented in certain papers which advocate provocative forms of self disclosure (cf. Slavin et al. 1998). Listening and commenting on what the patient says are still the backbone of what the analyst deliberately does.

CASE EXAMPLE

A man, Mr. L, very close to my age, consulted me regarding a disagreement with his wife. Some months later, he had been reflecting on his marriage and realized that there were serious rifts between the two of them that he had covered over by trying to accommodate rather than confront her.

I agreed to see him again but realized that I felt a gut reservation

[1] I am uncomfortable with the stark and clear polarity suggested by the terms schematic and symbolic. It is probably better to imagine these two pure forms as definers of a gradient with every conceivable mix in between.

that was a holdover from our earlier contact. I vaguely recognized it as one of the many versions of anxiety to which I am susceptible. When he arrived for this new phase of our contact, I thought I had nailed down what was making me nervous. For guys my age, he was the main Eddie Bauer catalogue entry and I was that addendum on the back page which stated that odd sizes and seconds were available on inquiry. He was no taller than I was but he just seemed "bigger." He was soft-spoken and very kind. I was puzzled that despite his gentleness, I was assigning to him the size and authority of a Marine commando. I focused in particular on two aspects of his appearance. First, I could not stop glancing at his half glasses which rested on his chest, suspended from a black lanyard which subtly circled his neck. They were posed like the binoculars of a vigilant field general. In the periphery of my vision, I also noticed the most unsettling of all my perceptions of him: he was wearing twill pants which were creased and wrinkle free.

Whatever it was that started to inwardly unnerve me soon announced itself in overt behavior. I leaned forward in my chair, never breaking my contact with him, so that I could pull down on the cuffs of my totally wrinkled chinos. I pulled and stretched, praying that when I let go the wrinkles would vanish, and with them all remaining vestiges of a defiant adolescent persona which at that moment I feared was still overtly tied up in the so-called casual way I dressed. I vowed that if I survived the mortification I was suffering at this moment I would finally listen to layers of introjected exhortations from my mother and wear pressed wool slacks. I want to make clear that this allusion to a conflict between my mother and me occurs to me now after the fact. Its long and complex history was unavailable to me in the moment.[2] In retrospect, it occurs to me that the central issue was, as they say, a gendered fight, the right for me as a male to be scruffy and not always compliant and kempt. But why had

[2] Jacobs (1986), McLaughlin (1987), and others offer rich associations to moments of enactment which they clearly mean to be taken as having occurred after the fact. Unfortunately, an unwitting ego ideal has emerged in the field as a result of these contributions, which courts the illusion that any analyst worth his or her salt could achieve this full-bodied self-reflection on the spot. This capacity then is also assumed to be integral to true empathy.

Mr. L come to resemble my Waterloo? Why was I initially so ashamed in his presence? And, despite intimations that my reactions might be enactments, I had but the barest clue at that time, *in the moment,* of how my discomfort might be a relevant signal of my interaction with Mr. L.

Several sessions following my symptomatic attempt to pull the wrinkles out of my pants, Mr. L began to be curious about what in his relationship with his mother had predisposed him toward being so accommodating. The context was his awareness that, despite the fact that he felt very disaffected with his marriage, he was very guilty at even the thought of wanting to leave his wife, let alone noticing his attraction to another woman. He then recalled several sexually tinged memories from childhood. In the first of these, his mother had some women over and they were standing in or near the bathroom. He was very young and he had to pee, so he did, right in front of them. Mother's expression, a stern and silent disapproval, was powerfully installed in his memory.

THE POWER OF EMPATHY—A CONSTRUCTED WISH OR A FOUND REALITY?

From the perspective of what language does (cf. Austin 1962; Wittgenstein 1953) as opposed to what it says, any definition of empathy derives its power from two distinctions it implicitly creates. The first is the contrast we draw between our empathy and our non-empathy. The second is the difference between the subject and object of empathy. With regard to the first distinction, we need to rightfully use the term empathy to point to the moments in a therapy in which we *feel* (not necessarily that we *are)* more as opposed to less on target with our patients. For example, when I was aware of my initial vague sense of anxiety, I was hardly prepared to view it as even a remote signal of, let alone an analogy to, what might be going on within Mr. L. However, a short time later, When I *formulated* what I imagined going on between myself and Mr. L, the very process of doing so felt *empathic.*

The moment we take seriously the formal meaning of being on target with our patients, we confront the second distinction embedded in the concept of empathy. This is the contrast between what the analyst senses the patient is feeling and what the patient actually feels. I term this the difference between the subject of empathy, i.e., the analyst's presumed understanding of the patient, and the object of empathy, i.e., what is on the patient's mind. Needless to say, every analyst's most cherished hope is to make this distinction minimal. Every new theoretical turn in psychoanalysis is in part driven by the desire to offer a better set of guideposts, be these the concept of ego defenses or countertransference enactments with which to reliably read what is on a patient's mind. In addition, each particular theory offers a unique construction of the way the subject and object of empathy are opposed, linked, and/or fused in the empathic process. For example, in Freud's view, my self-consciousness and sense of inhibition was an instance of telegraphy linking Mr. L's unconscious straight to mine. The subject of empathy, my awareness, is guaranteed to be literally isomorphic to its object, Mr. L's latent state of mind, by dint of the fact that the unconscious of the receiver and that of the transmitter are by nature symmetrical. Kohut (1959, 1984) shifted the seat of transmission from unconscious drive to the patient's subjective state and deemed empathy vicarious introspection. He analogized it to a sixth sense that for me invokes the image of a fusion, albeit a therapeutic one, of the subject and object of empathy.

Reed (1996) compellingly argued that within the underbelly of associations that cleave to the term empathy there resides an antithesis between the intrusive stance of an ego psychologist going after the deep unconscious and the passive stance of a self psychologist sharing and absorbing the patient's manifest mind-set. She was trying to retranslate what had become an extrinsic theoretical split into an intrinsic tension between opposing tendencies in every analyst's unconscious. In the process of her argument, she made the more general point that our communal theoretical language is always imbued with compromise formations. The manifest, secondary process meaning of various terms masks a primary process connotation that is synchronized with it (cf. Arlow 1969). In terms of empathy, a key pri-

mary process element residing within its underbelly is the wish for omniscience.

Latent conflict among analysts over how closely the subject of empathy can approach its object fuels the recursive debate by each generation to reconfigure empathy. A suggestion sooner or later arises of yet another plausible way that the subject of empathy can have direct access to her object. Inevitably, a sobering counterpoint appears to remind us that no one can have privileged access to the mind of another. For example, Schafer (1968) stated that "Every instance of empathy appears to depend on merging" (p. 153). Buie (1981) countered by stating that "One problem with this view is that implicitly it treats the phenomenon of merging, or fusion, literally, as if somehow there really were a genuine intermixing, blending of one person's personality with another's" (p. 285).

Recently there have been increasing efforts to seek out empirical evidence as to what degree of linkage can potentially exist between the subject and object of empathy. For example, Feiner and Kiersky (1994) argued for both a direct and an interpretive stage in the process of empathy based on the idea held by Gestalt psychologists that there is a demonstrable degree of isomorphism between a person's behavior and the inner state producing that behavior. Because of this isomorphism, the analyst can translate the stimuli of observed behavior into an emotional state that closely corresponds to what the patient is experiencing. The authors quote supporting research from the height of the Gestalt era that subjects nearly unanimously choose certain geometric orientations of lines to match certain emotions. Based on this evidence, they make a hypothetical leap toward another plausible mode of isomorphic linkage:

> Unarticulated experience, emotional qualities, and repressed contents are partly expressed through the prosody of language, which is defined by variations of pitch, volume, rhythm or cadence, and stress of pronunciation. These variations constitute a melodic quality that bestows both semantic and emotional meaning to speech. [pp. 430-431]

They state their bottom-line conclusion: "We believe that empathic perception often activates an internal process or experience that

shares certain properties with the experience of the observed" (p. 431).

In response to Feiner and Kiersky, two authors offered various counterpoints to the seductive promise of direct access to the object of empathy. Hayes (1994) borrowed Derrida's notion that the *parergon*, e.g., the frame around a work of art, has a critical role in defining the boundary between the work and its surround as well as contributing to the meaning of the art itself. He argued that by analogy the framing concepts in psychoanalysis, like the process of empathizing, is both defining of and defined by its object. Similarly, Stern (1994)[3] held that empathy, like most other analytic activities, is never the apprehension of a separate psychic reality. He stated this point as follows: "...the concept of empathic perception can be used in a way that obscures the recognition that interpretation is the basic process of experience" (p. 443).

I stress again that what distinguished this more recent exchange of views was the valuable citation of empirical research from outside of psychoanalysis. However, the Gestalt psychologists who were referenced had performed their experiments fifty years ago. I agree with Stern (1994) that this does not essentially invalidate Feiner and Kiersky's claim. However, more recent work is available. Gergely and Watson (1996) reviewed a vast amount of data from the developmental literature to support their hypothesis regarding the mechanism of parental affect mirroring. It is not surprising that the arguments that have attended the linkage between the subject and object of empathy find their counterparts in the research literature on theory of mind. This growing body of work is concerned with when and how infants adopt the intentional stance, i.e., attain the ability not to understand merely what another person is feeling but, in addition, to appreciate what that person might be *disposed* to doing about that feeling. The reining hypothesis (cf. Meltzoff and

[3] Donnel Stern (1983), in his earlier work on unformulated experience, explored the difficult divide between theory and the untheorized. However, on occasion, he fell into the trap of positing a "raw experience": "Before being articulated the experiences are relatively undifferentiated, and thus in the sense that they cannot be known—cannot be reflected upon—they do not exist. Words do not clothe experience. They construct it" (p. 10).

Gopnik 1993) states that an infant imitates the facial expression of the parent and, because of hard-wired links between the facial expression and the physiological concomitants of affect, the child's imitation leads to direct knowledge of the affective experience of another (note how close this is to the Gestalt hypothesis that the adult subject's registering of the other's behavioral cues will evoke an inner state in the subject that matches that of the object). Gergely and Watson believe that some form of "hard wiring"[4] probably accounts for an infant's most rudimentary ability to know another's feelings. However, it does not adequately account for the means by which infants learn the dispositional content of an emotion. They argue instead that infants have but the foggiest sense that various physiologic experiences, facial gestures, and primitive cognitions are linked as a discrete categorical affect. The infant depends on the parent's mirroring of his state so that by a complex process of contingency maximisation,[5] the infant can learn to integrate various inputs as a complex emotional experience replete with dispositional content.

The details of this fascinating hypothesis would take us beyond our present purpose. Suffice it to say, the empirical data offer support both to those in our field who cleave to a belief in direct access and those who are adamantly skeptical. Gergely and Watson indicate that the knowledge of one's own, let alone another's, emotional state is garnered in infancy through inference—inference, of course, that is supported and scaffolded by a mirroring relationship. On the other hand, the ability of the parent to serve as support and scaffold implies that the parent is *potentially capable* of a fairly accurate assessment of

[4] I use the term "hard wiring" cautiously, especially in an essay that is purportedly self-conscious about the way concepts are used. Thelen and Smith (1995) have devoted their work to pointing out the fallibility of this metaphor and have suggested a replacement, namely, "soft assembled" (p. 60) to convey the fluidity of any structure from a dynamic systems viewpoint.

[5] Contingency maximisation is the name for the way an infant automatically "plays the odds" in order to figure certain things out. For example, in experiments in which a string is tied from an infant's right leg to a mobile, it is hypothesized that an infant will separately figure out what are the necessary and the sufficient movements to turn on the mobile. In this process the infant hones in on the essential behavior that the desired result is contingent upon.

the infant's emotional state.

I will suggest a plausible way of drawing conclusions from the current opinions and data relevant to understanding the relation between the subject and object of empathy in adult interactions. Even though certain stimuli one receives from another may be capable of setting up basic resonances that are isomorphic with the inner state of that other, this data is never separable from the levels of perceptual and cognitive inference that are occurring in parallel with, and thereby significantly altering, the basic, isomorphic signals. In a word, we can never reliably access "raw data" or "unformulated experience." Empathy, in line with Stern's (1983, 1994, 1997) view, is essentially a process of interpretation. However, although our understanding is once again relegated to the hermeneutic circle, forever having to assimilate the object we wish to understand into what we already know, empathy is hardly a solipsistic process.

Two factors work to counter our inner prejudices and help us to move empathically closer to another. First is the contemporary reliance on interpersonal negotiation (cf. Mitchell 1993; Pizer 1992; Russell 1996). Understanding is something we achieve *with* our patients, not in spite of them. We offer things to be tried on, and, in a well-conducted therapy, what fits will eventually be worn. Worn, I might add, by both patient and analyst. I believe this process of negotiated understanding is what Benjamin (1988, 1995) is alluding to in her carefully conceived idea of mutual recognition.

Second, the analyst's ability to recognize her patient fully can be either helped or hindered by her theoretical vision. If, as I advocate, empathy is an attitude—an orientation toward trying to appreciate certain currencies within and between two subjects—then our theory is a valid source for the focal points we use to orient our imaginal/interpretive efforts. However, even our most compelling ideas are rendered in metaphors that fade both from overuse and from the challenge of new orientations. I will now proceed to the major thesis of my paper, namely the reconfiguring of the objects of empathy from within a dynamic systems perspective. I will describe two broad foci, namely, two major modes of internal representation from which evolve both the mutual and self-regulating aspects of the therapy.

A MULTIMODAL OBJECT OF EMPATHY BASED ON THE CONCEPT OF SCHEMATIC AND SYMBOLIC REPRESENTATIONS

Schematic Representation

Beebe and Lachmann (1996), Lichtenberg et al. (1992), Lyons-Ruth (1998), and Stern et al. (1998) have all put forward theories of therapy based on infancy research that implicitly or explicitly resonate with a dynamic systems point of view. Their models are heavily based on the distinction between the symbolic and schematic levels of relatedness and inner representation. Emphasis is placed predominantly on the schematic mode because its role in adult interaction is felt to have been misunderstood. The Sandlers' (1978) concept of the wished-for interaction and Bucci's (1993, 1997) multiple code theory also forge this distinction. There is significant overlap among all of these authors so that the "feel" of a schematic description can be conveyed by using any one model as an illustration.

For example, Beebe and Lachman (1994, 1996) have described three principles they consider salient organizers of mental representations that they call interaction structures. The three principles are: ongoing mutual regulation; disruptions and repair; heightened affective moments. Ongoing mutual regulation can be illustrated in the treatment of Mr. L. My early discomfort, regardless of whether it emanated from my personal vulnerability or my attunement to Mr. L's projective identification, became a signal that ushered in a complex set of affective messages back and forth. I will briefly represent the case material to highlight how these interactions might have been structured by the interplay of Mr. L's and my own schematic representations. The resultant process was at the schematic level guided by the ongoing mutual regulation of key affects. Mr. L was aware of his embarrassment over his vulnerability to women and at the same time caught in his guilt. He hoped that I would counter these feelings, not intensify them. In turn, I felt in Mr. L's manner and gaze the behavioral identification that accompanied what I now, in a symbolic mode, imagine were internal struggles with fore-

boding women that were being carried on even as he spoke of other things. However, without that reflective awareness at the time, I became identified with the guilty, submissive tendencies in Mr. L and for a while could not rise above it. Gradually, Mr. L and I reached higher ground as the affects were tamed both by the *intuitive sense* of the interaction and the *words and symbols* that feel like apt descriptors, i.e., the deeper entry into the symbolic mode. More will be said about the complex parallel process between the schematic and symbolic modes shortly.

In order to further characterize the schematic mode, the symbolic mode, and the pertinence of a dynamic systems framework, I will turn to Stern's (1995)[6] idea of the Schema-of-Being-with-Another. It refers to the internal working model the infant builds after repeated ordinary interactions. He states:

> This emphasis on interactive experience is key and marks a difference between the viewpoint adopted here and others. *It is my assumption that these representations are constructed from interactive experience with someone.* In that sense, they are not about objects (human or other), nor about images, nor about knowledge. They are about interactive experiences. Fantasies and imaginary elaborations and additions are seen as later reworkings.[7] [p. 81, italics added]

For Stern, every key schematic representation is a composite of information, similar to clips of various audio and videotapes, from various central neuronal subsystems. The encoding of visual perception, motor activity, and event representation are three subdivisions essential to the building of what are still little more than rudimentary sensorimotor schemas. However, two additional subsystems, the feeling shape (or contour) and the protonarrative envelope, have

[6] Stern has been the object of criticism for his leaps of imagination (cf. Wolff 1996). However, I personally regard his model as grounded in data provided from many sources. Even though many of his hypotheses will undoubtedly need to be refined, the idea that human protoconversation is foundational and linked to emergence and temporality is, I believe, here to stay.

[7] The fantasies and imaginative elaborations are what I am categorizing as the symbolic mode of process and representation.

the most to do with giving the infant's representation the meaningful grasp of an interpersonal happening. The feeling shape is the subtle emotional accompaniment to any daily activity, from the build-up of mild joy when finding a parking space in Harvard Square, to the waves of recrimination a therapist can experience during a session when a patient is lambasting him for missing the point (again, I am conjuring up the "raw" feeling shape that occurs before or alongside of the feverish formulating that the analyst will quickly begin to do in the symbolic mode to understand the affect). Each contour could be visually represented as a distinct waveform which is emblematic for the experience it has become inextricably linked to. The dimension of time is therefore critical to the identity of the feeling shape. Stern (1995) and others (e.g., Feiner and Kiersky 1994) offer an elegant analogy between emotional "riffs" and music. It would be unthinkable to expect that the recall of a single note could adequately evoke or represent the aesthetic sense of a musical phrase. Stern suggests that, similarly, the feel of key happenings cannot take shape in a moment, but emerges in its distinctive contours and rhythms over time.

The protonarrative envelope is analogous to the libretto of a musical piece. It comprises a sequencing of literal impressions (and, as development progresses, symbolic elements) that tell the story of various ordinary daily events. When linked to the affect shape, it transposes what might otherwise seem like a random series of events into those signature narratives, those "who-did-what-to-whoms/felt what-toward-whoms" called "introjects."[8] I place special emphasis on Stern's linkage of narrative elements with affect. He states:

> This notion that the temporal feeling shape provides the narrative line of tension is key, because it links the affect schema with the narrative schema. It is in this sense that affect—in the form of feeling shapes—plays a special role in coordinating and organizing memory and experience, as others have long suggested. [p. 91]

[8] Daily conversation is replete with "let me tell you what happened," meaning guess what she said, he said, they did. These are all instances of what Dennett (1989) has termed the "intentional stance."

Let me again return to the clinical example:

As I attempted in retrospect to further unpack my initial discomfort, I realized that I do not usually become that self-conscious about my clothes around men. It became plausible to me that Mr. L's memories of his mother's disapproval were symbolic emblems for certain schematic interaction patterns that were unfolding right in front of us. A familiar videotape was being constructed once again with my full participation. I speculated on how this might be happening and thought of his many references to his mother's facial expressions. While the patient was speaking amiably and smiling with his mouth, there was a certain furrow in his brow that was stern and disarming. When he paused, and I looked at him, I became anxious and concerned about what I would say next. This self-consciousness on my part was characteristic, but not just internally driven. The sternness in his glare, a sign of disapproval perhaps not yet consciously owned by him, was definitely incorporated into the rhythm of his response to me. I realized that I was beginning to glance up at him with a regular expectancy to see chagrin, or anger, or even a smirking grin. In a word, to paraphrase Stern, I was responding measure for measure to his affect contours with complementary versions of my own.

Although I hope that the above description and example implicitly convey what schematic representations are and how they arise within the dynamic system composed of the patient–analyst interaction, let me explicitly state how they are distinguishable from their symbolic counterparts. First, schematic representations are mainly encoded procedurally (cf. Brenneis 1996; Clyman 1992; Tobias et al. 1992). In other words, a schema of being with another is acquired like the knowledge of how to take a new route home after sitting in the car once with someone who drives you there. In neither case does someone really "think" about it. Second, schematic knowledge is descriptively, not dynamically, "unconscious" (cf. Stern et al. 1998). Third, at the level of schemas, two people are engaged in mutual or complementary acts that can be described as exciting, calming, angering, diverting, enactive. They are all ways that patient and analyst use to feel each other out and mutually work things through. The one thing that either person is not particu-

larly doing at the schematic level is deeply reflecting on what is going on.

Symbolic Representation

The moment that self-reflection starts to occur, events are being assimilated into the symbolic realm where exactly the opposite rules apply. First, in the symbolic realm, the encoded representations of meanings may not be verbal but they are declarative, i.e., the knowledge of self and other is being *reflectively* organized and reorganized. Second, if that knowledge is not consciously available, it may be descriptively unconscious or dynamically repressed or disavowed. Third, when two people relate at the more purely symbolic level, significant experiences are being self-consciously thought through, rehashed, taken apart, deconstructed, reconstructed, interpreted, and debated.

THE ELABORATION OF A MULTIMODAL CONCEPT OF EMPATHY

The thesis of this paper is now, hopefully, clearer. In the context of contemporary theory, the concept of empathy should orient the analyst toward an appreciation of the complex interactions between self and other, schema and symbol. My own vision of these interactions has been greatly influenced by Bucci's (1993, 1997) multiple code theory, a model of inner representation based on a study of analytic process. Her findings concerning how adults integrate emotional experience are very analogous to Stern's (1995) views of how infants engage similar tasks. Bucci's crucial addition is a vision of how the schematic and symbolic levels interact in the therapy process. She speaks of three modes in which emotional experience is recorded: subsymbolic and nonverbal; symbolic and nonverbal; and verbal. The first of these closely corresponds to what I am calling the schematic mode; the latter two comprise the symbolic mode. In her research on adult psychoanalysis, she has studied the referen-

tial cycle. In brief, this is the process by which procedurally encoded "raw experience" becomes assimilated into increasingly verbalizable symbols.[9] However, she is very clear that what she is observing does not fit with the traditional idea that primary process thinking, i.e., raw feeling and fantasy, finally yields to the ascendancy of a rational secondary process. Instead, she views the schematic and symbolic as two necessary, interdependent levels for the assimilation of emotional experience. The analogy is to perceiving something more fully by synergistically using hearing and sight. There is also the implication that each level, either separately, or via interaction with each other, may provide key therapeutic leverage at any given time in the treatment.

I return to the clinical vignette to illustrate the contrast and interplay between these two modes of representation. Although I had an available reservoir of experiences that involved feeling embarrassed at having to defend an aspect of my maleness to a woman, my schemas interacted with the externalization of Mr. L's own cadences of temptation and restraint acquired in an analogous battle. This is both old and new knowledge. It can be easily assimilated to the old and familiar because it is about "inner objects," in this case a confluence of two restrictive maternal introjects in one therapy relationship. This is an apt description in the necessary shorthand of the symbolic mode. However, expressions of everyday discourse, like "introject," "internal mother," "inner voice," "superego," result from the symbolic ellipsis of complex interactional schemas that are *felt out* for a long time before they are really understood.

Beyond getting the terminology straight, the idea of a multimodal empathy, i.e., a complex orientation toward two people interacting and inwardly reacting in a complex admixture of schema and symbol, raises questions of enormous therapeutic import. In psychoanalysis/psychotherapy with adult patients, we are just emerging from our habit of subtly devaluing the schematic realm and making it the adversary of the treatment. For example, Mr. L's extended "enactment"

[9] Although Bucci does note that high referential activity (i.e., linkage between symbolic and non-symbolic levels) often occurs around events in the transference, she does not specifically address the degree to which material encoded at any level is being *intersubjectively* organized.

of his discomfort is by traditional definition an acting in, or, a form of resistance, to realizing his submission to women and the aggression that putatively underlies this posture.

The dynamic systems perspective supports the idea that, at the symbolic level, these complex dynamics exist. However, the schematically organized "warm-up" period in this therapy was more than an avoidance. Vital sequences of non-reflective communication occur between patient and analyst that are *analogous to* (and clearly more complex than) the many species of emotive back and forth between mother and infant that are collectively labeled affect regulation. As I noted earlier, Mr. L and I compared notes regarding anger, mortification, confrontation, and submission that bypassed any self-conscious awareness. More importantly, these exchanges not only paved the way for proper mindful exploration and interpretation, but also accounted significantly in themselves for some of the beneficial outcome of the therapy. At the schematic level, Mr. L and I found by the trials and errors that Stern et al. (1998) term "now moments" what I would call a therapeutic *gradient of interaction*. This gradient points toward a particular regulatory endpoint, or "goal." In other words, I somehow fell into concordant embarrassment, savored it enough to appreciate what Mr. L was prey to, but managed to begin to counter it in myself and with him. At the schematic level, there is no such thing as taking a *neutral* stance. The analyst's empathic immersion is of necessity a simultaneous enactment that can be visualized as vectorial. The analyst will initially not be fully aware of how she is steering the interaction along one gradient or another.

It is to be hoped, of course, that this will come to the attention of analyst, or patient, or patient and analyst, as the referential cycle leads to a linkage between self and other, schema and symbol. I say "to be hoped," not to fall into the familiar canonization of insight, but rather to suggest that processing in the symbolic mode of course makes its own unique contribution to understanding and resolution. Psychodynamics are by definition a unique logic of symbols. They are critically helpful rules for rendering and reconfiguring, for instance, an inchoate immersion in anger and embarrassment as a clear pattern of "aggressive male strivings" unconsciously provoking "forbidding introjects."

THE MULTIMODAL CONCEPT OF EMPATHY: AFFECTIVE PARTICIPATION, ENACTMENT, IMAGINATION, AND INTERPRETATION

Lastly, I want to clarify further four components of the therapeutic interaction—affective participation, enactment, imagination, interpretation—which influence each other in parallel to create the multimodal process we call empathy. I will begin with affective participation and enactment. Enactment is the name of a set of symbolically rendered self-reflections and warnings the analyst uses to assimilate her awareness of her schematically organized affective participation. Once again, I turn to the case example:

> For many weeks after my cuff-pulling response to Mr. L occurred, similar, repeated interactions (without as overt a response on my part) gave me added grist to think about. I kept trying to nail down, in Russell's (1996) words, answers to the familiar question of whether it was me or him. In every subsequent meeting with Mr. L, I could still catch the echoes of the idealization and envy that I initially felt. Despite the ongoing sense of crisis in his life, he literally wore evidence that he was the kind of guy who kept things in hand. Had I elevated him in my mind as the antidote to my shame that my middle age found me still searching for creased pants? Or, was the admiration a front operation for my lurking, competitive feelings? The idea that I was projecting my idealization onto him of course led to the contrasting possibility that I was feeling a behavioral coercement (Sandler 1976) which signals the reception of a projective identification. Perhaps the sternness in his gaze did not represent simply a schematically based identification with his mother, but also conveyed his disavowed phallic/competitive urges. I felt that the guide to considering any of these ways of understanding was a feeling of fittedness. I tried to find the right clothes for my discomfort, namely, a metaphor that would hopefully render it both meaningful and capable of ultimately doing Mr. L some good.

This reconstruction of my attempt to frame the enactment illustrates two important functions of this term. First, as I have noted elsewhere (Fishman 1996), enactment is itself often employed as a speech act within the analytic community to mediate between a manifest endorsement of and latent uncertainty over any interaction that unmasks the analyst's emotion. After all, there has been ample justification in psychoanalysis for the fear that untempered affect in the analyst inevitably ends up in some kind of action harmful to the patient. If my cuff pulling were just the beginning of unmitigated displays of my shame, I, of course, do not think that would have been helpful to Mr. L. On the other hand, we now know that any feeling inevitably ends up embedded in some kind of action by dint of its essentially dispositional character (cf. Gergely and Watson 1996). For example, thinking and feeling govern the choice of all the words spoken and all the silences actively maintained.

A closely related latent implication that still travels in the underbelly of enactment is that the analyst lost control. In other words, if I were well analyzed, my shame reaction should have stayed contained in the trial-identification-ready-for-interpretation compartment of my psyche. The problem is that the shame, like most other telling affects, was at the moment of the cuff pulling unavoidable, unpredictable, and barely recognizable. Many terms which are synonymous with enactment defend the analyst's lapse into manifest emotion by blaming it on the power of the patient. For instance, there are names for extended enactments, like the interpersonal "grip" (Levenson 1972) or the patient–therapist "bastion" (Ferro 1993), or the "x factor" (Symington 1986). All of these words metaphorically evoke the same implications as Freud's (1895) original use of "resistance." In other words, these various expressions imply that I was falling under the spell of Mr. L's character or his internal objects.

I think it is a mistake to think of the affective immersion of patient and therapist in their relationship as a wrestling hold, passively inflicted, yet actively resisted, which needs to be broken. I prefer, along with Renik (1993) and others, to support another analogy: enactment is to therapeutic dialogue what the phoneme is to speech. Enactment, understood as the tendency for affects to be felt and to become mani-

fest to self and other, is not a species of dialogue; it is the essence of dialogue. To know someone better is of course to be gripped and moved. Metaphors framing the affective contours of intimacy are often couched in the passive tense.

Second, the concept of enactment connotes that an element (cf. Jacobs 1986) within the analyst's (or patient's) unconscious archives has become externalized. In other words, certain a priori aspects of my neurosis were waiting in the wings for their cue to direct the play of consciousness. By contrast, the notion of affective participation organized by a schema implies surprise. What happens does not as much reappear, as it *emerges*. The reaction that surfaced from within me was both familiar and new at the same time. It clearly sounded related to the other compositions in my shame repertoire, but on close study, its melodic structure was unique. In other terms, the feelings, thoughts, and actions of each participant in any human bond emerge in forms which do not support our traditional ideas of an archival unconscious or rigid character structure.[10] Ogden's (1994) concept of the intersubjective third is among the recent attempts to describe that aspect of the patient's and analyst's subjectivity that is uniquely formed in the interaction.

These two sets of distinctions between enactment and affective participation clarify the essential relationship between the terms. Enactment is a symbolic term used in our current discourse to categorize the analyst's affective participation as she becomes aware of it. As a symbolic element, the term enactment is employed in analytic discourse as a compromise formation between the sanctioning of permissiveness versus caution. In addition, it invokes us to imagine that the complexity of ongoing interaction is driven by a structured unconscious fantasy. In fact, both analyst's and patient's *assessment* of ongoing interaction is often driven by a relatively fixed set of unconscious fantasies.

The cognitions that lead any of us to use the term enactment thus include *imagination* and *interpretation*. As I stated, most experi-

[10]Stolorow and Lachmann (1983), Beebe, Jaffe, and Lachmann (1992), and many others are redefining transference as stemming from a system of organizing principles. By implication, character is also being similarly redefined.

ence in the schematic mode soon becomes assimilated into the hierarchy of meaning-making processes. Our everyday experience with our patients is inevitably transformed by our mostly silent acts of self-reflection into self object experience, the unthought known (Bollas 1987), potential space (Modell 1990; Winnicott 1989), and so on. This transformation, in turn, instigates and shapes what continues to transpire at the schematic level.

CONCLUSION

Dynamic systems theory is the overarching perspective that can implicitly or explicitly guide most of the models of adult therapy being offered by relational theorists and developmentalists. Dynamic systems theory specifically recognizes the equal importance of self and mutual regulation. I observe in this paper that from within this perspective, intra- and interpersonal experience is organized according to two modes, the schematic and the symbolic. I propose that the object of empathy is the enactive, imaginal, and interpretive efforts an analyst makes toward understanding both the schematic and symbolic discourse with her patient.

In view of my suggestion that every previous conception of empathy has been fashioned with an underbelly of wished-for omniscience, I close by advocating a caution about my own choice of metaphors. The idea of two people with synchronous affect contours in one key respect is like the ideas of primary process, self object transference, or core relational theme. It is another imaginative construct which helps us to see beyond the constraining limits of our common sense. Having spoken this caution, the idea of a schema of being with, of a blending of feeling, shape, and protonarrative envelope, as opposed to the more narrow empathic targeting of self psychology, keeps us fixed on the entire interactional flow between and within two subjectivities. Moreover, the idea of affect as the "atomic" particle of our subjectivity (even though it can never exist unalloyed to thinking and doing) continually reminds us that all of our other constructs, including that of the "self," are built from the record of what we feel in relation to our patients. I would argue that this

complex awareness keeps us from forging regrettable understandings which literalize rather than recognize our patients.

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CONVICTION AND CONVERSION: THE ROLE OF SHARED FANTASIES ABOUT ANALYSIS *

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This paper is an attempt to understand the origin of the analyst's conviction about both the patient's analyzability and the psychoanalytic endeavor. Clinical material will be used to illustrate the way that the intensity of the analyst's conviction is or isn't noticed or interpreted, by both patient and analyst. The primary hypothesis to be proposed is that the analyst's awareness of the transmission of conviction during conversion (or evaluation) can trigger recognition and use of a critical period for identification with an underlying mutual fantasy of intergenerational, analyst–patient conviction about analysis.

A patient of mine expressed the following thoughts and feelings:

> "How do you get to be an analyst? I don't mean where did you go to school, I mean I don't understand why you say the things you say…. They can't really be from books…." He was not someone in the field and I wondered why he was spontaneously coming up with these questions. "...because you say to me all the time, 'what do you think' as if you're so sure

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> that I know the answers.... But, how do you know when I'm wrong? I can't figure out if you *believe in a theory or something* about this, or if you're trying to say that you *believe in me* and something you think that I already know. I just can't figure this out." [Mr. A]

As I listened to my patient's thoughts, I was aware that he was expressing an ambiguity about the analytic process that paralleled some thoughts of my own. Although Mr. A's words had unmistakable undercurrents, I felt that he was not only expressing an internal conflict, but that he was also picking up on a tension that is inherent in the beginning phase of many treatments. The following paper will examine the possibility that a patient's associations can bring to the forefront of the analyst's awareness a not fully conscious representation of his/her conviction about analysis (an internal set of ideas and feelings) that is then subtly transmitted to the patient during the conversion from psychotherapy to psychoanalysis.

I think Mr. A is right that there are two related "beliefs" or convictions that I was communicating to him. On the one hand, his first question is whether I was communicating my conviction or belief in *him* and what he was capable of. As I thought about this, I wondered if one way this might be communicated is by the form of treatment I recommend and how this is probably understood in a particular way, given the realities of current analytic practice. In other words, given the current climate of opinion about psychoanalysis, it is more likely than not that a patient will think it is unusual to be seen in psychoanalysis rather than in psychotherapy. The way in which this is understood by the patient depends on his particular psychology, but the fact that the analyst is offering something that could be seen as unusual, special, or eccentric may need to be explored as part of the transference-countertransference feelings that then develop. Another patient of mine, Ms. B, revealed the fact that she had been discussing with her friends how unusual it was that I was recommending analysis instead of psychotherapy. She wondered if she was unusually sick or unusually special and she perceived me first as eccentric, and then as passionate or, as she put it, "having the courage of your convictions." Eventually she allowed herself greater access

to her own passionate convictions. The way in which I understood Mr. A's comment was in the context of a similar, if more subtle, version of this same process. That is, when I demonstrate an open-ended thoughtfulness—curiosity or interest in what a patient thinks or feels about something rather than taking it at face value—I am also communicating a kind of belief in the patient's capacity for deeper awareness. In both of these examples with Mr. A and Ms. B, I was communicating my feeling of conviction about my patient's special potential.

On the other hand, Mr. A's second point was that in addition to, or apart from, believing in him, I must also believe in a "theory or something." Here, Mr. A could have been attempting to understand (and I will argue that Ms. B was trying to get at this, too) the origins of my belief or conviction about analysis as a method of treatment. Again, most patients are aware that there is a broader mental health community in which not everyone is an analyst. The fact that the analyst is an analyst (as well as a therapist), and that because of this analysis as a form of treatment is one option among several, must therefore be understood as being an implicit communication about the values of the analyst. Another way of putting this is that my patient recognizes my countertransference in my desire to let him experience something that I already know about or believe in, but that he cannot, yet, know or believe. With both Mr. A and Ms. B, I was also communicating my conviction about analysis as a method.

In addition to the two points outlined above—the analyst's conviction about the patient and the analyst's conviction about the psychoanalytic method—there is a third point that I would like to consider in this paper. What is the *origin* of the analyst's feeling of conviction about both the patient and the psychoanalytic endeavor? In essence, the analyst knows that analysis is a way that the patient can experience his unconscious and that an analytic process involves a unique kind of attention that the analyst pays to the patient, his or her thoughts, and the evolving interaction. (Even though analytic work can be seen as part of a continuum in which we may also try to do the same thing with psychotherapy patients, it is usually easier to develop this kind of awareness with analytic patients.) However, one difficulty in the beginning phase of an analysis is that until the

patient has had a profound experience of his own unconscious he must, to some extent, rely on the analyst's belief or conviction as the bridge to that experience. Furthermore, why do I believe what I believe, how did my beliefs develop, and how do I replicate that experience with him, but with myself in the role of the analyst who, for the moment, is the one who believes? In the same way as my patient, in order to enter analysis myself and develop my own sense of conviction, I have also had to "believe" or identify with my analyst, my supervisor, "a theory or something" (as Mr. A said) which could operate as a bridge for me. Getting to this point of conviction or identification, crossing this bridge, is a very complicated, unique process for every analyst. It is a private journey that must, I believe, remain in the background, but one that also leaves its mark on all future analyses that we ourselves conduct. Inevitably, in some part of every analyst's recommendation of analysis there must be an echo of this history so that what the patient hears has a ring of authenticity which, in turn, indicates a very personal as well as professional sense of conviction. It has been my experience that patients often spontaneously bring up the assumption (although perhaps it isn't explored until later in the treatment) that their analyst must understand their role as the patient because he or she must have been in analysis, too. As this idea is elaborated, there often seems to be a fantasy of kinship, of fatherly/motherly/sibling mentoring, or of some kind of relatedness that involves being a part of the same family or an unfolding sequence of generations. One hypothesis to be considered is the possibility that these kinds of feelings are an illustration of the fantasy process[1] that is involved in the development of an identification with the analyst. Perhaps these feelings are also linked with early, subtle communications of the analyst's conviction about the analytic process.

If it is the case that the patient identifies with the analyst's feelings of conviction, then it is especially important that the steps of the analyst's inner process be further defined. According to the tripartite model (Morris 1992), the analyst's conviction could grow out of any

[1] A variant of the family romance fantasy (Freud 1909; Greenacre 1958) expressed in the transference-countertransference.

or all of the branches of training (personal analysis, supervision, course work, or the analyzing experience) which could, alternatively, be called the "conviction-world" (Almond 1997) of the analytic community. In addition, perhaps more thought could be given to what part is played by each of these branches and how the valence or "sap" of the training analysis gets carried back and forth and "imbues"[2] (Settlage et al. 1991) the theoretical or technical development of the analytic community.

In summary, I have taken Mr. A and Ms. B's comments as a catalyst to explore the following three points:

1. The role of the analyst's conviction about the patient and the specific impact that these feelings have during conversion or evaluation;
2. The role of the analyst's conviction about the psychoanalytic method and its particular significance during conversion or assessment; and
3. The origin of the analyst's conviction about both the patient and the psychoanalytic endeavor.

REVIEW OF THE LITERATURE

The importance of the analyst's conviction has not been sufficiently explored in the psychoanalytic literature. Although many current articles have focused on the analyst's attitude, the countertransference, the interaction, or the subjectivity of the analyst in general (Boesky 1982; Gill 1988; Joseph 1985; Ogden 1994; Renik 1995; Sandler 1976; and many others), the analyst's conviction about analysis has not been identified and studied in detail as a specific, important ingredient of the analyst's state of mind. In particular, the function that the analyst's conviction serves when psychotherapy patients are being converted to psychoanalysis may be important to understand.

Although I am interested in more than the use of the specific words "conviction" and "conversion," the definition of these two words

[2] That is, in much the same way that a mother-imbued toy helps the infant carry or internalize the memory of a positive experience with mother.

or the pairing of these terms may also shed some light on my questions. First, conviction is an interesting word because it has such paradoxical implications; it can be used to mean an overly rigid "firm belief" (Concise OED 1995, p. 293) or a powerful and passionate "opinion" (Concise OED 1995, p. 293)—both potential pitfalls for an analyst. Also, the fact that there is yet another use of the word, "the act or process of proving or finding guilty" (Concise OED 1995, p. 293) which coexists with the idea of a strong or passionate conviction, leads one to wonder (or leads an analyst to wonder) if the crime that is deserving of punishment is that of being strong or passionate in the first place. Similarly, the various meanings behind the choice of the word conversion in relation to the history of psychoanalysis, "the act of being converted, esp. in belief or religion or, Theol., the turning of sinners to God" (Concise OED 1995, p. 292) is also paradoxical and conflictual because it touches on the ambivalence that analysts have often felt about the place that should be given to religious, belief-system, or moral dimensions versus scientific and rational dimensions of psychoanalysis.

In presenting the dictionary definitions of conviction and conversion I am also aware that, like Mr. A, while I am defining a broader issue, I am simultaneously revealing some of my private conflicts about being an analyst. It has been difficult for me (and I suspect it may be difficult for many analysts at the beginning of our careers and, to some extent, for all analysts during the conversion phase) to identify or understand an underlying sense of strain or anxiety about becoming an analytic "true believer" in an era in which psychoanalysis is not perceived as an obvious step by many people in this profession or this society. Alongside my deepening recognition of the importance of my convictions or beliefs about analysis, I have also experienced what felt like an inevitable struggle with the opposite side of the conflict, the question of the legitimacy of "converting" someone to *join* me in what I have often perceived as my own personal belief system.

The specific questions to be explored below will not do justice to the many issues posed by this personal and historical juxtaposition of meanings; however, this paper *will* make an effort to understand the positive aspects of conviction. The negative repercussions of belief or

"religious fervor"—the *dark* side of conviction that inevitably accompanies all of the different theoretical perspectives within psychoanalysis—will be explored in a subsequent paper.

Review of the Literature on Conversion

There are several articles from the literature on conversion[3] that suggest that the conversion or evaluation process may be an optimal time for exploration of the transference-countertransference metaphor *and,* therefore, the potentially concurrent identification with the analyst's feeling of conviction. For example, Schlessinger (1990) and Skolnikoff (1990) express an implied interest in the analyst's conviction about the patient in relation to the general idea of understanding the analyst's emotional reactions or countertransference with a particular patient. However, in addition to the analyst's feelings about the patient there is the second issue of the analyst's transference to, beliefs about, or conviction about analysis itself as a method. Bassen (1989), Bernstein (1983), Horowitz (1994), and Skolnikoff (1990) also partially identify this second aspect. For example, Bassen makes the point that an analyst's wish to have a patient in analysis to further his/her career could result in "therapeutic zeal" (p. 88) or an overeagerness on the analyst's part to do analysis and the resulting loss of "neutrality" (p. 89) that that implies. However, phrases such as "therapeutic zeal" are used to refer to the analyst's career aspirations and not to a notion that an analyst's enthusiasm or conviction about analysis could, in some cases, be a positive factor insofar as it is a way of communicating an understanding of the analytic process that could be useful to patients.

In summary, although some of these authors focus on different aspects of the analyst's conviction than those addressed in this paper, they all come to the same conclusion that analysts should pay special attention to the nature of the transference-countertransference during conversion or evaluation. This litera-

[3] I am using the term conversion to refer to an extended period of evaluation as well as a more clearly defined psychotherapy stage.

ture sets the stage for consideration of the next question: the nature of the analyst's feeling of conviction.

Review of the Literature on Conviction

How much is understood or acknowledged by analysts about the rational and irrational feelings behind our belief in the analytic method or why do we believe we can analyze a particular patient? How much do we know about the complex and interrelated chain of experiences that ultimately bring analyst and patient to that unique kind of understanding which is necessary to begin analytic work? Perhaps the word conviction operates as a kind of shorthand for some basic, but not fully defined values or assumptions related to the analyst's attitude, assumptions that are communicated between the lines of analytic discourse both in our personal analyses and in the larger analytic community. In order to understand how and why analysts express feelings of belief or conviction, I have surveyed the literature for articles that referred to the analyst's beliefs, convictions, values, faith, love, hate, passion, and hope.

Conviction and the Analyst's Personality. The findings from the literature seemed to fall naturally into three different categories. The first category, which I will loosely designate as the personality or subjectivity-of-the-analyst school of thought, approaches an understanding of the analyst's conviction by arguing that the analyst is *always* directly or indirectly communicating his values and/or is limited by his personality. It would have to be assumed, therefore, that each individual analyst is *always* communicating his personal degree of conviction or lack of it whether he is aware of it or not (Deri 1982; Gedo 1983; Gerson 1996; Renik 1995; Winnicott 1975). Perhaps, as Mr. A first brought to my attention, the more than usual amount of background tension surrounding the subject of conviction (particularly at the moment of conversion) could be understood as an even greater demand that the analyst confront his subjectivity. For the sake of this discussion, I would like to use the subjectivity-of-the-analyst literature as the basis for the assumption that the analyst's conviction *is* a presence in the room as well as a source of conscious and unconscious

fantasy so that we are then able to go further in exploring what impact this has on the patient and the treatment. In other words, by taking for granted that there is a personal dimension to the analyst's conviction, we can also consider the idea that the analyst's conviction plays a part in stimulating some version of the (not necessarily conscious) mutual fantasy that the analyst is thinking: "My analyst helped me so now I believe I can help you."

Conviction and the Analyst's Love, Hate, Passion, and Hope. A number of analysts (Buechler 1995; Coen 1994; Hirsch 1994; Hoffer 1993; Manrique 1984; Mitchell 1993; and Winnicott 1975) draw attention to the fact that very intense feelings (such as the full range of loving, hating, hoping, and believing feelings between themselves and their analysands) are a necessary part of the analytic process and that affective constriction on the analyst's part interferes with the full analysis of the patient's emotional life.

Why is it hard to acknowledge the intensity of our feelings for our patients? Or, why is it difficult to clearly recognize that selecting a patient for analysis is a basic vote of confidence or an implicit, "I believe in you," as Mr. A suggested? At first I wondered whether this was simply a problem specific to me or to beginning analysts in general. It seemed reasonable to assume that less experienced analysts might have more worries about the technical considerations of the analytic frame or the impact of our private emotions on our patients. My own awareness of this subject was particularly heightened one day several years ago when, as I went out to the waiting room to "pick up" my patient, her face lit up in a way that reminded me of my then five-year-old son. I felt my own face light up in the same way that it had the previous afternoon when I literally *had* "picked up" my son as he ran across the schoolyard and jumped into my arms. At the time I felt unsure about how to understand my feelings. Did other analysts, at times, love their patients almost as much as they loved their children? It seemed to me that, in some ways, these feelings were more taboo or less talked about than the irritation or negative feelings that also come to the surface with patients. It took a while for me to accept that these feelings were a natural part of my development of my identity as an analyst. However, it eventually occurred to me that there is also a long-standing history of conflict that all analysts feel about loving their

patients that goes back to Ferenczi in the 1920s and Alexander and French in the 1940s. This history is probably intense and conflictual enough to be linked to our fundamental oedipal conflicts as well as to the theoretical questions—perhaps we convict ourselves of conviction? It may be important for all analysts to consciously acknowledge or be prepared for the fact that to some extent there is always a conscious or unconscious residue of guilt or self-doubt about these feelings even in the context of the current, more complicated resurgence of interest in these subjects.

In summary, none of the authors mentioned thus far puts equal emphasis on both of Mr. A's points: the analyst's belief in the patient *and* the analytic method. Rothstein (1995) is the only author (although he could be criticized for overemphasizing believing as opposed to thinking "objectively" about analyzability) who addresses both the analyst's conviction about his patient and the analyst's conviction about the analytic enterprise. He gives many clinical examples about how the analyst's "belief" (p. 54) or "optimistic attitude" (p. 41) toward analysis and his patients affect his ability to have an analytic practice. However, although Rothstein is acknowledging that, as Mr. A expressed, the analyst must "believe" in the patient and believe in "a theory or something" about the analytic process, he does not take the next step and explore the content or origin of the analyst's "theory or something."

Conviction and the Analyst's "Theory or Something." Britton (1998), Heigle-Ever and Heigle (1976), Livingston (1991), and Ostow and Scharfstein (1954), by examining what is fundamental about the psychoanalytic relationship, directly address the idea that believing in something is a basic human need.

Thinking in terms of a basic human need to "believe" is not an explicit part of psychoanalytic theory. Although analysts are constantly defining and redefining theory and technique, the "I believe" feelings or "I have conviction about" statements are usually between the lines of analytic discourse rather than the direct subject of discussion. No doubt this kind of soul-searching is done privately, but why couldn't there be more public discussion that is organized specifically in terms of thinking about the idiosyncratic or unique ways that every analyst comes to terms with analyzing in him or herself, *What* is it I *believe* in

about psychoanalysis? How much do I attempt to define it for myself, and how do I implicitly or explicitly convey this to patients?

A process such as this could be a way to discern what it is about our work that continues over time to touch us very deeply or what it is that remains fresh and natural about our theories. It may also be a way to understand more about why some analysts, even after many decades of training or practice, lose faith in psychoanalysis. Perhaps we are too quick to attribute these failures to the individual or to the individual's analysis rather than trying to understand what may also be a failure of the entire psychoanalytic community or the "conviction world" of psychoanalysis.

Essentially it has been my own search to understand what I believe in about analysis which has led me to write this article and also to try to understand what it was that made me feel that some analytic thinkers more than others were groping or feeling their way toward this hard-to-define "theory or something" about analysis which the analyst experiences as a very powerful personal belief. However, while I was in the midst of recognizing that I was engaged in a self-analytic search as well as a literature search, I became unsure about how to write this paper. Wasn't a self-analytic process an entirely different process from a straightforward literature search? Or could they be commingled? Perhaps I could subjectively capture something about the development of my analytic beliefs that would also be generalizable. It seemed worth a try. I looked over earlier drafts of my literature review and realized that I kept getting stuck in the same place.

On the one hand, I was drawn to the way this hard-to-define-something was described by some of the most creative psychoanalysts of past and current decades as the "third ear" (Reik 1948), "analytic instrument" (Isakower [in Jacobs 1991]), "memoire magique" (de Uturbey 1985), "reverie" (Bion 1977), "potential space" (Winnicott 1975), "analytic third" (Ogden 1994)[4], or "metacommunication" (Jacobs 1991) quality of psychoanalytic communication. At first I

[4] See especially Ogden (1994) and Reik (1948) for a fuller exploration of the tension between reality and fantasy and the analyst's comprehension of the patient through self-analysis. Although Ogden pioneers this viewpoint much further, Reik (1948) illustrates how this kind of understanding has existed as an implied part of our clinical lore.

wasn't sure why I felt compelled to single out *this* "theory or something" about analysis. Unconscious communication between analyst and patient seemed like such an enormous topic. What was it about these authors that made me feel they had this quality I was labeling conviction? I knew that part of my attraction to these theories came from the fact that I experienced these ideas as freeing me from my personal inhibitions about using the intuitive parts of my personality, loving my patients, and converting my patients to "my" belief system. Also, one of the questions I had about conviction was whether conviction transmission could be an unconscious transmission.

At the same time, I also wanted to consider the idea that conviction transmission could be both conscious and/or unconscious. Other kinds of analytic thinkers (equally as numerous in my stacks of file folders labeled "analysts with conviction") seemed to approach their commitment to analysis with just as much passionate conviction, but with an entirely different methodology than the "metacommunication" analysts. Whether it was Gray's (1990) precise, theoretically consistent and conscious listening for the shifting of defenses in the moment, Chused's (1996) simultaneous use of enactment and abstinence theory, or Adler and Bachant's (1996) clarifying, re-examination of the analytic neutrality ideal, I liked the fact that these analysts placed an equally high value on the conscious, thinking part of the analyst's mind.

And yet, it felt like an oversimplification to say that some analysts speak from the heart or use their personalities, feelings, or unconscious reveries while others emphasize the logical mind or theory building. I was still left with the question *why* is theory or thinking important if theory can't be neutral, or why was analysis about *both* "believing" in the patient and believing in a "theory or something." It occurred to me that thinking about what we believe in might be related to the concept of neutrality in the sense that it provides a feeling of separateness (Caper 1997)[5] from the patient that balances the strong

[5] Caper argues that because of the strain of being role-responsive, the analyst needs to use theory (and other internal objects) as the internal representation of the third which is necessary for interpreting both narcissistic separateness and oedipal exclusion.

emotional pulls of the analytic situation.

Another way of stating this is what do we mean *analytically* when we use language such as "love, hate, belief, and conviction?" Acknowledging the loving and believing feelings as an analyst means keeping in mind that analytic loving and believing is also pretend or as-if loving and believing guided by theory. In other words, an *analytic* belief would have to include the understanding that psychoanalysts have a unique perspective about *how* ideas are linked to feelings. Conscious of a vague sense that these sentences were too cerebral or abstract, I noticed that I began to think about my maternal grandfather. In my first submitted draft of this paper, I didn't include the thoughts about my grandfather. But, then I had to ask myself why was I deciding to leave out my personal history—or why now—and what did that mean about my beliefs as an analyst? In fact, I knew that my grandfather had a great deal to do with my personal integration of these ideas. In part it was because he had been analyzed, but it was also because of the way his analysis had influenced his thinking as an academic social scientist and as a person. I had always been fascinated by one of the opening sentences in his intellectual autobiography:[6] "I realize how closely my search for my subject matter and my search for my identity have been related" (Roethlisberger 1977, p. 1). In my analysis I had discovered, over and over again on many different dimensions, that what intrigued me about this sentence was how deeply psychoanalytic it felt. This sentence captured something central about my connection to an important family member who had been a source of warmth *and* conflict for me, the symbolic reasons behind my choice of this profession, and the feeling that I loved my analyst the way I had loved my grandfather. Then it occurred to me what I was doing. I realized that thinking of my grandfather now was a way to picture or imagine or grapple with what he meant to me, who I was, who my analyst was to me, and to put all of these ideas and feelings together. In a way I

[6] This book is described as an *intellectual* autobiography because it is an anecdotal account of the birth of social science as a "scientific" discipline and my grandfather's role in this development at Harvard. It is a noteworthy historical irony that one of his major contributions, "the Hawthorne Effect," is now also a generic term used to refer to the idea that all experiments, to some degree, fail at the attempt to be objective because of "experimenter bias."

was trying on or constructing a picture of my place in an unfolding sequence of generations. Wasn't this part of the internal fantasy process of identification or intergenerational succession, and the process of analytic intergenerational succession as well? Consciously connecting and integrating all of these ideas and feelings made it clearer to me that I had identified with my analyst and my grandfather because they had both communicated to me, between the lines, "Believing in something (and someone) can be helpful to you as it was to me."

Then, I thought, of course psychoanalysts have a unique perspective about how ideas are linked to feelings because we think about transferences and because of the role of the analyst's analysis. In other words, I was returning to my original question: What is the origin of the analyst's conviction? And, the missing "something" was my own analyst, and myself as an analyst with my patients, constructing a mental picture of my analyst. Now I felt I understood more about how conviction, or the uniquely psychoanalytic link between ideas and feelings in psychoanalysis, is connected to the way that ideas are imbued by our experiences with our analysts. It also seemed much clearer to me that my interest in the idea of conviction transmission had to be directly related to something I had experienced early on in my own analysis and wanted (consciously or not) to transmit to my patients. Although my family tie to my grandfather—someone who was analyzed and someone who thought deeply about similar kinds of issues—makes the process of my identification with my analyst easier to compare to the familial identifications between generations, I also believe that analysts without such direct linkages in their family backgrounds (and patients not in this profession) make use of similar kinds of meaningful links as part of their processes of identification. The structure of the fantasy, "I can help you the way my analyst helped me," would essentially be the same.

To flesh out these ideas again, in a different way, I will explore in the following case examples whether it is possible that I was consciously and unconsciously trying to sort out and define my own process of conviction transmission with Mr. A and Ms. B, and in so doing, subtly communicating both my doubts and beliefs to them.

MR. A

Mr. A was a 29-year-old business executive who was seeking treatment because of chronic anxiety and depression.

I was struck by Mr. A's acute perceptions of me, my thinking process, and the entire psychoanalytic process, as is demonstrated in the excerpt presented earlier. In some part of Mr. A's mind he must have known that he had a special sensitivity toward other people and he must also have known that this proclivity was related to something he needed to work out about himself. Perhaps because he couldn't quite put his finger on a way to describe all of this he kept going back to his question about what I believed in. This attitude of Mr. A's fit in with a great deal of the spoken content of his story of being overburdened by the expectations of two very needy parents. It seemed wise in his case not to begin the analysis immediately, but to wait and learn more during an extended period of psychotherapy. At this early stage of discussion about frequency and analysis, I wondered if he experienced it as *his* desire to do analysis or as mine. In the context of several interpretations about Mr. A's use of me and others as "the ones who believed," I suggested that we spend an open-ended period of time, at a twice-weekly frequency, coming to understand more about what he believed or what he wanted from analysis. Mr. A responded, "But I feel like I need to start the analysis right now in order to know for sure that you really believe in me, that there's hope for me. Sometimes I feel so sure that you do believe in me. But I want to know more about how you figure it out. I know you're probably wondering if I believe in myself, but does that mean you think I already know something? I really want to know what you believe in." Around and around he went, vehement at times, about his need for me to tell him that I believed in *him* and to divulge and define *what* I did believe in.

Despite Mr. A's discomfort, I continued to ask him in more detail what he thought about the way he was preoccupied with my thought processes instead of his own. As he talked, he admitted that in various ways he thought he was a "master at psyching people out." He wondered if he could have been an analyst, if I had ever been a patient, and he speculated about what my problems might be. Not infrequently

Mr. A got "too close for comfort" and made some uncannily accurate guesses about my psychology, including the ways in which he imagined I had been helped in my own analysis.

Not surprisingly, I began to feel an increasing degree of uncertainty about what I was doing. I found myself becoming more and more preoccupied with Mr. A's questions about what I believed in. I questioned specifically what I thought about Mr. A, such as why had it seemed so important to me to wait to do analysis with this patient, or what made me interested in or "believe" in him. I also began questioning more generally what I knew or believed in about analysis as a method. It felt especially important that this patient seemed to be pushing, even intruding, not only on my personal perceptions of myself but also on the crux of my definition of what analysis was. I didn't want (nor did he, I thought) to concretely tell him what I "knew" about the psychoanalytic process, or to seem by my response to simply be reassuring him that I believed in him, yet I knew I still didn't understand why he was putting so much pressure on me. As I thought more about this, I wondered if perhaps Mr. A was picking up on some doubts I had about his analyzability, and if I was waiting to begin the analysis because, in Mr. A's words, I wasn't sure if I believed in him. I became more aware of some recurring thoughts I had had at various points during discussions with other analysts about the idea that patients who want analysis aren't necessarily the best analytic patients. After thinking in a more deliberate way about what I felt about Mr. A's analyzability, I was able to decide that, despite some doubts, I did want to go ahead and give the analysis a try. I felt that the decision I made was partly based on psychoanalytic *ideas* I had about analyzability, and partly based on a more conscious awareness of a *feeling* (what had previously been an unconscious hunch?) I had that I thought Mr. A had described quite well by his use of the word believe. Prompted by these thoughts I decided to summarize some of what I was thinking out loud during one of these hours. I said, first, that I had done a lot of thinking about his questions and felt I understood more than I had at first about why his wish to begin psychoanalysis right away and my suggestion that we wait would feel like I really didn't "believe" in him. I added that although I may or may not have made the right decision when I sug-

gested that we wait, I thought that the feelings that had come up for him were similar to feelings that he had had all his life about how others didn't believe in him and how he didn't believe in himself. I also asked him why he hadn't thought that by carefully considering what doing analysis might mean, I had intended to demonstrate by my actions my desire to understand him, which was also a way of saying that I believed in him. I am sure that this time I spoke to Mr. A with more feeling in my voice. I also think that he finally experienced what I communicated here as, "I believe in you and I believe in something about the analytic method."

At first, Mr. A insisted that I'd never before said what I said that day quite so clearly, and for that reason he did finally believe me, or believed that I believed him. I thought to myself that this was true and that I was probably speaking now with more conviction about my understanding of the analytic process after the previous period of uncertainty. Perhaps struck by the contradictions and the vehemence implicit in his insistence, Mr. A suddenly realized that he was terrified to discover that he didn't necessarily believe in anything that I knew, and, in fact, he expected me to be threatened by his ability to think because perhaps he would be the one perceptive enough to see that I knew nothing at all.

Although it didn't happen in one day, a centrally important metaphor was briefly opened up in a way that allowed for much richer exploration in the future. Similarly, shortly afterward, when he did make the conversion from therapy to analysis (the process took about six months), the old and new ideas were integrated in an interesting way. On the one hand, as a result of the decision to do analysis, he felt, as he had predicted, overwhelmed with relief that I believed in him. He began to tell me with much more confidence the things he knew about his family and himself. At the same time, in the midst of those periods of self-doubt and self-blame, Mr. A was now also aware that he was deeply suspicious of my comments. Perhaps I wasn't any different than his mother after all, but selfishly needed him to tell me that I was always right and he was always wrong. Although this was only the beginning phase of his analysis, a few months later Mr. A was able to look back and make the following comments about the conversion phase of his treatment: "What's strange is that now I realize I

didn't really want what I thought I wanted from analysis. I thought I knew that you were different from my mother, but really I secretly thought you were the same. Or in a way I did and in a way I didn't. So I was right and you were right, and we were both wrong, too, about the way I thought you believed in me."

MS. B

Ms. B, a 32-year-old architect, began therapy because of her chronic ambivalence about whether or not to marry her boyfriend. I have selected Ms. B as a subject for this discussion because in many ways her problems are a direct contrast to the problems of Mr. A. Not only did Ms. B avoid any sort of musing about what I "believed" in, but as time went on she described in more and more detail her feeling that she found it hard to believe that she or I or anybody could believe in anything. Passion or conviction in her friends or colleagues, when it was noticed at all, was also seen at a distance as strange, eccentric, or weird. Put in the context of a comparison to Mr. A, one could say that she acted as if she took it for granted that I didn't believe in her and that she didn't believe in me. One of the best examples was the way she ignored my recommendation that we begin an analysis and meet more frequently. However, these were such automatic reactions that neither of us was able to articulate, at first, exactly what was missing.

Although in the beginning Ms. B wasn't particularly aware of any of this as a problem, eventually she began to reflect on what she called her "skepticism." What did it mean, I asked Ms. B, that she was not particularly interested in becoming an analytic patient? "Nothing, really," she said, "You just believe in that old-fashioned Freudian stuff. None of my friends see their therapists that often. I don't see why I need it that much."

Gradually Ms. B began to understand in small and big ways as we analyzed different characterological or defensive maneuvers (her lack of appetite for food, boredom, "acting cool," avoiding thinking about her feelings about me or the treatment) that she was depriving herself of an affective experience of life by keeping everything at a cool,

dispassionate distance. Not surprisingly, this same attitude was haunting Ms. B in all of the important areas of her life. She had been living with her boyfriend in an okay relationship for three years, but she couldn't commit either to marrying him or to leaving him. She was also frequently dissatisfied with her career, but not convinced enough about what exactly, if anything, was wrong to know what to do about it. Slowly, she started to talk about the idea that what was missing in her life was passion.

Looking back at the slow evolution throughout two years of Ms. B's twice-a-week psychotherapy into a four-times-a-week analysis, it is interesting to note that she also focused on my reactions to her as a starting point to enter into a discussion of doing analysis. As I now think about this case retrospectively, I wonder if I was slower, more passive, or more affectless than I needed to be in the way that I followed up my initial recommendation. I also wonder if I was overly focused on her defenses rather than mine, if I was embarrassed about my passion, if I felt I should be "cool" like her, or if I was uncomfortable about the fact that I wanted her as a patient as much as I did. In general, this case has made me wonder, when does one decide to focus on the patient's defenses and when does one decide self-analysis is necessary? Although I recognize the limits of retrospective analysis, it does seem to me now that I was avoiding these feelings and that they would have been accessible earlier on if I had been paying more attention. After all, why did it take me so long to consider the idea that Ms. B's perceptions of me as strange and eccentric might be reaction formations and that she also saw me as passionate and creative?

On one particular day, Ms. B seemed especially jittery and embarrassed (rather than bored) by my interpretation that it was she who stopped herself from getting everything she could out of life, in almost every area, including taking seriously the idea of doing analysis. I noticed this time when I mentioned the idea of analysis, I spoke with more feeling in my voice, whereas previously when I had been tempted to speak in a more passionate way I made more of an effort to hold myself back. Ms. B later referred to this day as a turning point, and described it in the following way: "For the first time I believed that I could take myself seriously enough to, maybe, go all the way with

something. Why else would you be so serious about seeing me so often? None of my other explanations made sense and so I decided I had to at least try it, and I guess I really realized then that never trying things all the way was my problem."

What kind of inner process was Ms. B describing by emphasizing that it was first the analyst who took her seriously before she was able to take herself seriously? At a later point ten months into the analysis, Ms. B compared this moment to another moment in which she perceived me as "passionate" and "having the courage of your convictions." In this instance I questioned, as I often did, her claim that she didn't know what she was feeling, and also asked her how she felt about her idea that I seemed to take her more seriously than she seemed to take herself. Again, I was aware that I was not trying to tone down my desire to speak more affectively. Ms. B replied, "Somehow when you asked me that question it really hit me and I envied you that you could be so passionate about this even when I was acting so insecure. It's like when you told me you thought I could do more with my life if we did psychoanalysis. I felt if you were passionate and had the courage of your convictions, then I could too."

Although the meaning behind Ms. B's perceptions of my passion or conviction did not become clear to her right away, she was able to tell me later in the analysis that it felt like I was a "big sister" letting her borrow a sexy dress, and that by being the first one to wear it I had made it more acceptable. In terms of my feeling of conviction about analysis and about Ms. B, I noticed that when I allowed myself to show more of the enthusiasm I was feeling, it enabled me to analyze the transference-countertransference, or to think about asking Ms. B how she felt about my having "passion" when she didn't. Ms. B was then able to associate to a series of dreams dating from early on in the therapy in which I was a famous movie star known for her passion and creativity. Again, as she talked about these dreams, she admitted feeling that she wanted me to "go first" so that then she could be who she really wanted to be. During termination, Ms. B also had a dream about her analysis that encapsulated this dynamic. She told me, "We were both about five years old and we were excitedly jumping up and down on the couch-bed saying, 'We did it!'" It was also

during this time that Ms. B revealed her fantasy that I must have gone through an analytic process similar to hers and so, in that way, perhaps we *were* sisters. Although more could be said about the defensive aspect of Ms. B's need to have me "go first," the disguising of her envy, and many other layers of the transference, the meaning of her use of the analyst during the conversion stage has important implications.

THE ROLE OF THE ANALYST'S ANALYSIS: A THEORY AND SOMEONE

I would now like to return to the incompletely developed third question of this paper: the role of the analyst's analysis. Why is it mentioned so infrequently (Jacobs 1991; Ogden 1994; and Silber 1997 are a few exceptions) that all analysts are operating quite intuitively from a base of experience that comes from their own analyses? Although more could be said about how conviction develops out of defining the "theory or something" we believe in, or from experiences analyzing and in the larger analytic community, another important part of this process might involve an explicitly self-analyzing part of the analyst's mind that recognizes how his or her personal beginning in analysis affects the beginning stage of each analysis she conducts. Each analyst with each new patient could potentially confront the ghost of her analyst and herself in the consulting room with the same kind of intense love, passion, hope, and heightened affect that the mother of a new baby confronts the ghosts of her mother and herself in the nursery (Fraiberg et al. 1975). The beginning and conversion phase of analysis has been compared to the dating period of a new romance, but it could also be compared to the infant's earliest months. All three of these moments are particularly powerful times for feelings and unconscious memories to be stimulated because they are threshold moments of special commitment or new beginnings. It seems both self-evident and not fully acknowledged in our literature that the analyst's personal analysis rests at the center of our clinical lore. The word "lore" seems appropriate because this kind of knowledge is passed on from person to person, often at key moments or

turning points in personal analyses or teaching/mentoring relationships, and is therefore more like family lore than it would be in a straightforward or exclusively abstract intellectual tradition. Could it be that the "something" about the kind of unconscious communication between analyst and analysand alluded to by terms such as "third ear," "analyzing instrument," "analytic third," or "metacommunication" mentioned above has to do with this fantasy of an intergenerational chain of identification from patient to analyst, analyst to patient? That is, the analyst's conviction about his/her patient's analyzability and psychological capacities is based, in part, on a parallel re-creation of the maternal-paternal or family-like bond that is transferred from the analyst's own personal analysis.

During the same period that Mr. A was bringing his questions to me, I was also preoccupied with a question that corresponded with something I had learned from my analyst. As mentioned in the above case illustrations, I often felt a great deal of enthusiasm when recommending analysis and wondered whether I should "say it with feeling" or try to tone down my affect and adopt a more "neutral" tone. Although I knew in a general way that this conflict was a reflection of my efforts to wrestle with issues of neutrality, subjectivity, and the ways in which I was different and similar to my own analyst, I had not quite allowed myself to think about the fact that my analyst was quite comfortable "saying it with feeling." I also later realized that in a generalized, hard-to-describe, theoretical/personal way, my analyst was able to communicate (although it was not explicitly stated) this very emotional, passionate, or conviction dimension of his commitment to the analytic enterprise and to me. However, perhaps my questioning about all of the above was also partly based on the fact that this mutual fantasy was not fully verbalized between us.

Our literature has not emphasized enough how these conscious, unconscious, or in-the-process-of-becoming-conscious links in the analyst's mind directly affect the interpretations that are made or not made to the patient. Silber (1997) goes even further to describe a more conscious example of something similar when he says, "As my patient can be made to feel more free with his aggression, I also, *by identification, join him* and experience the emergence of new feelings of anger toward my long-departed analyst" (p. 38, italics mine). A

more conscious version of my inner process might have been: as my patient feels freer to wonder about my conviction about analysis and my belief in him, I also "by identification join him" and revisit the way my analyst introduced me to his conviction about analysis and his belief in me. It is exactly these kinds of parallel or sequential identification processes that I hope I have been able to illustrate by presenting the above clinical vignettes side by side with my self-analytic examples.

Jacobs (1991), building on Isakower's definition of the analyzing instrument, and as a part of his definition of metacommunication states, "...reconstruction of the patient's childhood is often accompanied by reconstruction of the analyst's childhood...these are independent if overlapping processes.…The analyst 'knows' his patient... through his own parallel life experiences.…This is one of the most important effects of the analyst's own analysis" (p. 132). This concept could also apply to memories of the analyst's analyst as well as the analyst's childhood, and it would follow, therefore, that analysts should pay special attention to the origins of their feelings of conviction during the conversion or evaluation phase of treatment.

Silber (1997), in an article commenting on Jacobs's ideas, defines the part of the analytic process that makes these kinds of identifications possible in the following way:

> That interface connecting up the unconscious analytically tuned elements of each participant locked into the specific task of analyzing...the early mother–infant attunement is harnessed in a new joint effort, carrying over the safety from that earlier unspoken bond…something very akin to the reciprocal intimacy of that early mother–infant connection, that archaic familiarity, is switched on when what approximates the described "analytic instrument" does take hold...there is a connection being made and this leads to a *conviction* on the analyst's part that his intervention is correct because of the emotional resonance experienced. [p. 39, italics mine]

Not only does Silber explicitly emphasize that the "emotional resonance experienced" leads to a feeling of "conviction" (and then compares that analyst–patient resonance or bond to the mother–in-

fant bond), but he also acknowledges that the analyst, either consciously or unconsciously, is revisiting his experience with his or her own analyst. Slightly different but related ways of describing this aspect of the analytic process are also partially discussed or hinted at by the other writers mentioned above. For example, Isakower's (in Jacobs 1991) use of the words "glued" and "severance" when describing the connection and disconnection of the analyzing instrument at the end of the hour, de Uturbey's (1985) suggestive term "memoire magique," and Winnicott's (1975) "potential space" are all attempts to describe the pre-oedipal nature of this bond. Although this part of my attempt to define the processes or mechanisms of conviction and conversion is the most speculative, it is also this last question that may be the most important. If analysts could be more conscious of the nature of their early connection to their own analysts, it might be one of the crucial defining links in a successful transfer or conviction/conversion to analysis. In retrospect, I think I could have done a better job converting Mr. A and Ms. B if the above *ideas and feelings* had been an integrated part of my understanding of the analytic process.

SUMMARY AND DISCUSSION

1. What is the role of the analyst's feelings of conviction about the patient? First, I have argued that analysts have strong passionate feelings, such as loving and believing in their patients, and that technical considerations related to this special intimacy could be more conscious, more developed, or more acknowledged in our literature. Put more simply, in the context of the larger analytic community or our "conviction-world" (Almond 1997), we experience strong feelings for our patients as we do our parents, our children, or our analysts and we may consciously or unconsciously communicate this *conviction* when we make the commitment to undertake an analysis. If this kind of awareness were consciously and carefully used, it might facilitate more understanding about the partially conviction-generated processes of identification between patient and analyst.

Although with some patients it may feel right to make the recommendation for psychoanalysis in a more modulated tone, with others a fuller range of affective expression may be very important. The attention that analysts pay to tone of voice could be motivated not only by a general, attuned, role responsiveness (Sandler 1976) created in the transference-countertransference, but also by a more specific awareness of what is generated by the analyst's conviction about the analytic endeavor and belief in that particular patient.

2a. What is the role of the analyst's conviction about the psychoanalytic enterprise? As Mr. A and Ms. B brought to my attention, every analyst's personal/theoretical version of his analytic beliefs, although sometimes elusive and hard to define, may be the crux of what he communicates to patients whether he knows it or not. The analyst's ability to communicate a sense of conviction to patients may be related to how much she has tried to thoughtfully define this process for herself. A self-analytic process of coming to terms with what we believe in as analysts may involve a greater awareness of the fact that our analytic theories are informed and imbued by our experiences with our own analysts. By becoming more aware of this kind of conviction transmission, more analysts may also be able to recognize an underlying fantasy of intergenerational analytic succession that connects us to our forebears through our own experiences in analysis and training and to our patients as inheritors of a psychoanalytic *family-like* legacy.

2b. Is the conversion/evaluation phase an optimal moment or critical period? The importance of the conversion or assessment phase is related to the fact that something special and pivotal often happens in the beginning, commitment moments of new relationships. In many situations in daily life it is understood that we all savor and relive these kinds of special moments. For example, we catch our breath as we see a young bride walking down the aisle, or we get nostalgic looking at pictures of a newborn baby. Fraiberg (1975) has used moments such as these as clinical opportunities for mothers and infants. In a similar way, the infancy and commitment stage of each new analysis could restimulate memories of our personal beginnings with our own analysts. This emotional resonance between patient and analyst may also be reminiscent of the mother–

infant bond, as is argued explicitly by Silber (1997) and suggested by others above.

3. What is the origin of the analyst's feeling of conviction? How much do analysts allow into their awareness their knowledge of the special intimacy of analysis, the intensity of their commitment to their theories about analyzing, its unique personal/theoretical connection to their own analysis, and the return of those first, special moments with their analyst as they are re-created with each new patient? I have tried to identify different facets of this subtle process in the literature review and the clinical and self-analytic material above. The fact that I couldn't find answers to my questions simply by reading the literature also speaks to the nature of psychoanalytic knowledge or the way in which psychoanalytic knowledge may be generated through one's own analysis. By asking the question, what are some of the values that are implicit in psychoanalysis, I became more aware of the ways in which this is not an *exclusively* [7] intellectual tradition, but also a community, or a family-like community with a legacy. Part of what makes this community *family-like* is the balance between ideas and feelings (Caper 1997), or convictions, which are passed on from person to person across generations in the context of one very significant relationship, the training analysis, in many other important personal/professional relationships in the larger analytic community, and in our relationships with our patients.

I would like to make one final speculation. Although many analysts assume that identification is a crucial factor in analysis, much is still unknown about why, when, and how new identifications are formed. For example, Warren Poland, in his Introduction to Jacobs's (1991) "Use of the Self" asks, "What does it mean to know someone else?…and how vast are the differences from the ways one knows oneself? How does human experience get internalized?" (p. xv).

To put the pieces together that I began with, is it possible that what my patients have taught me regarding the nature of the relationship between the analyst's feeling of conviction about analysis, the patient's feeling that the analyst has confidence in him or her and

[7] I do not intend to underestimate the importance of theory. Instead, through repetition of the phrase *ideas and feelings,* I am hoping to stimulate discussion about the imbued nature of psychoanalytic theory.

the process, and then the patient's ability to make the shift from psychotherapy to analysis is that these are the building blocks of identification? Developmentalists also describe this process in terms of the best environmental conditions for growth (Loewald 1957; Ericson 1952) or the mother's "confident expectation" (Benedek 1938). If the hypothesis proposed at the beginning of the paper connecting the patient's idea that his or her analyst was also a patient with fantasies of kinship or family relationships is also evidence of beginning identifications, then it makes sense that a patient would be acutely aware of the analyst's personal sense of conviction. In both of these clinical examples, these ideas—either that the analyst was a patient, that the analyst "believed" in the patient, that the analyst "believed in something," or, in Ms. B's case, her experience of me as a big sister, or big sister patient—emerge at critical moments in the transference.

Finally, I have made some similar observations while working with parents of toddlers and preschoolers. Child therapists (using developmental theories) encourage identification processes when they discuss with parents their questions about how to help their children become more confident or less easily frustrated. One idea that seems to intrigue both parents and children is to have parents tell their children stories about their own childhoods. Quite a few parents have reported to me that their children grow remarkably wide-eyed and are able to quietly listen to stories of how "when Mommy was little she got mad, too, when Grandma said she had to share her toys." Or, *"You* cried, Mommy, when you found out there was no Santa Claus?" It is as if the idea that Mommy was a little girl, but is now so big, gives them a pathway or a bridge for imagining that they, too, will become bigger in the context of an ongoing, growing family. Of course these parallels are not exact and these ideas are exploratory, but I would like to advance the hypothesis that the same principle is at work with our patients. In other words, our patients hear or imagine a similar family story behind the analyst's sense of conviction and this history of conviction then operates as one part of the bridge or foundation for the patient's own conviction, future development, and identifications with the analyst in the context of the ongoing generativity of psychoanalysis.

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ON THE THERAPIST'S REVERIE AND CONTAINING FUNCTION

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Containment and interpretation are two inseparable aspects of the psychoanalytic technique. This is better understood by Bion's clinical metaphors of "container-contained" relationship and the capacity for reverie. Bion, continuing and expanding Klein's concept of projective identification, has transposed this from what happens to an infant to what happens in the link between mother and infant; until now he laid emphasis on the mother's (or therapist's) ability to contain the primitive anxieties which the infant (or the patient) experiences. He described three types of links—love, hate, and knowledge—and proposed two metaphors which laid the foundation of a new and efficient frame of reference of the analytic process and technique, namely, the container-contained relationship and the reverie.

Two clinical vignettes will illustrate the pivotal function of the therapist's reverie within the therapist–patient interaction. In the first case, a dead (internal) object of the patient was contained in the context of the session, enabling the patient to contain and sustain the psychic pain and her self-destructive tendencies; the second case stresses how the therapist's reverie, during a silence, revealed a bad part of the patient's self, which was lost through projective identification.

INTRODUCTION

New ideas in psychoanalytic theory and technique always stem from older contributions. Klein, introducing her concept of projective identification, reestimated Freud's formulations on early object relationships. Klein considered that the internal mental mechanisms (e.g., projection) and drives imprint their action on unconscious phantasies (like projection identification). In her text, "Notes on some schizoid mechanisms" (Klein 1946), she makes reference to outbursts of anger in infants and records that "the other line of attack derives from the anal and urethral impulses and implies expelling dangerous substances (excrement) out of the self and into the mother. Together with these harmful excrements expelled in hatred, split-off parts of the ego are also projected into the mother…are meant not only to injure the object but also to control it and take possession of it" (p. 102).

Bion, continuing this line of thought, has transposed this from what happens to an infant into what happens in the link between mother and infant. He gave emphasis to the mother's ability to contain the primitive anxieties which the infant experiences and which are projected into her.

This description of link is facilitated by a bipolar image. It is the metaphor of the concept "container-contained." As such, Bion refers to the very early relationship of the infant to its mother's breast, that is, when the infant directs his anxieties into the breast. If this experience is pleasant (a mother who can endure and contain anxiety), a feeling of reassurance is established. If the experience is not pleasant (a mother who is anxious and unable to hold the aggressive and anxious trends of her infant), then the response sent does not contain any processing of the projected material, which in turn inundates his immature "ego." As Elisabeth Bianchedi (Panel Report 1996) has pointed out, "the mother's mind functions as a link" and in this sense "the breast is a link" (p. 575).

Although Winnicott was the first to place the creation of the subject in the space between the infant and mother, it was Bion who had described an important new concept in psychoanalysis, namely, the "links" between human beings. He described L (Love), H (Hate),

and K (Knowledge) and their counterparts -L, -H, -K, in order to bring together cognition and emotion and to determine the patterns of relationships between infant and parent connected to growth and psychic equilibrium.

In this relationship Bion includes another aspect: the mother's reverie, which complements the infant's projective phantasies. Reverie is a specific function of the mother which allows her to feel the infant in her, and to give shape and words to the infant's experience. This, according to Bion, is possible since the mother is influenced by the infant's preverbal material (that is, she is influenced by his projective identifications) and produces her own thoughts and reveries, in which this given material is processed in her own particular way (Bion 1959, 1962).

The clinical value of the container-contained and the reverie concepts is underlined by another analyst, Ogden. His conceptualizations could be seen as a contribution to the better understanding of the transference-countertransference interaction. According to Ogden, during a session, "the analyst's psychological life in the consulting room with the patient takes the form of reverie, concerning the ordinary, everyday details of his own life…which are not simply reflections of inattentiveness, narcissistic self-involvement, and the like…rather it represents symbolic and protosymbolic (sensation-based) forms given to the inarticulate (and often not yet felt) experience of the analysand..." (1994, p. 82).

This psychological activity is often viewed as a disturbing experience to the analyst, who then tries to deny or overcome it, that is to say, to be emotionally present with the patient. Ogden not only acknowledged reverie but he embodied it in his analysis of the transference-countertransference phenomena. Moreover, he proposed a new conceptualization of the analytic process by his notion of the "analytic third." He writes: "The analytic third, this third subjectivity...is a product of a unique dialectic generated by/between the separate subjectivities of an analyst and analysand within the analytic setting" (1994, p. 64).

In this respect, reverie is a unique experience of the therapist and is connected with countertransference. The elucidation and the in-depth analysis of these experiences will allow, progressively during

the therapy, reverie to become a useful therapeutic function along with understanding and interpretation. In conceptualizing reveries, Ogden (1997) stressed that they are derived from the "interplay of the unconscious life of the analysand and that of the analyst" (p. 593) and that the creation of reveries is partly "an unconscious intersubjective construction" (p. 569).

The analysis of preverbal experience is a prerequisite for an analyst who is sensitive to non-verbal communication and countertransference and who simultaneously endeavors to put into words and describe non-verbally expressed anxieties. The analyst might take into consideration that he must become the container of the non-verbally expressed anxieties and subsequently must then understand them with empathy as the patient has the need to project these anxieties and the unbearable aspects of his personality, because he himself is unable to endure them or expects someone else to understand what he has experienced. In this process, moreover, containment and interpretation co-exist and are viewed in an overall analytic relationship. It is evident that a successful process will be formed when the therapist discovers the specific method of function for his patient: when to speak, when to interpret, and when to be silent.

CLINICAL VIGNETTES

To clarify these theoretical points I will present some clinical fragments from two analytic therapies.

The first case refers to a patient whose major difficulties were centered on sadomasochistic enactments in her close relationships. During the third year of her analysis, Ms. X started to feel that my interventions and the insight she was achieving during the session caused her pain. Subsequently, I also realized that I was being very cautious so that reenactments of her traumas would not be reported in the process of the analysis. I supposed that at this time period, in which the process of understanding within the analytic relationship had stopped, the key link was -K.

In a Friday session Ms. X appeared uninterested and detached; she remained silent for a long time. I noticed that the position of her

body was different from other times. Her hands were placed in such a way that her face was hidden from my view. She sat much deeper in the couch and her stance revealed that she was distant. Although the overall picture depicted a state of calmness, it became apparent to me that she was trying to hide something of herself. Later, when Ms. X was still silent, I began to have a reverie. An incident came to mind which had affected me negatively, one that had happened with a colleague of mine at a seminar two or three days before. I had felt annoyed with her for the way in which she had spoken about one of her patients. I also recalled the anger I had felt as well as my derogatory thoughts. This, in turn, brought to mind a similar incident many years ago with another colleague. These recollections startled me and I wondered why they had surfaced now. I could not even understand whether this had something to do with my patient.

As Ms. X spoke, I concentrated again on her associations. She made reference to another woman at work whom Ms. X disliked intensely and felt that the other woman shared the same feeling. Ms. X complained about the unethical way her colleague worked. I realized that this woman was being presented as a totally bad person. Then, she said, the thought that this woman may be a patient of mine had crossed her mind and made her furious. The anger was directed toward both her fellow worker and me. Her associations were accompanied, for the first time during this period of detachment and stalemate, by emotions of anger and disappointment and created an uneasy atmosphere. Consequently, Ms. X had mentioned that this thought now seemed to her as paranoid and she could not understand what had caused her to think of such a thing. She asked me to help her to find the meaning of these feelings. Ms. X then relaxed. Her posture changed and she became thoughtful. My mind, too, became clearer and the session proceeded on the issue of her anger.

Following Bion's formulations, we could see this communication as a mixture of links in -K and in H, and then a K link is present again.

Focus now on my reverie. I observed that in this theme, twice there was a figure to which my anger was directed. It was an unexpected entrance into my consciousness of a theme of my own personal life, that is, "a bad object": the negative feelings toward my colleagues, the feelings of annoyance connected with these thoughts,

and finally the effort to accept and tolerate these feelings. But if the reverie was an independent quality of the container, then we have to consider container and contained as a linear process and not as a complex communication, which was Bion's intention. Analyzing the reverie of mother—or therapist—the influences from the infant—or the patient—should also be included. Moreover, the container-contained relationship stresses the reciprocity axiom; reverie is both the product of the mother—or therapist—and of the infant. Following these theoretical notes, we have to broaden the analysis of the clinical instance: the patient, Ms. X, could not bear to contain the bad object (of her childhood) in her mind and to elaborate and transform her bad feelings. Perhaps this was due to her incapacity to function as a container of them. She tried to escape from the pain by hiding herself. The therapist had these reveries as a resonance of her inner struggle with these emotions. He was now the person who contains and who suffers (annoyance, wondering); he was the container of her projections. At the same time, an elaboration of these projections in his psyche, in his internal object relations, was happening. When Ms. X started to speak—not only after her silence, but also after her therapist's silence which was filled with his angry feelings—she gave the verbal form of the persecutory anxieties attributable to a very close person. All the intensity of her feelings and the psychic pain were contained in the first instance in the context of non-verbal communication; then they were contained in the verbal communication.

I would like to add, following Bion's and Ogden's ideas, that not only was a complex communication revealed at the session, but, beyond that, a transition of the patient's experiences, through the reverie of the therapist, had happened. This fact makes the contained more tolerable and enables the persecutory anxieties and the anger to be discussed, as the last part of the session showed. She came back to the process of thinking because her anxieties and feelings were contained in the therapeutic dyad.

The second case is Ms. L, a patient who came to therapy one year after her father's death, when she felt that she was at a deadlock with all her relationships. A decade ago she had had her first analysis, which she interrupted after three years. Regarding this experience, she had

declared that "the analysis and my therapist had provided me with absolutely nothing." She could not remember anything from her treatment, and if she were to meet her therapist again she would not even recognize her.

In the course of therapy it became apparent that a central issue was the effort of Ms. L to become relieved from her excessive and prolonged mourning, and more precisely, from her internal dead object. I made the conjecture that, using projective identifications, she was led to relationships characterized by feelings of misery, dissatisfaction, and "death" on both sides. This was understood as the repetition of her past. For several reasons, which gradually appeared in her associations, her parents decathected from little L, and an unresolved "dead mother complex" was formed. We owe the description of this complex to André Green (1990). According to him, the basic characteristics in this case are, first, that it takes place *in* the presence of the object which is itself absorbed by a bereavement, and second, the loss in this case is the "loss of meaning."

During the first year of her present analytic therapy, a similar situation appeared in the therapeutic relationship. The aim of the projective identifications of Ms. L—who at the time was filled with despair, depression, and thoughts of suicide—was that the therapist should contain the dead object and despair. This had been manifested in a session when I realized, for no reason, that I was in an unpleasant and tense state of mind. Feeling sad, I was unable to find any words to help her; my mind went blank. Then, I questioned the possibility of changing the therapeutic setting to that of a supportive technique or to that of giving her medication, since she herself had asked for it. While I was thinking about this, I went into a reverie about my own children. I was trying to imagine what they would ask of me when I returned home. Then I was brought back to my patient and I thought that "a good parent should be a good therapist." I was not sure if this thought was mine or whether I had heard it. Then I felt better and more secure. I once more was able to discuss the origins of her emotions and her difficulties in her relationships. The session continued in a smoother manner, although Ms. L kept complaining about her life's miseries. Leaving my office, I tried to understand why I "escaped" from my patient by thinking about the alteration of the setting and by

sinking into a reverie about my own family. Because this session was distressing for me, I could not reach a conclusion; but I wondered whether my reverie was related to Ms. L's pressure to contain her and care for her as an infant.

Coming to the next session, she immediately said that after our previous session, "her burden had diminished, since she was able to speak and was released," because perhaps she "felt free and could communicate with her therapist, without theories interfering." Later on, she referred to a dream in which *she was in her therapy hour, the climate had taken an erotic turn, and the therapist had told her that there was a reason for terminating it; and she had said, "that is why I was sad." Then the therapist stood up and disappeared, jumping out of the window. Feeling terrified, she ran to see what had happened and saw that her therapist had gotten up and was fine, having sustained only a few cuts on his face.*

This dream represented many different levels of the transference-countertransference interaction. In brief, my understanding is as follows: initially there is a good (erotic) relationship with the object, which finally withdraws and is transformed into a dead object; thereafter, she pursues bringing it back into her life. With regard to the whole situation, due to identification with the internal dead object, Ms. L was led to think of committing suicide or to have a deep feeling of "death." Also, my inability to find the words and my thoughts of changing the setting were in part due to my identification with the projected-into-me dead object. At the same time it was an opportunity for her to have these projections elaborated so as to make the psychic pain more tolerable and to ensure a reparation process. I hypothesize that my capacity for reverie, in parallel with the avoidance of acting in any way, permitted an elaboration of the patient's painful feelings; but in the form of painful feelings I myself felt not unlike a "sojourn" (Bion 1967, p. 92).

CONCLUSION

Grotstein (1981), discussing the nature of projective identification, clarified that reverie refers to (maternal) receptivity, including the mother's mental activity when the infant normally projects into her.

In a footnote he adds: "In psychoanalytic practice, the analyst uses a reverie, corresponding to Bion's maternal reverie, which allows for the *entrance* of the projective identifications as countertransference or as projective counter-identifications, which can then be prismatically sorted out and lent themselves to effective understanding and ultimately to interpretations." According to this statement, therapists should allow the entrance of the projections of their patients into their mind. Reverie is an indicator of their receptivity. It is also a function of the therapist's mind to elaborate, give shape and meaning, and finally communicate verbally something that patients are not yet able to transform into thoughts, or deny it as being painful. Disavowed parts of the personality could find a way to be understood and better contained. [1]

This might be a new direction, a risk of the psychoanalytic technique which could be successful or not, but one which at least should permit therapists to encompass their whole personality for the benefit of their patients.

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[1] The difficulties lie in clearly describing and analyzing what intersubjective unconscious communication is and how it occurs. Bion (1962) uses maternal reveries as a metaphor because he perceives them as an indication that there are links with the child. At the clinical level, Grinberg (1990) suggests a transformation in the analyst's personality, a state of convergence with the anxieties and emotions experienced by the patient. Analysts' reveries should emerge as a "response to unconscious communication from the patient" (Jacobs 1993). It is true that the above author avoids using the Bionian terminology, such as reverie; he prefers to refer to the "subjective experiences of the analyst" and to his "unconnected memories" as a reflection of both the patient's communications and influences and the analyst's capacity to empathize with the psychic pain of the analysand.

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AN INTERSUBJECTIVE APPROACH TO ENTITLEMENT *

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Entitlement is an emotionally based but not necessarily pathological mode of experiencing psychic reality, one which belongs to both analyst and patient participating in the intersubjective matrix. I use myself as an example of an analyst who initially believed he was constructively analyzing treatment-resistant entitlements. The course of the work involved identifying expressions of entitlement in myself, as well as in the patient or supervisee. I came to understand that distinctions such as normal or pathological, entitled or counterentitled, often become irrelevant. The focus of the work shifts toward uncovering the bidirectionality of entitlement experiences, revealing the varying elements of entitlement and discovering how they function in the therapeutic relationship.

In this paper, I will consider a particular emotional aspect of the analytic experience: the sense of entitlement or the feeling of being special. I conceive of entitlement as an irrational but not necessarily pathological mode of experiencing psychic reality, one which belongs to both analyst and patient participating in the intersubjective matrix (Billow 1997, 1998, 1999).

Analysts often label insistent and demanding patients as "entitled." It may seem to be a curious imaginative stretch to place the

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empathically inclined, dedicated psychoanalyst in the clinical domain of such characters as Shakespeare's villainous Richard III, whom Freud (1916) considered as the embodiment of malignant entitlement. I contend that patients frequently make this association, experiencing their analysts as grasping for power, insisting on their way, and likening to seek revenge when thwarted.

This assessment of the analyst's motivations may press upon the patient's awareness precisely when the analyst approaches the patient's perceived entitlements. It is a given that the analyst and patient each have a view of what constitutes legitimate—or illegitimate—entitlements. But neither view is necessarily invalid, or even transference dominated. Thus, the patient's reaction, while having a defensive aspect, also may be a thoughtful criticism of the analyst's technical as well as personal contributions to the interaction.

This understanding differs from traditional conceptualizations about pathological entitlement, which emphasize narcissistic relational configurations of the patient, while neglecting the therapist's dynamics and contribution to the interaction (as in Coen 1988; Freud 1916; Grey 1987; Jacobson 1959; Kris 1976; Ladan 1992, 1995; Levin 1970; Michels 1988; Morrison 1986; Murray 1964; Rothstein 1977; Volkan and Rodgers 1988). The basic premise of the intersubjective approach is that psychoanalytic data are mutually generated, co-determined by the organizing activities of both participants in the reciprocally interacting subjective worlds of patient and analyst (Stolorow 1997). Hence it is important to consider contributory subjective factors of the analyst, such as authoritarian and regressive tendencies, the bias of the analyst's diagnostic and technical orientation, as well as of countertransference, on what is perceived to be pathological entitlement, and the analyst's level of tolerance for perceived entitled behaviors in others.

Freud (1916) himself implied a symmetry between patient and analyst when he candidly acknowledged the universality of entitled beliefs: "We all demand reparation for early wounds to our narcissism, our self-love" (p. 315). Thus, in this essay on the "exceptions," Freud briefly considered the analyst's entitlement, a particular aspect of what is usually referred to as countertransference. I

also wish to illustrate how in some instances there can be a conflict between analyst's and patient's values concerning entitlement, quite apart from transference and countertransference per se. What one individual may consider special, such as the analyst's wish to analyze or the patient's wish to be accommodated, may feel antagonistic to the other's sense of security and well-being. Clarifying the difference in values may sometimes relieve impasses and stalemates in treatment.

Whereas at one time entitlement was considered primarily as a manifestation of a pathological insistence on being an "exception" to reality (e.g., Freud 1916; Jacobson 1959), contemporary psychoanalysts have recognized that the sense of entitlement represents a basic human need to feel loved and to be affirmed as special (Dorn 1988; Kriegman 1988). Maintenance of self-affirmation and a feeling of healthy entitlement is enhanced when one feels the empathic receptivity of others. However, when one feels thwarted in having basic empathic needs met, pathological attitudes of excessive as well as restricted entitlement may arise, interfering with healthy strivings (Levin 1970). Such exaggerations and inhibitions of entitlement exist or develop in the psychoanalytic situation, and the analyst as well as the patient are vulnerable to exhibiting variants of these unrealistic attitudes and inappropriate behaviors.

THE ANALYST'S VULNERABILITY TO IRRATIONAL ENTITLEMENT

Many aspects of the analytic relationship suggest the analyst's vulnerability to irrational entitlement. Traditionally, he or she is the special one with exceptional power and moral authority (see, for example, entire issue of *Psychoanalytic Quarterly*, 1966, 65, No. 1). As Michels (1988) has emphasized, the asymmetric nature of the therapeutic situation tends to promulgate the analyst's "rights" over the patient's: "Both metaphorically and actually the therapist sits in the most comfortable seat, controls the time and place of meeting, receives payment, and is protected from discomfort" (p. 55).

Michels takes for granted that the analyst sits in the seat of the expert and is legitimately entitled to protection from discomfort. Many theorists disagree, of course, and even suggest the opposite (Billow, in press). The analyst's view of reality, like the patient's, is affected by "irrational emotional involvement," anxiety and discomforting ignorance, all of which may contribute to as well as interfere with a successful psychoanalysis (Renik 1996, p. 392; also Bird 1972; Boesky 1990; Racker 1968; Renik 1995; Searles 1965; Skolnikoff 1996). Bion (1973) advised that "in every consulting room there ought to be two rather frightened people: the patient and the psychoanalyst. If there are not, one wonders why they are bothering to find out what everyone knows" (p. 13).

At times, the analyst may be unwilling or unable to tolerate not being "special," feeling his or her expertise rejected or ineffective. An anxiety situation may evolve in which the analyst's primary experience is of the patient malignantly not caring about or understanding his or her therapeutic ministrations, and perversely blocking the analyst's efforts to love and to be loved. This was indeed the situation which Freud (1916) described. The "exception" was the individual unresponsive to the analyst's insights, "one of the components of love" (p. 312).

Freud did not consider that the analyst, feeling unjustly deprived of love and narcissistically wounded, may respond to the patient's perceived entitlements by evasively drawing upon entitled attitudes of his or her own. Instead of mentally processing subjective pain and anxious confusion, the analyst may resort to rigid thinking and illusion, transforming the analysand's thoughts and feelings into fixated ideas of transference, defense, or resistance.

In this situation, theory and technique have a strong component of hallucination (Grossman 1995). The psychoanalyst's technical theory regarding the treatment of entitlement may come to represent an illusory path to omnipotent Truth. When "truth" itself becomes "special," employed "with a big T...this gets people into a frame of mind in which they become unable to think" (Russell 1927, p. 265, as quoted by Schwaber 1996, p. 10).

Thus, psychoanalytic ideas, put into therapeutic action, may po-

tentiate a patient's rebellious entitlements, since the patient may feel—quite correctly—misunderstood and uncared for. The literature on entitlement has not adequately appreciated how the analyst, believing to be properly utilizing theory and technique, may behave like the "exception," and thus contributes to the often-reported escalating dramas and negative therapeutic reactions characterizing treatment.

The patient experienced as pathologically entitled may make the analyst particularly vulnerable to not thinking, and hence, to counterentitlement. Coen (1988) characterized entitled individuals as using sadistic demandingness and projective identification to promote sadomasochistic bonding. They "mandate" empathy, experiencing the therapist as a selfobject who must be omnipotently coerced to give, rather than one who gives out of genuine love and caring (Shabad 1993b). Ladan (1992) described the entitled analysand's inveigling the analyst to indulge the patient's secret fantasy of doing something else and not being in analysis. Eigen (1995) reported a case in which the patient's possessive demandingness had as its goal forbidding the analyst from having "his own mind or history or unconscious" (p. 37).

Attempts to control the other's mind, and to resist or counter such control, may be, then, important aspects of an interaction involving entitlement. One of Richard III's joyous triumphs was his success in seducing Anne's mind, and not Anne herself, whom he promptly discarded. An unfortunate fate of seduction and abandonment may await the analyst whose mind is overwhelmed by the patient's irrational entitlements, or by one's own.

In each of the following case examples, I attempted to analyze what I experienced as the patient's (or supervisee's) excessive or inhibited attitudes of entitlement. I also volunteered and encouraged an analysis of my own entitlements, positive and negative, excessive and inhibited, as I came to understand their possible roles in the interaction. I tried not to assume a position of superior knowledge and judgment, or to assume that my perceptions were necessarily correct, or more correct, than the patient's. In each situation, I found the interaction to throw a fresh and unexpected light on the psychoanalytic experience.

CASE 1: EXPLORING RIGHTEOUS INDIGNATION

"I can't work now," one individual regularly reported during our first months of psychoanalytic therapy. "I'm so angry I need to ventilate." He would fume silently, becoming quite flushed, sullenly not complying with my encouragements to speak. Soon I no longer needed, or wanted to encourage him. He occupied many sessions angrily denouncing his customers, supervisors, and fiancée, all of whom treated him unjustly. My precursory efforts at exploring feelings, transference, character, or genetic patterns were impatiently and rather harshly rebuffed. My attempts to bring attention to his responses only seemed to aggravate him.

When what I perceived to be righteous indignation emerged, I most often adopted a respectful, interested silence. However, this stance felt seductive, manipulative, and inauthentic to me, given my own quickly mounting feelings of indignation. I experienced him enslaving me in his narcissistic fantasy (Kohut 1971, p. 275; see also Kernberg 1975, p. 298), inhibiting my healthy entitlements to think, feel, and respond as I wished. I rationalized my inactivity as empathic accommodation, respecting his fragile ego defenses, in the service of building a positive alliance in which he would feel cared for and understood. But I wondered whether my concern was for my own faltering ego defenses, rather than his (Billow and Mendelsohn 1990), my fear of betraying my ambivalent feelings, and my wish to end a session in which I felt particularly ineffective and helpless.

I often felt tempted to identify and explore his unquestioned right to explosive anger, and occasionally ventured to ask why talking calmly and trying to understand his anger did not supply adequate ventilation. Unfailingly this provoked indignation, a disgusted sigh, and a comment such as "I can't understand why you would say that! You're supposed to be a sympathetic professional!"

Gedo (1977) has described how the therapist, in responding to "infantile claims" of patients, by necessity must maintain "maximal tact and empathy...any failure in this regard is inevitably followed by humiliation and outrage" (p. 792). This patient's claim, I decided, was for me to understand and accept his view of reality, his emotions,

his use of me.

Blechner (1987) has characterized two contemporary views of treating entitlement: the "frustration" and the "gratifying." I prefer the terms "interpretative" and "accommodative." The first, originally promulgated by Freud (1916), emphasizes maintaining traditional psychoanalytic boundaries and recommends analyzing dynamic, genetic roots of entitlement (e.g., Coen 1988; Jacobson 1959; Ladan 1992, 1995; Shabad 1993a). Michels (1988) advises not "to placate or mollify the patient by gratifications that grow out of a desire to dilute the patient's resentment and disappointment or bribe him into pseudo compliance...the therapist must be sensitized to the patient's response to it, accepting and tolerating anger or dissatisfaction and interpreting resistances to expressing, or even experiencing, the frustrations of the treatment" (p. 56).

Winnicott and Kohut, in contrast, view entitlement as expressions of need, and attempt to adapt the environment so that the underlying desire, aim, and object may be discovered and experienced. Analysts influenced by their theories have stressed the importance, and often the inevitability, of living through a lengthy period in which the therapist provides a holding environment before the patient is ready to tolerate interpretative activity (Bromberg 1983; Gedo 1977; Stark 1994). The analyst, so as not to iatrogenically encourage the patient to "forfeit" a trust-building stage of healthy entitlement, must distinguish a period of "normal and necessary omnipotence (specialness, uniqueness) from pathological omnipotence" (Grotstein 1995, p. 6). At times, manifest wishes are therapeutically gratified without analysis.

The patient implicitly adhered to the gratification theory of therapy in which he considered ventilation and automatic confirmation to be a right, and also, a method of cure. He found me to be unsympathetic in even introducing the frustration-interpretation theory.

I was disheartened by his disappointment in me. He had named a truth about my entitlement, while I was trying to name his. I was *supposed* to be a sympathetic professional, but other feelings predominated, including my perhaps irrationally based wish to follow my theory of cure rather than his. I felt guilty for not behaving more sympatheti-

cally, in addition to feeling guilty for not helping him get a better understanding and control of himself, even though these were not his goals.

Chastised, but still not willing to renounce my right to maintain a frustration-interpretation technique of entitlement, I took the opportunity to extend the discussion to include his implication regarding my deficient capacity to love and understand him. I acknowledged that, as he had discovered, I was not that sympathetic a professional. Judging from his tone, I continued, he seemed to be morally offended by me, and I could understand why he would feel superior and indignant.

I braced myself for his disapproval, which I received, but something in his tone seemed markedly different. It was softer, and I detected a gleam of new interest in me and curiosity about what I had to say. "What do you mean, I feel superior?" He said he had never considered himself as superior. He acknowledged that he became angry when anyone would be insensitive and inconsiderate, as I sometimes was, but he never considered himself above or better than anyone else. Again, his tone as much as his words, implicated my failure in moral and professional judgment: "I can't understand why you would say this about me."

Feeling emboldened, I continued the dialogue: "You may not be aware, but you are sounding superior right now. You say that you can't understand, but I believe you are saying that I don't understand, and that I should." He looked flabbergasted, but he did not explode. In fact, his anger turned into the first warm smile of our relationship. This he countered by shaking his head, as if to say I had done it again with my latest unsympathetic intervention.

All in all, the interaction seemed a success. I believe my acknowledgment of the validity of his indignant feelings, of his "right" to be entitled as a response to my perceived entitlement, relieved a pressure to retaliate by excluding all other thought and behavior. Thus, I somehow succeeded in helping him establish some distance from what I diagnosed as his thought-controlling, "super[ior] ego" (Bion 1977). A mental space now existed in which he could tolerate the frustration of considering the reality of someone else's ideas, my ideas of me, my ideas of him, my ideas of what constituted a thoughtful analytic inter-

change. Mixed with his anger was what I took to be gratitude for my active interest and persistence.

In now perceiving that he cared for me and what I had to say, I felt more confident that I could care for him, and for the first time, I felt truly sympathetic. I found blessed relief from my own guilty feelings of superiority. As we have continued our work, I have found it easier to accommodate his indignant mode of processing frustrating experience, while he more easily accommodates my lack of sympathy, i.e., my pressure to identify, discuss, and interpret his righteous indignation. Thus we mutually recognize certain entitled elements in each other's subjectivity.

I suggest that our interaction illustrates the existence of entitlement "thresholds," a reflection of personal limitation in capacity or willingness to function in a relatively relaxed and creative manner when confronted by perceived entitlement from another. Individuals feel entitled to their entitlement, but often do not extend the same privilege to others. Thus, a patient may respond to the analyst's inquiry with indignation and recrimination, and further, may attempt to make the analyst feel malignantly entitled when he or she attempts to analyze entitlement. As in this example, the patient does not merely project and provoke, but may quite accurately identify irrational, even pathological entitlement in the analyst's personality and use of theory and technique. And as others do, the analyst may reach a personal threshold, a limited toleration for such exploration, and may contribute to the irrational entitlement in the consultation room while attempting to analyze it.

Certain claims of entitlement may lower the analyst's threshold, such that his or her own retaliatory counterentitlements are more obviously brought into play. The analyst needs to be aware of characteristic responses to pressure to "do something that he feels he should not, or ought not, or doesn't want to do" (Blechner 1987, p. 249). To avoid his or her own experience of impotency and submissiveness in the face of a patient's aggressivity, the analyst may collude, circumventing reality and creating an illusion of peaceful coexistence (Ladan 1992). Not analyzing entitlement may be a narcissistic defense rather than a necessary technique, indicating the analyst's irrational entitlement. On the other end of the accommodation-interpretation con-

tinuum, an analyst may precipitously intrude upon a patient's psychic readiness, demonstrating an entitled disregard of the intersubjective reality.

CASES 2 AND 3: WORKING WITH MANIFESTATIONS OF INHIBITED ENTITLEMENT

In a situation of restrictive or inhibited entitlement (Levin 1970), the individual feels "not entitled" to a feeling or an attribute of specialness which is believed to exist within someone else, and which may be feared as well as envied (Bacon 1995). The individual feels without rights, or powerless to assert rights, in a world of powerful others, and may exhibit self-effacement, social withdrawal, and masochistic mental activity, fantasy, and behavior. In the following case anecdotes, the individuals felt restricted in their rights, particularly when comparing themselves to me and my rights. They attributed certain entitled psychologies to me and treated them as my inalienable "personal possessions." In the first example, it is "feeling like a real analyst"; in the second, it is a "critical attitude." I attempted to focus on the rigid fantasy constructions by taking a previously unexplored look at what my psychology and clinical presence were possibly contributing to the other participants' persistent beliefs in my specialness and their lack of specialness.

Case 2

My patient, an advanced analytic candidate at our Institute, expressed difficulty in setting fees adequate to his level of considerable experience. "I guess I'm not ready to accept a regular fee; I'm not a regular analyst, a real analyst. I don't have it yet."

"What's 'it'?" I asked.

"I don't know, a certificate of authority. Am I certifiable?"

Was he saying, I asked, that one has to be crazy (certifiable) to be a real analyst, and had he anyone particular in mind?

"Not you—you're a real analyst and you're not crazy. You can relax and rest on your laurels."

"What laurels?" I inquired.

"You know, your age, accomplishments," and then, with hesitation, "thinking you deserve it all, thinking you are a big, hot shit. I don't think you think of yourself that way—maybe I do. I do. I don't think I would want to be in treatment with somebody unless I thought he was a big, hot shit."

I said, "But maybe I do think of myself that way, too, and what is worse, that I haven't been aware that I do." I asked him to expound on his assertion regarding my possible overblown view of myself.

He said it was not healthy to think you are "something"; that was being delusional. His father, in a related professional field, "always acted like the certified professional, even with us kids." Apparently, the patient needed to see me as professionally important, but was afraid of the consequences to our relationship if I also saw myself as important.

I agreed that if one acted only as a professional, as in being a professional analyst, and not also being a person, one would be delusional indeed. I suggested that he did not seem to be sure whether I acted like a person or was a person. He conceded that maybe he did wonder whether the spontaneous, human qualities he saw in me were simply techniques mastered in analytic training, "like in a course, 'Basic Techniques in Realness.'"

I asked what gave him the impression that I might be adopting a role. He said he was touched that I permitted him to question my behavior. I replied that I could not stop him from doing so. Then he realized: "I've stopped me from questioning your behavior, or from admitting to me that I do it all the time. In fact, that's probably all I do!" He then continued with associations linking me to his father. He spoke of his fear of his anger toward his father, his father's possible envy of him, oedipal rivalry ("having it all" included mother), his desire to be like his father, and his desire not to be like his father.

This all made sense, of course, but in a rather intellectualized way. I felt that we needed to get back to his belief that my sincerity camouflaged an underlying grandiose self-involvement. At a moment which I took to be opportune, I interrupted him and asked: "Who are

you associating to, a big, hot shit, delusional analyst?"

He smiled broadly, through tears. "This is like before, when you asked me why I thought you might be role-playing. I can't believe that you are really interested in my opinions, and that you respect them, particularly if they're about you, no, about anything. I'm always waiting for the subtle put-down that never comes. It makes me nervous, like I can't trust you. With my father, I could count on feeling bad. It's kind of a secure feeling."

We made much analytic mileage analyzing the transferences described here. But his experience also reflected realistic and quite important dimensions of our relationship. Regarding my contribution: in the little analytic pond of our Institute, I am "special," entitled by status, authority, even age. Moreover, in our Institute's corridors, I do maintain the role of "the analyst," and would feel uncomfortable to relinquish it. Regarding his contribution: he would be naive not to expect put-downs from his teachers, I being one of them. Worse yet would be his situation with faculty and peers should he relinquish his "real person-hood" acolyte status. With some humor and irony, we acknowledged the legitimacy of his perceptions of my entitlement and his nonentitlement. The discussions have released us from our rigid positions on the entitlement-nonentitlement continuum, as we move toward a mutuality and equality in our relationship.

Case 3

In a second case example of manifest inhibited entitlement, an analytic candidate, under my supervision, tended to swallow her control case's stream of complaints and dissatisfactions. The patient was free-associating, the therapist reasoned, and therefore her spontaneity should not be challenged. Further, since there were grains of truth in everything the patient said about her, the novice analyst felt she would be hypocritical to criticize the patient's criticisms.

The candidate volunteered that she had a mother who felt it was her privilege to criticize her daughter, since it was for her own good. I asked her to consider whether being critical was a privilege, and to consider how her mother and her patient possessed a privilege but

she did not. I then inquired whether such a privilege existed in the supervisory relationship. It did. Criticism in supervision, as in her relationship to her mother and to her patient, was a one-way street. I teased her a bit. Could she not challenge me since, I presumed, I did not spend our time spontaneously free-associating? She replied with humorous recognition, "True, but you're supposed to criticize me, it's part of your job. Okay, I get it, I'm a hypocrite after all! I don't want the power to criticize. I don't like doing it, but I guess I like getting it."

I said that I didn't like her privilege very much, my having to criticize her. She replied, "Don't worry, I criticize me for you, so you don't have to do it." I said I was still worried, because no matter which of us played out "critical me," I would not get a chance to be anything else. I reminded her of the old saw of who controls whom, the sadist or the masochist? The enactment of her restricted entitlement, left undiscussed, threatened to overpower and control me. I suggested that her patient, like me, might not like feeling special all the time, and might feel burdened and alone in being the sole critical one, and that the patient might find relief in addressing this unbalanced aspect of the interaction.

In these examples, I did not, and could not, renounce my right to be special, which included a right to be an authority or to be critical. The goal was not to "cure" or "banish" all expressions of forthright and restricted entitlement, but to transform what was being mutually enacted and defended against into emotional ideas—some realistic, some not—which could be thought about and developed in the intersubjective context.

CASE 4: SEGMENT OF AN ANALYSIS

After a long period of the patient's distrust, a productive relationship ensued with a woman with a history of maternal deprivation. Although capable of doing psychoanalytic work, she developed a predilection for bringing to her hours physical possessions, such as photographs and mementos, to "share" her life. She brought in food, such as two

pieces of cake, to celebrate her birthday or the occasion of an anniversary of treatment. She paid the most cursory attention to any interventions I made around such behaviors, such that I realized that despite my efforts, these were incidents of accommodation and gratification.

When I suggested that she consider sharing her life without bringing in "the evidence," she compromised on "picture sessions." In these hours, or segments of therapy hours, she detailed her trips, children's projects, new interests, progress in sports activities, and so forth. I soon realized that she was following the letter but not the spirit of my mild injunction. I brought this to her attention, and she agreed, unenthusiastically offering one of my own, uninspired formulations, i.e., "I guess I want you to care for me the way my mother didn't."

I concluded, from her habit of parroting my interpretations, that she had decided that I needed to be considered special in the "analytic" way that I periodically insisted upon. I was extracting attention and taking it away from her. She was going to have to put up with my tedious need to discuss the meaning of her behavior, our relationship, and so forth, before I would be able to return to her caretaking. The patient seemed to confirm Bromberg's (1983) observation that certain individuals found interpretations to be empathic disruptions and processed them as a sign of the analyst's narcissism.

We had, then, each been experiencing the other as excessively entitled, and had responded with an unacknowledged, characteristic interactional mode: I confronted and interpreted her entitlements, while she accommodated mine. When I tentatively offered this opinion, she interrupted, beginning to cry. With a newly found freedom of expression, she turned her eyes to the ceiling of my consultation room and asked rhetorically of it: "Yes! Why do we always have to analyze?"

I had no difficulty considering her complaint regarding my timing and pacing, and I felt willing to discuss with her how to modify my technique. But she did not want to talk further about the situation between us. She had transformed herself into a picture of "relentless woundedness," to paraphrase Stark (1994) who described a character type of "relentless entitlement." She was a sensuous image of hurt and distress. Again, those pictures! I thought. I felt clumsy and

guilty for imposing my subjectivity (Aron 1991) over her developmental need. I made a tacit agreement with myself not to always analyze.

It was an agreement I apparently could not keep, for I found myself asking in a subsequent session, what did she want to do if not analyze? I had stumbled on the right question, for she put into words what much of her behaviors were about. She wanted me to look at her and to treat her and everything she did as special. We then came to understand how her demandingness camouflaged her underlying sense of inferiority. She felt that I could not really care for her but, rather than ignore her felt need, she attempted to control me by acting hurt and arousing my guilty compliance. I asked her whether it was merely an act, or whether she found it genuinely hurtful when I pressured her to have analysis the way I wanted, rather than the way she wanted.

My willingness to acknowledge my own entitled demandingness released a flood of memories concerning her willful mother's bossy and entitled behaviors, and her own desperate need to acquiesce to them. These sessions were often painful to her. But she also evidenced much pleasure, describing the analysis as a "haven" wherein she truly felt special, cared for, and understood. I did not challenge, interpret, or disrupt these emerging pleasurable feelings. I assumed that the patient was basking transferentially in what Bromberg (1983, p. 459) has described as a curative period of undisrupted "core fantasy of entitlement." I believed that I was providing an environment in which she could build, or rebuild a stage of hallucinatory, idealized, symbiotic objects.

I did not comprehend a quality of her pleasure until, after a year in this phase of our work, she confessed that even in the sessions in which she did intense grieving, she often became sexually aroused by being in my presence and hearing the sound of my words. She admitted that in several sessions she purposely brought herself to orgasm. I realized that she had been sexualizing our sessions, taking in my words as phallic objects to be enjoyed. The pictures, once again! Words functioned on the level of sexual hallucination.

I wondered aloud: "Are we having sex now?"—acknowledging to both of us my sincere confusion. She sheepishly replied that we were

not, and asked if I were angry with her. I replied quite honestly that I was too surprised to be angry, and that I was trying to understand the situation between us.

I thought of her plaint, "Why do we always have to analyze?" Perhaps the woman was speaking for every patient's hatred of analytic entitlement. The patient wants to be a special person, and not simply a patient. The analyst wants to be an analyst, and not simply a special person. Even now, I wanted to control and construct the relationship in my way, putting experience into words, clarifying, interpreting, all of which called attention to me and my understanding of the patient's clinical reality. In her hallucinatory sexuality, she could construct the relationship in her way, and could both retaliate against and enjoy my control.

I have described two approaches to the treatment of entitlement, between which there is some tension. To simplify, one difference between the technical approaches is not *whether* or not to analyze, but *when*. The accommodative and interpretive techniques converge on the belief that when the underlying dynamics come to be clarified, the manifest claims of entitlement may lose their urgency. In practice, each clinician finds his or her own compromise between gratification and frustration, accommodation and interpretation (Blechner 1987). But on what basis is the compromise reached? How do we know when the patient is ready to move on and can tolerate the frustration of non-accommodation? There is, of course, no definitive or purely objective method of assessment. The analyst must rely on what we once called "clinical intuition," and now subsume under "subjectivity."

I had believed I was sensitively accommodating to, and perceptively analyzing, the woman's regressive entitlements. From one point of view, I was. But from another, I had been enacting a fantasy treatment, missing crucial aspects of the woman herself, and her use of me. She did not disturb my gratifying fantasy of our relationship, and I did not succeed in disturbing hers. Our interaction has demonstrated to me how little the analyst knows, or can know, about him- or herself, much less about the other person in the consultation room. It is a measure of the analyst's illusionary entitlement to believe otherwise.

CONCLUSION

The analyst's entitlement to assert professional prerogatives, such as intervening, making interpretations, or remaining silent, may be influenced by a realistic consideration of technique, by perhaps unavoidable limitations in understanding another person or oneself, and by irrational attitudes and behaviors, all of which may affect the interaction. Thus, many subjective factors within the analyst play a significant role in assessing whether a patient's perceived entitlements are appropriate or inappropriate, intractable or readily analyzable. The technical challenge involves, then, deciding how and when the analyst may "share" his or her subjectivity (Aron 1991) concerning (what the analyst experiences as) the patient's entitlement. A controversy may arise, since the patient may reveal decidedly different opinions about the types and distribution of entitlement in the consultation room. It is quite possible that the patient has formed such opinions not only on the basis of his or her representational configurations, but by a realistic, if previously unrealized or unpublicized, assessment of the analyst's own entitlements.

As so often happens in psychoanalysis, controversy breeds opportunity, for now the analyst may encourage a dialogue. The focus enlarges to include the mutual consideration of the analyst's perceived entitlements and their effects on the analytic relationship. To the extent to which the dialogue may be meaningfully sustained, the dilemma of accommodation versus interpretation is partially resolved. Entitlement becomes a topic of thoughtful conversation rather than a mode of processing experience. Both parties may begin to understand how they have been accommodating to, and reacting against, the other's perceived entitlements, as well as their own.

I have used myself as an example of an analyst who initially believed he was constructively analyzing treatment-resistant entitlements. The course of the work in each of the four cases involved identifying expressions of entitlement in myself, as well as in the patient or supervisee. I came to understand that such distinctions as normal or pathological, entitled or counterentitled, often become irrelevant. The focus of the work shifted toward uncovering the

bidirectionality of entitlement experiences, revealing the varying elements of entitlement and discovering how they function in the therapeutic relationship.

The analyst may achieve greater freedom to participate in a lively, appreciative, even humorous manner, when he or she owns personal entitlements as part of the ongoing action. This entails the analyst accepting that, like the patient, he or she needs to feel and to be treated as special, and that, when threatened, characteristic defense patterns are likely to emerge in the interaction. The patient may quite accurately perceive aspects of the analyst's psychology of entitlement, and may use and abuse such knowledge in the therapeutic relationship. At times, the positive trajectory of the work may seem to dissolve in a heated exchange of views regarding perceived entitlements. This dialogue may be expressed in a reactive vocabulary of unacknowledged entitlement: denial, protest, rationalization, indignation, recrimination, appeasement, hallucination, accommodation, even interpretation.

I have attempted to demonstrate how these different expressions of entitlement and reactions against perceived entitlement may become constructive building blocks in a working, mutually empathic relationship. I have suggested that progress is more likely to occur when the analyst acknowledges subjective and interactive aspects of entitlement as they emerge and are discovered in the ongoing clinical work. As always, when the analyst is receptive to the patient's view of reality (Gill 1994), relatively non-defensive and non-authoritarian, interpretative activity is more likely to be respected and integrated into the psychoanalytic work.

The goal is, of course, to get beyond labeling, judging, submitting, rebelling, and retaliating, to the experience of mutual recognition. Ironically, as the psychoanalytic dyad learns to confront mutually the interpersonal realities of entitlement, each participant may realize that attitudes of entitlement are universal, and that his or her entitlements are no more special than the other's.

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OBSOLETE TERMINOLOGY CONSTRICTS IMAGINATIVE THINKING

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The term "castration anxiety" is used throughout the psychoanalytic literature as an organizing concept regarding a variety of anxieties in both males and females. This paper is a proposal that the continued automatic application of the concept of "castration anxiety" for *all* of a female's anxieties about her genitals is inappropriate because it is not consistent with clinical data. Using accurate terminology is important because the conceptual language we use can significantly influence the way we think, and thereby can influence the way we listen to patients. I propose that in regard to girls and women we use "female genital anxieties" as a general term, and reserve "castration anxiety" to refer to certain specific manifestations of those anxieties.

The insights emerging from Freud's understanding of his own unconscious conflicts were for many years extended to include the psychology of the female. Actually, Freud himself invited his female colleagues to make revisions in his theories about women. Much has been written to revise the older views and to develop a description of the unique characteristics of female development that conforms to modern psychoanalytic thinking. However, the psychoanalytic lexicon has not yet confronted the problem of using "castration anxiety" as a wide net to describe a girl's anxieties.

Horney (1924) and Jones (1927) were lonely voices strongly questioning whether Freud's descriptions of boys' development was applicable to girls. Horney advised that many phenomena representing a girl's "dread of vaginal injury" should be separated from "castration fantasies in the male sense" (p. 65). However, it was fifty years before analysts responded vigorously to Freud's suggestion for revision.

Brenner (1982) included "castration anxiety" in the list of the

"typical dangers of childhood." However, he went on to say, "There is less agreement as to the role of castration anxiety in the psychic conflict of girls." He wondered whether there can be "true castration anxiety" in a girl: "Is it possible for a girl, to whom it is obvious that she is without a penis, to fear castration?" (p. 96). He pointed out that Freud thought it was not possible and that the fear of loss of love "plays the role in girls which is comparable to that of fear of castration in boys" (p. 97). Brenner thought that Freud's position was contradicted by abundant clinical experience, but he included the fear of losing a fantasied penis, not a real one, as well as "anything *symbolizing* the idea" (p. 97, italics added).

Many mainstream psychoanalysts have continued to use this widest conceptualization of castration anxiety in women—that is, including not only fears of injury to the genitals, but also fears of injury to any and all fantasied or symbolic forms of the male genital. Thinking of this kind inhibits the capacity to listen to the details of what patients say and leads to the illusion of "knowing" the meaning of their associations. Here it is relevant to question the usefulness of the term "phallic phase" in regard to the development of girls, who do not have a phallus. Parens (1990), using two decades of longitudinal direct observation of young children, concluded that "phallic phase" was not representative of the girl's first genital phase. He proposed that "we identify this period not as the *phallic* or *phallic-oedipal* phase but rather by the more general term, the *first (or infantile) genital phase*" (p. 745, italics original).

Mayer (1985) was the first to answer Brenner's question about "true castration anxiety" in a girl, stating clearly that such anxiety is experienced "over losing that genital which is actually possessed" (p. 332). She reported observations of a girl's early awareness of a potential inner space and on the basis of analyses of adult women made the unique suggestion that some women have fears about that inner space being sealed. She hypothesized that the frightening fantasy of the loss of the vulva and the "opening" was due to forbidden sexual pleasures. In considering what we are to call that anxiety, Mayer concluded, "It seems eminently sensible to rely on the time-honoured term 'castration anxiety,' bearing in mind that this castration anxiety in women is not the equivalent of the phallic castration complex as it has been

described since Freud's early expositions of female psychology" (pp. 341-342). Mayer does retain the "traditional" concept of "female castration *complex*" to refer to "the girl's fantasy of having had a penis that was lost" (p. 332). For purposes of clarity, in her 1985 paper she refers to such fantasies as "the *phallic* castration complex" (p. 332, italics original).

A major advance occurred in 1990 when Doris Bernstein made an attempt to understand the role of "female genital anxieties" in female psychic development, viewing the girl's genitals to be as important to her as the boy's genitals are to him (p. 152). She reviewed Roiphe and Galenson's 1976 studies and pointed out that "they have viewed their material from the standpoint of a 'genital equals phallic' perspective and have not addressed the issue of integrating the issue of the girl's own genitals into her body ego" (p. 152). She emphasized that the fact of girls' genitals differing from boys' in every respect has "multiple effects on psychic structure and forming mental representations that have pervasive influences on female mental functioning" (p. 153). In addition to identifying the major anxieties and using the phrase "female genital anxieties" to describe girls' characteristic genital concerns during development, she also discussed the attempts at mastery that are typically female, many of them quite different from those of boys. She added, "I do not mean to suggest that 'castration-like' anxieties do not appear in women; these refer to a host of fears and fantasies about lost, damaged or missing parts of the body. I have found these ubiquitous in the analyses of women. However, I have not found that they serve exclusively or even dominantly to describe women's genital anxieties" (p. 153).

At a symposium on "The Psychology of Women" at the New York Psychoanalytic Society, Shaw (1993) said that, "For many years, the traditional psychoanalytic viewpoint addressed female genital anxieties from a predominately phallocentric perspective….This approach failed to account for those aspects of a girl's fears of genital damage that are shaped by the nature of the genitalia that she actually has and values." She illustrated her point of view with clinical data. Her 1995 paper discussed further the inexactness in our use of the term "castration anxieties" as well as the ambiguities remaining in the use of the term "female genital anxieties."

Olesker's 1998 paper attempted to differentiate *female genital anxieties* from *castration anxieties* in females. Her attention to detailed data is just what is needed. My only disagreement is with her suggestion that the two terms be separated into two major organizing concepts. My proposal is to use *female genital anxieties* as the overall category, of which castration anxiety is one significant variety. Fears about the loss of an illusory penis is another variety, although it is relatively infrequent. All women certainly have fears and fantasies about lost, damaged, or missing parts of the body. The fact that many, if not most, little girls play at having a penis during their early development does not mean that a fantasized penis persists in most instances. Girls very frequently play at having and being many things they are not and do not possess. Privileging "castration anxiety" as having a separate developmental line can lead to theory-bound thinking about women.

My impression, and that of many other analysts, is that studies of female development have led to important and helpful rethinking about male development as well. The tendency to globalize male anxieties about injury simply as castration anxiety can inhibit learning more specifically about a particular man's fears. The attachment to our habitual ways of talking and thinking has been widely written about. Satisfying the human longing for organizing concepts can obscure the confining effect of those concepts and consequently inhibit more creative thinking. Papers in our most prestigious analytic journals continue to refer to women's castration anxiety as an all-embracing, non-specific phenomenon. I urge that analysts start using language that reflects our improved understanding of female development. We have an excellent method of treatment that should not be undermined by remaining attached to an outmoded terminology. Our journals are a major influence in the direction of change.

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BOOK REVIEWS

DIVERSITY AND DIRECTION IN PSYCHOANALYTIC TECHNIQUE. By Fred Pine. New Haven, CT/London: Yale University Press, 1998. 224 pp.

Recently a colleague[1] quipped: "Nowadays being neutral means remaining equidistant between Owen Renik and Fred Busch." If you're reading Fred Pine's *Diversity and Direction in Psychoanalytic Technique,* you may add Brenner, Kohut, and Kernberg to the list.

"Diversity in Technique" and "Diversity in Theory" (the titles of the first two chapters) are inherent in our field and in the highly individualized nature of each analyst, of each patient, and, therefore, of each analysis. It is from this highly individual standpoint, from a "personal statement," that Pine speaks to us. He brings us back to the simple but, perhaps, not often recognized idea that the reason we have a diversity of theory and technique is that our patients bring to us problems from all spheres of their psychology: drive, ego, self, and object relations. There is, therefore, a potential to do a disservice to the patient if one theory is used exclusively: "When the mind is viewed single-mindedly...failures to understand become a real danger" (p. 127).

The chapter on therapeutic action, with a focus on the interaction between interpretation and the relationship, offers a useful review of the contributions of Loewald and Gill. This leads to a careful discussion of the contemporary issue of self-disclosure and the important task of "distinguishing between work that is for the psychoanalyst and work that is for the patient." Pine's clarity of writing is exemplified as he describes one way of dealing with countertransference: "Something is happening between us here and I think I have been caught up in it and detect it in my way of working; if I can process it and put it into words we will learn something about you" (p. 77).

This serves as a preparation for the next chapter, "A Contribution to the Analysis of the Psychoanalytic Process." Taking again an historical perspective and starting with Strachey, Pine focuses on the specifics of

[1] Jeffrey Urist, Ph.D.

the moment when an interpretation is offered, with an emphasis on the relational aspects. He stresses the benignity of the analyst, not as a general factor, but "at the moment when it counts—when the patient's forbidden wishes and expectations of attack by conscience are at center stage" (p. 91). He interweaves this view with Winnicott's notion of survival and Loewald's idea of ego integration.

Pine then discusses the ego in the session. Using a developmental perspective, he stresses the importance of the assessment of the level and intactness of ego functions as a guide to the timing and form of interpretation. This allows the detection of "the patient's signaling readiness—conceptualized as an ego activity—to participate in the work in some particular area" (p. 114). He expands the discussion to the many factors that lead to the decision to interpret. He places the focus on affect. He follows Jacobson's view that painful affect (and defenses against it) are the common ground that binds theories together. Along with Busch, he does not assume that a sign of distress is a response to a drive derivative. He leaves room for "distress also in relation to repetitive object relations growing out of strain trauma from the childhood era or painful subjective states of self around deficits in parental care, or feelings of humiliation or helplessness in relation to defects in ego function" (p. 118).

This discussion of the ego opens the way for the chapter on "Conflict, Defect, and Deficit." Here Pine spells out the importance of recognizing deficits (any faulty parental provision) and defects (any aspect of the ego that is not functioning) as separate entities, as well as their role in conflict. He alerts us to the complexity of their interaction. For instance, conflict may produce a situation where a child is later unable to receive what the parent has to offer, leading to an experience of deficit. This requires differential diagnostic work over time before a conclusion can be reached. Without leaving an interpretive approach, he makes the point that if the analyst does not recognize deficit or defect situations, he or she runs the risk of retraumatizing the patient.

While the book is filled with clinical vignettes, Pine devotes his next chapter (Chapter 7) to "Clinical Considerations Regarding Interpretation in the Four Psychologies." What are the guidelines determining the choice of interpretation (in one psychology or another)? It all depends. Pine's answer lies in the details of the moment-to-moment

interaction and in careful listening.

To the critics of his eclecticism Pine replies that when it comes to making a technical choice at any moment in time we are all eclectic: we have a multitude of choices of intervention. His suggestion that we use the four psychologies only adds to our choices, and in his view enhances our capabilities. "I conceive all the issues addressed by each of the psychologies to be relevant to the mental life of all persons and I see interpretation as central to the analytic way of working with them" (p. 156). He elaborates on the notion proposed earlier that work in the different psychologies does not automatically entail different approaches. His examples highlight the centrality of affect in formulating an intervention.

As a developmental theorist, Pine incorporates a developmental view into his thinking. He completes the book with a chapter on "The Use of Developmental Perspectives in Adult Clinical Practice." As with the four psychologies, this is one among many guiding perspectives. The essence of his view is best summarized in his own words: "The core idea is that life-as-lived is a developmental process continually presenting each of us with age-related adaptive tasks; these new tasks are often approached by bringing to bear old styles of defending and mastering and, along with these, old wishes, repetitions, failures, and enactments" (p. 199). He reminds us that they have a significant role in psychoanalysis: "Developmental tasks too can be hot if recognized as such" (p. 201). The book ends with a brief postscript, a succinct summary of his views.

This book, with its emphasis on technique, is the logical sequence to Fred Pine's earlier work, *Drive, Ego, Object, and Self: A Synthesis for Clinical Work* (Basic Books, 1990), which had a more theoretical bent. It represents a thoughtful exposition of one analyst's dedication to understanding his patients. It can help us expand our listening to include as comprehensive a view of the patient as possible. His clinical examples (particularly in Chapter 7) illustrate his viewpoint. Ironically, however, at the same time that he emphasizes that "technique is in the details," Pine repeatedly tells us that he has omitted many details. He makes the point that his aim is to illustrate his own reasoning process, but he also states: "I have not attempted to give patient histories or process notes in sufficient detail for the reader to make fully independent decisions about what is going on" (p. 157). Of course, there are limits as to how

much material one can include, but the examples suffer from that because it is difficult for the reader to assess his particular choice of technique in the overall context of the clinical issues at hand. It begs for a sequel with fewer cases in more detail.

From the standpoint of theory, the book does a good job of underscoring the importance of using theories as guidelines and not as prescriptions. Analysts of all persuasions will benefit from this clinical exposé. In addition, Pine's breadth of perspective and his dedication to listening to and understanding patients should give this book a prominent place as a teaching tool.

JEAN-PAUL PEGERON (ANN ARBOR)

INFLUENCE AND AUTONOMY IN PSYCHOANALYSIS. By Stephen A. Mitchell. Hillsdale, NJ/London: The Analytic Press, 1997. 292 pp.

Stephen Mitchell has been in the forefront of those theorists who construe the analyst's position in the psychoanalytic situation to be fundamentally interactive, irreducibly subjective, and of significant influence upon the form and expression of the patient's transference, conflicts, and associations. While his views have presented analysts with new ways of looking at relational factors in the analytic dyad, their contribution to the deconstruction of classical assumptions about the analyst's stance raises some very serious questions for our theory of technique. If the analyst is as deeply embedded in the analytic relationship as authors such as Mitchell maintain, objectivity and neutrality are impossible for the analyst to achieve. Should they then be discarded as technical goals toward which the analyst aspires? If they are discarded, with what concept will we replace neutrality as the cornerstone of our listening stance? Without neutrality, how are we to safeguard or even understand the conditions needed to protect the patient's autonomy?

Influence and Autonomy in Psychoanalysis is Mitchell's attempt to address these questions. His answers rest with an approach to psychoanalytic practice that seeks neither to minimize nor deny the analyst's influence on the patient. Rather, Mitchell wishes to contain the potential for the negative impact of unintended influence and maximize the potential for positive, intended influence by confronting the existence and

inevitability of that influence head-on. "The patient's autonomy is not something to be protected from the analyst's influence...[Instead,] a particular psychoanalytic form of autonomy emerges as the patient absorbs and is increasingly able to reflect on, deconstruct, and reconstruct his analyst's influence" (p. 25).

For Mitchell, the most constructive safeguard of the patient's autonomy is the analyst's acknowledgment, both in theory and in practice, of the fundamentally interactive nature of the analytic relationship. To critics who would object that such an emphasis is incompatible with analyzing at a level of psychological depth, Mitchell replies that "attention paid to interaction in the analytic relationship does not diminish or distract from the exploration of the patient's unconscious; it potentiates and vitalizes it" (p. 19).

According to Mitchell, "the discipline [of analytic work] is not in the procedures, but in the sensibility through which the analyst participates" (p. xi) in the analytic process. His "view of the analyst's knowledge and authority…portrays the analyst as an expert in collaborative, self-authorizing self-reflection, in developing useful constructions for understanding the analysand's experience" (p. 227). In place of neutrality or other prescribed rules that seek to guide the analyst's technique by constraint, he proposes an attitude of "imaginative participation" and "self-reflective emotional involvement" in the analytic relationship.

Central to the exploration of the analyst's influence is the question of why patients change. As Mitchell defines the problem, at the heart of each theory of therapeutic action lies an assumption that the analyst is able to exert some "direct channel" of influence upon the patient, one that will somehow escape the reductive orbit of the patient's dynamics. Thus, classical analysts assume that it is the informational rather than the relational component of interpretation that leads to change; Kohut assumed that the analyst's empathy could "bypass the patient's conflicts and [reach directly to] developmental longings poised for growth" (p. 51); contemporary Kleinians assume that it is the analyst's "interpretations of the patient's relation to interpretations" that will prove decisive; and so forth.

In contrast to these views, Mitchell proposes that successful interpretations work because they transform old relational patterns—"the

patient experiences them as something new and different, something not encountered before" (p. 52)—in ways that have meaning for both patient and analyst. That is, it is the continual "struggling together to find a different kind of emotional connection" (p. 60) that proves decisive for change. Whether this formulation represents a true solution to the problem of "direct influence" or is just another version of it in the form of "new relational experiences" must be left to each reader to decide.

Given his belief that any theoretical model of the analyst's intentions—to be neutral, empathic, authentic, holding, etc.—represents an ideal that is impossible to attain (p. 192), it is an open question as to whether Mitchell actually believes that true solutions to such problems really exist. As I read him, I believe he would say that perhaps all that is possible are one or another analyst's subjective preferences for one or another's ideals that we aspire toward, knowing full well that these can never be reached. It is these impossible-to-reach ideals, however—neutrality, empathy, authenticity, holding, etc.—that will prove more or less useful as technical precepts in the hands of a given practitioner. What Mitchell, himself, reports as being most useful in *his* analytic stance "is not aspiring to a state of nonintention, but remaining as open as possible to a flow of a variety of intentions, all of which then become the object of self-reflective scrutiny (p. 193). No matter what conclusion readers come to about these matters, their attempts to grapple with the issues that Mitchell raises will be well worth their efforts.

Influence and Autonomy in Psychoanalysis is a clearly written, thoughtful, and provocative book. It addresses vital, contemporary issues in clinical theory and the theory of technique. It illuminates the historical sweep of psychoanalytic thinking about interaction across various schools and offers detailed examinations of interaction in the interpersonal and Kleinian traditions and in the work of contemporary theorists such as Jacobs, Ehrenberg, and Ogden. Its aims may best be summarized by citing the concluding paragraph of Mitchell's chapter on "The Analyst's Intentions":

> This is both the worst of times and the best of times for psychoanalysis. In this age of delegitimised authorities and cynical management of care, we have been challenged to shed anach-

> ronistic claims to authority and knowledge and, at the same time, to refind what is best and most important about psychoanalysis to anchor a renewed sense of pride and relevance in the impact we have on people's lives when we do what we try to do" [p. 201].

Mitchell's book is a successful and significant contribution that rises to this challenge.

HOWARD B. LEVINE (BROOKLINE, MA)

THERAPY OR COERCION? DOES PSYCHOANALYSIS DIFFER FROM BRAINWASHING? By R. D. Hinshelwood. London: Karnac Books, 1997. 249 pp.

R. D. Hinshelwood has created a thoughtful and stimulating work in which he makes an important contribution to the understanding of the professional ethics of psychoanalysis. Author of *A Dictionary of Kleinian Thought,* the writer presents his ideas in a clear and concise manner. As a result, the monograph can also serve as an introduction to modern Kleinian ideas. His empathic and appropriate use of clinical examples supports the theoretical exegesis. Because the author uses and elaborates the same clinical cases, the reader meets Hinshelwood the analyst as well as Hinshelwood the theoretician.

Although he refers to medical and psychiatric ethics as well as to philosophy, his essential argument is psychoanalytic. A major goal of psychoanalysis, he believes, is integration. Actions which enhance integration are ethical; those which do not are unethical. Integration is a fundamental ethical principle which underlies both autonomy and rationality and is associated with the psychological function of self-reflection.

Torture, coercion, and brainwashing have aims which differ fundamentally from the aims of psychoanalysis. The goals of torture, coercion, and brainwashing are to destroy the personality's cohesiveness and to render the individual vulnerable to outside control. The purpose of psychoanalysis is to integrate; the purpose of torture is to disintegrate. As the author writes, "an influence on another person is more ethical

the more it promotes an integration of his personality and less ethical the more it enhances a split in his personality" (p. 208). Hinshelwood also examines psychiatric hospitals and reaches a similar conclusion. The "institution is more ethical in so far as it allows for the potential re-integration of the patient; and less ethical in so far as it works against the eventual possible re-integration" (p. 174).

Although the author emerges as a humanistic and understanding individual who presents modern Kleinian thinking in a succinct and lucid manner, there are some unnecessary and gratuitous criticisms of Anna Freud which jar the reader of this interdisciplinary work. In fact, they are unfortunately reminiscent of the 1941 through 1945 Freud-Klein controversies. The comments are a disintegrating aspect of an otherwise well-integrated volume.

In sum, R. D. Hinshelwood has given us a stimulating, interdisciplinary work and an important addition to the literature on psychoanalytic ethics. Students of psychoanalysis, ethics, and philosophy will benefit from this volume.

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RECOVERED MEMORIES OF ABUSE: TRUE OR FALSE? Edited by Joseph Sandler and Peter Fonagy. Madison, CT: International Universities Press, Inc., 1997. 250 pp.

The first section of this book reads like a lively news account of a remarkably exciting event: the transactions of a spirited June 1994 conference on the validity of recovered memories of early sexual abuse which was jointly sponsored by the Psychoanalysis Unit of University College London and the Anna Freud Centre. Three formal papers were delivered, followed by a panel discussion, to an audience which was comprised of psychotherapists and psychoanalysts, patients who recovered memories of sexual abuse during psychotherapy, and some individuals who had been accused of sexual abuse by patients in treatment. This meeting was extraordinary because of the openness of all participants to listen to other points of view without rancor. I had the strong impression that there was a process of healing for many of the participants: the emotional pain of those who suffered alleged abuse was keenly felt, and

there was much sympathy, too, for the anguish of those who claimed to have been falsely accused.

The first two papers by Lawrence Weiskrantz and John Morton, from the perspective of academic psychology, address the validity of recovered memories of sexual abuse occurring in early childhood. Weiskrantz is skeptical about the "remarkable outbreak in America of something like 20,000 cases of MPD [multiple personality disorder] since 1980" (p. 14). He reminds us that remembering is more a process of reconstruction than reproduction, and he discusses the difference between *procedural* and *episodic* memory. Procedural memory is a nonverbal "memory" of experiences which are largely motoric and are stored separately from episodic memory of verbally registered experiences. He argues that experiences of sexual abuse in early childhood would be stored as nonverbal procedural memory, and he seriously questions the veracity of "recovered" verbally encoded memories of detailed early events. Morton outlines a cognitive theory which includes a consideration of memories felt to belong to the self and those which are dissociated from the core personality. He also discusses the formation of MPD within this framework.

Valerie Sinason, a psychotherapist at the Anna Freud Centre and the Tavistock Clinic, presents a beautiful clinical paper which includes her work with David, a severely learning disabled adult. This deeply troubled man remembered an externally corroborated traumatic incident of anal abuse and also claimed he had been penetrated anally by his father. Sinason met with David's parents and poignantly discussed his accusation of paternal abuse which led to the revelation of the father giving enemas to his son. Sinason was then able to link the actual sexual abuse David suffered with the enemas his father had administered. This treatment brought relief to David and defused a potentially destructive family situation. I admire this wonderful work and shudder to think of the disastrous effects to David and his family that a less well-trained clinician, dedicated to ferreting out abuse, might bring. Sinason's paper is followed by a lively panel discussion in which these issues are further elaborated.

The second part of this book is comprised of two papers that were not given at the conference. The first of these, "A Psychoanalytic Theory of Repression and the Unconscious," by Joseph and Anne-Marie Sandler,

begins with a careful review of Freud's conceptualizations of repression and the unconscious. They note the sometimes confusing ways in which Freud used *unconscious* to refer to the system unconscious as well as to its contents, and they also detail the different ways in which he used the term *repression*. Repression accounted for the force which kept contents of the system unconscious from consciousness as well as the barrier which prevented preconscious contents from becoming fully conscious. The Sandlers attempt to clarify these vagaries in Freud's thinking by distinguishing between the *past unconscious* and the *present unconscious,* ideas which they have been developing in a series of writings over the last fifteen years. The *past unconscious* is comprised of "dynamic templates…structuring organizations that form the basis for the immediate here-and-now unconscious strivings…linked with…procedural memory" (p. 174). Unconscious fantasies largely occur in the province of the *present unconscious* and are active compilations of the "templates" from the *past unconscious* with perceptions of current objects. The Sandlers also refer to deep unconscious fantasy (in the Kleinian sense) as belonging to the *past unconscious*. Finally, *repression* is seen as occurring in the *present unconscious* while the barrier between what is in the *past unconscious* and the *present unconscious* is more an artifact of the different ways in which these two organizations are cognitively structured.

I find the Sandlers' contributions to be helpful, yet also somewhat obscuring. Their emphasis on the present unconscious is useful in conceptualizing the transference as an active integrative process; however, the past unconscious seems to be left as a more static conception. The connection of the past unconscious with procedural memory, while in keeping with current theories of cognition, appears to give scant attention to the active working of the primary process: it seems like the "seething cauldron" has been replaced by consommé. Furthermore, I think we as psychoanalysts, in our attempts to build bridges with related disciplines, i.e., the cognitive or neurobiological sciences, should not too quickly abandon or modify our insights into the human mind simply because they may appear "unscientific." The notion of procedural templates of memory is useful but flat, lacking the passionate enlivening fizz of our more familiar ideas of the unconscious.

In "Perspectives on the Recovered Memories Debate," Peter Fonagy and Mary Target convincingly argue that "psychotherapists who are com-

mitted to helping their patients recover memories are in danger of betraying those patients…" (p. 184). They review the literature on the vulnerability of memory to suggestion and emphasize that memory is also a process of construction. I found their discussion of recovered memory therapies most illuminating. While noting that the recovery of memories of sexual abuse can be helpful to patients, there are also the dangers of the appearance of false memories with which the patient and therapist may collude for their own reasons. The clinician may foster an idealized transference in which he/she sides with the patient against the "bad" parent. This reinforces splitting and may actually lead to the destruction of families. When false memories are the focus of the clinical work, then the treatment may become an "as if" experience. They conclude that "recovered memory therapies are in pursuit of a false god" (p. 216) and stress that truly helpful treatment addresses the patient's psychic reality.

The strength of this book is to convey the breadth of the controversy surrounding the question of recovered memories of early sexual abuse during psychotherapy and psychoanalysis; however, I found it somewhat disjointed and uneven in quality. This volume could have profited from a closing chapter that attempted to integrate the variety of points of view touched upon into a coherent psychoanalytic perspective.

LAWRENCE J. BROWN (NEWTON CENTRE, MA)

OPEN MINDED: WORKING OUT THE LOGIC OF THE SOUL. By Jonathan Lear. Cambridge, MA/London: Harvard University Press, 1998. 345 pp.

Psychoanalysis and philosophy have often shared an ambivalent and at times antagonistic relation to one another. While each discipline generally acknowledges the merits of the other, each claims to possess a truth the other lacks. But as Wittgenstein wrote in his *Philosophical Investigations*, progress in philosophy will remain truncated until psychology is thoroughly examined in its *doxa* and conceits. Psychoanalysis, in its conceit, will remain at a standstill unless it embraces philosophy. Together they form a union few disciplines aspire to surpass.

Few scholars offer the psychological insight and philosophical rigor

in articulating the human condition as does Jonathan Lear. Lear, himself an analyst and a philosopher, has that rare ability to wed the two disciplines with cogent facility. *Open Minded* is an attempt to show the intimate bond between a psychoanalytic critique of the self and society and the philosophical foundations that inform its coherency. In the spirit of Plato's vision of the psyche,[1] psychoanalysis is, in Freud's own words, "the science of the life and the soul."[2]

Lear's book is more appropriately a collection of essays. Some readers seeking a structured, unified theme might view this as an overall shortcoming because the topics drift into many nuances of psychoanalytic theory, contemporary sociopolitical commentary, and a philosophical critique of ancient Greek culture and its applicability to modern democracy. But Lear attempts to weave an eclectic tapestry of insights into human nature that require meandering through many different schools of thought. Defending Freud from the bane of postmodernism, he shows that the unconscious is an indispensable organization of meaning which prefigures individual conscious, social, and political life. What is ubiquitous to the structure of mind is that it radically resists notions of transparency, thus the logic of the soul is derived from unconscious *activity* that provides order and meaning to personal and collective phenomena.

Lear provides fascinating reinterpretations of the Oedipus myth, Platonic revisions of transference, irrationality as a psychophilosophical

[1] Although more robust and intricately defined, Freud's notion of the psyche mirrors the Platonic notion. Compare from Plato's *Republic:* "…in the soul whereby it reckons and reasons the rational, and that with which it loves, hungers, thirsts, and feels the flutter and titillation of other desires, the irrational and appetitive—companion of various repletions and pleasures" (4:439d; also see *Laws,* ib. 9:863b sq.; ib. 5:727c). Plato also ascribes to the soul the cause of moral qualities *(Laws,* 10:896d), ends and virtues *(Republic,* ib. I:353d sq.), and the influence of character *(Laws,* 10:904c sq.), as well as mental sickness *(Gorgias,* 479b). But perhaps the best allusion to Plato's notion of the soul by Freud is his analogy of the ego and the id as a rider on horseback *(Standard Edition,* Vol. 19, 1923, p. 25), whereas Plato refers to the soul as a charioteer with a pair of steeds *(Phaedrus,* 246 sq.). Cf. *The Collected Dialogues of Plato,* ed. E. Hamilton & H. Cairns (Princeton: Princeton Univ. Press, 1961).

[2] Freud's concluding remarks in his preface to *New Introductory Lectures* are more appropriately translated "the life of the soul" *(Seeleenleben liebt)* rather than Strachey's translation as "mental life" *(Standard Edition,* Vol. 22, 1933, p. 6).

problem, and the nature of fantasy utilizing the Rat Man as a case example. Building on the theme that psychic life is pure restlessness, Lear shows, like many process thinkers, that mental life is a process of becoming. Paying tribute to Hans Loewald, Lear highlights the importance the concept of Eros has for psychoanalytic thought. Eros is then further explored in the context of Plato's *Symposium,* leading Lear to engage Aristotle's ethics, the notion of tragedy and catharsis, and Wittgenstein's emphasis on the role of language in structuring social reality. Through a mélange of psychoanalytic and philosophical hermeneutics, the reader is drawn into a complex and integrative network of personal dramas and conflicts that are enacted in social institutions and customs culminating in the communal identification that led Hegel to envision the ethical life of *Geist* as "The I that is We and the We that is I."

Lear probes many intriguing ontological facets of the structure of the mind that give rise to what we may call the soul, yet I will focus upon only one point here. Echoing Loewald, Lear argues that Freud's drive theory accounts for "the elements of mental life" (p. 134). In today's climate, in which psychoanalysis faces rigid group identifications that have all but displaced Freud's drive model for relational, interpersonal, and intersubjective accounts of psychic functioning, Lear's statement holds the key to understanding what Freud meant by the soul. Analysts who profess to have abandoned drive theory face the challenge of articulating the dynamic processes that make mature psychic structure possible. Largely misinterpreting drives *(Triebe)* to flow from instinctual currents that are biologically determined, fixed, and inflexible mechanisms rather than malleable and teleological processes, contemporary psychoanalysis has strayed away from essentialist explanations of mind to nominalist and postmodern approaches that malign our understanding of the universal processes that are common to us all.

Freud is very clear in telling us that the force or pressure *(Drang)* of a drive acting as an urge is its "very essence" *(Wesen).* As Freud says, "Every drive is a piece of activity."[3] Unconscious drives—falling under the general principles of Eros and the death drive *(Todestrieb)*—are intrinsic impulses that forge psychic growth, and through the various trans-

[3] "Instincts and their vicissitudes," *Standard Edition,* Vol. 14, 1915, p. 122.

formations and vicissitudes instituted by ego organization, they become the primary ontological thrust behind the temporal processes that constitute psychic development. In fact, the ego is merely a differentiated and modified form of id activity, and the superego is likewise a modified extension of its original ground.[4] This is why Freud's model of the mind is monistic, with ego activity being the epigenetic transformation of its original unconscious essence. Consciousness is therefore the appearance of unconscious structure. For Freud, the soul *(Seele)* is the unification of the three psychical agencies that constitute mental life.[5]

Hegel shows, as does Freud, that there is an internal logic to the developmental unfolding of the soul. One of the more interesting aspects of Hegel's logic of the dialectic is that each mediated dynamic begets a new immediate. As the soul awakens from its unconscious beginning—a "nocturnal abyss"—it forges a path toward natural consciousness and becomes ego *(Ich),* only to further develop as an ethical agency.[6] The ego, through a series of internal divisions, external projections, and reincorporations constituting the internalization process, is the very dialectical movement behind the coming into being of self-con-

[4] The question of whether the dual drives have separate essences should be considered apart from their phenomenal status. Freud is a monist with respect to the development of the ego: "[T]he ego is identical with the id, and is merely a specially differentiated part of it.…The same is true of the relation between the ego and the super-ego.…The ego is, indeed, the organized portion of the id" ("Inhibitions, Symptoms and Anxiety." In the *Standard Edition,* Vol. 20, 1926, p. 97). If the ego is a differentiated and more refined psychic organization of the id, then they both would participate in a mutual essence. Freud's dualism of the drives should therefore be viewed as structural distinctions responsible for the dialectical configurations that constitute psychic life.

[5] In "New Introductory Lectures on Psycho-Analysis," Freud specifically refers to the three psychic agencies and their structural relations as "the three provinces of the apparatus of the soul" *(die drei Provinzen des seelischen Apparatus),* not "the three provinces of the mental apparatus" *(Standard Edition,* Vol. 22, 1933, p. 72).

[6] From the *Encyclopaedia of the Philosophical Sciences,* M. J. Petry (ed.) outlines Hegel's Philosophy of Spirit in *Hegel's Philosophy of Subjective Spirit,* Vol. I: Introductions; Vol. 2: Anthropology; and Vol. 3: Phenomenology and Psychology (Dordrecht, Holland: D. Reidel Publishing Company, 1830/1978). Hegel discusses the unconscious development of the soul in the Anthropology, especially §§ 389-408, and in the development of theoretical spirit, especially in the stage of presentation *(Vorstellung)* in the Psychology, § 453. Also see my article, "Hegel on the Unconscious Abyss: Implications for Psychoanalysis," *Owl of Minerva,* 28, 1996, pp. 59-75.

scious reflective life.

Lear argues that Freud's concept of Eros is more important for understanding the psyche than is the death drive, even though both borrow from the resources of the other as an accompanied or "alloyed" counterpart. Freud says, "Neither of these instincts is any less essential than the other; the phenomena of life arise from the concurrent or mutually opposing action of both."[7] Conflict, negation, and destruction become the ontological force behind the elevation of psychic structure, which is the positive significance to the negative that drives the mind toward higher shapes of consciousness. Whether in the service of Eros as the drive toward unity or in the regressive destruction of pathology, death is our inner being, for life is the consequence of negation. Therefore, the union between life and death is the ontological fabric of the human soul to which all other dialectical polarities arise. In working out the logic of the soul, Lear reminds us that unconscious activity becomes the foundation of psychic reality. As in his last contribution, *Love and Its Place in Nature,* Lear's sensitivity toward the question of what it means to be human makes us deeply appreciate how psychoanalysis, like philosophy, is a way of being.

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[7] Freud's Letter to Einstein, "Why War?," *Standard Edition,* Vol. 22, 1933, p. 209.

SYMBOLIZATION: PROPOSING A DEVELOPMENTAL PARADIGM FOR A NEW PSYCHOANALYTIC THEORY OF MIND. By Anna Aragano. Madison, CT: International Universities Press, 1997. 435 pp.

"Thus, a frequent problem in the analytic context, an apparent copious flow of verbosity, can be a major resistance to the process itself" (p. 351). Such is the bane of *Symbolization: Proposing a Developmental Paradigm for a New Psychoanalytic Theory of Mind*.

Aragano states that during her training, she became aware of the shortcomings of Freud's applications of principles in physics to explain metapsychology. Attempting to develop a comprehensive theory that could include diverse analytic orientations, she proposes a new model

based on the role of symbolization and its interplay with language. The model was her doctoral dissertation published in 1992 and this book is, in essence, her dissertation.

In three introductory chapters, Aragano traces theories of thought and cognition by various developmental psychologists and integrates their contribution into Freud's psychosexual stages of development. Building on her thesis that a theory of mind needs to encompass symbolization, Aragano presents an interdisciplinary discussion. Although interesting, it becomes recondite and abstruse. For instance, she examines Marchack's archeological investigations of cave engravings and Langer's philosophical discussions of the relationship between symbolization and abstraction but fails to show their relevance to psychoanalysis. Aragano asserts that conceptualizing the mind as multilayered allows one to consider symbolization as developing along a continuum that can incorporate the conscious-unconscious dimension, primary and secondary process, prerepresentational and representational world, and language.

Aragano's developmental model of symbolization, presented in the fourth chapter, consists of six overlapping stages in which she illustrates the evolution of symbols. Since she states that her focus is on "…structural transformation" instead of development, chronological ages for the stages are not presented. This is a curious notion since her subtitle states that hers is a developmental paradigm. For example, stage 1, "the protosensory anlage," corresponds to early infancy, when the mind and the body are undifferentiated from each other; stage 2, "primal or archetypal signs and signals," is marked by the growing capacity to think about events. Stage 3, "symbol function," is the child's ability to evoke thoughts and experiences through words; stage 4, "language" ("primary symbolization") is the organization of words to convey tone, meaning, and experience. In adolescence, stage 5, "secondary symbolization," the capacity for abstract thought and "…the formulation of a 'self' " are noted, and stage 6, "reification of self," is the level of self-understanding acquired through psychoanalysis by the process of putting affects, thoughts, and experiences into words, which strengthens the observing ego.

Concluding this chapter, Aragano argues that psychoanalysis is a "talking cure" because language supersedes action. This point is well

taken, but she does not develop it to illustrate the role of language and symbolization. What should be her climax—"Abstractive organization alters structure. Talking cures" (p. 328)—goes limp.

The final chapter, "Psychoanalysis Revisioned: Implications of a Revised Theory," is unconvincing. Aragano states that there is a strong need for interdisciplinary work, but there is no attempt to demonstrate this in her thesis. For example, she refers to the importance of biology, neurophysiology, and child development, but she does not at all integrate them. What fun this book could have been if neurophysiology had been interfaced with psychoanalysis and an example from child development had been provided!

Claiming that her model can embrace many phenomena, she eliminates the need for terms such as ego or self, and presents a purportedly unified psychoanalytic theory that integrates "…such illusive aspects of human expression and apprehension as creativity, intuition, and empathy" (p. 357). This is an ambitious aim, indeed. It is not surprising that it is not reached. Aragano concludes the chapter by discussing the implications of transformation, sublimation, and transfiguration to her model. How and why these three terms are chosen is unclear. For instance, she states that her model can expound on the notion that conversion, somatization, and psychosomatic illness are the inverse of sublimation. She supports this claim by citing Loewald's thesis that if sublimation is a higher transformation, then conversion and somatization are its opposites. Once again, her idea is not well developed and it is greatly oversimplified.

Aragano's assertion that the stages in her model are developmental and overlapping raises several questions. Clinical examples in this book are scant, but she does make several references to the schizophrenic's use of symbolization and desymbolization. Schizophrenics do think concretely. How can this be compared to or equated with the thought processes of children, who do not have the educational, emotional, or cognitive sophistication of adults? Such reasoning grossly underestimates the schizophrenic process. Additionally, Aragano touts that her model of symbolization is based on development. How does this relate to schizophrenia? According to her model, are the thought processes in schizophrenia regressions? Are they fixations? Missing in Aragano's argument are any references to other clinical groups.

Because Aragano has difficulty culling the essence from a theorist, she writes long summaries of a paper, criticizes the author's stance, and then states that her model will resolve the shortcomings of the previous research. Consequently, the material she presents comes across as unrelated and unintegrated, and the reader questions the purpose of including some passages.

In her book, Aragano repeatedly says that the chapter in which she presents her model will answer many questions and fill some gaps. These teasers are reiterated so frequently that when the reader finally gets to the apocalyptic chapter, it is anticlimactic. Perhaps unconsciously, she realizes that if these repeated promises were not there, the reader would likely give up.

If more careful attention were given to grammar and style, comprehension of this book would be immensely enhanced. I would be remiss if I failed to address the countless and repeated grammatical errors in the book. These flaws detract from its readability. The following sentence, typical of many, illustrates its "copious flow of verbosity":

> Anyone who has seen their infant clinging, felt the powerful clutch of a tiny hand gripping tightly to hoist him- or herself up to the upright position; or observed the expression of desperate thrill in effort and risk color a vital moment of developmental thrust; any parent who has seen their floundering adolescent pitched furiously against one's prenumbral authority or watched the fearful challenging to face the world but do it alone, will attest to the inherent turbulence of change, the intrinsic role of volition, the pain of gain, and the inherent struggle toward resolution, completion, and reintegration occurring at each maturational step [p. 88].

Weak sentence structure, misplaced punctuation marks, run-on sentences, redundancies, lack of parallel structure between dependent and independent clauses—all make comprehension of Aragano's ideas difficult for the reader.

The style and format of this book are undeveloped, as are its five chapters. Scant headings and subheadings make the reading ponderous. The limited number of charts contributes little to understanding the text. Much of what is presented in *Symbolization: Proposing a Develop-*

mental Paradigm for a New Psychoanalytic Theory of Mind is not new and causes one to wonder whether an entire book was needed to present these ideas, or, as I believe, it could have been presented in one or two comprehensive articles.

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FANTASIES OF LOVE AND DEATH IN LIFE AND ART: A PSYCHOLOGICAL STUDY OF THE NORMAL AND THE PATHOLOGICAL. By Helen K. Gediman. New York/London: New York University Press, 1995. 214 pp.

Gediman brings to the complex topics of love and death a rich background of knowledge and clinical experience. She fearlessly explores the separate and interwoven themes in myth, literature, art, music, her own clinical material, and current psychoanalytic theory. Tristan and Iseult, Siegfried and Brünhilde, are two of the pairs of legendary lovers the author uses to discuss subthemes—the femme fatale, "good" and "bad" deaths, twin narcissism, sadomasochism, and conflicts over merger and autonomy. The interweaving of clinical theory and cultural artifacts is masterful and persuasive, and the reader will come away with clearer conceptions of the many variations on the themes of loving and being in love. By categorizing and exploring both themes and subthemes, the author provides the reader with a compendium of ways to think about and understand subtle, complex topics often shrouded in muddle or mystery.

Gediman garners the fruits of others' works, such as that of Kohut, Mahler, Greenacre, Person, Bergmann, and Kaplan, and then adds compelling insights of her own. Addressing an audience of psychoanalytically informed readers, she brings order and clarity to her subject without reducing its complexity.

The book is divided into two parts. The first addresses *Liebestod* (love-death) fantasies, taking up narcissism, creativity, and Romanticism. It is a pleasure to discover new meanings in age-old fantasies when clinical thinking is set side by side with cultural exploration. Tristan and Iseult in their various incarnations are understood as embodying universal themes.

> The lovers repeat echoes of preoedipal trauma and conflict in endless variations, which they then attempt to master by alternating rhythmically their self-created obstacles and distrust with their blissful reunions…[expressing] both the wish and fear of symbiotic fusion and merger. The wish may reflect a defensive regression prompted by oedipal anxieties or a repetition of the bliss of original symbiosis; the fear may reflect the drive to advance to new libidinal positions and the thrust of the drive for ego autonomy and growth that preserve the sense of self and separateness. [p. 63]

Gediman expands our understanding of the psychology of love through her exploration of the creative-adaptive conditions required for integrating the experiences of loving and being in love. She arrives at her main thesis of a continuum of normal and pathological influences on romantic love-death fantasies by contrasting the extreme and pathological states with the normal.

The second half of the book is devoted to resurrection symbolism in art and life and the interface between the two. Gediman's aim is to use classical legend, theology, and iconography, particularly that of Italian and Northern Renaissance painting and sculpture, to "illuminate the unconscious meanings of patients' resurrection fantasies" (p. 90). Likewise, she uses the resurrection fantasies of a particular patient to "expand the context for understanding and interpreting certain latent meanings in works of art in which the manifest content is that of resurrection" (p. 90).

Gediman touches lightly on the resurrection theme in Wagner's operas, but the majority of her discussion concerns art historian Leo Steinberg's book *The Sexuality of Christ in Renaissance Art and in Modern Oblivion*.[1] Steinberg's brilliant and dazzlingly thorough book is characteristically provocative. He chooses a red-hot theme—Christ's erections in Renaissance resurrection imagery—and argues for a totally cool explanation: religious proof of God's incarnation. Gediman is on track in her suspicion that there is much more to be said, and she walks in where Steinberg refused to tread. Knowing that art historians are chary

[1] Steinberg, L. (1983). *The Sexuality of Christ in Renaissance Art and in Modern Oblivion*. New York: Pantheon.

of any psychoanalytic interpretations, Steinberg set up his readers by providing all the evidence for psychological-psychoanalytic explanations but denying their validity. She follows Steinberg's lead, taking up various aspects of the erection–resurrection equation, and finds rich ground for complex interpretation: reunion with lost objects, shame, guilt, and the wish for conflict-free sexuality, to name several.

In a thoughtful case study the author explores the resurrection fantasies of her patient, Dr. D, a late middle-aged man whose life's leitmotif could be characterized as a compulsive quest for sexual encounters in an effort to prolong his life indefinitely. The clinical material is compelling and instructive about the complex ways in which individuals seek immortality.

If we focus entirely on the principal subject of the book, little fault can be found, as the author admirably fulfills her aims. Turning, however, to Gediman's use of the arts to explicate her thesis leads us to a problem, in that creativity comes through in this book as inherently pathological.

Though I am fairly certain that the author would not openly subscribe to such a view, its presence as a subtext is felt from beginning to end. The problem begins with Gediman's use of the term "pathography" as signifying a psychoanalytic biographical or psychobiographical approach. She has adopted this usage from Ellen Handler Spitz, who had resurrected a term that was used briefly and discarded early in psychoanalytic biographical work because it was a misnomer. Gediman uses Spitz's definition of the pathographic method as "tracing a theme in the life of the individual whose work is being studied."[2]

"Pathography" implies pathology and almost automatically besmirches psychobiographical studies with the taint of artist as troubled patient. Although some psychoanalysts have concentrated on artists as cases, the majority of recent, informed psychobiographical studies focus upon the complex inner life of the artist in the context of the period in which he or she lived and worked without reducing the artist to patient status. By referring to the myriad ways an artist's biography can be studied as "pathography," Gediman subtly perpetuates an old but

[2] Spitz, E. H. (1985). *Art and Psyche: A Study in Psychoanalysis and Aesthetics.* New Haven/London: Yale University Press, p. 90.

widespread fantasy that artists must be crazy to be artists. Many artists in the past and present live lives no more pathological than those of the next normal neurotic.

A number of consequences seem to flow from Gediman's adoption of Spitz's misnomer. Gediman exclusively addresses iconographic aspects of the arts, leaving formal considerations aside—an unfortunate tendency found frequently in applied analysis. It is one which often earns authors undeserved disdain from the art side of their audience. All humans struggle with common themes, but artists lift them to sublime heights through the form of their art. It is precisely that which makes them palatable to the rest of us mere mortals. By excluding formal considerations, Gediman falls prey to "analyzing" artists for their fantasies while paying insufficient attention to their sublimatory capacities.

Gediman's view of creativity as pathological is more sharply etched in her chapter, "Detecting Pathological Variants," which explores the resurrection theme. Here the author falls into a fallacy that weakens her otherwise sound arguments for reading art from a multidetermined perspective. She equates idiosyncratic with pathological as a counterpoise to historically based normative:

> When we find idiosyncratic rather than universal elements in the fantasies of artists and audiences, as well as those expressed in art which are motifs…not embraced by a particular iconographical tradition or by a particular theological or sociological reading, we are likely to be stepping out of the normative and into the pathological realm. Universal psychological fantasies and iconographic traditions would underscore the normative; idiosyncratic renderings would signify the pathological. [pp. 167-168]

Given the evidence from the rest of her book, it seems unlikely that Gediman believes anything "idiosyncratic" to be "pathological." If such an equation were true, then anything that breaks norms and introduces new solutions—formal or iconographic—to an artistic tradition would be a sign of sickness. Perhaps this is one of the unsuspected byproducts of using the word "pathography." It suggests by implication that a careful psychoanalytic biographical study is automatically aimed at uncover-

ing an artist's illness rather than at explicating the miracle of individual creative solutions which artists find for universal issues.

Originality may receive a push from pathology or it may not. Artists, like all of us, are faced with life dilemmas. When we solve them in our own particular ways, especially if our solutions differ from those of our neighbors, they should not be labeled as pathological. An original artistic solution is a variant of the historical norm. It can arise from an individual artist's pathology, but it might instead emerge as a different solution because the artist had the wit, talent, and originality to forge new solutions; that would be idiosyncratic but not necessarily pathological.

Gediman has worked hard to hold to the perspective that in complex human functioning there is a wide spectrum of behavior and inner dynamics, from normal to pathological, on each of the themes she considers. Her fine book demonstrates how much is to be gained from interdisciplinary work, how culture and case material can enrich each other, but how easily language can give unintended messages.

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ABSTRACTS

RIVISTA DI PSICOANALISI. XLII, 1, 1996.

Abstracted by Antonino Ferro and Maurizio Collovà.

Intrasubjective and Unconscious Origin of the Experience of Self as an Individual. Carla De Toffoli. Pp. 79-93.

The author analyzes the route through which psychoanalysis has reached the "relational field of the couple, the emotional forces underlying group life and transgenerational transmission." She inquires into the idea of the individual mind as a structure on its own and into the experience of self as the making of an individual subject.

Before considering these subjects through clinical exemplification, she provides a clear, useful illustration of the theory which guides her work in the session. Realization of the unpredictability of the events taking place in analytic work becomes evident. Analytic work is comprehensible only in a dyadic dimension. Moreover, it becomes clear that the analyst has a responsible role in the analytic process, through continuous symmetries and asymmetries with the patient.

The role of the oneiric work as a guarantee of the individual elaboration of subjective routes and meanings, eventually obscured or abused by meeting the Other, is highlighted. The research perspective the author tries to develop is ultimately Bionian: psychoanalysis contributes to the fight for expanding the mind, against tensions which pull toward an explosive solution of it.

Is There Still a Space for the Patient's Individuality? Vincenzo Bonaminio. Pp. 97-110.

The question arises from expanding the relational model which increasingly highlights the strong inclusion of the analyst's personality into the analytic scene. The review of some of the positions of the international literature shows a kind of meta-model connecting some very different points of view. The author is interested in showing how this sometimes creates forced, confusing closeness between models which start from opposite vertexes, for instance the individual and bipersonal models of mind. Bonaminio underlines the risk of an ever-decreasing consideration of and respect for a *private* area of the patient's mind. The value of this area also consists in showing the

incommunicable, the limits of the patient's transformative availability. The author is particularly concerned not to lose sight of the Other's need to locate him/herself and not to reduce the self to a merely relational dimension.

Secret Identity: Routes of Contemporary Femininity. Emma Piccioli and Giangaetano Bartolomei. Pp. 9-32.

Beginning with their clinical experience with female patients, the authors observe a distance between the woman emerging from Freudian theory and the one visiting the analyst today. It is necessary not to lose contact with the social transformations, including a different idea of woman and different routes leading her to reach an identity. The fundamental question is: "What is it, for a genetically and anatomically female individual, to have a feminine psyche? And how does it get reproduced?" They begin their considerations by summarizing Freud's position, and then move on to more recent observations. In particular, they refer to the studies of Chasseguet-Smirgel and Stoller with their notion of "*nuclear* gender identity." One particular clinical case clarifies the painful and difficult journey of a woman, closed in between the expectations of society which wants her to be *autonomous* and the interiorized expectations of parents, which produce a feeling of *anguish,* both in the sense of poverty and sorrow. The authors consider the subject of woman's guilt, then conclude their considerations with the importance of gender identity. The study of the psychoanalytical theory of femininity can supply the material for a deeper consciousness of historical changes in psychoanalytical thought and its connections with other social processes.

Imitation, Representation, Identification: Their Role in Development and Transfer. Mauro Mancia. Pp. 225-247.

The author presumes the existence of a "relative isomorphism" between the mental processes underpinning the mother–child relationship and those activated in the relationship between patient (child or adult) and analyst. He considers the processes of imitation, representation, and identification during emotional and cognitive child development, beginning with the ideas of Piaget and ending with the most recent observations of the cognitivists. These characterize a child who is immediately given a "primary intrasubjectivity," able to construct representations of the outer world (beginning from the intrauterine). Through this excursus, the author defines his own position, which is a synthesis of different present positions: the pulsional and the relational. Mancia qualifies the pulsion as desire and its relation with the environment in which it has to be satisfied. It is from the quality of this meeting that different emotional forms and potentialities grow.

For the author, thought cannot totally identify with language, as Piaget suggested, but with the transformative process which gives symbolic mean-

ing to experience. This is the point which mainly concerns psychoanalytic practice and theory, as is shown by some really interesting clinical situations. The author ends by underlining that imitation can be the defensive mode, in respect to introjection, dependence, and separation. Analysts, with the exception of Gaddini, often disregarded this possibility.

Psychic Strategies Towards Self-Destruction: Notes on Self-Destructive Behavior. Franco De Masi. Pp. 549-566.

The author investigates the reasons why, in serious pathologies, the pull toward self-destruction ceases to be a sign of alarm and becomes the pleasure of self-destruction. Beginning with the Freudian idea of death drive and its subsequent transformation by M. Klein, Winnicott, Rosenfeld, and H. Segal, De Masi considers Smirgel's (1986) position, linking the death instinct to pleasure, reversing the hypothesis Freud made in 1920.

In the following development of his work, the author makes a hypothesis about the link between narcissism and the death instinct and asks the following question: "What is it that attracts the patient so much to estrange him from this link?"

The analysis of the "foetus condition" toward which the patient moves is considered: on the one hand, as a mental status protecting from over-stimulation; on the other, for some other analysts, e.g., Segal (1993), it is a violent process, self-mutilating, involving the need to cut the sense organs. The clinical stories of two psychotic patients clarify the author's position. He considers the return to a foetus condition as dismantling the sense organs, as destruction of the psychic apparatus and emotional and relational reality, an operation of de-mentalization and decapitation. The effect is to close oneself in a pleasant sensorial prison whenever the drive for life arises again, a prison which it is not easy to get out of. The analyst has to take into account the pain these patients have to deal with and their means of facing it.

New Interpretative Hypothesis of the Trauma Concept. Giampaolo Kluzer. Pp. 405-423.

The author carefully goes through Freud's elaboration of the theory of trauma. A careful reading of *Inhibition Symptom and Anguish* (1925), where a final formulation is reached, underlines Freud's attempt to find a common basis between transference neurosis and traumatic neurosis. He also considers Freud's insistence on maintaining the notion of traumatic neurosis as a sign of his belief in the irreducible complementarity of the binomial: external reality = psychic reality.

Trauma is due to outside intervention but also, according to Baranger (1988), to the absence of the object, something that should have happened, but didn't take place. Referring once more to the 1925 work, he takes into account the ideas of authors such as Winnicott, Balint, Bion, and others,

considering the implications of trauma and the feelings of loss, guilt, introjection, incorporation, until reaching the important concept of *après coup*.

Through this examination, two positions become clear: the concept of trauma cannot be unequivocally reduced. On the one hand trauma would refer to a catastrophic breaking of the psychic apparatus. The continuity of self-representation and representation of the outside world would be put at risk. On the other hand, it would have the characteristic of novelty, which surprises the subject, making it necessary to reinterpret the significance. Specific to this reinterpretation is the concept of *après coup*, a mechanism able to link the fantasy aspects and the event in a temporal continuity which guarantees the integrity of the Ego, i.e., the organizational element of the psyche. The addition of a dramatic clinical case reviews the previous theoretical considerations.

"Please, Close Your Eyes (Eye)": Notes on Acting and Remembering. Francesco Barale. Pp. 425-454.

Starting from some memories of an analysis, the author thinks about the analyst's "acting" and the possible derivative effects. He considers Freud's theorizing about this and its ambiguities, which led to several future enrichments and developments. Following the event of remembrance in psychoanalysis, until its disappearance in Kleinian and post-Kleinian psychoanalysis, the author reaches the present reflection. His outline concentrates on the transferal hic et nunce, with particular reference to the relational and "interactionist" positions.

The author sees in the Freudian ambiguities an intrinsic characteristic of psychoanalysis; if we abandon it we would risk oversimplifying and flattening both theoretically and clinically. He suggests a functional, dialectic link between acting and remembering, through which there is a reopening of temporality in the present, a dual construction, resulting from the patient–analyst relationship. He ends his essay with a new case, showing the transformative ability analysis has on memories, analysis which weaves new memories and more livable stories. This is what the author tries to do in the special meeting with the patient.

Publisher's Erratum: The abstracts of the Forum der Psychoanalyse which appeared in the April, 1999 issue are edited versions of English summaries which appeared in the Forum and are published with permission of the Journal.