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THE BOY IN THE IRON MASK: SUPEREGO ISSUES IN THE ANALYSIS OF A TWO-YEAR-OLD ENCOPRETIC

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The paucity of psychoanalytic literature on encopresis is surprising given its frequency as a presenting symptom. Vignettes from the analysis of a two-year-old encopretic boy are presented to demonstrate the prominence of superego determinants, even in a child so young. The implications of this finding for understanding encopresis are subsequently discussed, including the common feature of depression. Technical issues arising from a sensitivity to these superego contributors are demonstrated, and the importance of addressing a child's sadistic superego directly in order to facilitate insight is emphasized.

Thirty years ago Morton Shane (1967) commented on the paucity of psychoanalytic articles on encopresis. In trying to understand this lack of research into a difficult and prevalent childhood problem, Shane harkened back to the thoughts of Anthony (1957) who a decade earlier had commented that, "Clinicians on the whole, perhaps out of disgust, prefer neither to treat them [encopretics] nor to write about them. The literature as compared with enuresis is surprisingly scanty...and superficial" (p. 157). Despite Shane's excellent and thought-provoking attempt to understand encopretic symptoms from a developmental perspective, there have been few attempts to expand his thinking or to offer complementary formulations to help in understanding this particular symptom. The relatively low number of such articles (Baird 1974; Glenn 1977; Rosenfeld 1968) is striking

given the prevalence with which such symptoms are seen in clinical practice.

Another possible reason for this peculiar state of affairs may have to do with an unstated shift in psychoanalytic thinking about psychopathology. That is, one finds far fewer articles on neurotic symptoms, in general, in the current day analytic literature than was the case forty years ago. My impression is that analysts, both child and adult, are more concerned with characterological issues than with symptomatic ones. There are several reasons for this shift in focus, but the most relevant for the point which I will emphasize in this paper has to do with what Gray (1982) has referred to as a developmental lag in clinical thinking. To be sure, Gray has been concerned about the impact of this developmental lag on our theory of technique. But I believe that it has also affected our diagnostic thinking as the clinical emphases dictated by the structural model have shifted psychoanalytic scrutiny away from a focus on symptoms to a focus on the interplay of structural conflicts within the psyche. The focus on symptoms seems to have been so heavily embedded in topographic emphases on mental content and instinctual fixation that, without realizing it, we have largely abandoned thinking of our patients in terms of symptoms as we have become more accustomed to considering the vicissitudes of ego, superego, and object relational issues that contribute to the complexity of their personality organizations. After all, it is generally their personalities (and their component conflicts) that we analyze, and not so much their symptoms.

One can see evidence of this shift in conceptual understanding as one examines the different dynamic formulations that have been offered to explain the etiology of this puzzling and unpleasant symptom. Not surprisingly the earliest formulations stressed instinctual conflicts with significant emphasis placed on anal conflicts. Thus, Freud (1908) linked fecal incontinence to anal character formation when he commented that the childhood of such personality structures had been characterized by a "comparatively long time to overcome their infantile incontinence alvi..." (p. 170). Likewise, Fenichel (1945) emphasized that habitual rectal incontinence was "a sign of a marked anal neurotic organization" (p. 234). Prugh, Wermer, and Lord (1954)

stressed the regression from oedipal to anal conflicts as a key etiological factor.

As the clinical implications of the structural model have become more integrated into psychoanalytic thinking, the array of etiological factors has been expanded to include ego and object relational contributions to the formation of this symptom. For example, Anthony (1957) noted that children suffering from secondary encopresis have a prematurely rigid and structured ego in contrast to primary encopretics whose egos function poorly, resulting in disorganized and uncontrolled behavior. Likewise, Lustman (1966) reported ego weakness and inadequate superego formation in a latency-aged encopretic. Shane (1967) formulated encopresis to involve "a serious defect in impulse control" (p. 300) with significant impairment in reality testing. He saw the encopretic as arrested at stage two (A. Freud 1963) in the developmental line of bladder and bowel control wherein the mother's control of these bodily functions are not internalized.

Problematic parent–child relationships are a primary contributor to the symptom. Shane (1967) emphasized the necessary attainment of object constancy to make bowel control autonomous, and described how disappointment in the mother during the separation-individuation process can cause the toddler to lose an internalized desire to be clean. Rosenfeld (1968) also highlighted difficulties in the mother–child relationship as a significant contributor to encopretic symptom formation. Thus, she noted that mothers of such children seem highly ambivalent toward their children, resulting in significant conflicts over anality and aggression. "The mothers' anxiety around control of aggression contributed to an intolerance toward age-adequate aggressive behavior in their children" (p. 59). Finally she concluded that such children become so disappointed in their mothers, and fearful of their destructive impulses toward them, that they displace their impulses onto their feces and treat them as though they were objects. Baird (1974) also emphasized parent–child psychopathology as contributing to this symptom, noting an interactional pattern characterized by withholding, infantilization, mishandled anger, and miscommunication. Thus, encopresis becomes "an efficient, highly condensed, symbolic representation of all these patterns in

the child's communication with his world" (p. 146). In contrast to most authors' emphases on the mother–child interaction, Baird also emphasized the father's contribution.

Examination of a number of the cases reported in the psychoanalytic literature suggests that it might be useful to examine more closely the superego contributions to this complex symptom in order to arrive at as thorough a dynamic formulation as possible. In contrast to Lustman's (1966) report of inadequate superego formation, many of the cases described in the literature show evidence of prematurely rigidified and primitive superego functioning. Glenn (1977), for example, emphasized the sphincter morality in his treatment of Betty. He also noted that "the preoedipal superego precursors, which occur in both boys and girls, were conspicuous in Betty's case" (p. 155). And the treatment process which he described reveals numerous sadomasochistic conflicts that involved harsh superego injunctions. Stevie S, the latency-aged boy treated by Shane (1967), was strikingly provocative during his treatment and revealed a prominent need/wish to be punished, indicative of superego pathology. And Liza, the four-and-one-half-year-old girl treated by Rosenfeld (1968), was strikingly sad at the time that she presented for treatment while having a history of accident proneness characteristic of children with strong unconscious guilt and wishes for punishment.

This sadness corresponds with my clinical experience that the prelatency encopretics whom I have treated have generally shown remarkable constriction of affect at the beginning of treatment. They lack the spontaneity and exuberance that typify prelatency children. Anthony (1957) noted a similar tendency in children suffering from secondary encopresis—they were overcontrolled and emotionally inhibited. Such atypical overcontrol and inhibition in a prelatency child is suggestive of a punitive superego precursor. The case vignettes that follow will describe portions of an analysis of a two-and-one-half-year-old boy whose presenting demeanor involved such severe emotional constriction that it was as though he wore a mask which prohibited or covered any excitement, pleasure, or spontaneity. The process of his analysis demonstrates that prematurely rigidified and punitive superego introjects contributed significantly to his encopretic

symptoms. Following this case presentation I will discuss some of the implications of such issues for child development, more generally, and for understanding encopretic symptomatology, more specifically. Finally, I will discuss technical issues raised by the prominence of superego contributions to the child's symptoms. I will not discuss to much extent environmental contributors to this child's difficulties, although obviously his relationship with his parents must have contributed to the superego that will be described. But I do not want to take the focus away from his superego which was strikingly rigid and punitive at two years old.

BOBBY

Bobby T was a two-and-one-half-year-old boy with a brother two years his senior when his parents sought consultation about his extreme regression following ear tube surgery several months earlier. Bobby was prepared for the surgery as well as any child analyst would recommend with straightforward discussion, reading age-appropriate books about hospitals and attending the widely acclaimed orientation program of the local children's hospital.

Consequently his parents were surprised and dismayed when his behavior changed three to four days after the surgery. Bobby became unusually oppositional, and his anger and defiance continued unabated at the time of his consultation four months later. Physical attacks on his parents and brother when angered began several days after surgery along with hitting and throwing things at glass doors and windows in defiance of parental prohibition. Bobby also grabbed toys from his brother and friends while accusing them angrily of being "bad." He also became dangerously wild, seeming to court disaster by running into the street, climbing to dangerous heights, etc.

Most disturbing to Bobby's parents was his regression in toilet training. Bobby had been successfully toilet trained just prior to turning two (five months prior to surgery); this training had occurred easily and without coercion. Thus, his parents were surprised when, some days after surgery, Bobby said: "No big-boy pants. Want diapers."

But they readily acquiesced and allowed him to use diapers again. Within one month Bobby requested "big-boy pants" again. No sooner had he given up the diapers than he began again to urinate and to have bowel movements in his pants. He refused to use the potty when caught in a position indicating a bowel movement in progress, saying: "Leave me alone. Not ready yet." Bladder control had been reestablished by the time of the consultation but his encopretic symptoms had worsened.

His developmental history indicated unusually intense conflicts over aggression and early superego introjects that alternated erratically between being ineffective and being overly strict and inhibiting. For example, negativism began at eighteen months and expanded into oppositionalism that went beyond the norm by the time that Bobby was age two. He routinely defied any rule and, in fact, would automatically test any rule the moment that it was established. Standard discipline of using timeouts failed, and offering Bobby choices was only mildly helpful. Spankings and scoldings also failed to alter his oppositionalism. In contrast, more overt expression of anger by Bobby did not occur until after the surgery. Tantrums were not part of his oppositionalism. Internal conflicts over aggression were apparent in the Ts' report that prior to the surgery Bobby reacted to anger-provoking situations in play group by going to sleep instead of reacting aggressively. Bobby's face was remarkably impassive during my evaluation and he displayed none of the typical excitement or exuberance of the prelatency child even after he had gotten to know me for several sessions. His parents acknowledged that he showed the same emotionless face when he was being defiant and when he was being disciplined. Inhibition of affect seemed related to his conflicts over aggression and suggested a harsh and rigid superego precursor.

BOBBY'S ANALYSIS

The Early Phase

Bobby's discomfort with aggressive impulses early in the analysis was apparent in his regular tendency to return to his mother in the

waiting room, climb into her lap, and suck his thumb whenever he became angry with me or uncomfortable with the aggressive tone of his play. In general his play was constricted, nonverbal, and lacked much fantasy elaboration. Two repetitive themes of dumping things on top of each other or crashing things into each other were Bobby's early rudimentary attempts to express his anger. But any interpretation that the dumping and messing play had to do with his feelings about his poops or his anger made him anxious and he fled to his mother. Bobby responded to one such interpretation by trying to throw things, and then fleeing to his mother in apparent fear of his poorly controlled impulses and/or fear of my fantasied response. After several sessions I realized that Bobby's defenses were simply too weak to contain the impulses and anxiety that were being generated by the lack of limits in our sessions. Thus, I decided that I would have to act as an auxiliary ego until his defenses were strengthened. Toward this end I instituted a variety of behavioral limits including encouraging him to help me to clean up at the end of sessions, hypothesizing that Bobby needed me to demonstrate that I could help him contain his impulses because he felt unable to control them himself. Soon it became clear that he also needed me to demonstrate that I could make him feel safe from his "bad guy" feelings, that is, from the criticism of his sadistic superego introjects.

And, indeed, Bobby tolerated his anger in the transference better by the end of the first month of analysis as I became more adept both at providing behavioral controls and at interpreting his superego. For example, I limited the degree of dumping he was doing one session. Bobby responded by heading angrily for the door to the waiting room until I interpreted his wish to flee from his anger at me because he was afraid that he could not be the boss of his angry feelings. Based on other recent work, I added that I knew these feelings made him feel like he was "a bad guy." For the first time Bobby stopped his flight and returned to playing as though he no longer felt overwhelmed by anxiety. I understood this increased affect tolerance to indicate an identification with my improved ability to contain his impulses and to understand his anxiety and guilt.

By the second month of analysis, Bobby's play was significantly less inhibited as he used more toys and verbalized their action in a rudimentary fashion. Guilt and anxiety over his aggressive impulses were foreshadowed in a play sequence about a "crazy baby" who drove and acted "wild"—smashing into things and running over things. Soon Bobby acted wildly with me and then fled to his mother. When he returned, the play resumed with a car driving wildly until it hurt itself and had to go to a hospital. Bobby then picked up a toy gun and played at being a bad guy. I believed that Bobby was telling me that he had been punished for being a wild and uncontrollable bad guy by being sent to the hospital.

Superego elements in these conflicts were expanded further in themes of men being jailed for fighting or killing somebody; punishment for aggression was a prominent concern for Bobby. Several times he interrupted such play to have his mother take him to "poop," suggesting a relationship between "pooping" and these conflicts. And, indeed, he again brought his mother back into sessions as his conflicts over aggression became more manifest in the play. I interpreted that Bobby wanted his mother to help him to be the boss of his angry feelings and of his poopies because he felt he was bad for having them. Greater comfort with his angry feelings and verbal expression of them became evident, and Bobby became better able to work with defense and superego interpretations.

Guilt and anxiety over anger toward his mother emerged with Bobby's greater comfort at revealing his internal world. He played at shooting the "mommy" puppet and then shot me, suggesting an early maternal transference. In one sequence the baby monkey beat up the mother monkey. Bobby then fled the scene and ran to his mother in the waiting room. Upon Bobby's return I interpreted how much he still wanted help with his angry feelings because he felt like such a "bad guy" for having them and worried that he could hurt somebody. Bobby responded by shooting the mommy monkey, himself, and then punished a "bad guy" for hitting people. Thus, he demonstrated his guilt over his anger toward his mother. This less-than-three-year-old boy already had a far more harsh and rigid superego precursor than one would expect in a child his age.

Deepening of the Analysis

Bobby's sensitivity to separation was highlighted by his extreme regression during my first vacation in the third month of the analysis. Halfway through that one-week hiatus, Bobby's symptoms, which had largely cleared up, returned with a vengeance. Extreme control battles occurred in almost every arena of his life. He became so provocative in taunting and hitting his older brother that his brother cried that he did not want a brother. Bobby cried routinely in his sleep at night and his enuresis and encopresis returned. He began to use his blanket and favorite stuffed animal as transitional objects, insisting on taking them everywhere. Most telling of all was the rapid resurgence of courting disaster (and punishment) as Bobby "accidentally" burnt his finger on a hot iron, lay down in front of cars, locked himself in the bathroom at the barber shop, and ran recklessly up and down bleacher seats while attending a rodeo.

Upon my return, the maternal transference deepened in our sessions together. Bobby again tested me, as he had done earlier, to see whether I could control his impulses and keep him safe and "good," just as I counseled his parents to do, by setting firmer limits in order to attenuate his anxiety. He balked at attending our sessions, fell asleep in the car on the way to them, and complained to his mother that he hated me, reactions and feelings which I interpreted as a result of my having left him for a week. During one session wherein Bobby had been shooting me, he ran out suddenly to his mother and started kicking her, seemingly illustrating that I was his mother in terms of his angry transference and that my "abandonment" of him had been experienced from the perspective of a maternal transference. During another session, Bobby played at having the baby monkey hit the mother monkey and vice versa. Then the baby monkey started to hit Dr. Sugarman. Bobby's repeated references to "bad guys" during such play sequences seemed to indicate both his guilt over his anger at me and at his mother, as well as a possible unconscious fantasy that his "badness" had caused him to lose me as punishment.

Once again I reinstituted limits on Bobby's messes and impulse expressions in an effort to reduce his anxiety. These limits included

cleaning up at the end of sessions so that he could see that his "messes" did not have to seem permanent. I also interpreted that Bobby was afraid that his angry feelings had caused me to go away and leave him for the week, and he wanted to make sure that I would be the boss of his bad guy feelings and protect him from being punished and hurt. Within a few sessions he stopped his struggles about attending sessions and seemed eager and happy to see me.

Improvement at home accompanied this change. There was also a shift in color preferences when painting or coloring. Until this point Bobby had always preferred somber colors, such as blue or black, over brighter colors. But his preference shifted to brighter colors as he became less guilty and frightened and more accepting of his emotions in the analysis. In fact Bobby began to skip around the house singing, "happy, happy, happy." And he became more autonomous with toilet activities as his increasingly rare accidents were linked to environmental triggers such as scoldings by his mother. At this stage Bobby's improvement seemed motivated primarily by his wish to please his maternal introject. He made comments such as: "Cookie Monster doesn't clean up the mess like I do. His mommy will be mad" or "I did poopy. Mommy's going to be proud of me." Superego ideals were apparent when Bobby would say, "See, I'm not a bad boy."

Bobby's guilt and anxiety over his anger were elaborated more verbally and symbolically as his anxiety diminished. During one session a "bad guy" wore a patch over his eye. I said that this looked like his brother (whose visual problems necessitated a patch at that time). Bobby agreed and explained that the "bad guy" with the patch had hit another man and hurt that man's eye, necessitating the patch. It seemed that the "bad guy" was being punished for his aggression by needing a patch also. Bobby seemed to take the talion of "an eye for an eye" quite literally. Castration anxiety seemed interwoven with superego injunctions not to be an aggressive "bad guy." Other evidence of castration anxiety also emerged. Bobby entered one session with a sword and tried to knock over my floor lamp. He then became "king of the castle," only to end the session with a "broken" Jeep being towed away.

During the fifth month of the analysis, Bobby told me proudly

that he was now big enough that his father allowed him to go up on the roof with him. He then complained that fleas had bitten him while he was up there. While showing me his flea bites he surprised me by suddenly dropping his pants and showing me his penis, and his castration anxiety. Such concerns were evident in his increasing discomfort with competition. For example, he interrupted a card game with me to proclaim: "Oh, no—I'm going to win." I said that he did not seem sure that he wanted to win. Bobby then won the game but immediately declared me a winner also, as he remained uncomfortable with defeating me.

Bobby's anxiety was exacerbated as he anticipated my one-month vacation at the end of the first year of analysis. In one of the last sessions before I left, he told me anxiously that he had forgotten to return one of the blue robots that I had allowed him to borrow. I said that it sounded like he was afraid that I would be mad at him and again think that he was bad; Bobby admitted that he was worried. I reminded him that he had worried that I had left him during my spring vacation because he was bad, and suggested that he might have a similar worry this time. He did not respond directly. But during the last session before my vacation, he made a suitcase out of construction paper and pretended to leave on a vacation. I said that he wanted to leave me before I could leave him.

Illuminating the Precipitant of the Symptoms

Continued analysis upon my return allowed Bobby's development to get back on track as he engaged phallic issues more clearly. For example, he carried a long stick between his legs, hitting the door and ceiling of the office with it. Soon he said that he was not big like his father but would get big and strong if he drank milk, adding a seeming non sequitur that babies get thrown in the water and sharks eat them up. I said that he must want to be big and strong so as not to have to worry about that. He agreed. I thought to myself that this statement probably had something to do with a time that he had fallen in a lake before his surgery.

Soon the lake incident became a preoccupation, both in sessions and at home. He told his mother that he had feared he would drown when he fell in the lake. And he told me that he had been afraid that a shark would eat him up so that he was all gone, and that this would make his "mommy and daddy mad." Superego projections were coloring his representational world by quite a young age. Such working through led Bobby to remember a time earlier in the analysis when his father had started the car accidentally while he was under it. In one session Bobby had a "good" policeman chase a "bad" policeman. Then the "good" policeman's Jeep needed to be fixed. It began to drive away while the man was underneath fixing it. I said that the car was driving with the man still under it. Bobby replied that cars did not do that and then said that sometimes cars *do* do that. Consequently I remembered out loud how his daddy had once started the car when he was under it. Bobby agreed that his daddy had done that, but refused to discuss his feelings about it. In another session he wanted me to play at running a car over him, and then tried to wrap the Venetian blinds cord around his neck. I stopped him and interpreted that he felt like he was so bad that he should be punished for his feelings about his daddy starting the car while he was under it.

Bobby's ability to express verbal fantasy improved markedly and more sophisticated defenses, such as displacement and externalization, became evident. Nonetheless, superego injunctions against his own aggression remained a primary conflict. During one session Bobby wrapped his hand in a cord and said that it was in jail because it had thrown rocks or telephones at people. I reminded him that he had thrown a toy telephone at his mother in the waiting room recently, which had made him feel like he was a "bad guy." I added that he was telling me that his hand was in jail because he seemed still to want me to help him not do things like throw rocks, things that made him feel like a "bad guy." Then I added that he also seemed to want me to punish him. Self-directed anger remained evident. After I set a limit on his behavior in one session, Bobby turned a toy gun on himself and pulled the trigger. I interpreted the defense against his anger at me. And his transference remained primarily maternal. For example, a "bad guy" said that he hated his mom and then fell down and

was injured. I interpreted that the guy felt so bad for hating his mom that he punished himself by falling down. Bobby expanded the theme to the mother being lost and taken by burglars, spelling out his fear that his anger led to punishment by abandonment. In another session a "bad guy" lost his mommy and went looking for her.

Such working through gradually allowed us to establish that Bobby often felt like a "bad guy" and assumed that things happened to him because of his badness. Once again he brought up the lake situation, allowing me to interpret that he feared that his daddy had let him fall into the lake as punishment because he was so bad. Although Bobby readily discussed further details of the episode, he denied feeling that his father had behaved purposefully. Soon, however, he had me tell him a story about a boy who was under a car when it started. Bobby went on to tell me that he was a "bad guy" and that he wanted to kill his daddy when he grew up because he hated his daddy. Rapid regression after these expressions of anger followed as Bobby fell asleep in his mother's lap in the waiting room, and once again refused to leave her.

Regaining Developmental Momentum

Continued working through of his guilt and anxiety led Bobby to become more verbal about wanting my help with his "bad guy" feelings. Conflict expression was increasingly confined to sessions and the Ts seemed far more comfortable with his episodic aggression at home as Bobby stopped his more flagrant misbehavior and regained bowel and urinary control. Oedipal themes became predominant in his play during sessions. Consequently a brief regression to messing, defiant behavior in sessions seemed related directly to the oedipal material. Exploration led first to Bobby's anxiety and guilt about my allowing him to "borrow" toys from my office. This parameter, which I had introduced initially because of his prominent anxiety about separation, had come to stimulate guilt over his wishes to steal my valuables. I interpreted accordingly and stopped allowing him to take toys home. But an alternation between phallic-oedipal themes and

messing, defiant regression continued. Finally I interpreted to Bobby that he had been wanting to take my things—my toys, my ship, and probably my penis. I said that he was acting once again like the little boy who used to make messes and not listen to rules because he was afraid that his big boy "taking feelings" would make me angry, and that I would try to take his penis away from him as punishment.

Bobby confirmed this interpretation by asking me to read him a story about a boy who was eaten by sharks, and then tell a story about a baseball player who chased sharks away with his bat. I wove into the story an interpretation that the little boy wished that he could have a big bat like the baseball player. Bobby interrupted me excitedly to talk about the little boy getting a big bat and beating up the shark on his own. Bobby appeared at the next session wearing toy glasses, seemingly an identification with me, that I took to indicate the prominence of oedipal conflicts in the transference.

Superego reactions to phallic aggression continued as men were jailed for speeding or fighting. But Bobby's ability to express such themes without running to his mother in the waiting room indicated that his superego's harshness had been reduced through analysis. He bragged to me about how tall he was getting and appeared for one session dressed like Superman. Themes of people being punished by falling off ships or falling into water after being bad occurred repeatedly. I pointed out that this theme had been coming up frequently. Bobby reported that he remembered falling in the lake on his family's vacation. I suggested once again that he thought it had happened because he was bad. Bobby admitted that this was so, and mumbled something about his father which I could not understand and which he would not repeat. Later in the play I had my action figure talk about being angry that its father had allowed it to fall in the lake. Bobby's figure responded by saying that his daddy had pushed him into the lake one time because his daddy was mad at him. Our figures commiserated with each other about how angry they felt toward their dads for such behavior.

Soon Bobby elaborated directly on his fantasy that he had been pushed into the lake by his dad to punish him for his anger toward his mother. In one play sequence, a baby threw its mother into the

mud after sticking its fingers in her face. Then the baby also fell into the mud. I interpreted that the baby was being punished just as Bobby had felt punished by his dad. Bobby agreed. His behavior continued to improve at home and his flirting with danger seemed a thing of the past.

Oedipal issues became overt in the transference as Bobby cheated at board games with me and then created obsessive rules that made it difficult for him to win. Or after winning he would declare that I had won also. I interpreted that Bobby felt bad if he defeated me. He agreed and asked if it was time to stop. I said that I thought he wanted to leave in order not to think about winning so much; winning made him feel like he was a bad guy who might get punished. Bobby resumed his competitive play, this time with action figures, and shot off my figure's various body parts, culminating in shooting off my figure's penis. He actually swaggered around the room after doing so.

I will stop this presentation of vignettes from Bobby's analysis at this point. Let me emphasize again that these vignettes have been chosen to highlight the contribution of Bobby's prematurely rigid and punitive superego to his symptoms. Other contributors to his encopresis were also addressed and worked on in his analysis. But it is my hope that these vignettes offer enough clinical data to demonstrate the thesis of this paper as well as to clarify how I worked with his superego.

DISCUSSION

Superego Issues in Encopresis

Bobby's work in the analysis amply demonstrates that superego elements played a prominent role in the genesis and maintenance of his encopretic symptoms. Throughout the analysis he repeatedly showed excessive self-criticism toward impulses arising from the gamut of developmental levels. At the time that he began analysis, Bobby's punitive superego injunctions were causing him to inhibit virtually all affect expression to the point that his face was mask-like and de-

void of emotion or expression. Narcissistic regulation was seriously impaired as he seemed to believe that he and his inner contents (feelings, thoughts, impulses, and feces) were bad. In addition, he was stifling a variety of ego functions in his effort to avoid being a "bad guy." Language and fantasy functioning were both inhibited in an effort not to think of or say anything "bad."

Verbalization of affect increases the ego's control over affects and drives while helping the child to distinguish fantasy and reality (Katan 1961). Children learn to verbalize their affects and to use them as signals through their mother's acceptance of their emotions and ability to put them into words (Tyson 1996). "If the mother is successful ...identification with her will include identification with her demands for drive restraint but also identification with her recognition of and regulatory response to affects as signals" (p. 181). But Bobby's mother seemed unable to recognize or regulate his anxiety or aggression. Only motoric expression was left as a vehicle for communication, given the lengths to which Bobby felt he must go to contain his badness; and even motor expression was inhibited in terms of facial features and spontaneity while playing. Encopresis was both a regressive response to his superego attacks and an attempt to elicit punishment to forestall even greater danger from harsh superego criticism. Thus, his early impulsive behavior, both at home and in sessions, seemed not to indicate an inadequate superego and a failure to internalize impulse control arising out of psychological deficit. Rather, I understood it (as well as his encopretic symptoms) as a concretization caused by superego criticism interfering with symbolic functioning (Segal 1957, 1978).

At the beginning of the analysis, Bobby was even more concrete than usual for a child his age. The harshness of his superego prohibitions against aggression, combined with the pervasiveness and intensity of his anger, left him virtually unable to verbalize or express symbolically, via play, internal states or mental contents. His superego forerunners, evident in his play, showed the absence of an internalized representation of his mother as a loving presence. Such a state of affairs is likely to have impaired his ability to feel safe and to be able to regulate his affects. He depicted his maternal representation as

critical of aggressive and active impulses. Hence, he could not identify with his mother and her abilities both to accept and to regulate such impulses. The preponderance of sadistic superego prohibitions would deprive him of symbolic channels for affect representation and modulation.

Instead, Bobby's cognitive processes remained concrete and characterized by symbolic equations wherein the symbol remained experienced as the actual object (Segal 1957). Angry thoughts felt tantamount to physical attack because he failed to internalize his mother's use of affects as signals. She responded to his angry thoughts and words as an attack; thus, he saw them that way also. Bobby's impulsiveness was the only means left to his immature ego wherein ego functions (such as cognition) that might promote better control were compromised by internal conflict. In such instances only behavioral action or psychosomatic discharge are available channels for impulse expression because they are so concrete and do not require the greater abstracting or symbolic capacities that are impaired by conflict.

Likewise, Bobby's encopretic symptoms did not reflect a failure to adequately internalize parental expectations and standards about bowel control. Rather, they involved a defensive externalization and concretization of his prematurely rigid superego prohibitions against aggression so that he unconsciously invited punishment for the badness which he assumed had led to him being pushed into the lake and having surgery. Thus, his encopretic symptoms should not be viewed as simply a developmental arrest along the developmental line of bladder and bowel control. Instead, his symptoms should be seen as involving internal conflict in which punitive superego injunctions played a significant role.

The pervasiveness of Bobby's guilt and the premature rigidification of his harsh superego indicated that he had experienced the precipitating surgery as a punishment for his "badness." Bobby repeatedly demonstrated that he regarded his aggressive impulses as bad and something for which he would be punished. The timing of his surgery, at the height of separation-individuation and developmentally normative aggression, combined with harsh and critical parenting, predisposed him to assume that all unpleasant occurrences

were a punishment for his "bad" anger. Thus, any upsurge of aggression could promote anxiety which led to punishment-seeking behavior. His wildly aggressive behavior also seemed to reflect an attempt to enlist environmental help in controlling the impulses which he feared he could not control and which he was convinced would lead to some other frightening punishment.

The analytic material demonstrates the early origins of neurotic conflict (Nagera 1966) as well as the superego (Tyson and Tyson 1984). That is, the prominence of Bobby's superego in the etiology of his encopresis highlights the coherence and influence of the superego far earlier than oedipal resolution. The degree to which it participated in his symptom picture seems to warrant it being considered more than just a superego precursor. The construct of the superego as a structure refers to a group of functions that work in integrated ways and have a slow rate of change. When a superego exerts as prominent and consistent an impact on a child's inner world as Bobby's did, it seems unnecessary and even inconsistent with the clinical data to call it a precursor and to differentiate it from the superego proper only because its content is preoedipal. Bobby's superego in the later stages of the analysis that were presented did not seem functionally different even when the content had become oedipal. Instead, Bobby's complex inner world supports the Tysons' (Tyson and Tyson 1990) emphasis on a developmental line of superego functioning. His critical superego at the beginning of the analysis was clearly based on his desire to comply with the demands of the maternal introject so poignantly illustrated in comments like "I did poopy. Mommy's going to be proud of me." But this early superego was as structuralized as the oedipal superego later apparent in Bobby's analysis.

Some might see Bobby's encopretic symptoms as a regressive response to traumas such as falling in the lake or undergoing surgery. But I believe that such situations are filtered through the individual's (even a child's) psychic structures which then determine how the individual experiences them. What is traumatic for one child is growth-facilitating for another. And I believe the clinical material supports my thesis that Bobby's harsh superego led him to interpret these occurrences in the ways I have described. In fact, some of the "traumas"

were actively precipitated by Bobby in a defensive effort to externalize his superego and replace internal guilt and anxiety with external "punishment."

Depression in Encopresis

Given Bobby's prematurely rigid and punitive superego at the time that he began treatment, one might question whether he should be considered to have been depressed. His preference for somber, muted colors over bright, primary ones at the beginning of analysis suggests depression. Certainly he demonstrated a number of the characteristics found in childhood depression at the Hampstead Clinic (Sandler and Joffe 1965). These include his manifestly affectless demeanor that gave the impression of great unhappiness, an incapacity for pleasure, a sense of feeling unloved, an inability to accept help or comfort, and difficulty making an emotional connection with the analyst. And the sense of inner badness which Bobby revealed over time illustrates the narcissistic depletion that characterizes depressed children (Bene 1975). Furthermore, the clinical material that unfolded in regard to Bobby's fantasies about both parents seems to indicate the disappointment in the idealized object that leads children to become depressed (Sandler and Joffe 1965) or to develop a depressive basic mood (Mahler, Pine, and Bergman 1975). The degree to which similar superego manifestations have been reported in other encopretics (Glenn 1977; Rosenfeld 1968; Shane 1967) raises the possibility of a more significant link between encopresis and childhood depression than has been recognized.

Technical Implications of a Superego Emphasis

Bobby's superego was strikingly rigid and punitive by the time he was two and one-half years old. Throughout the analysis he expressed repeatedly his belief that he was bad for a multitude of emotions, impulses, and behaviors. The prominence of superego issues in his psychopathology led me to conduct the analysis in a way that I believe

applies Gray's (1987) emphasis on analyzing structural conflict to the child analytic arena (Sugarman 1994). Modern thinking on child analytic technique stresses the need to interpret current conflicts and to de-emphasize interpretations of the past (Fonagy and Moran 1991; Kennedy 1979). Interpretation of current intrapsychic conflict with children removes impediments to structural development and maturation. Such structural change is maximized through facilitating conscious ego solutions to conflict (Chused 1992; Gray 1987). But promoting insight and conscious awareness of mental processes is difficult with child analysands, particularly ones as young as Bobby. "Language is less often a useful vehicle for promoting insight than behavioral enactments. That is, insight in a child may sometimes arise more from doing and perceiving something in a new way within the session than from new cognitive awareness" (Sugarman 1994, p. 331).

One of the factors that contributes to a child's inability to observe his or her own mental functioning is the immature, drive-laden nature of the child's superego (e.g., Sugarman 1991). Self-other differentiation and self-reflection become impaired by conflict if the aggressive-sadistic nature of the child's superego remains so unneutralized that narcissistic depletion occurs. Becoming aware of one's inner reality becomes too risky to the child if superego attacks will be stimulated by conscious experience of impulses, wishes, and fantasies. Complicating the matter further with children Bobby's age is their tendency to act on interpretations of impulse whereby the analytic verbalization of impulse is experienced as an invitation to enact it (Sandler, Kennedy, and Tyson 1980). Bobby's anxious returns to his mother in the waiting room after some of the early and premature interpretations of impulse demonstrate the young child's difficulty in dealing with such interpretations.

A reasonable implication can be drawn that interpreting the child's superego as Gray (1987) suggests can help the child learn to observe his or her own mental conflicts with less anxiety. Toward this end I generally interpreted superego manifestations to Bobby and the defenses that he erected to deal with them before I approached his impulses and emotions. These superego manifestations were interpre-

ted both within the play and in the transference. For example, I believed that an important (albeit not the only) determinant of Bobby's wish to see me as an auxiliary ego at the beginning of the analysis was his wish to enlist my help in being good and avoiding the reproaches of his superego. Approaching his material from the vantage point of the superego allowed Bobby to gain access to and become aware of the numerous fantasies and impulses that he feared; and he subsequently gained greater comfort with his emotions and impulses. He learned to verbalize them via his identification with my attempts to put his conflicts into words. As he did so and became able to use affects as signals, his capacity to symbolize improved, as did his ability to express himself verbally to an even greater extent. That is, an emphasis on superego interpretation did seem to give Bobby's ego greater control over inner states, and he became able to use affects as signals rather than become overwhelmed by them. It is tempting for the child analyst to emphasize interpretation of impulses in cases such as Bobby's because aggressive derivatives are so apparent. But doing so risks increasing the child's anxiety or triggering further superego recriminations that interfere with insight.

In conclusion, vignettes from the analysis of a two-and-one-half-year-old boy have been presented in order to emphasize the importance of superego issues in the genesis of encopretic symptoms. Attention to this determinant of these symptoms leads to a greater appreciation of the early appearance of neurotic conflict as well as the early origins of the superego. Finally, it suggests that many encopretic children suffer from childhood depression and problems in maintaining narcissistic equilibrium due to such superego issues. Awareness of this possibility expands the goals of such analyses beyond symptom relief to full analysis of the sadistic superegos and guilt that torment these children. It also leads to important technical implications about how to facilitate their awareness of their internal conflicts.

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PLAYING ONE'S CARDS FACE UP IN ANALYSIS: AN APPROACH TO THE PROBLEM OF SELF-DISCLOSURE

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A policy of consistent willingness on the analyst's part to make his or her own views explicitly available to the patient is discussed and illustrated by clinical vignettes. Playing one's cards face up is contrasted with contemporary conceptions of selective self-disclosure by the analyst, especially with respect to the way ground rules for the analytic treatment relationship get established. The objective of the analyst playing his or her cards face up is to create a candid dialogue, thus facilitating maximally effective collaboration between analyst and patient. Concerns about the analyst's self-disclosure foreclosing exploration of the patient's unconscious fantasies and transferences, or intruding upon the patient's autonomy, are addressed, as is the relation between self-disclosure and an individual analyst's personal style.

I think we can say that there is by now significant consensus among contemporary analysts concerning at least some aspects of the problem of self-disclosure. It's widely agreed that we need to re-think what we even *mean* by an analyst's self-disclosure, given that everything an analyst does is self-disclosing somehow or other, and given as well that every purposeful effort by an analyst at self-disclosure is likely to obscure some things about the analyst while it reveals others (e.g., Greenberg 1995; Renik 1995; Singer 1977). At the same time, it's widely agreed that intentional self-disclosure by an analyst, however

we conceptualize it, is an important element of clinical method (Miletic 1998). Clearly, we need to develop ways of thinking systematically about what, when, and how an analyst optimally discloses; but generalizations concerning this subject always elicit concern. No one wants to lose sight of the importance of taking into account case-specific factors and judgments particular to the clinical moment (e.g., Aron 1991; Cooper 1998; Rosenbloom 1998).

Analysts, overall, are reluctant to unequivocally endorse self-disclosure (Moroda 1997). Nonetheless, my own experience has been that clinical work benefits when the analyst takes a stance from which self-disclosure, rather than anonymity, is the norm. When I analyze, I try as best I can to play my cards face up: that is to say, I'm consistently willing to make my own views—especially my own experience of clinical events, including my participation in them—explicitly available to the patient. I find that it is crucial for an analyst to have what Frank (1997) calls "an attitude of willingness to be known by the patient" (p. 309). This attitude toward self-disclosure directly contradicts not only the long-standing, traditional technical principle of analytic anonymity, but the more contemporary idea that it is helpful for the analyst to be "selective" about self-disclosure, thereby maintaining a "relative anonymity" (e.g., Jacobs 1999).

I mean to propose that playing one's cards face up in analysis is a useful overall policy, a general principle that best directs an analyst's conduct in the clinical situation. Commitment to this policy can be difficult and requires discipline. An analyst's personal values—tensions between the analyst's narcissistic and altruistic interests, for example—are fundamentally and decisively implicated in the effort to play one's cards face up. Ehrenberg (1995, 1996) speaks directly to this aspect of analytic self-disclosure when she discusses it in relation to the analyst's emotional availability and vulnerability. Often, what is at stake for the analyst in describing his or her own experience is exposure to a kind of explicit, unameliorated scrutiny by the patient that can be most distressing. A willingness to self-disclose, in these moments, involves a choice for the patient's welfare over the analyst's comfort.

However, while there are ethical aspects to decisions concerning

self-disclosure, the main virtues of playing one's cards face up in analysis are practical. The attitude toward self-disclosure that I want to discuss is consistent with any number of trends in contemporary analytic thinking that take the analyst off a pedestal and permit the patient to claim greater authority, thus expanding the patient's functioning in the treatment situation. More and more, we have been leveling the clinical analytic playing field; and an important part of this process has been the discovery that explicit communication by an analyst of his or her experience is crucial to the sort of cooperation between analyst and patient that permits honest and open-minded clinical investigation. As Gerson (1996) puts it, "By allowing the patient access to himself or herself as a subject in the analysis, the analyst reveals a process of knowing rather than a known product" (p. 642).

Some colleagues have understood these developments to stem from a *Zeitgeist*—a movement toward greater democracy in the culture at large, a post-modern turn in intellectual life (e.g., Bader 1998). I don't agree. Over the years, there has been an evolution toward less self-importance and more candid self-exposure by analysts, and we fail to appreciate its significance if we dismiss it as determined by political aims or academic fashion. We have every reason to think that it has been motivated by immediate, pragmatic considerations: analysts have been learning how to establish a more collaborative treatment relationship with their patients because it yields better clinical results. My impression, which I would like to discuss and illustrate in some detail, is that playing one's cards face up is a more effective clinical practice than the deliberate pursuit of even relative anonymity.

NEGOTIATING SELF-DISCLOSURE

Of course, questions have been raised about the utility of purposeful self-disclosure by an analyst. One often-expressed, understandable concern is that too much emphasis on the merits of the analyst's self-disclosure disposes to an intrusive clinical approach (e.g., Mitchell 1997). Actually, I don't think the problem of intrusiveness by an analyst is specific to the activity of self-disclosure. Any aspect of an analyst's

method (whether it arises from the analyst's preferred theory, the analyst's character, or, very likely, both), whatever its virtues, will also have the liability of impinging upon the patient's freedom one way or another, and constraining analytic investigation. The only safeguard against intrusion by an analyst, I believe, is for the analyst to remain open to input from the patient about his or her technique. Certainly, a policy that directs the analyst toward self-disclosure has to be accompanied by a willingness on the analyst's part to pay careful attention to his or her decisions concerning self-disclosure and to deal with them collaboratively within the treatment relationship. The following still holds for me.

> I would say that an analyst should try to articulate and communicate everything that, *in the analyst's view,* will help the patient understand where the analyst thinks he or she is coming from and plans to go with the patient… I emphasize *in the analyst's view* because, clearly, patient and analyst may disagree about what it is useful for an analyst to disclose, in which case the matter becomes open for consideration—neither the analyst's nor the patient's view being privileged *a priori*…
>
> By acknowledging that an analyst's judgments concerning what constitutes relevant…disclosure on his or her part are subjective, we indicate a role for the patient as constructive critic of those judgments. This is a reciprocal of the analyst's familiar role as critic of the patient's self-disclosure. We know that when a patient tries to say everything that comes to mind, an analyst is able to point out things the patient overlooked. Similarly, when an analyst tries to make his or her analytic activity as comprehensible as possible, a patient is able to point out things the analyst overlooked. [Renik 1995, pp. 485-488]

In my observation, self-disclosure by an analyst does not lead to undue focus of attention upon the analyst at the patient's expense. In fact, just the opposite is the case: the more an analyst acknowledges and is willing to discuss his or her personal presence in the treatment situation, the less room the analyst takes up and the more he or she

leaves for the patient. A reticent analyst looms large, occupying center stage as a mysterious object of interest. The patient remains very well aware of being engaged in an encounter with another individual human being; and the patient's need to know the analyst's intentions, assumptions, values—the patient's need to know about the person with whom he or she is actually dealing—does not go away, even if the analyst deems it irrelevant to exploration of so-called "psychic reality" (see Renik 1998). I think we are all familiar with how a game of "Guess What's on My Mind" tends to be initiated when an analyst tries to remain even relatively anonymous. Too many patients have wasted too much time playing that game. My experience has been that, ironically, self-disclosure helps an analyst *avoid* becoming an intrusion. Here is an example.

Anne

In her analysis, Anne repeatedly seemed to need to relinquish critical thoughts about her husband when they arose, turning to self-doubt instead. Growing up, Anne had experienced her mother as loving, but quite controlling and intolerant of independence, let alone contradiction from her children. Anne and I discussed the possibility that her difficulty in feeling critical of her husband might connect to a sense of danger that she had learned in relation to her mother.

Anne was a TV journalist whose career was really starting to take off. One day, she described how her husband had seemed conspicuously uninterested when she was telling him, with great excitement, about a story she was working on. Anne considered that her husband might be threatened by her success; but after a time, she decided instead that there must have been something about the way she had been talking to her husband that turned him off.

After listening to her account, I said, "I'm confused. What gives you the impression that your way of talking turned your husband off?" Anne responded, with slight irritation, "I don't think you're confused, Owen. I think you have a view of what's going on. Why don't you just say what you think?" Well, of course, Anne was right. I wasn't really

confused. My hypothesis was that Anne had once more felt the need to criticize herself instead of her husband. However, I didn't know for sure that Anne was abdicating her critical capacities, and I expressed myself inconclusively because I wanted to leave room for the possibility that in this instance she might actually have been perceiving something about herself that warranted her self-criticism. I explained this to Anne.

She considered. "That makes sense," she said. "I can understand where you were coming from. But why didn't you just explain your concerns? Instead, you presented yourself as confused, and that wasn't really true—not to mention that it goes against your policy, which you've explained to me, of making your thinking explicit so that we can discuss it if we need to. Not that it's such a big deal, but why did you bullshit like that?"

Good question, I thought, and said as much to Anne. I told her what came to my mind. I was aware of not wanting to seem controlling like Anne's mother. The kind of presumptuousness that Anne felt she got from her mother was something I particularly dislike, so I was taking pains to be sure Anne experienced me differently. As the hour ended, I was thinking out loud in this vein in response to Anne's question.

The next day Anne began by saying how useful the previous session had been. She was curious about my personal reasons for reacting as I did; but the really interesting thing to her, the more she thought about it, was that I had been, in a way, intimidated by her—sufficiently concerned about her disapproval to even misrepresent myself a bit. She had never considered that I might be worried about her opinion of me. She always thought of me as completely self-confident and self-sufficient. She thought of her husband in the same way, but revising her view of me made her question her view of him too. Last evening she told her husband what had happened in her analysis and asked him whether he worried about having her approval. He told her he did. For example, he said, when she talked about her work, he was very reluctant to say anything because she frequently seemed to think that he was leaping to conclusions about what she was telling him.

So, Anne pointed out to me, there *was* something she did that

made other people back off from her. In that sense, she had been right the day before when she had distrusted the idea that her husband was too competitive to be interested in her work, and had wondered instead whether something about her way of talking to her husband had been the problem. Similarly, Anne went on, whatever my susceptibilities were, she realized that she had played a role in my becoming so careful with her that I pretended to be confused when I wasn't. Anne continued to elaborate how useful it had been for her to recognize that she could inadvertently intimidate other people by communicating her exaggerated sensitivities. She and her husband had gone on to have a very long talk about it last night, and afterward they'd made love more intimately and passionately than they had in years. Sexually, too, Anne felt, she'd been shutting her husband down without realizing it. Obviously, she concluded, she was too ready to assume that the people she cared about would treat her the way her mother had, and this expectation was having unintended, destructive effects in her personal relationships.

Discussion

To begin with, I hope I have illustrated what I mean by playing one's cards face up in analysis. At a couple of points during the session, Anne asked me, essentially, what I thought I was doing: first when she challenged my statement that I was confused; then, after I explained my understanding of why I'd said that I was confused, when she pressed me to explain my motivation for misrepresenting my state of mind. Each time Anne asked for my view of what I was up to, I gave it to her. I didn't decline to answer her questions, or even defer answering them, suggesting that Anne reflect upon her reasons for asking me what I thought I was doing. Instead, I responded to her inquiry as a constructive request for information that would be useful for her to consider, and we took it from there. Clearly, I was not striving for even relative anonymity. On the contrary, my aim was to be as explicit as possible about my own view of my participation in events.

Although I talked quite a bit about my own experience of events,

there was no evidence that Anne experienced me as intrusive. Actually, she and I collaborated on the nature and extent of my self-disclosure. Sometimes Anne asked me to say more about what was on my mind; at other times, she was explicit about feeling that it was not useful for her to inquire further about my thinking. Anne established her own need to know, and it seemed to work out very well. She certainly did a lot of profitable self-investigation, much of which could be described as transference analysis.

I find that I am able, by and large, to establish an atmosphere in which my patients feel free to ask me to say more if they think I need to explain myself further, or to say less, if they think I'm talking too much; an atmosphere in which I, in turn, can inquire into a patient's motivation if the patient appears to me either excessively interested in hearing from me, or conspicuously incurious about my ideas. Anne and I operated in such an atmosphere, and in my opinion, it is a sine qua non for honest, unfettered, and consequential analytic inquiry. Needless to say, there are times when collaboration about the analyst's self-disclosure is hard to achieve, and when this happens, the reasons for it are invariably worth understanding. It has been my experience, however, that my willingness to self-disclose elicits in my patients neither an insatiable curiosity about me, nor a wish to learn my opinions so that they can be taken as received wisdom. My impression is that in general, patients do not want to be intruded upon, and are happy to collaborate with their analysts to avoid being intruded upon, given the chance.

In this respect, the interchange with Anne that I've described has to be understood in the context of the history of her analysis. I intend my vignette to portray not only a particular clinical moment, illustrative of a policy of playing one's cards face up in analysis, but the effect of operating on the basis of that policy over time. Anne obviously felt quite free to confront me with her observations and inferences about my participation because from previous experience with me, she anticipated that if she did, she would get an accounting from me, and we would continue to discuss what we were doing—as each of us saw it—as long as that seemed useful. Had I been less forthcoming all along in her treatment, I doubt that Anne would have been as able to

inquire into my view of my own activity as she was in the hours I've reported.

AUTHORIZING THE PATIENT AS COLLABORATOR

It should go without saying that an analyst's view of his or her own participation in clinical events is irreducibly subjective. I think Greenberg (1995) sums up the situation perfectly when he says: "I am not necessarily in a privileged position to know, much less to reveal, everything that I think and feel" (p. 197). An analyst cannot reliably give an accurate, complete account of his or her participation in clinical events. Therefore, the point of an analyst's willingness to self-disclose is not that it provides the patient with an accurate, complete account of the analyst's activity. (For example, I was unable to explain myself very satisfactorily to Anne, as she was quick to point out!) *Rather, the benefit of an analyst's willingness to self-disclose is that it establishes the analyst's fallible view of his or her own participation in the analysis as an appropriate subject for collaborative investigation—something analyst and patient can and should talk about explicitly together.* This makes it possible for the patient to open up analytic opportunities by calling to the analyst's attention aspects of the analyst's functioning of which the analyst would otherwise not be aware. Anne's inquiry into my claim to be confused is an excellent instance in point.

Precisely for this reason, colleagues influenced by Sullivan and the interpersonalist school have for years been advocating the virtues of actively soliciting the patient's observations about the analyst's personal functioning within the treatment relationship (e.g., Aron 1991). However, they have tended not to recommend that the analyst respond with reciprocal self-disclosure to the patient's input. The assumption has been that an analyst's "…self-revelation can foreclose full exploration of the patient's observations and his reactions to them…" (Greenberg 1991, p. 70).

My clinical experience has led me to a very different conclusion. I have found that when a patient makes a pointed comment or in-

quiry about an analyst, if the analyst does not respond by giving his or her own view about what the patient is bringing up, if the analyst is unwilling to pursue an explicit exchange of views with the patient, as needed, then the patient concludes that the analyst is not really interested in receiving active consultation. When a patient calls an analyst's attention to aspects of his or her participation in treatment that the patient feels are significant, even problematic, and the analyst, instead of saying what he or she thinks about the patient's observations, encourages the patient toward further self-reflection, the patient learns that offering his or her observations will not be interpersonally consequential, and the patient becomes much less interested and willing to offer them. I find that when an analyst does not operate according to an ethic of self-disclosure, the analyst, despite claims to the contrary, discourages free confrontation and questioning by the patient. The analyst's unwillingness to make his or her own views available conveys to the patient that the analyst wishes to protect him- or herself by avoiding scrutiny. Usually the patient complies.

A willingness to self-disclose on the analyst's part facilitates self-disclosure by the patient, and therefore productive dialectical interchange between analyst and patient is maximized. When, on the other hand, an analyst refrains from making his or her own views fully available, for whatever ostensible reason, the patient eventually responds in kind and dialectical interchange between patient and analyst is constrained. It takes a second analysis for the patient to fully say what he or she thought about the first analyst, and a third analysis to say what he or she thought about the second analyst, and so on. In order for a patient to want to volunteer his or her interpretations of an analyst's experience (Hoffman 1983), the patient needs to have responses to his or her interpretations from the analyst.

I should note that by emphasizing the patient's role as a consultant to the analyst, I am diminishing neither the importance of the analyst's self-analysis nor the utility of obtaining consultation from colleagues. Both of these practices have been highly recommended and much discussed in our literature, with good reason. However, even if we regard the analyst's self-analysis as a central, ongoing aspect of clinical work, we can acknowledge its limitations. There is

significant truth, after all, to the old joke that the problem with self-analysis is the countertransference. Consultation with colleagues, too, while it is a valuable resource, is not a cure-all. An analyst only seeks consultation when he or she feels it is needed, and even the shrewdest consultant cannot proceed very far beyond what the treating analyst presents. The patient, however, is in a position to offer uniquely informed, in-the-moment consultation, even if the analyst has not identified a need for it. Had Anne not picked up on my claim to be confused, for example, I would never have noted it, let alone thought that it was worth looking into.

SELF-DISCLOSURE AND THE ANALYST'S STYLE

My own style as a person, and therefore as an analyst, is toward the active, exhibitionistic rather than the reserved end of the spectrum. All things being equal, I usually prefer to mix it up with a patient and field the consequences rather than risk missing out on an opportunity for productive interchange. By suggesting that the analyst play his or her cards face up, however, I am not rationalizing my personal style or elevating it into a technical principle. Willingness to self-disclose, as a policy, can and should apply across the individual styles of various analysts. In fact, whatever an analyst's particular style, by playing his or her cards face up, the analyst increases the probability that he or she will receive consultation concerning his or her personal style from a patient—which is exactly what an analyst is most likely to need, inasmuch as it is our personal styles that generate our blind spots.

When Anne inquired into my way of expressing myself, eventually exposing a subtle hypocrisy on my part, she was analyzing a component of my personal style. Even more salient was the patient who said to me, explaining how she felt I was getting in her way, "You know, Owen, I think you believe it's important for an analyst to be open and non-authoritarian, that you try to be that way with me, and that it has been very helpful overall. But besides that, I think you have

a personal stake in not being seen as domineering and unfair, so that when I see you that way, rightly or wrongly, you're quick to react and to try to sort it out; and that gets in the way of you being able to listen to me sometimes. So, ironically, you can wind up doing the very thing you're trying to avoid" (Renik 1998, p. 572). There I was, the analyst hoisted by his own petard: the atmosphere created by me playing my cards face up permitted my patient to constructively criticize me for a tendency on my part to explain myself too much! Thus, a disconcerting but exemplary consultation from a patient, which illustrates that a policy of willingness to self-disclose does not direct the analyst to talk about him- or herself all the time, but instead permits collaboration between analyst and patient concerning how much and what the analyst says about him- or herself.

Apropos this last example of the benefits of an analyst's willingness to self-disclose, I'd like to consider the relation between playing one's cards face up in analysis and idealization of the analyst by the patient. When an analyst adopts a posture of anonymity, it invites idealization of the analyst by the patient, posing an important obstacle to analytic work (see Renik 1995). On the other hand, an analyst's willingness to self-disclose obviously does not prevent idealization of the analyst by the patient, since it is at least as easy for an analyst to be idealized for being open, candid, or forthcoming as for any other reason. (There's a well-known story that makes the point. It's about the old Jewish man who gazed at himself in the mirror and mused, "You know, I'm not very good-looking; and I'm not very smart; and I'm not very rich; but boy, am I humble!") Furthermore, we know that idealization of the analyst by the patient is a crucial, useful phase in certain analyses—perhaps, to some degree, in all analyses—so that for an analyst to be intolerant of being idealized can be as much of a problem as for an analyst to require being idealized. I want to emphasize, therefore, that although I think we should not systematically *encourage* idealization of the analyst by the patient via a stance of analytic anonymity, the purpose of playing one's cards face up in analysis is not to *discourage* idealization of the analyst by the patient. Rather, *the purpose of an analyst playing his or her cards face up is to facilitate examination and revision, when necessary, of the analyst's modus operandi, what-*

ever it is—whether, for example, the analyst is too impatient with being idealized, or too eager to be idealized.

FORMS OF SELF-DISCLOSURE

In speaking of playing one's cards face up in analysis, I am referring to a consistent policy of willingness on the analyst's part to self-disclose. I mean to contrast playing one's cards face up with notions of selective self-disclosure (see, e.g., Jacobs 1999) which direct the analyst to consider non-disclosure his or her default position and self-disclosure an exceptional activity. I want to make clear, however, that an analyst's systematic willingness to self-disclose does not prevent the analyst from taking into account case-specific factors and judgments relevant to a particular clinical moment. Case-specific factors and judgments relevant to a particular clinical moment never mitigate *against* self-disclosure; they determine the *form* of an analyst's self-disclosure. The problem is not *whether* to self-disclose, but *how* to self-disclose.

Sometimes, playing one's cards face up in particular clinical circumstances seems a relatively straightforward matter. For example, when I awoke one morning, bone-tired with a very sore throat, I immediately telephoned Anne, who was my first patient of the day. "I'm sorry for the short notice," I said, "but I'm going to have to cancel our appointment today. It's nothing serious. I think I've got that twenty-four-hour virus that's been going around, so I hope to be in tomorrow." Anne thanked me for calling and wished me a speedy recovery.

Now, it is very rare that I cancel an hour on short notice, and I thought it likely Anne would worry if I didn't explain the reasons for my cancellation. I'm sure some colleagues would argue that by reassuring Anne, I foreclosed a useful opportunity for her to investigate her fantasies about my cancellation—for example, fantasies expressing hostile wishes toward me. I don't think so. In my view, had I cancelled without explanation, it would have been a contrived and mysterious act. Anne's reaction to such unnatural behavior would have afforded her little opportunity to investigate her manner of participa-

tion in ordinary human relationships.

Actually, we did meet the next day, and Anne began her hour by reporting a dream from the night before, following my cancellation. The dream was that she was lying on a couch, reading a book by Faulkner. Her first association to the dream was the title of one of Faulkner's novels, *As I Lay Dying;* and it made her remember that after my call, she'd had the thought that maybe I was sicker than I realized. Anne was embarrassed to recall thinking that because she felt it reflected her childish anger at me for not keeping our appointment. She was dying to see me, and I should drop dead for canceling! Clearly, my reassurance did not prevent Anne from entertaining a hostile fantasy. I would suggest that, in fact, having had my explanation for the cancellation available to her facilitated Anne's recognition that imagining me gravely ill was an expression of her own anger. If she had been left in the dark about why I cancelled, she could have more easily chalked up her *As I Lay Dying* dream to realistic concerns.

There are times, on the other hand, when the direction indicated by a policy of playing one's cards face up is not self-evident. One summer day, Anne walked into my office wearing a short dress made of thin, silky material that clung to her body, revealing every curve to advantage. Did a willingness to self-disclose direct me to tell her what was on my mind? Of course not. For an analyst to play his or her cards face up doesn't mean that the analyst free-associates. What it means is that the analyst does not keep his or her thoughts private *as a matter of analytic principle*. When an analyst chooses not to say something to a patient, the choice is made on the same basis as it would be in any conversation: What is the purpose of the communication? Is it likely to be understood as intended? I could not see that anything helpful would be achieved by telling Anne that I was turned on to her; in fact, I could imagine some negative consequences. I decided to keep my sexual feelings to myself for the same kinds of reasons that would lead me not to express sexual feelings stimulated by, let's say, my teenage daughter or one of her friends.

Now, as it happened, things became more complex when Anne, obviously aware that she had made an impression, asked coyly as she

entered my office, "Like the dress?" I said simply, "You look terrific." She smiled and thanked me. During the hour, her thoughts returned a number of times to my appreciation of her as a woman and my apparent comfort in acknowledging it. Various implications that this interaction had for her came to mind, especially in relation to what she had experienced as her father's rigid defenses against the anxiety stirred up in him when she began to mature sexually.

I chose to respond to Anne's flirtatious inquiry with a direct, but circumscribed description of my response to her. It seemed to work out very well. Of course, other ways of handling the situation might have worked out equally well or better. My point is only that while playing one's cards face up means that the analyst makes every effort to render his or her experience available to the patient, the particular way an analyst chooses to communicate his or her experience is determined by ordinary, pragmatic considerations. There was nothing specifically psychoanalytic about the aims and concerns that led me to limit as I did what I disclosed to Anne. I agree with Fitzpatrick's (1999) summary of the issues involved in dealing with the erotic aspects of the treatment relationship:

> While dangers of exploitation and overstimulation from disclosure of sexual and loving feelings by the analyst are well known, they may be counterposed by less obvious but equally strong dangers of confusion and seductiveness when the subject of the analyst's feelings remains taboo. We need a way of discussing these vital responses to our patients that will be neither exploitive nor withholding, but clarifying. [p. 124]

THE ANALYST'S SELF-DISCLOSURE AND COLLABORATION WITHIN THE TREATMENT RELATIONSHIP

Elsewhere (Renik 1998) I have discussed what I see as the disadvantages of various versions of the concept of a special, psychoanalytical

reality. I think it is of the utmost importance that we acknowledge that the clinical psychoanalytic situation is ordinarily real. What the analytic treatment relationship can be, within ordinary reality, however, is extraordinarily candid. That requires courage on the part of both participants. In order to be candid, a patient needs candor from his or her analyst.

Of what does an analyst's candor consist? As I mentioned at the beginning of these remarks, inasmuch as an analyst's activity is always determined in part by unconscious motivations, the concept of self-disclosure by an analyst is problematic. No matter how hard an analyst tries to play his or her cards face up, some cards will remain face down—and the analyst cannot know which ones, or how many. In other words, an analyst's effort to play his or her cards face up does not provide the patient with a reliable account of the analyst's activities. What I've suggested, however, is that an analyst's willingness to engage in self-disclosure does establish ground rules that make for a more truly collaborative, mutually candid interchange between analyst and patient about the treatment relationship than can take place when the analyst pursues a policy of even relative analytic anonymity.

I realize that a radical policy of willingness to self-disclose goes against long-standing, even currently prevailing, views in our field. I submit that self-disclosure by the analyst is an issue about which we can benefit from consultation from our patients—perhaps an issue about which we are *especially* in need of consultation from our patients. Most of all, I would say that we should be interested in the judgment of those patients who come to us simply to be healed, without any ambition to become analysts themselves. For example, Anatole Broyard (1992), fiction writer and essayist, in his extraordinary memoir entitled *Intoxicated by My Illness,* described what he wanted in the way of an interchange with his doctor. Broyard was reflecting upon the healing relationship in general, but I think what he had to say applies very well to clinical psychoanalysis in particular.

> While he inevitably feels superior to me because he is the doctor and I am the patient, I would like him to know that I feel superior to him, too, that he is my patient also and that

> I have my diagnosis of him. There should be a place where our respective superiorities can meet and frolic together. [p. 45]

Does this sound like the kind of treatment relationship that is facilitated by cautious self-expression on an analyst's part, designed to preserve a degree of anonymity? I don't think so. Broyard goes on to make the following recommendation:

> …In responding to [the patient], the doctor may save himself. But first he must become a student again; he must dissect the cadaver of his professional persona; he must see that his silence and neutrality are *unnatural*… [p. 57]

My impression is that Broyard speaks eloquently and cogently for most patients, and I think we are obliged to take what he has to say very seriously. If we believe, as Hoffman (1983) suggests, that the patient is a legitimate interpreter of the analyst's experience, then we need to listen to and respect the thinking not only of the patients we treat, but of those (the overwhelming majority) whose objections to clinical analysis are such that they do not come to analysts for treatment.

According to the popular view, an effective therapist is candid and forthcoming—like the ones we see in *Ordinary People* or *Good Will Hunting*. I agree with the popular view, the naive idealization that characterizes movie portrayals of psychotherapists notwithstanding. It seems to me that we are justified in recommending to analysts a policy of playing one's cards face up because, as a general rule, self-disclosure by an analyst is in the patient's best interest; and, in my opinion, the burden of proof is on an analyst who chooses to adopt a stance of even relative anonymity to show that the analyst is not protecting him- or herself at the patient's expense. When an analyst is consistently willing to self-disclose, the patient is more fully authorized as a collaborator in the clinical work. The patient's active participation may require the analyst to endure a measure of disconcerting exposure, but the analyst may also discover that he or she is no longer practicing an impossible profession.

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SOME IMPLICATIONS OF THE ANALYST FEELING DISTURBED WHILE WORKING WITH DISTURBED PATIENTS

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The analyst's experience of patients' disturbances is explored as an aspect of analytic technique. A number of premises are examined. First, it is expected that the analyst is committed to tolerating and understanding disturbances evoked in him by his patients' personalities and their disturbances. Second, that he regards the disturbances evoked in him as a form of manifest content to be understood in the usual method of association. Third, countertransference attitudes may propel the analyst toward rapid formulaic conceptions of his patients' disturbances or to considerations of diagnostic designations carrying serious, if not pejorative implications, such as borderline, narcissistic, perverse, or sociopathic. Such attitudes may also underlie the urge to consider psychotropic medications in response to the patients' disturbances. A selected review of the literature as well as illustrative work with disturbing patients are presented in support of the paper's premises.

There are many patients who are particularly disturbing to analysts both during a consultation and/or in the course of their analyses. It is not uncommon for analysts to respond to their own disturbances by deciding the patient is not suitable for a standard analysis that relies primarily on interpretation of elements of the patient's conflicts. Instead they may feel that the patient needs a preparatory psychotherapy and/or analysis combined with psychotropic medication and/

or a modified analysis which attempts to repair hypothesized defects in the patient's personality. These recommendations against analyses may be justified by diagnostic considerations (particularly those that lend themselves to pejorative elaboration such as borderline, narcissistic, perverse and/or sociopathic and the like), by diagnostic considerations that are considered indications for psychotropic medication, and/or by formulations that stress the influence of trauma, particularly early trauma in the genesis of the patient's hypothesized deficiencies. I suggest that, *in some cases,* these recommendations against analysis are rationalizations that analysts employ to diminish the unpleasure they experience with disturbed and disturbing patients.

In this paper I will focus on analysts' uncomfortable reactions to such disturbing patients, proposing that if self-analytic scrutiny is rigorously applied to them, productive analytic work with these difficult patients may be facilitated. For example, in the face of the tendency to readily prescribe psychotropic medication to such patients, I suggest that analysts' efforts to understand their own sense of disturbance with disturbed and disturbing patients *may* facilitate a better result in selected patients than would be achieved by combining analysis with psychotropic medications.

I will pursue the goal of this paper by selectively reviewing the history of analysts' attitudes toward the subject of the nature of the analyst's involvement and participation in the analytic relationship. Then I will present a brief vignette of an analysis I frequently experienced as disturbing, but that was successfully completed a decade ago, and data from a two-week period of more recent analytic work with a disturbed and disturbing patient. I will demonstrate that my ability to tolerate and understand the disturbances evoked in me by the first patient's anger and the second patient's depressive affect, and his repetitive, rageful, critical, and denigrating and at time paranoid attacks, facilitated the analytic work. Finally, I will discuss some of the theoretical implications of the clinical data.

The reality of analytic work is that the intensity of disturbances evoked in the analyst may be of much more than a signal nature and may persist for weeks and even years. I am espousing an analytic attitude that welcomes the disturbance as both evidence of a patient's

involvement in the analysis and as an opportunity for self-analysis.

The history of discussions of the analytic relationship, and its contribution to analytic technique and the therapeutic action of psychoanalysis, can be characterized as dichotomous. Freud's (1912, 1915) recommendations concerning abstinence and neutrality as well as his metaphors of the analyst as surgeon and/or mirror were progressively idealized and ritualized. This is in stark contrast to Freud's actual behavior with patients. Although stories of Freud's exploitation of patients abound, his formal recommendations were proposed to protect colleagues and analysands from the temptations of self-defeating exploitations. Ferenczi's (1920) revolutionary technical suggestions, as well as subsequent suggestions by Alexander and French (1946), added reactive impetus to the tendency to idealize Freud's technical recommendations.

This trend reached its zenith in the 1950s in debates about what constitutes proper psychoanalytic technique. In private seminars, Isakower popularized the concept of the analyst's functioning with the term "analyzing instrument." (Edited summaries of his ideas were later published in 1992.) Isakower conceived of the analyst as capable of observing his own evenly hovering attention (p. 207) and his patients' associations while experiencing a minimum of personal discomfort. This idealization viewed the analyst's disturbances as modulated and serving a signal function. Anything more reflected the possibility of a countertransference problem and/or the presence of an unanalyzable subject.

The years 1953 and 1954 are noteworthy in the history of considerations of the analyst's functioning in the analytic relationship. Eissler (1953), from an idealized perspective, explored the technical management of neurotics for whom correct verbal interpretation was insufficient to effect the integrative balance of their egos. He stated, "in the *ideal* case the analyst's activity is limited to interpretation" (p. 108, emphasis added). He discussed the possibility of "advising the patient" (p. 109) in the midphase of a "stalemate[d]" (p. 109) analytic situation to facilitate the use of interpretations. He defined this advice as a "parameter of a technique" (p. 109) and saw it as "a deviation...from a technique which requires interpretation as the *exclusive* tool" (p.

109, emphasis added). He proposed the validity of parameters as long as their influence was analyzed before termination. In addition, Eissler noted that in delinquents, "the basic rule is inapplicable because of the patient's intentional and adamant refusal to follow it...and insight cannot be conveyed to these patients by verbal interpretation—at least not in the initial phase of treatment" (p. 113). The characteristic behavior of patients Eissler designated "delinquents" may be found in other patients, particularly those whose personality organizations are characterized by action.

Stone (1954) seems to have considered a number of patients sicker than those discussed by Eissler. He understood that analysts working within "the widening scope" (p. 567) of psychoanalysis would experience significant disturbances within themselves in the course of their efforts to help their disturbing patients. From a more realistic rather than idealized perspective, Stone (1954) broadened the concept of parameter to "modifications" (p. 573) in technique. He emphasized modifications necessary to facilitate a "positive transference" (p. 588) that can withstand the inevitable hostile transference.

Stone was particularly interested in the analytic relationship and the influence of the therapist's personality upon it. He stated, "a therapist must be able to love a psychotic or a delinquent and be at least warmly interested in the 'borderline' patient" (p. 592). "...the therapist's personal tendencies may profoundly influence the indications and the prognosis" (p. 593).

I believe Stone (1961) wrote *The Psychoanalytic Situation* largely in response to his concern with the tendency of analysts to sado-narcissistically invest and ritualize the work. He stated, "I must state my conviction that the nuance of the analyst's attitude can determine the difference between [the analytic relationship and situation being experienced as] a lonely vacuum and a controlled but warm human situation, which does indeed offer...gratifications, along with its rigors" (pp. 21-22).

Subsequent years have witnessed a debate concerning the functions of the relationship in the therapeutic action of psychoanalysis. Some have proclaimed that analysis cures through love by re-creating the mother–infant relationship characteristic of the earliest years of

life. Arlow and Brenner (1966) wrote a paper that reads, in part, as a reaction against these tendencies. They emphasized the fundaments of the analytic situation, "the obtaining of data concerning the interplay of [the] conflicting forces [of the mind] to help the patient resolve or master intrapsychic conflicts through insight and understanding" (p. 43). They emphasized their appreciation of the need for flexibility in the application of technical principles: "depending... upon the capacity of the analysand to maintain his working relationship in the analytic situation, it may become necessary for the analyst to afford the patient some measure of gratification" (p. 35). They state their agreement with Stone's and Fenichel's (1938) stress on "the importance and value of being natural, human and unaffected in one's dealing with patients" (p. 41). However, they emphasized "that it may be extremely detrimental to an *analytic* situation for an analyst to behave toward a patient in ways that would be quite natural and expected in other social and professional situations" (p. 41, italics in original).

I am in basic agreement with Arlow and Brenner's perspective. However, in this paper I emphasize that although I consider the act of interpreting elements of conflict the uniquely defining characteristic of analysts' functioning in the analytic relationship, I view it as a nodal point that represents the culmination of a period of analytic work. In this paper I propose to explore an aspect of the work that is aimed at contributing to the ultimate analytic action of interpreting. In two cases I will consider the influence of my ability to tolerate and understand my response to my patient's disturbances upon the analytic work.

In stressing the influence of the analyst's ability to tolerate disturbances evoked in him, in the service of understanding his patient, I am emphasizing what I believe is implicit in Stone's suggestion. Stone suggested that the analyst had to be able to love a psychotic or delinquent in order to help him. At its fundaments the analytic relation is a loving and nurturant relationship within which adults can get relief from symptoms and pursue the possibilities nascent in their developmental potentials.

One problem with this conception derives from the profound subjectivity associated with the word "love" and the concept "loving."

How does the analyst love his patients? First, he attempts to accept them and experience them as just other human beings more similar than different from himself. At the beginning of the work, he is particularly alert and interested in patients' sensitivities and aversive responses to his offer to attempt to be of help. In addition, he is prepared to be disturbed by his patients, particularly his disturbed and disturbing patients.

In this paper, I emphasize that the analyst's commitment to tolerate and understand the disturbances evoked in him is an aspect of loving his patients. I am not suggesting that analysis cures through love. However, I am emphasizing that the form of relating I am describing is a sublimated form of loving that is a fundamental aspect of the data-gathering processes which characterize analytic work.

About fifteen years ago, my attention became focused on the significant influence of my response to a patient on the course of an analysis. Because Mr. S's analysis was completed about a decade ago, I can only report it schematically in this paper.

CASE 1

Elsewhere, I have described successful work with Mr. S, a very angry, 38-year-old, single engineer (Rothstein 1998, pp. 6-7, 140). He began our work expressing very intense anger in response to a number of my recommendations. Mr. S was a large, well-built man. He was an excellent athlete in violent sports and was prone to violent outbursts. Some of his reports of these experiences and his behavior made me quite anxious, more anxious than I had ever been with any other patient. He reported using a baseball bat to break the lights of a car that was double-parked, blocking the exit of his car. On occasion, Mr. S would slam my office door as he left. Mr. S's anger frightened me in a way that was "different." For a number of years I fantasized his physically attacking me. These feelings and fantasies influenced my view of his prognosis as guarded and evoked diagnostic considerations such as "narcissistic" and "paranoid" to help me manage my disturbance. I tolerated my disturbance for a number of years, but thought of it as a

"realistic" response to his pathology. It was not until a date told him that she felt that having sex with him was like being raped that I uncovered in myself an unconscious fantasy of being raped by him. The point I am emphasizing is that my anxiety was not just a response to Mr. S's pathology; it derived from my unconscious conflicts. Once I understood my own conflicts, the anxiety abated. Understanding my conflicts helped me to relax and function more effectively in our collaboration. The patient who had seemed so difficult could now be worked with more comfortably in the standard manner.

CASE 2

Mr. Q is a 40-year-old, single, African-American corporate executive. He originally sought a candidate analysis at a traditional institute, for lifelong difficulties, shortly after graduation from a prestigious university. He is extremely bright and articulate and was intensely motivated to begin analysis. In spite of positive sentiment by two interviewers, two other senior colleagues were cautious. One felt, "He is on the verge of a homosexual panic. The danger of a paranoid break is very great. The promiscuous fantasy life is a thin defense against the homosexual panic." Another stated, "This man has an incomplete ego and incomplete self-representations." As a result of these cautious sentiments he was felt to be not suitable for analysis with a candidate.

Soon after this evaluation, he began a reduced-fee analysis with a recent graduate. This failed after twelve years. Although Mr. Q maintained an idealized hope for cure throughout that experience, it was characterized by bickering. He complained constantly about his analyst's habitual lateness and his intransigent refusals to acknowledge a countertransference problem. He was enraged at his analyst's suggestions that the analyst's lateness be treated as "grist for the mill" and by his comment that Mr. Q's responses to it were more intense than those of any patient he had ever worked with.

A disturbing two-week period of work from the third year of his reanalysis is presented. It was characterized by bickering and enraged critical attacks on the analyst. Mr. Q's entire analysis has been marked

by repetitive bouts of such critical, enraged, and denigrating attacks on analysis and on this analyst. An important aspect of our collaboration has been my effort to tolerate and understand the disturbances these attacks evoked in me, particularly a frustrating sense of helplessness to reach him and engage him in meaningful dialogue concerning these episodes.

I understood his current disturbance to be a response to a number of significant disappointments he was experiencing in and out of the transference. He had just turned forty, he had experienced a very significant business setback, and had just missed the fifth analytic session of the preceding week due to the Fourth of July holiday. He was very agitated and depressed. He seemed persuaded that I was very angry at him and was about to lose control. He attributed much of his distress to his convictions concerning me and my states of mind.

He began the Monday hour after the holiday weekend by saying, "It's hard for me to talk about it. I'm depressed. It's qualitatively and quantitatively different from my second shoulder operation, but it's bad. It's the July Fourth weekend and I didn't go anywhere or do anything. I'm forty and I don't have a life. I was supposed to have a blind date last night and it got canceled. It will happen this week."

In reaction to the disturbance evoked in me by his depressive affect and his mode of communicating which I experienced as a complaining whine, I attempted to clarify the distortion that he did nothing over the weekend by asking, "You had two dates earlier in the weekend?" I missed the obvious transference implications at the moment for a variety of reasons. Among them was my wish to avoid the disturbance evoked in me by my anticipation of the denigration of me that a transference interpretation would probably have elicited. It was his style to respond to such interpretations with a statement like, "I knew you would say that. You analysts are always exaggerating your importance and putting yourself in the center of things."

In response to my request for clarification, he responded, "Thursday night I had dinner with the Spanish woman. She slept over. We had sex. It was good. She really likes me. Friday morning I had breakfast with Sarah. It was really intense. We spent the day together. Even though she doesn't want to have sex unless we have a relationship,

she gave me a blow job. Saturday I called Carmen [the Spanish woman]. We spent the day and night together. She went home on Sunday. I began to realize I hadn't done any work for Monday. I began to feel terrible about work. I hate it and there is nothing I can do about it."

I responded in what I thought was a humane, empathic manner, not, for the moment, considering what its impact might be on the intensifying homosexual transference. I said, "It is very difficult." He responded in an angry, denigrating tone. "I knew you'd say that. You're so predictable. All your interpretations are so predictable. You're only interested in my work situation." He paused and said, "I feel so hopeless about analysis. Maybe Stillberg [his first analyst] was not so great but I spent twelve years with him, two years with you, and years before that in psychotherapy. Nothing has changed, except maybe my sex life. I'm not confident this process can do it for me. Maybe I shouldn't struggle with you and work at it. Maybe I should go on Prozac. All you can do is focus on my work situation."

I responded, "Your work situation seems to be the acute stimulus to your being depressed." He responded angrily, "That's not true. Other people go away for the weekend." (I think to myself that there is no mention of my having left him for the weekend.) He continued, "I'm embarrassed to talk about it. And what about my height? I hate how short I am. That depresses me also." (I thought to myself that I, like his brother, am much taller.) Then I said, "This seems to be one of those times when you need to be critical of whatever I say." He responded in a more enraged and denigrating manner, "That's your usual second line of defense. It's so predictable."

I interpreted, "It's difficult for you at this moment to entertain the possibility that you enjoy denigrating me." He responded, "That's true; you're predictable. Is the session over?" As I said "yes," I felt deflated by his hostility, negativism, and pessimism. I conjectured that he wanted me to feel defeated as he felt defeated in his life in general and at his job in particular. I further conjectured that his denigration of me helped him to defend against his envy of me.

Mr. Q began the next session by saying, "I have a lot on my mind. To compound my depression, my good shoulder is painful. I had a

bad day at work with Jack [his boss]. I'm really worried about what happened yesterday. You don't like to be criticized and you say I like to denigrate. I don't agree. I think you miss huge chunks of what is important. Today I'm a lot more concerned about my shoulder than I am about work, and your response is always unsatisfactory. I can't believe you expect me to take your response seriously. Your response is ridiculous. I don't feel good about being here..." After a long silence, he repeated, "This is getting ridiculous. I don't know if I can continue to do this..." He went on, "I don't think you'd ever say this isn't working. It's like with Stillberg. I get addicted to you and could stay for fifteen years..."

After about fifteen minutes of similar associations, Mr. Q paused and said, "I have things on my mind and I guess I'll say them 'cause I'm paying for the session and I don't want to waste my money. I had a dream last night. A bunch of people were having champagne with their dinner and there was some notion that I was going to sue them for having champagne when things were such a disaster. I had the thought in the dream that a perfect breast fits into a champagne glass." He associated, "I don't know what the fuck the dream means. It could be my anger at the people at work who are going to be drinking champagne when I'm not." (I thought to myself that the dream confirmed my previous emphasis concerning the genesis of his immediate depression.) He continued, "The dream could be my envy of your weekend. Neither one of those interpretations resonate with me. I can never imagine your admitting you had a bad weekend. I see you as having a huge ego. Am I denigrating you? I guess I am."

I interpreted, "I sound like Jack." He responded, "Yes, I can't criticize him either. When I do he goes nuts. That's how I feel here." He paused and then continued, "I do not know what I'm going to do about my situation. If my good shoulder is fucked up, then I'm really in trouble. I guess I have trouble being anywhere right now."

The first half hour of the third hour of the week was characterized by angry complaints. Then Mr. Q reported a dream: "I was in a room off a corridor in a modern office building. I think a party was going on. I was wearing a white polo shirt. I stepped out in the hallway. Everyone in the room was afraid to step out in the hallway. Little

black letters were being shot down the hall like from a machine gun and then stickers or decals were being sprayed all over me." He associated, "In Shakespeare or Hamlet there is a line about using language like a dagger. It makes me think about what's going on here. The room in the dream is the meeting at work this coming Friday. There will be questions and answers and my language will express my murderous rage about being screwed in the deal. I just remembered another dream fragment. I was going into a cafeteria to eat. I could see into one of the mother-fucker partner's office who engineered the deal. Then I went into the bathroom and I could see into his office." He associated, "It makes me think of the similarities between what's going on here and there. Not much is going to come of that. The question is, how irrational and overreacting are my responses here and at work? No doubt I overreact to everything."

By the fifth session of the week, the impact of the week's work, the positive vicissitudes of external events, and his notifying me that he would cancel a session the following week, all influenced him to be in a better mood. The cumulative effect of these factors contributed to his feeling more potent, and therefore less threatened and less likely to experience my interpretations as anal penetrations. He became progressively more able to consider the transference implications of the week's experience. In particular he was able to reflect on its genesis in childhood power struggles in which his father attempted to impose agendas on him.

Finally, by the fourth session of the next week, Mr. Q was able to be less defensive while considering that his denigrating, critical complaining about analysis and my function as his analyst served to diminish his incipient homosexual panic. He began that session by reporting, "I'm in a really bad mood." After complaining for a half hour he reported a dream: "I was reading the *New York Times,* and in the right-hand column there was an article about the guy I'm named after, who was a civil rights worker in Mississippi and who was killed in the struggle to register voters. In the dream, he stole the Klan's uniforms, thereby rendering them impotent. I was impressed and thought it was an ingenious tactic, and yet I was disappointed that his modus operandi wasn't more violent and that he hadn't killed the bastards."

He continued, "My association to the dream is like it's what happened here with you yesterday. It's akin to my taking the diploma you get from a psychoanalytic institute and removing it from the wall. Then I can see you as an ordinary individual with wacky responses. I'm not sure of it, but it's what comes to mind." I responded, "I think that's right on." He said, "I'm not sure." I interpreted, "You experience me and my competency as a threatening potency. In response to your anxiety you seek to find something about me you can criticize to create the sense of my impotency."

Mr. Q responded, "It's hard to argue with that, but I'm having trouble sorting out what's my homosexual anxiety from my fear you are not hearing me and my sense of your incompetence." After a pause he asked, "Why am I doing this now?" I interpreted, "Your business setback, turning forty, your trouble with your shoulder, all contribute to your increased sense of vulnerability and to your being more sensitive."

He responded, "That makes sense." He was silent for a while and then resumed his complaining. Then he said, "The amount of anxiety and anger I feel is overwhelming. I hate my life right now. Obviously, a lot has to do with work. I hate Jack." [He elaborated.] "If I talked about all the things that go on with him, all I'd talk about is wanting to kill him. That makes me think of my mother asking me to speak at my father's sixtieth birthday party. She knows how much I hate public speaking. That makes me want to rip her head off. I'm so ambivalent about my father; I'd have to lie. For him to be retired at sixty makes me sick." [He elaborated.] "Where is someone who is helping me? That obviously is my rage at you." Work in the transference-countertransference momentarily diminished his anxiety and enabled him to experience the displacements into the transference from Jack and from the sources of transference, his parents.

Mr. Q began the fifth and last session of the week by criticizing and denying the possible validity of my interpretation of the dream he reported the previous hour. He continued his criticism of me, stating, "My experience of what's going on here is I have to shout to be heard." After elaborating, he noted, "I'm in one of those incredibly angry moods. Carmen called and my mother called. I'd like to kill

them and get them off my back. As I was driving here I felt like killing everyone who got in my way in traffic. I'm very angry. I don't feel good about being here. I don't feel good about communicating. I imagine there is this hostility between us. I believe you've been out of control."

After listening to him elaborate these impressions, I attempted to interpret them as projections. In response he asked, "Are we just going to ignore the validity of my criticisms of you and attribute it all to anxiety about my homosexual wishes?" I responded by answering, "Yes!" After a pause I continued, "Yesterday's dream portrays me as trying to kill you. If you feel I am threatening your life, it is understandable that you would want to defend yourself by critically attacking me." Mr. Q responded by accusing me of being murderously enraged at him, and elaborated this notion by describing my tone of voice. At this point, I responded countertransferentially by experiencing an urge to diagnose him as paranoid. I have referred to such diagnosing urges as "name-calling" (Rothstein 1998, pp. 77-90). Then I commented, "In the dream and in your thoughts in response to it, you experience me as truly wanting to kill you. There is truth in your perceiving my occasional frustration in response to you. However, that does not pose an actual threat to your life." This work heralded a brief period of productive exploration of his projective tendencies and his fear of losing control of his murderous feelings.

During this time it was difficult for me to be with Mr. Q. In response to the intense level of his resistance and its projective and attacking nature, I on occasion experienced countertransference hate. At such moments I would think, "Okay, quit the analysis, leave already!" Alternatively, I would remind myself that Mr. Q wanted me to feel that way. This reminder helped me to stay with him through this mutually disturbing period of analysis.

About six weeks after the two weeks of analytic work described and on the last evening of my vacation, after being away from Mr. Q for one week, I dreamt that I was fifteen minutes late for my session with Mr. A. I thought to myself that I was treating him sadistically as his first analyst did, by keeping him waiting. I felt panicked at the thought that I had set myself up to be humiliated by him. In the dream,

I reported this to my wife, who interpreted, "You enjoy being humiliated by him." I thought she was correct. Upon awakening, I reflected on the masochistic gratification explicit in my collaboration with Mr. Q. These reflections helped me to be more comfortable as I greeted him for his hour that evening.

DISCUSSION

The analyst's countertransference is both a response to and a shaping element of the analysand's transference. As the analyst works to tolerate and understand his disturbances in response to his experiences of disturbing patients, he minimizes their shaping influence and learns more about his patients and himself. The lesson seems to be *the more disturbances the analyst is able to tolerate, the more he is likely to learn about his patient and himself.*

It seems clear that Mr. Q was disturbing to his first analyst, to me, and to evaluators at the traditional institute where he first sought our help. These colleagues attempted to diminish their discomfort in part by labeling, or diagnosing him. I have described such diagnostic activities on the part of frustrated and disturbed analysts as "name-calling" (Rothstein 1998, pp. 77-90) and suggested that the urge to do so can be considered a possible indicator of countertransference.

There are certain similarities between my experiences of Mr. S and Mr. Q, as well as important differences. In the case of Mr. S, I was a bit "paranoid," while in the case of Mr. Q, he was the more "paranoid" collaborator. Both cases are amongst the most disturbing ones with which I have ever worked. It is important to stress that although each man struggled with intense negative oedipal conflicts, I experienced them quite differently. Mr. S frightened me; I feared being physically hurt by him. Mr. Q repelled me; I feared he would humiliate me by returning to the referring analyst and reporting my failures to him. Analyzing my unconscious wishes to be hurt in these ways helped me to be more comfortable in our collaborations.

Prior to understanding the masochistic determinants in me that contributed to my experiencing Mr. Q as disturbing, my commitment

to tolerating my disturbance allowed me to become aware of a pattern within the hour. Mr. Q would often critically attack me for the first half to two-thirds of the hour. If I resisted responding defensively, he would then shift the focus of his associations and often report a dream that might be worked on productively.

However, prior to my dream in which my wife interpreted my masochistic gratification, my occasional defensiveness in response to Mr. Q's critical attacks contributed to our experience of the analysis as a series of arguments or fights. Subsequent to my dream I was able to disengage from these enactments. I could interpret Mr. Q's wish to fight with me. More specifically, I interpreted his competitive wish to defeat me. This interpretation was helpful to Mr. Q. In addition, I became more able to create an environment in which he could experience the depressive affect associated with a series of events experienced as competitive defeats. These defeats contributed to Mr. Q's sense of being defective. It is important to help patients associate to their disturbances in the same way that they associate to the elements of a dream.

How does my perspective compare with the contributions of other analysts, working from different theoretical perspectives, who have described working with and thinking about disturbed patients? My answer to that question inevitably reflects my subjectivity. My comments on the literature are therefore not intended to reflect a thorough review of the subject, but rather to consider those colleagues whose work has influenced my development.

Bion (1962) contributed to the development of Melanie Klein's ideas by proposing a theory that explained the influence of optimal mothering on the development of infants' fantasy lives, thinking, and personality development. His contributions had significant technical implications for analysts working from a Kleinian perspective. In particular, they influenced them to be cautious concerning early, deep reconstructions.

Bion also conceived of the mother's "containing" the infant's projective identifications. What is important to our discussion is not only the idea that this is the infants' first form of communication, but that mothers are *affected* by their infants' distress, and their responses are

fundamental to infants' development. Bion elaborated his notion of container and contained to conceive of the mothers' optimal responses as essential facilitators of children's progression from the persecutory experience of the paranoid-schizoid position to the depressive position. He elaborated these ideas to develop a theory of thinking and implicitly a theory of therapy. Mothers and analysts "contain" infants' and analysands' projective identifications, thereby facilitating the transformation of primitive fantasies (beta elements) into less disturbing and more creative fantasies (alpha elements).

Kohut (1971, 1977, 1984) described characteristic transference and countertransference phenomena he believed to derive from arrested development of the self. The emphasis of his formulations is on mothers' empathic failures early in infants' lives. Kohut described a mirror transference that characteristically evoked boredom as a countertransference response. He described an idealizing transference and analysts' countertransference discomfort with delegated idealization. Analysts' attention to these characteristic disturbances would help them to be more empathic facilitators of their patients' selves. More specifically, the technical implication is that empathic understanding (similar to Bion's "containing" and Modell's "holding") would facilitate the emergence and development of primitive grandiose fantasies (similar to Bion's beta elements) and the development of the self. In addition, interpretive attention would focus on patients' disturbing experiences of analysts' inevitable failures as optimal empathic "self-objects." Kohut's (1984) emphasis in understanding the therapeutic action of psychoanalysis was on the ameliorative influence of analysts' nonverbal empathic understanding of patients. Interpreting, or as he preferred to say "explaining," was of secondary importance. He employed this emphasis to account for the fact that talented analysts of all theoretical persuasions get good results.

Modell (1976), drawing on Winnicott's (1965, 1969) ideas in a manner quite similar to Kohut, proposed a concept of "holding" (p. 288) to help analysts deal with their disturbances in response to analysands' self-involved aloofness, often experienced by the analyst as boredom. He conceived of this holding response for patients with disorders in ego development, which he felt would facilitate a

repair of their arrested early development.

I have experienced all these contributions as admirable efforts at working with disturbing patients. In that sense they have been helpful to me in developing an analytic attitude toward my experiences of disturbances with my disturbing patients. However, in my view, the limits of these formulations are that they suffer from being premature formulations; they explain disturbed patients and their disturbances as developmental disorders due to disruptions of relationships with mother during infancy or the toddler phase. The analyst is thought to be capable of repairing their (developmental) disturbances by providing some form of optimal responsiveness within the limits of the analytic relationship.

In recent years a number of colleagues have explored the subject of the analyst's participation in the creation of clinical events. It is beyond the scope of this paper to comment on these contributions except to note that they have influenced my interest in my subjective involvement in the work. Most notable in this regard are the contributions of Jacobs (1991), Boesky (1990), and Renik (1993).

The perspective emphasized in this paper derives from the organizing perspective of "compromise formation theory" (Brenner 1994). Analysts' disturbances are considered manifest contents to be understood in the context of the flow of both verbal and nonverbal associations. Self-analytic attention to the analysts' disturbing responses to patients facilitates the ultimate goal of interpreting the elements of patients' conflicts that contributed to these disturbances.

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REVERSING THE NEGATIVE CYCLE: INTERPRETING THE MUTUAL INFLUENCE OF ADAPTIVE, SELF-PROTECTIVE MEASURES IN THE COUPLE

BY DAVID A. BERKOWITZ, M.D.

The author discusses factors that shape the subjective meanings each member of the couple gives to marital interactions and the intersubjective disjunctions between the partners that can result. These include adaptive, self-protective mechanisms, the wish for mastery, guilt, and defense against grieving. Through illuminating these factors, psychoanalytic couple therapy can enhance empathic awareness of how each partner's attitudes, actions, and once adaptive defenses can actualize the other's transference expectations and evoke his or her painful and traumatic childhood relationships and experiences.

INTRODUCTION

Psychoanalytically informed couple therapy has borrowed from and elaborated on several related conceptualizations from individual psychology and the one-to-one therapeutic situation in order to form a bridge between the internal world of the individual and the interpersonal world of the couple. These have included such concepts as pro-

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jective identification, shared unconscious fantasy or assumptions, transference, and unconscious cueing and role relationship. Projective identification—wherein one member of the couple disavows and projects into, or actually induces, an aspect of self in the other—frequently has been used to describe and explain the dynamics of couples in conflict (Zinner 1977). A classic example of this process was Dicks's (1963) "joint personality," in which a hypermasculine husband was intolerant of his wife's emotionality because of rigid defenses against his own repudiated, repressed, dependent yearnings, which had been projected into her.

The shared fantasy, another bridging concept, refers to "layered, latent, ubiquitous, interlocking fantasies" containing themes that are consciously or unconsciously shared (Sander 1989). The shared fantasy has enormous explanatory appeal for understanding the dynamics observed in many couples. For instance, one often sees problems in intimacy related to a shared narcissistic vulnerability (Berkowitz 1985) or to a shared unconscious fear of abandonment (Avery 1977).

From the therapeutic side, simply discerning a shared fantasy can often enhance the empathy each spouse has for the other, which itself can beneficially influence the marriage. Uncovering a shared fantasy can thus be a crucial first step in the therapeutic process with many couples. However, while in cases of marital discord one always sees interacting unconscious fantasies or a shared participation or accommodation in neurotic conflicts, a shared fantasy cannot always easily be found. In addition, given the enormous complexity of marital interaction, it is important for the therapist to exercise caution in the attempt to fit the marital dynamics into a mutually shared dynamic or fantasy. Such attempts can narrow the therapist's focus and lead to oversimplifying the complicated, interacting dynamics of two individuals who each have unique intrapsychic issues and past experiences. Thus, although certain types of shared fantasies or assumptions may be compelling conceptually, in the clinical setting such conceptualizations often fail to do justice to the complexity of the marital interaction.

Sandler (1976) found the idea of putting parts of oneself into the

analyst insufficient to explain and to understand the processes of dynamic interaction in the transference and countertransference. He therefore posed the notion of role responsiveness to unconscious cues as an alternative to projective identification for understanding the workings of transference in individual therapy or analysis, describing countertransference as a compromise between the therapist's own tendencies and the role the patient unconsciously attempts to impose. Analogous to the individual analytic situation, attitudes and behavior in couples often can be understood as compromises between what arises from within each person and the adoption of the role relationship that is being unconsciously assigned to him or her by the other (Berkowitz 1984; Sandler and Sandler 1996). The wife's dependency in Dicks's example of the "joint personality," for instance, is fostered by a combination of her husband's unconscious need for her to play the dependent role and of her own inherent tendencies to act dependently. The situation with a couple, however, is more complicated than that of individual therapy. Rather than a "neutral" therapist[1] who carefully attempts to monitor his or her own countertransference, we are dealing with multiple, interacting partner-to-partner transferences and countertransferences in couples.

Porder (1987), too, found problems with the concept of projective identification. He argued persuasively that examples of projective identification often could be better understood as compromise formations, which included as their major component an identification with the aggressor, whereby an affect is induced in, rather than projected into, the other, and the childhood roles are reversed. In Avery's (1977) formulation of the dynamics of the sadomasochistic marriage, both partners struggle for power and control by inducing the fear of abandonment in the other. They do so because unconsciously they feel this is the only way to protect them-

[1] Of course, we know today, in light of the contemporary understanding of intersubjectivity, countertransference enactment, and social constructivism, that there is no such thing as a "neutral" therapist. I use the term here only to make my point that there is a greater complexity of transference and countertransference phenomena in the couple.

selves against the shared fantasy that they will once again become the helpless victims of a spouse who is perceived as a powerful and sadistic parent who withholds the love that the vulnerable child vitally needed for psychological survival. Because the two positions are viewed as either/or in unconscious fantasy, identification with the aggressor is a critically necessary defense for protecting the individual from the dreaded repetition of the earlier painful and helpless situation. Each tries to prove that he or she is more needed than needs the partner, because to need the other arouses the fear that the other will become empowered to reject and abandon, or use and exploit, i.e., to repeat the old trauma. While projective identification and identification with the aggressor are closely related concepts, the induction aspect that is assumed in projective identification seems more clearly articulated in identification with the aggressor.

Centrally related to all of these ideas is the notion of transference, traditionally defined as the repetition and displacement of feelings, thoughts, and behavior originally experienced toward significant early childhood figures onto the analyst or others in a current relationship (Greenson 1967). As one universal, ubiquitous determinant of every adult relationship, transference makes a crucial contribution to marital conflict (Berkowitz 1984). In an effort to offer a further understanding of the manifestations of transference within the couple, in this paper I will discuss some additional ways of conceptualizing marital conflict that I find clinically relevant. I will focus on factors that shape the meanings each partner gives to marital interactions—meanings that can in turn contribute to the "intersubjective disjunctions" (Atwood and Stolorow 1984) that often result between the members of the couple. These factors include, among others, adaptive, self-protective mechanisms, the wish for mastery, unconscious guilt, and defense against grieving, all of which may contribute to actualization of the partner-to-partner transferences and a tendency to reenact experiences from earlier relationships. I will illustrate these concepts with clinical vignettes throughout the paper, followed by a longer case example, and conclude with a more general discussion of treatment implications.

INTERSUBJECTIVITY, DISJUNCTIONS, AND STRUCTURES OF MEANING

As Levine and Friedman (1998) point out, contemporary analysts often use the term "intersubjectivity" to mean or imply very different things. Although it is emphasized to varying degrees in the literature, the common thread that runs throughout various conceptualizations of intersubjectivity is the idea that whatever takes place between analyst and patient is determined by mutual influence (cf. Dunn 1995; Levine and Friedman 1998). For instance, the intersubjective view holds that psychopathology in general cannot be considered apart from the context in which it arises and in which it is expressed. In the therapeutic situation, the therapist's view of the patient's psychic reality is shaped in part by the therapist's subjectivity, which is influenced by many factors, including his or her theories, beliefs, commitments, hopes, fears, defensive needs, wishes, character, experience, values, and gender.[2] Renik (1993) has referred to this as the therapist's "irreducible subjectivity." Interactions between analyst and patient are codetermined by the unconscious dynamics and defensive needs of both participants in the analytic process (Hoffman 1992). Analogously within the couple, each partner's perception and experience of the other also are shaped by his or her subjective perspective, and interactions are reciprocally and mutually influenced. As it is often said, members of a couple may bring out each other's best or worst attributes. The notion of intersubjectivity as mutual influence also fits with the earlier mentioned application to couples of Sandler's (1976) concept of role responsiveness, wherein each partner's attitude and behavior represent compromises between the individual's intrapsy-

[2] Gender is a very important aspect of the therapist's subjectivity that can contribute to misunderstanding in work with couples. As Buie (1981) has pointed out, empathy can be limited when there are no readily available points of reference in the mind of the therapist, such as those based on similar anatomy and experience. The therapist must then rely on his or her imagination and, in fantasy, try to imitate the patient in order to apprehend the latter's experience. When the couple therapist and patient are of different genders, it can limit the therapist's capacity to empathize with the opposite-sex spouse.

chic dynamics and the role assigned by the spouse.

An intersubjective perspective that emphasizes mutual influence in the couple can help to correct a tendency to view marital problems one-sidedly. For instance, it has been said that there is one relative contraindication to analytic couple therapy, namely, markedly unequal levels of psychopathology (Titchener 1966). Certainly each member of the couple brings his or her inherent psychopathology to the marriage. In some cases when there truly are significantly dissimilar levels of pathology, one spouse may be able to work through enough of his or her guilt so as to be able to leave the relationship. However, an intersubjective viewpoint alerts the therapist to the possibility that, what on the surface may look like very unequal levels of psychopathology, may in fact, on a deeper level, turn out to be dyadically mediated, co-constructed symptomatic expressions in the seemingly more pathological partner. The therapist's belief that one spouse is disproportionately troubled also may, in part, reflect his or her biases. As Trop (1997) has described, it is important for the therapist to analyze the roots of any of his or her own subjectively affected assessments of the spouse who is viewed as the problematic one. While there is a risk that a therapist who is influenced by an intersubjective perspective might persist too long in working with a couple where one spouse seems to be significantly more disturbed, I believe that the risk may be outweighed by the fact that a therapist with such a viewpoint may be more likely to approach such a situation with greater optimism about what might be therapeutically achievable.

At times it is useful to see intersubjective influence as stemming from (cf. Atwood and Stolorow 1984) the interaction of the two unique ways any couple has of organizing what from the outside looks like their common experience. In other words, each partner in a marriage interprets the other's actions and words according to his or her own multi-determined, unique organizing principles (see also Trop 1994, 1997). Neither member of the couple can be fully objective, and both are limited by a view from within their own subjective experience. As Winer (1998) points out, in marital treatment we are working with perspectives. An appreciation of the fact that each spouse's perceptions of marital interactions are subjectively determined can

help the therapist validate each partner's subjective experience in the presence of the other without invalidating the conflicting other point of view (Stechler 1998).

Atwood and Stolorow (1984) also described the occurrence of transference-countertransference-based "intersubjective disjunctions" in which the analyst assimilates what the patient is saying into his or her own subjective configurations, resulting in a significant change from what it means to the patient. Because, as I have discussed, both partners assign meaning to the other's attitudes, behaviors, and ways of relating based on their own subjective organizing stances, marital conflicts or disjunctions can result, analogous to those in the analytic situation. Therapeutically, I find it helpful to formulate and clarify the manner in which both partners structure meaning and the manner in which their unique ways of interpreting experience interweave, impact, or clash with one another. Such clarification and explanation can enhance reality testing of both partners' projections and fantasies about their spouse's motivations and can lead to greater empathy, as they progressively come to understand the basis of their spouse's perceptions, attitudes, and experience of the marital interactions. An intersubjective perspective and an awareness of the possible occurrence of intersubjective disjunctions can help the couple therapist to understand and interpret, as I will describe, how one spouse's most adaptive, self-protective measures can re-create a painful earlier set of circumstances for the other.

ADAPTATIONS: THE AFFIRMATIVE APPROACH TO RESISTANCE

In addition to the concepts I described earlier that attempt to bridge the gap between the internal world of the individual and the interpersonal world of the couple, I have also found it useful to focus on the ways in which conflict in a couple is given form by the mutual influence and the interaction between each person's earlier adaptations and defensive patterns. Although they may now be anachronistic, these adaptive mechanisms were once vitally impor-

tant to self-protection and emotional survival.[3]

This approach to understanding the couple is consistent with an affirmative view of resistance as put forth by Schafer (1983), Kohut (1984), Killingmo (1989), McLaughlin (1991), Slavin and Kriegman (1992), Bromberg (1995), and others. Resistance traditionally has been defined from the analyst's vantage point as opposition to free association and the therapeutic process. From observable resistances, we infer underlying, unconscious defenses, whose function it is to protect the self from both interpersonal and intrapsychic dangers. Resistances thus have important adaptive and coping functions and need to be understood and approached in an affirmative rather than an adversarial manner. Therefore, as Schafer (1983) suggested, one should focus on "what resisting is *for* rather than simply what it is *against*" (p. 162).

ADAPTATION, TRANSFERENCE, AND ACTUALIZATION

The reemployment of earlier modes of adaptation in current relationships is driven by the unconscious persistence or reactivation of wishes and fears related to primary figures, which are alive in the transferences to the analyst, couple therapist, and partner, despite the conscious awareness that he or she is different from the childhood figures. The best adaptive mechanisms employed by one member of the couple can then actualize for the other his or her most problematic relationships with important early objects through replicating aspects of the earlier circumstances. By "actualization," I refer to the experience of reality that occurs when the other's behavior seems to have fulfilled one's expectations (McLaughlin 1991; Sandler 1976). In contrast to Greenson's (1967) emphasis on transference as a distortion, today we believe that transference responses are also of-

[3] Titchener (1966) also suggested paying attention to interlocking defenses in marital therapy, although he did not focus on their adaptive aspect and had as his goal the neutralization of the drives for the purpose of greater drive control.

ten appropriate to contemporary stimuli in that the patient frequently perceives or experiences something in the analyst's responses that makes the transference seem "plausible" in Gill's (1982) term. Therefore, exploration of the transference must also include understanding the patient's experience of the current, here-and-now interaction that has contributed to shaping it. Similarly, when one member of a couple acts in a manner that is congruent with the other's expectations and predictions, the partner-to-partner transference becomes credible or plausible. Such interaction in the couple is reciprocally influential, akin to the interplay of transference and countertransference in individual treatment. Interweaving adaptations in interaction may thus lead to negative cycles of relating.

For example, when Mrs. A acted counter-dependently, as she had been forced to fend for herself as a girl, her husband felt like he didn't matter—that she did not need him. The intersubjective disjunction that resulted arose in part because Mr. A experienced this attitude solely as rejection, as he assimilated it into his own past experience with a rejecting and unavailable parent. When, in addition, in her self-sufficiency Mrs. A acted in a highly organized manner to the point of being slightly controlling—because that had been the only way she had been able to get her needs met as a child—he felt as if he were once again up against his very controlling and domineering mother. He participated compliantly, but reluctantly, and in this way he could feel that at least he was not submitting to a woman's agenda this time, thereby preserving a semblance of autonomy. Completing the cycle, his remobilization of the adaptive mechanism he had used in relation to his mother reinforced his wife's feeling that she was once again left alone with the burden all on her shoulders, as in girlhood.

In another instance, in the R couple (a case reported by Maltas [1998] and discussed by me [Berkowitz 1998]), the wife had been sexually abused by her brother in childhood and now refused sexual relations with her husband. Her husband had felt rejected in childhood owing to his mother's relative neglect of him and a preference for his older sister. Mrs. R's self-protective mechanisms, including dissociation and sexual refusal, were remobilized in response to her trans-

ference to her husband as an abusive brother, and evoked Mr. R's painful childhood experiences of neglectful rejection. Mrs. R's best adaptive measures thus actualized her husband's transference to her as an emotionally unavailable, depriving, and rejecting mother. In a negative cycle of interaction, becoming more desperate, he expressed his needs in an increasingly assertive manner, thereby confirming and actualizing her transference to him as a demanding as well as abusive brother. She, in turn, redoubled her efforts to protect herself. Each one then felt the relationship was on the other's terms, as it once had been in childhood, and resorted to more extreme measures in an effort to shift the balance of power.

Mrs. R interpreted her husband's asserting his needs *exclusively* as exploitation, in part because she assimilated it into her own past experience with her sexually abusive and demanding brother. In turn, Mr. R reciprocally experienced his wife's attempts to protect herself by her dissociation and sexual refusal *exclusively* as rejection, in part because he assimilated it into his own past experience with a rejecting and neglectful mother.

In another case, Mr. B became angry when his wife gave him several presents on his birthday, but did not make him feel "special" by providing a celebration with candles and a cake. When I asked what it was like for him, he said he felt depressed. I asked him to associate to the depressed feeling as well as to his anger, and he spoke poignantly with deep feeling of never having felt special to his mother, and of having felt lost in the crowd of siblings and cousins as a middle child in a large extended family. A further association was that his mother "easily gave the material things," but never made him feel truly "special." Thus, although his wife had spent a great deal of time carefully picking out presents for him, the structure of meaning into which he assimilated her gift giving made it hard for him to see the expression of love and caring in his wife's presents.

In another example of a chronic marital impasse related to an interaction between earlier adaptive measures, Mrs. C wanted more affection, warmth, and sexual intimacy with her husband. She complained that he would often be spacey or would sometimes leave the house and disappear. But he experienced her expressed need for

greater affection and warmth as intrusive control, due to his assimilating her needs into his experience of an earlier relationship with a father who demanded that he not separate. I interpreted his tendency to perceive her needs for warmth and closeness one-sidedly because they were reminiscent to him of his father's intrusive control. I asked him if the only way he had been able to have an autonomous life, separate from his father, had been by sneaking out. He confirmed my hunch by replying that in high school, the only way he had been able to see his friends was by "slipping out," because his father had constantly demanded his presence and involvement. I then clarified how his "spaciness" expressed covert rebellion. I also pointed out how it seemed to have functioned once as an adaptive defense: that tuning out his father had helped him preserve some sense of autonomy.

I also interpreted Mrs. C's tendency to experience her husband's spaciness as a personal rejection, because his behavior evoked and was assimilated into her experience of early paternal abandonment and ongoing maternal insensitivity and unresponsiveness. It was hard at first for her to see that her reaction was based also in part on a transference to him as both her abandoning father, who had left her for a time early in life, and her insensitive mother, who had rarely listened to her feelings. However, the intensity of her anger toward her husband, when she felt abandoned or not cared about, provided the clue to the fact that these old relationships had been actualized and were being relived.

REENACTMENT AND MASTERY

The marital interactions I have been describing are not merely the result of passively evoked reactions by members of the couple to one another's provocations. Rather, active attempts are also unconsciously made to recruit the other into reenactments of earlier relationships. I use the term "enactment" here as defined by McLaughlin (1991), who emphasized "a conjoint process of attempted mutual influence and persuasion" in the analytic situation to mean an act intended to forcefully influence or persuade another to react. The processes in

marriage involve a subtle combination of both passively reacting to another who spontaneously conforms to one's unconscious neurotic or characterological needs, fantasies, and expectations, and actively nudging or prodding the other into reenacting various aspects of early relationships. As Sandler (1976) described with regard to the individual analytic situation, "Such manipulations or attempts to provoke situations with the analyst are an important part of object relationships in general and enter in 'trial' form into the 'scanning' of objects in the process of object choice. In the transference, in many subtle ways, the patient attempts to prod the analyst into behaving in a particular way and unconsciously scans and adapts to his perception of the analyst's reaction" (p. 44). The conflictual earlier relationships are recaptured and restored through complex reenactments in marriages, through which attempts are made to repeat familiar, painful aspects of those relationships and to rework them in the service of mastery.[4]

GUILT

The push toward mastery notwithstanding, clinicians frequently underestimate a couple's guilt, which may be manifested in self-defeat-

[4] It is important to emphasize that although the literature often stresses the ways in which spouses tend to choose one another on the basis of neurotic fit, and while the need to repeat and atone are a very important part of the complex motivation in marital object choice, there is also a healthy potential in many marriages that initially appear to be hopelessly ill matched. People often choose somewhat rationally, healthily, and optimistically in addition to neurotically. Even marital choice that is based on the need to repeat frequently includes attempts at mastery and resolution in addition to the reenactment of frustrating object relations. Therefore, while masochistic object choice definitely occurs, in my experience it is often a less important factor in marital strife than is interactional, dynamic conflict. Once the therapist has begun to address the conflictual interferences, the pathological object choice may prove to be less of a problem than it had first appeared. For example, a woman in a stalemated marriage was initially convinced that divorce was inevitable because she had chosen an impossibly domineering husband. This feeling continued until she was able to discover in treatment that the tone of his voice was reminiscent of her harsh, commanding mother, and that she had responded to him with chronically smoldering, covert rebellion and withdrawal, which, in turn, had provoked and intensified his anger.

ing behaviors. Interpretation of the self-protective aspects of a couple's motivation, which are more ego-syntonic and closer to consciousness, while crucial, is often insufficient by itself to produce full therapeutic change. Bringing into awareness the guilt that underlies self-sabotage may also be necessary.

By guilt, I refer to feelings that one deserves to suffer or to be punished. As Freud (1916) noted, these feelings are often unconscious and when present may lead to unwitting attempts to provoke failure or punishment. While guilt feelings may also be conscious or preconscious, it is unconscious guilt that often causes couples the greatest difficulty. Unconscious guilt mainly derives from unconscious, intrapsychic conflicts over sexual and aggressive wishes at preoedipal or oedipal levels. Common examples of guilt that I have observed in couples include guilt over feelings of rage toward significant early figures; guilt related to wishful fantasies and desires in situations of trauma or abuse; guilt related to fantasies of being responsible for a deceased, damaged, or suffering parent, sibling, or child; and survivor guilt. A more conscious or preconscious guilt may result from chronic hostility between marital partners or failure to meet the spouse's needs in an ongoing relationship. What unites these different, often overlapping kinds of guilt, and is key to marital disharmony, are varying degrees of one or both partners' intolerance of the success of a loving and fulfilling intimacy. In many instances, an individual's intrapsychic guilt is a feeling he or she brings to the relationship that is present from the outset. In such cases, the relationship may be acceptable to the superego and may be permitted to develop only if it contains a built-in end or inherent hardships or frustrations. As fulfillment in an ongoing relationship increases, or as partners dare to reach for more intimacy, guilt-determined prohibitions against such fulfillment may be mobilized and expressed.

Guilty feelings that are unconscious or preconscious are inferred from self-defeating, masochistic tendencies that occur on a spectrum. Avery (1977) has described the chronic trading of blows in the sadomasochistic marriage. Even in less primitive couples, guilt can express itself in chronic fighting, in fighting that erupts

after moments of closeness, in calling up old grudges during tender moments, and in repeating behaviors that are clearly known to upset or irritate the spouse.[5] While these interactions serve to discharge aggression toward the partner, they are simultaneously self-punishing and function to prevent a deeper intimacy from developing. Guilt in couples also can manifest itself in negative therapeutic reactions and premature terminations. Sometimes the therapist can elicit a preconscious feeling that only limited intimacy is permissible, a sense of not deserving a more fulfilling and happier relationship, or a feeling that things are going so well in other areas of the couple's lives that they do not deserve to have it all. An interpretation close to the surface addressed to one spouse might be something like the following: "Perhaps you provoke and alienate your wife, knowing full well what effect that action will have on her, instead of having the marriage go the way you consciously wish, because you are conflicted about a fulfilling relationship when your father suffered and was so unhappy in his own marriage."[6] It then might be pointed out how the other spouse colludes for analogous reasons. The manifestations of unconscious guilt in couples that I am describing, I think, help explain the frequent observation that marital partners may thwart each other's attempts to be intimate.

For example, in addition to Mrs. R's expectable responses to trauma, including the well-recognized sexual dysfunction of incest survivors (Kramer 1990) and her growth-promoting steps I have described, I believe that she also felt unconsciously bad and guilty over

[5] Although I am focusing here on guilt, these behaviors are also often co-determined by other motivations, including, for instance, the fear that increasing feelings of love for the other leave one more vulnerable to the other's power to control, hurt, reject, abandon, etc.

[6] Deeper interpretations, circumstances permitting, might follow from the gradual exploration of childhood deprivation and its attendant rage responses, as Novick and Novick (1996) have described. In their analyses of self-defeating adult patients, they describe shifts away from masochism when latency-aged (and older) aggression is transferentially reexperienced. Interpretive work on externalized guilt over aggression, they feel, moves the patient from a victim stance to one of accepting responsibility for sadism and guilt with a resulting decrease in self-defeating tendencies.

the incestuous sexual abuse. Furthermore, her guilt was probably intensified as a reaction to the unconscious intense sadistic and revengeful fantasies that inevitably accompany such trauma. Mrs. R undermined intimacy and, along with that, her own chances for fulfillment in a loving marital relationship. Out of guilt, she also denied her own sexual interests, projecting those into her husband. This denial was reinforced by her need to disavow desire, an aspect of her self-definition as victim (Levine 1990). Such denial is also in keeping with Kantrowitz's (1990) observation that patients who have been traumatized by sexual abuse tend to cleave defensively to the victim role because maintaining the stance of being the victim not only preserves their position as not being the perpetrator, but also punishes them for their reactive unconscious or split-off aggressive impulses. Her guilt also caused Mrs. R to miss the invitation that her husband extended to her to participate in a warmer, more fulfilling intimacy. Instead, she converted that invitation into solely a demand.

Less apparent to the couple prior to treatment were Mr. R's sometimes angry and demeaning ways of demanding sex from his wife (Maltas 1998), focusing only on her sexual refusals. Thus, perhaps to a lesser degree, Mr. R, too, seemed unconsciously more conflicted than he knew and also did not appear to have full internal permission for intimacy. His guilt may have contributed to his presenting his sexual demands in a self-defeating way, thus ensuring that they would not be fulfilled.

Maltas also stated that they both "demonized" the partner in order to elicit caretaking and protection from their individual therapists. I believe that they did so additionally out of unconscious guilt, communicating to the therapist how much they suffered with a frustrating partner in order to appease the therapist who, at a deeper level, also may have been seen in the negative transference as a potentially depriving, harsh, judgmental parental figure as well as a helpful protector.

For another example, in the earlier mentioned B couple, an additional element that contributed to Mr. B's inability to experience the expression of caring in his wife's giving him the birthday presents was his guilt, which made him feel that he did not deserve her love.

DEFENSE AGAINST GRIEVING

This last vignette also illustrates that one's subjective perspective and related intersubjective disjunctions can also reflect a defensive stance against affects too painful to bear that may emerge when frustrated longings are finally fulfilled. Mr. B's wife did in fact seem to go the extra mile, and one wonders whether his unremitting view of her as withholding, rather than as trying to make him feel special, protects him from the sadness and grief over childhood deprivation that he would feel were he to acknowledge her efforts. In this connection, formulations of the expression of postponed grief over childhood trauma at the time when one finally feels accepted, similar to the moviegoer who cries at the happy ending, or "tears of arrival" when one feels profoundly moved by a poignant, long-awaited fulfillment of a wish, seem relevant (Avery 1983; Weiss 1952). As the wife in another couple poignantly and tearfully stated, "One night he put his arms around me and fell asleep, and I lay there crying and crying. It hurts to all of a sudden realize how empty I'd been. I'd had this big black hole in me, and all of a sudden he was touching it. It was so painful, and part of me wanted to run the other way." Many would prefer to avoid such painful grieving, and the persistence of an angry, blaming stance toward one's spouse in part may represent an attempt to halt the welling up of tears at such tender moments.

CLINICAL ILLUSTRATION

Mr. and Mrs. F, a successful sales representative and his wife, parents of an only child, came to treatment after years of chronic fighting. She complained that although her husband had been a good provider, he "neglected" her both emotionally and sexually, causing her to feel intense anger and depressive emptiness, which she tried to fill by shopping, overeating, drinking, smoking, and endlessly redecorating their summer cottage. He complained that she became extremely angry when he failed to fulfill her needs, that she had intense needs to be held and to be found "irresistible," that she overspent,

and that she demanded that he admit that she was right and apologize to her on his knees after a fight.

Early on, I noted that both had been deeply hurt and were in great pain. After I knew a little more about them, I said something like this to Mrs. F: "Yes, you have been repeatedly deprived and unresponded to, but I wonder whether this yearning to be held isn't only related to your understandable wish to feel like a desirable woman. Is it also related to longer-standing feelings of emptiness and a need for reassurance?" I added that her anger over his depriving her paradoxically seemed to reinforce his tendency to avoid her. I then said to Mr. F, "Yes, your wife is angry, does want a lot from you and has overpowered you at times, but how come you avoid her so much, and why are you so afraid of closeness?"

We subsequently traced each of their central marital disappointments to cumulatively traumatic childhood relationships. In consequence of these, Mr. F had turned against his own yearnings for closeness long ago. We discovered that his avoidance of his wife was more than merely a reaction to her anger and punishing behavior. On the one hand, his mother had been controlling, demanding, and perfectionistic, with high expectations that were difficult to satisfy, and on the other, she had related to him as if he were an extension of herself, so that he had never felt appreciated and accepted or valued as a separate, independent young man. A preferred older sibling also had been very dominating and critical. His father, though warmer, also had held high expectations for achievement and had very little emotional relationship with him. These experiences had formed the basis for two of his fears of being close with his wife: first, that she would impose demands and expectations and would find him inadequate, and second, that she would use him to meet her own needs without regard for him as a separate, unique person. I suggested that while his wife's tone was reproachful, he seemed to hear mainly the implication that he was inadequate—related to his own deeper feelings that he was not fully a man and long-standing poor self-esteem based on the early experiences with his parents. His transferential fears of her, however, were actualized by her intense need for reassurance and her anger when she felt deprived and unresponded to.

We discovered that Mrs. F, too, was not merely reacting to her husband's avoidance of her. She had had long-standing feelings of depressive emptiness, related to a failure to feel loved and accepted, dating from an early childhood with a father who had yelled, at times hit her, and had demanded submissive apologies on her knees. Behind that was a relationship with an unavailable mother who, though somewhat idealized, was "weak," had not protected her, and whose approval she could never win. In addition to trying to fill up the emptiness and soothe herself in the ways that I described, Mrs. F also tried to relieve these feelings through being held and could never seem to get enough of that. I interpreted how, through identifying with the aggressor, she unconsciously repeatedly put her husband in her childhood role, by now demanding that he acknowledge her having been injured, and then apologize to her on his knees. However, I suggested that she did so in large part because due to her intense need for him, she unconsciously feared that he had the power to force her to submit and beg for affection and approval now as her father had forced her to do in childhood. Lending support to this understanding, she said that she feared feeling like a "wimp" yet again.

Her husband's avoidance of her, which was a reaction to his fears of once again being demanded upon, found inadequate, and being used, unconsciously re-created Mrs. F's experience with her rejecting parents and her profoundly painful sense that she was inadequate to light them up, thereby reinforcing her need for reassuring confirmation through being held.

In a moment of closeness and passionate lovemaking, she angrily reproached him for not saying something adoring to her. She said consciously she was aware of thinking, "So when is the next time he'll hurt me?" Noting the self-protective aspect of her anger, I said to her, "Maybe you call on your anger over previous injuries during tender moments as a signal, in part to remind yourself not to trust him, not to open up and let yourself be hopeful and vulnerable again." She readily agreed. In addition, I interpreted how her guilt contributed to her angrily sabotaging those times when her husband did reach out to her and did offer her the holding that she so desperately desired. Like Mr. B, she, too, seemed to fear and therefore defend against

the welling up of old grief were she to acknowledge their tender moment together. In calling up old grudges during tender moments and in reproaching her husband in the same way as her father had reproached her, much like Mrs. R, Mrs. F masochistically defeated herself and the potential for closeness. I pointed out to her that, while after years of feeling emotionally battered, it is understandably not easy to let down one's guard; the attempt to protect herself in such a way also served to undermine the very intimacy she (consciously) yearned for.

Mrs. F's tendency to reproach her husband, in turn, unleashed his anger because it re-created for him his experience with a critical parent whom he could not please. An intersubjective disjunction here thus involved his seeing what in his wife's view were her attempts at self-protection, solely as angry rejection by a woman whom, once again, he felt inadequate to satisfy. Yet, with his withholding and expressions of anger toward her, he, too, appeared to collude in defeating intimacy, suggesting that he also suffered from underlying guilt as well as a possible need to defend against sad feelings engendered by tender moments.

Finally, with regard to the parallel transferences toward the therapist, I interpreted that Mr. F tended to view me as if I also were a demanding mother, just as he perceived his wife, employer, and clients, while Mrs. F, in a partially erotized transference, saw me as potentially fulfilling her needs for being held and accepted, and hinted that she wished that I, too, would find her "irresistible."

TREATMENT IMPLICATIONS

Psychoanalytic marital therapy is interpretive and emphasizes dynamic understanding and insight into the effects of each spouse's early experience in significant relationships. The therapeutic alliance is established by addressing both partners' chronic sense of hurt and by the therapist's accepting the legitimacy of each spouse's subjective distress and complaints, without taking sides, which helps both to feel validated. The therapist's acceptance of each partner's distress and

complaints as legitimate does not endorse them as necessarily justified in reality, but it does confirm them as valid expressions of the subjective experience of each person. While both may compete for the therapist's love, wish the therapist to take their side, and fear the therapist's allying with the other (Avery 1977), the therapist must strive to maintain a balanced empathy. Of course the marital therapist is vulnerable to the countertransference pull to take sides under the sway of the considerable transference pressures inherent in work with couples. However, it is to be hoped that he or she has the best interests at heart of both members of the couple and the marriage, and therefore will recognize and use such lapses for informative purposes. Overall, the most important ingredient in building the therapeutic alliance with both members of the couple is their having the sense that the therapist is genuinely trying to see the issues from each of their perspectives.

Ultimately, the members of the couple need to be helped to realize that their responses are not merely reactive to one another. The current marital conflicts are linked by way of each partner's intense affects to past childhood relationships and to unrecognized motivations and actions spawned by those affects. For it is largely the dissociation or isolation of painful affects related to childhood traumas, be those traumas acute or cumulative, that leads to inflicting pain in the marriage via identification with the aggressor (Avery 1977; Blum 1987; Davies and Frawley 1994; Fraiberg et al. 1975) and enactment.

Similar to individual analytic treatment, elements of therapeutic change in couple therapy include a combination of the development of insight through interpretation and the internalization of the relationship with the therapist based on a new experience. Different from individual treatment and unique to couple therapy is the potential that the marriage itself holds to actually provide some of the acceptance and emotional support that were missing in childhood.

Part of what constitutes the new experience in both individual and couple therapy includes the therapist serving as a model for an empathic attitude toward the patient's self that the patient can identify with and then internalize. In addition, the therapist's approach with each member of the couple, observed by the other, provides a

model for an accepting and empathic interaction, each with the other. The therapist's emphasis on trying to understand meanings stands in marked contrast to the destructive blaming (Lansky 1981) that often characterized both childhood and previous marital interaction. This helps to promote an atmosphere of safety that is crucial for therapeutic exploration in couple therapy. Through experience with the therapist, then, each partner may become more empathic, by which I mean more capable of putting oneself in the other's shoes, as well as more compassionate and emotionally supportive. *I want to emphasize that it is a specific kind of empathy that we are trying to foster in couple therapy, namely, an awareness of how one's actions, attitudes, and behaviors can actualize the other's transference expectations and evoke his or her early painful, traumatic childhood relationships and experiences.* Much the same way as does an individual therapist or analyst, the marital therapist not only serves as a model, but also provides, up to a point, some of the important relational experiences for each member of the couple that, in addition to empathy, often had been missing in childhood, such as validation, understanding, and affective engagement. Equally important, through interpretation, each member of the pair gains insight into his or her own and the other's motivations. Interpretation of each of their transferences toward the therapist, as these parallel their transferences toward each other, can further enhance the understanding of the marital interaction. The therapist's countertransferences to each member of the couple can function both as an interference and as an important informative source of understanding about the partner-to-partner transferences and the impact that each of these has on the other member of the couple (see also Solomon and Siegel 1997).

An intersubjective viewpoint and an awareness of intersubjective disjunctions can heighten the therapist's attunement to mutual influence in a marriage and to conflicts that may arise from the tendency of both members of the couple to interpret marital interactions according to their own multi-determined, unique subjective perspectives. An affirmative approach to resistance and defense facilitates the understanding and interpretation of the ways in which conflict in a couple develops in part from the mutual influence of earlier self-pro-

tective measures that at one time had served adaptive and coping purposes. This approach enhances alliance formation, which then makes it possible to also point out the maladaptive features of their interaction in the present. Each member of the couple can begin to grasp the impact that his or her defensive functioning now has on the partner, including, for instance, how the experience of an old traumatic relationship may be re-created or actualized for the other. In my experience, this almost invariably helps place the other in a more human perspective and leads to a greater capacity for empathic understanding. This kind of new, reparative experience with the spouse that couple therapy facilitates can help to temper the deeply ingrained old convictions.[7]

For instance, recall our earlier example of the A couple, in which Mrs. A's tendency to be self-sufficient and counterdependent evoked for her husband his childhood experience of not mattering to a rejecting and neglectful parent. When the mutual influence of interweaving adaptations was interpreted, Mr. A could begin to understand why his wife vitally needed to maintain that defense and could begin to see her vulnerable side, the little girl underneath the counterdependent and pseudo self-sufficient exterior. Mrs. A, in turn, could begin to empathize with her spouse as the small boy who was fighting to preserve his autonomy rather than merely resisting her.

In a similar fashion, in the case of Mr. and Mrs. F, at a later stage of the treatment, the husband gradually could begin to see his wife also as a hurt and needful little girl behind her angry and frightening exterior. She, in turn, could begin to see her husband also as a vulnerable boy who was frightened of a powerful mother, rather than as solely rejecting her personally.

Finally, in pointing out their self-sabotage, the therapist implicitly gives permission for the couple to move forward and tolerate the painful affects related to success, thus opening the door to a deeper, more fulfilling emotional intimacy.

[7] In a related vein, Titchener (1966) suggested that in the mature marriage, the old patterns of defense and adjustment are seen as inappropriate in the context of an adult marriage.

SUMMARY

In summary, the purpose of my paper has been to describe how the understanding and interpretation of certain aspects of marital interaction is useful for promoting therapeutic change. In my view, the basis for the recurrent negative cycles of interaction in couples can be found in the mutual influence of their subjective ways of organizing experience, the partner-to-partner transferences (some of which are evoked and actualized), the once adaptive defenses that are remobilized in reaction to those transferences, the pressure to reenact earlier painful relationships in the service of mastery, and the powerful influence of unconscious guilt. The psychoanalytic couple therapist establishes an alliance with each partner and uses both the transferences to the therapist and his or her countertransferences to further the understanding of the couple's dynamics. Interpretation of the interplay between the partner-to-partner transferences and the adaptive reactions that they provoke can lead to mutually enhancing cycles and a specific kind of reparative empathy.

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THE WISE BABY AS THE VOICE OF THE TRUE SELF

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Sandor Ferenczi wrote about a typical dream of the "Wise Baby" and later used this figure to represent the child who is traumatized into precocious wisdom, who becomes "the family psychiatrist." We discuss Ferenczi's theory of traumatization and the "split self," noting how it was taken up in D. W. Winnicott's "True Self/False Self" conceptualization. We then present three patients' wise baby dreams to show how these trauma theories can be used in dream interpretation and how dream interpretation can support them.

Sandor Ferenczi was fascinated by a typical dream that he called "the dream of the wise baby." In 1923, he wrote a short communication under that title. Eight years later, while in the midst of his controversial technical experiments, he referred to the dream again in "Child Analysis in the Analysis of Adults." Finally, he gave the dream a prominent place in "Confusion of Tongues Between Adults and the Child," which he delivered at the Wiesbaden Congress in 1932, less than a year before his death. The dream of the wise baby, Ferenczi came to think, shows very clearly how people "autosymbolize" the narcissistic splitting in themselves which is their determinative way of responding to trauma. Now—after almost seventy-five years—Ferenczi's trauma theory is beginning to assume the important place it deserves in psychoanalytic theory, carried along by D. W. Winnicott's adoption of it into his theory of the split True/False self. But the dream of the wise baby has not followed the split self theory into contemporary psycho-

analytic writing. In order to appreciate how Ferenczi's and Winnicott's trauma theories can be used in dream interpretation, and how they can be elaborated by dream interpretation, we would like to present and discuss three examples of the dream of the wise baby.

FERENCZI'S WISE BABY: THE SPLIT-OFF SELF

Ferenczi's original short communication in German about the dream of the wise baby appeared in the *Zeitschrift fur Psychoanalyse.* A revised version of the whole note follows:

> Not infrequently patients tell their analysts dreams in which there are newborns, babies in their cradles, or young children, who are able to talk or write fluently, offer up profound sayings, carry on intelligent conversations, deliver harangues, give learned expositions, and so forth. I imagine that behind such dream contents something typical is hidden. The superficial layer of dream interpretation in many cases points to an ironical view of psychoanalysis, which, as is well known, attributes far more psychical value and permanent effect to the experiences of early childhood than people in general care to admit. The dreamer's ironic exaggeration of the intelligence of children, therefore, expresses doubt about psychoanalytic theorizing on this subject. But, because wise babies also appear in fairy tales, myths, and traditional religious history, as well as in paintings (see "Debate of the Young Mary with the Scribes"), I believe that they, furthermore, serve patients as a medium for deeper and graver memories of their childhoods. The wish to become learned and to excel over "the great" in wisdom and knowledge is a wish to reverse or overcome the situation of the child. Such a wish in dreams of this content that I have observed is also illustrated by the pithy exclamation of a ne'er-do-well: "If only I had understood how to make better use of the position of the baby." Lastly, we should not forget that the young child is in fact familiar with much knowledge that later becomes buried by the force of repression. [1926, p. 349]

In 1926, when he included this note among his collected papers, Ferenczi continued on with his line of interpretation by adding a footnote to the effect that he had recently observed that wise baby dreams "illustrate the child's actual knowledge of sexuality." As an appreciator of the instinctual drive theory in *Three Essays on the Theory of Sexuality*, Ferenczi was emphasizing what the wise baby knows about sexuality and what the dreamer remembers from babyhood about being helpless and at the mercy of those surrounding adults who know more. But by 1931, the wise baby dream had quite a different story to tell.

Ferenczi hoped to convey in "Child Analysis in the Analysis of Adults" how his innovative techniques had allowed patients to communicate their early traumatic experiences by sponsoring "deeper relaxation and more complete surrender to the impressions, tendencies and emotions" (p. 128) arising spontaneously in them during analytic sessions. He related that his patients would sometimes play childlike games of question and answer with him, if he spoke simply enough; that sometimes they actually played, drawing pictures or making up little poems and rhymes; and that sometimes they would sink out of such play into a "twilight state" in which they reenacted a childhood trauma, often while experiencing the analytic situation itself as a traumatizing abandonment.

When feeling hurt, disappointed, or abandoned by their analyst, Ferenczi's patients developed a "split of personality" along the lines of their childhood splits in response to trauma:

> Part of the person adopts the role of father or mother in relation to the rest, thereby undoing, as it were, the fact of being left deserted. In this play, various parts of the body—hands, fingers, feet, genitals, head, nose, or eye—became representatives of the whole person, in relation to which all the vicissitudes of the subject's own tragedy are enacted and then worked out to a reconciliatory conclusion.... [1931, p. 135]

In their fantasies, too, the patients often presented or auto-symbolized themselves as "a suffering, brutally destroyed part and a part which, as it were, knows everything and feels nothing" (p. 135). A

knowing head part might be fantasized as connected by a thread, for example, to a suffering body part. Or, in dreams, the knowing part could be represented by the wise baby. What the wise baby of a dream knows is the child's trauma story.

Taking up the notion of splitting again in his general description of "the mechanism of the genesis of a trauma," Ferenczi noted that part of the patient's body, or even all of it, becomes the site of the patient's "deadness"—it becomes flaccid or inert, killed. He called the wise baby or the head the survivor, much as contemporary trauma theorists understand that the body has memories of trauma, which the head knows about and can sometimes recall—or dream. Ferenczi commented:

> It really seems as though, under stress of imminent danger, part of the self splits off and becomes a psychic instance self-observing and desiring to help the self, and that possibly this happens in early—even the very earliest—childhood. We know that children who have suffered much morally or physically take on the appearance and mien of age and sagacity. They are prone to 'mother' others also: obviously they thus extend to others the knowledge painfully acquired in coping with their own suffering, and they become kind and helpful. It is, of course, not every such child who gets so far in mastering his own pain; many remain arrested in self-observation and hypochondria. [1931, p. 136]

In 1932, Ferenczi turned his attention from traumas of abandonment to traumas of abuse—traumas of "more love or love of a different kind" than children need—which may also be reenacted in the analytic situation, especially if the analyst is hurtful in his "professional hypocrisy" or his "restrained coolness" or even his "dislike of the patient." Abused children often become paralyzed, Ferenczi noted, and unable to express their reactions of hatred, disgust, or refusal. They cannot respond to sudden unpleasure with defense. In their anxiety, they are compelled "to subordinate themselves like automata to the will of the aggressor, to divine each one of his desires and gratify these" (1933, p. 162). The aggressor, with whom the child has identi-

fied, is installed intrapsychically, so the child loses any sense of the real person outside and is thus able to maintain tender feelings for the abuser. But, because the child has introjected at the same time the abuser's guilt feelings, the child is not able to consider the actions engaged in as entirely harmless and loving play—they become punishable offenses. The child then ends up feeling both innocent and culpable, "with the confidence in the testimony of his own senses broken."

When Ferenczi had described in more detail the mechanism of the genesis of a trauma of abuse and suggested that splitting can go as far as the condition now known as multiple personality disorder, he noted the two main ways in which children struggle to overcome their hurt. First, they use denial: a split-off part regresses into the state of happiness that preceded the trauma. Second, they may—and Ferenczi admitted he had only recently encountered clinically this mode of overcoming—activate "latent dispositions which, uncathected, waited in deepest quietude for their development" (p. 165). This traumatized child becomes a wise baby by activating latent wisdom and progressing developmentally:

> When subjected to a sexual attack, under pressure of such traumatic urgency, the child can develop instantaneously all the emotions of a mature adult and all the potential qualities dormant in him that normally belong to marriage, maternity, and fatherhood. One is justified—in contradistinction to the familiar regression—to speak of a traumatic progression, or a precocious maturity. It is natural to compare this with the precocious maturity of the fruit that is injured by a bird or insect. Not only emotionally, but also intellectually, the trauma can bring to maturity a part of the person. I wish to remind you of the typical "dream of the wise baby" described by me several years ago in which a newly born child or an infant begins to talk, in fact teaches wisdom to the entire family. The fear of the uninhibited, almost mad adult changes the child, so to speak, into a psychiatrist and, in order to become one and to defend himself against dangers coming from people without self-control, he must know how to identify himself completely with them.

> Indeed, it is unbelievable how much we can still learn from our wise children, the neurotics. [p. 165]

WINNICOTT'S TRUE SELF SPEAKS

As he experimented technically, and as his theorizing developed, Ferenczi interpreted the wise baby as the knowing (particularly sexually knowing) part of the self, then as the self-observing and self-rescuing part, and, finally, as the psychiatrist part that rescues everyone in the family. As these interpretations emerged, Ferenczi had shifted his attention from the intrapsychic effects of instinctual drive development to the intrapsychic effect—splitting—of abandonment traumas and, finally, of abuse traumas. But because Ferenczi died soon after his "Confusion of Tongues" lecture, he unfortunately did not have the chance to report further what he was learning from his wise children, the neurotics.

His analysand and student, Melanie Klein, then became the major theorist of splitting. But her emphasis was always on *object* splitting as an inevitable effect of instinctual drive development; she did not follow Ferenczi in his concern for traumas—either of abandonment or of abuse—except insofar as she considered weaning an inevitable trauma of development. In Klein's theory, a "paranoid-schizoid" position, in which both the infant's innate aggression and its weaning frustration are directed at an introjected mother, existing intrapsychically as "good" and "bad" part and whole objects, is normally followed by a "depressive" position in which the child tries to make reparations to the object-mother for its aggression. The child rescues the maternal object from its own anger.

More than any other analyst of the British group that heard the post-War Kleinians present this way of developing Ferenczi's theory, D. W. Winnicott understood both its importance and its limitation. He set out on his own path by assessing Klein's contribution (in a 1959 lecture):

> I would say that Melanie Klein represents the most vigorous attempt to study the earliest processes of the developing hu-

> man infant *apart from the study of child-care*. She has always admitted that child-care is important but has not made a special study of it. On the other hand there have been those who developed an interest in the child-care and infant-care techniques. Those who did this ran the risk of being considered traitors to the cause of the internal process. The work of Miss Freud and Mrs. Burlingham in the Hampstead War Nursery (Burlingham and Freud 1944) led to a development of the study of external conditions and their effect. It is clear that this dichotomy between those who almost confine their researches to a study of the internal processes and those who are interested in infant-care is a temporary dichotomy in psychoanalytic discussion, one which will eventually disappear by natural processes… [1965, p. 126]

In fact, of course, this dichotomy persisted for another thirty years because most of the Kleinians continued to confine their researches to study of the internal processes, relying upon Melanie Klein's insistence that object splitting processes result fundamentally from death-instinctual aggression. Ferenczi's attention to external conditions as they are internalized or absorbed was not further developed in the Kleinian camp. Winnicott, by contrast, found the "death instinct" theory unnecessary as he studied both the Kleinian "introjection processes" and the "absorption into the individual child of the child-care elements." Concerned with how the child is initially dependent upon the mother for "ego support," Winnicott cataloged the types of faulty ego development that come about with traumatizing lack of maternal support and the child's reactions—including aggression—to being unsupported. In comparison to Ferenczi, he gave more attention to the preoedipal period and less attention to libidinal frustration in the oedipal period and to sexual traumatization. But even his comprehensive and balanced approach to faulty ego development or narcissistic illness contained a danger of misunderstanding. Winnicott held:

> It is as if looking at narcissistic illness the clinician is liable to be caught up with the absorbed, or internalized, environment, and to mistake this (unless well prepared) for the real

> individual, who in fact is hidden and is secretly loved and cared for by the self within the self. It is the true individual that is hidden. [1965, p. 127]

The self within the self, or as he came to call it, the "True Self," was Winnicott's wise baby. But, while Ferenczi had emphasized the wise baby as the survivor self split off from the dead or deadened hurt self, throughout his 1960's papers Winnicott more optimistically presented the hidden True Self as able to retain its original sense of aliveness and omnipotence and as being protected by the False Self, which, in order to protect, complies with the environment. Pathology, he held, comes about when this normal developmental kind of splitting proves impossible; so, in comparison to Ferenczi's, his theory was more about trauma prevention or adaptive splitting than about survivorship.

> The True Self comes from the aliveness of the body tissues and the working of body functions, including the heart's action and breathing... the True Self appears as soon as there is any mental organization of the individual at all, and it means little more than the summation of sensory-motor aliveness... The infant then becomes able to react to a stimulus without trauma because the stimulus has a counterpart in the infant's inner, psychic reality. The infant then accounts for all stimuli as projections...[and] the infant is now able to retain the sense of omnipotence even when reacting to environmental factors that the observer can discern as truly external to the infant... [1965, pp. 148-149]

It is the mother's adaptation to her baby that permits the baby not only to retain its sense of omnipotence but also to adapt to the environment, to tolerate frustrations, to comply. Inevitably, a False Self is built up in this process. But the False Self can be either a healthy compromise with reality—manifest as a "social manner" (1965, p. 150)—or, at the other extreme, an unhealthy, split-off, pathologically compliant False Self which is mistaken for the whole child or the whole adult.

On the basis of his distinction, Winnicott developed his ana-

lytic technique, which always aimed at communication with the True Self.

> It is being recognized in the last few years that in order to communicate with the true self where a false self has been given pathological importance it is necessary for the analyst first of all to provide conditions which will allow the patient to hand over to the analyst the burden of the internalized environment, and so to become a highly dependent but a real, immature, infant; then, and then only, the analyst may analyze the true self. This could be a present day statement of Freud's *anaclitic dependence* in which the instinctual drive leans on the self-preservative. [1965, p. 134, italics in original]

Very important to Winnicott's development of a technique for allowing the true self to be analyzed was the work of M. A. Sechehaye, which she had summarized in *Symbolic Realization* and *The Autobiography of a Schizophrenic Girl*. Sechehaye described how her schizophrenic patient Rene, who had made no progress with conventional psychoanalytic technique, responded when she was given objects—a doll, a toy monkey, some red apples—with which she could symbolically represent her hidden self. She could do unto her doll what she had wanted and needed done unto herself in her time of dependency; she could represent her desire to suck at her mother's and her analyst's breasts by eating the red apples her analyst gave her. Winnicott himself used a piece of string or a squiggle drawing for autosymbolizing: he invited his child patients to complete the squiggle drawings he started, and he interpreted to them the pictures of themselves they spontaneously made.

THE TRUE SELF'S EXPECTATION TO BE LOVED

What Winnicott added to Ferenczi's theory was a sense of the degrees of trauma, or a sense of how the hurts of everyday infant care relate to the kinds of traumas of abandonment and abuse that Ferenczi stud-

ied. Winnicott also focused his attention on the preoedipal period and the formation of the ego, while Ferenczi had used Freud's notion of a trauma as a breaching of the stimulus barrier, an overwhelming of the formed ego, and focused on the oedipal level, emphasizing sexual instinctual disruption and frustration. Winnicott had assumed that some splitting is normal and facilitates trauma prevention; only splitting in which the False Self is mistaken for or experienced as the whole is potentially psychotic. As long as the True Self can still speak, it can be reached analytically. In Ferenczi's view, the analysis can foster a developmentally progressive leap forward by helping the patient draw on or cathect (in Ferenczi's words) "latent dispositions which, uncathected, waited in deepest quietude for their development" (1933, p. 165), and by fostering the integration of the child's wisdom into the whole of its developing self.

In Winnicott's view, such self-love comes about by means of dependency on the analyst, by "an anaclitic dependence that leans on the self preservative." That is, in Winnicott's view, therapeutic action comes about by means of the instinctual drives that push for self-preservation, the ones Freud had in his early instinct theory called ego instincts and contrasted with sexual instincts. Winnicott implies, but does not say explicitly, that these are drives for nourishment and care, for maternal attention and attunement to the child's needs—drives for attachment, affection, and development.

We have just translated Winnicott's thought about self-preservative dependency into terms stemming from Freud's concept of the self-preservative ego instincts, which he, of course, abandoned in the 1920s when he posited the "death instinct"—a step that Winnicott, as we noted, did not think necessary. Winnicott, in effect, worked with the older Freudian distinction between the sexual instincts and the ego instincts, and he found the ego instincts for preservation of the self by the caretaker to be the instincts primarily involved in healthy trauma prevention (as they are the ones primarily thwarted in preoedipally based splitting). In contemporary psychoanalysis, this thought of Winnicott's about dependency as the path to health—to the wise baby asserting itself—has been elaborated most clearly from within a culture that does not evaluate dependency negatively or say

it is just for infants and pathological if appearing in adults (as Ferenczi's student Michael Balint argued, for example). The Japanese analyst Takeo Doi, who was familiar with Ferenczi's and Balint's work, went nonetheless right back to Freud's self-preservative ego instincts in order to elaborate in Freudian psychoanalytic terms what is called in everyday Japanese *amae*, "the expectation to be sweetly and indulgently loved." Doi argued that this type of dependency need or expectation addressed to first caretakers, which can also be expressed with an intransitive verb, *amaeru*, "to presume upon another's love," is thwarted in various ways and to various degrees in each type of pathology. Such traumatizing is the root of pathology, which may become entwined with sexual instinctual thwarting (including the traumas of abuse Ferenczi studied) as a baby grows into the oedipal stage. This, we think, is Winnicott's theory elaborated without cultural inhibition or inhibition induced by following the later Freudian instinct theory to the exclusion of attention to the ego instincts. Doi's position implies that the True Self has a drive to be dependent and to be preserved in and by that dependency, to be developed and grown in it. The True Self, the wise baby, speaks to tell the adults—and the adult patient's analyst—what he or she needs; the baby speaks Truth to Power. And the Truth is: I expect you to lovingly care for me.

THE DREAM OF THE WISE BABY

This Japanese elaboration of the theoretical stream that flows from Ferenczi to Winnicott—this emphasis on expectation to be loved as an ego instinctual thrust for development—illuminates, we think, both the features of the dream of the wise baby that were observed by Ferenczi and the further features that we have observed and will present below. We have turned to Doi's *amae* concept to account for how wise babies represent in dreams the dreamer's wish for developmental rescue. We notice in wise baby dreams all of the caution about psychoanalysis and even mocking skepticism about it that Ferenczi's babies displayed, but also wisdom about how the analysis can work, about what help is needed.

In our experience, a dream of the wise baby first comes at a particular juncture between the opening and middle phase of an analysis. The patient is in a regressive period when dependency needs are prominent and frequently protested as the patient declares that the analysis is an indulgence. For the three patients we will present, who all play the family psychiatrist in their workplaces as well as at home, this time of longing for tenderness, maternal care, and indulgence was especially frightening: dependence meant allowing the analyst (not themselves) to be the family psychiatrist. In this *amae* condition, the patient will typically produce a big dream—like a "big job" (as the British call a big bowel movement)—that she or he carefully remembers and brings in like a gift, with a sense of portentousness. The patient indicates that this dream is somehow the whole story: past and present—even future—are all in it. The dream may be long and involved, with a number of segments, or it may feel connected to other dreams or recurrent dreams, as though it were a piece of a larger panorama. Its themes feel so familiar. But interpreting the dream is unsettling. The dream feels like a map of recently traversed analytic territory, a summary, but also an indicator of something just off the edge of the map—something dark and frightening. The big dream is the wise baby's dream; it contains what the wise baby knows: the story of the dreamer's traumatization, the story of the deadening of part of the self (in Ferenczi's terms), or of genesis of the pathological False Self (in Winnicott's terms).

And then comes a dream *of* the wise baby, a dream in which the wise baby actually appears and speaks—and the patient immediately says, "That is me." This dream may be a segment of the big dream—if so, it is usually one segment of three—or a dream dreamt during the next night or so. When the wise baby speaks, he or she issues an instruction to the dreamer and also to the analyst about the analysis. Generally, the wise baby tells the dreamer and the analyst to go slowly, not to work too quickly on the themes of the big dream. This is to keep the analysis from being retraumatizing as it comes close to the original traumas that the wise baby knows. Or the wise baby may indicate to the dreamer and the analyst that it is afraid that a step in the direction of freedom—freedom of speech—in the analysis will be fol-

lowed by a setback, a repetition of the original trauma, so caution must be taken. In effect, the wise baby is the voice of the True Self saying to the analyst, "Do not explore the False Self too abruptly; I need it for now as much as I need you."

In a broader sense, the message that the wise baby delivers is about the dreamer's development. We think that patients are doing what we call "developmental dreaming." That is, they dream their development as it has been and as they wish it to be: their developmental dream is a disguised fulfillment of an ego instinctual—not primarily a sexual instinctual—childhood wish. The wise baby knows how the dreamer's development got arrested or troubled, and he or she can point the way forward, even while begging that progress not be faster than is tolerable. The healing direction is into relationship with a person who will help the dreamer achieve dependency, as Winnicott said. The baby communicates: "It is *this* kind of love that I need, to remedy specifically *this* kind of trauma." If the dreamer was neglected or abandoned, in the dream the wise baby gets the helper's intense, focused attention; if the dreamer was bewildered or intellectually stymied by being physically hurt or abused, the wise baby gets enlightenment or sympathy for its struggling intelligence (or for the dreamer's learning inhibitions). The period of expectant dependency in the analysis, entered into so cautiously and hesitantly, then allows the analyst to later receive the negative transferences, to facilitate exploration of the traumatizing figure and reconnection with that reality without the patient being retraumatized, so that the traumatizing can be worked through.

As noted, the wise baby image frequently appears in the third segment of a dream (sometimes the big dream) or as one in a sequence of three dreams (it may also be in a dream that has three parts or three locales, three spaces). In one way or the other, the wise baby segment is *the third*, and it is related to the other two dreams (or segments or parts) as to "the mother" and "the father." The parents or parental figures appear not only as they were for the dreamer as a baby, but also as the wise baby wishes they might have been for its best development. Signaling that they are coming into their baby relation with the parents, patients often represent themselves at some

point in the dream sequence as naked, naked as a baby. In women, the wise baby may appear with the dreamer as an adult, a mother, and the dreamer is aware that she plays both parts in her dream, the mother and the baby—they are both her.

When the wise baby appears, as Ferenczi had implied by alluding to the painting of "Debate of the Young Mary with the Scribes" and other artistic renderings of wise babies, he or she addresses a group. Frequently, the group is the family group—the group for which the wise baby, as Ferenczi indicated, may be acting as the psychiatrist. But we have noticed that wise baby dreams also typically contain groups that are multiples of the figure who was centrally traumatizing to the dreamer. If this figure was the mother, she appears as many women who are all alike in some way. If the figure was a man—say, an abuser—the man appears as many men, all alike in their ominousness or their frightfulness. Sometimes both the family group and the enlarged and plural traumatizing figure will appear. Both are represented in one of the dreams we will present below, where there is a group made up of the patient's disheveled, depressed, neglectful mother in multiple, and then later, a group of "cold authority figures." In the second group, the whole adult family, including the dreamer herself, appears and is addressed by the wise baby.

THE LOBSTER DREAMER

Toward the end of the first year of her analysis, a middle-aged patient with many hysterical traits brought to her session a big dream, one with three distinct parts set in different locales. She later made a transcription of the dream in her journal, placing it with two other dreams that she had in the same night, the third of which presents her wise baby. Although she worked with the big dream for only one session, she came back to it frequently over the whole course of the analysis; she concentrated on the first part, scanted the second, which centered on her remote father who was preoccupied with his business and a mistress, and avoided the final part, which featured

her depressed mother in multiple. This is the big dream (the three parts of which we will number):

1. I was having a lobster dinner with [her child] and [her husband] on the wooded area at the side of our property. It was a Christmas Eve dinner. Strange to have lobster, I thought. Messy. I couldn't eat it all. "I'm not that hungry, I'll just have the claws," I said. One lobster hadn't yet been cooked for some reason, and at a point it started begging, claws snapping aggressively as it reached for food on the table, only to be pushed away like a dog. The scene had shifted here to my parents' kitchen dinner table with my husband and [child] seated in Mother's and Dad's places. I couldn't imagine that it would eat flesh of its own species, but at one point a piece of my lobster fell on the floor and the lobster hungrily scampered toward it. I thought to myself that we should have cooked the lobster because if it hadn't been fed for awhile it wouldn't make a very good meal—it's too starving.

2. Then, for some reason, I left to go to my music lesson with F at his house. It was Christmas Eve. I got there and no one was home. I also forgot my recorder. I couldn't believe it. Would I have to borrow his? …Then there was a black girl waiting too, and I asked, "Are you here for F, too?" I had seen her before, another student of his, but I was surprised he would schedule two people together. I said to her, "You won't believe it but I forgot my recorder." Then F and his family members came home…. I didn't have an exchange with him because he was preoccupied.

3. Then I was in my car, heading home. I realized that I was undressed and disheveled. I'd better get dressed before [my husband] saw me or he would be suspicious of me. I'm in my car naked, or almost naked, and I pull into an area that looks like I could change while driving—I'd done this maneuver before—looking for shirt, underwear—but as I'm in this area, all of a sudden [her mod-

> ern dance teacher] and another person were there. I hid myself, crouched down, and they didn't see me naked or near-naked. Then there were all these other women around in bathrobes or such—as if there had been some sort of tailgate sale-type thing—waiting in line to pay, or something. I was sort of trapped in this parking area, but then I got out and was thinking how I was sure no one at home had cleaned up the dishes from the lobster dinner—typical—I'd have to do it.

Below are her transcriptions of the second and third dreams in the sequence:

> The second dream: I went to Professor H's office and explained that I hadn't been in because I'd had so much work over the semester. She said she was glad I was there, that she really trusted/liked me and I could have come sooner. She wanted help with organizing books, or something about helping her to import/export books or something from/to Germany and the USA. I knew it would be a lot of work and I was feeling lazy or inadequate, but I went along.

> The third dream: A group of adults—cold authority figures—were trying to get this baby to do something—to cooperate in some way. They were surrounding him. I was one of the adults. The baby remained stubborn and difficult. Then I decided to take a different tactic, so I picked up the baby very maternally, and sweetly asked, "What's wrong?" and kissed the baby (a boy). His face and lips were all scrunched and hard, and he rejected the kiss, but then he softened and very sincerely, articulately, and eloquently talked to me. He explained his behavior, but the only part I remember was that he said, "It's all going too fast, I can't do it that quickly, that's why I appear so uncooperative." The implication of what was going too fast was "to be myself," "to reveal myself."

This patient, whose trauma was cumulative, with all the types of elements Ferenczi studied—early childhood neglect by a depressed

mother, abandonment by a preoccupied father, and abuse by a brother—knew immediately that she had autosymbolized herself as the starving lobster, begging for nourishment and attention. She has only herself to eat self-preservatively at the parental table, which she associated to the table of her present unhappy marriage. Then she represented herself as not having an instrument to attract or impress her male teacher, whom she associated to her preoccupied father. She could not draw him away from the other student, who was part of the father's other life. Finally, many months after the dream, associating back to it, she realized that she had represented herself in the third part, disheveled and nearly naked, as identified with her mother, who was often too depressed to get properly dressed in the mornings—and the mother was, then, multiple, which meant very, very frightening.

This child-father-mother dream has no exit; she can only return to the home where the lobster dinner dishes await her. But the next dream in the series represents her as a favored student of a professor at her college who deals in German books, like the books about psychoanalysis the patient was reading at the time. Her developmental way is pointed: she must go into the world, find others who will love and respect her, finding her well-equipped, even if perhaps not entirely adequate, and who want her to help, that is, who appeal to her helpful self, her rescuing self. She associated the professor with her analyst. Then, in the third dream, the wise baby appears and is induced to speak by the dreamer's own sweet mothering kiss, a self-loving kiss, which softens the baby, dissolves his shell. He asks that the analysis not go too quickly—"to be myself" is hard.

THE AMPHITHEATER OF TERROR

Another patient with many hysterical features, including an attention deficit, reported a very powerful dream, which, like many of her dreams, was "architectural" and symbolized her body. During the session at the end of her first year of analysis in which she presented the dream, she gnawed on her thumb as she often did, feeding on

herself self-preservatively as the Lobster Dreamer did. She also sounded many of her recurrent themes: she was afraid she was not attractive, not intelligent; her analyst would surely find her disgusting and stupid. Introducing the dream, she mentioned that there was an amphitheater in it, up in the older part of a house that had both new and old sections. In her dream narrative, however, the amphitheater was only alluded to. We will present her and her dreams from process notes in order to convey her as she was and as she worked in the analysis.

> I was going down steps which were getting older, more decrepit. There were cobwebs. [My husband] was maintaining this part of the house, but he had done nothing with it for a while, so it was funky. Then I was in this basement, stripped naked, getting ready to take a shower, and nothing was clean, so I felt very nervous. I found an old yellow mackintosh, which I was thinking about washing because it had not been used since I had the children. But then I thought I should get out of there, go up the rickety stairs, although that was very scary, too. But I thought maybe I should go back and turn out the lights. Then I debated whether to run away as I was so scared. I got into a linoleum area, neither new nor old, which I was thinking might make an office space for [the company she works for]. [A lesbian colleague from the company] was at the top of the steps, and I considered telling her about the amphitheater part of the house. That was it. This feels like a recurring theme, somehow.

In her associations, the three spaces in this house slowly revealed themselves to be her anus and urethra (the basement, with its dirt and its yellow coat), her vaginal opening (the linoleum area, "which is like a play area"), and her vagina and uterus (the amphitheater upstairs, in the interior of the house). Her urethra is the site of her first remembered physical trauma—an operation for urethral constriction when she was five. Her vaginal opening is the site of a second trauma—she was molested by an elderly neighbor when she was eight: he put his fingers in her vagina while holding her on his lap, and he scraped her, made her feel

ragged, like the torn-up linoleum in an apartment in which she once lived. In the dream, she was going to tell her lesbian colleague about the amphitheater and (she said in associating to the dream) maybe take her there:

> Perhaps she is you [the analyst]...I don't know. This is somehow about the psyche. There were lights. Something epileptic, apocalyptic, seizure-like. I don't know why. It feels weird to talk about it—it's like not about me. It's like an object I am describing; I don't connect to it. I have no idea what it's about, but I *should* know. But I don't... In many ways, it is beautiful. I guess seizures are being out of control. You're there and you're not; you shake—I shake a lot. For some weird reason I'm thinking about orgasms. Intense ones feel like there is a gap in time, seizure-like... What the hell is this?

When she came to the idea that the amphitheater represented her vagina and uterus, her further associations led to the speculation that she had had an orgasm when the neighbor molested her (perhaps also vaginal sensations during the earlier surgery), which she had found both exciting and also repellent. If she had gone into this amphitheater, she said, it would have been riveting, compelling; she would never have gotten out; it would have been like she was under a spell. She came to understand, as she worked on the dream, that she had split off the vagina-uterus area—disconnected from it, made it the part of her body that was sometimes "dead" (she used terms like Ferenczi's), although sometimes it was lit up and beautiful, too, compelling, entrapping.

In the amphitheater, she said, remembering more of the dream, there was a group of men in long, black, frock coats with beards and mustaches, quite Victorian. Several weeks before, she had seen a photograph of the neighbor who had molested her in his high old age. Hideous. He was, she was startled to notice and then to remember, bearded, mustachioed. Quite Sigmund Freudian, she laughed, nervously. Like Ferenczi's early patients, she was being ironical, in the dream and in associating to it, on the topic of psychoanalysis and

its weird notions about dreams and about childhood sexuality. But this was just a surface layer of interpretation. The Victorian neighbor was so terrifying that he became a group. Men. Then, later, she came to think that it was only one type of Men that terrorized her: "men who have sexual power, who are sexually preoccupied, and have a weird effect on me—like they immobilize me...stick me.… They are bloodsuckers."

As she became more and more amazed by what this architectural dream was telling her—"I said it was about my psyche, but it's about my body, isn't it? And my body was hurt, wasn't it, really hurt?" —she became frightened. Later, she remarked: "It isn't exactly that I hate my body; it's that I don't know how to be in my skin." Enter the wise baby, in a dream she had after a weekend break in the analysis:

> [A female friend, a few years older, who mentored her] and I were walking through a kids' park. There was a heavy, plump, drab-looking mother, with dirty-blond hair, wearing something in an ugly beige color. Her son, about three, was big, chubby. They were lower middle class, below-average intelligence types. The two of them were in a sandbox, and she was trying to pull him out while he struggled to step up and out himself. She said he went to a school for disabled children. She put his jacket on him, and I felt compelled to say—for him, you know, to speak for him: "He is doing the best that he can right now." I was surprised that [the mentoring friend] did nothing to help him, but sat off to the side, because she was going to do something more therapeutic later. She was observing him, and maybe was going to do something different than what I did. I was sticking up for the kid.

This patient had to disparage her wise baby—she explicitly said he was not smart, and he was awkward and chubby as she herself had been in her toddler years; so she had to come to his rescue herself, as she was also his drab mother. In this she was like the first patient, who had to kiss her wise baby to make him relaxed enough to talk wisely to her. But this patient had to go further and speak for

her wise baby in order to get the wise baby's job done: the analyst is instructed about not going too fast. As she went on to associate to the dream, she said of herself that she felt stuck in all the issues her architectural dream had raised, but wanted to say, "This is the best I can do—I am a little retarded, leave me alone." Her mentoring friend, who represented her analyst, would do something more therapeutic later, and was meanwhile being warned: do it later, not now, and do not take me by surprise. "I guess I don't want you to think I'm smart either, or you will expect too much of me when I'm not ready to do adult stuff," she told her analyst, recognizing that she often played the clown or the comedian in order to divert attention from the real intellectual abilities she had but could not trust.

Over the weekend, the patient had been feeling that everyone around her would find her stupid and incompetent. When friends came to visit, she had tripped on the stairs in front of them—"What a damn spectacle I made of myself!"—and spilled her drink all over herself. "I was like that child trying to step up out of the sandbox." Then she went on to tell about a woman resembling the lesbian colleague who had appeared in her architectural dream. Over the weekend, this woman had just confided in her that some years ago she had fantasized about having a sex change operation, "because she had so many issues about being a woman, and she had had such a hard time when she was young because her mother pushed her all the time to be more feminine, giving her pocketbooks and things that would look right." The patient had told this woman that she herself had confusions about what it meant to be female, and her mother, too, had been pushy and perfectionistic. But even as she had said this, she had thought, "I avoid those confusions," as in her dream she had avoided going into her interior feminine amphitheater room with the lesbian colleague.

The intense conversation about sexual identity, so exciting and disturbing to the patient, then provided material for a sequence of three dreams she had in one night, the third of which, once again, featured a wise child. In the first two dreams, she, who is not a homosexual, was making love to women—one with features in common

with her mother, one associated with her brother, the mother's favored child:

> The first one looked like the prostitute in the film *Deconstructing Harry,* and I was going down on her and kissing her, but her genitals were inside this box kind of thing, like those…what do you call it?...stocks that the Pilgrims were punished in. In the second dream it was my brother's wife's sister, and it was similar sex, and it felt very weird to me. In both dreams I was the aggressor, and I had an orgasm in one, and when I woke up I had my hand between my legs. I tried to call to mind how it had felt to have sex with [an emotionally abusive former lover] and what had been so compelling about it.

When asked, she told the third dream:

> I was with one of my college roommates, S [whom she associated with her current mentoring friend of the playground/sandbox]. Back in college, in a dorm… There were guys across the hall that we were friends with, but the status of this was not clear: Were we just friends? Did these men like me? In the dream I said I had a lot of work to do for [her company] and would probably flunk the courses—I wasn't cutting it academically. S said, "You had an affair." What is the big deal? I thought. In another part of the dream I had nails—like thin hairs—in my lips, and I was going to have something done surgically to my lips. Like having braces. I worried people would know. And then the last scene was this big Fourth of July pageant, and I was a young child, elementary school age. We were skipping to some kind of patriotic song. "Yankee Doodle Dandy," we sang. It was a fun ending to the dream; I was talking and playing, and very successful in school.

In this third dream, the patient appears in a playground as a precocious child who has none of the academic difficulties of the college girl, who is confused about her relationship with a group of men and defensive about a former lover. In these heterosexual relation-

ships, her surgically "nailed" lips (an upward displacement for her urethra, genitals) might be discovered; she might be shown to be like the prostitute, genitally boxed-up, punished. Combining elements of regression to a pre-traumatic, happy, fun time and progression into precocious maturity, the performer child, the wise baby, parades beyond all this and entertains everybody; she is just dandy on the Independence Day that the analysis will bring. "Maybe this work we do is going to be the American Revolution, huh?" she joked with her analyst, nervously.

THE WISE BABY AT THE END OF ANALYSIS

After a year of analysis, a third patient, anxiety-disordered and depressed, entered into a phase of great neediness, dependency, and expectation of the analyst's love. In sessions she often wrung her hands, as though these were (in Ferenczi's terms) the "dead" part of her. In dream after dream, the analyst appeared and was helpful, sweet, attentive. Then came a dream in which the wise baby entered in the guise of the patient's daughter, who, in waking life, was a late adolescent getting ready to leave home for college.

The dream of the wise baby opened with a scene in which the patient was traveling in a car with her analyst, her mother, and her daughter as a toddler. They were all returning to the patient's house, which she identified as both the house where she resides now and the house of her childhood, her parents' house. In the car, the toddler daughter was trying to speak, like an analysand in a session, as the patient explained:

> She was free associating for the first time, being articulate about feelings, and everyone was attentive. You [the analyst] were very attentive to the words forming. Something about a color. I said the color turquoise had meant something to me. She was expressing something about me, the mother —for the first time getting words out. Got to the top of the driveway, lots of cars in the drive, you [the analyst] were

> driving. Mother said, "You could drive on the grass." My husband would have had a fit! But first [the little girl] got out of the car, and me too. An adorable toddler! Pants, shirt, a push toy—one of those with a canister full of colored balls that pop up and make sounds as you push it in front. She goes running with it down the drive, with me after her. Then, in the courtyard, something happened. She lost her toy, or something, and she was crying hard. When the baby started crying, and before I got to her, she was desperately but facilely climbing the vertical wall of the courtyard to get out. When I got to her, she clung so tightly it was frightening. Now she said slowly and clearly: "There will be nothing to love." And I thought this meant no bottle.

The rest of the dream was set inside the house and presented first her brother, who had just been visited by the analyst, acting the part of his dentist. The patient explained that she had once chipped her brother's front tooth during a roughhousing game and been harshly scolded by her parents. Then she encountered her sister who was in her bedroom preparing to read the notebook in which the patient writes her dreams; she prevented this attempt "to invade my privacy." The brother and sister parts of the dream—like the father and mother parts of other patients' three-part dreams—show the siblings needing repair, instruction, correction, fixing, family psychiatry. In her childhood, the siblings had made the patient feel that she was inept, different, unlovable, and in these segments of the dream she was mastering these traumatized feelings.

What this wise baby conveyed to its dreamer and the analyst was: something happened; her toy was lost. Whatever it was, was terrifying—it made the baby climb the wall and cling to the dreamer-mother in fear, seeking help. The dreamer comforted her wise baby self, and was told by the wise baby: "There will be nothing to love." In the dream, the patient interpreted the statement: the baby will be hungry, unfed. The patient was frightened that more of the old trauma would follow upon the wise baby's moment of free speech and free association, in which she had revealed her feelings, shown her colors, including the color turquoise of her own eyes, which she typically

associated with knowing and with seeing that is dangerous. The moment in which the child ran off freely and gaily with the push toy was going to be brief. The analyst, after doing dentistry on the brother, had to go away, leave. The dreamer was abandoned.

As the analysis went on, the trauma story, which had all the Ferenczian elements—neglect, abandonment, abuse—became clear, and the large role her aggressive and invasive sister had played in it was established. The patient had been, literally and figuratively, time and again, pushed down, and this is what the patient associated to the "something happened" in the dream courtyard. Her joy and creativity and capacity to see, her wisdom—-all symbolized by the colorful toy—had been taken away. When the patient was in the last week of her analysis, preparing to end, the wise baby appeared again—out of the timeless unconscious—in exactly the same form and developmental stage that she had assumed in the courtyard dream. In this termination week dream, the patient was not present as the mother; the baby was on her own. She had gained what Winnicott called "the capacity to be alone," which is the True Self's capacity to protect and preserve itself. Her toy was restored. The large cast of familial characters was absent; only a shadowy sister remained:

> I was a toddler—me as a toddler. With my sweeper toy—the colored balls and the popping sound. I was pushing it along. And there was the very vague presence of my sister, who felt very large—but not the size of an adult. She was hovering all around me, in and at me; she moved where I moved.

The patient said that the sister was like a guard on a basketball court, closely checking her every move, but not keeping her from moving, not pushing her down. To the patient, as she analyzed her own dream without the analyst's help, the sister seemed to be staying close out of envy, envy of the patient's current relationships, including the one with the analyst. The analysis had, she understood, released her from developmental immobility and brought her to the point that she had the wisdom to explain others' motivations—she was her own wise baby.

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OEDIPUS AGAIN: A CRITICAL STUDY OF CHARLES LAUGHTON'S *THE NIGHT OF THE HUNTER*

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In this paper the Oedipus complex is reexamined through a film, The Night of the Hunter. *Study reveals a concealed fairy tale structure, a structure that, when presented against a mythic backdrop, is ideal for presenting a certain kind of oedipal situation, that of a vulnerable damaged father and couple (indeed, couples), revealing a skewed oedipal situation. The film, produced in 1954 and looked at forty years later in the context of psychoanalytic writings of the last decade (Bergmann, Feldman, Herman, Simon), provides a matrix with which to reexamine a fundamental psychoanalytic concept, the Oedipus complex. It is the mutual enrichment of art and psychoanalysis that this paper addresses.*

> Let me tell you straightaway the great secret which has slowly been dawning on me in recent months. I no longer believe in my *neurotica*.... (T)here was the astonishing thing that in every case, not excluding my own, blame was laid on perverse acts of the father...though it was hardly credible that perverted acts against children were so general... (T)here was the definite realization that there is no "indication of reality" in the unconscious, so that it is impossible to distinguish between truth and emotionally charged fiction. (*This*

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> *leaves open the possible explanation that sexual phantasy regularly makes use of the theme of the parents* [italics added].) [Freud 1897a, pp. 215-216; 1897b, pp. 264-265]

> Only one idea of general value has occurred to me. I have found love of the mother and jealousy of the father in my own case too, and now believe it to be a general phenomenon of early childhood, *even if it does not always occur so early as in children who have been made hysterics* (italics added)…. If that is the case, the gripping power of *Oedipus Rex*, in spite of all the rational objections to the inexorable fate that the story presupposes, becomes intelligible...but the Greek myth seizes on a compulsion which everyone recognizes because he has felt traces of it in himself. Every member of the audience was once a budding Oedipus in phantasy, and this dream-fulfillment played out in reality causes everyone to recoil in horror, with the full measure of repression which separates his infantile from his present state. [Freud 1897a, pp. 223-224; 1897b, p. 272]

Freud's letters to Fliess, quoted above, written more than one hundred years ago, represent the first psychoanalytic use of literature to clarify and stabilize clinical observation, a first effort in applied psychoanalysis. These tersely stated ideas were then published in greater detail in 1900 where, speaking of the impact of *Oedipus Rex*, Freud stated, "Like Oedipus, we live in ignorance of these wishes, repugnant to morality, which have been forced upon us by Nature, and *after their revelation we may all of us well seek to close our eyes to the scenes of our childhood"* (p. 263, emphasis added). Freud's imaginative leap, and his method, has affected all of psychoanalysis ever since, from notions about fantasy to those about memory, defense (especially repression), structure, psychosexual development, the vicissitudes of instinct, and trauma and its effects. His achievement has also provided subsequent generations of psychoanalysts with a scaffolding for their own observations—observations which have led to modifications and extensions of Freud's original findings. Scrutinizing *Oedipus Rex* eventually led Freud to conclude that the Oedipus complex is the "central phenomenon of the sexual pe-

riod of early childhood" (1924, p. 173), an inference which stemmed from a study of literature (*Oedipus Rex*, *Hamlet*) reverberating with clinical experience and self-analysis. Plausibility derived from redundancy.[1]

This paper will reexamine the Oedipus complex through a film, *The Night of the Hunter*. Some critics will question this approach. They will state that the psychoanalytic study of a rather obscure film can hardly be equivalent to Freud's study of *Oedipus Rex*. Of course that is true. This is not a voyage of fundamental discovery, nor are the relative artistic merits of Sophocles's play and the movie in question. Nevertheless, the very obscurity of the movie is its attraction, just as the ordinariness of the lives of our patients sheds light on the human condition. Careful study of the representation of oedipal situations in *The Night of the Hunter* enhances appreciation of the *Oedipus* trilogy and therefore clinical understandings.

THE NIGHT OF THE HUNTER

In 1955, Charles Laughton was asked to direct a movie based on a novel by Davis Grubb. Laughton asked James Agee[2] to write the script and Robert Mitchum to assume the leading role. The movie opened to mixed reviews, but also had the misfortune of opening shortly before *Not as a Stranger*, a major studio blockbuster, also starring Mitchum. With all its resources behind the latter, not much was invested in "merchandising" *The Night of the Hunter,* which was a commercial failure. Laughton was never given another chance to direct a film. The movie, however, has refused to go away. It is frequently shown in art theaters and in revival houses. It appears on late-night television. It has achieved something of "classic" status, while *Not as a Stranger* has been forgotten.

[1] A detailed discussion of method in applied psychoanalysis is beyond the reach of this paper. See Baudry (1984), Gabbard (1997), Hanly (1992), and Reed (1982).

[2] Although Agee is credited with the script, reportedly he was so ill at the time that the screenplay he wrote was unusable. Laughton rewrote the screenplay in its entirety (Callow 1988).

To begin with, the film seems to be a "chiller," eccentric and weird to be sure, but a chiller nonetheless. Its main outline is simple. It is the story of an unscrupulous evangelist preacher who preys on widows for their money, insanely following the voice of God. He eventually marries and then kills a mother (Willa) and torments her children (John and Pearl) while trying to find the hidden booty from their father's (Ben's) bank robbery. Certainly these are the ingredients of a tale of terror. But although the content takes into account elements of the film (i.e., terror, menace), its formal structure conceals a fundamental constituent. The movie is a fairy tale, Gothic to be sure, but still a fairy tale.

To help the discussion, I will present a "first reading"—a translation or "prose reading"—of the text that attempts to reveal its structure. Of course a movie cannot be presented adequately through this device, just as a patient cannot be adequately presented in a clinical case report. To those unfamiliar with the film, it is an effort to grasp its form and essential contents.

THE FILM TEXT

Once upon a time, in a distant place, a boy named John lived with his parents and his sister, little Pearl. The times were hard and John's father, Ben, barely scratched out a living in the dusty river town where they all lived. In those harsh days homeless children roamed the woodlands without food, traveled the highways and rivers, and slept in old abandoned car bodies on junk heaps. There were neither men nor women alive who didn't lust for that which they didn't have, nor burn with hatred for "them that had."

And so Ben robbed a bank and killed two men. He took the money and ran home to his children, where he stuffed it into the rag doll that little Pearl always carried around. Then he swore both children to secrecy, but to John was passed the responsibility for little Pearl and all that money. Ben made John swear to tell no one about the money—not even his mother, Willa, who "had no common sense"—and to guard little Pearl with his life. Then John saw blue men take

Ben away and, oh no!, the blue men beat his father who said, before he fell, "Mind what you swore, son!" Ben was hung for the murders, keeping his silence; the money was never found. He took his secret to the grave, leaving it to John, his good and true son, to bear that secret forever.

And then one day a "preacher" came to the dusty town, singing sweetly in the night as he traveled. He sought out John's mother and courted her. He told all concerned that he had consoled Ben, serving as his pastor in his last days in prison, and pretended great concern for the children, "those fatherless little lambs." But he was an impostor, a monstrous man interested only in money, a ravening wolf in sheep's clothing, a secret murderer of widows. Meanwhile, two busybodies, Icey and her husband Walt, who owned an ice cream parlor in town, "overcome" by righteous concern for Willa and her "poor, poor lambs," tried to arrange for "preacher" Harry Powell—for that was his name—and Willa to marry.

And marry they did. It was to be a marriage on the purest and highest level. For Willa realized that she had lusted for the stolen money as she had once lusted for Ben and now lusted for the preacher. When the preacher told her that the money was at the bottom of the river, she was so relieved that she felt herself just "a-quiverin' with cleanness." And now on her wedding night the preacher cleansed her of desire and Willa thanked the Lord for sending him to her.

But the preacher knew that the money must be hidden somewhere, and as he had harangued Ben in prison—for he had really been Ben's cell mate—he now did the same with John. "John, where's the money hid?" he would say. But John was loyal to his father and recognized evil when he saw it, even if no one else did. That "man of God" seemed to have bewitched everyone around him: the townspeople, Willa (who accused John of lying when he told her of the incessant questioning), and even little Pearl who now loved the preacher as though he were her own father.

One misty night Willa came home after long hours of work and heard the preacher with her own ears. That cruel man was pleading, "Where's the money hid?" and then he screamed at little Pearl, call-

ing her a wretch. Willa rushed into the house in disbelief. That night, after mumbling her prayers, while she was lying in her bed denying the meaning of what she heard, the preacher cut her throat from ear to ear! He carried her body to her old Model T and drove the car into the river. There she sat, her face serene, the current drifting her long hair across her gashed throat.

Well, when John found his mother gone the next day, he suspected the worst and knew he must run, for surely the preacher would torture and murder little Pearl and him. And so he tried to trick the preacher by telling him that the money was in the cellar under a stone. But the preacher forced them both to go with him and found that John had lied. When the preacher went into a towering rage and threatened them both with his knife, little Pearl, in terror, told the preacher where the money was. John then knocked a prop from under a shelf and down came a cascade of jars and bottles, knocking the preacher over. Then John pulled Pearl away and they ran up the stairs till they finally got out of the cellar. It was not one moment too soon, for the preacher was just behind them. The children then ran to the river, took Ben's skiff, which Uncle Birdie (an old river man) had fixed up for John, and got it into the water just a twinkling of an eye before the preacher fell howling into the muck, unable to catch them.

Thus began days and nights of a perilous flight down the river. For it seemed that the preacher Harry never slept. His sweet song was always nearby. But John persisted, though the nights were dark and the owls hooted and the dogs barked.

One morning as the sun rose and the rooster crowed, there, like a vision, old Rachel appeared. And she whisked little Pearl and John to her house to give them a good washing. At first she was ever so frightening with her heavy shoes and tough manner. But after a bit John felt less scared. There were other children too: Mary, Clary, and Ruby. They all seemed to be part of a family. John could hardly remember where he came from or who Willa and Ben were—but he knew that they were dead. He remembered his secret and lived in fear of the day when the preacher would come. And come he did one bright shiny day, with a stick-

knife in his hand. But loving old Rachel was there a-ready with her big shotgun. And the preacher ran off, snarling that he would return.

In the dark at night he did come back. He crooned his soft gospel song so sweetly that Rachel, sitting in her rocking chair, joined in. The mist made the night dark, but the moonlight reflected off it in strange ways so that Rachel could see the preacher silhouetted outside the window. Suddenly he was gone and there was nothing but silence. In the dark Rachel gathered her flock around her and told them stories. The clock struck three and suddenly a shadow was there. "Hide in the staircase, children," said Rachel as she faced the darkness.

"What do you want?"

"Them kids."

"I'm giving you to the count of three to get out that screen door, then I'm comin' across this kitchen shootin'."

And as the preacher's satanic face appeared, his hand lifting the open knife, she fired the gun. The preacher ran off, yipping and yelping into the barn with all the other animals.

In the morning the blue men came and they arrested the preacher. It was exactly as with Ben. John turned sick. "Don't, don't!" he cried. And he ran out with the doll, flogging the preacher with it.

"Here! Here! Take it back! I can't stand it, Dad! It's too much, Dad! I don't want it! I can't do it! Here! Here!"

There was a trial. John couldn't look at the preacher. John couldn't convict him, couldn't convict his Dad. The burden was so great. He didn't know what was going on.

And then it was Christmas. The children were all gathered around. John gave Rachel an apple and Rachel said that was the "richest gift a body could have." Then she gave John a watch. John looked like any boy, rich or poor, with his first watch. But he couldn't speak until Rachel said, "That watch sure is a fine, loud ticker." Then he knew everything would be all right and he was finally aware of everything that had happened. The long night was over. "This watch is the nicest watch I ever had," he said.

And they all lived happily ever after.

FOLK TALES AND OTHER STORIES

The fairy tale is one of a group of overlapping types of stories: myths, fables, cautionary tales, and the like (Bettelheim 1976; Darnton 1984; Frye 1963; Propp 1928, 1984; Tatar 1987, 1992; Thompson 1946; Tolkien 1966; Zipes 1983). All these stories have an oral tradition and are often told rather than read. They take place in the remote and unspecified distant past, but describe patterns that are everlasting. In that sense they explain, as Levi-Strauss (1955) puts it, "the present and the past as well as the future" (p. 173). And so told and retold, written and rewritten, they are passed along from one generation to the next.

These stories have one important element that binds them together. Unconscious fantasy thinking in the individual is brought into relation with the cultural group through the medium of the story. The fantasy thinking is thereby legitimized. We may recall that Arlow (1961) said that myth "is a particular kind of communal experience. It is a *special form of shared fantasy* (italics added), and it serves to bring the individual into relationship with members of his cultural group…" (p. 375). That is, the myth—and I would include all the types of traditional folk stories referred to above—permits the individual to perceive personal needs and conflicts in relation to culture. He can thus experience himself as *part* of a cultural group, accepted as one participating in a shared fantasy, which has been presented in the story.

Despite this central common factor, there are differences among the subtypes mentioned (Bettelheim 1976).[3] The feeling

[3] Recent biographies (Pollak 1997; Sutton 1996) and newspaper articles contain disturbing reports of Bettelheim's abusive treatment of children at the Orthogenic School in Chicago, which he directed. There have also been charges of plagiarism in *The Uses of Enchantment* (Dundes 1991). Some of the ideas I attribute to Bettelheim may indeed be those of Julius Heuscher (1963), although Heuscher himself "had not at all felt he was being plagiarized" (Sutton 1996, p. 13), and the passages involved do not seem to deal with the central arguments I cite. See Sutton (1996) and Pollak (1997) for details of passages. Also see Tatar (1992) for additional details and attribution.

conveyed by a myth is one of absolute uniqueness. The events could never happen to any other person, are awe-inspiring, and could not happen to an ordinary mortal. Whereas the myth conveys uniqueness, in the fairy tale the most unusual and improbable events are presented as ordinary. The most remarkable encounters are related in casual or everyday terms. It leads one to feel, "This could happen to you or me."

The myth is nearly always tragic, the fairy tale almost always happy. Thus the fairy tale is optimistic whereas the myth tends toward pessimism. Bettelheim remarks that "it is this decisive difference which sets the fairy tale apart from other stories in which equally fantastic events occur, whether the happy occurrence is due to the virtues of the hero, chance, or the interference of supernatural figures" (p. 37). In fact it is not clear when or why this change took place (Tatar 1987). But at some point in the eighteenth or early nineteenth centuries, the grotesque, violent, bloody, and perverse tales of oral tradition, which had pretty much been adult fare, changed. They became tales for the nursery, fairy tales with which we have become familiar.

Tolkien (1966) states the essence of the fairy tale is in *Faerie*, "the Perilous Realm itself, and the air that blows in that country" (p. 10), not in elves or fairies. Indeed, *Faerie* is populated mostly by flesh-and-blood human beings, like us, but who exist in a magical place and to whom any number of unusual things happen. As Tolkien points out, "one thing must not be made fun of, the magic itself" (p. 10). The magic must be taken as matter-of-fact.

Very likely the differences between myth and fairy tale are determined in part by the audience for whom the story is intended. The myth, by and large, is meant for the adult, the fairy tale for the child. What the child needs most is to be reassured that there is a happy solution to his problems. "...Therefore reassurance of a happy ending must come *first* because only then will the child have the courage to labor confidently to extricate himself from his...predicaments" (Bettelheim 1976,

p. 39).[4]

In contrast, when the adult confronts a myth his task is different. Members of an audience during and following a performance of Sophocles's *Oedipus Rex* are moved and attempt to understand the personal effect it has. That is, revival of conflict and reintegration takes place through the "telling" of the myth in the theater and its reexperience by the individual as a member of the audience (Freud 1900, pp. 262-263).

Because the fairy tale is written for the child, it is also written from the child's point of view, a matter of considerable importance in *The Night of the Hunter*. "An existential dilemma is stated briefly and pointedly" (Bettelheim, 1976, p. 8), which "confronts the child squarely with the basic human predicaments" (p. 8), i.e., death, aging, the loss of a parent. Figures are "clearly drawn, situations simplified" (p. 8). "Evil is as present as virtue, and given body in the form of some figures and their actions, as good and evil are omnipresent in life and the propensities for both are present in every man" (pp. 8-9). Because children cannot understand ambivalence but only polarization, the duality of good and evil must be presented by different people. Bettelheim says, "The figures in fairy tales are not ambivalent—not good and bad at the same time, as we all are in reality. But since polarization dominates the child's mind, it also dominates fairy tales. A person is either good or bad, nothing in between" (p. 9). As we shall see, *The Night of the Hunter* is presented almost entirely from John's point of view, and the figures in the film are presented in polar terms.

Bettelheim also points out that neither myths nor fairy tales are cautionary tales. For example, fables (like the story of the *Ant and the*

[4] Darnton (1984) takes issue with Bettelheim stating, as an example, that *Little Red Riding Hood* does not have the happy ending Bettelheim ascribes to it. In an early French oral version, not only the grandmother but the little girl is devoured. He believes Bettelheim erred in presenting versions of the tale as codified by Perrault and Grimm. But Thompson (1946), an authority Darnton cites, states that there are two endings to the tale, and that the fairy tale happy ending "seems to be designed for the nursery on the theory that children would be shocked unless the little girl were rescued" (p. 39). Thompson's point only strengthens Bettelheim's argument. Bettelheim differentiates the fairy tale from the folk tale, a point that Darnton seems to ignore.

Grasshopper) tell us how to behave and prevent us from being self-destructive. *Oedipus Rex* can "never be experienced as warning us not to get caught in an Oedipal constellation" (p. 38). Quite the contrary, it tells us that "Oedipal conflicts are inescapable" (p. 38). The polarity of the fairy tale permits the child to comprehend easily the difference between good and evil, but it is not presented, as is a cautionary tale, to stress the right behavior. The child chooses to identify with the characters not because of goodness but on the basis of whom he wants to be like.

The extraordinary and magical presented as ordinary; the story presented from the child's point of view; existential predicament and the need of the child for hope; the struggle toward a capacity for genuine ambivalence; the presentation of major unconscious themes of childhood—the movie is built with these elements embedded, establishing a "fairy tale" structure, although, as we shall eventually see, it is not without mythic elements. Our focus can now turn to the film itself.

FORM: THE FILM AS FAIRY TALE

The movie opens with a starlit sky. As the credits are presented, a chorus, off screen, sings a grisly lullaby:

> Dream, my little one, dream.
> All the wonder in the night
> Fills your darling heart with fright;
> Fear is only a dream,
> So dream, little one, dream.

This lullaby, nightmarish in itself, prepares us for a nightmare. A happy ending is presented (i.e., "fear is only a dream"), but hidden (i.e., it is embedded in the song). Thus in the very moments before the story begins, the film is presented to us, the audience, as a perverse bedtime story.

The film continues with Rachel, to whom we will be formally introduced much later, beginning to tell biblical stories to a group of

children, completely different in tone from the lullaby. It is the two together that establish the mood. Rachel says:

> Now you remember, children, how I told you last Sunday about the Good Lord going up into the mountain and talking to the people, and how He said, "Blessed are the pure in heart for they shall seek God"; and how He said that King Solomon in all his glory is not as beautiful as the lilies of the field. And I know you won't forget, "judge not, lest you be judged" because I explained that to you.

In the first moments of the movie we hear a cruel lullaby followed by firm, reassuring, biblical storytelling. Behind all of this is a backdrop of a starry sky with disembodied, unreal figures whom we do not know. The movie thus immediately presents a cruel, frightening "bad witch" mother (i.e., the lullaby) and a strong, reassuring "good fairy" mother (i.e., the storytelling Rachel) in an unreal, disembodied setting. From the first this is a story about good and bad, and we can expect the good to be very, very good and the bad to be very, very bad.

As Rachel speaks the camera descends over a winding river to a deserted house in a riverside village. Children playing hide-and-seek discover a murdered woman. We merely see legs and shoes (much like the legs and shoes of the wicked witch crushed by Dorothy's house in *The Wizard of Oz*). This initial shock-like scene is filmed totally from the point of view of the children, a warning for what will follow. What we are to see and hear is to be all like a dream. We are not to expect what we are to see to be real, but we are also expected (from the tone and style of Rachel's presentation to us) to appreciate the strange events we are to hear about in a matter-of-fact way. We have been introduced to a film presented in a style of magical realism. Almost every cinematic device aims at sustaining a mood of magic. If the film does not achieve the grandeur of *One Hundred Years of Solitude*, it certainly has its form.

The form is maintained by a variety of expressionist, impressionist, and even pop art techniques. Consider some of the scenes. Early in the film in a burlesque house the preacher's harsh aggressive ex-

pression contrasts with the flat, depressive audience and appears like a satirical painting. A revival meeting, immediately following the marriage of Willa and the preacher, filmed without a set—just flares and ecstatic faces—depicts the total subjugation of Willa to the preacher in a brief scene. The setting of Willa's murder, stark and cathedral-like; prayer and murder set together; the distorted angles in the room; the beatific-appearing Willa; the posture of the preacher as he listens for the voice of God; the murder itself—all are totally unreal, yet graphically portray inner experience. In many nighttime scenes, shadows are thrown in impossible directions, the improbability contributing to the magical unreality and atmosphere of menace.

Later, during the children's flight down a river, the presentation of nature itself (frogs, fireflies, dew-covered spider webs) is so unreal that what might otherwise have been a lyrical scene becomes an expressionistic distortion. Buildings appear flat, two-dimensional, and warped. At a moment of respite while resting in a hayloft during the flight, and eerily lit by a mere slit of moon, Pearl's legs appear from behind a haystack uncannily like those of the murdered woman at the beginning of the film. John in the background looks out on the improbably lit, bleak landscape.

In an earlier escape scene the preacher chases the children up the cellar stairs with outstretched arms for what seems to be endless time, recalling images both of anxiety dreams and of the film version of Frankenstein's monster.

In such scenes horror is combined with farce and pop art, relieving tensions through laughter. The startled, almost "jokey" look on the preacher's face when John knocks out the prop of a shelf and jars tumble on him exemplifies such a scene. Similarly, when the preacher falls howling into the river, having been barely evaded by John and Pearl, his expression stirs laughter as well as menace. The overall effect is stylized, theatrical, and unreal. Yet at the very same time the events are presented as magical, one is expected to accept them as ordinary reality and think, "Yes, this could happen to me."

This use of expressionism results in a nonintrospective film—the characters don't reveal themselves because they are not real characters. Here it is important to reemphasize that the film is made almost

entirely from John's point of view. This is accomplished not only through low shots from the child's eye level, but through the portrayal of characters as a child might see them, viz., all good or all bad. One might say that they are portrayed as one might in a story told to a child like John. The camera becomes the equivalent of a storyteller. Thus the inner conflicts of the characters, their thoughts, and the thematic material are expressed through a variety of external manifestations, not only the characters' utterances, but the backdrop, shapes, and shadows as outlined above. This approach lends itself to characters which are simplified and polar, i.e., the evil preacher; the good, albeit beaten down and weak-willed father, Ben; the good, but foolish Willa; the bad busybodies (Icey and Walt); the innocent (and therefore pre-moral) children; and, of course, the good fairy godmother Rachel.

Of interest, the effect of the film is somewhat different from that of the novel. The novel is highly introspective, the characters' thoughts and motivations made explicit. The effect is to make the novel more realistic, less magical, and more lyrical. Despite the exactness with which the film follows the plot and dialogue of the novel—and both impart a feeling of menace—the film's major effect derives from its stylized imagery. Its emotions and ideas are expressed through light and line as much as plot and action.

Perhaps the subtlest use of cinematic technique is also one of the most important and effective. It is the scene of a picnic early in the film where the preacher, assisted by his "disciple" Icey (the busybody), finally mesmerizes Willa. He tells her, with unctuous naiveté, that Ben threw the stolen money "into the river." Willa is now assured that the preacher loves "her," not her money, and summons John so that he can hear the good news with his own ears. Of course, John knows the preacher is lying. It is a scene where people are gathered together, but separate from one another, each with his or her own inner agenda, an agenda that is not expressed in words: Icey's contempt, hatred, and fear of men; the preacher's greed; Willa's fear of her own lust; John's awesome responsibility. It is a scene which is a turning point in the film because it propels Willa into marriage to the preacher and sets the stage for all that follows.

The scene has been very carefully set by the director in much the same way as a musician "sets" a poem. Elsa Lancaster (1983) states that her husband Laughton "set" the picnic to a vision of Seurat's most famous painting, *La Grande-Jatte*, "which shows a Sunday afternoon in the park, lack of activity, static figures" (p. 240). While the classic impressionists caught the light of the moment as they painted, Seurat made a scientific study of light and color and painted primarily in the studio. *La Grande-Jatte* creates an illusion of reality. The painting, figures frozen in a landscape for all time, invites us to wonder about its people, their lives, and their motivations. With the film stopped to a single frame, we can see its influence. The film, too, presents an illusion of reality. It presents psychic reality, i.e., the inner source of subjective experience, unconscious fantasy (Freud 1900).

There are two explicit references to the fairy tale theme in the movie, both at crucial junctures. One occurs early in the film after Ben has been hanged, when John and Pearl are going to sleep. There is a strange play of shadows on the wall and John, in response to Pearl's request, tells her a story: "Once upon a time," he begins...and unravels a tale of a rich king with a son and a daughter who "gets taken away by bad men." This is the very moment that the preacher makes his presence first known, his ominous shadow on the wall, a shock-like image as in the opening of the movie. The music in the background is Saturday-at-the-movies chiller music. We then hear the preacher singing the hymn, "Leaning on the everlasting arms." John reassures Pearl about the shadow. He says, "It's only a man." Note, by the way, the impossible optics of the scene. Once again illusion fits the emotion of the scene better than objective reality would have. John's comment will also remind us of Freud's ideas about the dream thought, "It's only a dream," i.e., the dream thought reduces the importance of what has been experienced through denial and thereby reduces anxiety. In fact, this scene is followed by the children going to sleep with John reassuring Pearl, and Pearl her doll, through a compulsive ritual: "Night, night; sleep tight; don't let the bedbugs bite."

The second reference to fairy tales occurs at the beginning of the

river journey, immediately after the narrow escape from the preacher. John has collapsed, exhausted, into the bottom of the skiff. The camera focuses on Pearl, and for the first and only time the movie is seen totally from Pearl's point of view. In Balter's (1981) terms, the "frame" of the film (i.e., its convention of being seen through John's eyes) is broken. She sings a song: "Once upon a time, there was a pretty fly. He had a pretty wife, this pretty fly." The boat is drifting through a shimmering night with fireflies. She sings on: "But one day she flew away, flew away. She had two pretty children. But one night these two pretty children flew away, flew away, into the sky, into the moon." The song ends unresolved, i.e., musically. We hear a frog twang. We really do seem to be in an unreal land animated by frogs, spiders, and fireflies. The song is important because it is Pearl's plight made explicit—flight, aloneness, and a defense against the loss of her mother (a flight to the moon)—while she is sitting appealing to her doll, Miss Jenny, for solace, the frame of the film (i.e., its fairy tale structure) momentarily broken, the reality of the character intruding.

These two overt fairy tale references flank the children's first seeing the preacher (an incident of *dread*) and their flight from him (a flight from *menace*).

CONTENT: THE PLOT, OEDIPAL THEMES, AND CONTEXT

What might explain the concealed fairy tale structure of the movie? After all, the film was an artistic and commercial venture intended for an adult audience. Why then was this cinematic form adopted, a form distinctly different from that of the novel? Seeking an answer to these questions requires considering another important theme of the film, the great economic depression in the United States.

The Depression is hardly mentioned in the film but is a backdrop, off screen, as ever-present in the movie as the night, the shadows, and menace. Sometimes we see it directly. During the children's flight down the river we see a poor riverside farmhouse. There is a tired farm woman at the door saying to herself, "Such times, when

young'uns run the road." She can offer John and Pearl only one potato apiece.

Throughout the whole film we hardly ever see a man at work. In fact men are not very much in evidence. Perhaps they are mostly loafing, or drinking, or trying to get work in the mines near Wheeling. The great Ohio River is mostly empty. The old river men are left, like Uncle Birdie, without work, spinning tales of the old days and watching the few remaining riverboats pass by the local landing. The river traffic is gone; farmlands lie fallow; factories and mills are silent. The area in which the film is set is the northern panhandle of West Virginia near Moundsville, down the river from the now largely dormant mills of Pittsburgh where the Ohio courses south between West Virginia and Ohio and then west along the southern border of Indiana and Illinois to meet the Mississippi at Cairo. It is the early 1930s. The proud West Virginia mountain men and women could recall that their parents had refused to secede from the Union along with the Eastern Virginians. A new state, West Virginia, loyal to the Union, was thus born during the Civil War. The children born then, especially men now aged, saw themselves betrayed and emasculated by a society and government for which their fathers and grandfathers had sacrificed much. They were now the forgotten men who sought a new deal, the promise of a future. Their children, the grandchildren of the settlers, exemplified by Ben Harper, are the betrayed.

Ben's very name, Harper, evokes the abolitionist John Brown[5], by some thought to be mad, by others, e.g., Emerson, a saint (Oates 1970). Brown led the raid at Harper's Ferry in 1859. In his zeal to provoke a slave rebellion, thinking himself an instrument of God and repelled by slavery, he led a bloody attack in which his own sons were sacrificed. After a trial he was hanged, as was Ben Harper after *his* raid on the bank. The historical figure of John Brown can be compared to a potential *composite* figure in the film—that of Ben *and* the preacher. When Ben, righteously protecting his children from the injustices of

[5] While the link of Ben Harper to John Brown through the "Harper" of "Harper's Ferry" must be seen as speculative, the historical link to the West Virginia of the Depression and the Civil War is persuasive to me.

the Depression, passed on the stolen money and responsibility for Pearl to John, he placed an almost insurmountable burden on his son. John was nearly killed by the preacher in his zeal to live up to his father's ideals. In fact, John Brown's sons *were* killed at Harper's Ferry supporting *their* father's ideals. The preacher of the film, in horror of women's "profane" temptations of the flesh, listening to the voice of God, killed "widders" to obtain money for God to plead His Word. He served God—a bizarrely distorted composite version of New England puritanism and John Brown's zealous and religious defense of black Americans. Instead of presenting a single, clearly ambivalent figure for a father, the film provides John with a more simplified situation: a "good" father and a "bad" stepfather (Kernberg 1966).

These themes of the 1930s resonating with the Civil War past, both subtly portrayed as a backdrop of the film, create a mythic atmosphere. The pessimistic adult world is a counterpoint to the fairy tale world of the child. Both interact in an important unconscious theme presented in the film. It is a fairy tale version of the "family romance" (Freud 1909). In a typical family romance fantasy, the child imagines and partly believes that one or both of his parents are not his true parents. Often it is the father who is assumed to be false and the real father to be some exalted personage. The child imagines that someday the real parent will appear and that he will be restored to his rightful place.

This subject is taken up directly in the novel. Rachel asks John to get her an apple and to get one for himself. Then she asks John, "Where's your folks?" John answers, "Dead." Later, John lies in bed thinking of the story of Moses that Rachel has told (imagining it to be a story of *two* kings) and, thinking of the preacher, says to himself: "Well, maybe he won't come at all now and maybe it wasn't none of it real and maybe there wasn't even any Mom or Dad or none of it and I am a lost King and Pearl is a lost King, too" (Grubb 1953, p. 219).

The family romance serves the purpose of protecting the youngster from the growing disillusionment with the parent, a disillusionment that is part of the necessary realistic reappraisal of parents as childhood is left behind. Fairy stories of the wicked stepparent per-

mit the child to identify with the plight of the youngster in the story (e.g., Cinderella) and give the child the satisfaction of seeing the stepparent destroyed without directly mobilizing aggression at his own, now degraded, real parent.

While John has the hateful preacher (a stepfather) to contend with ("You ain't my Dad! You won't never be my Dad!"), he does not have to contemplate the enormity of his own father's act, *nor his own fantasy life.* Here the central importance of this being a film to be seen from John's point of view becomes most evident.[6] John's fantasy life can best emerge through the use of a fairy tale format as long as his point of view, the point of view of a child, dominates and allows the relationship between the simplified characters to express it. At one level, as previously mentioned, the preacher as enemy protects John against the direct mobilization of aggression toward his own, potentially devalued father. It also protects him against the awareness of the fulfillment of his wishes—for he now has his father's power (i.e., his money) and his woman (i.e., Pearl, a substitute for his mother), an oedipal fulfillment. The film actually makes this explicit when we are shown a momentary glimpse of a graffiti on a wall: John loves Pearl. Even there the subtlety of the film is expressed—for the word "Pearl" is ambiguous and unclear. All through the film visual shocks (the opening vision of the murdered woman; *seeing* the shadow of the preacher; *looking through* the ice cream parlor window to see the preacher telling stories to Pearl) hint that in the past curiosity has led John to observe (or fantasize) frightening primal scenes and therefore fear danger from a wrathful father who therefore must be idealized and/or appeased.

Looked at from another angle one might say that Ben, disillusioned by a seceding Virginia and a fatherland which betrayed him after his grandfather bore the burden of standing against slavery, rejected its values and robbed and murdered. When he knows that he is

[6] We might wonder why the film is seen through John's (rather than Pearl's) eyes. It would be interesting to construct a parallel story, through Pearl's eyes, but the data of the film does not easily allow us to do that because its formal structure centers on John. Pearl is subordinated. Half the audience may be less than satisfied!

trapped and will be hung, Ben will not save his neck by telling where the money is. Rather he passes it on to John, who must now bear the burden of manhood.

But it is manhood passed on from a devalued father. Indeed, all the men in the film are portrayed as impotent and weak, i.e., other than the mythic and fairy tale central figures (Ben, the "preacher," John). Walt is ridiculed by his wife, Icey, for his sexual desire. Uncle Birdie, the old river man, sentimentalizes the past and imagines days of past glory, but is tyrannized by a picture of a wife dead for twenty-five years. The preacher appeases God whose voice he listens for; he is God's good boy killing women, "perfume smellin' things, lacy things, things with curly hair." By the killings he both submits to God, the father, and denies his own sexual desire—a dangerous and extreme regressive oedipal solution. But of course he too, finally, is abandoned by God.

A pre-adolescent boy, disillusioned with a father perceived as undeserving of his mother, has recourse to at least two solutions: he can imagine himself the son of an exalted man, a true father (i.e., a typical family romance fantasy), or he can idealize his father. What he cannot do is imagine himself in his father's place, i.e., without becoming psychotic.

In the film John idealizes his father and is determined to carry out his burden. He will be a "little man" and take care of Pearl and never tell anyone about the money. For the movie viewer, the presence of the wicked stepfather who may be hated and feared, alongside John's idealization, provides a perfect solution to the viewer's revived oedipal predicament.

There is yet another vicissitude which provides additional solutions for the viewer and the characters. It is the promise of a happy ending. After the ordeal of near capture by the preacher, there is a journey down the river. The river is a supportive and a safe mother. It is a passageway, a regressive way into the womb. But it is also a way out, a potentially wondrous trip along the Ohio, to the Mississippi, to the Gulf of Mexico, to the world, even to "the sky and the moon."

When Rachel appears, like a good fairy, a number of problems are solved for John. Rachel accepts John's gift of an apple, one might

say his sexuality, and authorizes his masculinity by her gift of a watch. There has been, until this point in the movie, a long period of dissociation. When John buffets the preacher with the doll stuffed with the stolen money, he says, "Here! Here! Take it back! I can't stand it, Dad! It's too much, Dad! I don't want it! I can't do it!" This is the cry of an overburdened, frightened oedipal boy. His fusion of the two (Ben and the preacher) into one—Dad—terrifies him. As a child he is not yet capable of genuine ambivalence toward his father. Rachel has taken over from the dead Willa, but rather than tell him he should love the preacher—as Willa did—she kills him, or at least contributes to his death, and finally legitimizes John. It is all right to have oedipal desires because there can be a happy end!

These scenes may also remind us of the many unemployed men for whom selling apples symbolized their despair. Apples are a powerful image throughout the film: selling apples, greed, tenderness, and sexuality. The men of the Depression took hope from a New Deal with its profusion of alphabet agencies and, pertinent to this movie, a bank holiday. There was again the promise of a future. The theme song of the time was "Happy Days Are Here Again," and its folk hero, of course, FDR—a great victor in the 1932 election.

The structure of the film—i.e., its embedded fairy tale structure—has particular advantages. Its fairy tale happy ending promises a resolution of oedipal problems, just as the New Deal promised a generation of men that they would indeed be permitted to be men again. The existential predicament of frightened, degraded, and angry adult men in West Virginia during the 1930s directly parallels that of the problems of the oedipal boy who fears his own parricidal wishes and tries to resolve them through idealization and/or wishful fantasy, i.e., a family romance.

DISCUSSION: OEDIPUS COMPLEX AND SITUATION

In the movie we face two directions simultaneously, viz., external reality (the Great Depression) and psychic reality (the family romance

and the Oedipus complex). While the oedipal boy attempts to resolve his problems through a family romance, adults who so proceed do so at their peril. Economic and political problems require economic and political solutions. How the adult responds will depend, at least in part, on the vicissitudes of previous mythic oedipal solutions. At the height of the economic depression of the 1930s, the American populace turned to a strong paternal leader (FDR) and a number of fairy tale heroes and heroines (e.g., Fred Astaire and Ginger Rogers) for solutions and hope, respectively.

The film presents a version of the oedipal situation and invites us to experience it. We will remember (Rose 1959) that Laius, fearing the prediction of Apollo that his own son will kill him, sends his infant son Oedipus out to be exposed and to die, first putting spikes through his feet so that his ghost cannot walk. Jocasta, his wife, is his accomplice. The movie presents not only a wicked stepfather (the preacher) and an idealized but weak Ben, but two "damaged couples" (Feldman 1989, 1990) as parents—Ben and Willa, and the preacher and Willa. Neither couple protects the children. In fact, both couples endanger them. John, who "knows" truth, is especially endangered. Now external reality *confirms* psychic reality. John's only recourse is defensive dissociation, an extreme psychopathological adaptation, until he is finally "saved" by Rachel.

In recent years there has been considerable emphasis on the role of trauma in human development and later psychopathology (Herman 1992). Some (Masson 1984)[7] have proposed that Freud dissimulated in supposedly denying the significance of childhood trauma and seduction in order to promulgate the centrality of the Oedipus complex. Others (Kohut 1977, 1984) suggest that the Oedipus complex is not an inevitable maturational necessity, but rather a frequent pathological formation resulting from not-good-enough parent–child interaction ("[empathic]...failures from the side of narcissistically disturbed parents," 1977, p. 247). Simon (1991) has surveyed the political, scientific, and epistemological complexities that

[7] Grubrich-Simitis (1988; 1997, p. 63-64) has clearly demonstrated the oversimplification and incorrectness of these charges. See also Freud (1939).

beset an examination of the Oedipus complex, a veritable minefield of obstacles.[8]

Recently Feldman (1990) stated that: "Many analysts have...come to recognize the presence of earlier, more primitive versions of the oedipal fantasies, and here the primary objects are often represented in a damaged state, not always differentiated from one another, and often felt to be threatening" (p. 37). He suggests that "when we extend the concept of the Oedipus complex to include the expression of early and primitive phantasies about the nature and interaction of the parental couple, we encounter features of these objects—including their vulnerable and damaged state—which are more frightening and more damaging than phantasies of apparently powerful, successful parental sexuality, and these consequently constitute a more serious threat to the discovery of psychic truth" (p. 41). Facing a dreadful reality in which he was virtually helpless to protect his family, Ben plundered a bank and killed two men and then passed on the burden to his son John.

Some have preferred to think of two complexes in interaction with each other, a Laius and an Oedipus complex (Bergmann 1992; Devereux 1953). I prefer to think of an oedipal *situation* (sometimes including a damaged couple like Laius and Jocasta) from which the familiar Oedipus complex emerges. This formulation does justice to the complexity of the original myth and the potential role of trauma. The father (Laius) *in fact* puts spikes through his son's feet and sets him out to die from exposure. He may well be responding to a fantasy—may we say an oedipal fantasy?—attributed to Apollo, that his son will kill him. Oedipus unwittingly kills Laius. This is a tragic story of catastrophic abuse followed by an equally tragic and catastrophic enactment by Oedipus. The movie parallels the myth in its presentation of trauma interacting with fantasy.

The formulation of an oedipal situation also encourages us to

[8] For example, Friedman and Downey (1995) have recently surveyed biological influences on mental representations of father–son aggression, focusing on testosterone influence on rough-and-tumble play. They propose that the sexual element that Freud suggested is a more variable element of the Oedipus complex than the aggressive element.

consider the range of a parental couple's possible relationships and behaviors—from mature, protective, and intact to primitive, threatening, and damaged—as a matrix out of which oedipal fantasies are shaped in the child and which, indeed, may be later enacted.

We may now finally return to the odd power of the film and its combined fairy tale, mythic form. By maintaining the fairy tale structure (the film through John's eyes) with its mythic backdrop (the off-stage Depression of the 1930s as it affects Ben), the movie portrays quite well a traumatic oedipal situation in which a vulnerable father and damaged couples (Ben and Willa, the preacher and Willa) lead to a primitively skewed and dissociated Oedipus complex (John). The fairy tale structure (hope) in apposition with its off-stage mythic elements (pessimistic inevitability) permits members of an audience to grapple with central oedipal situations for themselves. I believe this is why the film has endured.

Shengold (1989), in his book about the effects of childhood abuse and deprivation, comments usefully about the conundrum of human experience: "Too much and too little are qualities of experience.... Too much too-muchness we call trauma. Too much not-enoughness inhibits proper maturation" (p. 1). Later he adds, "The sins of the father are laid upon the children—but not, as Freud has shown, upon innocent children. Children are easy to seduce because they want to be seduced" (p. 4). While all parents may at times be seductive and at other times frustrate their children, relatively few severely abuse or deprive them. Most are "good enough." The vicissitudes of oedipal situations vary widely and, as *The Night of the Hunter* invites us to consider, with varying outcomes. One need not deny the power of fantasy to be aware of abuse or deprivation. One need not deny the Oedipus complex in order to credit the power, even the tragic power, of the environment.

A "cult" interest in *The Night of the Hunter* has kept the movie alive. This interest represents a cultural response to its embedded structure, a variation of that presented by Sophocles. Close study of *The Night of the Hunter* promotes a rereading of *Oedipus Rex,* which in turn fosters new ways of organizing psychoanalytic observations in the consultation room.

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BOOK REVIEWS

INTERNAL OBJECTS REVISITED. By Joseph Sandler and Anne-Marie Sandler. Madison, CT: Int. Univ. Press, 1998. 169 pp.

Joseph and Anne-Marie Sandler, in the preface to this comprehensive, yet succinct and clearly written book, state what they wish to accomplish:

> While the chapters still retain much of the quality of the original papers on which they are based, we nevertheless hope that the work we have put together into this book provides a theoretical basis for integrating a theory of internal object relations into an ego-psychological—or, more properly, a post-ego-psychological—frame of reference, taking what is appropriate from our own clinical experience and from object relational and Kleinian theory while trying to avoid simplistic formulations. [pp. xi-xii]

Their tone in this passage is characteristically modest, but I believe they have succeeded admirably. In one hundred forty pages of text, they construct a virtual textbook of contemporary psychoanalytic theory. There are knowledgeable and respectful roots in Freud, Anna Freud, and classical theory, but also forthright competence with current ego-psychological, developmental, and object-relational (mostly Kleinian) ideas. Late-breaking developmental research and cognitive science are not slighted. Lively clinical examples throughout illustrate how the authors' theory directly links to their practice of psychoanalysis. Abstruseness is at a minimum. Their theory is experience-near.

As Otto Kernberg notes in his respectful foreword, the Sandlers' methodology is to use theoretical building blocks—topics taken from contemporary theory. Each topic is carefully considered step by step, then gradually integrated into a unified whole. The book is far more

than the sum of its parts. Although each chapter is based on a previously published paper, new introductory material is added to each, and the originals are reworked and combined to increase the work's integrative power. Chapter order is carefully considered, and the cumulative power as one reads is impressive.

Joseph Sandler wrote most of the original papers. The book allows the reader to view his accomplishments in historical perspective. One grasps the scope, profundity, and intellectual integrity of his life's work, as well as the astonishing degree of integration and unification attained by the time of his sudden, tragic death last year. The first chapter, "On the Psychoanalytic Theory of Motivation," for example, leans heavily on his concept of the background of safety and its inescapable significance for human psychology. Sandler begins by recalling an exchange of views with Anna Freud in the late 1950s, just after he first presented the original paper on safety. She expressed concern that an emphasis on factors such as the need for safety, well-being, or self-esteem—even for mastery or "ego-tone"—could result in "mere" ego psychology at the expense of a depth psychology rooted in instinct and instinctual conflict.

Sandler's response was the first step in what became his life's work—to reconcile his new modes of understanding with his respect for the concepts and sensibilities of the classical tradition in which he was trained. Using an elegant clinical vignette, he demonstrates how a sexual symptom successfully analyzed along classical lines eventually was revealed through transference-countertransference analysis also to contain a sadomasochistic tie to a crucial, safety-supplying, internalized parental surrogate in the patient's early life.

The closing chapter, "A Theory of Internal Object Relations," leans heavily on his early, classic work on the representational world. The representational world of unconscious and conscious subjective experience is distinguished from the nonexperiential organizing structures of the mind, of which internal objects are centrally important ones. Thus, like the superego of traditional structural theory—also dangerously easy to reify or confuse with subjective experience—the internal object is a "dynamic template" for organizing experience, related to the implicit or procedural organizations of contemporary cognitive science.

Intrapsychic structures, processes, and organizations are arguably necessary to any useful modern theory and must be conceptually differentiated from the data of conscious or unconscious subjective experience.

Other building blocks include chapters entitled "The Striving for Identity of Perception," "On Role-Responsiveness," and "Comments on the Psychodynamics of Interaction." Further chapters relate affects, character traits, and stranger anxiety to internalized object relations or internal objects. Identity of perception is the theoretical concept straight from early Freud that keeps wish fulfillment in the very center of Sandlerian theory. What is wished for may include instinctual satisfaction, but wish, not drive, is the basic unit. There is an unconscious wishful fantasy—a wish for a particular relationship or interaction, modeled on experiences with significant early objects. Representational or narrative complexity, uniqueness, and nuance are not reduced to simple drive-discharge or drive-conflict paradigms. There are wishes, for example, for "holding" in the service of developmental growth; for safety, well-being, and affirmation; for mastery and defense; and for warding off painful affect states or seeking pleasurable or secure ones. Affects and affect signals are the primary regulators of psychic life. Character traits may also actualize within current relationships experiences and behaviors which are longed for based on prototypical early, now internalized, object relationships.

Role responsiveness and actualization are key concepts relating the interpersonal to the intrapsychic, and they allow a modern psychoanalyst to consider "normal" countertransference in addition to that activated by psychopathology and blind spots of analyst or patient. Central roles are assigned to unconscious phantasy, to transference understood as projected or externalized unconscious internalized object relations, and to an enriched contemporary understanding of construction and reconstruction. Analytic theoretical past and present are linked and integrated.

The book contains some of the most sophisticated and straightforward discussions I have seen of several important and complex psychoanalytic topics. Examples include the relationship of structure to experience, of interpersonal to intrapsychic, and of dyadic to triadic. Projective identification is discussed in relation to externalization and

displacement. The relation of theory to practice is richly considered. The authors argue eloquently, for example, that the use of both one- and two person psychological models are always present in sound clinical work. They also claim that all analysts use a not fully consciously integrated group of not always compatible theories in order to do all the things that must be done in their actual clinical practice.

This is also one of the best theoretical teaching texts I have come across. It could serve as a basic text for a theory course that belongs in the core curriculum of every psychoanalytic institute. Few institutes currently offer such a course, however, because the Sandlers' masterfully integrated theory does not fit smoothly into a traditional curriculum, where classical, object-relational, and developmental theories are usually considered separately. The Sandlers' theory represents the advancing frontier, the new paradigm. It is hands-on contemporary theory.

A caveat, however: this book is for those who like their theory neat. Very influential theorists—major contributors, in fact, to the very revolution that created the context that partly enabled the authors to achieve their theoretical feat—are barely mentioned. These are mainly our more philosophical or romantic theorists, especially the celebrators of the self and of transitional or intermediate states. Thus we hear little of Winnicott, Loewald, Kohut, or Laplanche. Bion's containment concept is more celebrated than those of Winnicott or Kohut. Significant areas are therefore slighted, such as intersubjectivity, self-theory, and the enigmas and ambiguities (and controversies) that exist clinically at the boundaries of personal and interpersonal, phantasy and reality. Experience is regarded as the sum of one's self and object representations and accompanying affects. The Sandlers give us an atomistic theory. Subjectivity is not a subject in its own right. Empathy is given short shrift. Spitz, Mahler, Jacobson, and Arlow are prominently mentioned to support the authors' views. Jacob Arlow or Paul Gray would find little, in fact, with which they could disagree in the book. It is very responsible—dare I say, conservative—theory, despite its strongly revisionist views on certain so-called classical conceptions.

Finally, since this is a coauthored book, I risk an unintended slight to Anne-Marie Sandler by putting in a last word of praise and tribute to Joseph Sandler. Many of Joseph Sandler's great contributions were multi-

authored. He always impressed me not only as a great thinker, but also as a great collaborator. I noticed a consistency of writing style in all his collaborations, and the style always reminded me of his own—crystal clear, highly readable, succinct, logical, modest. While known to be a more complicated man in his personal life, the consistent self-effacement and understatement in all these works suggested to me that in his writing and teaching he completely surrendered his own ego and personal agendas. He surrendered them, I imagine, not only to the ideas he eternally worked out, but also to his collaborators. I inferred that he must have gotten his collaborators' very best, and that this was because of his own clarity and sincerity as a thinker and as an analyst. We, his colleagues and readers, always benefited from this generosity as well. One must read much more than *Internal Objects Revisited* to appreciate fully the enormity of Joseph Sandler's personal contribution to the creativity and generativity that is the hallmark of psychoanalysis today. I suspect, however, that this book may be the work that endures the longest. It fully belongs to and shows his crucial role in defining what is currently emerging as the new psychoanalytic paradigm.

GERALD I. FOGEL (PORTLAND, OR)

THE CONTEMPORARY KLEINIANS OF LONDON. By Roy Schafer. Madison, CT: Int. Univ. Press, 1997. 441 pp.

Roy Schafer occupies a unique position in psychoanalysis. He is not only one of our leading theorists, but he also has the distinction of having studied under David Rapaport, a doyen of another time past. That means that Schafer had been deeply rooted in ego psychology, both in the higher theoretical and in the clinical aspects of it. At the same time, however, he seems to have remained open to other, then heretical, schools of thought. I recall a time when he spoke at the Los Angeles Psychoanalytic Society during the height of a "Kleinian purge," instigated by a virulent site visit from the American Psychoanalytic Association, who were troubled at the time that the psychoanalytic training there was not in the spirit of "typical American psychoanalysis" (their words). To everyone's surprise, including my own, Schafer measuredly

addressed many of the values of Kleinian theory and practice, demonstrating an unusual grasp of some of its intricacies.

This present volume flows in the spirit of that measured scholarship. Because of his unusually perceptive grasp of the issues involved between the American[1] classical school and the London[2] Kleinian school, Schafer is all the more suited to fairly compare them and to establish bridges between them. In carefully selecting key clinical contributions from members of this latter school, he is able to show them at work, so to speak, and to show how they think and feel about their technique with analysands in the ripe clinical moment. He has also carefully selected the works of an unusual group: the second (Hanna Segal and Betty Joseph) and mostly third generation of London Kleinians, including Edna O'Shaughnessy, Ruth Riesenberg-Malcolm, Michael Feldman, Elizabeth Bott Spillius, Eric Brenman, Robin Anderson, Ronald Britton, Ignês Sodré, Irma Brenman Pick, and John Steiner.

Some of Schafer's crisp evaluative summaries bear note:

> The clinical examples in the papers that follow will ... also show that, contrary to stereotype, these analysts remain keenly attentive to "real" circumstances and events in their patients' past, present, and future lives, including the treatment relationship itself; however, they systematically explore and emphasize the unconscious meanings of these "real" details.... Their eye is fixed on psychic reality, and they approach it as being constantly in flux, so much so that they do not allow many definite reconstructions. [p. xii]

The eighteen chapters are organized into elaboration of the following themes: (a) traditional Kleinian themes: clinical facts, phantasy and reality, splitting and projective identification, envy, cruelty, the paranoid-schizoid and depressive positions, the Oedipus complex, and manic reparations; and (b) newer themes: obsessional certainty versus

[1] I use the term "American" to distinguish the American version of classical psychoanalysis from classical psychoanalysis in other lands.

[2] It is of note that Schafer is so knowledgeable about Kleinian practice that he distinguishes between London Kleinians and those in South America, for instance.

obsessional doubt, the concept of understanding and not understanding, reassurance, countertransference, clinical facts, pathological organizations or psychic retreats, patient-centered and analyst-centered interpretations, psychic change, and the child in the adult.

In emphasizing the differences between the modern London Kleinians and their forebears, Schafer observes:

> Contemporary Kleinians follow the story line laid down by Melanie Klein and elaborated by her contemporaries and later followers, especially Joan Riviere, Susan Isaacs, Paula Heimann, Wilfred Bion, Herbert Rosenfeld, and Hanna Segal. They differ from Klein in their de-emphasizing and deferring detailed reconstruction of early developmental history. They prefer instead to stay, for as long as possible, close to, almost fixed to, the shifts in unconscious fantasy,[3] in the here-and-now clinical situation and most of all in the transference.... These Kleinians further differ from Melanie Klein in their emphasis on induced countertransference as an invaluable form of communication or at least as a source of information. [p. 4]

I found this particular citation to be a worthy summary of the new trajectory of the London Kleinians, who are apparently following the lead of Betty Joseph, who emphasizes the all-encompassing importance of the totality of the transference and countertransference situation. In a way, one could typify this new thrust as a parallel of the ontological-mystical ideas in Martin Buber's "I-Thou,"[4] and especially of outgrowths of Bion's[5] discovery and elaboration of the concepts of the container and the contained, maternal reverie, and alpha function. Bion, simultaneously with Paula Heimann and Roger Money-Kyrle, were, unlike Melanie Klein, aware of the enormously positive possibilities that lay in store with the analyst's countertransference receptivity to his/her

[3] "Blood is thicker than water." It is interesting how Schafer, the ego psychologist, refers to the Kleinian concept of unconscious *ph*antasy as "*f*antasy." A virtual ecclesiastical psychoanalytic war was fought in which the spelling of this term was a major issue (King and Steiner 1992).

[4] Buber, M. (1958). *I and Thou.* Trans. W. Kaufmann. New York: Scribner.

[5] Bion, W. R. (1962). *Learning from Experience.* London: Heinemann.

analysand. It was Bion's radical extension and revision of Klein's concept of projective identification that underlay this new—for Kleinians—-emphasis on the importance of primal external objects. Projective identification was extended from its exclusivity as an unconscious phantasy in the one-person model into an intersubjective process involving both participants. Consequently, one of the Ariadne threads running through all the clinical presentations in this collection is the acute level of countertransference sensitivity—moment-by-moment—demonstrated by the analysts with their analysands. Bion in particular seems to have made a lasting impact on Klein's descendants. While Kleinians used to be attacked for ignoring reality, these Kleinians observe with microscopic clarity how the analysand *re-creates* his/her reality out of the objects of external reality *in statu nascendi*.

Another concept that emerges from the Kleinian oeuvre that is relevant here in terms of their propensity to stay with the here-and-now in lieu of reconstruction devolves from their concept of the "infant of analysis." I gleaned—or perhaps even misunderstood—from my own erstwhile training in ego psychology that the infant or child in the analysand was located in the past but could be contacted through *temporal* regression. I learned as a Kleinian that there may be two "infants": the temporal one of actual infancy, and the "once-and-forever infant," the one who constitutes the ever-present psychoanalytic subject—of any age. Thus, *this* "infant" attempts to be born anew during each analytic hour as if this were his/her first hour of the analysis, yet paradoxically has memory of the infant who actually was once upon a time. This line of thinking had been implicit in Klein's thinking virtually from the beginning, but became explicit with Bion's injunction to "abandon memory and desire"—as though each moment is the first moment—without prejudice from memory or (mis)understanding or desire (pleasure-seeking). In other words, it would seem that to Kleinians, the present moment in the analytic relationship constitutes an eternal (infinite) or timeless moment in which the past and present are in some ways indistinguishable.

Another feature that seems to characterize each of the clinical presentations is the almost exclusive emphasis on unconscious phantasy in the respective analyst's interpretations. However, if one compares the

content of the interpretations about the analysand's phantasies, they seem more adult, that is, more "ego-friendly." Virtually any classical psychoanalyst would understand and probably approve of them. It is worthwhile comparing the level of linguistic sophistication between their clinical work and that of their forebear, Klein, particularly in her *Narrative of a Child Analysis*.[6] The difference would be that the latter (albeit hers was a case of a child analysis) elaborated unconscious phantasies that were characterized as primitive part-objects, whereas her descendants seem to have more respect for the adult sensibilities of their analysands, and while they still deal with part-object relations on the primitive level, the language addresses more the function and the *process* rather than the concrete body-parts. This idea is well represented in Robin Anderson's "The Child in the Adult: The Contribution of Child Analysis to the Psychoanalysis of Adults."

The foregoing brings up another feature of Kleinian analysis. Klein made her discoveries during the heyday of orthodox (id) analysis. Thus, her work typifies many of the characteristics of that bygone oeuvre. In fact, one can say that Kleinian analysis is in a way a direct continuation of orthodox analysis—except for at least one major difference. Klein disavowed primary narcissism, believing that the infant formed object relations, both internal and external, from the very beginning. Because of this belief, she was able to lay the foundations for the analysis of the infantile state of existence as it became iterated later in the infant's life in the dialectical relationship between the paranoid-schizoid and depressive positions. Orthodox and classical analysts were handicapped, in my opinion, by having no access to infantile mental life, thanks to the imponderable barrier imposed by the concept of primary narcissism. Even the work of Margaret Mahler and other infant development researchers were not able to parallel the intuitions and findings that Klein was able to attribute to the internal world of the infant.

In his "Epilogue," Schafer reveals that one of the features of Kleinian analysis which intrigued him was the dynamic activity implicit in the concept of unconscious phantasy. He saw an immediate connection with his own concept of action language; thus, the beginning and con-

[6] Klein, M. (1960). *Narrative of a Child Analysis*. New York: Basic Books.

tinuation of an affiliation began. I find Schafer's book of great value in introducing "sensible Kleinianism" to classical, especially American classical, psychoanalysts.

JAMES S. GROTSTEIN (LOS ANGELES)

IDEAS AND IDENTITIES: THE LIFE AND WORK OF ERIK ERIKSON. Edited by Robert S. Wallerstein, M.D. and Leo Goldberger, Ph.D. Madison, CT: Int. Univ. Press, 1999. 411 pp.

In concert with Lawrence Friedman's newly released biography of Erik Erikson,[1] this loving tribute to the man and his work by an array of distinguished colleagues and friends took this reader down memory lane. Back in the 1960s, when I was a student and he a university professor at Harvard, Erikson reigned supreme as the silver-haired psychoanalytic folk hero of our generation. Though he found himself marginalized by his fellow analysts (despite his essential loyalty to the Freudian canon and no doubt because of a charisma that could not easily be contained within the ranks), Erikson's was a looming presence in his heyday as academia's most popular icon, the mythic professor sans degree. Among undergraduates like me, he outshone the great school's other luminaries (Lowell, Watson, Levin, Alfred, Riesman, Moynahan, and more) because he spoke directly to our most pressing personal and collective preoccupations in a language at once familiar and revelatory. The vision he offered seemed to us comprehensible and subtle, simple and complex, infusing students and faculty alike with a sense of mission—both interdisciplinary and existential. While quietly playing with and reworking its theoretical frame in ways few colleagues have fully appreciated, Erikson made psychoanalysis come to life for the rest of the world.

During my subsequent journey through the labrynthian world of psychoanalytic training in the 1970s and '80s, I was shocked and disappointed at the degree to which Erikson's contribution was ignored. In

[1] Friedman, L. J. (1999). *Identity's Architect: A Biography of Erik H. Erikson.* New York: Scribner.

those days, he was regarded as too soft to be taken seriously, with the possible exception of his brilliant clinical work on the configuration of the manifest dream (Erikson 1954; see below). Preferring the delimited and jargon-laden contributions of his fellow ego psychologists and object relations theorists to Erikson's rich and evocative psychohistorical narratives, my teachers dismissed him as "good for college students." Later, when I had joined their ranks as a professor and training analyst and, shortly after his death, put together an all-day panel on Erikson for the December meetings of the American Psychoanalytic Association, I found myself equally dismayed by the few stragglers who managed to attend it. "Not sexy enough," Owen Renik told me later—not as sexy as a debate on self-disclosure between him and Judy Chused across the hall. "Not sexy," I mused, as I recalled the images of Erik and his dancer wife Joan striding like near-naked Norse gods across the beaches of Cape Cod.

By now Erikson had become identified with the schematizing and conservative ego psychologists of his era, and so on the contemporary scene his work was considered "a thing of the past." Never a full-fledged follower, neither was this quintessentially private man a leader—unlike those (or so I believe) less encompassing minds (Klein or Kohut) who, despite their tunnel vision, cultivated cadres of disciples for generations to come. Hence the obscurity that has come to envelop his singular brilliance.

Ideas and Identities reminds us of the range, capaciousness, and prescience of a forgotten man who was in fact ahead of his time. More so than most collections, especially those based on capricious symposia, this volume succeeds in demonstrating the assertion of one of its contributors, Robert J. Lifton, namely that "Erik was the most creative psychoanalytic mind since Freud" (Erikson 1954, p. 113).

Five of Erikson's seminal contributions are reprinted in this volume, including his famous letter of resignation from the University of California at Berkeley in the wake of the demand that its faculty sign a McCarthy-style loyalty oath. The other essays convey the major themes in his work. In "The Dream Specimen in Psychoanalysis" (1954), Erikson, ever the visual artist, finds new "depth in the [clinical] surface" as he demonstrates how the dreamer's central life cycle issues determine not

only the content but the form of the manifest dream along critical dimensions. Today we know much more than Erikson did about the actual events represented in Freud's "dream of Irma's injection." For example, there was the "first psychoanalyst's" need not to externalize his own guilt, as he averred, but rather to exculpate an idealized Fliess in the wake of the Emma Ekstein debacle and his wish to abort his wife's pregnancy with what would prove to be their last child (Anna, that is, who later pressured Hoffer, editor of the *International Journal of Psycho-Analysis,* to reject the piece, which found its way into the *Journal of the American Psychoanalytic Association).* Nonetheless, the major thrust of the essay, its application to interpretive work with actual patients, has stood the test of time.

Stressing the importance not only of libidinal zones but of *modes* and *modalities* in psychosexual development and in the evolution of the ego, and adding sociocultural influences to the mix, Erikson's "Problem of Ego Identity" sets forth an overarching conception of development through the course of the entire cycle as a function of somatic, societal, and psychic inputs. Like Heinz Hartmann, Erikson stresses *adaptational* opportunities and exigencies in determining how one "fits into" his or her social surround, and how, as a consequence of what Piaget would call accommodation, his or her personality "fits together." In this scheme, adolescence rather than the oedipal era, stressed by Freud, proves to be the nodal point in the individual's life cycle. The "identity crisis" typical of this period signals a transitional time in the transmission of generational authority when the "morality of childhood" is replaced by "the ethics of [the more or less independent] adult." Erikson's emphasis is on historical and cultural variation and specificity in shaping what outside observers would see as a person's character. He also suggests that identity, the sense that others affirm one's selfhood, is a more inclusive and descriptive construct than self, self-representation, or, for that matter, ego. Like "object relations," the sense of ego identity captures what today we would term the intersubjective representational world of the individual. Nowadays we might question the universality and invariant sequencing of Erikson's "Eight Ages of Man" in the absence of demonstrable biological maturation in adulthood. Nevertheless, the overview is more complete and clinically ap-

plicable than more genetically reductionistic models that focus on pathological conflict alone and ignore the whole person in the context of the real world.

Erikson was still at the height of his powers in his 1958 meditation on methodology, "The Nature of the Clinical Evidence." In this essay, he anticipates the contemporary preoccupation with the inevitable participation of the observer in constructing the data he or she encounters in the consulting room. Rather than make pretenses to an unobtainable objectivity or yield to a merely "narrative" truth, Erikson advocates "specific self-awareness" and "disciplined subjectivity" (p. 249)—an attention to one's personal and social context and consequent phenomenology—in processing the stories our patients tell us about their pasts. He put this principle into practice not only in his work as a clinical analyst, but as historian as well. In his "personal word" in the 1969 biography *Gandhi's Truth,*[2] a "letter" to his biographical subject, Erikson, situating himself as a Western commentator, struggles to come to terms with the cruel moralism toward family members on the part of this otherwise saintly and inspiring hero from Gujerat.

Alas, we see Erikson's powers beginning to fade (he would eventually succumb to senility) with his 1981 essay on Jesus, "The Galilean Sayings and the Sense of 'I.'" Rambling and unfocused, this chapter further reflects Erikson's identification with his wife's ardent Christianity and his lifelong effort to establish his religious and ethnic origins as the Jewish son of an unknown gentile father. However, it does provide a glimpse of the man toward the end of his life.

The remaining chapters, by the California Symposium's participants and other invited authors, evaluate and expand on these core ideas, sometimes in illuminating ways. Wallerstein's "Setting the Context" provides a clear and comprehensive overview of Erikson's place in psychoanalytic history. In her chapter on "Erik Erikson and the Temporal Mind," philosopher Marcia Cavell stresses Erikson's understanding of the unfolding of reflective self-consciousness, a theme central to her discipline. Neil Smelser, Director of the Stanford Center for Advanced

[2] Erikson, E. H. (1969). *Gandhi's Truth: On the Origins of Militant Non-violence.* New York: Norton.

Study, in assessing "Erik Erikson as a Social Scientist," dubs him the "quintessential interdisciplinarian," whose methodological limitations and inconsistencies do not detract from the insights offered by his "sociological idealism." Theologist Walter Capps tenders comments about Erikson's notions about religion. Addressing feminist skepticism, analyst Elizabeth Lloyd Mayer presents her replication of Erikson's early findings about intrusive and inclusive modalities in the configurations of play constructions in boys and girls. Robert Jay Lifton details his collaboration with his revered older colleague in establishing the discipline of psychohistory. In an elegant, scholarly essay, psychological theorists Seligman and Shahmoom convincingly demonstrate Erikson's "Anticipation of an Intersubjective Perspective." In a chapter drawn from his biographical research, historian Lawrence Friedman concentrates on Erikson's synthesis of psychoanalytic and historical perspectives into a general psychology, from which vantage he examined the human life cycle, and more specifically, American society. Like others, Friedman notes Erikson's rather unsystematic methodology as the price paid for his unexpected insights into the human condition.

Also included in the volume, which ends with Leo Goldberger's brief epilogue, is a letter of condolence on the occasion of Erikson's death in May, 1994. This interlude is out of place here, I believe, tending as it does in the direction of a hagiography otherwise eschewed by this olio of insightful and balanced reflections on Erikson's contribution to an array of disciplines.

In summary, this collection of essays, including new contributions as well as anthologizing Erikson's pivotal papers, provides a contemporary appraisal of the life's work of what biographer Lawrence Friedman has dubbed "identity's architect." In it, Erikson emerges as a psychoanalytic theorist deeply grounded in so-called classical instinct theory—perhaps even more so than Freud's heir apparent, Heinz Hartmann, with his notion of the "conflict-free sphere of the ego." In contrast, psychodynamic conflict remained essential to Erikson's understanding of motivation and change and of the dialectical and creative power inherent in successive and recapitulatory developmental *crises*. It was Erikson's aesthetic sensibility, his attention to the *form* of human consciousness, that provided him with the concept of *modes* and *modali-*

ties, and enabled him to discover the resonance between the psychosexual and psychosocial domains. In his configurational scheme, desire and social roles converge in the child-rearing practices particular to different cultures at different points in their collective histories to shape the evolving identity of a growing individual, whose fate is further determined by his or her biological predisposition. And thus, Erikson's work served to anticipate the two-person psychology of modern psychoanalysis and the multiculturalism of the academy. His efforts also presaged the renewed interdisciplinary spirit of our own era and our particular discipline's emergence from a "splendid isolation" that until recently threatened psychoanalysis with entropy and near extinction.

The roots of Erikson's preoccupation with identity and the generational cycle are clearly discernible in his oedipus-like confusion about and meditations on his own origins. His more private search for what the Classical Greeks called "recognition" (synonymous with *truth*) comes to life in Friedman's biography, a critique of which will no doubt appear in this periodical. I leave to another reviewer an elucidation of this quest, as well as of some more unsettling and potentially disillusioning revelations about the family life of a man many of us once regarded as a Gandhi-like guru. Besides, whoever Erikson the man really was, Erikson the psychoanalyst remains one of the most important psychological thinkers of the century his life spanned—a psychoanalyst for the ages.

I hope that these two books will revive an interest in Erik Erikson's complex, elegant, and truly cosmopolitan life work.

JOHN MUNDER ROSS (NEW YORK)

PSYCHOANALYTIC THERAPY AND THE GAY MAN. By Jack Drescher. Hillsdale, NJ: Analytic Press, 1998. 373 pp.

Drescher's monograph opens with the following statement: *"Psychoanalytic Therapy and the Gay Man* is not just a book about doing psychotherapy with gay men. It is also a chronicle of the historical state of relationships between two controversial cultural movements of the twentieth century: psychoanalysis and the political struggle for gay rights" (p. 2). This book would have been more successful had it con-

fined its aspirations to its first goal: doing psychotherapy with gay men. Drescher, a gay psychoanalyst trained at the William Alanson White Institute in New York City, presents a perspective about psychotherapy that follows upon and complements that of Richard Isay.[1,2] When discussing scientific/theoretical issues pertaining to homosexuality, however, Drescher abandons the tone of the professional psychotherapist and becomes polemical, often stridently so.

Drescher as clinician advocates standard psychoanalytically informed therapeutic practices, such as forming a bounded therapeutic alliance, exploring the many meanings of behavior, and avoiding premature closure. His approach seems eclectic but heavily influenced by Sullivan, Winnicott, and the object relations school. A topic he discusses in a particularly helpful way is the psychology of the gay adolescent. A common misconception of therapists who are not experienced in working with gay men and youth is that it is not possible to know that one is really gay until full adulthood. Teenagers often have difficulties understanding their sexual desires; during adolescence many who are not actually gay experience homosexual feelings, and these patients must be distinguished by clinicians and treated differently from those who are in fact gay. Drescher's insights about gay adolescents are helpful in that regard. Drescher also instructively utilizes Sullivan's ideas about dissociation and selective inattention in illuminating the deleterious effects of being "in the closet"—hiding one's sexual identity from others.

When patients talk about sex, many psychotherapists become anxious, even to the point of experiencing countertransference reactions. Yet experienced therapists recognize that appropriate discussion of sexuality strengthens the therapeutic alliance. Drescher's informative presentation of the clinical aspects of gay sexuality ring true and are particularly enlightening.

It is puzzling that such a thoughtful clinician should adopt a hostile stance toward sex research, including condemnation of individual

[1] Isay, R. A. (1989). *Being Homosexual: Gay Men and Their Development.* New York: Farrar, Straus, Giroux.

[2] Isay, R. A. (1996). *Becoming Gay.* New York: Pantheon Books.

researchers and of the scientific process itself. He is particularly suspicious of psychobiological scholarship, which he discusses in a slanted way, substituting disapproval for carefully reasoned assessment. For example, he states: "Although moral concerns are more routinely ascribed to religious narratives, scientific theories of homosexuality are just as likely to be based upon the personal beliefs and values of the theorizer" (p. 73). E. O. Wilson and A. Kinsey are among scholars presented as either being prejudiced or as having contributed to anti-homosexual attitudes: "Unsurprisingly, Wilson's altruistic 'homosexual,' like his counterparts in theories of immaturity and pathology, is also constructed from stereotypic gender roles" (p. 79); Kinsey's "scale, although wider in its scope than other classification systems, and intended to address only the issue of variability, created a homosexuality/heterosexuality continuum that implicitly polarized human sexual experience" (p. 70); Dean Hamer, a well-known geneticist, carried out research which suggested that homosexuality might be influenced by genes via sex-linked transmission.[3] Drescher believes that Hamer and his colleagues based their investigation on the prejudicial premise that "a gay boy has feminine qualities" (p. 49). It is unfortunate that Drescher attacks Hamer without himself critically discussing the area of genetic influences on behavior in general and sexual orientation in particular.

Drescher's consideration of prenatal hormonal influences on behavior is also cursory and incomplete. For example, investigations carried out on nonhuman animals indicate that their sexual and nonsexual behavior during adulthood is influenced by sex steroid hormones during prenatal life. It was not clear that this line of investigation was relevant to human sexual behavior until benchmark research carried out by Money, Ehrhardt, and others on patients with early corrected Congenital Adrenal Hyperplasia (CAH) and other conditions leading to prenatal virilization of females. These studies, and others of patients with diverse intersex disorders, indicate that prenatal androgen does indeed influence human sexual and nonsexual behavior in ways com-

[3] Hamer, D. H., Hu, S., Magnuson, V. O., Hu, N. and Pattatucci, A. M. (1993). A linkage between DNA markers on the X chromosome and male sexual orientation. *Science*, 261:321-327.

patible with what might be expected from laboratory studies.[4] The most robust influence documented to date has been on childhood rough-and-tumble play.[5] Although the data indicating prenatal sex steroid influence on homosexuality are not as compelling, there are enough positive studies to justify the conclusion that such influence is likely and that further research in the area is needed.

Drescher dismisses other research as well, often discussing it in a superficial manner. He strongly implies that any researcher who studies relationships between childhood gender behavior and homosexuality suffers from anti-homosexual prejudice. Selectively not attended to is the fact that a relationship between involvement in cross-gender sex stereotypic activities and interests, as well as adult homosexuality, is supported by numerous empirical studies carried out by many independent investigators.[6]

[4] Money, J. and Ehrhardt, A. A. (1972). *Man and Woman, Boy and Girl.* Baltimore, MD: Johns Hopkins Univ. Press.

Imperato-McGinley, J., Guerro, L., Gautier, T. and Peterson, R. E. (1974). Steroid 5α reductase deficiency in Man. *Science,* 186:1213-1215.

Imperato-McGinley, J., Peterson, R. E., Gautier, T. and Sturla, E. (1979a). Androgens and the evolution of male gender identity among male pseudohermaphrodites with 5α reductase deficiency. *New England J. Med.,* 300:1233-1237.

Imperato-McGinley, J., Peterson, R. E., Stoller, R. and Goodwin, W. E. (1979b). Male pseudohermaphroditism secondary to 17β hydroxysteroid dehydrogenase deficiency: gender role change with puberty. *J. Clin. Endocrinol. Metab.,* 49: 391-395.

Imperato-McGinley, J. I., Peterson, R. E., Gautier, T. and Sturla, E. (1981). The impact of androgens on the evolution of male gender identity. In *Pediatric An drology,* ed. S. J. Kogan and E. S. Hafez. Hingham, MA: Kluwer. Repr. in *Sexuality: New Perspectives,* ed. Z. DeFries, R. C. Friedman and R. Corn. Westport, CT: Greenwood Press, pp. 125-140.

Reiner, W. (1997). To be male or female—that is the question. Editorial. *Arch. Ped. and Adolescent Med.,* 151(3):224-225.

Bradley, S. J., Oliver, G. D., Avinoam, B., Charnick, A. B. and Zucker, K. J. (1998). Experiment of nurture: ablatio penis at two months, sex reassignment at 7 months, and a psychosexual follow-up in young adulthood. *Pediatrics,* 102(1):1-5.

Hines, M. (1998). Abnormal sexual development and psychosexual issues. *Baillieres Clin. Endocrinology and Metabolism,* 12(1):173-189.

[5] Friedman, R. C. and Downey, J. (1993). Neurobiology and sexual orientation: current relationships. *J. Neuropsychiat. Clin. Neurosci.,* 5:131-153.

[6] Bailey, J. M. and Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: a conceptual analysis and quantitative review. *Dev. Psychol.,* 31:43-55.

Drescher believes that only by studying individual patients with an open mind, case by case, can we truly advance "the work of therapy" (p. 82). The problem with this argument is that it is quite similar to that used by psychoanalysts of the past generation, who were convinced that homosexuality was inherently pathological. They too justified their beliefs with abundant data collected from their clinical experiences with numerous patients. One of the most important reasons that homosexuality was deleted as a diagnosis from the Diagnostic and Statistical Manual of the American Psychiatric Association was that researchers who used the scientific method to collect and interpret data were unable to document impairment of function or inherent distress among gay people.[7] In *Psychoanalytic Therapy and the Gay Man*, Drescher particularly criticizes the writings of Charles Socarides.[8] Although Drescher and Socarides have come to opposite conclusions about homosexuality, their *methods* of approaching data are similar. Each stakes out the moral high ground and uses clinical material illustratively to support his arguments.

Although Drescher is quite correct in pointing out that all research is subject to bias, historical and otherwise, only the scientific method offers a systematic way of diminishing such bias.[9] In disavowing this, Drescher joins the voices of those from various disciplines such as literary criticism, sociology, and philosophy who seem opposed to science itself. The scientific community has been concerned about their influence and has sponsored symposia on the topic. The interested reader is referred to "The Flight from Science and Reason"[10] for a thorough discussion of this area.

Because Drescher's clinical discussions are so solid, it would have been interesting if additional clinical topics had been included. In this

[7] Friedman, R. C. (1988). *Male Homosexuality: A Contemporary Psychoanalytic Perspective*. New Haven, CT: Yale Univ. Press.

[8] Socarides, C. W. (1978). *Homosexuality*. New York: Jason Aronson.

[9] Friedman, R. C. and Downey, J. I. (1998). Psychoanalysis and the model of homosexuality as psychopathology: an historical overview. *Amer. J. Psychoanal.*, 58(3):249-270.

[10] Gross, P. R., Levitt, N. and Lewis, M. W., eds. (1996). The flight from science and reason. In *Annals of the New York Academy of Sciences, Vol. 775*. New York: The New York Academy of Sciences.

day and age, for example, almost all gay men have lost loved ones to the HIV epidemic. Concern about HIV transmission influences attitudes toward sexuality, particularly of those not in monogamous relationships with HIV-negative partners. Discussion of HIV and the gay man would have added to this volume. Another important area is that of the middle-aged and older gay person, only discussed in passing in this book. The psychotherapeutic process itself could also have received additional attention.

Despite these reservations and because the clinical material that is discussed is so informative, *Psychoanalytic Therapy and the Gay Man* is a helpful addition to the literature. Those who have limited experience with gay patients will find it particularly useful.

RICHARD C. FRIEDMAN (NEW YORK)

CLINICAL UNDERSTANDING. By Gail S. Reed. Northvale, NJ/ London: Aronson, 1996. 312 pp.

This book is an expansion and extension of an earlier book by Reed (1994) on the current concepts of transference neurosis. Having a background in literary criticism, she draws on her expertise in that field as well, in defining and describing both the psychoanalytic process and the contributions that a psychoanalyst might make to the understanding of art and literature—hoping that these efforts will put a damper on "wild" applied psychoanalysis. She creatively blends the language of literary criticism with the language of psychoanalysis.

In her prologue, Reed presents a bold statement of the contemporary classical psychoanalytic point of view, which she unhesitatingly advocates. She points out some of the shibboleths and caricatures that have been too sadly earned by some psychoanalysts and which have been applied all too generally to other psychoanalysts for whom the classical point of view is primary in their work with patients in psychoanalysis. The fault lies in the psychoanalyst who misunderstands and misapplies the classical model, and not in the model itself. For her there are no shortcuts to understanding the meanings in the form and content of the associations to derivatives of unconscious fantasy/memory

organizations in each individual analysand. And she stresses repeatedly the unique, idiosyncratic meanings for each individual person, and in each work of literature and art.

Throughout the book, Reed adheres to an essential job description of the psychoanalyst: namely, the requirement that that person be able to tolerate and appreciate ambiguity, uncertainty, approximation, and the knowledge that there are always more meanings than we are aware of in our work with our patients. She gives clinical examples to demonstrate what she means. One of the best examples is the patient who referred to herself as a "rotten apple." Asking her patient about this description, instead of assuming she knew what her patient was talking about, led to associations that contributed to a deepening of the analysis. She contrasts contemporary classical theory with that of self psychology, where she finds that the interpretation of meaning lies within the theory and not within the patient. Classical theory offers an approach to discovering derivatives of unconscious fantasy/memory complexes within our patients, but it does not inform us what we will find nor what to say to the patient in interpreting meanings. The theory of self psychology presumes one knows what to find, as well as what to interpret. It is a closed, linear system that explains what it takes to be causes. Classical theory is open-ended, helical, and full of surprises. As a consequence, Reed believes that classical psychoanalysis and self psychology are incompatible. In addition to her clinical examples that demonstrate this incompatibility, she gives further evidence of what she means in a chapter on the antithetical meanings of the word "empathy," and she examines two poems: one by Marvell, where meaning is contained within the allegorical conventions of his time, and another by Mallarmé, which is open-ended and laden with ambiguity.

The incompatibility between classical psychoanalysis and self psychology is one of the problems Reed raises that have pedagogical implications for the education of psychoanalytic candidates. She writes that experienced psychoanalysts who have had a thorough training in classical theory may then find parts of self psychology to be useful adjuncts in their ongoing work. This is a quite different situation from that of beginning candidates in some institutes, whose initial theoretical courses are essentially surveys of the various models of the mind, a marketplace

of ideas with little or no statement about whether one model or another has primacy, and about where incompatibilities exist. This egalitarian approach to the teaching of theories has its consequences. The rigor and precision required to understand each patient's individual meanings of unconscious memory/fantasy may be minimized, even discarded by candidates because other models of the mind require less of the development of the capacity, in the tripartite system of education, for tolerating the ambiguity and uncertainty which are part and parcel of classical theory.

Another matter with pedagogical implications is the emphasis Reed places on the necessity for reconstruction in any analysis. She summarizes the contributions of several psychoanalysts to the ongoing discussion about narrative and historical truth. For her, reconstruction "is neither the forging of a mutual narrative nor the interpretation of an impressionistic symbolic meaning. Rather, it is an attempt to re-establish with the patient the original steps in his or her creation of a private symbol." For example, as far as she is concerned, to identify and interpret primal scene elements in a patient's associations does not suffice. In addition to the narrative accounting, it is important to discover what the analysand actually witnessed, or even was an actual part of at that time, and how each patient forms his or her own unconscious fantasy/memory schema. Like all mental phenomena, primal scene fantasy/memory follows the principle of multiple function/compromise formation. Reed suggests that part of the reluctance analysts feel about reconstruction is that, in that attempt, one is left open to the charge of suggestion.

In preparing her earlier book on transference neurosis, Reed conducted face-to-face and written interviews with experienced psychoanalysts who had also published articles in the literature. As one would expect, there were substantial differences among them in how they defined this concept, and how important a transference neurosis is or is not to them in their understanding of the therapeutic action of psychoanalysis. That book provides a lead-in for her writing about the transference neurosis in *Clinical Understanding*. She argues that the centrality of the transference neurosis and its resolution is no longer the defining feature that marks the scientific standing of psychoanalysis. And

patients who have clear-cut transference neuroses are not the only persons who can benefit from psychoanalysis.

The transference perversions are one descriptive classification of patients who can benefit from psychoanalysis, although there may be little or no demonstration of a transference neurosis. In addition to mechanisms of disavowal, splitting, and the creation of fetishes, Reed finds fundamental in these patients their limitations in the synthetic functioning of the ego. She sees them as functioning midway between neurosis and psychosis.

Reed says that there is relatively less ambiguity and uncertainty in writing about theory than there is in the practice of psychoanalysis. But the operative word here is *relative*. I know that other readers of this book will come away with different emphases and understandings of what Reed has to say about clinical and applied psychoanalysis. My only regret in recommending this book is its steep price: fifty dollars for a paperback.

WILLIAM E. BERNSTEIN (DENVER)

WORKING INTERSUBJECTIVELY: CONTEXTUALISM IN PSYCHOANALYTIC PRACTICE. By Donna M. Orange, George E. Atwood, and Robert D. Stolorow. Hillsdale, NJ: Analytic Press, 1997. 104 pp.

This volume, the fifth in a series by some of the same group of authors, leaves us with more questions than answers. For more than a psychoanalytic generation now, it has been commonplace to demolish a Procrustean couch view of the field. But what type of the many other beds available should be chosen? The authors seem to suggest that the patient and the analyst will work together, make their own bed, and then lie in it. Perhaps clinical theory, as well as metapsychology, has passed its endpoint—since the authors are largely ready to toss conventional principles and technique aside.

This slender book follows in the line of deconstructionism, similar to efforts made in various fields of the humanities. It presents its intellectual arguments quite well, but then leaves open exactly what remains,

and what, specifically, is teachable to novice practitioners. Much discussed is the contribution of various philosophers from Descartes on. Locke and Hume continued this trend toward isolation, which runs counter to contextualism. It is not until we read the contributions of Hegel, Mannheim, and Wittgenstein, writers of gestalt and phenomenological views, and the more recent work of Derrida and Foucault, that we can see the underpinnings of contextualism. Each of the earlier constructions is criticized, and this volume indeed may serve as a necessary corrective to many of the atomistic aspects of our field. However, it neglects the ingrained propensity that humans have for organizing sets of principles, largely in a dichotomized fashion. In enlightened minds, this tendency is always ready to be replaced by additional knowledge. Do any of us allow ourselves to feel that we are other than flexible in our thinking?

Briefly put, intersubjectivity theory is a metatheory of psychoanalysis, which carries with it a contextualist view of development and pathogenesis. "It views psychoanalysis as the dialogic attempt of two people together to understand one person's organization of emotional experience by making sense together of their intersubjectively configured experience." In this vein, it negates the view that the origins or continuance of psychopathology lie solely within the patient. Rather, it is seen as arising from an earlier intersubjective field, only to be replicated in the psychoanalytic situation, where change can occur.

The book consists of a number of differently oriented sections, each of which may interest readers. There is a presentation of various principles of the clinical aspects of contextualism, painted against the disparaged background of other views, such as classical psychoanalysis and two-person psychologies. For example, the case of Tim presents a discussion of self-disclosure, which is used not as a rule or anti-rule, but as something arising organically from the situation. A number of clinical vignettes are adduced to show the advantage of the intersubjective approach, but as so often occurs with abbreviated clinical material, they convince only those ready to be convinced.

There is a well-organized section which purports to show the errors introduced into our work by the writing of a wide range of philosophic thought, none of which is felt to encompass the therapeutic situation

satisfactorily. There is a portion dealing with those patients we would call "psychotic" or "borderline." Here an attempt is made to provide a contextualistic theoretical framework for such disorders. The authors make it clear that the medical models we usually employ are intrinsically in error. Again, an atomistic versus a contextualist view is compared, with the latter presented in a much superior light.

These views, in their broad sweep, are hard to disagree with. It is difficult, if not impossible, to be opposed to a view which does not consider interaction and context. My question, still troublesome after completing the book, concerns what exactly occurs to alter the state in which we find our patient. Of course, such a criticism may be leveled against all forms of psychoanalysis. Is this another case of "easier said than done?"

HAROLD R. GALEF (NEW YORK)

NEVERMORE: THE HYMEN AND THE LOSS OF VIRGINITY. By Deanna Holtzman and Nancy Kulish. Northvale, NJ: Aronson, 1997. 249 pp.

BECOMING AND BEING A WOMAN. By Ruth F. Lax, Ph.D. Northvale, NJ: Aronson, 1997. 253 pp.

It is an interesting experience to read these two books side by side. Lax begins with Freud: she compares and contrasts former ideas of female psychology with newer ones. Holtzman and Kulish take up the gauntlet from there, expanding our understanding with research, clinical material, and theoretical revisions. They no longer feel a need to look back, note changes, and justify them. How far we have come!

Lax reminds us that our theory significantly impacts on our therapeutic efficacy. Freud's limited theoretical understanding of women limited our ability to hear what it was that our female patients were telling us. We needed to be able to open our minds to the possibility of another way of understanding that which we were hearing.

In proceeding with a discussion of the analyst's pregnancy, a topic on which she has been a pioneer contributor, Lax notes the absence of

reference to the image of the pregnant woman in the analytic literature. Overlap is noted here with Holtzman and Kulish, who are encouraging us to listen more closely to our analysands and to hear and see the female imagery presented to us.

Myths are utilized as a source of understanding in both of these books. Lax explores the Balinese tale of Rangda in appreciating aspects of the mother–daughter relationship and the development of the "rotten core." This relationship is explored further in chapters on the use of an imaginary brother, the impact of the impaired child, masochism, and superego formation.

Two themes are central to this volume: (1) cultural influences interacting with intrapsychic issues; and (2) conflicting, unintegrated male and female identifications. These two elements interdigitate in many ways. Importance is placed on the impact of the cultural milieu, with its promotion of the submissive, subordinate female. The mother, feeling devalued, devalues her daughter, who internalizes this diminished sense of self. Feeling rejected, she rejects her mother and her own feminine self. She turns to her father, whom she idealizes and wishes to emulate. She is left with separate, conflicting, unintegrated mother and father identifications.

Although in reading this volume one notes the interaction of the cultural with the intrapsychic, one also becomes aware of the weight placed on cultural factors. The cultural ingredient as well as the identifications need to be addressed and appreciated. However, at times these seem overemphasized, unnecessarily complex, and utilized when other explanations, such as a fear of separation, conflicted aggressive strivings, or even simply oedipal competition, might prove more helpful. Many have addressed the conflict between autonomous strivings and strivings for connectedness; this is indeed a basic conflict for women. Perhaps it is so for men as well. Conflicted, unintegrated identifications as presented here relate to an aspect of this conflict, and this provides another perspective with which to understand it.

A chapter on genital anxieties deals with genital mutilation, another issue in which Lax has been in the forefront. In a chapter entitled "A Child is Being Beaten," she treats us to many of the new ideas on superego formation in girls. The importance of the mother's role is

emphasized and the equivalence of male and female superego formation is elucidated. Various types of pathology are noted to result when the father acts in collusion with the daughter's wish for an oedipal victory. Here we note guilt, inhibition of sexuality, female masochism, and unconscious guilt interfering with attainment of success in love and profession. The only addendum I might make to this exposition would be to note that, when present, an overload of hostility from heightened ambivalence, carried over from the preoedipal period, plays an important role here. Certainly, Lax does not neglect the role of aggression, as it is clearly a significant focus in her concept of the rotten core, in which the impact of the mother's emotional unavailability leads to a taking in of the mother's sadism.

Following the woman through her life cycle, the book concludes with a consideration of menopause and growing older. Much has been added to our understanding of female development. Clearly, Lax has had extensive experience and an intensive interest in women's lives and the ways they cope with the dilemmas with which they are confronted.

In their book, Holtzman and Kulish begin an investigation into yet another unexplored continent of the girl's experience, that of the hymen and of defloration. This book is the latest addition to what is becoming an extensive library on the new psychoanalytic understanding of female psychology, taken from the understanding of the girl's experience of her own body in relation to the important people in her life within the culture in which she resides. This is explicated from psychoanalytic data, and has become a very new, exciting, and helpful contribution to the understanding of girls and women. It is technically important as it facilitates a new way of listening to our female patients.

The authors began their journey with an analytic observation: the striking association of negation, doubting, and denial with thoughts of the hymen and defloration. In researching the analytic literature, they found almost no reference to these topics. There followed a scholarly search through classical and biblical myths, fairly tales, and literature. The authors embarked on extensive cross-cultural studies and then turned once more to analytic data derived from both male and female

patients. The data compiled from all of these sources are impressive. This is noted as the authors treat us to the benefits of their research in these various fields.

The significance of defloration for both participants, as well as for the community at large, is clear. It is a rite of passage, a taking of one's place in the adult world, a leaving behind of childhood. The girl is left with a sense of loss and the boy with a fear of retribution. Along the way, we note the value placed on virginity, the fear of hymenal bleeding—equated with menstrual bleeding—and the importance of thresholds, as well as a multitude of images symbolizing the hymen.

It is the clinical material that is most outstanding. It is abundant, clear, and helpful. It relates to the developmental and intrapsychic vicissitudes of the experience of defloration and all that it symbolizes. Clearly, defloration is an important milestone with different meanings for men and women. For the woman, it is connected with loss and sadness. Early anxieties about integrity, vulnerability, and attractiveness are revived, as well as rivalry with mother. Anger at mother, guilt over masturbation, and feelings of stupidity are prominent. The feelings of stupidity relate to the lack of a name for the genital, which is equated with a lack of acknowledgment of the girl's sexuality. The feeling of shame and humiliation relates to the blood and the close association with anality. Guilt over masturbation is revived, with subsequent fantasies of genital damage and bleeding. It is here that the "Nevermore" takes its significance: one is nevermore a virgin, nevermore an innocent, nevermore a child. And it is around this idea that the authors note all of the doubting, negation, and denial.

For men as well, negation and doubting are prominent. Positive oedipal themes, sadomasochistic conflicts, and castration anxiety are aroused. Beautiful clinical material illustrates the revival of these issues in the transference.

Defloration is related to the analytic experience in the sense of an opening up, a penetration, an exposure, a loss of innocence, an introduction to sexuality and to knowledge, a thrusting out of the Garden of Eden. Here as well, clinical material clearly illustrates these ideas. Along the way, two of Freud's most cherished concepts of femininity are challenged: first, the idea of the hostility that the girl feels toward

the man who takes her virginity. Holzman and Kulish note that when anger was present, it was directed more toward the man for subsequent emotional abandonment or toward the mother for lack of adequate preparation. The second concept is that of masochism; the authors found no data to substantiate the concept of innate feminine masochism.

The reader is presented with a confounding dilemma. Defloration is clearly an important developmental milestone recognized by a multitude of cultures. Literature abounds with themes of crossings, thresholds, and the consequences of traversing them. Marriage rituals clearly mark this entry into adult genital sexuality. Oedipal themes, with all of their many reverberations, are present in the multitude of symbols evoked in the intrapsychic representations. How is it, then, that there has been so little analytic note made of this momentous experience, and why do most of us, including this reviewer, continue not to hear the very clear, explicit references with which the authors shower us? Although I am certainly open to appreciating the significance of this material, I have not heard it expressed with the same clarity from my own patients. I will certainly be listening differently from now on.

If one were to be critical of this enterprise, one could fault the authors for being carried away with hearing references to the hymen and defloration. No doubt this is due to their interest in this neglected issue and their effort to present their case, or am I affected by my own denial and/or negation?

Abundant clinical material makes these two books accessible and meaningful to both the psychoanalytic clinician and the theoretician. They expand our purview in listening to and understanding our patients, making us mindful of the impact of theory on clinical practice and mindful of our need not to be wed to our theories but to try to keep an open mind, with a keen eye on our biases.

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ABSTRACTS

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Abstracted by Gabriela Legorreta.

IV, 1, 1996

Guntrip's Contribution: An Analysis of His Major Departure from Fairbairn. Morgan E. Forbes. Pp. 149-165.

Forbes defends Guntrip's work against the criticisms that he has distorted Fairbairn's theory. Forbes claims that the major differences between Fairbairn and Guntrip are not based on a misunderstanding on the part of Guntrip, and that indeed Guntrip's argument points to a major flaw in Fairbairn's thinking. In developing his position, the author briefly reviews some of the major foundations of Fairbairn's theory. Guntrip's departure from Fairbairn's basic assumptions is a result of his questioning the inner functioning of schizoid patients. According to Guntrip, a major problem for these individuals involves a "primary non-entity." This way of understanding questions the agent-action-object point of reference in Fairbairn's thinking. Guntrip claims that non-entity is a problem of absence: a psychological structure that should be doing something to something or somebody is either missing or inactive. Unlike Fairbairn's libidinal and antilibidinal egos, which have been repressed because of their attachment to hurtful objects, Guntrip's regressed ego has no attachments. This is the core of the difference between the two authors: Guntrip diverges from Fairbairn, who claims that the ego and its libido are primarily object-seeking. For Guntrip, the regressed ego does not seek objects; it withdraws from them.

The notion of the ego's primary aim is another major difference between the two theories. Guntrip equates his notion of a regressed ego with Winnicott's concept of a hidden "true self." Accordingly, he argues that the ego's primary aim is not object relations, but to become a person. Thus, he explicitly diverges from Fairbairn when he proposes that object relations are not the primary goal of human existence, but the means to what he considers the primary goal, that is, becoming a person.

The treatment of the developmental process and its clinical implications constitutes another major difference between Guntrip and Fairbairn. Fairbairn recommends psychic integration. The author argues that Fairbairn overworks the schizoid process in a way that renders his theory inconsistent. He further

claims that Fairbairn's theory is incomplete, and that his theory of schizoid disintegration could be supplemented with an account of how some other processes foster integration. Guntrip's theory fills this gap. Fairbairn's theory of the schizoid process could be completed with a theory of ego potential and its evocation, thereby creating a coherent, complete object-relational theory of personality. The author therefore concludes that Guntrip's departures from Fairbairn make an important contribution to object relations theory by addressing a significant inconsistency in Fairbairn's account of psychological development.

IV, 2, 1996

Analysis, Mutual Analysis, and Self-Analysis: On the Interplay of Minds in the Analytic Process. Theodore J. Jacobs. Pp. 255-277.

In this paper, the author discusses several issues that have raised complex questions and controversies in contemporary psychoanalytic thinking. Dr. Jacobs stresses that while such matters as countertransference, enactments, intersubjectivity, and self-analysis have been very valuable in opening up new perspectives on the analytic process, they have also led to much confusion. He focuses on the notion of countertransference, related questions of the analyst's subjectivity, and the question of self-analysis and working through in the analyst. The presentation of a clinical case, in which the patient's intuitive understanding of certain features of the analyst's personality played a crucial role, is used to highlight these. In this case report, an open and nondefensive listening to the patient's comments regarding the personality of the analyst, and the emotional effects they had on him, allowed a process of self-examination and working through to take place.

In an attempt to clarify the confusion and uncertainty that surround the use of the analyst's subjective experience, the author emphasizes that in using his or her inner experience, the analyst must not compromise the ability to listen to the patient. In the author's view, the analyst gives himself over quite totally to the patient. He loses himself, his personality, and his personal concerns in listening. It is this immersion that allows the unconscious of patient and analyst to resonate in such a way as to give rise to affects, fantasies, and memories in the analyst that are related to, and illuminate aspects of, the patient's inner world. The analyst makes no effort to focus on him- or herself. Rather, he or she allows what is stirred and mobilized from within to arise. Some of what arises is familiar, but when something out of the ordinary registers within the analyst—a strong affect, a fantasy, a daydream, or an impulse to act—the analyst's attention shifts to his or her internal world. This internal experience needs time to be processed before meaning begins to emerge. Clarifications and meaning may emerge in connection with the patient's associations, or sometimes through further elaboration of the analyst's fantasies

or dreams. At times, before some clear sense has actually become available to the analyst, spontaneous responses occur before the analyst is aware of what is happening. Such enactments are inevitable, but what is important is the analysis of these enactments and their effect on the patient.

Dr. Jacobs also presents his view of the notion of subjectivity and countertransference. He believes it is important to reserve the term "countertransference" for that kind of subjectivity caused by stirrings in the unconscious of the analyst that impede analytic work. As far as how the process of self-analysis and working through operate, he suggests that the process is a lot more complex and difficult than current psychoanalytic literature tends to describe. Resistances often operate to deflect the best efforts at self-analysis and to reinforce repression. Working through is a painful and long process that requires effort, tolerance of frustration, and confrontation with painful aspects of the internal world of the analyst. The process usually starts with the recognition of an old problem that resurfaces in the course of the analytic work and causes some problem. The process of working through can take the form of deliberate efforts, or it can operate silently beneath the surface as we think over experiences in our lives.

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Destruo Ergo Sum: Towards a Psychoanalytic Understanding of Sadism. Arthur Leonoff. Pp. 95-112.

This article examines the phenomenon of sadism separated from its association with masochism. Even if there is a tendency in psychoanalytic theory to retain the intrapsychic complementarity of sadism and masochism as active and passive expression of the same psychodynamic, this article stresses the need to differentiate the two phenomena. Following a brief review of Krafft-Ebings's, Freud's, and Klein's notions on sadism, the author suggests that sadism has tended to be obscured by the general problem of aggression, and, more often than not, closely allied with its severe forms. He further suggests that hatred and sadism should be seen as distinct phenomena; hatred is not the defining or essential characteristic of sadism.

In his attempt to explain sadism as a distinct entity, the author focuses on the sadist's primal anxieties, which he believes are linked to basic agonies surrounding annihilation. The sadist, faced with unarticulated primitive dread, triumphs over death by becoming its agent. Clinically, this dread can be expressed through a malignant fear of passivity, helplessness, or ego collapse. The sadist defends himself against this dread by achieving moments of sadistic triumph, which, through omnipotent control of the object, symbolically guarantees his survival. Leonoff therefore suggests that destructive narcissism and sadism describe overlapping phenomena from different points of view. Sadism is both a demonstration and affirmation of omnipotent triumph, not simply

over the object, but over the very idea of limits itself. In this regard, the sadist cathects death in order to become its master. Following this argument, the author makes a distinction between a sadistic and a narcissistic form of omnipotence. As a manifestation of the death instinct, sadism reflects a world where ideals and hopes for moral human relationships have been completely destroyed. In this context, the sadist easily admits imperfection. Therefore, the omnipotence of the sadist demands murder, symbolic or otherwise. This is totally unlike the omnipotence of the narcissist who envisions a limitless breast.

Leonoff suggests that sadism can be thought of as a perverse form of self-definition: "I destroy, therefore I am." Sadism can be defined by its aim of achieving self-definition and ultimate survival through the psychic or even physical degradation and annihilation of the object. Sadism leads by way of a continuum to severe savageries in which human beings are tortured and murdered for the self-definition of their tormentors. The sadistic pleasure does not lie in the pain inflicted on others; rather, the pain seems to be better located in the realm of narcissism. The sadist destroys the will of the victim by evacuating the libidinal self and projecting all weakness, need, and human vulnerability onto the victim/object. At the climax of this delibidinization, sexuality—overt or otherwise—becomes deeply involved in this perverse achievement.

V, 2, 1997

Grünbaum on Psychoanalysis: Effective Treatment or Placebo? Mary Anne Phillips and David G. Phillips. Pp. 243-260.

This paper offers a response to Grünbaum's criticisms of psychoanalysis, specifically focusing on his claim that any therapeutic gains from psychoanalytic treatment are due to an unintended placebo effect, and on his supportive argument that at best, studies show psychoanalysis fares no better than rival therapies, and at worst is totally ineffective.

The authors summarize the elements on which the philosopher bases his criticisms of psychoanalysis. According to the authors, the criticism based on the Repression Aetiology Theory is the most potentially damaging to psychoanalysis. This theory claims that repression is the cause of neurosis, a claim that constitutes one of the major tenets of psychoanalytic theory. Grünbaum bases his notion of the Repression Aetiology Theory strictly on what Breuer and Freud reported on their work in curing hysterical symptoms through the cathartic method. Grünbaum acknowledges that repressed memories have a causal role in the formation and maintenance of neurotic symptoms, but claims that the cathartic method for treating them is of limited value because of the finding that therapeutic gains are not always durable, and because durability of therapeutic gains is also vulnerable to the nature of the doctor–patient relationship. The authors believe that for these reasons alone,

Grünbaum claims that the apparent therapeutic gains of psychoanalysis are due to an inadvertent placebo effect.

In response to these criticisms and in support of the notion of a scientific basis for psychoanalytic theory, the authors present three arguments. First, they claim that, in using the cathartic method, Freud employed an informal scientific method in which the results were compared with two other forms of treatment. As a result, Freud had some reasonable basis for claiming that the results of the cathartic method were not due to a placebo effect.

Second, arguing against Grünbaum's claim that psychoanalytic cures come about because of the patient's tendency to conform to the physician's expectations, the authors suggest that the numerous references to "surprise" found in Freud's "Studies on Hysteria" indicate that the therapist did not expect the outcomes.

Third, the authors argue against the claim that psychoanalysis cure rates are no better than rates of spontaneous remission. The authors claim that such disappointing results arise as a consequence of serious deficiencies in treatment outcome studies. They base their discussion on a simile from somatic medicine, which they term the "Penicillin Analogy": if an effective treatment such as penicillin were tested in the manner in which psychoanalytic treatment has been, its therapeutic efficacy would also be brought into question.

The authors also suggest an improved methodology by which psychoanalytic treatment could be demonstrated to be effective. Specifically, they propose to use a more precise diagnostic category, and that division into nosological categories (different from the standard DSM-IV) is needed. The authors also conclude that to establish psychoanalysis as a science, it is necessary to view it in a more modest and realistic light, in much the same way as we view somatic treatments such as the use of penicillin.