Psychoanalytic Quarterly, LXXII, 2003

PSYCHOANALYSIS: THE TRANSFORMATION OF THE SUBJECT BY THE SPOKEN WORD[1]

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Psychoanalysis recruits the power of the spoken word to modify the subject's relationship with his or her own unconscious psychic processes. It helps the analysand to reclaim for his or her words the psychic integrity that was lost or never achieved due to the power of defensive dissociation and repression. The psychoanalytic dialogue and the working through mediated by it lead to the elaboration of self-narratives and interpretive understandings, which contribute to the transformation of the subject's self-experience. Such transformation is conditioned by earlier integration of experiences of satisfaction in the context of bodily dialogues and speech with primary objects.

> Without affect there is no effective language.
> Without language there is no effective affect.
> ——André Green (1986, p. 295)

An analysand arrives at the consulting room asking for help with painful feelings and behaviors that interfere with his life. He is a suffering subject who cannot make sense of his compelling feel-

[1] According to Matthews (1997), the French term *parole* is "defined by Saussure as the 'executive' aspect of language, comprising the combination of signs in the mind of a speaker and the 'psycho-physical' mechanisms by which they are externalized. Thence also of the utterances so produce" (p. 266).

ings, actions, or reactions, and who says to himself: *"I* know there is something wrong with *me* and I cannot understand *it."* The analysis he is requesting will achieve its transformative effects by *articulating through speech* his psychic experience, the realm of suffering encompassed between the two pronouns: the *I* that cannot make sense of the *me.*

I define the *subject* as the consciously experiential aspect of the self-as-agent (Meissner 1993). The self-as-agent stands for the total person in interaction with others, itself, and the world. I agree with Meissner's (1999) understanding of subjectivity:

> Aspects of agency and subjectivity are distinguished: Agency is attributed to the self-as-agent, encompassing all actions of the self (conscious, preconscious, unconscious) while the self-as-subject is the author of all conscious (and by implication preconscious) mental action. Self-as-agent and self-as-subject are the same in all conscious activity, but not in unconscious activity. Unconscious action has no subject, only agency. Unconscious derivatives achieve functional subjectivity insofar as they are incorporated and integrated with conscious experience . . . . The subject is only experienced in the performance of an action rather than known in the fashion of objects. [pp. 155-156]

When the patient begins with "I know," the self-as-agent is also the subjective, experiencing being who feels and is consciously aware that "there is something wrong with *me."* The *me* that escapes understanding stands for all the unconscious motivations and mental processes that, even when carried out by the self-as-agent and recognized as belonging to the self, elude subjective and objective knowledge. The task of analysis is to transform the unknown *me,* via the mediation of conscious verbal exchanges in the analytic situation, into the analysand's subjectively aware *I.* Analysis has no other tool but the verbal intercourse between patient and analyst to transform the subjective awareness of the analysand—or, as in the title of this paper, to transform the subject.

WHERE DOES THE SUBJECT COME FROM?

Freud, influenced by the positivistic and objective outlook of the sciences of his time, did not theorize about the *subject* (Moran 1993). Lacan (1966) was the first psychoanalyst to conceptualize the subject, which he understood in the context of his overall theory about the unconscious as structured like a language. Lacan's subject does not require the subjective awareness I postulate. For him, the subject "is not simply equivalent to a conscious sense of agency, which is a mere illusion produced by the ego . . . . Lacan's 'subject' is the subject of the unconscious" (Evans 1996, p. 195). "The subject is an effect of language . . . by virtue of his subjection to the field of the Other" (p. 196).

I believe that Lacan's assertions must remain only a broad theoretical construct unless we offer a psychoanalytic theory about how the *experiencing* subject comes into existence. Our task consists in finding the *living subject* in communications of past and present conflicts and making them subjectively available in the present, in order to transform the subject's pain into affectively meaningful self-understanding.

To create a theory about the transformative function of the spoken language *(parole* in French), we need to attend to three essential issues in psychoanalysis: (1) the speech matrix of relatedness into which children are born; (2) the bodily organism's urgency for the satisfaction of needs (drives) and as the substratum for subjectivity; and (3) the emergence of subjective awareness and of language.

The Speech Matrix of Relatedness into Which Children Are Born

Winnicott (1971) asserted that there is no baby without mother or mother without baby. He described the holding environmental function of the mother and her ability to respond to the infant's needs—and especially to the infant's spontaneous gestures —as the means of sustaining the infant's sense of being him- or

herself. Winnicott saw in maternal mirroring the essence of the infant's being constituted as a self. He included in such mirroring the total attitude of the mother to her baby, although his focus of attention was the visual mirroring of the face. He did not attend to the significance of the maternal voice and language in helping the baby to constitute him- or herself.

I suggest that Winnicott's classic contribution could be usefully enlarged to include the maternal voice, with its power to touch the child emotionally in her ascertaining the child's affective states and responding with actions and words. To paraphrase Winnicott, what does the baby hear when he or she hears the mother's voice? Winnicott's answer in regard to the child's visual perception of the maternal face is: "The baby sees himself or herself. In other words, the mother is looking at the baby and *what she looks like is related to what she sees there"* (p. 112, italics added). When the mother responds to the baby's spontaneous gesture by naming the need and addressing him or her with a particular, emotional tone of voice, and then satisfies that need, she has given the baby a verbal and an action interpretation of his or her subjective experience that brings the baby pleasurable satisfaction —before he or she understands language.

What the baby hears, feels, perceives in the affect of the maternal voice is recognized by the baby him- or herself as matching his or her internal world. Winnicott (1965) puts words in the baby's mouth: " 'I get back (as a face seen in a mirror) the evidence I need that I have been recognized as a being'" (p. 61). I suggest that we add the following to these words attributed to the baby: "I feel you know me internally because your voice touches me inside and then you satisfy me."[2]

It must be noticed that while the face mirrors the whole child, it does not have the somatically penetrating and affective power of the voice, which touches the child viscerally. Wolff's (1963)

[2] Obviously, neither Winnicott nor I include in these phrases anything but the good maternal face and voice that recognize the child. Failures to establish contact with the baby in both modalities are always deleterious to the developing child.

research demonstrating that children smile first to the maternal voice and later to the maternal face suggests that vocal mirroring precedes that of the face. Based on these assertions, I wish to make two proposals: (1) That the enjoyment of having been touched internally as a self by the maternal voice and speech, frequently announcing the impending satisfaction of needs, bestows on the experience of being spoken to the hope of being found by an object when one feels lost and wanting. I believe that this is the preconscious hope that moves analysands to accept the unusual arrangements of analytic treatment. (2) A child who learns to speak, but whose mother's language has not mirrored his or her inner experience, uses language in a way that does not engage the self (Marty and de M'Uzan 1963; Rizzuto 1988).

From the beginning of life, children are enclosed in a speech matrix. Frequently, the mother begins to talk aloud to the child still in utero. A patient of mine said to her fetus during a session: "Charlie, you make me laugh. You kick so much. Be quiet now—we [notice the pronoun] are in analysis." Her voice was affectionate, playful, and undoubtedly addressed to a boy.

As early as the fifth month, the fetus is capable of responding to sounds. Research suggests that babies who have heard in utero the mother's voice during ordinary conversations favor it after birth over any other (Kolata 1984). Four-month-old babies prefer words over any other sound, including rhythmic or musical ones (Butterfield and Siperstein 1974). These findings suggest that the prosodic components of spoken language have a profound effect on the baby's pleasurable enjoyment of the maternal speech and voice that is not connected with the satisfaction of needs. Mothers seem to know their babies' pleasure in their speech and voice because they keep their infants "bathed in sound" (Mowrer 1952) while they minister to their needs.

It could be said that the prosody of the human voice in the context of maternal care and relatedness is the earliest internalization of the mother as an object. The voice at this point has no linguistic value, but carries a powerful affective message that will soon acquire—through sound, pitch, and melody—the capac-

ity to suggest approval, prohibition, or affection (Fernald 1996, p. 62). Mothers and other adults modify the pitch, loudness, and melody of their speech in order to emotionally *engage* the baby (p. 83).

The engaging component of the prosody of human language exists cross-culturally and remains a persistent clue to relatedness in language at any age. During a conversation, the prosody of the other's enunciation gives an essential clue to hearing what is said as intentionally affectionate (i.e., engaging) or as ironic or sarcastic (i.e., distancing), thus transforming the semantic and relational meaning of the utterance. Analysts, aware of the great emotional power of the voice, strive to speak to their analysands with calm and even voices as a prosodic message that they mean to attend respectfully to the patient. The analysand, in turn, always listens not only to the semantic content, but also to the prosodic affective message in the voice of the analyst, as a clue to the emotional frame of mind and intention of the analyst (Rizzuto 2002).

Mothers not only mirror their children. They take the initiative to constitute their babies—*infans,*[3] incapable of language—as their interlocution objects long before the child has any capacity to become a speaking subject. They supplement the infant's incompetence by using any action of the child as a sort of dialogical response (Snow 1977), verbalized by the mother as an answer in a dialogue. If the child burps, for example, the mother might say, "That is a nice burp," making believe that it is the child participating in the dialogue. The mother addresses the child as *you,* the pronoun that constitutes him or her pragmatically as a partner in interlocution (Benveniste 1971), and she makes every effort to emotionally engage the child in a conversation with her. The mother continuously interprets the child's actions to ascertain his or her needs and desires. Frequently, she names aloud what the child wants before satisfying the need ("*You* are sleepy, aren't *you*? Okay, I'll put *you* to sleep"). Such sequences connect, through the mother's speech, the child's internal needs and de-

[3] A Latin word meaning "incapable of speech."

sires as a self addressed by the pronoun *you* with the pleasurable satisfaction of needs. The words precede and announce the pleasure.

Once the infant begins to say word-sounds, the mother (and the family with her) coaches the child to name things and wishes and to use language appropriately, grammatically and syntactically, and progressively insists that the child take charge of mastering the native tongue. As soon as the child is capable of articulating his or her desires and feelings with words, parents demand that the child use language to obtain what he or she needs. The end result of this process of acquiring the mastery of language in a constant interaction with mother, father, and family is that the entire structure of language becomes emotionally significant. Prosody, the semantic meaning of words, the structure of the sentence, and even grammatical forms become embedded in a complex matrix of emotional meanings and object-related interactions and messages that color for each person the significance of speaking itself.

I call the result of this process *the emotional history of words.* The history of the individual with his or her objects, as the result of such a process, is so clearly written in the language used by that individual that I could paraphrase Freud (1905) by saying that no one who speaks can keep secret major portions of his or her life history from the ears of a good listener.[4]

This brief review of maternal and family speech involvement with the child shows that it shares with the analytic situation the fact that the mother's efforts to engage her baby as a unique self attend to—as the analyst does with the adult patient—the internal experience of the child. Analysis is *the second instance in life* in which another person tries persistently to ascertain the internal experiences and needs of the subject by naming, describing, and interpreting them with his or her own speech. The difference is that the mother satisfies the uncovered needs first with her an-

[4] "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret" (Freud 1905, p. 77).

ticipatory speech, and later directly, while the analyst satisfies only the need to make sense of oneself and one's suffering while accepting fantasies of direct, wishful satisfaction. Yet, in both cases, the experiencing subject is found there, in the subject's experience and in the subject's need, by the object—mother or analyst—who finds through his or her own perceptions and feelings the words to make sense of the subject's subjective experience.

The child's conscious self-awareness of subjective experiences emerges when maturation makes self-consciousness possible. When that moment arrives, the child has at his or her disposal a vast array of memory processes and unconscious mental representations of having had his or her needs satisfied in the context of having been mirrored through spoken and facial responses and of having been engaged by the maternal initiative as a partner in playful interlocution. It is at this moment that the child, who by now has some language available to use, begins to construct preconsciously and consciously the first narratives about him- or herself in play and in words. During this period of preconscious self-narrative, words can be and are used for reorganization of self-experience in the fashion that Freud (1887-1904) described to Fliess:

> I am working on the assumption that our psychic mechanism has come into being by processes of stratification: the material present in the form of memory traces being subjected from time to time to a *rearrangement* in accordance with fresh circumstances—to a *retranscription*. [p. 207, italics in original]

When a child narrates to the parents, "Baby, boo-boo," describing a recent scrape on a knee, the child may as well be organizing a narrative of other internally felt hurts. I am asserting that spoken language has the potential to review, revise, and re-arrange preexisting memorial processes (representations) according to developmental or actual new experiences. The term *Nachträglichkeit*, understood as "retrospective reconstruction of the

psychological significance of . . . trauma" (Thomä and Cheshire 1991), seems the most apt to describe the potential of speech, interpersonal or internal, to reorganize the meaning of past subjective experiences.[5] In fact, I would suggest that to name an experience is, of necessity, a *nachträglich* reorganization of an original experience in the present relational moment with a real or internal interlocutor. This analysis-specific transformational power rests on its potential to retroactively *(nachträlig)* describe, name, and revive the emotions of past experiences in the present.

The Bodily Organism's Urgency for Satisfaction of Needs (Drives) and Its Function as the Substratum for Subjectivity

Understanding the satisfaction of needs in psychoanalytic terms implies the construction of a theory of the psychic representation of the need and of its satisfaction. Freud (1915, 1940) described the internal somatic tensions of the body as the source of the demand for the psyche to form a psychical representative *(psychische Repräsentanz)* of the drive (need). However, as Green (1987) has pointed out, "there is no analogical relation between internal somatic excitation and the psychic representative of the drive" (p. 361). The demand of the physiological excitation requires its transformation into psychic representation as a drive (a psychical need) which in turn elaborates the process of satisfaction into psychic life.

It seems doubtful that the need (drive) representation may precede the first experience of bodily satisfaction if the need (drive) is understood as a bodily "stimulus applied to the mind" (Freud 1915, p. 118) that has to find its satisfaction (aim) through an object external to the organism. Hunger, thirst, and need for bodily contact cannot be satisfied but by food, liquids, and another body. The infant is incapable of obtaining on its own any of those compelling and life-sustaining satisfactions. Unless the ma-

[5] Lacan (1966) must be credited for calling attention to Freud's use of the term *Nachträglichkeit.*

ternal object is there to offer food and warmth, the child has no means of knowing either his or her own need, except by bodily tension or by the object that can make it disappear.

I, therefore, concur with Green (2000) that "the object is the revealer of drive" (p. 1). This leads me to think that at the moment of revelation of the drive, the psyche must also make a representation of its state of being satisfied, in conjunction with the perception of the experience (Freud 1900, p. 566) and of the object as an inseparable component (even if an obscure and elementary one in the early stages) of the psychic representative of the need (drive). The memory of the subjective state of past satisfaction—or frustration—is reawakened whenever the need, now existing as a psychic representative, is prompted by somatic tensions. Subsequent satisfactions enlarge, transform, compound the varieties of satisfactions, but the memory processes that have already been registered remain as the organizing nucleus of the progressive transformations of the representative itself. I propose that such a representative is susceptible to transformation, which requires that the need be satisfied according to the updated modalities of satisfaction registered in the representative. These new modalities move (in the sense that a need or drive "moves") to seek the repetition of modified pleasurable satiation.

What happens to the developing infant when the object reveals the infant's needs (drive) and satisfies them? How does the infant register *satisfaction?* This is a question that Freud did not ask. Freud (1900) described only the child's need to "recathect the mnemic image of the perception [of satisfying nourishment] and to re-evoke the perception itself . . . to re-establish the situation of the original satisfaction" (p. 566). Freud's description includes only the process and leaves out the self-as-agent who must carry it out. So we must ask: Does the child have an obscure capacity to be self-referential and self-representing? We do not know the answer. However, after the satisfaction has been achieved, does it suffice to have it registered in the need (drive) representative? I believe that we must postulate a mode of registering the experiencing self as a whole, which is not yet

self-representation; rather, it is an earlier psychic register of the unitary body/psychic-need (drive) representative/object/satisfied /self, centered around the experiencing subject. Without such an antecedent, it would be impossible to create a psychoanalytic theory of the subject as emerging from experiences of bodily satisfaction. To address this point, we must briefly revisit the psychoanalytic theory of representation.

Freud (1891) gave us a masterful description of the formation of external object representations as the thing-representation component of the "psychic word." He made three very significant assertions about those representations (Rizzuto 1990): (1) they all originate in the senses, the periphery of the body, and travel to the cortex by means of a transformative process that makes them suited for the speech apparatus; (2) they are expandable because all perceptive processes are also associative processes; and finally, (3) they contain *all* the stimulations that prompt people to speak spontaneously. This last point is essential to psychoanalytic technique.

Freud created his description of thing representation in such a fashion that the objects seem to be conceived in isolation from their surroundings. Whether or not object-representations take the form of isolated objects cannot be known because object-representations are unconscious. However, in conscious perception and recollection, objects *are never represented alone.* They are always in a context connected with actual experiences. We are incapable of representing *a* chair; we always represent a particular chair in a particular setting. I suggest that something similar occurs with the perception of oneself as satisfied because, at least consciously, we are not capable of imagining ourselves as isolated entities. Whenever we think or feel about ourselves, we locate ourselves in *scenes* with people, explicitly or tacitly present, in a particular circumstance.

If this is the case in our conscious life, then, it could be that in the sequence of body/psychic need (drive) representative/object centered around the experiencing subject and its satisfaction, the element last registered in the representative is the state

of the experiencing subject during the satisfaction. Perhaps two simultaneous processes occur. One is the registration of the particular need, and the other, the registration of the experience of the satisfied subject as a total self, biological and psychical. If to this idea we add my earlier suggestion of the transformation of the need (drive) representative through experiences of satisfaction and frustration, I join Green (2000) in seeing the drive as "the matrix of the subject" (p. 1). It is the matrix not because it is a drive, but because it registers the continued transformation of the appetitive needs (drives) of an experiencing subject continuously transformed by its experiences of satisfaction and the affect they carry with them, while remaining the same agent/subject who experiences them. None of these experiences can be objectified consciously as memory processes. They remain unconsciously present as an affective tone of the subjective experience of well-being or of the dis-eased discomfort of knowing that something is wrong.

Freud did not offer a theory about the internal representations of the subject's experience. How can we theorize about it? First, we must avoid conceiving internal representations—as Freud seems to have done with thing representations—as the isolated satisfaction of only one need. Human experience is far more complex. Actual children (and adults) experience simultaneous needs. The hungry baby needs not only food, but to be held comfortably, to have facial contact with the mother, and to feel that he or she is being *engaged* by the mother's actions and words as the person whom the baby is in the baby's own right. The complexity of the moment of satisfaction of any need suggests that at a given moment, some aspects of the total need might be satisfied while others are not. A mother may offer good milk, but hold her baby so stiffly that the baby cannot relax. She may feed the baby well and hold him or her comfortably, but her voice may not make contact and her face may show sadness. A patient of mine expressed this most graphically: "My mother fed her daughter [the patient herself], but not me."

I suggest that early in life, the subjective aspects of these experiences of the complex satisfaction of needs are registered

as obscure, affectively colored memories of bodily exchanges with an object capable of engaging or failing to engage the total child during the moment of satisfaction of needs. I do not believe that they can return to the mind as recollections or that they form self-representations. Instead, they remain alive as affect-laden, bodily-self-as-agent unconscious memories, capable of acquiring the full force of a driven need that demands satisfaction. This situation changes with the arrival of language and its potential to articulate subjective experience.

The Emergence of Subjective Awareness and of Language

As early as the third postpartum month, mother and child begin to establish intentional patterns of communication as part of the satisfaction of needs and during moments of playful engagement. These patterns become a dialogue of bodies in which each member of the dyad contributes its part in constructing rituals and games (Sander 1964). A pleasurable dialogue is established when the messages between mother and child are complementary and their expressed affect is similar enough (Rizzuto 1988; 1991): invitation–acceptance, greeting–greeting, laughter–laughter. When the maternal affect is not similar enough or her message is not complementary, the child experiences rejection and displeasure. When the child senses that the adult *intends* to communicate with his or her self *as* that self, the child develops a *wish to communicate,* to be *engaged* with the mother and others. All these communicative experiences are embedded in maternal speech addressed to the baby as a partner, even when the baby is too small to participate.

The emergence of the child's capacity to use sound as words takes place in the context of these established, multilayered, bodily affective communications between mother and child. Spoken language can be separated from these affective communications only for research purposes, but in actual life, the two cannot be teased apart. Words acquire their meaning in this matrix of bodily dialogues and obtain their full power to establish affective con-

tact with the mother from memory processes of preverbal participation in pleasurable or painful gestures and rituals. We must ask: Is the thing-representation that is linked to the verbal representation to form the "psychic word" in any way associated to the drive representative as I have described it?

I believe that Freud's (1891) assertion that to perceive is to associate is true. That being the case, when the child learns words from the mother, the thing representation for those words, constituted by visual, tactile, auditory, and other sensory elements (Freud 1891, p. 79), must become unconsciously associated to the perception of the satisfaction of need and the communicative moment between mother and child. I believe that this unconscious associative process between thing representations and the experience of satisfaction is the essential link to words that gives them the power to access subjective experience. If this were not the case, we could only speak about external objects or about ourselves as perceived objects. *It is this unconscious connection between thing representation and subjective experience that makes psychoanalysis possible as a talking cure.*

It is through such associations that words find their complex links to primary processes that lead to the reawakening of subjective experience. Unconscious and conscious fantasizing must be included as part of the subjective experience itself. The potential of language to "touch" the individual internally, viscerally, comes from this association between thing representation (originating in the body periphery) and associated somatic and visceral, subjective experiences of satisfaction that occurred while maternal words enveloped and touched the child affectively. In the words of a bulimic patient: "I won't let you touch me with your words . . . . I feel what you say in the pit of my stomach . . . . When I talk [to you], it fills me up, and it empties me out when somebody else talks to me" (Rizzuto 1988, pp. 375-376).

Personal pronouns appear after the child has available between 118 and 272 words for things and actions (Gesell, Halverson, and Amatruda 1940, p. 192). The child's usage of pronouns before twenty-two months of age indicates only the child's spo-

ken appropriation of turn-taking in speech, without a clear sense of the self. The child masters first-person pronouns at twenty-four months and second- and third-person pronouns at thirty months. At this point, the first-person pronoun appears to refer to the child's sense of being him- or herself (Sharpless 1985)—i.e., to the capability of subjective awareness. The personal pronouns *I* and *you* will, from this moment on, serve two essential functions. First, linguistically, these pronouns are indispensable tools for establishing a dialogue between the addresser and the addressee in any instance of discourse. We can only address another by using a personal pronoun. As Benveniste (1971) points out, "The form of *I* has no linguistic existence except in the act of speaking in which it is uttered" (p. 218). This means that the linguistic referent of a personal pronoun is always individually and dialogically specific.

Second, at the psychic level, once it appears, the pronoun *I* gathers into a conscious, unitary experience the self of the speaker as a subject who experiences that self in conscious awareness. Before the pronoun came into existence for the child, the unification of experience was supported by maternal mirroring in actions, facial expressions, and words. Now the progressively internalized mirroring (Meissner 1981) and its effect upon the child's sense of being him- or herself become linked at conscious and preconscious levels to the pronouns *I* and *me*.

This is the case in normal development, when the child's emotional *engagement* with the mother has been firmly established. When the child's emotional integration lags behind the developmental appearance of the pronoun *I* as a linguistic tool, a dissociation may take place between the conversational *I* and the psychical *I*. That was the case with my bulimic patient quoted briefly above, who *experienced* herself as an *I* for the first time during analysis. She said: "It is the first time in my whole life that I have said *I* and meant it" (Rizzuto 1988, p. 378). The bodily consequences of her psychically owned—not just linguistic—*I* experience were immediate: she did not have to overeat and was able to look at her naked body in the mirror for the first time,

feeling that "My body from the neck down truly belongs to me" (p. 379). Up to that point, she had felt that she lived in her head, behind her eyes.

When the spoken word is able to capture the wish to engage in the type of communication that was initiated by the child's bodily experience of being satisfied as him- or herself, the child develops the wish to speak to another and to be spoken to. As Jakobson pointed out, "we speak to be heard and need to be heard in order to be understood" (Jakobson quoted in Waugh 1976, p. 26). Jakobson called this function of establishing subjective contact the *phatic* function of spoken language, exemplified by the question "Can you hear me?" (Waugh 1976, p. 25).

The wish to communicate now requires that the child learn to objectify subjective experience in words. The child cannot create neologisms. He or she must use the words learned in intercourse with the family, the mother and father in particular. Those words are not simply semantic referents to objects internal or external, but carry with them unconscious associations to the scenes when they were used, to synchronous experiences of satisfaction or frustration, and to fantasies ensuing from them. All those clusters of potential associations link words through primary and secondary processes to actual and private experience of the individual's subjective life. The semantic referent of words is only a narrow band of meaning in relation to the immense associative network of conscious and unconscious memory processes and the affects they arouse. This associative network of interpersonal, affective, and bodily experiences gives words the power to reawaken and reelaborate subjective experience during psychoanalytic treatment. This was illustrated by my patient, for whom feeling herself as an *I* while saying *I* permitted her to own her body and eliminated her need to overeat.

Preverbal experiences—and even self-representations that cannot become recollections, but which have remained dynamically active as unconscious memory processes—may be indirectly accessed and worked through without direct conscious aware-

ness, through the metaphoric return to bodily experiences mediated by the associative network (Rizzuto 2001). This may explain the spontaneous disappearance of certain psychosomatic symptoms during analysis.

When frustration and trauma have colored earlier communicative experiences, the patient may need to dissociate from the words spoken to him or her in order to prevent the repetition of suffering evoked by the power to touch, both bodily and subjectively, that words carry with them. My patient illustrated this point, too, in saying: "I swallowed my mother's words and they ate away at me" (Rizzuto 1988, p. 370). She had to vomit them by vomiting food.

I must attend to a final point before discussing the power of psychoanalytic speech to transform the subject. The third year of life brings with it a tremendous developmental spur of new cognitive functions, advances in symbolic understanding, the capacity for self and object constancy, self-object differentiation, and intense emotional triadic involvement. Children of this age become aware of psychic reality and "can distinguish between dream images, thoughts and real things . . . . They start pretend games and easily appreciate someone else's intention to pretend (e.g., that daddy is a dog)" (Fonagy and Target 1996, p. 219). The three-year-old, however, is not yet capable of understanding his or her own or others' ideas as representations of the mind; instead, these ideas appear as replicas of reality, what Fonagy and Target call the "psychic equivalent mode" (p. 219). The child can also function in the pretend mode, "in which ideas are felt to be representational but their correspondence with reality is not examined" (p. 219). "A feature of this way of thinking is that there must be no correspondence between the 'pretend world' and external reality" (p. 220).

The fourth and fifth year of life progressively integrate the two modes into "a reflective, or mentalising, mode of psychic reality" (Fonagy and Target 1996, p. 221). The child understands mental states as representations. This achievement is the newly acquired capacity for mentalization, the capacity for a theory of mind (Premack and Woodruff 1978), involving

> . . . intuitive ideas that all of us possess concerning mental functioning and the nature of perceptual experience, memory, beliefs, attributions, intentions, emotions and desires. Understanding and correctly anticipating the other's expectations and ideas is far more important than appreciating the physical circumstances and mechanical aspects of human interaction. [Fonagy 1991, p. 640]

Mentalization is characterized by the attribution of intentionality to oneself and others. Language separates the mental world of oneself and others from factual reality through the introduction of the relative pronoun *that* followed by a verb, such as in Fonagy's (1991) example: "He feels that the paper is too long" (p. 640). Mentalization is not only a "prerequisite for normal object relations" (Fonagy 1991, p. 650), but also a prerequisite for the capacity to play, to make believe, and most important, for the full use of all the potentialities of language. These include the ability to imagine the intentions of the interlocutor and his or her internal affective and mental states through words, as well as the capacity to create emotionally meaningful metaphors by preconsciously utilizing derivatives of unconscious associations to words.

The capacity to mentalize cannot be achieved without the participation of the object:

> In order to achieve the integration of these two modes of experience . . . the child needs repeated experience of three things: his current feelings and thoughts, these mental states represented (thought about) in the object's mind, and the frame represented by the adult's normally reality-oriented perspective . . . . The child needs an adult or older child who will "play along," so that the child sees his fantasy or idea represented in the adult's mind, reintrojects this and uses it as a representation of his own thinking. [Fonagy and Target 1996, p. 221]

In my understanding, mentalization is a variation of a modulated and modulating mirroring function, similar to face and voice mirroring, but one in which what is reflected and modula-

ted is the child's mental representation. When the child arrives at this moment, he or she has developed all the necessary capabilities to participate in the speech and language requirements of the psychoanalytic process. The main defense against mentalized experience is repression (Fonagy 1991, p. 641), which acts to remove from awareness those acts of fantasized or perceived mentation that are intolerable to the conscious subject. Preverbal and prementalization processes that are psychically disturbing require more primitive defenses. When the object has been persistently unavailable to help the child mentalize terrifying beliefs, fantasies, or thoughts, the child frequently becomes symptomatic; he or she develops a character structure in continuous struggle with such mental processes, as may happen with borderline patients.

Having arrived at the oedipal level of psychic development and of language and thought mastery, the child becomes capable of a full, conscious and unconscious psychic life. A self-narrative process begins in which the child addresses the self as an object in inner discourse: "'I said to my self'" (Bollas 1982, p. 348). From this moment on, the child constructs fantasized self-other scenes based on previous and current experiences, and uses language *retroactively (nachträglich)* to give affective meaning to earlier experiences. Such was the case of a three-year-old boy who had learned that his mother had a seed implanted in her belly to make her pregnant with his sister. He asked if his mother had loved him when he was as small as a seed, and once reassured that she had, he exclaimed: "Mummy loved *me* when I was a seed!"

The effectiveness of our analytic work is made possible by the self-narrative reorganization of subjective experience mediated by the *emotionally engaged,* spoken dialogue between patient and analyst. In this work, very obscure preverbal experiences may acquire, by the mediation of their being reawakened in the transference, the possibility of meaningful description and naming. Pathogenic fantasies and thoughts portraying unbearable scenes and beliefs may be mentalized for the first time through the continuous understanding of the analyst. Finally, well-mental-

ized scenes and ideas that are intolerable to the ego ideal and the superego may return to conscious awareness upon the analytic modification through dialogue of their forbidding demands.

THE TRANSFORMATION OF THE SUBJECT BY THE MEDIATION OF PSYCHOANALYTIC SPEECH *(PAROLE)*

The Analytic Situation

The analytic situation is a binding agreement between an analyst and a patient to work within the confines of the setting and under the aegis of the fundamental rule. The patient is to follow the fundamental rule while the analyst, as the paid expert, listens and comments, guided by his or her training as a psychoanalyst. The setting and the rule, in freeing both partners from all other concerns, enable them to participate fully in the specific task of analysis: the exploration, articulation, and transformation of the patient's affect-laden symptoms, pathogenic memories, beliefs, convictions, and unconscious fantasies into conscious, subjective experience.[6] The setting is akin to a well-structured game, such as chess: only certain moves are allowed, and any breaking of the rules interrupts the game (Rizzuto, unpublished). Analysis takes place through both partners' devotion of exquisite attention to the psychic moves each makes in playing this structured game.

The fundamental rule prescribes the manner in which the analysand is to use language. By enjoining the analysand to say *to him or her* all that the analysand becomes aware of—be it thoughts, feelings, sensations, or perceptions, whether meaning-

[6] The aim of psychoanalysis has evolved over time, together with theoretical conceptions of the structure of the mind and of psychopathology. At first, the goal was to make the unconscious conscious, and later to transform id material into ego material. The aim further evolved and became "to secure the best possible psychological conditions for the functions of the ego" (Freud 1937a, p. 250). Influenced by the thinking of child analysts, some see the goal of analysis as to restore inhibited or thwarted development. Recently, the notion of achieving optimal ego functioning has been seen to prevail over any one theoretical orientation.

ful, absurd or shameful—the analyst asks the analysand to use language in a manner that he or she has never done before. The analyst promises to listen respectfully, thus offering a minimal guarantee for the analysand to attempt to implement the fundamental rule. The analysand's previous utterances have been organized under the rules of ordinary discourse tailored to the subject and moment of the communication with a concrete interlocutor, in order to achieve emotional communication and shared cognitive understanding. This is the first time in the analysand's life in which he or she is asked to use subjective experience as the exclusive object of attention and as the subject of verbalized communications. Furthermore, the analysand is invited to disregard the principle of discourse that necessitates a communicative goal. He or she is instead simply asked to describe the inner experiential landscape as accurately as possible. That landscape will become the subject matter of the entire analytic enterprise and the object of the analyst's analytic listening.

Analytic listening is very different from listening to ordinary communications. What the analyst listens to in the analysand's utterances is not only the words themselves, but also the experiences present in them, as well as the manner of their delivery. Such listening would be a violation of the subject's privacy if it were to be used in everyday life, a breaking of social and interpersonal boundaries. In analysis, it plays a role comparable to the medical practitioner's physical examination: to search for the signs and indications of hidden processes not obvious to the one who has them. The analysand has surrendered the right to privacy of thought and feeling in order to let the analyst examine the emotional thinking that the analysand does not know he or she is carrying out.

The triple deviation from ordinary discourse—present in (1) the manner in which the analysand is requested to speak, (2) the manner in which the analyst commits him- or herself to listening, and (3) the surrender of social boundaries of conversational discourse—creates a totally knew human field in which the subject's private experiences are the focus of the joint attention of both

members of the analytic dyad. Such radical change in the use of language not only "structures the whole analytic relationship" (Laplanche and Pontalis 1973, p. 179), but also creates the indispensable conditions for transformation of the analysand's unknown *me* into a subjective *I* capable of describing, naming, and experiencing the self.

Furthermore, the analyst attends to more than words by letting the whole analysand, with gestures, bodily movements, affects, and reactions, impress on the analyst the nonverbal messages delivered by the analysand's self as agent of his or her conscious and unconscious processes and being. Not since infancy has the analysand been attended to by an adult whose entire being is tuned into the analysand's experiences, with a sort of maternal preoccupation, to ascertain his or her subjective experiences and psychic mode of functioning. This exquisite attentiveness, in the context of an analytic situation—which gives the analysand the analyst's voice but deprives him or her of visual feedback—contributes to the creation of conditions facilitating the analysand's affective attachment to the analyst as a real object, as well as the transference onto the analyst of feelings and fantasies from earlier objects.

The patient is motivated to speak by the dynamic pressure of unconscious derivatives of repressed past mentalizations; by the dynamic power of never-mentalized thoughts, beliefs, and fantasies; by the urge of obscure preverbal experiences; and by cravings of primary symbolization (Green 1977, p. 152)—all in active struggle with early and later defenses warning the patient about the affective risk of expressing them, even in derivative form.[7]

[7] Green's primary symbolization refers to registration of experiences at the earliest time, when affect and representation are not distinct. Preverbal experiences represent the self, the other, and the world in affective perceptual and action modalities that are not connected to words. Primary symbolization and preverbal registration of experience condition the possibility of mentalization in a later stage, but are not themselves mentalized. When mental processes become accessible to verbal interactions with a responsive adult intent on understanding the child's experiences, the latter is capable of mentalizing them. Mentalized experiences are then susceptible to potential repression under the pressure of conflicting goals.

The tension present in the patient's language and other nonverbal manifestations stems from conflict between the dynamic push to find delayed expression and satisfaction of unfulfilled obscure and unarticulated bodily and psychic needs, and the original terrors and fears that impeded mentalization of desire and fantasy or which prompted the repression of mentalized representations. These tensions now interfere with the analysand's free associations. The analyst's task is to find in the patient's verbalizations pointers and hidden guideposts that will enable both partners to articulate as part of an affectively tolerable mentalized *scene* (a complex representational subjective narrative) those mental processes that are dynamically active, but are not capable of conscious mentalization or are not acceptable to the superego. The analyst is like a detective seeking to reconstruct the original subjective crime scene by tracing the fingerprints of unbearable or unacceptable experiences, in order to help the patient to articulate them into an analytic narrative that can then be accepted and owned by the patient.

The Analytic Process

Green (1977) asserts that the "elaboration of the representation remains at the center of our analytic work," in order "to enable these representations to be put at the disposition of the analysand" (p. 151), to help him or her establish "live intrapsychic communication" (p. 152). I fully agree with Green and will now elaborate on my manner of understanding the task.

If representation, including representation of affect, is understood in the way described above—as a complex that always includes a self-referential component, just as dreams do (Freud 1900)—then the analyst's technical task is to attend to three basic types of experiences that seek to find or to avoid conscious representation and verbalization.

Primary Symbolization. If the patient is struggling with obscure, confused, and confusing feelings and mentation at the level of primary symbolization, the analyst's technique must attend

to every derivative that would help the patient to transform these into a mentalized representation. The work here requires a prolonged and attentive process of assisting the analysand to describe feelings, snatches of memories, actions, perceptions, and metaphors until it is possible to find a sufficiently cogent way to describe a psychic experience that has never been represented. What tools does the analyst have to do this work?

First, the analyst needs the evenly hovering attention of a mother intending to understand her child's bodily and wishful states, until these states impress themselves upon the analyst in an internally descriptive manner. These impressions may take the form of the analyst's own sensations, fantasized actions, remembered or new imagery, memories of the analyst's own childhood, or of metaphors or thoughts carrying some preconscious construction of the patient's state of mind.

The analyst must not impose his or her inner experience as a tool for interpretation, but should help the patient to further articulate what is emerging between them. It is only when there is an obvious convergence of imagery and feelings between the two partners that the analyst may describe or give a name to the experience, if the patient has not already done so. The patient's response is the sole indicator of whether or not the analyst has, after this prolonged process, created an affectively bearable representation of the experience.

All the analyst's communications to the patient must pass through the narrow door of the pronoun *you*; there is no other word in any language to reach the analysand's inner experience. If the analysand's emotional linguistic development has given him or her the experience of affectively finding the self in this pronoun, the analyst's words cannot fail to reach the analysand, at least at a certain level. If he or she is like my bulimic patient, who used pronouns without feeling them, the analyst has to first work at finding a way of making the patient accessible as the addressee of the analyst's use of *you*.

This most difficult of tasks cannot be achieved merely by employing the semantic meaning of words. The analyst's affect

in using *you* is the key element in convincing—or in failing to convince—the patient about three indispensable facts. First, that the analyst intends to *engage* the patient, as him- or herself, when addressing the patient; second, that in using this form of address, the analyst's *intention* is benign and aims at meeting the patient as him- or herself (the voice's capacity to mirror affective states), and not to invade, rob, or destroy the patient's inner world, but rather to help him or her represent subjective experience; and third, that the analyst's intention in speaking is to fulfill the essential task of communication, to offer a complementary verbal gesture to the patient's words, colored by an affect similar but not identical to the patient's.

When these conditions are fulfilled, the patient may be ready to represent for the first time experiences that up to this point have remained unconscious, somatized, or unnamed. If all these conditions obtain, the patient will be able to *re-cognize* him- or herself as the *I-subject* and owner of such representation. I believe that in many analyses, even those of good neurotics, we encounter pockets of experience that require the use of this technique.

Preverbal Experiences. Preverbal experiences cannot be remembered consciously, but are ever present in the patient's modalities of relatedness and in his or her character structure. The history of earlier nonverbal experiences is inscribed in obscure, nonlinguistic representations of the self and others, guiding the patient's manner of perceiving the objects who address him or her, in the patient's feelings and perception of him- or herself as an object for others, in the patient's manner of handling the self as an object for him- or herself (e.g., the fear of being hit, the conviction of being foul smelling), and in patterns of self-handling in relation to bodily and psychic needs.

Preverbal experiences appear most frequently in transferential convictions and enactments, as well as in acting out and in somatizations. Frequently, they have been blended and reinterpreted *(nachträglich)* through later verbal narratives (e.g., "You must take care of me," "I cannot let anyone near me—I stink"). Here, the analytic technique attends most specifically to the patient's modes of relating or avoiding.

The analysand may not believe that words mean anything between people.[8] The patient's words may be distracting or enticing, full of detail as a way of keeping the analyst at bay. They may, on the other hand, be embedded in intense affect (e.g., Valenstein's 1962 affectualization), or they may be concrete words and narratives that do not reveal inner experience. The main defensive purpose of these styles of verbalization is to avoid communication with an object who the patient assumes does not want to communicate with him or her, or who he suspects may use his communications to abandon or destroy him or her emotionally. This assumption suggests that the analysand does not find (and has not found in previous verbal communications with objects) the help needed in order to find him- or herself in his or her own experiences (Myerson 1991).

The working through of this difficulty is accomplished mainly by paying great attention to the patient's convictions about who he or she is for the analyst as the interlocutor in the analysis, and helping the patient to recognize him- or herself in his or her own actions and words. The analyst's technique consists in attending not so much to the content of the patient's associations, but more to the manner in which the patient addresses the analyst as a relational object. We are here at the core of transferential issues present in all analytic cases, because in all patients, language as a tool for communication emerges only after the basic patterns of relatedness through maternal engagement and mirroring have been established. Few patients have experienced such solid preverbal communication patterns that they can at once fully entrust their words and themselves to the analyst as a new object.

As mentioned, the working through of these issues requires that the analyst pass through the narrow door of the pronoun *you*. The patient will not be convinced of the analyst's goodwill toward him or her as an object for shared communication unless the conditions described in the previous section obtain. When

[8] "This is like a play. You say your part and I say mine. But we don't mean anything" (Rizzuto 1988, p. 369).

the analysand begins to feel that he or she is in the hands of a safe object that can encompass and contain his or her feelings and thoughts, then the analysand can let him- or herself get close to unnamed, pathogenic preverbal experiences. Now they can be made sense of—not as a remembrance of the past, but as living experience *(Erlebniss)* in the transferential situation itself.

In this revived experience, when the analyst says *you,* the patient feels that he or she is experiencing him- or herself with the analyst. Frequently, patient and analyst create a narrative of events that makes sense to them. For example, my bulimic patient concluded that for her parents, "nothing was real about me. My mother would never hear me, no matter what I said or did" (Rizzuto 1988, p. 380). What is worked through here is not a representation, but the living transformation of modalities of early and later relatedness that have seriously interfered with psychic life. What is transformed are experiences shared by analysand and analyst as partners in nonverbal and verbal dialogues. Then, and only then, the analyst as a new object (Loewald 1980) creates the conditions for first representing and verbalizing, and subsequently mentalizing, subjective states. The analyst accomplishes this by allowing old communicative patterns to emerge and by helping the patient to make sense of these, while continuously addressing the patient verbally and affectively as the *you* who had and is having the experiences. The effect of these changes is illustrated in my bulimic patient's words during termination: "I'll miss you talking to me about me" (Rizzuto 1988, p. 380).

Repressed Mentalized Representations. At the core of psychoanalytic work are those pathogenic representations that have been formed as mentalized *scenes,* unconscious fantasies of desirable interactions, and thought processes connected to wishes and actions that, if conscious, would inevitably elicit painful affect under the vigilant prohibition of the parental superego (Freud 1933, p. 67) and the ego ideal. The individual is torn between the desire to fulfill the interactions depicted in these scenes and the basic psychic fears of being maimed, punished, losing a love object, or losing that object's love. I am emphasizing the word

scene because I believe that, whether we are talking about unconscious fantasies, simple desires, or even obsessive thoughts, in the end, all these represent the subject's self, just as dreams do, and the self's obtaining or failing to obtain satisfaction from a direct or indirect interaction with a libidinally cathected object.

Pathogenic representations have a staggering complexity and subtlety. I will attempt to describe only the most obvious component elements here. First, it must be said that pathogenic representations have a great power of conviction, for the same reason that delusions do: "there is a grain of truth concealed" in them (Freud 1907, p. 80). That grain of truth may include actual perceptions of interactions with parents and with other significant objects, the parents' actions and attitudes, their real or attributed motives, their expressed or suspected intentions, their explicit or assumed feelings, and any other thought, word, action, or feeling that the patient believes he or she perceived in the object at a given moment.

Second, to that grain of truth must be added the subjective affective and perceptual stance from which the person experienced the moment and upon which he or she interpreted it. A child's minor fall may be conceived of as a punishment for bad desires, as a warning, or as a happy event that brought about much-desired loving and care. I am trying to say that there is no organization of a represented scene, no matter how factual and external it is, that does not include the point of view of the participating subject at the time. Emotions and desires felt at the time may be revived or may appear in a defended form when the scene or its derivatives return to consciousness, allowing their exploration and eventual working through.

Third, representations include intentionality, however obscured and disguised it may be. This has nothing to do with perception; it has to do with the easily demonstrable fact that after a certain age, we take for granted that what is there—whatever it is—is there because of someone's intentions. A thing was placed there for some reason by somebody. That is, in fact, the foundation of all detective and psychoanalytic work: somebody intended it; there was a motive.

Fourth, there is plot. Representations do not register external and internal perceptions as a photograph does. They are organized in the shape of a narrative (as dreams are) about the subject as desiring, overtly or obscurely. It could be as simple as "I saw, heard, felt," and so on, supposedly in the manner of a witness registering a fact to a convoluted story stemming from meager or rich events. The filmmaker Ingmar Bergman is a master at showing the narrative of impending suicide by detaining the camera's focus on the expanding and contracting nostrils of the actor's face. In fact, we are all a bit like Bergman, capable of building full narratives from the narrowest of perceptions, internal sensations (as in the case of the hypochondriac), and even from coincidental fantasizing in a split second.

Fifth, the experiencing subject is always at the center of the plot in the representation, as the central organizer of the experience itself. This centrality of the subject is the key element calling for instantaneous repression when the representation conflicts with the parental superego or the ego ideal.

Sixth, there are sensory, somatic, and visceral connections present in the representation itself, as part of the very structure of the representational process. The sensory elements constitute the structure of perception, while the somatic and visceral components inscribe the affect of the purported experience of satisfaction or its absence. These bodily components of representations frequently appear in derivative form in the metaphors patients select to describe their experiences (Rizzuto 2001).[9]

Seventh, there is drama—that is, affects linking subject to body and plot, intentionality, affective point of view, and the essential grain of truth that is reawakened as soon as some derivative of the representation becomes preconscious. The drama concerns the unsatisfied desire—which, because of the power of the defenses, is believed to be insatiable. It is this drama that continu-

[9] I must repeat at this point that whether we are talking about need or desire, the experience of satisfaction is never of a single element, but rather of complex levels of interaction between people.

ously incites the unconscious self-as-agent to try over and over again to find communication and satisfaction acceptable to the superego and the ego ideal.[10] When such clever attempts fail, the self-as-subject, that is, the patient, experiences anxiety, acts out, or develops symptoms that prompt him or her to exclaim: "I know there is something wrong with me!"

The task of analysis is to find that *me,* masterfully hidden and yet present in the representational complexity of the patient's associations. The progressive discovery of that *me* comes to light for the first time in the presence of the analyst as the dialogical and transferential other, who addresses it as a *you* in its diachrony of feeling from childhood to the present and its synchrony of dialogical and transferential affect. *I propose that the analysis of the pathogenic representations by the attentive examination of free associations in the context of a respectful and interpretive transferential dialogue, one that focuses exclusively on the patient's experience as the* you *addressed by the analyst, is the essential element in bringing about the transformation of the subject and the elimination of symptoms.*

The pronoun *you* is the critical linguistic tool the analyst has to achieve the transformative process. A brief look at Freud's (1937b) prototypical reconstruction illustrates the function of this pronoun:

> Up to the *n*th year *you* regarded yourself as the sole and unlimited possessor of your mother; then came another baby and brought *you* grave disillusionment. Your mother left *you* for some time, and even after her reappearance she was never again devoted to *you* exclusively. Your feelings towards your mother became ambivalent, your father gained a new importance for *you* . . . and so on. [p. 261, italics added]

In this passage, Freud is offering his patient a narrative reconstruction of his early desirous representation of the psychic re-

[10] I link the term *communication* to Freud's (1891) assertion that all stimulations to speak spontaneously originate in the region of object representations (conceived by him as thing representations).

lation between the patient and his mother, followed by a description of events that contradicted such representation and the effect they had upon the young boy's earlier convincing representation. Freud had no other way of accessing his patient's subjective experience as a child, as an older child, and now as a man in analysis but to use the same pronoun diachronically in a synchronic interpretation for that analytic moment. Freud's intent here is to help the patient to make sense of himself. Regardless of how much present-day styles of interpretation may differ from Freud's, no analyst can analyze without passing through the narrow door of the pronoun *you*. When the patient feels or says "That is me," the analysis is well on the way to achieving its goal.

The patient's response of "That is me" reveals the process of objectification of the self in an act of self-recognition in the present. The pronoun *me* condenses at that moment the recognition of oneself in a particular state of being, but does so in the presence of the analyst as a dialogical other who recognizes the patient and his or her mental processes for what they are. The moment affords the transformation of old scenes, representations, and thoughts by the mediation of words and affects experienced with the analyst in the double function of transferential and real object of the patient's desires and communications. The revisiting of the representations in this context may bring about the "rearrangement" and "retranscription" of "memory traces" and representations that Freud (1887-1904, p. 207) suggested take place when "fresh circumstances"—analysis, in this case—make these possible.

Such fresh circumstances, which we call the psychoanalytic situation, bring with them a modality of discourse capable of opening up representational sources of past affective experiences, for and with an analyst whose entire attention and affective empathy is focused on discovering the analysand as the subject of his or her psychic life. The process of opening up the representational source brings to life every aspect of the patient's being that contributed to the formation of the representations: the sensory, somatic, and visceral body; the relational modalities of earlier and

later communication; snatches of unmentalized traumatic moments; fleeting or organized conscious and unconscious fantasies, as well as past and present thoughts in the form of repressed or present-day mentalized thoughts.

The entire parade of mental processes brought in by free association and defenses against it cannot help but transform the representations themselves while the subject reexperiences them in the present, new context of an analyst who is capable of holding them in mind. The key organizing instruments in the transformational process are the analyst's verbal feedback of describing, naming, and interpreting the patient's representations and experiences with a tone of voice and a manner of phrasing that reveal his or her intention to keep in touch with the patient's affect of the moment. When the content of the analyst's words is an apt description of the patient's experience, and the affect echoes well enough the patient's past and present emotions, he or she feels that essential sensation of true communication: "I have been heard." The patient is no longer alone with his or her most dreadful secrets. Patient and analyst can speak together meaningfully about the patient's self and the two of them. The telescoping of reinterpretations (Breuer and Freud 1893-1895, p. 133) now allows the reelaboration of firmly held beliefs that have been supported by the structure of the analysand's representations.

The transformation effected in the representations and in the experiencing subject by the dialogical exchanges under the organizing power of the pronoun *you* facilitates internal speech—talking to oneself as another (Bollas 1982)—even about previously forbidden matters. Yet, the task is not completed until the patient carries out an essential psychical action (Freud 1914) of a narcissistic nature: he or she accepts the self as a valuable object, without having either to fulfill the demands of compelling desires or to submit to the defenses against them. My bulimic patient summed up her life and the giving up of her defenses as follows: "I was born normal. My parents were so righteous and we children felt so bad about ourselves. I wanted to be heard, to be known. I responded with a lifelong temper tantrum. Now I am ready—I am over the temper tantrum."

TECHNICAL CONSIDERATIONS

This understanding of the psychoanalytic process suggests some technical considerations. We need to assess the dialogical capacity of the analysand, rather than taking for granted that he or she is capable of speaking about him- or herself. Frequently, the first —and at times, a prolonged—part of the analysis consists in discovering and working through the modalities of noncommunication that dominate the analysand's speaking style of relating to his or her self and others. One extreme is represented by eating-disordered patients who do not believe that words mean anything. The other extreme is the hysteric who produces the best of associations as a seduction, hiding behind them.

The first analytic task is, therefore, to strive to establish an analytic situation in which words from both sides can be heard and accepted as meaningful communications to be taken with the utmost seriousness. That is so, because the analyst is not interested in the words themselves, but is *intent on finding the experiencing subject in the patient's words.* There is no technique that can teach an analyst to have such an intention. It is not a technical issue; it is an existential and moral-character issue, revealing a true wish to find the patient where he or she is. It is the equivalent of Winnicott's (1965, 1971) maternal preoccupation. The ideal goal is to arrive at the moment when the analysand can say, "I want to tell you . . ."

The manner of attending to free associations, together with other communications and enactments and their interpretations, must offer the patient maximal autonomy and participation. The analysand is the only one who holds the key to his or her troubling representations. The private associations and insights awakened in the listening analyst must not be used initially to attempt interpretations, but rather to help the patient in further explorations of his or her own. The aim is to make the patient curious about what comes out of his or her own mouth. This is the most effective tool I know of to further the exploration of the patient's most repressed and unbearable representations.

It is true that the analyst must always be alert to the emergence of defenses that interfere with the exploration of the representation, and alert to the fact that his or her efforts to work through the defense are an essential part of the process of permitting the full emergence of the representation. I am saying two things here: First, that the analyst who is clever and quick in interpreting may interfere with the process of emergence of significant aspects of representations and related associations. Second, the agent of the analysis is the patient. The analyst must remain an assistant, a Socratic midwife, who facilitates the patient's task of delivering the contents of his or her mind and narrating experiences.

When interpretations are needed, it is essential, particularly if the material is emotionally or transferentially loaded, that the analyst make every attempt to convey the interpretation in an emotional climate that shows the analyst to be doing his or her best to remain in emotional contact with the patient. The analysand's acceptance of the interpretation depends no more on its accuracy than it does on its ability to make the patient feel that the analyst, wishing to understand, is talking to the patient about his or her self. I repeat my patient's words: "I will miss your talking to me about me." I believe that this affective component of the analyst's words gives the accurate interpretation its power of conviction. I consider it equivalent to the grain of truth that gives power to convictions.

The careful reconstruction of the components of the representations examined during analysis has a remarkably paradoxical effect. Analyst and analysand have arrived at the representational components by the potential of spoken words to evoke and bring back to life sensory, somatic, and visceral components of the representation, together with perceptions of intentionality, desire, fantasy, plot, and drama. Once the reconstruction has been achieved, something happens to the words that brought them about. They have now acquired a fullness of meaning, as a new, joint analytic experience, and as a reintegration of their vast representational network, which transforms them from meaningful

linguistic tools into much fuller psychic words. They are no longer only words of language, but also the words of a self—a living person—who has learned to speak meaningfully, both to another and to him- or herself as another.

I shall end as I began: "Without affect there is no effective language. Without language there is no effective affect" (Green 1986, p. 295). When the analyst's words are intended to reach the patient emotionally (the phatic function of speech *[parole])* by interpreting both the patient's verbalizations and the patient as the affective subject in them, the psychoanalytic process can transform the experiential subject.

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Psychoanalytic Quarterly, LXXII, 2003

A NEW MODEL FOR CONCEPTUALIZING INSIGHTFULNESS IN THE PSYCHOANALYSIS OF YOUNG CHILDREN

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Traditional definitions of insight fail to take into account the cognitive and developmental limitations of young analysands, who lack the capacity to mentalize. It is suggested that insightfulness be redefined as promoting mentalization in young children. Gaining this key psychological function furthers the internal integration and self-regulation necessary to regain developmental momentum. The central importance of promoting such development in child psychoanalysis suggests that the facilitation of a mechanism for self-understanding, not the interpretation of content, is essential. Insightfulness is facilitated by employing a range of interventions beyond the interpretation of resistance and content, rendering meaningless the distinction between interpretive and relational aspects of the analyst's role.

INTRODUCTION

What is it about a psychoanalytic hour with a child that warrants calling it a good one? And how does the accumulation of these hours help children to change? In general, we believe that our child analysands have regressed and/or become stuck in less mature ways of regulating themselves and their troublesome affects. As a result, developmental momentum is disrupted and the de-

velopmental process is distorted. Analysis cures by modifying the conflicts that are causing the regression and/or fixation. Somehow the regressed compromise formations are destabilized so that conflictual elements are reintegrated at more mature levels. "The treatment process may be conceptualized as a freeing of those components so that they may be acted upon by newly emerging integrative modes" (Abrams 1980, p. 305). With such reintegration, self-regulation increases. Put another way, child analysis cures by reorganizing and reintegrating repudiated unconscious structures or functions with higher-order conscious ones (Fonagy and Target 1996c). Thus, good analytic hours (Ablon 2000; E. Kris 1956; Mahon 2000) and the good analytic work that precedes them promote such reintegration and self-regulation. Promoting structural development is essential in child analysis.

This understanding of the mutative impact of analysis leads us directly to the issue of how the child analyst promotes such reintegration and self-regulation. E. Kris (1956) emphasized the importance of insight with adults; the good hour was one in which the ego's integrative capacities had been so improved by prior analytic process that the patient was now capable of newfound insight. Child analysts have emphasized that more than insight is necessary to warrant an hour's being good (Ablon 2000; Mahon 2000). They have done so, in part, because the developmental immaturity of the child requires technical interventions beyond verbal interpretation of unconscious conflict. Thus, the nature and role of insight in child analysis continue to be debated and difficult issues. Yet they remain crucial in understanding how child analysis cures.

THE ROLE OF INSIGHT

Because the child's ego is still in the midst of a developmental process, one must look beyond the integrative function of the ego when trying to understand how such insight occurs in the analysis of young children. E. Kris (1956) emphasized the necessity of three functions working in harmony to bring about the insight

characteristic of a good hour: (1) the ability to control regression so that it remains temporary and partial; (2) the ability to observe oneself objectively; and (3) the ability to control affective discharge. None of these three ego functions can be taken for granted as already established in child analysands, particularly prelatency ones.

In fact, these developmental limitations led Kennedy (1979) to conclude that five-year-olds lack the developmental maturity for insight. Secondary process thinking is not firmly established; implicit memories are still being consolidated; past and present are easily blurred, as is the distinction between conscious and unconscious. The capacity for self-observation is far more limited in children of this age, and is generally used to maintain current states of well-being rather than for active self-understanding (Kennedy 1979). The egocentrism of young children and its associated magical thinking also make self-observation difficult.

Likewise, children of this age have difficulty with the controlled, temporary, and partial regression that E. Kris thought necessary for insight. Interpretations of impulse, for example, are too easily experienced as permission to act by such children (Kennedy 1979; Sandler, Kennedy, and Tyson 1980; Sugarman 1999). With prelatency children, the analyst must remain cognizant at all times that sudden and extreme regression can follow interpretation of drive-laden wishes, for example. Complicating the attainment of insight even further is the tenuous ability to control affective discharge seen in these children. They often have problems with affect tolerance and affect regulation because of their cognitive immaturity and unreliable defenses. Affects easily become overwhelming and disorganizing, rather than serving a signal function. Externalization as a defense against powerful emotions makes these children far more prone to enactment than adolescent or adult analysands.

The child's cognitive limitations also affect the analyst's ability to use words in his or her interpretations, making the attainment of insight with young children even more complicated (Joyce and Stoker 2000; Miller 2000; Sugarman 1994).

> 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]

Finally, the prelatency child's developmentally limited concept of time interferes with insight. The prelatency child's "sense of the continuum of past, present, and future is still relatively underdeveloped and contributes to this difficulty. Real insight of how the past affects current experience will be extremely rare in the under-five" (Kennedy 1979, p. 17). Hence, past and present can easily merge for the prelatency child, not only because of cognitive and developmental immaturities, but also because the developmental process has a forward and backward quality, carrying with it the inevitability of some regression before the next progression (Kennedy 1979).

These various limitations on the capacity of young children for insight pose a serious conundrum for child analysts and for our understanding of therapeutic action. In general, most child analysts continue to stress the importance of insight in leading to structural change and removing the obstacles to developmental momentum, held to be the goals of child analysis. To be sure, in the analytic treatment of children, we are well aware of the child analyst's role as a developmental object (Sandler Kennedy, and Tyson 1980; Scharfman 1971; Sugarman, in press), as well as the need to provide developmental help (Fonagy and Target 1996a; Greenspan 1997; Hurry 1998; Olesker 1999; Yanof 1996). And there has even been a suggestion in the child analytic literature that insight is not crucial to the mutative impact of child analysis (Cohen and Solnit 1993; Scott 1998). "Play with a child psychoanalyst can have a developmental promoting impact with a minimum of verbalization and interpretation" (Cohen and Solnit 1993, p. 50). Nonetheless, most child analysts view insight as essential to therapeutic action, usually emphasizing the contribution of the analyst's function as a developmental object, or the provi-

sion of developmental help as only a prelude to facilitating insight in young children. "When we help prelatency children to establish pathways from self-observation to insight, we find the need for developmental assistance such as extending the pathways for externalization" (Schmuckler 1999a, p. 353).

In this paper, I would like to examine the issue of insight in young children in detail. Specifically, I will attempt to clarify what we mean by *insight* in such children, with an eye to clarifying its relationship to insight in adults and adolescents. Following this clarification, I will examine issues of technique with young children in order to consider the means by which we are most effective in promoting insight. It is my hope that such discussions can help us better understand the complexity of the psychoanalytic process with young children.

WHAT IS INSIGHT IN YOUNG CHILDREN?

Traditional views of insight focus on the analysand's gaining access to his or her own thoughts and the contents of the internal world—*and* realizing that his or her inner world both arises from past experiences and currently causes his or her troublesome symptoms, inhibitions, emotions, behavior or character traits. Essentially, insight has been described as the gaining of intellectual and emotional awareness into the unconscious mental contents contributing to the clinical phenomena in question. Contemporary structural or ego psychological theorists (e.g., Busch 1995, 1999; Goldberger 1996; Gray 1994) might describe this view of insight as an example of how topographic-era thinking (raising unconscious mental content to consciousness) continues to intrude into modern-day psychoanalytic theory without being recognized as such. Nonetheless, most analysts think of insight as gaining an understanding into the *whys* of psychological life, even with children (e.g., Hoffman 1989). And a focus on the whys will inevitably lead to mental content, though the nature of that content will vary according to the theoretical predilection of whichever analyst is speaking.

But we cannot readily apply this definition of insight to young children because they are incapable of reflecting on their own thoughts and mental life until they first realize that both their own and others' mental states are constructed, and that these mental states are the causes of both theirs and others' words and actions (Mayes and Cohen 1996). Young children must first possess what has been called either a theory of mind (Mayes and Cohen 1994, 1996) or the capacity for mentalization (Fonagy and Target 1996b; Target and Fonagy 1996c). Yet this ability develops in normal children only gradually between the ages of four and six (Mayes and Cohen 1996), though its developmental roots have been traced to infancy (Fonagy et al. 2002).

What do we do, then, with prelatency children who come to our attention and begin analysis well before they are old enough to have a well-defined theory of mind? Complicating the matter further is the likelihood that mentalization will be delayed, if not derailed, in those children whose difficulties are sufficiently disruptive to cause them to be brought for analysis. Serious disruptions in the environment or serious developmental difficulties are likely to cause young children not to use their cognitive capacities for representing the minds of others, particularly their caretakers. Research has shown that children's capacity for self-reflection correlates with their security of attachment (Fonagy et al. 1991; Fonagy and Target 1997). Infants and children who experience a secure attachment learn that their mental states are appropriately understood and responded to by their caretakers. And those who do not experience a secure sense of attachment are vulnerable to the inhibition of key mental processes, including mentalization. Thus, the capacity for mentalization will be disrupted in some children; they come to analysis never having developed this crucial ego function beyond some minimal level. Other children will develop mentalization, but then have it impaired by internal conflict.

Fonagy and his colleagues (Fonagy et al. 1993) point out that essential mental processes are as vulnerable to conflict and defenses as is mental content. For example, a child of parents who

harbor murderous wishes toward him or her might inhibit the awareness that others have mental states in order to avoid recognizing the parents' homicidal impulses. Gray (1994) makes a similar point:

> Many highly developed skills make use of ego processes that are utilized quite out of the range of consciousness, and, in many instances out of the range of available understanding . . . . The emphasis here has been upon those ego functions that are involved in the process of self-observation. Ego functions that have become drawn into compromise formations might . . . be regarded as handicapped by conversion symptoms within the ego itself. [pp. 23-24]

From this perspective, it makes sense to view the promotion of insightfulness with young children as a process whereby the child analyst helps the young child to develop a theory of mind.[1] That is, insightfulness with prelatency children aims less at helping the child become aware of the complex *whys* of his or her difficulties; instead, it facilitates the child's realization that he or she has an inner world, that this inner world arises out of important experiences with and fantasies about the environment, and that it contributes to the child's emotions, self-esteem, symptoms, and behavior. Via insightfulness, the young child does not gain access so much to repudiated mental content as to a key psychological process that has been derailed by internal conflict. What is essential to the analysis of young children is the facilitation of a mechanism of self-understanding. *To be sure, awareness of repudiated content will usually accompany the development of mentalization. But the point of insightfulness is to regain access to inhibited or repudiated mentalization, not to specific content per se.*

I believe this point is what Schmuckler (1999a) has in mind when she says the following:

[1] The term *insightfulness* will be used henceforth to emphasize the process nature of the phenomenon. I am suggesting that a growing capacity for insightfulness (as process) precedes the achievement of insight (as content) (Silk 2002).

> While it is true that the insights of the very young are not enduring in most cases, their presence suggests the question of whether our emphasis ought to be on the persistence of particular insights, or, rather, on finding creative ways to extend the pathways (grids, perhaps) that are required to establish such connections. [p. 352]

A theory of mind serves as the pathway or grid that is important for the young child to develop.

This definition of insightfulness, with its emphasis on helping the young child to develop a crucial mental process that has been inhibited, or to regain one that has been lost to conflict, does not always require an observing ego and an explicit conscious awareness with accompanying verbalizations that the contents and processes of the mind are being observed. "For children, much of the analytic work goes on at an unconscious or preconscious level. This raises a question about whether the analytic work with children needs to be brought to their conscious awareness" (Yanof 1996, p. 106). Reflective functioning or insightfulness can become evident in displaced form—for example, in a child's play during analysis—without a conscious and explicitly observing ego. A two-year-old boy in analysis can elaborate a play scenario wherein a child withholds his stools because he is angry at his mother, while being unable to reflect on his own anger or how it affects his toilet behavior. Young children's fragile affect tolerance can make the conscious awareness of their own emotions or impulses too threatening. Displacing such internal states into concrete play makes them more tolerable.

The conscious ego is not necessarily an observing ego in our youngest patients. Developmental research shows that children develop "pragmatic" or implicit knowledge about mental states significantly earlier than they can demonstrate "elicited" or explicit knowledge about the mind (Mayes and Cohen 1996). A host of developmental research has found that by age three, children use the words "*thinking* or *remembering* in contextually correct ways when referring to their own actions and feelings and sometimes those of others . . . just after thirty-six months of age, children spon-

taneously attribute differentiated beliefs, feelings and desires to characters in their play" (Mayes and Cohen 1996, p. 129, italics in original). But a direct question (or interpretation) designed to elicit explicit understanding of these mental states will be too abstract and/or too anxiety arousing to allow the child to demonstrate his or her self-knowledge. It is the young analysand's capacity for implicit or pragmatic insightfulness that allows child analysts to make articulate interpretations of conflict within the play, despite the child's inability to make sense of or work with such interpretations when they are made outside the play and directly about the child.[2]

Younger analysands simply lack sufficient affect tolerance and the subsequent capacity for an observing ego to allow them to utilize such interpretations. Their representational capacities have not yet developed sufficiently to allow for the ego split and affect regulation necessary to explicitly and consciously observe their mental processes. Nonetheless, they can be helped to know themselves progressively in increasingly abstract ways. Through our interventions, we promote increasingly higher forms or ways of knowing oneself. Our interventions to promote self-knowing throughout the course of an analysis lead to an increasingly differentiated and cohesive sense of self that becomes more and more stable across diverse emotional states and when manipulating diverse symbols. These increasingly higher forms of knowing form a developmental sequence of self-knowing, each step involving a new level of cognitive-affective integration (Abrams 1980). Thus, it seems reasonable to talk of a developmental line of insightfulness or mentalization that occurs in child analysis. Such an approach to formulating the ways in which insightfulness develops is easily integrated with more traditional views of the concept. "More commonly, however, insight follows a slow, gradual accre-

[2] The concept of *implicit* or *pragmatic* insight should not be taken to mean that the child is capable of an unconscious mode of understanding that has not yet developed in the immature conscious ego. Rather, the child's limited tolerance of intense affects allows interpretations in the displacement to be used as an aid to "knowing" such internal states.

tion of self-knowledge about oneself. As resistances are interpreted, repressed ideational content returns and is now accepted by the ego, so that psychic reorganization is facilitated" (Moore and Fine 1990, p. 99).

I will demonstrate below that many technical strategies are required to promote such insightfulness in young children, particularly when insightfulness is redefined to emphasize process as well as content. But child analytic experience supports the emphasis on self-knowledge as a gradual step-by-step process wherein increasingly higher-level insightfulness is attained, culminating in self-knowledge that is accessible to a conscious, observing ego.

In general, child analysts view the goal of child analysis to be the removal of obstacles to the developmental process and the regaining of developmental momentum that has been disrupted by inner conflict. Thus, promoting the development of mentalization is quite in keeping with more traditional views of the child analytic process. Via mentalization, the child builds up a world of mental representations. Self-object differentiation is promoted by the gradual awareness that others as well as the self have internal worlds that affect their behavior and often do not coincide with each other. Empathy for others develops out of the realization that others can have beliefs or feelings different from one's own. Complex social conditions are more easily understood and navigated by the child who has a theory of his or her own and others' minds.

Likewise, reality testing is facilitated, separation-individuation is promoted, and the primacy of secondary process thinking is enhanced by a theory of mind. Interpersonal relationships feel safer because they are more comprehensible to the child who understands that others' actions are dictated by their own mental states (Mayes and Cohen 1994). Affect regulation (Bradley 2000) is improved by a theory of mind. Aggression, for example, is handled better by children who can reflect on their own or others' thoughts and feelings (Mayes and Cohen 1993a). Learning the distinction between fantasy and action provides the child with alternative pathways for affect discharge.

> For the oedipal-aged child, the transformation of aggression and the blending of aggressive and libidinal wishes toward the same person are made possible by the ability to understand the nature of one's own and others' mental states and of the relationship between mind and action. [Mayes and Cohen 1993a, p. 162]

Prelatency children brought for mental health consultation generally have problems with impaired affect regulation, frustration tolerance, self-image, fragile reality contact and thought organization, pervasive magical thinking, and difficulties comprehending human exchanges or empathizing with others—all suggestive of an impairment in mentalization (Fonagy and Target 1998). It is my contention that we best help these very young analysands by developing insightfulness as defined above. Learning that thoughts and feelings are mental representations, as well as attaining an understanding of interactions in terms of mental states, promotes the reintegration of repressed, immature structures into developmentally mature, conscious ones necessary for improved self-regulation.

Essentially, insightfulness involves learning to observe one's internal states, which often leads to knowing something previously unknown about oneself (Joyce and Stoker 2000; Miller 2000). Knowing becomes the goal of child analysis (Abrams 1980; Koch 1980). Through the establishment of an analytic process characterized by specific technical strategies to be described below, we implicitly (and later explicitly) help our prelatency analysands learn to know themselves, and eventually their own minds. As the analytic process proceeds successfully, the young child moves along the developmental line of insightfulness, so that mentalization eventually comes to include conscious, explicit self-reflection on his or her own mental functioning (Abrams 1980; Sugarman 1994). The sort of ego split advocated long ago by Sterba (1934) appears toward the end of analysis, while earlier forms of mentalization (insightfulness) are promoted in the initial stages of treatment. Fonagy (1999) has noted a similar sequence with adult patients, wherein the sort of insightfulness I am defining

leads eventually to the restructuring of the representational system in which the content of the representations changes. Unlike in analyses with older children and adults, however, our emphasis is less on the particular content (repressed wish, defensive maneuver, or superego injunction or ideal) than on communicating to the young patient our interest in the inner world and the importance of knowing it.[3]

My definition of insightfulness is in keeping with the work of Koch (1980), who found that

> The value of any single therapeutic intervention rested not so much on its immediate elucidation of a defended wish or conflict but on its part in facilitating more general processes/functions which had failed to develop or whose budding development became inoperative or ineffective secondary to psychic conflict. [p. 19]

Koch's emphasis on therapeutic action involving the internalization of the analyst's knowing function is another way of conceptualizing this definition of insightfulness as the fostering of mentalization or a theory of mind. The analyst's psychological mindedness is internalized and facilitates the child's insightfulness.

THE FACILITATION OF INSIGHTFULNESS

In general, analysts talk of promoting insightfulness via interpretation when they describe therapeutic action with adults and with older children and adolescents. We assume that pointing out and understanding the reasons for the analysand's defenses, superego recriminations, and repudiated wishes lead to the knowing of oneself that promotes structural change. Slade (1994) and Scarlett (1994) remind us that this emphasis on insightfulness as arising

[3] I do not mean to suggest that we focus less on process with older children or adults. But we are more likely to address content verbally in our attempts to elucidate process.

from verbal interpretation is developmentally incorrect for many children. The revised definition of insightfulness with young children that I am suggesting requires a more complicated approach when its technical implementation is considered. Defining insightfulness as gaining a theory of mind transforms our technical focus on interpretation of mental content[4] into a complex array of technical strategies used by the child analyst, all of which are important in promoting the young child's ability to mentalize. Verbal interpretation of content (id, ego, or superego) loses its privileged status as the only way in which to impart insightfulness to the young child. Instead, all the techniques child analysts include in their armamentarium that are useful in promoting the ability to mentalize—including verbal interpretation—qualify as vehicles to facilitate insightfulness.

This new definition of insightfulness and broadened set of techniques for facilitating it leads to a shift in our understanding of therapeutic action in the analysis of young children. Once one accepts that any intervention facilitating the young child's capacity to recognize and to know his or her own as well as others' minds functions in the service of insightfulness, the distinction between providing developmental help and providing insight loses much of its relevance. In fact, the notion that analysts *provide* insight, with its implication that the child is the passive recipient of the unconscious content verbalized by the analyst, must be reformulated. Redefining insightfulness as a process that is *promoted* by the analyst lends itself to the analogy of a competent tutor teaching a new skill to a neophyte (Wilson and Weinstein 1996). The child analyst's techniques for promoting insightfulness involve "creating the scaffold necessary for the evolution of capacities in the one with less developed or sophisticated psychological skills" (p. 169).

Hurry (1998) has pointed out that child analysts have at best been ambivalent about—if not downright loath to consider—

[4] *Mental content* refers to more than id wishes; defenses and superego manifestations also have content. Thus, I am suggesting a shift away from an overemphasis on content having to do with any of the tripartite structures.

interventions other than verbal interpretations as crucial components of the analytic process:

> Child analysts have always used such techniques as helping a child to be able to play, to name feelings, to control wishes and impulses rather than be driven to enact them, to relate to others and to think of and see others as thinking and feeling. They have done such work intuitively and, at times, lacking a fully developed theoretical framework in which to view it, they have undervalued and sometimes failed to record it. [p. 37]

This tendency appears even in the work of Fonagy and his colleagues, who noted the crucial importance of developmental interventions in successful analyses at the Anna Freud Centre (Fonagy and Target 1996b), and yet, in the same year, felt the need to distinguish genuine child analysis involving interpretation of conflict from psychodynamic developmental therapy (Fonagy and Target 1996a).

This distinction between the child analyst's functioning as a developmental object and as a provider of insight continues to occur in our literature (e.g., Olesker 1999; Schmuckler 1999b; Yanof 1996). For example, helping a child to lower his or her stimulation level, to identify and delineate affects in order to encourage affect regulation, and to remember repressed affects become defined as developmental help. Once one redefines the technical intervention of promoting insightfulness as helping the child reach the capacity to mentalize, however, it becomes logically untenable to designate some interventions that do so as offering developmental help, and others that also do so as promoting insight.

Elsewhere (Sugarman, in press), I have raised the question of whether traditional developmental object interventions might be more accurately considered transference interpretations at a concrete cognitive level. Insightfulness is insightfulness, and any intervention by the child analyst to the child analysand that pro-

motes self-knowledge and the cognitive-affective integration that it involves is functionally the same. Certainly, there are several types of interventions that do so, and it is important to become aware of and to be able to distinguish among them. It is also important to decide which of them is most appropriate with any young child analysand at any particular moment in the analysis.

But the continuing tendency to see verbal interpretation of content as the primary road to insightfulness creates an idealized and inaccurate representation of genuine child analysis in our minds that most prelatency analyses rarely reach. Such an unrealistic ideal can create countertransference problems for the analyst of young children and lead to countertransference pressure to interpret prematurely what the prelatency child's play *really* means, in order to feel that *real* analysis is taking place (Slade 1994). It also fails to do justice to the emotional and relational aspects of insightfulness. The continued presence of this ideal in our theory of technique is a sign of the developmental lag in technique noted by Gray (1982).

Such a restricted definition of insightfulness generally carries with it the implicit notion that one must help the child learn the unconscious meaning of his or her productions. That is, the emphasis remains on making the unconscious conscious or deciphering the real meaning of the child's symbolic productions (Scarlett 1994; Slade 1994). But such verbal interpretations are often too abstract for the young child who has not yet developed or who has defensively inhibited the ability to mentalize. As such, these interpretations remain "outside the neighborhood" and fail to expand the child's ego mastery. They suffer from all the same technical difficulties Busch (1993, 1999) has noted when analysts fail to interpret "within the neighborhood" and to address their adult patients' conscious egos. Regression, anxiety, and resistance ensue even more dramatically with young children than with adults when the analyst overemphasizes the verbal interpretation of unconscious meaning. At best, such interpretations are

accepted passively, without the sort of ego integration E. Kris (1956) thought so necessary. "Interpretation outside the ripeness of the material is indoctrination and produces compliance" (Winnicott 1971, p. 51).

This is not to say that the analyst's words do not matter in the analysis of young children. But they can promote the prelatency child's theory of mind in many ways, of which the interpretation of content is only one—and a particularly rare one at that. For example, the analyst's ability to articulate the young child's feelings or to translate the imagery of the child's play or drawings into feelings helps the child learn to modulate and channel emotions into verbal symbols and to delay acting on emotional stimulation (Miller 2000; Olesker 1999). This putting words to feelings is different from interpreting unconscious content. The goal is not to decipher the latent or secondary symbols of the unconscious (Scarlett 1994). Instead, the child is taught the words for the feelings implicit in the drawings or play. The analyst's interventions remain on the workable surface and address the child's conscious ego (Busch 1995, 1999). In this way, the child learns to differentiate affect states and to distinguish different emotions. Self-regulation improves as the prelatency child gains a sense of inner mastery, integration, and regulation, while the need to resort to primitive defenses is reduced. Likewise, the analyst's use of words to reference internal states within the play helps the young child consolidate a variety of mental boundaries, including conscious-unconscious, inside-outside, wish-reality, and self-other (Slade 1994). Simply being a consistent, sentient adult, one who puts words to otherwise confusing or unbearable internal states, allows the analyst to help the young child who has been unable to develop or has had to defensively inhibit the capacity for mentalization (Scott 1998).

Insightfulness via the Relationship

This latter point highlights how the definition of insightfulness I am advocating emphasizes the importance of the relational

context between analyst and analysand in its development (Fonagy 1999). Research clearly demonstrates that the capacity for self-reflection arises out of a secure emotional attachment to the primary caretaker (Fonagy et al. 1991; Fonagy and Target 1997). One can extrapolate that the child analyst, too, must create a safe relationship for the young child to become interested in and curious about both the analyst's mind and his or her own. Target and Fonagy (1996) suggest that

> . . . this aspect of the analyst's role with the young child may be the same as this aspect of being a parent, in that the analyst's awareness of the child's internal world enables the child to dare to think of his feelings and thoughts as representations rather than replicas of reality. [p. 460]

Put another way, the analyst's interventions create an environment where the aim is to *know,* in a relationship with someone interested in knowing (Miller 2000). By reflecting back to the young child what he or she is saying in his or her play in the language of mental states, we help the child to link his or her capacity for imagination to reflections on the inner world (Mayes and Cohen 1992). Access to imagination and fantasy is crucial for the child to develop an awareness of and interest in the inner world of mind (Mayes and Cohen 1992). Thus, we promote insightfulness in our prelatency analysands in part by providing a relationship that values their inner world. They then internalize our awareness of them as thinking selves. Our interest in their minds helps them feel motivated to learn insightfulness. Development becomes stimulated by love, not just frustration. In this way, thinking and self-reflection are intersubjective.

Others have suggested that this relational potentiating of mentalization can best be understood by utilizing Vygotsky's concept of the zone of proximal development (Wilson and Weinstein 1992a, 1992b, 1996). This concept has been used to refer to a set of interactive processes between analyst and analysand that promotes psychological functions or processes in the analysand sim-

ilar to the way in which a child learns from important others in his or her life. Essentially, the state of being in the zone of proximal development between child analyst and patient

> . . . calls to life in the child, awakens and puts in motion an entire series of internal processes of development. These processes are at the time possible only in the sphere of interaction with those surrounding the child . . . but in the course of development they eventually become the internal property of the child. [Vygotsky 1956, p. 450, cited in Wilson and Weinstein 1996, p. 170]

That is, the analyst's ability to mentalize becomes internalized. For this reason, the relationship with the child analyst is unique and crucial in promoting the young patient's insightfulness. Not just any "other" will do. Through our understanding of the child's mind (based on what is implicit in his or her play, drawings, and so on), we provide him or her with our perceptions of how he or she feels and views the world (Miller 2000). This sort of interpersonal feedback both stimulates the child's curiosity about the workings of the mind and helps him or her to contemplate the workings of our minds. The latter aspect parallels the ways in which infants learn a reflective capacity by observing their caretakers' minds (Fonagy et al. 1991). Just as with his or her parents, it is the young analysand's sense that we care and are interested that leads him or her to be interested in our minds.

Ultimately, the resolution of conflict that allows the child to gain or regain the capacity for mutative insightfulness (mentalization) requires the analyst's facilitating interactions. Through the analyst's interventions, the child analysand realizes that his or her internal states can be recast into more advanced forms of representational self-knowing. Internalizing the analyst's knowledge of the analysand's mental workings (not just unconscious content) builds new structure and increases the young child's capacity for self-regulation. Self-definition, and hence self-regulation, develop as the child patient internalizes a thinking self from the interaction with the containing object.

Insightfulness via Play

Recasting insightfulness as the capacity to mentalize or to have a theory of mind broadens our understanding of the importance of play in promoting it in these young patients. Few of us are likely to agree that play alone is sufficient to bring about structural change and the regaining of the ability to mentalize. Nonetheless, promoting the ability for imaginative play in analysis does facilitate psychological health by enhancing the young child's access to and interest in the world of feelings, ideas, wishes, beliefs, emotions, fears, and so forth (Cohen and Solnit 1993; Mayes and Cohen 1993b; Scott 1998; Slade 1994; Yanof 1996). To the degree that our young patients are in psychoanalysis because their early development has interfered with either attaining the capacity to mentalize or with using that capacity in an unimpaired fashion, the ability to play and to fantasize freely becomes a guidepost or sign of analytic progress and mental health in the way that free association does in the adult.

Contemporary ego psychology posits the ability to have access to one's own associations in a relatively uninhibited fashion as a sign of mental health (Busch 1995, 1999; A. Kris 1982, 1990). Being able to reflect on one's inner workings with a minimum of restriction is a sign of ego expansion or mastery. Yet many, if not most, adult patients come to analysis lacking awareness of or interest in reflecting on their own or others' minds. Adults whom we decide to analyze are those whom we infer to have a capacity to mentalize that is being partially inhibited for defensive reasons. Thus, we often spend the opening phase of the analysis in teaching our adult analysands the importance of reflecting on themselves. In essence, we teach them that their minds' workings are both important and comprehensible. The analysis of resistance that characterizes ongoing analytic process generally involves working with our patients to understand their subsequent departures from self-reflection.

As child analysts, we do the same thing when we play with our young analysands. By assisting them in the development of a narrative in their play, we help them to consider various relational paradigms, to differentiate affect states, to distinguish different emotions, and to distinguish speaking from acting on affects (Miller 2000; Scott 1998; Slade 1994). When we help children articulate the mental states of the characters in their play and delineate connections between the characters' minds and actions, we promote our young patients' ability to see the inner world in action outside themselves in a venue that is less anxiety arousing. Young children's concreteness makes it easier to "see" others' minds (even imaginary others') than their own. They learn to imagine inner lives and that order can be created within. Learning to play coherently and meaningfully consolidates and integrates their inner world. Play helps to catalyze a freer internal processing of experience (Koch 1980). Thus, promoting young children's play, even without interpretation, helps them to see themselves and their world more openly and to reshape it actively within the play (Alvarez 1988; Cohen and Solnit 1993; Herzog 1993; Scott 1998). "It is by means of play that they are discovering what they feel, what they know, and what they want" (Slade 1994, p. 91).

Again, it must be emphasized that it is our playing as child analysts that promotes insightfulness. A play group will not do. We are able to use our knowledge of the workings of the mind to stay one step ahead in the play and to lead the child analysand to articulate his or her conflicts within it. Direct content interpretations are minimized with young children. Instead, we ask questions about a character's feelings or actions in ways that lead the child to realize the conflict expressed within the play. In this way, a subjective sense of self expands and coalesces while new cognitive-affective integrations occur (Neubauer 1993).

Even when we do interpret, our interpretations are often not classical interpretations of repressed content. Instead, interpreta-

tions are utilized best by young children when they refer to the here and now and are within the play (Joyce and Stoker 2000; Miller 2000). Interpretations that ask these young analysands to step outside the play and reflect on what they really think, feel, believe, or wish can be disruptive and can interfere with insightfulness. "The child can in pretend mode use his growing capacity to mentalize without the immediate threat to his internal equilibrium that might arise as a consequence of too direct reference to internal experience" (Joyce and Stoker 2000, p. 1148).

As mentioned above, Mayes and Cohen (1996) have found that a number of mental functions occur earlier in play than in experimental situations in the real world. Cognitive attainments such as knowing that people act on the basis of an inner world are demonstrated more easily when the child is in the midst of imaginary play. Fonagy and Target (1996c) suggest that the young child can tolerate experiencing the mind as representing ideas, desires, and feelings so long as it is "just pretend." The pretend mode in children's play is characterized by the child's assumption that the internal state being depicted has no relationship to the outside world and no implications for it (Fonagy et al. 2002). If such internal states are experienced as real, the young child feels anxious because his or her developmental immaturity remains at a mode of psychic equivalence wherein ideas are experienced as real. In the psychic equivalence mode, the child assumes that his and others' internal worlds match external reality (Fonagy et al. 2002). Magical thinking makes the child's own emotions, impulses, and fantasies seem real and hence dangerous; murderous fantasies are lethal in this mode, for example. Only with cognitive maturity or analysis does the psychic equivalence mode become integrated with the pretend mode, so that the child learns to differentiate inner reality from external action. Such interpretation is necessary for mature levels of insightfulness. Thus, premature interpretation outside the play can cause anxiety because that which is interpreted can feel too real to the child and stress his or her affect tolerance too much.

Interpretations in displaced form are also effective because displacement is a defense that continues the child's attempts at conflict resolution (Neubauer 1993, 1994). "Thus, while most defense mechanisms restrain drive derivatives, displacement places them where ego mastery over them may be obtained" (Neubauer 1994, p. 108). Furthermore, Mayes and Cohen (1996) remind us of the young child's cognitive immaturity, suggesting that play puts mind in an action context, more readily perceived by the young child for whom action remains a concrete mode of thinking. Interpreting outside the play can confuse the child and cause anxiety because the young analysand may not yet understand that play reflects his or her own mental states. "By staying within the play, the analyst stays within the form of mental action and at the level of understanding most available to the child" (p. 138). Busch's (1993) adage that interpretations must be within the neighborhood is as relevant to analysands of this age as with those much older. But the neighborhood at this developmental stage involves structure more than content.

By staying within the play with our young patients, we help them to integrate the psychic equivalence and pretend modes, an integration necessary for full mentalization to occur. Our interventions allow the child to see his or her fantasies or ideas represented in our minds, to reintroject those representations, and to make them his or her own (Fonagy and Target 1996c; Target and Fonagy 1996). Frightening ideas can be talked through and thought about in the play, gradually becoming recognized as inner phenomena, not real.

A brief vignette from early in the analysis of a sadomasochistic three-year-old girl illustrates this important technical point. At one point, the child played at having a pen tear up pieces of a magazine that she had brought in from the waiting room. She then tattled on the pen to me. I told the pen (not the girl) that I thought sometimes it felt it was very bad and tried to get me to be the boss of its tearing feelings so that it did not feel so

bad about itself. That interpretation stopped the ripping of the magazine. Then the patient threw a puppet into the closet for being mean. I said maybe the puppet wanted us to help her to be the boss of her mean feelings so that she did not have to feel so bad about herself. The girl agreed, elaborating the need for the puppet to be the boss of its mean feelings.

Interpretations like these, within the play and about here-and-now conflicts, helped this child learn to reflect on her own inner world and to articulate it to the point that she could address her anxieties much more directly with me and with her parents during the latter stages of her successful analysis.

INTERPRETIVE STRATEGY

Standard theory of interpretive strategy should be adhered to even when we interpret within the play. Interpreting defense before impulse is even more important when analyzing young children, because they are so easily frightened by their impulses and emotions and because they can so easily take an interpretation of impulse as an invitation to act (Miller 2000). Interpreting an encopretic's wish to "poop" on the analyst, for example, runs the risk of the young child's trying to enact the wish. In part, it is the fragility of this distinction between fantasy and action that renders interpretation of impulse so frightening to young children. And the superego should also be addressed early on in an attempt to promote insightfulness (Sugarman 1994, 1999). The interpretation of the above-mentioned little girl's superego-based wish for me to help her control her tearing impulses is one example of how the superego can be addressed in these children early in an analysis.

Unlike attempts to promote insightfulness with older children and adults, however, the point of such interpretive strategies with younger children is to allow the prelatency analysand to gain a theory of mind, more than to render the unconscious conscious or to promote ego ascendancy over the id. Defense interpreta-

tions simply allow these patients to reflect on themselves (their defending selves) without being overwhelmed by anxiety about what they might find. Certainly, such interpretive work allows the emergence of impulses, affects, recriminations, and other defended contents to emerge in the play also. And these are taken up in turn. But what is insightful is the expansion of the mentalizing process, not the ability to represent any particular mental content.

Likewise, the young child's immature, drive-laden superego is a significant obstacle to the capacity to mentalize. The more sadistic and primitive it is, the more anxious and/or narcissistically depleted the young child will be when he or she attempts to examine mental processes in the session (Marans, Mayes, and Colonna 1993). The self-knowing and later self-observation necessary for mentalization require a more benign superego. "Acknowledging one's inner reality becomes too risky because of the superego attacks that might be stimulated by conscious experience of impulses, wishes, and fantasies" (Sugarman 1994, p. 332). But, again, the point of superego interpretation is less to make conscious any particular superego injunction or the impulse against which it is deployed, and more to help the young child realize that he or she has guilt feelings that are part of the mental world. Certainly, superego content must be addressed in order to gain awareness of guilt feelings. But the emphasis is on self-knowledge. Gaining self-knowledge of one's guilty self expands the child's understanding of the mind, allows greater self-reflection without feelings of guilt, and increases self-cohesiveness.

CONCLUSION

In conclusion, the role of insightfulness in bringing about structural change is as important in the psychoanalyses of the very young as it is in the treatment of older children and adults. But the nature of insightfulness, as well as its technical implementa-

tion, is different with prelatency children. Their developmental immaturity interferes with their capacity to mentalize and to have a well-articulated theory of mind. Furthermore, the developmental issues and experiences that have contributed to their needing analysis can also lead them to defensively inhibit this crucial mental function. Thus, insight into any particular mental content has limited utility because the child does not yet understand the importance of his or her own or others' internal workings.

I have suggested that a more relevant definition of insightfulness with children of this age is the gaining of the capacity to mentalize described by major researchers in the field (Fonagy and Target 1996c, 1998; Mayes and Cohen 1994, 1996). Once we have helped our young patients to gradually gain access to this capacity, or to regain it after it has been defensively inhibited, they can master all the other important developmental accomplishments for which it is a prerequisite. The developmental process can then resume.

This definition of insightfulness broadens our technical emphasis to include any technical strategy that facilitates mentalization under the rubric of promoting insight. With this expanded technical emphasis, we find that it no longer makes sense to differentiate the provision of developmental help from the promotion of insightfulness in young children. The former sort of interventions are just as geared to the facilitation of a theory of mind as are the latter. Preadolescent children vary a good deal in their capacity to express and understand conflicts verbally (Mayes and Cohen 1993b). Therefore, the child analyst resorts to many techniques in addition to verbal interpretations to promote insightfulness. Forming a therapeutic alliance in which it is both safe and important to know the inner world, facilitating imaginary play in which all kinds of mental states can be represented freely, and putting words to mental states—including the anxieties and superego recriminations that make mentalization intolerable—are all facilitative of mentalization.

At times, the child analyst may even be called upon to set limits and/or intervene behaviorally with young children to concretely confront their beliefs or anxieties about the omnipotence of their impulses (Sugarman, in press). Containing an out-of-control child's behavior in a session can be a concrete interpretation that the child wants the analyst to control his or her behavior via this interaction. Such interactional interpretations may promote more internal processing than would verbal interpretations with certain children or at certain times in an analysis. In the words of Mayes and Cohen (1993b):

> At the very least, the child analyst serves not only as observer and interpreter of the material the child presents within the hour, but often is called upon actually to participate in the child's play, to keep the child physically safe during moments of intense anger and frustrations. [p. 1235]

Each of these types of interventions promote insight as it has been defined above. They do far more than provide developmental help. Relationships can be as effective as verbal interpretations in modifying representational structures (Fonagy 1999).

Words do remain crucial in the analysis of young children, particularly in the promoting of insightfulness. But the point of putting what the analyst knows into words is different. Our words are a necessary accompaniment to the other interventions mentioned above, in order to focus the young child's attention on his or her mind as well as the analyst's. Content becomes important insofar as verbal comments that are ill timed, unempathic, too anxiety provoking, or simply wrong will fail to make the mind a safe or interesting focus for the young child. But the point of content is to facilitate process or function. In many ways, this approach to defining insightfulness is quite similar to those of some contemporary ego psychologists who emphasize the importance of facilitating the ego's expansion rather than the making of unconscious contents conscious (Busch 1995, 1999; Gray 1982, 1986;

A. Kris 1982, 1990). This approach differs in form only because the young child's immature ego requires interventions that involve concrete action or play as an intermediate step to thinking of mind. Nonetheless, thinking of mind—that is, insightfulness —remains mutative in child analysis.

As Busch (1999) points out, the patient's freedom to use his or her own mind is the most crucial part of the change process. To promote this freedom with young children, we must intervene in a cognitively and emotionally meaningful way. When we do so in the ways described above, we are promoting insightfulness.

Acknowledgments: The author wishes to thank Drs. Jodi Brown, Fred Busch, Jack Novick, and Stephen Silk for their helpful comments.

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Psychoanalytic Quarterly, LXXII, 2003

ON BEING LONELY: FEAR OF ONE'S OWN AGGRESSION AS AN IMPEDIMENT TO INTIMACY

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This paper considers loneliness from the point of view of compromise formation and the development of fantasy as a means of defending against painful affect. Our idea is that at least one strand of loneliness derives from longing for an ideal object with whom one would never have to feel aggression and from whom no aggressive actions would have to be tolerated. The development of such a fantasy in a middle-aged man is traced to early loss of a parent with missed mourning, and is shown to be ameliorated by psychoanalytic treatment that allowed the mourning to take place.

> Loneliness razors into each
> sunup, every sunset,
> and, like a pitiless sword,
> with its victim—my heart.
>
> —Gordon Parks (2000, p. iii)

INTRODUCTION

Loneliness is limited neither to those who come to psychoanalysis or psychotherapy complaining about it, nor to those who are alone. Although many patients who complain of loneliness are women (Lieberman 1991), we want to show that loneliness is an equal-opportunity misfortune, available to men as well as women.

Some people complain that they cannot find the right person to share life with; others do not want to share their space; others believe that no one could stand being with them full-time—but not having someone may leave all of them feeling lonely and/or ashamed (Gillman 1990). We offer the idea that loneliness protects against the dangers of loss of control of aggressive impulses toward the person who represents the ideal object, and that interpreting the fear of aggression toward a loved one may alleviate the need to defend against this fear.

CLINICAL CASE

While sociological studies (Weiss 1973) and psychoanalytic ones (Lieberman 1991; Rucker 1993) document the statistical chance that a woman is more likely to be alone than a man, the experience of loneliness is not limited to women, as mentioned above. Many men, single and married, suffer from isolation and fear of intimacy.

One such man taught us a great deal about both aloneness and loneliness when I treated him for several years.[1] Mr. A was a political scientist and an activist on behalf of oppressed poor people. His days were filled with meetings and productive interactions with his constituents and colleagues. He had a loyal, long-term staff. He had never been married when he came for analysis at age forty.

The analysis succeeded a twenty-year psychotherapy with a male therapist, who retired and suggested to Mr. A that he would benefit from more intensive treatment. Mr. A longed for a family, and in spite of his professional success, which he attributed to his own hard work as well as the benefit of his long psychotherapy, he considered himself a failure in his personal life. He entered a four-times-per-week analysis on the couch, which con-

[1] This patient was treated by one of us (A.K.R.), but the discussion reflects the views of both authors.

tinued for five years, with the stated goal of "getting a personal life."

In the second year of his analytic treatment, Mr. A reported that since his teen years, he had spent a lot of his free time playing a private game of imaginary baseball. This consisted of being alone and imagining a baseball league with teams and players whom he made up in his head. The players all had batting averages, the teams played on a regular schedule, and he enjoyed watching their season unfold in his mind. This activity kept him company during long, lonely weekends, and often in the evenings as well. We talked about his baseball league very often. At first, it seemed to make up for his lack of friends, but as time went on, he recognized that he preferred it to getting too close to people. He was capable of working closely with others, but only in groups and when there was a project to accomplish together.

Before the specific session to be described, Mr. A had been thinking that the baseball league pleased him because he was in complete control. His father had died when he was three years old. He and his younger brother had grown up with their widowed mother, who had been subsidized by her own family of origin so that she could stay home to care for them. He recalled always having felt the lack of a father. He thought that their family was poorer than the neighboring ones because of the lack of a father. Thus, he came to analysis seeing himself as the victim of a social system in which women did not work and therefore had less money than men, and in which children of single mothers were poorer than children of two-parent families. In the early sessions, the analyst refrained from challenging these ideas. They veridically described his experience. Pushing him to see that there were more personal reasons for his isolation, or even that he was isolated, would have been too great a blow to the self-esteem he derived from his belief that he was mastering his loss by seeing it as a social problem. What ap-

pealed to him about this compromise was his belief that he could be a savior to disadvantaged youngsters who had not had a fair start in life because of this social inequity.

In the course of treatment, Mr. A began to complain that the sessions were boring. The analyst agreed with him too much; the sessions were not challenging. He was not learning anything new; he was only hearing himself reflected back. He recalled his earlier therapist, who had confronted him more, made more challenges of his rationalizations. At this point, I thanked Mr. A for his supervision and began to ask what else his social isolation might mean for him personally in relation to his own development. I said that the exploration of more personal meanings would supplement and deepen his understanding, without replacing or denying the social problem that he so clearly saw as important for any young man who had grown up without a father.

The patient's stories about himself featured ways in which he had escaped his home: by staying in friends' homes, by going away to camp in the summers, and eventually by leaving home to be on his own in a very adventurous way that furthered his social activist goals. I asked whether he had substituted more neutral, nurturing contact with social groups for the highly charged emotional atmosphere of his home. In this context, he began to talk about how his mother beat him when he was a little boy. Now he emphasized the event that had brought him into his first treatment: the day late in his adolescence when he had first hit back. Hitting back ended the abuse, but frightened his mother; she had then sought out a therapist for him.

In a way that was similar to the patient's discussion of his use of neutral social group settings and social theories as better for his development than his home environment, I suggested that he had used his first therapist as a protection against his rage at his mother and her rage at him. He had begun to utilize that therapy to explore his own options—but mostly, he wanted

the therapist to act as a father to protect him from his mother's beatings.

Mr. A gradually began to see that he had needed a father for protection against his mother's seductive intrusiveness as well as her physical abuse. We explored his resentment of his mother's insistence on inspecting his stools until he was six years old. We came to understand his need for control as a reaction to the feeling that she had too much control over him. We saw this in the transference as well, as he refused to come for morning sessions and frequently requested rescheduling. Later, he described his brother's inexplicably fond memories of their mother; he believed that his brother was never beaten. Why would she treat them so differently? He recognized that he himself must have had something to do with it.

The gradual nature of Mr. A's change was indicated by these progressive reframings of his early life and of his current defensive patterns. In both the earlier treatment and in the current analysis, he continually attempted to understand how he had managed to survive with the bad mother he believed her to have been. He had alternating views of his mother: sometimes he saw her as all bad, while at other times, he saw her as attempting to be a better parent in a self-defeating way.

A Key Session

At a time when the patient was seeing his mother as abusive and her abuse as the major case of his distancing himself from other people, the following hour took place.

PATIENT: Oh, did I give you the check?

ANALYST: Yes. On Tuesday. Or was it Wednesday? No—Tuesday. And I gave you the insurance form that day. [Here I am thinking that I should recall the exact day and that Mr. A might feel wounded if I do not. Confused, I think that he wants me to

focus. He has been talking about insurance all week. It seems to me that he is asking for reassurance about the safety of the analysis in testing my memory. I am relieved to recall the day and want to reassure him.]

PATIENT: I continue to feel relaxed. It's strange. I have nothing to feel relaxed about. I brought my car in to be fixed. It hasn't been fixed since the accident. Not that it will take much fixing, but they never give you the right time. So I didn't get to the dentist. That's the other thing I was going to do this morning. I never know how long it's going to take. This is a simple cap. I can't tell whether it's his fault or the people who made the cap, his lab. If I can't have any idea how long I'm going to be at the dentist . . . What right do I have to miss a couple of hours of work? I pressure myself. It all started with the car accident. I was hurting myself then.

ANALYST: Mmm-hmm. [I am thinking that Mr. A is unused to being annoyed without having a tantrum, as with his annoyance at the car mechanic and the dentist.]

PATIENT: I went to the office. It was all decorated for Christmas, and I was aware that the staff did it to please me. I really love to have that. There was a new, big tree and all the office doors were covered with gift wrap. And lots of wreaths. I do it so well every year. And this year they did it for me. All these people want is my praise. Where do I miss their needs?

ANALYST: Am I missing it?

PATIENT: What? What does that have to do with it?

ANALYST: Am I missing your need for praise from me? [Here I am trying to find out if he can experience anger at me while in my presence without having a tantrum.]

PATIENT: Well, not as much as I need or want. You don't do enough, maybe. Barry wanted me to meet people from Bos-

ton who do videos of interactions. Everything revolves around asking what I'm doing right, not what I'm doing wrong.

When I was training, I had a professor in urban anthropology who was always asking what went wrong, not what went right. I was a good researcher—I worked with young adolescents. There was this kid in the group, Frankie. Everybody made faces at him. They hated him because they were rough kids and he was this goody-two-shoes. He was a big kid, bigger than them, and he went to parochial school and got good grades. Even I hated him because he was always so nice to me—an ass licker. I went to this group and I helped the group tell Frankie what they didn't like about him. It was good that they put it into words. So this professor called and said Frankie's mother had called her and wanted to know what I did that made Frankie fall to pieces.

So they kicked me out and I had to go to another place to do field study. And my professor there, I showed her my first report, and she said, "What do you think of it?" She wanted me to pick out what I was doing that was helpful. It charmed me. After two or three of those comments, I asked her what was wrong in what I did, and she told me to criticize it myself, ask what I didn't like about what I had done. It charmed me and disarmed me. I knew it worked on me, so I did it when I worked with the kids. And when I taught.

I was replaced at my first placement. I had to go to the dean and my mentor told me to go in there and say it was all my fault and I would not do it again. But I said I should just stay there and shift my major to social advocacy or political policy and fix up the organization. My boss there said she'd hire me tomorrow. The dean said something that changed my life: "Mr. A, when are you going to take responsibility for your actions? It's up to you to survive to take care of the kids you care for." Later, I got to teach unskilled minority students and I just did what my professor taught

me. I used to help my research assistant when she worked with the gangs and I showed her how to do that. I don't need that video bullshit. I know I don't praise my staff enough.

I hated the psychoanalytic bullshit that used to go on in school. When I was in the group home, it didn't work. The whole life of the home was analyzed every day. I took the model from Redl—there were no rules. We decided what to do in each situation as it happened. There was this multicultural, multiracial staff trying to do everything. The staff was furious at me. I finally said to myself: "Look, they're the ones who have to be there at 3:00 A.M." The staff was scared; the kids were out of control. This nice staff person got a black eye. I had told them they had to put their body between the kids when two kids start to fight. She did it, but she waited too long, so she got hit. I know it's very hard to be a child care worker. Psychologists and social workers and even anthropologists look down on them.

After that, I changed everything. I had the workers make a set of rules themselves, only I insisted that they show them to the kids. I would side with the kids, but then I saw I had to understand the staff too.

ANALYST: Just as I make the mistake of siding with you against your mother when she was on duty twenty-four hours a day, seven days a week, all alone. [Here again I am attempting to enable Mr. A to safely experience his anger at me. Is this too confrontational? I think that he has almost made the inference in his remark about the house parents.]

PATIENT: No. The staff was not like my mother!!!

ANALYST: Neither was your mother. [Bingo. He is expressing his anger at me toward me, without displacing it back onto his mother. I push him a bit farther, and he is angry but does not explode.]

PATIENT: Yeah? Like Tammy [his chief of staff]. I was provoking her; I see it now. It was subtle, but she reacted to it. I could

apologize, but I did it again. I would just forget some of the people she told me to call, or I wouldn't do it when I was supposed to. She's weak in meetings; she needs me to be there. I've tried very hard in the past two weeks. She's been warmer in response. I had a professor once who was a gentleman. He'd ask me how I was doing and tell me about his life. I knew he was interested in me.

When Tammy gets down to business right away, I feel down. She does this thing where she puts me down by saying: "Did you do this yet? Did you do that?" Then she finds something I didn't do. It's inevitable—there's bound to be something. Then she can put me down.

My staff could be videotaped and see themselves and ask, "What did I do wrong?" I know Jason needs more praise. He showed me a sports trivia game he made up. It's good to teach reading and study skills; he's got the idea.

I remember a time with my mother when I was older—I wouldn't do it when I was younger—but my mother wanted to take me to a Greek restaurant up the hill for my birthday. I wouldn't go. She used to take us there for a treat. Then she would make us order the most expensive thing, even if it was not what we wanted. When I said no, I saw her hurt. I felt bad because she did care for me and wanted to do something nice for me. I feel mad at what you said. [He cries.] I can't forget all the terrible things she did. She threatened to throw me out and give me away.

ANALYST: So you provoked that in school and at your jobs. You got yourself thrown out.

PATIENT: [Sobs] What? What?

ANALYST: When you see her as all bad, you protect yourself from your longing for her. [Here I wonder whether I have it mixed up. Is the anger defending against the longing or the other way around? I decide to think provisionally that each defends against the other.]

PATIENT: [Sobbing] When?

ANALYST: Now. Here. With me.

PATIENT: [Sobbing] When I was nineteen—when I knew I had to get away from her. I was better off that she died. And with Dr. L. He helped me by not saying, "You are a bad person." While I was seeing him one day, I got angry at my mother and threw jelly beans all over the house. I knew it was good. Other times I had hit her or hurt myself. But she called Dr. L and demanded to see him, only he refused. Good technique! He knew it was not right to do family work and individual together. She was so paranoid. She'd say, "What's going on between you and Dr. L?" In the session, he asked me what happened. WhenI told him, he was shocked. He said, "That's all?" I'm so angry with you right now—I'm this little kid who'll never get over what my mother did to me. I don't want to give it up, and you're telling me to give it up.

The other night, I was with Mollie on the subway and I saw this little girl crying because she didn't know where her mother was. Then we saw her mother; she was stoned. All made up, looking a little like a prostitute. But she didn't care that her daughter was crying—she didn't care, no. I said, "She's stoned." Mollie was just like my brother: "How do you know?" I said, "I know! She's a fucking piece of shit. She's stoned." I was angry at the kid for clinging to her mother. But how could she know? She's looking for her mother when she isn't stoned—when she's good, when she takes care of her.

ANALYST: Good. Have a nice weekend. See you Monday.

My intervention about whether I was included in Mr. A's feelings about his staff surprised him at first, but on reflection, he was able to realize that he had also been talking about himself and me. The patient could then notice that he was not prais-

ing his staff enough because of a feeling that I did not praise *him* enough. In that intervention, I understood that he saw me as the mother-boss. This interpretation introduced a new dynamic in the session, eventually leading to material that opened the view of his mother as not all bad. This engendered an affective connection: there were now two people in the room, collaborating.

Achieving such a rapport is the first goal with isolated patients like Mr. A. Although rereading the account of this session leads me to think in retrospect that I may have been too active, or that I crowded too much into one session, it came after many years of preparation and did lead to fruitful interchanges.

Most important in my mind at this point was Mr. A's expression of rage toward the bad mother. This was to prove to be the theme of the next phase of treatment. We elaborated and specified the rage expressed in his uncharacteristic expletive, "She's a fucking piece of shit." The conviction that this stranger was stoned on drugs was likened to his impression that his mother had been depressed, evidenced by her smoking and engaging in compulsive card playing. His comment that the stranger's makeup was "like a prostitute's" expressed rage at his mother's sexuality. The subway was a place of dirt, noise, and danger. The whole vignette was used like a dream, as a nodule for associations.

The Ensuing Treatment

This session included themes that echoed other sessions, and that were important in the analysis even though they were barely represented in this single session itself. Interpretations were intended to link the session to preceding ones, deepening the meaning of what had already been understood about the patient's need to keep away from any intimate relationship—whether with a man or a woman. The major interpretation was the statement that "Not even your mother was your mother," which pointed to his fantasy of his mother as all bad.

Mr. A described his mother as bad in this session, using the woman in the subway as a metaphor for her (and for the analyst), although he knew that she had wanted to do something loving for him in taking him out to dinner. Both earlier and later sessions focused on the bad analyst who wanted to give him something bad. The image of the bad analyst was interpreted as a way for Mr. A to keep his original mother in mind, even though she was no longer present in reality, and as a way to understand the world he had constructed as a child. How did he come to see his mother as bad? The interpretation that the person in reality was not as bad as the bad mother of his fantasy had value; he cried when he heard it. She had become bad in Mr. A's mind when she left him by being depressed, and again when she left him by dying. Losing someone bad seems less painful than losing someone whom you loved and who loved and valued you.[2] While the analyst understood this in Mr. A's case as a fantasy, a Kleinian analyst might have considered it an integration of the good and bad objects, which healed the split and resulted in achievement of the depressive position (Klein 1963).

The preceding vignette encompasses a hypothesis that would be elaborated in later sessions: that the patient's picture of his mother was colored by an even deeper anger at his father, who had abandoned the family when Mr. A was a toddler. Thus, the longing for love from a father was a compounding factor, rendering insatiable his longing for his mother's love. At the same time, his rage at his father intensified anger at his mother for imposing limits on his autonomy and for failing to provide him with a father, as well as for her inattentiveness during her mourning over the loss of her husband.

As Mr. A came to understand the extent to which his feelings toward his mother were colored by the displacement of rage from his father onto her, he began to see women in his current envi-

[2] The bad mother is a fantasy that Arlow and Beres (1991) discussed as one created to defend against loss.

ronment differently. He was surprised to notice that his deputy, a woman who stood by him through decades of political battles, was not the weakling he had thought her to be. He noticed that she was sought after for meetings and negotiations, and that her silence and reluctance to confront people were perceived by others as tact and empathic understanding. He saw that he had relied on her in the past to heal the wounds he had caused with his rougher, confrontational style. He reported that other members of his staff remarked on the change in his behavior. Gradually, he began to tell me about more contacts with friends and how much he enjoyed them.

The groundwork for this change in the patient's object relations had been laid by his identification with his previous long-term therapist and by his experience with his current analyst, and, most important, it was codified by a series of key interpretations. These interpretations were that: (1) his childhood transgressions were actually attempts to reengage his mother after she became despondent over the loss of her husband; (2) his image of his mother had been skewed by his fantasy, rather than being simply a veridical picture of her as a parent; (3) this fantasy was colored by his rage at her for being unavailable when she was depressed; (4) his displaced rage from his father to his mother reinforced his view of her as bad; and (5) her behavior toward him was acknowledged as unreasonable and provocative.

Mr. A's fantasy of his mother was thus modified by analytic interpretation. I think that my interpretations of the affective or drive aspect of his object relations were much more meaningful than the understanding put forth in his first therapy—that is, their development as a reaction to his truly bad mother of infancy. This view was also more accurate than my first understanding of Mr. A's fantasy of the bad mother, which was as a defense against sadness at her loss. It was the understanding of his fantasy in terms of his rage at his father for abandoning him that provided the impetus for change in Mr. A's current object relations.

Another important aspect of the treatment that followed the session presented here was a prolonged series of attacks on the analyst. The patient came late, forgot appointments, claimed that his effectiveness at work was being sapped by the emotional demands of the analysis, and generally evoked a concerned and sometimes intense worry. When the analyst recognized that her rescue fantasies were being mobilized by this apparent regression, the fantasy of the all-powerful mother came into the treatment. Mr. A had made his mother out to be omnipotent in order to protect him, the way other children had fathers to protect them. He made a constant effort to show both himself and the analyst that the analyst could not force him to come to his sessions, highlighting that it was the convergence of her rescue fantasy and his fantasy of being rescued that had previously fueled the treatment, but that now needed to be made explicit, let go, and mourned. He was able to relinquish and mourn this only very slowly—perhaps as mourning at last for the early loss of his father, while also mourning the loss of his belief in a rescue fantasy.

Expression of his rage and elaborations of its meaning alternated with descriptions of how the patient was increasingly able to deal more realistically with various people in his life. For example, he could now fire incompetent staff members without needing to humiliate them, and he could support certain constituents without starting fights with other constituents. He could do what he had earlier marveled at in other people: make up after a quarrel instead of cutting off the relationship forever.

A rage like Mr. A's has been described as characteristic of children who lose parents early in their development (Cohen 1990; Wolfenstein 1969). This kind of rage may appear when mourning for the lost parent has not taken place. Theory based on the absence of mourning asserts that children cannot mourn until they have achieved adolescence. However, it appears that later mourning in treatment is possible, and child analysts have

asserted that even young children can mourn the loss of a parent if they are allowed and encouraged to do so in treatment. As Cohen (1990) describes, there are some adults who have lost parents as children, missed the mourning, and consequently developed destructive rage, but who can mourn later in treatment what they did not mourn as children.

Mr. A's treatment focused on the modification of his rage, succeeding in modifying it as mourning began to replace the rage. I believe that it was this process that allowed him to see himself and others in a new way. No longer afraid that he would destroy others with his rage, no longer needing to see them as potentially dangerous provocateurs, he was capable of becoming more comfortable with and more generative toward others.

This patient's treatment followed an indirect and sometimes seemingly meandering path. For a period of time, the analyst needed to accept the patient's view that the reality of his commitment to his career barred his finding a mate. He used this reality in a way that women patients sometimes use their minority status, weight, age, infertility, or commitment to career as rationalizations for remaining alone. An intermediate stage in which the patient understands him- or herself as unwilling to settle for a less than ideal object can lead to the position evidenced in the session described above, when the patient comes to see that the fantasied mate is the perfect object who will never stir up the patient's aggression.

Mr. A's idea that he could have relationships only when they were governed by the rules of the game was a theme evidenced by his constant, obsessive, imaginary game of baseball. That theme was echoed by the idea that he could arrange for trainers to come to his office and teach his staff rules by which they could interact with one another. His observation that he could interact well with co-workers, but failed in his personal life, was one that the analyst related to the patient's fear of being abandoned by her, by his mother, and by other women in his life, as

well as by his father. He was observed to counter his fear of abandonment by isolating himself, so that he did in an active way what he feared might happen to him, thus turning passive into active. His longing for closeness was expressed in the baseball fantasy, which turned his aloneness into a world peopled with many competing men and an admiring audience.

Brenner's (1974) idea of loneliness as a longing for the return of a specific lost object implies that Mr. A's refusal to marry can be seen as an act of loyalty to his mother, who might return to him if he were to keep waiting for her; this view illuminates as well his having remained in the family home for decades after her death. Fantasies of resurrection surfaced at this point in the analysis in the idea of termination. If his mother could come back, his father could, too. His fantasy was of a blissful return to the time before his father's death, before his brother's birth—a time when it was just he, with both father and mother adoring their little boy.

Being angry at his mother and seeing her as all bad could easily have had its roots in the early loss of his father. As Mr. A progressed in analysis, the theme of the loss of his first therapist, a male, and the loss of his father became more prominent. The best way to understand Mr. A now seemed to be Wolfenstein's (1969) observation that rage predominates in the affective life of children who have lost a parent early and were unable to mourn the loss successfully. The interpretation of the woman whom Mr. A had seen on the subway as not so bad, and the statement that even his mother was not so bad, were elaborated so that he could then see how he had displaced his rage from his father to his mother. He understood his need to displace it onto her as a way of avoiding the loss of what little good feeling he might have had toward his father after experiencing his death as abandonment.

Mr. A's persistent quest for the lost parent was expressed primarily in his experience of his first therapist as a parental figure,

and secondarily in his repeated election contests at his work, in which he won his constituents' votes, thus giving him a job that he experienced as sustenance. Yet the initial long psychotherapy with no resolution proved that no one could help—a characteristic fantasy seen in those who have been unable to mourn early loss (Cohen 1990).

While the patient's rage was a defense against the utter despair of losing his father, achievement of this understanding took a long time, having gone through the route of first coming to an understanding of his mother's temper as a defense against her depressive affect at the loss of her husband. Once Mr. A was able to understand her as struggling to cope with her unmanageable feeling of loss, he observed that he felt less furious with her. This led to my remarking that he might feel less worried about whether I would accept his rage if he saw that I could understand it as a defense against his grief. Eventually, this in turn led to his accepting his own rage as a defense against his grief, and to the realization that he had controlled that grief for years and no longer needed to worry that he would not be able to keep it in check. This allowed the patient to build increasingly intimate relationships, both with people at work and with those in his social life. He was finally able to fill his life with individuals he truly cared about and who cared for him.

SUMMARY AND CONCLUSIONS

This case illustration shows one way of working with a patient who comes for analysis to deal with the symptom of loneliness and the sometimes concomitant feeling of inner aloneness. Loneliness transcends diagnostic categories, but it is most profoundly painful when experienced as inner aloneness. Both people who are alone and those who experience inner emptiness can be lonely, despite leading apparently full social lives. Loneliness can result from a longing for a perfect object with whom one

would never have to feel aggression. This dynamic is related to the early loss of a parent when mourning is missed and rage becomes the predominant affect. The interpretation of fear of aggression in relation to a beloved other may free the patient to try establishing intimacy with another, and the experience of the contained aggression of the analytic relationship contributes to the ability of the patient to discover, accept, and use such an interpretation. In the clinical example provided, the gradual working through of this insight via remembering, forgetting, refinding, and making discoveries in new situations was a long and painful one, but one that, according to the patient, was ultimately worthwhile.

Acknowledgment: The authors wish to thank the members of the American Psychoanalytic Association Discussion Group, "Toward an Understanding of Loneliness and Aloneness in Women."

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Psychoanalytic Quarterly, LXXII, 2003

IDEALIZATION AND PSYCHOANALYTIC LEARNING

BY ROBERT ALAN GLICK, M.D.

Idealization is an intrinsic part of psychological maturation, but it is also a potential barrier to psychoanalytic learning, and must to some degree be outgrown if an analyst is to develop a natural authority and individual style. Unrecognized idealizations stifle analysts' engagement in the transferences of their patients, and so compromise the ability to freely experience and analyze them. Attention to real life and the lessons it teaches counterbalances the tendency to idealize and encourages lifelong psychoanalytic growth.

Learning about psychoanalysis and about ourselves as analysts is a complex, lifelong process that requires, among other things, the working through of specific idealizations and of our needs to idealize. In this paper, I explore the impact of idealization on formal psychoanalytic education and on psychoanalytic learning in general. In addition, I suggest that attention to life lessons and accumulating clinical experience can counterbalance the tendency to idealize and can encourage psychoanalytic growth.

My thinking about this aspect of the process of working through was stimulated by an invitation to give a named lecture at my institute. It is a great honor to be asked to do such a thing and a great privilege. But the honor brings with it many questions and

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An earlier version of this paper was presented as the 45th Sandor Rado Lecture of the Columbia University Center for Psychoanalytic Training and Research and the Association for Psychoanalytic Medicine, on June 4, 2002, in New York.

self-doubts: What have I to offer that is worthy? Do I have anything sufficiently interesting and instructive to say to other analysts? As I struggled to balance the full weight of my anxieties and uncertainties (as well as the powerful contrary temptation to hold forth—to pontificate), I recognized a particular perspective on analytic learning that I wanted to explore. I decided to call it "the Polonius problem." How do we contend with the pressures and enticements that, in the long and anxious process of learning to be analysts, seduce us away from our difficult path—especially the temptations of idealization? How do we grow into our own authority? How do we gradually transform our life experiences—which include but must also transcend our necessary idealizations—into mature ideals and usable ideas?

In Shakespeare's *Hamlet* (1603), Polonius makes a very famous speech to Laertes about life in the real world, as the latter is departing for his education abroad. His advice, aimed to protect his son from painful errors, is lovingly offered, and in many ways it is entirely appropriate. But as Shakespeare artfully makes clear, Polonius's laundry list of aphorisms is empty, and the man who mistakes them for wisdom is tiresome, bombastic, and ultimately foolish. Vital lessons about life, and about life as an analyst, cannot be learned passively or statically. They must be lived in active and dynamic experience.

To learn about analysis and about ourselves as analysts, we must work through many specific idealizations, and more generally, our need to idealize. This need is woven into our experiences of necessarily helpful identifications, many of our countertransference reactions, and a variety of other phenomena that may compromise our analytic learning. We all struggle with the Polonius problem, from both sides and in both directions. We are both Polonius and Laertes, both parent and child, teacher and student, analyst and patient. We hear and we speak many aphorisms, but however lovingly they are offered, they cannot create useful and effective self-knowledge; worse, at times they may preclude it.

Now, in my investigation of the Polonius problem—my investigation of how analysts learn (or not) to be themselves, and of how idealization fits into this learning—I am not speaking of the general challenges of analytic education, but of the more individual ways that we learn what sort of analysts we are. And by *what sort of analysts we are,* I explicitly do *not* mean our identifications with prescribed frames of reference, points of view, or psychoanalytic schools—classical, neo-Kleinian, self psychological, relational, and so on. I am thinking about the process of how we get to know ourselves, how we both discover and create in ourselves a natural psychoanalytic style. This process is synchronous with and contingent upon the painful working through and humbling relinquishment of certain profound, cherished, and burdensome idealizations: about analysis, about our analytic heroes, and about ourselves. Polonius's best advice cannot save us from this—and may even make it harder.

Analytic learning, and its intrinsic wish for mastery, necessarily involves processes of identification with idealized icons of knowledge and power that for better or for worse are ubiquitous throughout our lives. Idealization (and its less respectable twin, grandiosity) are universal processes by which we make attachments, learn, grow, regulate self-esteem, and defend against impulses, dangers, and anxieties, particularly unconscious fears of shame and humiliation. Idealization is an important tool in our navigation of infantile fixations, universal positions, painful failures, and working-through experiences. In short, whatever one's school and one's resultant terminology, idealization is an important part of maturation. But if we are to achieve adult pleasures and values, and to pursue realistic (that is, realizable) ambitions, we must sometimes, however reluctantly, give it up.

Our wish to idealize and to hold on to our idealizations, while universal and easy to understand, poses potential dangers for analysts and can work against us in significant ways. Arlow (1982) wrote about how problematic idealization can be in training, and how mythologizing can lead in our institutes to indoctri-

nation. He warned that this can severely compromise analytic learning (see Kernberg [2000]). Idealizations are formidable resistances; they protect us from the "shame" of uncertainty and ambivalence, allowing us to maintain familiar and gratifying attachments to valued, powerful, and supportive objects. In this, we parallel our patients, who also wish for idealized objects, both old and new, that provide cherished familiarity or needed repair, and from which they can receive a sense of security and strength. But they, and we, pay for this security with some of our own autonomy and authority.

Freud (1923) conceived of the ego as "the precipitate of abandoned object cathexes" (p. 29), and I will go so far as to suggest that the core of analytic learning is the precipitate of abandoned idealizations. The familiar sources of analytic learning—one's own analysis, supervision, peer discussions, reading, consulting, teaching, supervising—all leave residues for us to idealize, and, as we shall see, to de-idealize.

Idealization has had a prominent place in the analytic landscape since Freud. Even in this day of contentious pluralism, it appears in every theory of mental structure and function and in every model of analytic process, especially the earlier ones. In fact, I sometimes think that our analytic predecessors had a much easier time than we do. They seem so certain, so clear, so authoritative in their understandings of the structure of the mind and the process of analysis. They invite us to trust them, and to idealize both their formulations and themselves. Our generation has neither the same self-confidence nor the same epistemological authority. We live in an analytic world in which we must acknowledge our subjectivity; it is a lens through which we have no choice but to look. It is a lens that can either sharpen our vision or distort it, and we cannot always or readily know which. And as I will discuss shortly, since we now know ourselves to be not neutral observers or unbiased interpreters, but influential participants, we must recognize that our own unconscious values and

potentially idealizing perspectives influence and shape the analytic process. Our participation is not only reactive, but proactive. And so we must work out a much more delicately nuanced relationship with authority, both within ourselves and in our analytic work, than was necessary in times gone by.

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In an effort to address the paradox of our simultaneous need to idealize authority and its distorting and compromising effects, I will explore two processes through which we analysts learn: first, analytic training, and second, "on- and off-the-job training" —that is, what we learn from our work with patients, and in a quieter and much less acknowledged manner, from our own lives. Both our patients and our lives offer us abundant opportunities for analytic learning.

ANALYTIC TRAINING

We all know that psychoanalytic education is difficult, demanding, and costly. The learning is hard, transformative, and thrilling. And it is an invitation—at times an induction—into idealization. Sometimes, as Arlow (1982) said, it is even an indoctrination. Idealization is an intrinsic aspect of analytic training. More than that, in some ways, it is deliberately encouraged, and it starts incubating insidiously even before training begins. My generation of analysts trained in what seems, looking back, to have been a more naive time, but for us the initiation into the idealization of analysis began even before we decided to apply for analytic training. Analysts seemed to us to possess powers of penetration and understanding that were as mysterious as they were profound. We were all well schooled in the process of taking exams and making application for professional advancement. But the process of application for analytic training was quite different, unlike anything we had prepared for or could really

understand. I clearly remember believing, and being encouraged to believe, that my acceptance (or rejection) would depend on the absence (or presence) of some basic indescribable flaw in myself, some deep and irreparable fault line in my essence as a human being. That flaw was the lack of something beyond adequate intelligence and motivation, the quality called *analyzability*. With that quality, I could become a member of the elect; without it, I would be banished as defective. The travels to various dimly lit offices on the Upper East Side and the interviews that took place in them retain in my memory much more the quality of vividly remembered anxiety dreams than of waking events. The interviews required submission to a stressful paradox: the more you could reveal about your doubts, your limitations, and your weaknesses, the greater the evidence of your potential for analytic health and eventual elevation to the analytic elite. So it began.

SUPERVISION

Once actually in analytic training, faced with the mounting uncertainty and insecurity that come with it, the need to idealize and to rely on the power of idealizable authority grows. I am fortunate to have had much excellent supervision as a candidate; still, the following very painful and therefore very valuable example of submission to an imposed idealization of analysis has stayed with me and has continued to teach me over the decades.

The patient was a passive and dependent man in his late twenties, whose sense of himself and the way he lived his life was decidedly and self-protectively boyish. His career was adrift. His father had died years before, and he relied on his mother for various forms of support. He had been living for several years with a somewhat older professional woman whom he felt he loved and who loved him.

Contending with our own and our shared anxieties, this patient and I created an analysis, and he was working in it and improving in his life. When evidence of a deeply troubling ambivalent homoerotic transference emerged, the patient became anxious about the nature and meaning of our relationship and about the value of the analysis. He announced that he and his girlfriend planned to marry—something she had wanted and that he had been stalling on for months—and that they would do it relatively soon.

My supervisor, instructing me in his view of analysis, had been inviting me to identify with him and his (I belatedly came to recognize) idealized sense of the analytic process. He was, I thought, wisely and helpfully teaching me about my role as steward or guardian of a unique experience. With more than a little awe, I had been learning to nurture, preserve, and defend *the analysis,* which remarkably to me, had been taking on a life of its own—something that, as a novice, I found both captivating and unnerving.

At this particularly dramatic juncture, my supervisor declared with intimidating authority that *the analysis* must be preserved and protected from the patient's insufficiently analyzed flight from the transference into marriage. I was instructed to tell the patient that if he did not delay the marriage by several months—until we had had sufficient time to explore what this development meant —our work together would end.

Here is the painful part. I dutifully but unhappily conveyed this edict, and the patient promptly and bitterly left the analysis. He was not the only one who was bitter.

My point is *not* that my supervisor, in telling me to stop the acting out or stop the analysis, was giving me problematic instructions—or worse, bad advice. It is that he was not teaching me how to analyze. Even if his directives had been good, he was not encouraging me to think about and experience what was going on for myself, or to consider crises in a new, and hope-

fully analytic manner. Like Polonius, he was giving instructions, and these may well have been painstakingly distilled from hard-won experience. But *I* was not acting from my *own* experience, or even from my own understanding of analysis. Rather, I was acting from an idealization of analysis in general and of his authority in particular.

There was a crucial subtext to this story. I myself had married early in my training analysis. This added to my unconscious identification with the patient and to his analytic vulnerability. Furthermore, my supervisor's rejection of this path for my patient left my faith in my own analysis and my own judgment temporarily shaken. (I learned years later that the supervisor had had a loveless marriage that was ending at around the time he was supervising my work.)

I also recognized—as a result of this experience, and for the first time but not the last—something important about my relationship to authority: that my idealizations and my attendant compliance, far from protecting me from all ills, could lead to painful disappointment in myself. This realization forced me to a wish to know my own mind.

I became aware as time passed that analysis is a collaboration and a negotiation—that analysis is about the mutative power that comes from the exploration of meanings and meaningfulness in self-experience. It is not an abstraction, some sort of refiner's fire separate from the vicissitudes of real life in which all neurotic impurities are burned away, leaving behind only complete truth and perfect health. Eventually, I was able to see that my supervisor had been right to try to teach me about the enormous power of the transference, a force to which we must attend at all times, but that he had been wrong about one thing: analysis is for the patient, not for the analyst—or even for *the analysis* itself.

This experience taught me several hard lessons. But even so, I have had to relearn them many times over. At the risk of being "Polonial," I would like to share them:

- Don't do anything in an analysis that you don't believe in.
- Know what you believe in and why you believe in it.
- Never assume that who you are and where you have been in life can be removed from the analytic process.

TRAINING ANALYSIS

If idealization is corrosive in supervision, it is even more dangerous in training analyses, where its presence and influence may be harder to recognize, and where the risk of narcissistic collusion between the unconscious needs of training analyst and candidate is ever formidable.

Considered the fundamental analytic learning experience, the training analysis is a most peculiar blend of apprenticeship, rite of passage, intimate emotional attachment, mentoring, and therapy. A training analysis is one place where the patient truly wants to be like the analyst, and where a healthy residuum of identification with an analyzing self is encouraged—in short, a training analysis is a situation ripe for insufficiently analyzed idealizations. (It must be clear that several tons of grist about my need to idealize were delivered to the mill of my training analysis by the supervisory crisis I have just recounted, and that its wheels needed to grind thoroughly and finely.)

Training analysis is supposed to set in motion a process that creates and propels self-reflection, maturation, flexibility, and emotional receptivity. It is also supposed to foster patience with and openness to intense interpersonal and intrapsychic experience. It is a crucible in which narcissistic illusions are investigated, and in which many, although certainly not all, of our infantile idealizations (and the grandiosities that go hand in hand with them) can emerge and give us pause. In the best case, these are then seen for what they are: residue of childhood wishes and fears, not facts or realities of adult life. Optimally, after going

through the complex and unsettling experience of suffering and surrendering our grandiosities and idealizations, we are left with ideals, values, and principles that can guide us in our work and in our lives. Idealization ultimately gives way to new modes of being. This process of suffering and learning is akin to Loewald's (1960) notion of the disintegrative and reintegrative experiences that are part of the therapeutic action of psychoanalysis —the destabilizations that are necessary for growth.

What about the results of training analyses? One of the common legacies of a training analysis is a lingering sense of disappointment in the analysis, or perhaps a wish to surpass the analyst. These are not bad or unexpected outcomes, and in fact are much to be preferred to a breathless sense of gratitude. Appropriate disappointment reflects a loss of the idealization inherent in the training analysis process. Similarly, the wish to surpass is a recognition that our analysts, like our parents, were limited by the times in which they lived, by their circumstances, by their educations, and by their own inevitably imperfectly analyzed narcissism. And this is a valuable recognition. Even after all the working through of individual idealizations, we still feel our struggles with the tendency to idealize. Again, it is not the loss of particular idealizations that is the profitable legacy of an analysis; it is the modification of the *need* for idealizing, which may endure long after the particular idealizations are gone.

In the end, successful candidates come out of training analyses with a peculiar and personalized set of skills that allow them to do, understand, and tolerate the work of analysis. They should also have acquired in the process the working "conditions of safety" that allow analysts to create the necessary atmosphere of safety for their patients. Patients can feel safe enough to expose intense and intimate transferences only when they sense that the analyst can bear them without recourse to outside authority. Therefore, conditions of safety for the analyst rely heavily on the working through of the need to idealize—the need to turn to

an internal representation of an "outside authority"—particularly in analytically stressful times that demand flexibility and resilience (see Smith 2001). As I noted above, the sense of security that idealizing affords can only exist at the cost of one's own analytic authority and autonomy.

DOING ANALYSIS

Effective analysis is usually not a situation of uninterrupted safety and comfort for the analyst. And as this is not a trivial consideration, I will turn now from the rewards and risks of idealization in our own development as analysts to the experience of our patients' idealizations of us. In our work, all manner of conflicts are evoked, activated, and otherwise brought to life. We are subject to the pressures, demands, and gratifications of our patients' idealizations and corresponding devaluations. There is plenty to be learned from this, but it cannot be learned Polonius-style. It is learned by experience, and very often the experience hurts. Our patients find every weak spot, every vulnerability that burdens us, every piece of insufficiently analyzed narcissism that encrusts us and therefore compromises our capacity to recognize certain transferences. An analyst's unconscious fears of shame and humiliation may keep him or her from allowing or recognizing or analyzing a patient's narcissistic conflicts with authority and his or her defensive need to idealize. And even when the analyst does not know that such an inhibition exists, the analyst can be very sure that the patient will do his or her best to challenge it, so as to engage the analyst more fully in the transference scenario.

On the other hand, sometimes in the service of resistance, our patients, like us, hope to let sleeping dogs lie, and idealization can serve that purpose, too. When we find ourselves feeling too comfortable, too effective, too good as analysts, we may be missing the more uncomfortable learning that would come from

the confrontation of their (and our) cherished defenses. Patients give us unending opportunities to continue our own analyses, and we should be grateful to them for this painful education.

But just as we must not wear our patients' idealizations too comfortably, neither, as Kohut (1966) warned, must we reject them too readily. We can like being idealized too much, but we can also avoid it too much. Neither is constructive. We must try to find a balance between the need for the constructive power of identification (both in ourselves and in our patients) and the equal need, eventually, to outgrow it. This tension in the analytic process can and should require us to pay careful attention to what we are doing and exactly whom we are doing it for. Our struggles to outgrow our own idealizations may help us appreciate our responsibility to provide our patients with both opportunities for necessary idealization and opportunities to relinquish it.

BEING A TRAINING ANALYST

When one becomes a training analyst, residual transferences from one's own training analysis can return like Hamlet's ghost, demanding attention and redress. Idealizations die hard. The inevitable incompleteness, the unfinished business of one's own analysis, may be revisited in the training analyses one conducts. As I have said, even after long analysis of the idealization crisis in my own supervision, my transferences to authority returned many times to walk the night. Indeed, Loewald (1960) continues my Hamlet theme with his notion that analysis should "turn ghosts into ancestors" (p. 29)—that we must let go of certain attachments while still retaining them as part of our evolving separate identities.

In my own experience as a training analyst, especially in the early years, I have sometimes been uncomfortable with idealizing authoritarian transferences. The mantle of that kind of authority is heavy and ill-fitting, and it invites insidious counter

resistances. While confidentiality forbids my offering any specific vignettes from training analyses, I reveal only myself in acknowledging that a familiar form of the Polonius problem for the training analyst is the temptation to supervise candidates instead of analyzing them. I have found this to be especially true when candidates, for complex transferential reasons, describe their anxieties about holding onto a control case. Easily recalling my own anxiety and anguish about "failed cases" in training, I tend to feel a strong pull to assist and protect. How easy it can be to puff oneself up behind the couch and offer the perfect intervention, the bon mot that will save the day for the candidate. How tempting and pompously gratifying to be the wise, benevolent analyst—but it is candidates' need to learn *for* themselves *about* themselves and the analytic process that is at stake when the analytic pair collude to maintain the mutually gratifying and yet inhibiting grandiose aspects of authoritarianism. My supervisory vignette is an illustration of just this type of problem.

BEING A TEACHER

Using our experience as members of a Freud reading group in the early years after graduation, Jerry Fogel and I (Fogel and Glick 1991) wrote about the process of idealization and de-idealization. We looked at the process by which what we considered the *theoretical identity* of an analyst is formed: that is, the implicit theoretical assumptions that organize and give meaning to clinical work. Our idea was that by taking Freud's measure anew, we would bring him and all our idealized teachers down to a more human size. As the group went through the complete *Standard Edition,* we felt as if we were looking over Freud's shoulder as he developed his ideas. Relatively young teachers, intoxicated by our growing theoretical and clinical sophistication, we became excited by his excitement. We felt as if his discoveries were

our discoveries. We were traversing the terrain of idealization once again, this time in a group and in the service of deliberately integrating our theoretical knowledge with our own maturing analytic experience. By applying Freud's ideas to our lived work as analysts, we gradually changed them from received wisdom into experienced ideas of our own. Eventually, we began to de-idealize Freud in this process, and being able to more clearly see our idealizing transferences to him and to theory had a significant impact on our teaching—which we felt became more open, more effective. Reading now as practicing analysts and analytic teachers, not as idealizing students, we could try to test Freud's insights, which began to lose their iconic quality to become our own.

Now, nearly a dozen years later, I recognize that paper as a coming-of-age document, a rite of passage, our personal solution to the Polonius problem, if you will. I remain convinced that the synthesis and integration of theory and clinical work are lifelong processes that require effort, patience, collegial support, vigilance, openness to experience, and the humility that follows on those. I feel much less burdened now than I did by the weight of all those idealizations—of Freud, teachers, supervisors, mentors, analysts; time and experience have indeed continued the process that Jerry and I, as relative neophytes, described with such passion. It is also true, as I have noted, that today I am aware as well of the other side of the Polonius problem, and my challenges seem to have more to do with my dealings with myself as an authority who feels the heat of the idealization and de-idealization processes in others. As in all analytic dealings with idealization, there is plenty to be learned about one's unconscious needs and predilections from both sides of the process. My struggles about what would be worthy enough to comment on here showed me again—as if I needed any further convincing—that these issues never die. We remain always in the middle of all of it, in a lifelong process of wishing to ideal-

ize and to be idealized, of fearing the same, and of searching for ways to deal constructively with the experiences of shame and loss that are often our lot.

The kind of analyst a person is goes well beyond the espousal of any theoretical point of view, and has to do with a subtle but deep analytic self-functioning, what has been called implicit relational knowing (see Stern 1998). This includes the procedural modes of relating that shape our interactions with others and with ourselves—in other words, our tone, our style, our coloration, our posture. It is loosely analogous to the way that, if you are a tennis player, you know how your body tends to come in under a serve; or if you are a writer, the way your imagination uses an incident in real life as a starting point. More pointedly, it is in your manner and style as lover, partner, spouse, parent, or colleague—your biases, values, and attitudes—your character structure. It is related to, but not limited to, a conscious sense of what kinds of patients or problems you do or do not like to work with, a set of analytic predilections reflecting your strengths and weaknesses.

Racker (1957) implied this in his classic exploration of countertransference, when he spoke of the analyst's "personal equation" (p. 354); so did the hermeneutic philosopher Gadamer (see Friedman 2000) in what he affirmatively calls our prejudice. Implicit relational knowing consists of all our own wishes, fears, needs; how we load the dice and how we play the game, the biased lens through which we look at life. As I noted earlier with regard to our distorting idealizing lens, we as analysts must remain vigilant not only of how we respond to our patients' impact on us, and not only of what we find in the analytic situation, but also of the ways in which we direct, shape, and create one kind of analytic process or another—what we carry with us and bring into the analytic situation.

Greenberg (2001) looked through an interactional lens at the evolution of analytic ideas about therapeutic action and analytic

goals. He suggested that we are less secure about the former than we are about the latter, and that our uncertainties about the active ingredients of our analytic work create an inescapable tension. For Greenberg, this tension is situated between our problematic "natural inclinations, on the one hand, and the unattainable but prescribed professional stance of abstinence, neutrality, and anonymity—on the other." As analysts, we live in tension. We must not try to avoid it or deny this fact; it is true and useful, if not pleasant. "The tense analyst is likely to be the best analyst," concludes Greenberg, but he cautions against the ideal of the "tormented analyst," as "too much conflict will inevitably breed distraction." It is in navigating these crosscurrents, not in following other people's rules, that we learn about maintaining our analytic equilibrium, and in the process, about analysis and ourselves.

I suggest that this tension, this unavoidable dialectic in which we function, is a major stimulus of our continuing education: we learn most from the ambiguities, the uncertainties, and even the dangers of analysis. We are subject to more occupational hazards and on-the-job stresses than just bad backs. Out of the intense pressures of the transference and the need to preserve our own sense of safety and satisfaction and to protect our self-esteem, we seek to lessen our own tensions in subtle, pervasive, and sometimes opaque ways, which may fall anywhere along a broad spectrum of idealizational vicissitudes. The bad habits of mind —the bad analytic hygiene, if you will, the "repetitive emotion" disorders that we develop in response—can include residual overvaluations of beloved teachers at the expense of our own independence of thought, acceptance of our patients' positive transferences as true, the belief that analytic understanding transcends everything else and that insight equates with strength of character, and so on and on and on.

This brings me back to Polonius and his untimely demise. He meets his fate while concealed behind the curtain in Ger-

trude's chamber—that quintessential oedipal bedroom—while seeking to learn the truth of Hamlet's madness, the secrets of his lovesickness. Hamlet, for his part, was hoping to avenge his dead father by killing the hated uncle, his latter-day oedipal rival. It all ends up as a tragicomical mistake, and I must again try to resist the temptation to push the analogy too far, to wax Polonian. But I can fairly say that in *Hamlet*, authority dies with the death of Polonius, and that authorities *must* die—or, more kindly, they must let go their hold on us (and we must let go our hold on them), so that we may learn our lessons through our own experience.

SELF-ANALYSIS AND COUNTERTRANSFERENCE

So what are analysts to do? We work in a situation where participation is inescapable, where everything we do (knowingly or not) affects the analysand in more ways than either of us can *ever* know, and certainly in ways that we can never predict. How do we undergo what Kohut (1966) calls our "forms and transformations of narcissism" (p. 243) into wisdom, tolerance, flexibility, and humor? How do we acquire the tools and learn the skills for this continuing self-scrutiny, our "autodiagnostics"? Analysis is hardly a foolproof field when it comes to validating our hypotheses about what is going on in our patients—or in ourselves. What protects the conscientious analyst from self-justifications and self-fulfilling prophesies? That is, how do we learn to see more clearly what may be useful to the patient, and not only what we need to find?

I spoke earlier about the sources of analytic learning, and I want to connect them now to countertransference and self-analysis. If you ask analysts how they learned, they will tell you: "From my analysis (mostly), from my supervision, from reading, from peers or consultation, from teaching and supervising." If you

ask them *what* they learned, however, they tend to tell stories about particular experiences with patients that unsettled them or surprised them, usually experiences in which they made some mistake or revealed something about themselves—often to themselves, and sometimes to the patient. They describe situations in which they got glimpses of themselves, usually accompanied by some form of discomfort or suffering, from a different, more objective perspective. In other words, the *what* is usually some slight or large blow to a narcissistic aspect of the self, to some assumption of knowledge or presumed influence that is proven to be illusory. The *what*—the painful but important lesson—is learned from life, not from theory or technique. And further, it illustrates the *how*.

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Here is a vignette that describes an everyday kind of situation in the life of any working analyst. The patient is a man who has been in a helpful and progressively deepening analysis for a couple of years. He views me and the experience in a positive light. He has been able to feel increasingly free in his life, less inhibited and afraid of his own impulses and of doing harm or injury to others. The particular session I will describe comes during a week when he has been exploring his fears of making some assertive financial decisions.

In an effort to deepen his understanding of his dilemma, I have been suggesting that he is again afraid, both within and outside the transference, of the consequences of his aggressiveness and competitiveness. I sense that my interpretations, while generally right, fall flat. I have a feeling, which grows during the session, of vague sadness and ineffectiveness. At the end of my day, I have a sense of disappointment in myself as an analyst—not a unique experience. Driving home, I find that the patient seems still to be with me, and I feel burdened and irritable. It fades; I get home. At dinner, my wife and I catch up on the

day, and she tells me about a call from our son, a grown and independent man with a family. He had reported that his work was going well and that he was quite likely to be getting a raise. I was planning to call and congratulate him when the patient and our session came back to me. I had a fleeting fantasy of wanting to call the patient and congratulate him, too. What I realized—actually, what I *felt* and could now more fully appreciate—was that the patient needed *his* evolving independence to be recognized. He did not need to be reminded—once again—of his fear of his aggression.

I was aware that I was losing my son, at least his need of me; perhaps I was also beginning to realize that he would one day surpass me. This insight felt true and meaningful when applied to my patient as well. The real issue was not whether or not to call the patient or to congratulate him in the next session. Rather, I had come to terms with my countertransferential inhibition about recognizing his process of separation from a benign authority and his craving to have this recognized. I had been unaware until that moment of the absence of this transferential theme in the analysis.

My countertransference resistance, it is clear, obscured my seeing what was going on between the patient and me. Moments like this are hardly dramatic in the life of an analyst; on the contrary, they are quite ordinary and somewhat bittersweet. I wanted to remain an idealized, needed, and powerful father, and I was protecting my authority (and by proxy, that of my analyst—and my father, and Freud, ad infinitum). No big news. But recognizing it allowed me to listen and to learn about this patient's struggle for and against independence in a clearer and richer way. I came to see an aspect of my own idealization of the theoretical construct of fear of aggression as having a defensive purpose in relation to the experience of loss. This was instructive, and it was my willingness to recognize my own participation in the idealization process that afforded me the opportunity to learn. To paraphrase Hamlet: The readiness was all.

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While it would seem obvious that self-analysis of some kind is an essential element in how and what an analyst learns, self-analytic work is neither simple nor easy, and it is not a learning process that can ever be standardized or routine. It is "a variable and highly personal matter," as Jacobs (1991, p. 175) suggests in his book on countertransference and self-analysis, and we must pay attention to our own resistances (unconscious as well as conscious) to probing self-examination. We can and do fool ourselves with our insights into our countertransferences. Even as we recognize one recurrent and problematic aspect of ourselves, we may be obscuring other, deeper understandings. Our insights can be decoys, as Jacobs calls them, attracting our attention away from perhaps more painful features that remain out of sight. We may, as the phrase goes, cop a lesser plea.

What does the well-intentioned analyst do in the face of such sometimes insuperable barriers to self-analysis? I have suggested that the work of analysis, and of life itself, can, as water sculpts the earth by erosion, wear through certain forms of idealization and grandiosity to reveal the more finely structured issues of conflict and identifications, of love, lust, and loss, that underlie our analyzing experiences. Often we are propelled into a bit of self-analytic work by a particular moment, a glimpse into a new layer of unconscious experience. Of course, the real work of self-analysis that follows such a glimpse is very challenging. Akin to the leisurely reading of a long, involved, and at times obscure novel, it is a recurrent reintroduction to the characters and the narratives that, through accretion, establish a story in our minds—like, for example, the story of my unconscious relationship with authority. I think that the work forces this process—both in the waves that wash over us from moment to moment in an analysis, and more important, in the tidal fluctuations,

the long ebb and flow of our emotional experience as analysts and human beings.

LIFE LESSONS IN ANALYTIC LEARNING

Under optimal conditions, several elements facilitate effective self-analysis and evolving self-knowledge for the working analyst. These include:

(1) The experience of effectively analyzing other people, which exposes us to the endlessly creative ways that human beings grapple with their dilemmas.

(2) Complex, layered, sustained relationships. These allow us to experience ourselves from differing perspectives, to complement the refracting lens of the transference and analytic interaction, and to expose our uncomfortable wishes and fears. Without such relationships, I believe, it is hard—perhaps impossible—to do our work.

(3) Interests beyond psychoanalysis and relationships beyond those with psychoanalysts. There is a kind of psychoanalytic myopia, a nearsightedness of looking only inward. The world involves so many large issues, such an infinite variety of experiences and points of view, that it is crucial to know and to feel something about them. I would be wary of an analyst whose world is limited to psychoanalysis.

(4) What might be called *life lessons,* an aspect of analytic learning that has gotten relatively little attention in our literature. By this, I mean the powerful and transformative adult experiences, both ours and our patients,' that significantly reframe our perspectives, our judgments, and our interpretive inquiries.

We analysts spend a great deal of our energy thinking about the role of early childhood in our patients' lives (and in ours as we work), as well we should. We do not, in my opinion, give sufficient weight to the way adult experience shapes us and the analytic process. The recognition that we continue to be molded by life and by our interactions is at the core of the therapeutic ambition of psychoanalysis. Life itself continuously attacks our idealizations and grandiosities, whether we know it or not. It also provides us with opportunities, not always welcome, to recognize the danger of ignoring the impact of personal, societal, and cultural events on our own and our patients' lives, and of our patients' lives on us personally and professionally. (Indeed, these are difficult times; I do not need to say any more about the climate of terror and war that envelops us.)

In short, as analysts, as healers, we must be realists. This demands a certain humility. We must temper our therapeutic zeal and learn to appreciate the contingencies and serendipities that life offers. When we do, we inevitably become, perhaps against our analytic will, moral philosophers of a tragic and ironic bent. We develop a sense of what can and cannot change and what can and cannot be predicted. This quiet, philosophical perspective probably evolves most directly and forcefully from our personal relationships outside analysis—with spouses, partners, parents, children, grandchildren, and friends. It comes from threats to these relationships, in us and in the people closest to us.

Some years ago, the sudden illness and death of a close friend and colleague evoked in me both searing grief and a quiet terror about my own vulnerability and mortality. These found their way into my working life in many forms, well beyond the acute period of shock and sadness. There were certain narcissistic defenses that I heard with a different ear. Resistances conveying a sense that the clock was not running, that there is no need to grow up and make difficult choices, troubled me more than they had. I did not quite lean over the couch and

shout: "Do you really think you have all the time in the world to make up your mind and face certain realities???"—but I was aware of the impulse, and I found more tactful ways to bring to my patients' awareness the illusions of eternal youth and endless potential.

Joyous events shape us as analysts and resonate in our working lives as well. For a time, becoming a grandparent dominated my thinking about life's trajectory. I had more fantasies of leaning over the couch, this time to show pictures and tell stories about the remarkable new members of my family.

For us working analysts, it is our own experiences and those of our patients—the marital crises, deaths, divorces, and failed ambitions—that teach us how relationships rupture and are repaired, what is at play and what is at stake. I am not suggesting that experience always makes us wiser and more insightful, but it is folly to idealize theory over the impact of adult experience—our own or our patients'—on our values, expectations, and biases in the work of analysis.

There are many ways to live deeply fulfilling lives, not all of which are accessible to us; if we pay attention to real life, we learn this from our patients, too. From their experiences and our own, we learn to distinguish moral complexities that Polonius never tackled; we are forced to recognize that ethical imperatives, values, guiding principles, and beliefs are highly individual and that they come in shades of gray. We learn to tolerate these uncertainties and ambiguities and to feel genuine respect and open-mindedness for the creativity with which people make necessary compromises and concessions as they navigate their lives.

At a certain level, analytic exploration and a successful analytic outcome demand that both analyst and patient, together and alone, face what are, for lack of a better or more technical term, the inescapable big questions about the contingent nature of our existence, and the ways in which we all struggle to create

meaningful lives. As we know, life is a process, not an outcome; we are in control of so much less than we wish.

CONCLUSION

In this paper, I have suggested that one of the many ways we learn about analysis and about ourselves is by recognizing and working through our idealizations. In spite of and because of the heroic and mythic history of Freud's self-analysis, we must remain humble and skeptical about the effectiveness of looking inward. As analysts, we are always in danger of assuming that we know ourselves better than we do. Fortunately, as I have suggested, our patients and the other important people in our lives help to disabuse us of this notion and to keep potential hubris in check. In the final analysis, as it were, I believe we do best when we take our work seriously, but not ourselves.

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Psychoanalytic Quarterly, LXXII, 2003

PSYCHOANALYTIC SUPERVISION OF THE DIFFICULT PATIENT

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Control cases from the broad group of non-neurotic but potentially analyzable patients appear with increasing frequency. The intense, complex transferences they develop place great stress on the psychoanalytic relationship and evoke marked countertransference reactions in psychoanalytic candidates, which reverberate within the supervisory relationship. Through application of a case study method, common themes emerge in the candidate–supervisor dyad: idealization of the supervisor and of classical technique, identification with the patient, parallel process enactments, difficulty maintaining the analytic frame, and the importance of concurrent training analysis. Classical supervisory techniques must be adapted to the "difficult" (non-neurotic) control case. Complex countertransference issues must be carefully addressed while maintaining the teach/treat boundary.

INTRODUCTION

Psychoanalytic candidates and supervisors find themselves in a troubling position when confronted with the "nonclassical" or more disturbed control case. Well-documented treatment issues include the management and interpretive handling of: (1) primitive aggression, sadism, and devaluation; (2) propensity toward action, both analyzable enactment and dangerous acting out, includ-

ing threats to the frame and boundary violations; (3) narcissistic vulnerabilities, ego weaknesses, and regressive tendencies; and (4) primitive defenses such as splitting, projective identification, denial, and flight. From the supervisor's perspective, because these cases are more difficult to treat, they inevitably create more difficulties in supervision. From the candidate's perspective, reliance on the classical model, as experienced in personal analysis and as taught in classes and supervision, may leave him or her ill prepared for the challenges encountered when analyzing such patients. Our research on these difficulties has led us to emphasize understanding the candidate's and supervisor's narcissistic vulnerability in these situations and the various defensive strategies employed to cope with it.

Personal analysis and psychoanalytic training, by definition, create a significant degree of narcissistic imbalance. Treating the difficult patient tends to exacerbate and magnify characterological problems and flaws in psychic makeup. Moreover, this regressive pull occurs in a particularly vulnerable context for the analytic candidate, because the case is being used to fulfill training requirements. The patient's aggression and sadism, destructive acting out, and primitive wishes and defenses continually tax the candidate's developing capabilities, undermining his or her already precarious self-esteem.

Typically, analytic candidates respond to this narcissistic imbalance with an idealization of the analytic techniques they have been learning. When the difficult patient does not respond as expected—which is regularly the case—the candidate easily feels like a failure. He or she may particularly fear criticism by the supervisor. Difficult training and pedagogical situations may ensue. For example, the patient may generate narcissistic rage in the candidate because the candidate feels incompetent or ashamed. The candidate may then try to keep this "incompetence" and rage out of the supervision, becoming quite constricted. Or, in more difficult situations, the candidate may project rage and incompetence onto the supervisor, becoming "difficult" in the supervision. Whatever the scenario, the candidate's therapeutic work may be

compromised, and there will be obstacles in the path of a model of supervision limited to instruction about psychodynamics. (This is often misconstrued as the classical model of supervision.)

Candidates who have extensive previous experience doing psychotherapy may have an additional problem. Feeling thwarted in their attempts to be "analytic," they may fall back on previously mastered supportive techniques. They may feel a need to gratify the patient rather than to analyze, and may seek similar support and gratification from the supervisor. This abandonment of analytic neutrality is often rationalized as a parameter. The candidate may feel in conflict with the supervisor if the supervisor attempts to teach a middle route that fully takes into account the difficulties of the treatment but envisages a more neutral stance.

Sometimes a candidate who wants the difficult patient to match an idealized picture of a control case attempts to gratify the patient in order to mask the less conscious feelings of helplessness and frustration. When the patient shows no inclination to conform to this picture, the candidate's efforts at gratifications may become not-so-subtle attempts to manipulate the patient into conforming to "the analytic situation." An unconscious power struggle may ensue that actually intensifies the patient's defenses, and the candidate's own defenses may in turn become intensified in the supervision.

Just as the candidate's institutional vulnerability is heightened when treating the difficult patient in control supervision, so, too, is the supervisor's. He or she may feel concerned about the effect on reputation should word get around the institute that the supervision is not going well or has failed. Moreover, the supervisor has specific educational dilemmas to work out. How is he or she to provide feedback without wounding the candidate, and yet not gloss over all the problems in the treatment? And how is he or she to handle the distress often felt in these supervisions? When the supervisor senses that the candidate has difficulties learning, that the supervised treatment is not going well, or that he or she is unsure about the candidate's capabilities, the supervisor may fall back on all the same defensive maneuvers we have described for

candidates. There is very little reflection in our field about the strains on the supervisor, and not much discussion in the literature or between colleagues about the acute difficulties of some supervisions.

As members of the IPTAR Study Group on Psychoanalytic Education,[1] we found that each of us had at least one supervisory case that was extremely troubling and that we were initially reluctant to speak about it. We also found that going over supervisory process in the group revealed dynamics in the supervision previously not in awareness. This in turn led to specific technical suggestions to improve the supervision. We found this experience most valuable when we placed the emphasis on the candidate rather than on the patient. It did not help our efforts to improve the quality of the treatment by trying to get the candidate "to do it our way." Rather, when we focused on the supervisory process itself, patient care improved. The experience of presenting and listening to difficult supervisions provided necessary support for occasionally distressed supervisors, and led to technical changes that helped reestablish and maintain supervisory neutrality.

REVIEW OF THE LITERATURE

There is a large literature on psychoanalytic supervision. Our intention here is to present a distillation of it from the point of view of classical supervision of the difficult case. Solnit (1970) has stated that in general, the literature on supervision fails to develop a theory of the supervisory process. The teach-or-treat dilemma is handled mostly by viewing supervision as a continuum between

[1] The IPTAR (Institute for Psychoanalytic Training and Research, New York) Study Group on Psychoanalytic Education began meeting monthly in 1992. The group members were initially drawn together by an interest in psychoanalytic pedagogy. We were aware of other projects aiming to apply psychoanalytic principles to the development of psychoanalytic education (such as at meetings of the American Psychoanalytic Association in 1981, 1993, and 1997, and at the International Psychoanalytical Association in 1995; see also Filho 1996). However, our particular focus became the supervision of the difficult patient. By *difficult,* we mean the broad spectrum of non-neurotic but potentially analyzable patients.

learning and therapy. Supervision veers closer to treatment "the more the transference [to the supervisor] enters into the purview of the supervisory process" (p. 359). Since we have found that there is indeed more transferential pressure between supervisor and candidate in the supervision of these difficult cases, we examined the literature in order to develop a theory that takes Solnit's remark into account. The guiding principle here is Blatt's (1993) statement that because difficult patients are

> . . . being seen more frequently by candidates early in their analytic careers, we have to reformulate the role of the supervisory process, and how it can continue to contribute to candidates' consolidation of their appreciation and understanding of classic analytic technique and their emerging identity as analysts. But at the same time, we have to provide the kind of support and supervision that enable our candidates to be effective therapeutically with these more difficult and demanding patients.

From the point of view of treatment, Bergmann (1993) has stated that "those who adhere to the narrow scope [of psychoanalysis] have for all practical purposes lost the battle . . . . If psychoanalysis is to survive, it will have to develop new techniques of treatment for these patients" (p. 205). Clearly, we will also have to develop new techniques of supervision if we are to simultaneously help our candidates treat these patients, while maintaining appreciation of the classic paradigm.

Arlow's (1963) well-known article on the general principles of classical supervision makes several bridging points. Supervisors in general must be attentive to shifts from reporting about the patient to identifying with him or her, producing parallel process (p. 581). In the supervision of the classical case, Arlow is particularly attentive to those moments when the candidate's identification with the patient interferes with understanding and interpretation. There are multiple sources of such identification of candidate with patient. In the more difficult case, we have found particularly pertinent Arlow's remark that "the therapist may identify with the patient by sharing with him a common method of warding off

anxieties" (p. 585). These anxieties may be foreign to the candidate's personality, inevitably leading to unconscious identification with the patient's defenses.

Gediman and Wolkenfeld (1980) extended Arlow's work on parallel process in classical supervision. Most germane to our approach is their point that parallel reenactments occur because multiple identifications are required by all three participants for the unfolding and success of the analytic process and the supervisory process. The inclusion of the supervisor is crucial. Inevitably, the transferential pressure exerted by the candidate upon the supervisor can produce supervisory countertransferences. It is critical, then, that the supervisor maintain a self-analytic function. Katz (1995) stated that "parallel process phenomena may be as inevitable in the supervisory situation as are transference and countertransference in the analytic situation." If the supervisor does not maintain a self-analytic function in the cases where transferential pressure is greater, it is also conceivable, as Katz stated, that parallel process may be unconsciously initiated "from the top down"—i.e., from the supervisor's failure to understand the candidate due to his or her own identification with the candidate's anxieties and defenses in these difficult situations. Giovannetti (1991) makes the compelling point that supervision may be contaminated by "a conspiracy to preserve the narcissistic fantasies of both [supervisor and supervisee], with consequent avoidance of the real fragility of each" (p. 171).

Searles (1965b) states that candidates inevitably feel superego pressures as an artifact of training, leading the candidate to put the supervisor in the superego position (p. 584). Cohen-Lewis (1990) makes the same point, adding that the candidate expects the supervisor to be "critical, judgmental, and punitive" (p. 124). Searles (1965a) adds the practical suggestion that in order not to overburden the supervisory situation with superego anxieties, the supervisor should most often confine him- or herself to remarks about what the patient is doing. Searles found that his own problems in the supervision of difficult cases derived from "temporary unconscious identifications by the therapist" with the patient, as

well as from his own identifications with the therapist (p. 166). The judgmental attitude that the supervisor experiences in such a situation can be modified, says Searles, once the supervisor understands that much of the antagonism in the supervision can be traced to the candidate's unconscious attempt to communicate "the kind of behavior the patient was exhibiting concerning which . . . the therapist was most in need of assistance from me" (1965a, p. 166). Schlesinger (1995) contrasts the analytic patient—who will sooner or later inform the analyst if something is going wrong—with the candidate in supervision, who is more likely to absorb discomfort than to confront the source. Given the power differential and the wish to move on with training, candidates may prefer to "cover for" the supervisor, which in turn deprives the supervisor of discovering how he or she might have erred or could have been more helpful to the candidate.

The foregoing can be integrated with an important statement by Caruth (1990). She says that

> . . . the impact of a particular patient's treatment process upon the student must . . . not be underestimated in understanding the supervisory process. For example, work with very disturbed patients may lead to an appearance of greater disturbance in the candidate during the supervision process than actually exists intrinsically in the supervisee. This may arise from the student's transitory identifications in the service of empathy with a very sick patient, rather than from a pervasive ongoing pathology of the student. [p. 187]

The most detailed discussion of our topic is Adelson's (1995). The necessary modifications of standard classical principles in the treatment of the more disturbed patient will make the candidate anticipate criticism from the supervisor (p. 33). Certainly, the candidate "knows that he or she will be evaluated by the supervisor, adding to the fear of criticism" (p. 36). The supervisor, then, must be "extremely sensitive," because the candidate can be caught between the two fires of countertransference reactions to the patient and fear of the supervisor's judgment (p. 40). Adelson reminds us that many of these patients

> . . . wreak havoc on the self-esteem of even the most experienced therapists . . . . They will attack or . . . project their rage and then feel themselves to be victims of the therapist's sadism. This deadly combination can make the therapist feel incompetent, inadequate, and guilty—in short, miserable. [pp. 43–44]

The supervisor then has to help the therapist, who feels overwhelmed and incompetent, face intense countertransference reactions. Overall, the supervisor's task is "to help the student cope with a demanding and, at times, seemingly irrational patient without becoming entangled in a parallel process" (p. 46).

CLINICAL METHODOLOGY

Over the course of the study, a total of six supervisory cases were presented. A case discussed in considerable detail in the literature (Wallerstein 1981) was also explored by the group, which then had the opportunity to do follow-up interviews with both the supervisor (Herbert Schlesinger) and the then-candidate (Howard Shevrin).

Each supervisory presentation consisted of brief descriptions of the patient, the candidate, and the history of the analysis and supervision to date. Over a period of months, each supervisor presented process material from supervisory meetings, consisting of his or her re-creation of the candidate's process presentation of the analysis, along with his or her interventions and discussions with the candidate. All these materials were annotated with the supervisors' thoughts, reactions, and rationale for any interventions.

The issues and potential problems with this approach were considered. We felt, as did Wallerstein (1981), that this form of data gathering had the potential to serve as a starting point in articulating the issues: Wallerstein saw "systematization" as beginning rather than ending at such a point. We proceeded to examine areas such as those used by the San Francisco Group in the COPE study (Wallerstein 1981). For example, we looked at the candidates' activ-

ity, their understanding of the clinical material, their responses to the supervisory process, and their learning and countertransference issues. We also tried to assess the supervisors' understanding of the analytic process, their own work, and their ways of intervening with candidates. In line with Fleming and Benedek's (1966) approach, we looked at specific and sequentially presented candidate–supervisor interactions, and particularly those that emerged in the context of difficulties and impasses with these more difficult patients.

On the whole, we tried to immerse ourselves in the material before beginning to categorize it. In this light, we also addressed each supervisor's affective reactions (e.g., when the supervisor would suddenly feel critical of the patient or the candidate), and we looked at the process within the study group during the presentations and over time. We wanted to see if the group process might shed light not only on the educational issues, but also on the clinical and supervisory processes themselves (e.g., the appearance of a sudden urgency in the group to sort out the material).

It was from the vantage of these perspectives that the group began to identify recurring issues. Categories were gradually developed, which were then utilized within and between case examples. In the following section, we will present the seven supervisory cases we studied. Each vignette illustrates multiple issues and themes; therefore, we will refer back to the cases in subsequent sections.

CLINICAL VIGNETTES

Supervision of Ms. A

Ms. A had first sought supervision on difficult psychotherapy cases after she had taken a course on psychopathology with the supervisor. She had sought Freudians for her teachers, her analyst, and her supervisors. Ms. A was a talented and mature woman who began her studies in the field after raising a family. She had had considerable psychotherapy experience with seriously disturbed patients by the time she began her first analytic control case.

The patient was a highly gifted creative writer from a deprived and violent background. At intake, he had presented the following problems: intense anxiety, depression, a sense of isolation and alienation, and persistent thoughts of impending disaster and mutilation (his and others' heads being crushed, his legs being slashed methodically, being hit by a car). He appeared to be using dissociation to defend against the pressure of regression—he poured out this graphic and gruesome material in a very bland way. In supervision, the candidate reported this material in a similarly bland fashion. The supervisor, who had previously been gratified by the candidate's mastery of psychotherapy, was now disappointed that Ms. A did not seem able to draw upon her repertoire of ego integrative techniques, even though this had been a focus during the psychotherapy supervision.

The supervisor tried to discuss Ms. A's idealization of analysis and of her supervisor by suggesting that while she was trying to go deeper with the patient, she seemed to forget her supportive techniques. The supervisor encouraged Ms. A to apply those techniques in this case, but she did not do so. Feeling that a sound supervisory alliance had developed, the supervisor raised her concerns about the candidate's lack of affect in the face of the flood of horrifying material from the patient. The supervisor suggested that the patient was inducing this lack of affect. Ms. A replied that she herself had been experiencing "an uncomfortable feeling about not feeling." Ms. A then spontaneously added: "I want to tell you something about myself: My mother constantly threatened suicide, which I dealt with by not taking her seriously." The supervisor then initiated a discussion of which part of Ms. A's reaction to the patient required analytic attention and which required supervisory review. The discussion of how Ms. A had dismissed her mother's suicide threats illuminated her countertransferential blocking out of the patient's dissociation.

But even after this issue was taken up in Ms. A's personal analysis, a problem remained. When she wore the mantle of psychotherapist, Ms. A was able to utilize all the ego supportive

skills she had learned. When she donned the mantle of psychoanalyst, by contrast, her idealization of that role clouded her perception of the patient's severe psychopathology and inhibited the application of appropriate supportive techniques. In her eagerness to be an *analyst,* she mistook the patient's dissociated regressive imagery for free associations. Only after it became clear that she idealized analysis and all that was analytic did she become free to ask questions about this patient in supervision—and particularly about when to do ego supportive work versus uncovering work, and how to establish the delicate balance between the two.

Supervision of Dr. B

Dr. B was a relatively young, married man who had taken a class with the supervisor. The supervisor was aware of the candidate's idealizing attitude. Dr. B was quite eager to have a patient in analysis, and this was his first control case.

The patient was a 20-year-old woman, a college senior from a very troubled background. The patient's mother was abusive, and her father had left when the patient was twelve. The patient had casual sex with many men, often accompanied by heavy drinking. She had been eager to enter analysis because she felt that only the most intensive therapy would help her; however, she often missed sessions or got the times wrong. At the beginning of the supervision, the supervisor stressed to the candidate that the patient's analyzability was questionable. The major agenda was to determine whether she could be stabilized in her therapy.

Dr. B dealt with the patient's absences and confusions over time by taking an apparently neutral stance of simply letting the patient talk about what was going on, without understanding the need for more active intervention. At first, the supervisor took an educational stance, explaining to the candidate why he needed to think about parameters that would eventually be analyzed if the treatment "took." Although Dr. B listened attentively, his treatment of the patient did not change.

Then Dr. B started a supervisory session by saying, "I did something bad." Inwardly, the supervisor was startled by this statement because the patient so often spoke of herself in this way. Dr. B went on to say that the patient had called him about a meeting at her part-time job that conflicted with the time of her session that day. He said that the patient's call had felt to him "like a wave . . . . I just said, 'Okay, can you come in fifteen minutes earlier?' I knew that somehow that was the opposite of what we've been talking about, and that I'd have to tell you about it."

The supervisor responded that he and Dr. B should now look at the process going on in the room between them: it was almost as though the patient herself were coming to see the supervisor. The candidate said he was aware of that: "I was able to think about how we've been talking about frame issues only afterward, but not at the time. But when I did think about it in retrospect, everything you've been saying really clicked for me. In the session, though, I didn't ask her about calling me to change the appointment or how she reacted to my doing it, because it's just not there for her."

The supervisor wondered if Dr. B was more identified with the patient than he knew. He had not been able to talk about the patient's changing the session time "because it just wasn't there for her." Was it possible that what the supervisor had been saying to him "just wasn't there" for the candidate either? It was only after joining in her enactment that Dr. B could think about what was going on. Then he continued the process by "confessing" to the supervisor. Furthermore, Dr. B seemed to continue the enactment when he told the supervisor that after the next session, the patient took out her date book and said that she really wanted to get the times straight. He reviewed the times with her. The candidate seemed to think that he was telling the supervisor that he had started to change his stance with the patient.

Dr. B began the next supervisory session by saying, "I want help from you about the transference." He went on to provide the details of the patient's material. Since the supervisor thought

that the interventions around parallel process the previous week must have had some effect on the candidate, he did not want the session to end without some investigation of the candidate's reactions. The supervisor asked Dr. B what his experience of the last supervisory session had been. Dr. B replied, "What I remember most is your saying, 'Well, how can I help you with all this?' I was thinking about it all week. She does seem more organized. She's been coming to sessions on time and is getting her course work done, but . . . how can I explain? . . . She has this beseeching quality, as if she's asking me to do something for her."

The supervisor told Dr. B that he sometimes experienced the candidate in the same way, and wondered if his opening question about the transference was a similar kind of communication to the supervisor. Dr. B concurred: "It's true—I don't get it. What's going on here?" After a pause, he said, "Wait! I just thought of something I haven't told you. I have a younger brother who's like her . . . not so bad, but pretty bad." The supervisor asked him if he had just thought of this, and Dr. B replied, "No, actually. It occurred to me right after our session last week, but then I forgot about it. I'll tell you this: With my brother, I eventually turned a deaf ear, because I finally saw there was nothing I could do." In response, the supervisor wondered aloud what it was like for the candidate to work with this kind of patient and to have to "do" something.

Dr. B began the next supervisory session by referring to the previous one: "I thought I should tell you more about myself. It's not just my brother. I also had an abusive, intrusive mother who did terrible things to me. My brother was the one who had to witness all this, and even though I got the worst of it, somehow I had the means to keep myself together, which he never did." Thinking about both the patient's loss of her father during her adolescence, and the candidate's attitude toward his supervisor, the supervisor asked Dr. B if he might reveal something about his father—but only if he were comfortable, and only if it would help the supervisor to understand Dr. B's difficulties with the case. Dr. B answered that he had seen his father only during

summers, and that his father was an idealized figure for him. Knowing that the candidate was in analysis, the supervisor commented that overall, his difficulties with the patient could be worked out in supervision if Dr. B could bring the other issues to his treatment, in which case he might have a valuable experience.

In a subsequent clinical session, the patient told Dr. B more about her promiscuity. She then missed her next session, a Friday, and Dr. B said that he had decided to "stick by analysis" and not call her. The supervisor asked him how he experienced this decision. He said that he was worried that over the weekend the patient might have gone to a bar, picked up a man, and could have gotten hurt. The supervisor understood his concerns, as they were based on the patient's actual behavior. The supervisor also said that he agreed with not calling her because this would help to structure the treatment. The supervisor then asked Dr. B if he could think of any way to turn his experience into an intervention with the patient.

"No," Dr. B replied, "that's my problem with her. I still feel that when we get into the transference, I somehow bungle it, and that happened in the next session she came in for, on Monday. She started right out by saying that it was only over the weekend that she realized she had forgotten the session. She said, 'Well, I guess it's one of those resistances.' Then she said that she assumed that I knew that she wasn't run over by a car or anything. I asked her if there was anything in the last session that had upset her, and she said yes, that whenever she spoke about her mother she felt a block, a wall, something she couldn't get beyond." The supervisor asked the candidate whether he thought that the "block" was related to her missing the session, and he answered, "Of course—but that's what I can't think of when I'm with her."

Here were two people—one a patient, the other a candidate—with abusive mothers and distant, idealized fathers. The supervisor believed that the candidate had not been able to understand the patient's need to put him in the idealized, structuring paternal position because the candidate was putting his supervisor in

that position. The supervisor did not think that the candidate was generally prone to such serious countertransference reactions; it was more that a patient with a background similar to his own had become his first analytic patient, stirring up crucial issues that were enacted in the treatment and in the supervision. The candidate was eventually able to carry this case to a successful termination.

Supervision of Dr. C

Dr. C was a Hispanic woman in her early fifties, in her fourth year of analytic training. She had had two prior control supervisors. The first, whom she saw for two years, had a relational orientation. She found this supervision comfortable and helpful, but lacking in depth. The second supervisor, whom she saw for one year, was from a more classical orientation. Dr. C reported feeling uncomfortable and criticized in supervision, but attributed her discomfort to the supervisor's personality. She spoke of these unsatisfying prior experiences in terms of differing theoretical orientations within analysis. She hoped the current supervision might focus on the advantages and limitations of classical and relational theoretical models. Dr. C sought this supervisor after her experience with him as a guest lecturer. She had completed her analysis some years prior, and at the first supervisory meeting, she requested a referral for a second analysis.

The patient was a 28-year-old woman, also Hispanic, who at the time was beginning her fourth year of a four-times-per-week analysis. She was attending a graduate program in a health-related profession and had recently married a student from the same program. She was described as petite, attractive, and emotionally reactive. She began analysis stating that she felt a "void," that "something was missing" from her life, and that she felt she could do better than she was doing. She reported frequent panic and rage attacks. The analysis was conducted in English, but at times the patient lapsed into Spanish, to which the candidate responded in kind.

From the description of the course of treatment, presented in the first two supervisory hours, the patient appeared to have developed intense transference reactions to the analyst almost immediately, tending toward rapid regressions, loss of ego capacity, and concrete experience of her transference reactions. She was prone to outbursts of anger, projective distortions, and self-destructive acting out. The history revealed sexual boundary violations by her father and physical assaults by an older brother, with tacit acquiescence and denial on the part of the mother. Themes in the early material concerned body image, untrustworthiness of parental figures, and boundary violations; there was an onrush of incestuous themes and rape fantasies. She expressed the conviction that her parents and the analyst were secretive, rigid, and hypocritical.

As Dr. C began presenting process material in supervision, it appeared that she did not have a very clear understanding of the nature of the patient's borderline structure and defenses. She did not appear to appreciate the intensity of the patient's primitive transference: her terror of engulfment, merger, and abandonment; her fear of overwhelming regression; and the nature of her outbursts of rage, which were generally followed by projection and guardedness. Dr. C did not seem attuned to the process of the sessions or the appropriate levels at which to intervene, nor did she have recourse to a model of pathology that would enable the patient to become more analyzable. For example, Dr. C tended to take a supportive/educational approach to the patient's anger and distress, and was generally unaware of the transference developments from moment to moment or from session to session. Her efforts to avoid the patient's transference anger often exacerbated underlying anxiety.

Dr. C's manner of presenting material was highly controlled and guarded, and the supervisor frequently felt that only very carefully selected portions of the clinical interaction were being presented. Dr. C often brought up questions about how the material might be viewed according to different theoretical orientations. Her anxiety, conflicts, and ambivalence about this patient

were reflected in her polarized view of theoretical models, supervisory styles, and clinical interventions. She was highly identified with this patient's history, dynamics, and professional work. She was also ambivalent about starting her own reanalysis, periodically offering vague reasons for her delay in contacting the analyst to whom the supervisor had referred her.

Thus, the supervisory process had to accommodate a patient who was fragile and difficult and a candidate in limited possession of the clinical tools needed to work with her. The analytic work was further compromised by countertransferential overidentification with the patient's dynamics and defenses. The supervisory work was made even more difficult by Dr. C's guarded and controlled demeanor, which quite possibly covered fragility. And she was still not in analysis.

The supervisor sensed that enabling Dr. C to successfully reenter analysis would not be an easy task, and might well constitute the most realistic goal and successful outcome for the supervision. Taking the lead from the candidate's obvious need to be in a supportive and educational supervisory environment, the supervisor's initial focus was on helping Dr. C stay close to and tuned in to the flow of the material, demonstrating how to listen for latent transference issues. The supervisor tried to help Dr. C distinguish free association from verbal action, in which words might be used not to convey meaning but rather to destroy it, or to affect the analyst concretely. The supervisor also focused on educating Dr. C about the nature of the patient's pathology and helping her articulate potential clinical approaches.

This approach very gradually enabled the candidate to feel more comfortable revealing more about her own history and countertransference. This in turn facilitated the supervisor's making more direct connections between the candidate's issues and her work with the patient, and the consequent advisability of her reentering analysis. Dr. C did begin reanalysis midway into the supervisory year. Although this was followed by improvement in her conduct of the case, she chose not to continue in supervision beyond the required length of time, citing a need to learn to work independently.

Supervision of Dr. D

Dr. D was in the middle of her training and beginning her first control case with a difficult patient, who presented as helpless, rigidly controlling, and manipulative. The patient had succeeded in getting the candidate to charge an inappropriately low fee. When the supervisor questioned the fee, the candidate barraged her with all the reasons the patient could not manage a higher fee—she was too helpless, infantile, frightened, and angry. As the supervisor began to help elucidate the particular psychodynamics behind the patient's conflict, Dr. D revealed that she had known intellectually that she was participating in devaluing the treatment, but she had been unable to move away from this position until this supervisory session. The candidate had spent the previous two sessions telling the supervisor that she did not know how to raise the fee, asking for specific directions in a helpless way, and revealing her fears of the patient.

Dr. D then reported the following process material:

> I began the session by telling the patient I would like to review the fee with her and would like to increase it to $60. She had been in the middle of writing me a check for the previous month's bill and immediately shot off the couch—as though I had slapped her. I tensed up and groaned inwardly. I started to punish myself: Why couldn't I have waited, why did I have to smack her with this suddenly? But I quieted down and told myself it was going to be all right . . ."Let's hear what this means to her," or something like that. She told me that now was not the time for me to bring this up, and she wasn't going to think about it at the moment as she had important things to discuss. Of course, she angrily challenged the need for a new fee, and I said that the old fee wasn't appropriate for her or me or the treatment, and that the new fee seemed more realistic and appropriate to her earnings. I was surprised when she agreed, noting that the fees her friends paid were much higher, and saying that she had known all along I would have to reconsider the fee. As a matter of fact, she had expected me to raise her fee

some time earlier, and she had both wanted me to and *not* wanted me to. The original fee felt like a gift, and she wanted to hold onto it for as long as she could; but then she also wondered why I wasn't raising it and whether she were responsible, ending up by wondering if I was any good as an analyst. Then she went into how she felt that she might not be able to manage the new fee, discussing her various expenses and what could be changed to make the higher amount possible. Then, if all else failed, she might have to cut back her sessions.

The supervisor asked the candidate, "Where is the new space you went to early in the session you just described?"

I guess that's the first time I took up an analyst's space. I liked it. I knew I shouldn't have blurted out the new fee before she settled in, but what is important is that I was comfortable listening, analytically exploring, and free. I felt free of her control and manipulation, free of my own guilt, free to be there for all of her. And what made it possible was my telling you a few weeks ago that I didn't know how to analytically raise her fee. I'm like the patient—thinking I'm supposed to know how to do this, and I'm afraid of what you'll think of me as I expose myself for not knowing. I also needed you to listen to what I was afraid of—that she would call me a money-grubber, that she would nail me for being inconsistent and not living up to my word about the low fee, that I would be destroying her treatment, that she would get so angry she would have to leave, that I wanted her to leave treatment because I'm so angry at her for controlling me into continuing to work at a low fee.

I don't think I was even so afraid of her anger as much as I was feeling responsible for her treatment, which meant I had to gratify her. When she left, she reminded me of how I had once waited until the end of a session to announce a vacation, and how she had kept in her anger all the following week. So on the next Monday when she saw me, she had exploded with rage and couldn't hear anything—and the real issue behind her anger was never discovered. Maybe it was better in this case that I

> announced the fee at the beginning, because now she knew she was angry about giving up a gift that really shouldn't have been hers in the first place.

Dr. D was able to stand up to the patient's accusations, though she fantasized that the patient would attack her for being a "money-grubber." The supervisor observed that Dr. D was inclined to accept too little for her work, and posed the question of what was wrong with receiving a reasonable fee—seeking a modification of the candidate's superego that would enable her to analyze the attack by the patient rather than become victimized by it.

In this case, we see how a candidate may identify and overidentify with a patient by sharing a common method of warding off anxieties (helplessness). It should be noted that the supervisor did not analyze what was behind the candidate's fear of being called a money-grubber, because enough superego amelioration had occurred to free the candidate to go on to appropriately treat the patient.

Supervision of Ms. E

The supervisor had previously supervised Ms. E in an internship setting in which she treated young children. He was impressed with her former background as a teacher at an urban therapeutic day care center that was run according to psychoanalytic principles. Ms. E had taken a number of psychoanalytic courses and seminars, but had never sought analysis herself.

Ms. E sought out the supervisor when she began analytic training. She chose to share certain aspects of her history, including the sudden and tragic loss of her father in an automobile accident when she was a child. As the supervisory work progressed, it appeared that Ms. E had turned the supervisor into a "reincarnation" of her father—an idealized analyst. She seemed awestruck by the supervisor's formulations of the case, as though he had some magical access to psychoanalytic knowledge that she herself could never acquire. The candidate's resistance to internalizing what she learned from the supervisor as part of her professional

work ego for the sake of retaining this idealized parent–child relationship jeopardized her development as an analyst.

During the previous supervision, the supervisor himself had developed an idealized view of the candidate. He projected an expectation that she could do the analytic job, ignoring her real difficulties. For example, the first strategy the supervisor attempted in relation to the difficult analysand whom she was treating was to draw upon Ms. E's past experience with day care children. He supported the intuitive capacities she had shown at that time. But this approach proved ineffective. During the course of presenting this supervisory case to our study group, the supervisor became aware that he had denied Ms. E's rigidity and her sadistic attitude toward the patient. Ms. E herself was very goal directed and tended to treat her own "failures" with harsh self-criticism. She was judgmental toward her difficult patient, treating her the way she treated herself.

The patient's "misbehavior"—impulsive out-of-town trips, breaking the frame—was very stressful for the candidate, and Ms. E struggled with her own response to the patient. The candidate's stance in supervision and the way she dealt with the patient's acting out in the treatment became more rigid and disciplined. For example, when the supervisor suggested that she use an intervention such as "How does this work for you?" in order to highlight the patient's ego functioning, Ms. E brought this to her patient as "Have you always acted on your emotions? How does that work for you?" Thus, Ms. E's hostility toward the patient's lack of self-control emerged.

The supervisor felt considerably helped by his experience with the study group, which highlighted the candidate's sadism toward the patient. He chose not to confront Ms. E, instead emphasizing that her job was to maintain the frame and to be consistent. He felt that this gave the candidate something to do so that she would not attack the patient. He then began to model this work on a didactic level, consistently pointing out the importance of the frame and inviting the candidate to understand how its maintenance would be helpful for the patient.

Ms. E recognized her tendency to become rigid and angry with the patient, but experienced this as something wrong, while the supervisor discussed it as an indication for personal analysis rather than as an occasion for moral judgment. Ms. E went into analysis with a referral from the supervisor (though not without first expressing a strong desire for the supervisor himself to be her analyst). With her entry into analysis, Ms. E's tendency to idealize the supervisor diminished somewhat, and she became able to hear the supervisor's comment that "All I do is go on the data that you bring in. There is no magic here." The difficult patient eventually terminated, and Ms. E continued in supervision on another patient—one with neurotic, not borderline, symptomatology.

Ms. E's character issues impacted this second treatment in a more benign fashion. She wanted to help the patient with her problems, rather than allowing therapeutic regression. With this case, she became mildly frustrated when she could not immediately make things better, but without hostility toward the patient. When the supervisor inquired about what got in the way of allowing the patient's regression, Ms. E could acknowledge the anxiety she felt that she was not really working unless she was actively interpreting. She had developed some perspective on what was prompting her anxiety and an acceptance that its exploration belonged in her own analysis. She could also accept her supervisor's saying, "Waiting is doing something; making choices and decisions is doing something, too."

The supervisor contrasted the first patient with the second one, pointing out that there the candidate had a different role. With the difficult patient, one had to "interpret up"—to help the patient's ego integrate. Although the second patient was neurotic, Ms. E still felt anxious that she was not doing enough. The patient was moving along, but Ms. E was left with some resistance to acknowledging her own effectiveness as an analyst. As she de-idealized the supervisor, she was forced to recognize herself as the effective agent in the treatment. In an effort to facilitate this de-idealization, the supervisor pointed out that, whereas in the treat-

ment situation, the candidate was in the hot seat and had to act in the moment, in supervision, both parties had time to reflect because the material was necessarily filtered.

Supervision of Ms. F

Ms. F's patient was a 28-year-old, professional woman in the process of divorce. Enactments and a seemingly endless series of life crises complicated the treatment. A typical example was her sudden announcement that she was leaving for the West Coast in a few days to attend a conference—and then, while there, she became sexually involved without realizing how it had all come about. Such events would be reported in sessions with little reflection on the patient's part. Splitting was a major defense.

The supervisor believed that this patient required active interpretation of her enactments in terms of defensive splitting and the underlying aggression. Ms. F's previous supervision on this case had been based on a somewhat different premise—that in time, the patient's psychic functioning would be revealed by free association. The supervisor's efforts to encourage the candidate actively to interpret the enactments seemed to fall on deaf ears, and the patient ultimately terminated.

Ms. F then began analytic work with a new patient, a 34-year-old professional who had had some heterosexual affairs, but who had been in lesbian relationships for some time. The patient's presenting problems were in the work arena. She was quite depressed at the time she began treatment. In this analysis, Ms. F again conceptualized the case in terms of an ego deficit that required reparative treatment. She subtly rejected the supervisor's focus on actively and consistently intervening around the multiple frame issues that dominated the treatment.

In retrospect, the supervisor felt that the candidate had been cold and excluding of him. In the countertransference, the supervisor experienced a vulnerability that the candidate played on. The study group helped the supervisor identify his sense of exclusion. Ms. F had kept the supervisor out: she sat in cold

judgment and stayed in supervision only for the exact number of required sessions, announcing at the last hour, with no discussion, that this was the end.

The supervisor saw the candidate as having the capacity to cut off and demolish whatever help the supervisor gave. For example, Ms. F said to him: "The patient said, 'I always find it helpful, but I don't want to come here today.' So I did what you said, using your words: 'When you are angry, words don't come.' The patient then asked, 'What do I do with this kind of information?'" The candidate felt that she was insufficient with the patient, and the supervisor felt insufficient with the candidate. He first tried to teach, but Ms. F wanted a peer relationship and did not internalize the supervisor's views or instruction. His countertransference manifested in his being unable to recall the case without reference to his notes.

A SUPERVISION FROM THE LITERATURE

In *Becoming a Psychoanalyst: A Study of Psychoanalytic Supervision,* Herbert Schlesinger (1981) documents his supervision of Howard Shevrin, when the latter was a candidate at the Topeka Institute (the Menninger Foundation). This was a "classical" supervision of a nonclassical case, in that the supervisor limited his verbal interventions to instruction about psychodynamics. In his notes, however, Schlesinger indicates that "questions about the patient's early development" gave rise to doubts about her analyzability (p. 288). Supervisor and candidate were both aware of the patient's tendency to eroticize the transference too quickly.

From early on, Schlesinger thought that there was "serious evidence of difficulty in the analyst's work" (p. 288). He was troubled both by the lack of a demand quality in the patient's associations, as if she really did not expect to get any help from the treatment, and by the candidate's failure to see this problem or to think about his own contribution to it (p. 294). These difficulties also contributed to problems in the supervision. Schlesinger felt that he was not "really in touch with what he

[Shevrin] is doing with the patient" (p. 289), and experienced "growing distress as he [found] himself kept out of meaningful teaching contact with the analyst" (p. 291). However, Schlesinger's maintenance of a model of supervision in which only psychodynamics were discussed did not lead him to see the importance of bringing his own inner distress into the supervision in a way that could be helpful to the candidate. The supervision ended unsatisfactorily for both parties.

We are fortunate that *Becoming a Psychoanalyst* contains data from Shevrin (1981) about his experience of the supervision as well. He recounts that he was alarmed from the beginning about the extent of the patient's sexual acting out (p. 322). However, he felt that he could neither honestly report the details to his supervisor, nor convey to him his "sense of futility, even despair" when he felt confronted by the supervisor's "silent condemnation." Shevrin also notes a real discrepancy between himself and Schlesinger over basic issues of dynamics and technique. He knew that the patient had not really engaged in a standard analytic process: "I was frankly puzzled by the patient's silences, her delays in telling me about escapades, her fears about getting involved in the analysis" (p. 325). However, Shevrin felt that Schlesinger did not encourage a supervisory encounter in which these issues could be aired and modifications of standard technique suggested.

Ultimately, Shevrin understood the patient's difficulties in engaging in the analysis as the patient's fear of her "greedy possessiveness; were she once to grab hold, she would not let go, and this would doom both herself and the analyst to becoming the victims of her oral-aggressive impulses" (p. 325). This dynamic formulation was not made in the supervision, and its effect upon the analytic process was not elaborated. This illustrates our most general point that to help the candidate improve the treatment of a difficult patient, supervisory boundaries must be expanded to allow discussion of such difficult issues.

In follow-up interviews conducted by our group with both Schlesinger (on May 19, 1998) and Shevrin (December 16, 1997), both parties reflected back on this unhappy experience, now al-

most thirty years earlier. Schlesinger maintained the importance of a pedagogic stance in supervision. He did not believe that the supervision of difficult cases demanded any basic changes in supervisory technique. Shevrin reported on his second supervision of the same case; he found the second supervisor's style to be much more open, allowing him to speak more freely about the case, and noted that this supervisor's familiarity with preoedipal dynamics led to more productive clinical interventions.[2]

DISCUSSION

Candidate Themes

Idealization. In all our cases, the candidate chose the supervisor on the basis of a prior contact in a didactic seminar or a previous relationship in psychotherapy supervision. While this is a common and acceptable way for candidates to choose their supervisors, we have found it to be a dynamic factor worth special attention in the supervision of the difficult case. Idealizations hidden in these choices tended to interfere with the learning process. As the literature suggests, candidates tend to be more narcissistically fragile in these supervisions. One might expect candidates to rely on an idealized relation with a supervisor to manage feelings of vulnerability, incompetence, and anxiety. However, we found that idealization tended to interfere with the learning process in supervision. Ms. E's general resistance to internalizing anything from her supervisor, for example, was related to her idealization of him in the service of maintaining her child-

[2] In other recent communications, Schlesinger and Shevrin reminded us of further difficulties that attended this supervision. Schlesinger commented that he had selected an expectably classical case. However, difficulties presented by a case that turned out to be far more disturbed illustrate the multiple stresses that emerge in the supervision of the difficult patient. These stresses were probably magnified by a particularly compromised supervisory frame: multiple professional relationships between Schlesinger and Shevrin, the pressure on Schlesinger as a member of the COPE study to present a classical supervision, and the fact that this study was being conducted without the knowledge or consent of Shevrin.

hood paternal relationship. Dr. B's idealization of his supervisor kept him from understanding his patient's need to put him in an idealized, structuring paternal position. In later phases of these supervisory relationships, it was possible to address the idealization of the supervisor directly. It is our impression that this issue does not come to the fore as regularly in the supervision of the more classical case.

Similarly, we found that classical technique itself tended to be idealized, for various reasons: the desire to learn classical technique, the wish to demonstrate growing technical expertise, the safety provided by its rules, and especially the evaluative pressures of the training situation. Several candidates had been clinicians for many years prior to beginning analytic training. They tended to idealize psychoanalysis and classical technique, disregarding and devaluing previously mastered and—in certain difficult analysands—appropriate psychotherapy techniques. This contributed to idealized fantasies about what analysis should be capable of effecting and what the supervisor should be able to provide, interfering with the learning process. In the supervision of Ms. A, for example, the candidate utilized her idealization of free association to rationalize her defensive silence in the face of the patient's dissociated, regressive imagery. Dr. C used her interest in various competing psychoanalytic paradigms to mask her anxiety and ambivalence about her patient.

Identification with the Patient. This was a major issue in all cases. Arlow (1963) described how such identification interferes with the candidate's ability to interpret, to understand the material, and to maintain an analytic frame of reference. In the control analysis of the more difficult analysand, such identifications occur in the parallel context of the patient's compromised ego and fluctuating sense of self on the one hand, and the candidate's nascent and often shaky professional analytic identity on the other. We found that the patient's feelings of helplessness, powerlessness, and resentment tended to induce parallel feelings of incompetence and impotence in the candidate, which was then intensified by the fact that he or she was being evaluated in a new learning situation.

Magnification of the Candidate's Psychological Vulnerabilities. Caruth's (1990) point cited in our literature survey deserves special emphasis here: in general, candidates tend to look worse in their work with difficult patients. Each of the four supervisors in our group reported anecdotally that when his or her candidate used a supervisory session to report on a different, less disturbed case, they were startled by how much more capable the candidate appeared. When candidates have difficult patients as their *first* control cases, as occurs more and more frequently, we found that the combination of idealization, identification, disappointment, and anxiety often magnifies or exacerbates the candidate's character pathology.

Dr. B's patient, who had such trouble remaining clear about the schedule, was his first control case. The supervisor had a difficult time sorting out characterological issues (a seeming block when it came to structuring the patient) from induced countertransference (the patient's characterological disorganization). The candidate may also appear to have limited talent, as with Ms. A, the extremely competent therapist, who appeared quite *in*competent when she became overly immersed in her first control patient's copious descriptions of his violent fantasies.

Parallel Process Enactments. It is well known that overidentification with the patient's conflicts and/or defenses contributes to parallel process re-creations in the supervisory setting. Parallel process phenomena were emphasized in three of our cases, and we hypothesize that such phenomena are more frequent and/or more intense in the supervision of the difficult patient. The parallel process in the supervision of Ms. F—the candidate's feeling insufficient with the patient and the supervisor's feeling insufficient with the candidate—could not be worked with, to the detriment of the supervision. With Dr. B, the parallel process—the candidate's presenting himself to the supervisor in the same way that the patient presented herself to the candidate—was focused on explicitly, as an aid to didactic teaching and experiential learning, to considerable benefit. Similarly, in the case of Ms. A, the parallel process of the candidate's bland demeanor as she re-

ported her patient's bland description of gruesome material had to become a focal point of the supervision.

In both the latter cases, effective resolution of the parallel process difficulties led to a revelation of personal material related to the candidate's difficulties in dealing with a disturbed parent. A semiadaptive defense from childhood tends to be reactivated in the work with such patients, inevitably reproducing such defensive maneuvers in the supervision. We do not advocate any analysis of the candidate's personal material. We did find discussion of it invaluable in providing the candidate with an in vivo understanding of the transference-countertransference experience of the treatment and the supervision (Katz 1995). In turn, this helped resolve the parallel process enactment in the supervision.

Difficulty Maintaining the Frame. Dynamically, analysts understand why the boundary-setting functions of the frame are such prominent issues in the treatment of the difficult patient. Nevertheless, one of our most striking findings was that in *all* the cases we studied, candidates had problems handling difficulties with the analytic frame: e.g., lateness and absence, problems with times, fees, phone contact, and so on. The candidate typically responded in a passive and nonintervening manner. For example, Dr. B had difficulty handling his patient's confusions with session times, Dr. D had difficulty with the fee, and Ms. F had difficulty with the patient's sudden, unannounced departures.

This problem, too, was often related to issues of idealization and identification. Due to the idealization of classical technique, candidates could not readily differentiate work with the difficult analysand, in which the management of such issues needs to constitute the foreground and focus of the treatment, from work with the higher-level patient, where such issues generally form the stable background of the treatment. Due to possible identification with patients' blurring of boundaries, candidates themselves can become blurry about the importance of boundary issues. Clinically, candidates can often fail to appreciate why and how to deal with the frame.

The problem in supervision is that it becomes more than a matter of *teaching* about frame issues, because these issues are so

often manifested in parallel process. We have found, however, that such parallel process moments are the point of access to resolving a candidate's difficulties in this area—as in the case of Dr. B, whose problem in handling the patient's confusion with the schedule was resolved only when Dr. B made it clear to the supervisor that he was replicating his own position in his family, in which he had felt that there was nothing he could do for a sibling who was very much like his patient.

The Importance of Concurrent Training Analysis. In the supervision of the more difficult case, the atmosphere is highly affectively charged, often because the candidate is regularly exposed to the direct expression of drive material—for example, Ms. A's patient's graphically aggressive fantasies, and Dr. B's and Dr. Shevrin's patients' promiscuity. It is one thing to learn the necessity of liberating repressed drives, but quite another to feel assaulted by them. Candidates can feel overstimulated, frightened, angry, or even ashamed.

Another inevitably charged issue is the anger and frustration provoked by the frame violations and devaluations of treatment that we found in all cases. Further, in two of our cases, revelation of the candidate's personal history—Ms. A's mother's suicide threats and Dr. B's family situation—was essential to resolving supervisory impasses. The model we propose urges candidates to be open about such issues. We advocate neither exclusion of this material from supervision, nor exploration of it in supervision. Once this material has been made use of in a way appropriate to supervision, then the supervisor can emphasize, in a way that is not merely "passing the buck," that it may also be an important analytic issue for the candidate.

Work with the difficult patient affirms the importance that we already place on the candidate's concurrent training analysis. For example, Drs. C and E had already completed their analyses. It became clear, however, that identifications with their patients' conflicts or defenses made it too difficult to treat their patients effectively. It became a primary goal in supervision to help these candidates reenter analysis.

Supervisor Themes

Maintaining the Supervisory Alliance. The establishment of trust and a sense of safety is an essential ingredient in any psychoanalytic endeavor. In the work with these difficult patients, we found that the stability of the supervisory alliance came under constant pressure. These patients' chronic feelings of insecurity and mistrust, in conjunction with their tendencies toward projection, splitting, and boundary blurring, were often played out in the supervisory settings. We observed that the supervisory alliance needed to become a central focus more often than is the case in supervisions of more classical cases. The Schlesinger–Shevrin supervision from the literature is one situation in which this focus did not occur.

Educational Instruction. In the majority of cases we examined, didactic instruction was the significant mode of intervention, particularly in the early stages of the supervision. The supervisors in our group found it especially helpful to offer instruction on how to approach different levels of ego pathology in an analytic setting. Supervisory approaches then addressed the state of the candidate's work ego (and superego). The supervisor strengthened the supervisory alliance and helped avert potential supervisory impasses. For example, it proved helpful for the candidate to understand that ego weakness often interacted with dynamic conflict in these patients. As in the supervision of Ms. A, what the candidate took to be analyzable transference regressions that could be treated with standard interpretive interventions needed to be distinguished from disruptive flooding and psychic disorganization. This distinction is not always clear to candidates. Such lack of clarity can lead the candidate to make interpretations that exacerbate the patient's pathology, impairing the candidate's sense of therapeutic effectiveness. When Ms. A was able to make this distinction, she regained her sense of competence and became less self-critical.

The candidates in our sample also needed to learn to understand that free-associative speech can also be verbal action, as in

the case of Dr. C. In these situations, the supervisor may find it a difficult educational task to convey the difference between interpreting free associations and intervening around issues of how the patient destroys meaning or concretely tries to affect the analyst. Often this amounts to the teaching of a different kind of listening, one that emphasizes process rather than content.

Candidates also needed instruction—as did Ms. E, for example—on how to intervene on the side of the ego. Supervisors needed to distinguish analytic ego-supportive techniques that deal with pathological defenses, failures in synthetic functions, impulsivity, and the like from nonspecific, supportive approaches. The point here is to clarify technical models so that when support is needed, candidates do not simply fall back on nonanalytic modes of working. Such supervisory instruction carried the added advantage of helping the candidate to de-idealize classical technique and to ameliorate self-criticism and a sense of failure.

One of the most helpful forms of instruction was about induced countertransference. When treating the more difficult case, the candidates in our study often felt that the disturbing affects and thoughts that they experienced with their patients should remain outside the supervisory process—as products of their own pathology and incompetence, too shameful to bring up. Rather than inadvertently supporting this idea, the supervisors found it most helpful to teach candidates about why and how these reactions are a common part of the treatment of such patients, and are, in fact, the very thing that supervisor and candidate need to look at in order to understand the patient. This proved to be enormously relieving to candidates, easing superego pressures, clarifying patient–candidate boundaries, and strengthening the supervisory alliance.

In this regard, it was especially helpful when the supervisor was able to demonstrate the use of his or her own self-scrutiny of countertransference reactions in comments to the candidate. Additionally, when the supervisor was able to think and hypothesize out loud, in tentative and trial fashion, he or she offered the candidate a model of an analyst at work, struggling with is-

sues to which there are no quick answers or easy fixes. Although not mentioned in our clinical reports, supervisors often commented that conveying to the candidate a sense of the difficulties they would have in treating such patients helped to maintain a deidealized atmosphere in which problems could be spoken about more freely.

Invariably, in the treatment of such patients, some aspect of the candidate's character pathology or some central dynamic conflict will actively interfere with the handling of the case. In some instances, this will be clear at the outset of supervision; at other times, it will remain obscure for a period of time. Such countertransference issues must be addressed in supervision in order for a successful outcome to occur. However, we propose avoiding the two poles of the teach/treat continuum; that is, we believe that, while it is inappropriate to analyze the candidate—since to do so would violate the boundary between supervision and personal analysis—there is more to be done than simply suggesting that the candidate take up the issue with his or her analyst. When the candidate's issues become stimulated by the patient and are played out within the supervision, we propose that they be taken up gradually as in vivo examples of what is going on in the treatment. This can only be accomplished, however, in the context of a well-developed supervisory alliance, in which sufficient supervisory space has been created for such topics to be addressed in a productive fashion.

Without employment of these educational approaches, we found, candidates tended to try to "make" their cases into classical ones, with the resultant bypassing of acting out and chaos—a strategy that ultimately exacerbated the candidates' feelings of failure.

FUTURE RESEARCH AND SUPERVISORY DEVELOPMENT

(1) There may be a circular benefit to studying and trying to systematize the supervision of severely character-disordered patients. In the process of trying to articulate dimensions of the

supervision, we may find that our understanding of the therapeutic action in the *analysis* of these cases is further elucidated—especially with regard to such issues as analytic boundaries, the work to make a case analyzable, how ego weakness may improve over the course of an analysis, and so on.

(2) Our work and the work of others may support the further establishment of supervisory groups. Such a group serves not only research interests, as we have seen, but can also function as a training tool and resource for both new and experienced supervisors. This might facilitate a climate of greater willingness to discuss one's own work and difficulties in supervising.

(3) There is a need for an examination of different phases of supervision. (For the most part, the time dimension was missing from our sample of cases.) For example, what issues tend to arise with candidates during specific phases of training?

(4) With additional research efforts, there could be a further systematizing of the variables we found relevant with our rather small group of more disturbed patients. Our hypotheses should be tested on new cases in more controlled circumstances. Further, it would be of value to see if some of our pedagogical recommendations proved predictive and useful to the supervisory process.

Acknowledgments: This paper is dedicated to the memory of Betsy Distler, M.P.S., an original member of the study group, who gave the authors inspiration to write this paper. The authors also wish to thank Rena Greenblatt, Ph.D., for her assistance with clinical methodology.

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Psychoanalytic Quarterly, LXXII, 2003

ON SUPERVISING THE PREGNANT PSYCHOANALYTIC CANDIDATE

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The role of the psychoanalytic supervisor is complicated when the psychoanalytic candidate is pregnant. Pregnancy is a special event that brings a unique set of opportunities, as well as problems, into the analysis, though in the past, it was usually regarded only as an impediment. The goal of this paper is to help the supervisor of the pregnant candidate to seize the opportunities and mitigate the problems. The authors make practical suggestions about the handling of maternity leave and the complex theoretical and technical issues surrounding the question of when and how to tell the patient about the analyst's pregnancy.

Pregnancy and childbearing, important milestones in the life of a woman, often coincide with the lengthy process of psychoanalytic training, creating special and complex issues. Today there is a preponderance of women psychoanalytic candidates, with a

[1] Our study group on the supervision of the pregnant psychoanalytic candidate, formed under the aegis of the Committee on Psychoanalytic Education of the American Psychoanalytic Association, began in May 1993 with nine members: Robert Gillman, M.D.; Marianne Goldberger, M.D. (chair); Nadine Levinson, D.D.S.; Elizabeth Lloyd Mayer, Ph.D.; Malkah Notman, M.D.; Henri Parens, M.D.; Albert Sax, M.D.; Beth Seelig, M.D.; and Ronda Shaw, M.D., all of whom were training analysts with a special interest in female development. Most were experienced supervisors of candidates, including pregnant ones; half had themselves been pregnant at least once during their psychoanalytic training. The decision to examine the experiences of the group and those of colleagues resulted in this paper, written by the six continuing members of the original study group.

greater number of pregnancies occurring during candidacy. This paper focuses on the role of psychoanalytic supervisors in facilitating the training of pregnant analyst-supervisees. Among the areas considered are the pedagogical issues for the supervisor; the impact of pregnancy on the dynamics between supervisors and their supervisees, and between supervisees and their patients; basic assumptions and myths concerning training during pregnancy; and issues surrounding maternity leave. Studying these areas has made us more aware of the fact that pregnancy can be anxiety producing for all concerned. We propose that the analyst's pregnancy introduces into the analysis a unique set of problems and opportunities for both supervisor and supervisee, sometimes requiring the analyst to modify standard technique, such as by introducing the fact of the pregnancy.

When the analyst is pregnant, she may find it difficult, if not impossible, to adhere to certain generally accepted principles of analysis, such as "The patient determines the subject matter of the analytic hour" (Fenichel 1941, p. 44). Ordinarily, we strive to avoid imposing our own agenda upon the patient, but with a pregnancy, the analyst has introduced an important dynamic constellation that will have to be addressed. Pregnancy brings the analyst's personal (and sexual) life directly into the analysis, without consideration of the analysand's needs. The timing of the pregnancy leaves the patient no choice: it is based solely on the needs of the analyst and makes no allowance for the readiness of a particular patient to deal with the fantasies and affects that will inevitably be stirred up. The unborn child is actually in the room with the analytic dyad. Fantasies about the baby's father become much more difficult to ignore.

Pregnancy introduces an element of surprise and urgency that is not generally present in analysis. An interruption of the treatment by the analyst is certain, but its timing cannot always be planned with accuracy. The material of the "analytic surface" (Panel 1993; Levy and Inderbitzin 1990) will now include the patient's conscious and unconscious responses to the complicated stimulus of the analyst's pregnancy.

For the pregnant candidate, the issues begin before her candidacy and before she becomes pregnant. The desire to be an analyst and the desire to be a mother often, if not always, have many common psychodynamic roots, particularly the reparative and caretaking needs behind these choices. In the conflict between her patients' needs and the demands of her pregnancy, she will inevitably experience anticipatory anxiety and guilt about falling short in the valued tasks of caring for baby and patient, fearing that she will not be able to do either adequately (Wayne 1987).

The candidate may have postponed pregnancy during medical or graduate school, and therefore be in a position of making crucial reproductive choices during analytic training. Postponing children until after analytic training may result in an inability to bear children at all. Postponing analytic training until after childbearing may be equally unrealistic. Conflict between the desire for a successful career and the desire to be a mother is common, and contributes to ambivalence about both motherhood and analytic training (Moulton 1979). This ambivalence can make the task of the pregnant candidate exceedingly difficult, especially as she will have to deal with her patients' ambivalent responses to her pregnancy. The transition to motherhood reawakens old conflicts at every developmental stage, to which new and creative solutions are now possible (Bibring 1959).

Our research found that if supervisors fail to appreciate the special circumstances involved with pregnancy during training, they may add to the complexity of the issues faced by the pregnant analytic candidate and her patients. In the most extreme situation, a supervisor who either ignores the pregnancy or actually disapproves of it can turn a potentially joyful event for the candidate into a misfortune for the analysis. Contributing to the possibility of such a result is the outdated attitude in some psychoanalytic institutes that pregnancy is a hindrance to analytic training. When one candidate we encountered told her male supervisor that she was pregnant, he said, "I cannot imagine a pregnant analyst."

Clearly, the analysis of the candidate's responses to her pregnancy belongs in her personal analysis. But since these factors will have a powerful impact on the course of the analysis she is conducting, they are also issues to be discussed directly in supervision, adding to the responsibilities of the supervisor. The supervisor's challenge is to help the analyst avoid converting this important milestone in her life into a millstone or stumbling block in the analysis of her patient. The supervisor can help the analyst turn the evocative nature of the pregnancy into a positive force for the analysis.

REVIEW OF THE LITERATURE

The topic of the pregnant analyst is relatively new and is sparsely represented in the psychoanalytic literature (Campbell 1990). Most of this literature, beginning with Hannet (1949), outlines the central tasks necessary for the pregnant analyst to adapt to the practical and developmental challenges imposed, while simultaneously attending to the heightened transference-countertransference themes intensified by the pregnancy.

Lax's landmark paper (1969) was the first to give detailed clinical material from the analyses of six patients and their responses to her pregnancy. She remarked on the paucity of literature on this topic, but her paper did not stimulate additional such writing for many years. Furthermore, Lax did not address the subject of supervision. When discussed at all, supervisory aspects have concerned pregnant psychiatric residents (Butts and Cavenar 1979) or psychotherapists (Baum and Herring 1975; Fenster, Phillips, and Rapoport 1986), but not psychoanalysts. This group of papers emphasized negative interactions, such as envy in the supervisor and guilt in the supervisee, but they were written mostly from the perspective of the supervisee. There was a predominant implication of negative bias toward the psychiatrist or psychotherapist who became pregnant. In some examples, the pregnancy was simply ignored.

Fenster, Phillips, and Rapoport (1986) were the first to give an informative description of the various problems that occur in the supervision of pregnant psychotherapists. These authors noted that the negative impact of the supervisor can "unwittingly create conflict for the therapist" (p. 10). This paper included a review of Fenster's (1983) doctoral study of twenty-two analytic psychotherapists in training, which documented a spectrum of reactions to the supervisor, including discomfort, hypersensitivity to criticism, new feelings of attachment and dependency, and reparative moments. The authors found that most pregnant therapists preferred a female supervisor, desiring a significant model for identification. Penn (1986) and Lazar (1990) also provided a variety of helpful technical guidelines for the pregnant psychotherapist.

Literature on supervision of the pregnant psychoanalytic candidate has only recently appeared. Dewald's book on supervision (1987) included an example of a pregnant candidate, but said little about the impact of the pregnancy on the candidate, on himself as the supervisor, or on the analytic process. Bassen (1988), in discussing the impact of the analyst's pregnancy on the analysis, offered technical guidelines regarding when to tell the patient about the pregnancy. She pointed out that bringing in reality issues too early inhibits the unfolding of the transference meaning, whereas telling too late risks neglect of separation issues. She suggested that the candidate who tells too early is focused on the reality of the pregnancy and is colluding with the patient to use that reality as a defense against the symbolic meaning of the pregnancy in the transference.

The first detailed and informative paper on the pregnant analyst was written by Uyehara et al. (1995). It concerned a female supervisor and a group of candidate-analysts who had one or more pregnancies during their training. The paper focused on telling the patient about the pregnancy. The decision of how and when to tell was influenced by reality concerns, countertransference, and a variety of clinical issues specific to the patient and to the vicissitudes of the treatment. The authors found that

how and when the patient was told were crucial in determining whether the case went well. They suggested that telling should await some awareness from the patient, while reserving enough time (optimally before the end of the second trimester) to deal with attendant issues. Related matters, such as the imminent motherhood of the analyst, also need time to emerge, they found. Our own work owes a great deal to this landmark paper, and in fact confirms all its findings.

In another important paper, Imber (1995) cogently discussed some of the problems facing the supervisor, illustrating her points with examples from the supervision of three pregnant candidates. She emphasized that pregnancy highlights the ways in which the analyst's life enters the treatment room and the supervisory situation. In trying to provide optimal supervision, Imber struggled primarily with the thorny supervisory conflict of "teach or treat." She came to the conclusion that both are possible when the candidate is pregnant, and both may even be necessary in the service of the candidate's education.

Much has been written in our field about matters such as abstinence, anonymity, and self-disclosure. The analyst's pregnancy can be regarded as an "inescapable self-disclosure" (Pizer 1997, p. 453). Hence, among the many clinical and pedagogical matters that supervisors need to consider—and even challenge—are abstinence and anonymity (Abend 1982; Arlow 1963; McGarty 1988; Schwartz 1987), teach or treat (Issacharoff 1982; Jacobs 1995; Sarnat 1992), gender issues (Fenster 1983; Fenster, Phillips, and Rapoport 1986), and parallel process (Goldberger 1992; Stimmel 1995).

CHALLENGES IN SUPERVISING THE PREGNANT CANDIDATE

The Candidate's Pregnancy as a Special Event

In the course of every analysis, special events may occur whereby outside reality intrudes on the analyst's anonymity—such

as chance meetings outside the office, telephone calls, emergency absences, illnesses, relocation, marriage, divorce, and death. The literature on such events was summarized and discussed by Imber (1995—see also Imber 1990; Weiss 1975). But these events are only partly analogous to pregnancy. Illness in the analyst mobilizes a different set of fantasies in both parties, as does relocation of the analyst. Certain manifest similarities do exist as consequences of these events, such as their time-limited quality, the need to set dates, interruptions, and the analyst's momentary focus on reality, all of which can serve as organizers for defenses and transferences.

The analyst's pregnancy contains an additional constellation of realities: (1) it extends over a period of time, rather than occurring briefly; (2) it is almost always known to the analyst before the patient; (3) it becomes more evident with time; (4) it is time limited; and (5) it ends with a prolonged interruption imposed by the analyst. The unusual technical challenges faced by the pregnant candidate carry the added difficulty that she is often inexperienced, perhaps treating her very first analytic case. There is also an element of uncertainty, since one cannot be sure the pregnancy will go to term.

When the patient learns that the analyst is pregnant, he or she often feels surprised and caught off guard. This sudden intrusion mobilizes intense transference reactions and fantasies, well before they would otherwise have emerged. Many patients are reluctant to talk spontaneously about such intrusions, and a candidate may have difficulty recognizing a patient's associations to them, especially if they touch on areas of discomfort for the candidate: feelings of guilt, anxiety, ambivalence, or excitement. A candidate may minimize the impact of her pregnancy through conflict or inexperience, leading to a conspiracy of silence that puts the continuity of the case at risk. This is a time when good supervision is crucial. It is also a time when most candidates have an increased need for support, advice, and reassurance, and when many women search for role models and mentors. There is a potential for a more intense relationship with the supervisor and

a potential for transference displacement. The supervisor must decide what sort of involvement is appropriate and useful.

When to Tell the Patient That the Analyst Is Pregnant

Is there a time when the analyst should announce her pregnancy if the patient has not directly addressed it? How does the supervisor help the candidate know when to tell, and what advantages and disadvantages must the supervisor be aware of in choosing a time? As our discussion will elaborate, our recommendation is that more is gained than lost by the analyst's bringing up her pregnancy before the end of the second trimester if the patient has not already done so. Ideally, the patient will recognize and acknowledge the pregnancy early enough to permit an exploration of the pregnancy's multiple meanings. However, if the patient's defenses prevent conscious awareness of the pregnancy until very late, or if the patient does not recognize and acknowledge it, the analyst does not have the leisure of waiting indefinitely due to the impending interruption for maternity leave.

Postponing the introduction of the pregnancy until after it is publicly known runs the risk that the patient may find out from outside sources and feel even more betrayed by the analyst. Telling early (before physical changes in the analyst are obvious) may help to mitigate feelings of humiliation that sometimes follow failure to notice what "everyone" can see (Uyehara et al. 1995, p. 119). If possible, it is best to discuss the patient's feelings and fantasies about the pregnancy separately from the issue of maternity leave. But this is often prevented by concerns about the analyst's impending "disappearance." For some patients, these concerns may seem paramount but may actually be screening other issues, such as envy, rivalry, competition, and murderous wishes.

Whenever the candidate introduces the reality of her pregnancy, she has to be alert to the effects of intruding on the patient's autonomy, as well as the effects of bypassing defenses.

Telling something personal to the patient has many potential unconscious meanings beyond the pregnancy as such. Telling can evoke competitive conflicts, exhibitionist-voyeuristic fantasies, and primal scene material. There is a risk in telling the patient too soon. Premature disclosure may preclude a more informed, uncontaminated analytic opportunity to understand the unconscious meaning of the pregnancy for the patient and what it means in the transference to know or to not know.

Telling too early may reflect blind spots of the inexperienced candidate, who is under pressure to get the information into the open because of her own concerns. Rather than waiting to see how material develops, she may try to take control because of the immensity of the changes she is facing. Candidates may feel as guilty for having a secret as for forcing the pregnancy into the analytic space. A candidate may fear her patient's aggression as well as her own, and telling early circumvents a more powerful buildup of rage and resentment. Also, since the risk of miscarriage is greatest in the first trimester, telling too early could result in the patient's having to deal with the idea of the analyst's pregnancy while the analyst is herself dealing with a significant loss.

The single most difficult issue for the candidate is how to recognize when her patient is consciously aware of the pregnancy. Many patients, because of their own conflicts, remain only questionably aware of the pregnancy for many months. Their awareness may continue to be subliminal. When associations contain oblique references, through dreams or displacements, to various aspects of the general subject, it is hard to be certain of the patient's consciously available awareness. Even when they know, patients may be unable to talk about it or may use strong denial. Just as patients may have difficulty knowing, so may analytic instructors.

An amusing anecdote illustrating this point came from a pregnant candidate who attended classes regularly, but did miss one class at the end of her eighth month. As her classmates were asking each other if perhaps she had delivered her baby, the semi-

nar leader (a father of four) asked what they were talking about. He had not been aware that she was pregnant!

On occasion, the patient's associations seem to clearly reflect conscious awareness of the pregnancy, but the candidate is unable to recognize their significance—or, because of her lack of experience or her inhibitions, she believes they are not sufficient to warrant interpretation. On the other hand, the candidate may overestimate the clarity of the patient's associations due to her own need to get the fact of the pregnancy out in the open. The role of the supervisor is crucial here. The following example from our experience illustrates the subtleties involved in deciding when to tell.

A candidate was in her second trimester and far enough along to be wearing loose clothing. The supervisor thought that her patient's indirect allusions to the pregnancy did not yet indicate conscious knowledge because of the patient's pervasive obsessional defenses and generally constricted character style. The week after the candidate discussed this issue in supervision, the patient dreamt that he was holding a baby in his arms, and then he threw it out the window. The candidate now assumed that "he must know" and mentioned her pregnancy. The patient was taken aback, completely surprised, since his awareness had been only subliminal.

The need to distinguish between conscious and subliminal awareness was discussed well by Stuart (1997):

> Recognition of the therapist's pregnancy may first occur at the threshold of consciousness, as in dream material . . . . The pregnancy's first showing does not have the self-evident quality of an unambiguous, supraliminal stimulus and may partake of some characteristics attributed to subliminal stimuli. [pp. 349-350]

One patient acknowledged—*after* the analyst announced her pregnancy—that for the preceding two or three weeks, he had found her more feminine and attractive.

When a patient cannot consciously register the analyst's pregnancy, supervisors are most useful if they can suggest ways in which the analyst might address the patient's defenses. For example, a patient started missing sessions, took actions at work that might lead to transfer out of town, and became increasingly preoccupied with a passionate love affair, while the analyst's visible pregnancy seemingly went unnoticed by the patient. This patient had characteristically handled fears of rejection through avoidance, disavowal, and identification with the person whose rejection she feared. The supervisor thought that the subliminally perceived pregnancy was leading the patient to shut out the analyst, thus accomplishing both a retaliation against her and a denial of her own fear of being excluded. The supervisor suggested that the candidate make interventions that showed the patient her need to make things happen before they happened to her, and to address the patient's fear of experiencing anger at the analyst. These interpretations subsequently facilitated the patient's ability to become conscious of the pregnancy.

Beyond the fifth or sixth month, the longer the analyst waits to deal directly with the fact that she is pregnant, the less time there will be to analyze the patient's unconscious conflicts and negative responses to the pregnancy, to the baby, and to the separation of maternity leave. Our own observations largely confirm those of Bassen (1988) and Uyehara et al. (1995) that failure to tell in a timely fashion may result in the patient's leaving analysis. Patients in their first year of analysis and those with fertility problems are especially vulnerable. Furthermore, any patient told late will be more at risk of unanalyzed identification and enactments that threaten the analysis, as in the example of one candidate who was unable to recognize and interpret the patient's preconscious awareness of her pregnancy, leading to the patient's becoming pregnant out of wedlock. In the enactment, the patient was identifying with the analyst's silence about personal matters, reacting to the analyst's general reserve as a model to support her defense of not knowing and inhibiting perceptions about the analyst. Such patients are unable to recognize what is "obvi-

ous," and may then respond with mortification and outrage when their defenses are interpreted.

We found analogous issues in the supervisory dyad in which the candidate could not "hear" the supervisor, such as when a candidate expressed a sense of being betrayed by her supervisor, feeling that the supervisor should have been more directive or explicit about the need to interpret pregnancy material earlier. However, no matter how explicit the supervisor may be, the candidate has to be ready to hear the supervisor. We must keep in mind that pregnancy is not just a special event in the analysis; it is also a crisis in the candidate's life, particularly if it is the first pregnancy, carrying with it many new conflicts that can interfere with both analytic and supervisory listening.

The following example supports our conclusion that more is to be gained than lost by the analyst's bringing up her pregnancy before the end of the second trimester, if the patient has not already done so. A candidate had become pregnant shortly before starting the analysis of her first supervised case, an obsessional and narcissistic young man. Initially, she had not told her supervisor that she was pregnant as she was fearful that she might lose the baby. When she did tell him early in the second trimester, she expressed guilt over not having informed either the supervisor or the patient that she was pregnant when she began the analysis. Her supervisor, who had no prior experience in supervising a pregnant candidate, was kind and supportive, telling her that she had done exactly right.

However, he also told her that she should not inform the patient, but should wait until it came up in the material. By the third trimester, the candidate was becoming uneasy about the supervisor's continued advice not to tell the patient. He explained that she should not intrude her own issues into the patient's analysis, and stated that it was premature to tell the patient because he did not hear any awareness of the pregnancy in the material.

The candidate sought out one of us, who suggested that she ask her supervisor how much notice he would give a patient if

he knew he was going to interrupt the analysis for three months. He responded, "I hadn't thought about it from that perspective," and agreed that the patient should be told. The patient appeared to take the news very calmly and went on talking about the material he had been discussing previously. A few days later, he commented without much affect that, based on the analyst's due date, she must have been pregnant at the time he began analysis. Her efforts to explore his feelings about the fact that she had not told him went nowhere. He maintained that it was merely "interesting." After the conclusion of the analyst's maternity leave, he did not resume the analysis, nor did he return the analyst's calls. The supervisor expressed astonishment at this outcome, as he had not heard anything in the material indicative that the patient might flee.

Of course, there is no way of knowing what the outcome of this case would have been had the patient been informed of the pregnancy earlier. However, there would have been greater opportunity to uncover analytically the powerful feelings—likely narcissistic injury and a sense of betrayal—that led to his fleeing the analysis. The deceptively mild comment about the analyst's having been pregnant before the analysis began was the only indication that he had been mulling over the unwelcome news. While there was a natural reluctance on the part of both analyst and supervisor to prematurely interpret his denial and isolation of affect, we can speculate about communications from the patient that may have been missed by both the inexperienced analyst and by her supervisor, who was inexperienced in working with a pregnant supervisee.

Maternity Leave and the Resumption of Analysis

The supervisor can be especially helpful with the details of how to discuss maternity leave and arrangements for resuming treatment. Patients often bring up the analyst's maternity leave soon after realizing that the analyst is pregnant, and before the analyst is ready or able to discuss details. The patient's anxiety

and need to know often pertain to fears that the analyst may not return after giving birth. Doubts about the analyst's return often persist long after the dates have been settled and discussed. They may be unconscious, or conscious but unexpressed.

In one case we examined, only after the analyst returned from her maternity leave was the patient able to tell her that "I really thought that once you had your baby in your arms, you'd decide to stay home." This patient had insisted that she needed to know the exact dates of the maternity leave well in advance. The analyst had been uncomfortable providing such precise information, since the exact delivery date was unpredictable. However, her supervisor helped her to separate her own anxiety about the delivery from the patient's severe preexisting anxiety about abandonment, which was being exacerbated by the pregnancy. Neither analyst nor supervisor realized the extent to which the patient was terrified that the analyst would really never return, but it was clear that the patient might flee the analysis if she were not given exact dates. They decided that for this particular patient, the leave would be of three months' duration. Only after her return did it become possible to explore the patient's previously unspeakable fear.

Although the length of leave is a personal matter and the decision is up to the candidate, in our experience, it most often falls between six weeks and three months. Some candidates are not aware that too lengthy a maternity leave could put the treatment at risk. In one extreme example, a candidate, whose two supervisors did not discuss with her the four-month maternity leave she had planned lost both of her analytic patients and almost all of her psychotherapy patients.

If the candidate does not explicitly mention what she has planned for her leave, the supervisor should inquire about it. Plans for each patient should be discussed individually so that candidates know that resuming work can be gradual and geared to the needs of both patient and analyst. The plan need not be the same plan for every patient. Some analysts and patients prefer setting a definite date to begin maternity leave, such as one

or two weeks before the expected due date. (This is probably the best model for child patients.) Other patients prefer to stay in analysis as long as possible, and to be notified at the last minute in order to minimize the length of the interruption. An analytic attitude can be maintained if these plans emerge as a result of discussion between analyst and patient.

The candidate needs to decide whether to sign out to another analyst during the leave or to take calls herself. Some patients are comfortable simply knowing that the analyst will answer telephone messages. Other patients may need to be seen during the analyst's leave. Sometimes candidates fear that it would be "unanalytic" to see a patient a few times during an extended leave; but this is not necessarily the case, depending on the nature of the contact. Candidates who are inexperienced mothers are often hesitant to discuss their return to work because of their uncertainty about how things will go. Most first-time mothers are anxious about leaving their babies to return to work. Supervisors should be aware of this anxiety and be available for guidance. When the analyst is uncertain, an approximate time frame can be indicated.

Supervisors can be very helpful during the frequently difficult first postpartum year. We have observed that first-time mothers with colleagues and friends who have gone through this experience are much less anxious and less in need of guidance. They will have already networked about ways to get good child care and have made the necessary arrangements before resuming their professional work. If anxieties are present, they usually emerge spontaneously, especially with a female supervisor. However, not all pregnant candidates are able to get peer support. We feel that it is appropriate for the supervisor to inquire about such matters if the candidate does not bring them up.

Defenses against Aggression

Supervisors need to be aware that conflicts over aggression are likely to become major issues at this time. Often the preg-

nant candidate has a strong need to deny aggressive thoughts directed toward her baby—her own as well as those of her patients. Very primitive forms of aggression may be stirred up in patients, and will need to be dealt with sooner than might have been the case had the analyst not become pregnant.

Milder forms of aggression, such as sibling rivalry, are easier to recognize and accept. For example, as one female supervisor was helping her supervisee to recognize the patient's sibling rivalry toward the baby, the candidate confessed her own feeling of rivalry with her unborn son. This was her first child, after several years of marriage. She told the supervisor that, starting in the second trimester, she had had several dreams of misfortune befalling the brother who was born when she was five. She felt that his birth had disrupted her "princess" lifestyle. In addition, she realized that her wish to bring her baby to a supervisory session once he was born carried with it the ambivalent wish to show her supervisor what an interference the baby could be.

Supervisors must be sensitive to evidence that the candidate has not noticed the patient's hostile and sadistic thoughts and fantasies. Listening to patients expressing vivid fantasies of harm or death to the baby and to the analyst can be very difficult indeed. For example, one male patient had the fantasy of smashing the baby against one wall and the placenta against the other. In subsequent hours with that patient, the candidate steered away from material about her pregnancy. She was able to recognize this avoidance when it was pointed out to her, but was not able to stop the avoidance for some time.

These vignettes illustrate that the pregnant candidate may well have had difficulty with her own aggression toward her patients, as well as toward her unborn child. She may have unconsciously expected her patients to be pleased by her pregnancy, to be as proud as she was, or to take care of her; she may have become angry if they failed to meet these expectations. Guilt over the anger may then follow. The analyst may also feel

guilty for leaving her patients or for outdoing them. Many pregnant candidates feel guilty for putting their own desire to have children before their commitment to their patients. While these are matters to be taken up in the candidate's personal analysis, when they are reflected in the analytic work, they enter the province of the supervisor.

The Candidate's Defenses against Erotic Transference

Helping the pregnant analyst recognize defenses against the erotic transference may be one of the most challenging tasks for a supervisor. Supervisors of either gender may be uncomfortable about the intrusion of the candidate's pregnant body into the analysis and may avoid working with such issues or minimize them. Lax (1969) discussed colleagues who claimed that their patients did not notice that they were pregnant, likening their statements to the "Victorian conviction that children really are blind to the changes in their mothers' bodies and that they do believe in the stork" (p. 371). She commented that some of these women actually began embroidering large tablecloths or making Afghans during their pregnancies, unconscious of the fact that they were hiding themselves from their patients, yet sending a significant nonverbal message to them not to see or talk about the pregnancy or the fact that the analyst had been revealed as a sexual person.

Recognition of the fact of the analyst's sexuality will have a profound impact on the work. Supervisors who have never been pregnant or who have not had experience with pregnant candidates are sometimes less aware of the erotic transference. When a supervisor colludes with the analyst in avoiding conscious awareness of her pregnancy, there is generally a mutual need to avoid dealing with the analyst's sexuality.

One candidate told us that when she was pregnant, one of her patients mentioned having noticed a red convertible in her driveway, at a time when he knew that she was pregnant but had

hardly spoken about it at all. He had strong reactions to the appearance of this car, with various fantasies that it belonged to the patient's husband or another man. Both supervisor and candidate were aware of multiple derivatives of intensely competitive feelings in the material, but neither was aware of the burgeoning erotic transference. For example, when the patient alluded to issues pertaining to rivalry, there was a subtle excitement in his voice. When the candidate inquired about this tone, the patient denied the slightest awareness of it, and disavowed its presence. Subsequently, he had the idea that perhaps his analyst was somehow excited by the sporty red car. He also had thoughts that the analyst liked the car and was attracted by the potentialities of a convertible. It was only later, in the analysis of other patients during her second pregnancy, that the candidate's widening range of experience allowed her to recognize with confidence the presence of erotic transference manifestations in those red convertible fantasies from some years before.

As with aggressive themes, the mutual avoidance of erotic material may be rationalized by the belief that it would be premature to interpret it. The pregnancy itself is a physical enactment, not put into words for some time, confronting a patient with the analyst's complex bodily reality. Waiting too long to help the patient deal with this aspect may result in the patient's enacting rather than verbalizing in response.

Sometimes a female supervisor identifies with the candidate as a new mother and focuses on mothering, to the detriment of the analytic work. This may lead to a mutual countertransference resistance to hearing the patient's sexual feelings. It may be difficult for a pregnant analyst to allow herself to hear the oedipal rivalry stirred up in her patient, now faced with the fact of her impregnation by a man. Likewise, it is easier for the analyst to avoid the erotic transference and to take refuge in the sibling issues that are also inevitably intensified by the pregnancy. The woman supervisor must be aware of her own maternal countertransference in order to be able to help the candidate with her blind spots.

DISCUSSION OF THE SUPERVISOR'S TASKS

Overcoming Assumptions and Myths about Pregnancy and the Pregnant Analyst

There are old myths about pregnant candidates that do not hold up in the light of data from the growing number of female analysts who have had children in the course of their training. Yet the idea that being pregnant is not compatible with practicing analysis is not uncommon even today. Sometimes a supervisor seems annoyed that the analyst has "complicated" the analysis by becoming pregnant. These attitudes toward pregnant candidates may unfortunately be an acceptable view in some analytic institutes.

Formerly, a pregnant woman was often considered to be too inwardly directed and too focused on the pregnancy to be sufficiently involved even in her own analysis. Similarly, a supervisor may have the idea that pregnancy in the analyst is incompatible with doing analytic work, and that the amount of tension and preoccupation inevitably evoked by pregnancy is distracting and diminishes the analyst's sensitivity to the patient's material. These beliefs based on outdated theoretical constructs are not supported by clinical data, and have since been replaced (see Goldberger 1991). Adherence to the older convictions can impair supervisory functioning.

In the past, when women did not influence the choice of courses or the organization of psychoanalytic training, analytic institutes did not pay much attention to gender differences in candidates. This has now changed. A leave of absence because of pregnancy or caring for young children has become more common, but is still sometimes regarded as—and treated as—implying a lack of seriousness, or as representing a choice between "femininity" and "work," rather than as a reasonable life arrangement. The idea that long hours of work are requirements for commitment is still prevalent in some institutes, even among candidates.

A supervisor's beliefs about such issues are sometimes outdated and counterproductive, and have gone unchallenged because there has not been sufficient open discussion about supervisory experience. Several members of our group were consulted for supervision by candidates who had been rejected by other supervisors.

The Supervisor's Gender

The literature on how men and women differ as psychoanalytic supervisors is sparse. Most of what we know is anecdotal. Several themes emerged as we listened to our pregnant candidates describe their experiences with supervisors. A pregnant candidate was a rare occurrence in the experience of many male supervisors who had been trained before the prevalence of female analytic trainees. Furthermore, most female analysts from that cohort had kept their pregnancies hidden as much as possible. Many special issues for female analysts concerning training and practice were neglected (Schuker and Levinson 1991). For supervisors trained in earlier years, these issues may not have been analyzed in their own experiences, and most likely did not come up in analytic seminars or reading. Inexperience, as well as unresolved issues, may therefore have led to a failure to approach the pregnant candidate in an optimal way.

A male supervisor may not have had experience in recognizing his own competitive or envious feelings toward a pregnant candidate. The need to defend against a wish to be impregnated can be very powerful in some male supervisors. This can result in unconscious hostility or excessive "chivalry"—that is, protectiveness. For example, a supervisor might avoid ordinary confrontations lest he seem too aggressive. Fears of being excluded from the forthcoming mother–child dyad may also remain unconscious for the supervisor and may interfere with optimal listening.

Furthermore, women often report that they describe their own reproductive experiences differently to a woman than to a

man. In fact, they are generally more comfortable speaking in detail to a woman about feelings and fantasies about menstruation, orgasm, pregnancy, female body parts, and menopause. Infertility, involvement in some of the procedures of the new reproductive technology, and miscarriage can pose important problems. The candidate might not discuss these issues explicitly with any supervisor, but is even less likely to do so with a male supervisor.

We have already discussed the tendency of female supervisors to overidentify with the mothering aspects of the pregnant candidate. Conversely, female supervisors who have never been pregnant may have to contend with feelings of competition and envy. Other rivalrous female supervisors may express unconscious feelings by denying the impact of the pregnancy or by overemphasizing the candidate's vulnerability.

Other Technical and Countertransference Issues

The most typical conflicts that arise in the pregnant candidate are reflected in guilt over abandoning the patient or over subjecting the patient to the conflicts that pregnancy might stir up. As a result, the supervisor may at times feel as if he or she is being asked to treat rather than to teach the candidate. Optimally, the candidate is still in a personal analysis during her first pregnancy, since she will be facing new issues that would not have appeared so prominently in her previous analytic work; the situation may be especially difficult when a pregnant supervisee is no longer in analysis.

The pregnancy can stimulate additional potential countertransferences in the supervisor. These can range from annoyed distancing from the pregnant analyst to overinvolved counteridentification. Supervisors may get vicarious pleasure from the candidate's pregnancy; they may project from their own experiences of pregnancy. Supervisors who have themselves had difficulty with pregnancy (either their own or that of a spouse) may assume that the candidate will have similar difficulties.

Also, this is a time when the supervisee is acutely aware of needing practical advice. Frequently, the pregnant candidate will look for a female supervisor or will find an informal, "extra" supervisor who is female. The designated supervisor should be understanding of the candidate's need for an auxiliary mentor. If the supervisor recognizes that there are special pedagogical needs when a candidate is pregnant, he or she will be more likely to aid the candidate in obtaining the help she needs, without feeling slighted or concerned that the appropriate fulfillment of these needs might represent an interference. Supervisors who themselves have had limited personal experience with pregnancy might benefit from consultation with more experienced colleagues. Although many analysts withhold the details of an illness in order to allow expression of the patient's fantasies, that is not possible with a pregnancy because it gradually and inexorably becomes more and more evident. Announcing the pregnancy can be regarded as a shift in technical neutrality that mobilizes a patient's fantasies and transferences, but it is often hard to assess the degree to which this mobilization is accessible to consciousness.

Hence, the supervisor must consider the relative importance of the "analytic surface" (Panel 1993; Levy and Inderbitzin 1990) —that is, the advantages and disadvantages of waiting until material about the pregnancy is sufficiently evident on the surface. This dilemma about surface is inseparable from a focus on defenses. When the patient cannot consciously register the analyst's pregnancy (or the analyst cannot recognize the derivatives that indicate the patient's knowledge), supervisors can be most helpful by addressing the patient's defenses that interfere with knowing.

SUMMARY AND CONCLUSIONS

When an analyst becomes pregnant, two major, separable issues are introduced into the analyses and psychotherapies she conducts: (1) there is now a third person in the analytic space; and (2) an interruption in the analytic work will be inevitable. Both these issues require exploration. The analyst's pregnancy should be

openly acknowledged by the end of the second trimester in order to allow sufficient time for these tasks to be adequately processed prior to the interruption.

The analyst's pregnancy will stimulate intense conflictual feelings in both patient and analyst, especially involving issues of aggression and sexuality. Open discussion about these affects in supervision, in the service of treating the patient, are of utmost importance. Of course, supervisors need to be aware that the pregnancy is likely to stir up intense, potentially conflicted feelings within themselves as well. Recognizing the profound and universal impact of pregnancy will increase the chances that this event will be dealt with effectively and productively in the analysis.

We hope that we have clarified some of the special supervisory tasks created by the special event of the supervisee's pregnancy in the course of her psychoanalytic training. We regard these tasks as didactic, not psychotherapeutic. The supervisee's treatment continues to belong in her personal analysis. However, discussing common difficulties that often arise during pregnancy, and pointing them out to the candidate when they seem to be developing in her work with the patient, are teaching functions that the supervisor can and should perform.

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Psychoanalytic Quarterly, LXXII, 2003

ADDENDUM TO FREUD'S "CRIMINALS FROM A SENSE OF GUILT"

BY ARNOLD GOLDBERG, M.D.

In his classical paper on criminals from a sense of guilt, Freud (1916) postulated that the particular misdeed of some criminals was preceded by guilt. The guilt that seemed to instigate a criminal act was thus a longing for punishment, which would in turn allow for a period of quiet and contentment. Freud felt that the origins of such guilt that initiated some criminality dated from the oedipal period and its murderous fantasies. I should like to offer an addendum to this very insightful and cogent explanation.

Ideally, I would like to present a case of criminal behavior that revealed supporting material for my thesis in an analysis. Issues of confidentiality prohibit this, so I can offer only a particularly brief version of a case that I feel is supported by a number of similar cases with similar dynamics. Suffice it to say that the case is a member of Freud's (1916) category of "theft, fraud, and even arson" (p. 332).

To begin, I shall offer a number of assumptions that are well supported in the literature. The first is that there is a biological component to many depressions. This would seem to be beyond controversy, although no single case may be proven to be representative of this fact. The second is that a variety of behaviors serve to alleviate depression. This is substantiated in both the pharmacological and psychological literature (Goldberg 2001; Kaplan and Sadock 1994). Indeed, a number of hypotheses ex-

plain the relief as stemming from behavior involving the release of dopamine.[1] One such hypothesis includes the formulation that the particular form of misbehavior used to relieve the depression is in itself not fixed, save that it regularly results in guilt. The following case is intended to serve only as a focus for discussion and is not meant as evidence.

Ms. S exhibited a form of criminal behavior that seemed clearly related to a long-standing and profound depression of suicidal dimensions. This depression was regularly, albeit momentarily, relieved by her criminal acts and was likewise inextricably bound to the punishment—inevitably imagined—that might ensue. Thus, there was a twofold result of her misbehavior: relief followed by guilt.

Ms. S recalled compulsive masturbation as a child, which was called "the bad thing" by her mother, who chastised her daughter for flagrantly and repeatedly masturbating. It is difficult in retrospect to disentangle the depression from the masturbation, inasmuch as one could postulate either guilt over the masturbatory fantasies or masturbation to relieve a depression having biolog-

[1] It is of some interest to correlate the work that has been done and is being done on the psychophysiology of behavior disorders. In the 1980s, we learned of the release of endorphins or endogenous opiates during exercise as well as during the vomiting phase of bulimia. A proposal was offered to support the idea that anorexia nervosa and bulimia are states of autoaddiction. Study of the use of self-medication in the treatment of depression has proceeded along two lines: The first had to do with the analgesic effect of opiates, while the second had to do with alterations in neurotransmitters during depression. This hypothesis was used to explain the comorbidity of drug dependence and depression. But the most intriguing reports involved the concept of the reward deficiency syndrome (RDS), which posits that those who overindulge in potentially compulsive activities, such as gambling, eating, and sex, have a variant gene. This gene allows certain individuals to gain pleasure from the release of dopamine in such risky activities. One interesting report was of patients with Parkinson's disease who had episodes of pathological gambling, who self-medicated and released dopamine via this behavior disorder. All in all, there is ample evidence that certain behavioral disorders both relieve depression and/or stimulate a transitory pleasure that obliterates both anxiety and depression.

ical origins. Most psychiatrists and analysts who have examined Ms. S conclude that she suffers from a biological depression. Whatever may be primary, it seems clear that layers of both misdeeds and guilt have played a role in the self-treatment of depression. Her misdeeds seem to have a beneficial pharmacological effect on her depression, and they inevitably lead to guilt, which has a beneficial psychological effect on her depression by way of the punishment that results.

As a child, Ms. S would ask to be punished alongside her brother for whatever wrongs he had committed, while herself being innocent. Freud (1916) introduced masochism in the light of a similar dynamic (p. 333n). Although some criminal behavior may warrant the added diagnosis of masochism, the latter is probably best seen as a complication of the former.

In brief, I offer the thesis that some childhood biological depressions are relieved by a variety of misbehaviors. These are well explained in the literature on psychopharmacology (Kaplan and Sadock 1994). Early masturbation, with its accompanying fantasies, may relieve depression and may also be a forerunner of various delinquent acts of later years. These masturbatory fantasies are followed by guilt, which becomes the focal issue in the affective life of depression. This guilt leads to punishment, which in turn alleviates the depression. Thus, there is a dually successful effort to treat depression: by misbehavior and by punishment.

Freud (1916) ended his brief article by wondering how many criminals belonged to this group who long for punishment. It is of no small moment that, prior to her treatment, Ms. S very much wanted to be imprisoned. She welcomed her guilt and punishment inasmuch as they lessened her depression. With treatment, she became less depressed, less given to criminal behavior, and less longing for punishment. Recognition of the critical role of biology as a causal agent of depression allows psychoanalysis to join hands with this field in a better understanding of criminal behavior.

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Psychoanalytic Quarterly, LXXII, 2003

DYNAMIC SUPERVISION CONCERNING A PATIENT'S REQUEST FOR MEDICATION

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During supervision, a psychiatry resident casually mentioned her response to a depressed patient's request for a change of antidepressant: she prescribed a new one. Should this have been the cause for supervisory intervention?

This is a difficult question. The prescription of antidepressant medication is routine and normative in current mental health practices. Psychiatrists regularly prescribe SSRIs for depressed and anxious patients, and psychoanalysts routinely prescribe for depressed analysands or refer them for medication. Medication is a first-line treatment for depression and anxiety, recommended by psychiatric textbooks and by the American Psychiatric Association (2002).

In this climate, it is a challenge for a psychoanalytic supervisor and a trainee involved in treating a patient dynamically to consider possible antitherapeutic elements of complying with the patient's request. To look at the prescription of medication as a countertransference compromise formation seems almost anachronistic (Blackman 2003). Nevertheless, the following supervisory sessions with Dr. X, a psychiatry resident at Eastern Virginia Medical School, led to some possibly instructive discoveries regarding her patient's request and her response to it.

Dr. X's Treatment of Mr. A

Mr. A, a 37-year-old, married man, entered treatment for depression due to confusion over his infidelity during his marriage.

His wife did not know about his affairs, but he felt guilty and conflicted about them. When the woman he had been furtively seeing for many months began to talk about leaving her husband to marry Mr. A, his depression intensified. Mr. A's family physician, who had referred him to the resident clinic, had already medicated him, first with Prozac and then with Wellbutrin.

During the first month of once-a-week, dynamic psychotherapy with Dr. X, Mr. A canceled two sessions. He had canceled at least twenty-four hours ahead, as was required by the clinic to avoid being charged. I pointed out to Dr. X that, notwithstanding his compliance with the cancellation policy, the missed sessions indicated resistance that she should address. Following this initial advice, Dr. X brought Mr. A's distancing and avoidance to his attention. He responded by noting his tendency to create distance in all relationships, including those with his wife and his mistress. He guiltily confessed to being self-centered. In the following session, Mr. A reported that he had decided to break off with the mistress and that he wanted to try to work out his problems with his wife.

The patient did not cancel any more appointments. A few weeks later, Dr. X reported in supervision that Mr. A had "pressured" her for "a good twenty minutes" to change his medication back to Prozac. Some months prior, his primary care physician had switched him to Wellbutrin because Prozac had caused sexual dysfunction, insomnia, and agitation. Mr. A remembered those side effects, but still wanted to restart Prozac to relieve his upset over losing his girlfriend. Wellbutrin, he argued, was not relieving his grief, and he had begun overeating. Dr. X's response, which she reported to me without much emotion, was "So I gave him the Prozac."

I felt somewhat critical of Dr. X for continuing to medicate the patient, rather than interpreting his wish to use medication as a defense against grief, especially since he did not manifest any notable weakness in affect tolerance. But in considering the psychopharmacological culture prevalent in twenty-first-century psychiatry residencies, I decided to engage the therapist's curi-

osity regarding her thought process in medicating her patient. She initially said, "I just thought, 'Whatever! Let's move on.'"

I responded by expressing my understanding that she seemed to feel worn down by the patient's persistence and desperation. She responded, a bit guiltily, that she knew her feeling of exasperation should not be an indication for medicating a patient. After Dr. X thought further about her decision to change Mr. A's medicine, she volunteered that, frankly, she was uncomfortable giving him *any* medication, since she felt his main problems involved narcissism and hostility toward women. I commented that it is difficult to be completely aware of one's reactions to patients during sessions. She responded by reflecting further on her interaction with Mr. A, and remembered feeling impatient and irritated. She then said, "I think I gave him the Prozac partly to get back at him, since I knew that he had bad reactions to it." Although she had not been aware of it during her session with the patient, she now commented that she disliked feeling bullied by him. She confided, with some irony, "It was almost like I was saying to him, 'Screw you!'"

I then asked Dr. X if she was interested in exploring her countertransference in more detail. (I later realized I had unconsciously responded to her affective reaction by asking her permission before intruding any further into her thinking.) She agreed, and thoughtfully considered that she had felt somewhat denigrated by Mr. A's request for medication. It had meant to her that he was taking over her role as a physician, making unilateral decisions about his medication without respecting her opinions.

Further, we discussed how Dr. X's "Screw you" comment might refer to something sexual as well as angry. When I clarified that she seemed to feel Mr. A was trying to force her to do something she did not want to do, she associated his pushiness with an unwanted sexual approach. We agreed that she had defensively acquiesced to his wish for Prozac in order to avoid her conflict about her anger toward him for his coerciveness. When I linked Mr. A's description of Prozac's prior interference with his sexual functioning, she immediately spoke her thought that giving him

the prescription was "castrating." In other words, his demands had led her to a compromise formation: she avoided consciousness of her anger at him, but simultaneously retaliated by prescribing Prozac to symbolically castrate him.

To paraphrase Marcus's (1980) definition, countertransference is a therapist's reaction that has its roots in the preconscious or unconscious of the therapist, is specific to the patient's transference or other material, and defensively interrupts or disrupts the treatment. Dr. X's prescription of Prozac seemed to have its roots in her preconscious conflicts, since she became aware of them through a shift of attention. Her activity in medicating the patient at his insistence also disrupted the therapeutic process, in that she became involved in a detour from her prior work on his character problems; that is, she did not confront the narcissistic, distancing, and controlling defenses that he was using with her. Instead, these mechanisms of the patient were gratified and, if anything, aggravated.

To pursue the missing third element (specificity to the patient) of her countertransference reaction (per Marcus 1980), I explored with Dr. X whether her reaction to Mr. A's demands was typical of her personality or more specific to this particular patient. She explained openly that she is an "aggressive" person who, generally speaking, does not cave in to people when she has distinct opinions or ideas. She added that she had come to make exceptions during her residency: at times, she kept her mouth shut and "went with the flow" in certain areas of instruction in which she did not agree. When I expressed curiosity about which areas caused her such defensiveness, she singled out psychopharmacology as the most dogmatic. She felt that she had been subtly coerced into agreeing to "prescribe medicine for everyone" by one psychopharmacologically oriented faculty member. Her submission to his point of view was unnatural for her, but she consciously avoided conflict with him in order to finish her residency (i.e., to adapt). As she was speaking to me, Dr. X realized that she had displaced onto Mr. A—whom she also experienced as coercive—some of her retaliatory anger toward this rigid psy-

chopharmacologist-teacher. In other words, this dynamic had also contributed to her countertransference compromise formation.

Returning to Mr. A's pathology, Dr. X considered that Prozac had had an inhibiting effect on his sexuality and an agitating insomniacal effect, and that Mr. A was likewise aware of these negative effects. She then wondered, "Why would a patient want me to do something to him that would make him uncomfortable or even harm him?" I suggested that perhaps he unconsciously wished to suffer. Dr. X then recalled that the patient had recently been talking about guilt over his infidelity. She then formulated that his desire for Prozac might reflect a wish that she punish him for his indiscretions. I added that an SSRI could also defensively relieve his guilt by chemically diminishing his sexual urges.

Dr. X then expressed some concern that she might be too "aggressive" in interpreting the patient's conflicts during his next session. Since I did not want her to feel pressured by me, I reassured her that she need not address all the dynamics we had discussed in one session. We agreed that she should use her judgment, see what material Mr. A brought in, and give thought to any other dynamics she picked up as well. The issue of medication was bound to come up again. When it did, she could take up the dynamics of the whole matter.

In the next supervisory hour, one week later, Dr. X reported that Mr. A had taken the Prozac, but at his own dosage (20 mg. per day instead of 60 mg. per day), in an attempt to avoid sexual dysfunction. She described how he had again argued his case regarding his need for medication. She then interpreted to Mr. A that his arguments regarding medication reflected his unconscious attempt both to bully her and to induce her to retaliate and punish him. The patient's reaction to this intervention was to blush and start laughing. He associated his arguing with Dr. X about medication to the manner in which he manipulated closeness and distance with his wife and his mistress, and then recalled the following dream:

> I am at a strip club, in the back with prostitutes. I started to sleep with one prostitute, but I was not interested in her and went to the next one. I didn't want to make any commitments. I was having sex in different rooms with different beautiful girls. During the whole time, my cell phone was ringing, and I was getting calls from my girlfriend, my wife, and my office. Also, throughout, I seemed to be carrying boxes as I went from one room to another where the prostitutes were.

Dr. X felt pleased about the progress of treatment. The recall of the dream seemed to be a response to her intervention and appeared to reflect Mr. A's complex conflicts about women, sex, and control, possibly including transference elements. She was able to see the importance of tracking the patient's associations to the dream as he proceeded in treatment.

The "Good Supervisory Hour"

Much as in Kris's (1956) experience with good analytic hours, Dr. X began her "good supervisory hour" with a mundane recitation: her tedious discussion with her patient about possibly switching medications. When I encouraged her self-reflection, she associated to her own defenses and affective reactions. After she allowed herself to become aware of her retaliatory fantasies and affects ("Screw you!"), her increased self-awareness seemed to enable her to continue to pursue a dynamic approach to her patient.

What had initially appeared to be the standard therapeutic activity of prescribing an antidepressant for a depressed patient turned out to be a countertransference compromise formation that included passivity, reaction formation, and the symbolic enactment of retaliatory castrating fantasies.

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Psychoanalytic Quarterly, LXXII, 2003

A BRIEF COMMUNICATION ON DEFLORATION

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The subject of a woman's defloration and its meaning as an important life event have been little studied in psychoanalytic literature. Thus, it was with great interest that we read "Flaubert's *Madame Bovary:* A Study in Envy and Revenge," by Arlow and Baudry (2002), in the *Psychoanalytic Quarterly.* Leaning heavily on Freud's (1918) formulations in "The Taboo of Virginity," Arlow and Baudry contend that Madame's Bovary's rage toward her husband and her destructive behavior, including a ruinous affair, can be largely explained by a need for revenge against him for her defloration. In his essay, Freud suggested that women might suffer a narcissistic injury from the "destruction" of the hymen, unconsciously perceived as an unforgivable castration. Freud's dramatic example of a woman's revenge against her deflowerer is the biblical Judith, whose castrating, murderous rage incites her to cut off Holofernes' head.

Arlow and Baudry, two males writing about a male novelist's characterization of Emma Bovary, validate our findings on attitudes of men toward a woman's defloration (Holtzman and Kulish 1996, 1997). In extensive research, based on clinical material from psychoanalyses of men and women, cross-cultural studies of attitudes and practices concerning the loss of virginity, fairy tales and myths, and literature written by males and females on the topic of defloration, we concluded that defloration is dynamically different for males and females. In a woman, loss of virginity brings feelings of sadness and loss—perceived loss of mother's protection, of purity, of childhood, and of a fantasized internal

penis. Additionally, it can be accompanied by fantasies and fears of genital mutilation and feelings of shame and humiliation, which often originate in early childhood.

This was evident in our psychoanalytic patients as well as in writings by women about defloration. For example, in *The Country Girls Trilogy and Epilogue,* by Edna O'Brien (1960), and *The Lover,* by Marguerite Duras (1985), it is the mother who springs into the girl's mind after her defloration, with anxious thoughts of her disapproval or ambivalent and competitive thoughts of stepping into her role. The revengeful hostility and binding to the man who deflowers the woman, suggested in "The Taboo of Virginity" and other early psychoanalytic literature, were not typically present in our female cases. For girls, giving up of virginity is a developmental step, accompanied naturally by ambivalence, but also by possibilities of sexual pleasure and self-growth. Perceived emotional or actual abandonment by men after defloration does evoke rage, as in Anne Sexton's (1964) poem "The Wedding Night," a lamentation for lost love and for the precocious giving up of virginity. With the exception of instances of forced penetration or rape, however, it was not the defloration per se that aroused women's anger and the need for revenge.

Beginning with Freud, the early psychoanalytic writings about the loss of virginity include several ideas that are erroneous. The idea that after a *mutually agreed upon* defloration women typically have hostile and aggressive feelings toward men is a case in point. We feel this idea of revenge against the deflowerer is an example of a male fantasy projected onto the female. Additionally, the central importance of the mother in a girl's development was not appreciated in these early accounts.

We found that with men, the loss of the female's virginity and the breaking of the hymen arouse different feelings and reflect different underlying dynamics. These include obsessive mentation, which defends against positive oedipal anxieties aroused at the idea of being "the first." We did not see in men who are the "deflowerers" the sense of loss and sadness seen in the women who are "deflowered." Because guilt-ridden, unconscious sadomaso-

chistic fantasies are often stirred up in men's minds by the act of penetration and defloration, consistent associative links with ideas of death and castration appear. Clinically, we found that men manifested unconscious fears of castration and destruction by their father and/or mother, perceived as retaliation for their forbidden urges evidenced in the act of defloration.

Another dominant theme in men's minds, writings, and behaviors is the desire for possession and ownership of the woman. Thus, the interpretation of Flaubert's novel by Arlow and Baudry is an example of these attitudes of *men* toward defloration. The themes in the novel and in Flaubert's other writings concerning loss of virginity, as documented by Arlow and Baudry, correspond to the scenarios in literature written by male authors, such as Shakespeare (1623) in *The Tempest,* Joyce (1922) in *Ulysses,* and de Lorris and de Meun (1275) in *The Romance of the Rose,* who depict a woman's defloration from a man's vantage point.

Arlow and Baudry cite direct references in *Madame Bovary* to defloration and imagery of castration and physical damage. For example, they note Charles's bungled surgery on a young man, resulting in an amputation followed closely by an interchange between Emma and her lover about defloration and the need to be the "first" love. Such themes of castration, punishment, and possessiveness are consistent with our observations about men's fantasies about defloration. Arlow and Baudry go beyond this, however, to argue that defloration is a central force in *Madame Bovary.* They state that they find Emma's "unmitigated rage" (p. 213) toward her husband "surprising" and unclear. They account for this by the hypothesis of a woman's unconscious fantasy of being damaged by defloration and a consequent need for revenge.

As Arlow and Baudry are well aware, however, their focus on this one dynamic aspect of Emma's character is necessarily narrowed. Indeed, they extend their understanding of Emma's reaction to her husband and her circumstances to considerations of her narcissistic character. In addition to emphasizing her penis envy, they point to her narcissism and her "defective sense of self" (p. 230). Nevertheless, in the need to build their argument about

the importance of defloration in explaining Emma's actions, they have selectively ignored other material in the text. They begin with an arguable premise that Emma is irrational and inexplicably full of hatred and that her husband is long suffering, kind, and undeserving of this attitude.

While it is beyond the scope of this brief communication to explore the many possible intrapsychic motivations for Emma's hostilities toward her husband, we would like to point out that Flaubert's complex characterizations suggest additional reasons for Emma's rage, such as her disappointment with the weak, "feminine" figure of her husband, anger at an uncaring, depressed mother, or being a replacement child for a dead brother. However, we are not proposing a better reading of Emma's fictional character than that of Arlow and Baudry. To argue over Emma's unconscious motivations is to fall into what seems to us the fallacy of treating a fictional character as a psychoanalytic patient. Rather, we are arguing that Flaubert's ambiguous and ironic style of writing is open to many interpretations, and that Arlow and Baudry's reading of the text may be constrained by their male perspectives.

We would like to comment in particular on only two passages that Arlow and Baudry use as illustrations to argue their case. Utilizing their method of analyzing the text in terms of context, sequence, and contiguity, we find that their presentation of evidence for Emma's behavior and motivations is skewed by omission of the immediately preceding lines. First, Arlow and Baudry quote a passage to demonstrate Emma's inexplicable assault on Charles after he expressed a desire to dance with her at an aristocratic party (Arlow and Baudry, p. 216). They omit an important descriptive sentence, which immediately preceded the quoted passage: "Charles's trousers were too tight at the waist" (Flaubert, p. 67). In describing Charles's foolish appearance and dress, Flaubert provides us with other reasons for Emma's disdain of her husband than the ferocious revenge postulated by Arlow and Baudry.

Second, "in a particularly revealing incident" (Arlow and Baudry, p. 216) depicting Emma's demeaning comments regarding Charles's smoking of a cigar, Arlow and Baudry again omit the immediately preceding passage that could explain some of Emma's reactions: "Charles proceeded to smoke. He curled and pursed his lips around the cigar, spat every other minute, shrank back from every puff." This is immediately followed by the sentence quoted by Arlow and Baudry to illustrate Emma's hostility: "You'll make yourself sick" (Flaubert, p. 75).

We argue that this selective reading leaves out wonderful descriptive segments that suggest other interpretations for Emma's feelings and behavior. Flaubert consistently pictures Charles's personality as ineffective and ridiculous, which offsets his steady but stolid devotion stressed by Arlow and Baudry. Thus, it does not become necessary to push the story to fit into a narrowed thesis of a singular need for revenge on Emma's part.

In his analysis of *Madame Bovary,* Culler (1974) demonstrated how Flaubert's style of description depicts Charles's weakness and stupidity from Emma's perspective, but nevertheless gives "a modicum of objectivity to her dissatisfaction" and suggests "a measure of truth"(p. 140). In the final analysis, however, it should be emphasized that Flaubert's complex narrative style leaves the "reality" ambiguous and often makes it difficult to state whose vantage point—Emma's, the narrator's—is being represented.

Thus, the interpretation by Arlow and Baudry of Flaubert's novel, and the novel itself, to the extent that their reading is plausible, demonstrate the unconscious psychodynamics in males about defloration that we encountered repeatedly in our research and clinical experience. Men, and not women, perceive the woman's need for revenge against the man after her defloration; men, and not women, consistently perceive defloration as a form of castration. We do applaud Arlow and Baudry's focus on this important event, defloration, which affects male and female psyches in intense and multiple ways.

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BOOK REVIEWS

LIFE NARCISSISM, DEATH NARCISSISM. By André Green; translated by Andrew Weller. London/New York: Free Association Books, 2001. 262 pp.

André Green needs no introduction to American readers, since he is now established as one of the premiere French interpreters of Freud and psychoanalysis in the Gallic style. His work is increasingly available in translation and is becoming more familiar on this side of the Atlantic. The present volume was both translated and published in the same year and brings us a collection of Green's essays spanning the years 1966-1980, together with a lengthy preface and postscript from 1982. While the content may seem somewhat dated to American readers, it is always an interesting intellectual exercise and something of an adventure to follow the labyrinthine twisting and turning of Green's arguments—invariably thought provoking and challenging.

As we have come to expect from previous and contemporary work of Green, the discourse centers on and develops out of the Freudian corpus. Most of what Green offers is commentary on Freudian texts. But as we open these pages, we step into an almost Kleinian world of psychoanalytic mythology, the world of life and death, of the forces promoting life and death—not as dialectical opposites of manifest and conscious experience, but as cognates, inexorably and profoundly assimilated one to the other in the curious and at times profoundly disturbed and disturbing bilogic of the depths of the unconscious.

Green writes from within the French analytic milieu, strongly influenced by British Kleinianism and object relations theory, engaging in an ongoing dialogue with his French colleagues. American contributions to the understanding of narcissism and the self are largely ignored or their importance downplayed. Pri-

ority in expanding the role of narcissism is given to French authors, especially Grunberger and Lacan, in preference to Kohut. While claiming a privileged place for narcissism in French analytic discourse, Green is careful to dissociate himself from prevailing opinions and to chart his own idiosyncratic course. A fundamental dimension of his approach, which he shares with many but which might meet a greater degree of questioning from non-Gallic theorists, is the ubiquity (not in question on anybody's terms) and exclusivity (much in question from other perspectives) of transference as the basis of not only analytic treatment, but also of analytic theory. Many of Green's clinical animadversions are concerned with clarifying and deepening our awareness of the role of narcissism as it plays itself out in both the patient's transference and the analyst's countertransference.

Throughout the book, discussion is carried on at a high level of abstraction, at times ascending to the heights of obscurity. The style is inescapably Gallic, eschewing clarity or simplicity of exposition and striving for a density of formulation that can be more mystifying than enlightening. But one always has the feeling that even in the murkiest of waters, Green is after something worth seeking, even though it may not be very clear to the struggling reader what that might be. I do not know whether this is endemic to French psychoanalytic writers—or to philosophers, for that matter—or whether we can attribute this propensity to a cryptic Lacanian influence.

Nor is the author much given to providing clinical examples. There are some, enough to leave the reader with the impression than Green has and does work with patients, but the clinical material remains scanty and thin. I found myself often yearning for more of it in order to help me decide what the point of the discussion might be at that juncture and whether it made sense to me. Where referred to, the clinical material seems to gravitate to the lower orders of the psychopathological spectrum—to the more disturbed levels of borderline and psychotic functioning.

This emphasis leaves one wondering about the extent to which the exposition of primitive and seemingly ultimate dynam-

ics of the human psyche reflect the quality of narcissism and its derivatives at these levels of personality organization, and whether expressions of narcissism at more developed neurotic and characterological levels are qualitatively different or not. For the most part, rather than clinical material, there is a smattering of clinical interpretations described, centering on the dynamics of narcissism and usually making good analytic sense from the standpoint of Green's basic postulates, but more rooted in the intellectual argument than in concrete clinical facts. These factors all contribute to making *Life Narcissism, Death Narcissism* a tough read, but one that has its moments, and that once completed, leaves the reader with a feeling of accomplishment.

One salient feature of the argument is the appeal to what the author calls *self-object relations,* as complementing classical Freudian drive theory, especially in conceptualizing more severely borderline and narcissistic forms of pathology. Here the dialectic between narcissism and the irreducibility of the object weighs in. Narcissism is then passed through the filters of *Eros* and *Thanatos* to emerge in the form of *life narcissism* and *death narcissism.* Life and death reach equivalence in the ultimate resolution of each in the release from all desire. Negative hallucinatory wish fulfillment is erected as the model for psychic activity: it is not unpleasure that replaces pleasure as motivating substructure, but the Neuter. The return to inanimate neutrality is the driving force behind the petrification of the ego, resulting in anesthesia, anorexia, inertia, inhibition, and psychic death.

One gasps as Green plunges into the depths of primal mythology and joins primary narcissism with death. The nirvana principle of the *Project* is recast as an absolute striving toward primary narcissism. Involved in the mix is negative narcissism, the dark side of positive narcissistic cathexis, that exercises its inexorable, regressive pull back to the zero point. The author offers a description of primary narcissism that is encompassing in its reach:

> The division [between primary narcissism and the ego ideal] enables us to get a clearer idea of the most extreme

> purposes of primary narcissism. There is no contradiction in thinking of it simultaneously as the state of absolute quiescence from which all tension is removed; the prior condition for the independence of satisfaction; the closure of the circuit by means of which the negative hallucination of the mother is fixed, paving the way for identification; and the process of appropriating the ideal so as to be able to attain the highest degree of perfection in which invulnerability is the ultimate aim. The stage which would necessarily follow this invulnerability would undoubtedly be that of *self-begetting abolishing sexual difference.* [p. 89, italics in original]

Primary narcissism, in this construction, is an investment in the zero point, so that the drive of the death instinct to the zero point of nirvana closes the loop of instinctual dynamics, transforming death into life and life into death. In the thought-numbing logic of the unconscious, opposites become identical and synonymous.

One of the subplots in the story is an attempt to enter into the dialogue emerging around the understanding of the self, the subject, and its attachment to the first-person pronoun *I*. This is rendered as an incompleteness in the terminology of narcissism that calls for closure. The referent of *I* remains diversified and unclear, applying to the ego for some, to the self for others, with the usages more descriptive than theoretical, and connotations for questions related to identity and individuation remaining unclear as well. The insistence on defining the self in terms of narcissistic investment reflects an adherence to the early construction of Hartmann: separating self from ego and appointing the self as the repository of narcissistic cathexes, a perspective on narcissism and the self that perfuses Kohutian self psychology as well. In the light of contemporary thinking about the role of the self in analytic thinking, this may prove to be an excessively confining frame of reference from which to sustain a more comprehensive concept of the self. I would submit that the self includes structural and dynamic properties that may incorporate narcissistic dynamics, but are not limited to them.

This concern merges with issues related to the role of narcissism in the transference situation in which both objects, analyst and analysand, are divided according to object-related and narcissistic object-cathexes on the part of both subjects. In the intrapsychic forum, by the same token, the self is related to its own self-representation in both objectal and narcissistic terms. Thus, Green urges the importance of the study of the relationship between object transferences, narcissistic transferences, and their intersection.

In his discussion of ego representation, the author makes some helpful distinctions. The ego is an agency that does the representing, and therefore is not as such representable. In his terms, what we would call a self-representation is a form of object representation that has been invested with narcissistic cathexis. This usage does not distinguish between a narcissistically invested self-representation and a narcissistically invested self-object. In any case, representations of the self are object derived and must endure the unremitting tension between yearning for unification with the object and corresponding loss of self. Relation with the object constitutes a trauma in which the dangers of reunification are counterbalanced by the intolerability of separation. The ego's defenses are aimed not against anxiety, but against the object whose independence releases anxiety. One resolution of this tension is in narcissism: instead of striving for union with an object outside itself, the ego adopts the option of finding an object within itself and investing it with libidinal cathexis.

The development of narcissism takes a variety of imperiling twists. The emergence of the ego ideal, for example, in the search for perfection, offers very little consolation, but adds a further burden of renunciation of pleasure: pride prevails over satisfaction. As Green puts it, "It is not so much a question of making a virtue of necessity as of making a necessity of virtue" (p. 67). Then again, sublimation and identification, as expounded in *The Ego and the Id,* modify sexual libido to ego libido by way of desexualization—an abandoning of object cathexes—resulting in

an undifferentiated neutral energy, a form of mortified libido that lies more directly open to the power of the death drive. One notes the conceptual inversions wrought by the compounding of narcissism and the death drive: aim inhibition, sublimation, identification, and the ego ideal are absorbed into the embrace of the death drive. As if this were not complexification enough, Green adds, "From this point of view, primary narcissism is Desire for the One, a longing for a self-sufficient and immortal totality, for which self-begetting is the condition, death and negation of death at the same time" (p. 90).

In this framework, birth is the primal catastrophe that sets us on a lifelong quest to regain as closely as possible the ideal conditions of intrauterine existence. The first birth is followed by a second in the loss of the breast, whereby the ego and its attendant reality principle come into existence. This is the trauma that creates the irresolvable tension is object relations and drives the ego back regressively toward primary narcissism as the terminal point of the death drive. The outcome is the development of a narcissistic carapace, a protective shield of coldness, indifference, and distance to fend off the narcissistic wounding from the object, preserving the illusion of self-sufficiency, omnipotence, and invulnerability. Repression is drawn into the service of preserving this carapace.

Green goes on to distinguish forms of narcissism: bodily, intellectual, and moral. The latter is the more absorbing, having close linkages with moral masochism in the resort to asceticism and renunciation; but for the moral masochist, the motivation is guilt for unpunished transgressions, while for the moral narcissist, it is more shame for not living up to the ideal, of not being or pretending to be more than the individual is. Punishment for the moral narcissist comes in the form of a redoubling of pride, provoking new renunciations. The implicit satisfaction in renewed impoverishments is that of narcissistic enhancement and superiority, which lie at the root of pride. Thus, the moral narcissist lives in a state of constant tension between ego ideal and superego, between shame and guilt, between narcis-

sistic gratification and punishment. Green then extends his discussion into the religious context, in which the ideals of the ancestor-god are stacked up against the dogma/prohibitions of the exalted parent. In this, the author seems wedded to the Freudian outlook, ignoring more recent thinking in the area of psychoanalysis and religion.

There is more to whet the reader's appetite: an interesting discussion of bisexuality and its implications for concepts of gender identity, and a long discussion of the dead (i.e., lost, depressed, or unavailable) mother. It is difficult to convey the richness and complexity of Green's thought, in view of its undercurrent of classical and literary allusions and its philosophic mode of discourse. If the style tends toward the pedantic and threatens at times to overwhelm the reader with density and complexification, it is nonetheless thought provoking and enriching.

There are inevitable limitations. The discussion is largely focused on French and Kleinian themes, reflecting a significant neglect of American sources, except for passing references here and there. There is no attempt to integrate thinking from this side of the Atlantic, especially the contributions of ego psychology or self psychology or relational or intersubjective perspectives. There is also no acknowledgment of current efforts to develop an understanding of the self outside Kohutian circles. Some of this may be understandable, since even the most recent parts of this volume date from a score of years ago. But the omissions limit the scope and usefulness of the book.

The other constraint (some might not regard it as such) is the close adhesion to Freud. Most of the content is offered by way of comment or interpretation of Freudian texts or positions. While some of the interpretive formulations are of considerable value and interest, the overall scope and theoretical synthesis are compromised, especially in relation to discussions of object relatedness, which is transformed into almost exclusively drive-derivative terms, and self-object relations, in which self-concepts are restrictively attached to ego functions. If one

were to step outside the framework of Freudian mythology, the metapsychology embedded in these pages might take on a different form. This reader was left with the distinct impression that old themes and old issues were being addressed in deeper and at times problematic ways—the merging of primary narcissism and the death drive being for me the most troubling. Acceptance of the argument put forth would seem to imply acceptance of a Kleinian canon in which both mythical processes are accorded real and dynamic status. While many, if not most, analysts on this side of the Atlantic might tend to disparage or find little applicability for the death drive, Green embraces it with Kleinian fervor. By the same token, the status of primary narcissism has been taken largely as a theoretical construct, helpful perhaps in completing a theoretical construction, but not a real entity in any sense. Green's discussion proposes it as not only real, but also dynamically powerful and fundamental. Has he redeemed and given new life to mythic ghosts? Or is he only perpetuating a misguided and misleading shibboleth of analytic mystification?

The propensities of the author's dialectic reflect a common direction of Kleinian thinking and much of the rest of psychoanalytic thinking on the continent. Analytic concepts are driven to their ultimate and often most primitive extreme. I do not know whether this reflects an inclination of analysts from these schools to focus more on primitive forms of psychopathology (the psychoses, primitive affective disorders, and malignant forms of narcissistic personality disorder)—although I confess that I have been impressed in my other readings of Green's works that when he draws attention to patient material (which seldom occurs), the patients seem to come from the lower order of psychic disturbance and structural defect. In any case, it strikes me that Green's treatment of narcissism speaks more to that range of pathology, and accordingly emphasizes the primitive, negative, and most pathological extremes of narcissistic dynamics. If there is acknowledgment of life narcissism, we hear little of it;

it fades into the background, while death narcissism looms large in the foreground.

The drive to primitivize these concepts forces narcissism so conceived into conjunction with its diametrically primitive opposite, the death drive. Does this conceptual conflation of opposites tell us something fundamental about the nature of narcissism in its most profoundly unconscious structure and expression, where opposites become synonymous and synonyms opposed? Or is it a conceptual legerdemain, an artificial coercion or tour de force driving narcissism into the realm of the negative, the self-destructive, and death? The positive aspects of narcissism, including the discussion of the ego ideal, are entangled in this compulsion to the negative, so that the multiple and significant contributions of life narcissism in its moderated and integrative forms—which we seek to help our patients achieve in the interest of living good and productive lives—are of little interest in the shadow of death narcissism. The concept of identification with certain aspects of the narcissistic integrity of the analyst, not necessarily within the confines of the transference, seems to have little relevance or interest in Green's perspective. Furthermore, the idea that moral narcissism—a concept of substantial importance, in my view, and a useful contribution to our better understanding of narcissism—might serve constructive, self-preservative, and adaptive purposes in the promotion of self-esteem and identity finds no advocacy here.

In sum, the richness of Green's argument on the nature and analytic function of narcissism is challenging and in many ways provocative. It brings to the attention of American readers a point of view and a way of analytic thinking that unveil profound and even disturbing conclusions, but that must be read with a series of provisos in mind and not a few grains of salt. The adventurous and stout of heart and mind will not regret turning these pages. For everyone else, *caveat lector!*

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TOXIC NOURISHMENT. By Michael Eigen. London: Karnac, 1999. 226 pp.

ECSTASY. By Michael Eigen. Middletown, CT: Wesleyan Univ. Press, 2001. 100 pp.

Griefs[1]

I measure every grief I meet,
with analytic eyes.
I wonder if it feels like mine,
Or has an easier size.

I wonder if they bore it long,
Or did it just begin?
I could not tell the date of mine,
It feels so old a pain.

I wonder if it hurts to live,
And if they have to try,
And whether, could they choose between,
They would not rather die. . . .

I begin my discussion of Eigen's books with poetry because it feels difficult to capture in prose the response I experienced as I read, and then partially reread, his work. These are not analytic writings in the usual sense of the word. Eigen, a psychoanalyst from New York, describes psychoanalytic/psychotherapeutic work, certainly, but he does so in a way that feels rather like embarking on an unplanned journey to multiple new lands, using a mode of transportation in which one is, at any given moment, traveling sedately on land and then unexpectedly hurtled into the air, only to be brought down suddenly to fall into rushing waters.

Perhaps the sense of surprise, pleasure, confusion, and chaos that I experienced as I read has to do with the fact that Eigen is looking with analytic eyes at the lives of people for whom life is an extremely painful endeavor, and for whom death often feels

[1] Dickinson, E. (1890). *Collected Poems of Emily Dickinson.* New York: Avenel Books, 1982, p. 32.

like a welcome choice. He describes these people as patients for whom "emotional nourishment and poisons can be so interwoven that it is difficult, if not impossible, to tell the difference between them" *(Toxic Nourishment,* page xiii). At the same time, he asserts that "a light at the center of personality must face and come through conditions threatening the very basis of its being" *(Ecstasy,* page viii). These books, then, are about helping our patients (and ourselves) to confront extreme hopelessness with therapeutic skill and with the belief that there is in each and every one of us something that can help us transcend the depths of despair, rise above the hopelessness, and begin to function.

In *Toxic Nourishment,* Eigen gives us detailed and vivid accounts of his work with people who were damaged by parents who either hated them passionately or loved them only as extensions of themselves. Both such hate and such love are toxic for the child toward whom they are directed. These children often grow to be adults who are either aware of their severe self-destructive tendencies, but feel helpless against them and want help, or who see their self-destructiveness and feel completely at home with it. He writes about patients who are seriously suicidal, who fear aliveness, who use "self-nulling" processes other than suicide, and who are incapable of letting themselves enjoy anything good or beautiful. He tells us how he works with these patients and tries to help them. His description of his work indicates the deep influence of Winnicott and Bion, but in surprising and interesting ways, Eigen draws on Freud's thinking as well.

For instance, the author writes:

> Freud scandalized reason by suggesting that people clung to illness because it was secretly gratifying . . . . Freud's view too easily then degenerates into pre-Freudian moralism. The patient does not want to get better . . . . Freud's challenge is more multilayered and difficult. We are in conflict with our life and death drives, which are partly antagonistic—cooperative with each other. Aliveness gets us in trouble. Fear, shame, guilt, caring, tone us

> down. Sometimes we tone down too much. Death becomes more powerful than life prematurely. Once this process gathers momentum, crossing over from death to life can be nearly impossible. Nevertheless, the fact that death feeds on life can provide some ground for hope. It is always possible that life can find a helping hand, whatever the odds against it. *[Toxic Nourishment,* p. 154]

In his attempts to lend a helping hand to his patients, Eigen refers to Winnicott's idea of "original madness" *(Toxic Nourishment,* p. 171). He understands this to refer to a deep madness within all of us, which we cannot tolerate knowing because we are not equipped to know it. Like the infant who turns away from that which he or she cannot stand to see, we turn away from feelings within us when they feel intolerable.

Eigen talks about the experience of feeling pain and horror, and screaming in response, in an attempt to bring a caretaker to one's side. He suggests that if this fails, the screaming sometimes becomes a substitute for feeling itself. At other times, it becomes meaningless. He believes that "if one's scream becomes meaningless . . . the capacity to respond to what bothers one can suffer grave lacunae, or even fail to develop" *(Toxic Nourishment,* p. 166).

The author's premise is that to experience original madness as such, one would have to experience what cannot be experienced. However, he agrees with Winnicott that therapy offers the possibility for the patient to dip into his or her original madness in manageable doses. The therapist needs to help the patient to experience "bits of madness . . . and repeated spontaneous recovery" *(Toxic Nourishment,* p. 167). I found this particular part of *Toxic Nourishment* to be beautifully written and convincingly argued, with rich clinical details. These are valuable ideas in working with the kinds of patients about whom Eigen is writing (and some would say in working with all patients). It is humbling to realize that not all of us in our work as analysts/therapists are always capable of working with our patients in a way that allows them to be "mad" with us. At times the

temptation to move the patient too rapidly toward saner feelings and behavior is very strong because of the discomfort we experience within ourselves as we experience our patients' madness.

In his newer book, *Ecstasy,* Eigen moves forward from the ideas presented in *Toxic Nourishment.* While maintaining many of the same theoretical beliefs, he emphasizes that beneath and beyond the destructive forces at work within a person, there is an underlying capacity for ecstasy that helps him or her to confront "suffering, degradation, annihilation, and an endless play of destructive forces that exert deforming pressures" *(Ecstasy,* p. viii). In this book, Eigen talks not only about his patients, but also more openly and clearly about himself, as well as about people whose work has influenced his thinking in profound ways. These include "Freud, Lewin, Lacan, Bion, Winnicott, Jung, Reich, and Kohut, rubbing against, sometimes melding with, Plato, Plotinus, William Blake, the Bible, Shakespeare, Kabbala, Spielberg, and everyday dramas of corruption and integrity" *(Ecstasy,* page viii).

Ecstasy presents an account of how Eigen takes in influences from all around him and metabolizes them in an effort to make sense of life, both for himself and for his patients. He talks of what he learns from his patients and from his family. He speaks honestly about the struggle that doing therapy can sometimes become. These are refreshing descriptions that challenged me to think about and reexamine some of my own ways of working.

Ecstasy feels very much like a collection of spontaneous thoughts put together. It reflects the kind of therapeutic talent needed to work with deeply disturbed and very difficult patients, a talent that allows one to be mad with one's patients in an effort to help them move beyond their own madness. Reading *Ecstasy* also requires a kind of madness on the part of the reader, in order to undertake the journey necessary to understand what the book has to offer.

Eigen writes:

> At any moment, a therapist may be too alive or dead for a given patient . . . at a given time, in a given way, and

> vice versa . . . . It feels good to relax one's grip on bits of personality one holds onto and repeatedly fine-tune one's self. *[Ecstasy,* p. 49]

In these books, Eigen offers each of us the opportunity to do this.

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SEXUALITIES LOST AND FOUND: LESBIANS, PSYCHOANALYSIS, AND CULTURE. Edited by Edith Gould and Sandra Kiersky. Madison, CT: Int. Univ. Press, 2001. 308 pp.

Over the past decade, new writings have deepened the psychoanalytic exploration of female homosexualities. This aptly entitled compilation, *Sexualities Lost and Found: Lesbians, Psychoanalysis, and Culture*, is a diverse collection of papers that aims to remedy past omissions of lesbian love from analytic discourse. The contributors to this collection agree that female homosexuality is not pathological. They write from various psychoanalytic theoretical perspectives, including Freudian, interpersonal, intersubjective, relational, and postmodern. Queer theory, sociocultural, philosophical, and performative viewpoints are also presented. The collection's four sections seek to explore clinical material and clinical theory, to theoretically deconstruct "the myth of lesbian identity," to illustrate the impact of culture on lesbian personal and artistic expression, and to comment on changes in psychoanalysis and the lesbian community.

I believe that analysts can contribute to understanding human sexuality by sharing clinical material drawn from individual patients, while remaining cognizant of inevitable countertransferential and theoretical biases. As I have noted elsewhere,[1] those women who experience homosexual interests, impulses, fantasies, or

[1] Schuker, E. (1996). Toward further analytic understanding of lesbian patients. *J. Amer. Psychoanal. Assn.*, 44(Suppl.):485-508.

identities include a wide range of individual personalities and present with a variety of core dynamic issues, gender role identifications, and developmental histories. To understand some of this variability and its meanings, as well as to reconstruct the experiential and other factors contributing to object choice, we need to explore and discuss actual analytic material. The existing analytic literature on this topic remains limited.

Thus, I found the clinical papers describing individual patients to be the most valuable component of this book. While written from diverse perspectives and variable in analytic depth and quality, they stimulate new questions. McDougall's outstanding clinical paper on gender identity and creativity begins the collection. She revises theoretical conceptions from her previous work,[2] in which she showed that a group of highly disturbed patients had salvaged precarious identities through homosexual object choice. In this poignant new description of a single long analysis—one that includes actual process material—the patient's family circumstances and the parents' unconscious wishes appear to have contributed to an adult homosexual orientation. The patient was a replacement child for a stillborn son, and she held an unconscious childhood belief that she should have been a boy so as to serve as reparation for mother (and father), while she also fought for her right to a female identification. In the analysis, she reclaimed lost parts of herself and regained the ability to use both masculine and feminine identifications in creative activity. McDougall's support for her patient's agency and authenticity emerge clearly. McDougall concludes that early childhood experiences and the parental discourse on sexuality and sexual role, rather than innate factors, figure as key influences on sexual role identity and sexual desire.

Kiersky's presentation focuses on common homophobic assumptions that lesbian desire is illusory or unreal. She describes how the reality of (lesbian) desire can be lost in childhood and

[2] McDougall, J. (1980). *Plea for a Measure of Abnormality.* New York: Int. Univ. Press.

adolescence because of a lack of attunement and validation from the external environment. She feels that this trauma can exile lesbian women to a "shadowland" where their erotic desires and sexual identity are imbued with secrecy, shame, guilt, and self-disgust. She shows that validation through a therapeutic relationship, as well as through analysis of internalized homophobia, may aid recovery of the capacity for desire. Kiersky does not consider whether experiences of "exiled desire" can occur regardless of orientation in women for whom sexuality is invalidated. That might have led her to consider the role of shame and secrecy, and to raise questions about the need for validation of women's sexuality in general. Are women more responsive to interpersonal sanction or disapproval of their sexuality? Additionally, Kiersky fails to distinguish the experiences of primary lesbians from those whose orientation changes later in life.

Gould's essay claims that revitalized representations of the body self and erotic desires can emerge out of analytic work. She sees women's desire as evolving out of an affectionate mother–daughter relationship and physical contact, with girls (as well as boys) identifying and disidentifying with both parents. Sexual desire occurs along a continuum rather than being static and binary (hetero/homosexual). Gould argues that a discrete sexual orientation may serve a defensive function, although in her example, bisexual desires serve as defense. She presents a case description of a young woman whose mother was intrusive and controlling and whose father was sexually overstimulating. A clinical fragment and three dreams illustrate both homoerotic fantasy themes and masochistic heterosexual behavior. Gould suggests that the homoerotic themes reflect the patient's intense struggle to resolve an ambivalent tie to her mother and to appropriate her own body. The patient's homoerotic fantasies later became part of an expanded range of fantasies that signaled individuation from her mother and formed a component of less masochistic heterosexual relations. Gould quotes Schuker to ar-

gue that we should unpack desire rather than making assumptions about the meanings of a homoerotic transference.[3]

In his "Gender Panic in the Analytic Dyad," Drescher humorously describes the countertransference pitfalls of working with a lesbian patient as a gay male analyst. In a clinical vignette, he reports erotic transference/countertransference feelings with a lesbian patient, in which each homosexually identified participant wishes to take heteroerotic sexual feelings out of the transference/countertransference interplay in order to decrease gender panic. Ultimately, Drescher finds the concept of sexual orientation to be an obstacle to the appreciation of wider subjectivities of both the patient and himself. He holds that gender identity and sexual orientation should be seen as processes and products of interaction, rather than as fixed biological structures, but omits investigating how psychically developed identifications might acquire fixity and meaningfulness.

In another stimulating clinical paper, Bassin presents analytic material during a three-year period of infertility experienced by a lesbian analysand. Exploration of the patient's fantasy that infertility was a punishment for her lesbianism led to deeper understanding of submission to an internalized parental authority that demanded heterosexual behavior. Bassin suggests that parenthood requires emancipation from the original oedipal parental couple, with multiple identifications, rather than a submissive idealization of heterosexuality. She delinks maternal capacity and the wish to be a mother, as well as the affliction of infertility, from erotic object choice. Bassin's case does not include a developmental history of interest in maternity. We do not yet know whether lesbian mothers with a history of gender-role atypicality or primary lesbianism differ in maternal interest or style of mothering from those lesbian mothers who have had more typical feminine gender-role development or who discover lesbian identity later in life.

[3] Schuker 1996 (see footnote 1, p. 498).

The book's theoretical section, entitled "Deconstructing the Myth of a Lesbian Identity," contains several speculative papers that aim to define the category of *lesbian* and to deconstruct and revise theories of lesbian desire. Those theoretical beginnings, however, rest upon a paucity of clinical confirmation.

A thoughtful theoretical article by Lesser, "Category Problems: Lesbians, Postmodernism, and Truth," challenges both the long-standing "sexual orientation view" that categorizes sexuality in binary terms (hetero/homosexual), and the postmodern view that encompasses a model of sexual fluidity. Lesser correctly perceives the theoretical task as recognizing uncertainty, rather than conjuring theories of sexuality to reflect our own values and preferences. While offering a critique of the homo/heterosexual binary, she also warns against reducing sexuality to an essence (of stability or fluidity or both) that produces a new norm. Lesser maintains that binary categories are historical and cultural constructs, creating boundaries about deviance and normality, and reviews how they are embedded in homophobia, history, and politics. A belief in stable sexual orientation may distort analytic listening, postmodern critics emphasize. In contrast, those postmodernists have argued, sexuality should be represented as fluid and contextual. Lesser concedes, however, that the postmodern theorists have used anthropological and historical data as well as midlife conversions to point to sexual fluidity. Lesser makes the point that the anthropological demonstration of plasticity and diversity of sexual practices across cultures does not demonstrate sexual fluidity within every individual. She describes a patient who had had a midlife conversion to lesbianism and whose subsequent heterosexual attraction then disturbed her sense of a stable sexual identity. While Lesser feels that this patient might be understood as "prefer[ring] a story of stability" (p. 132), rather than of fluidity, we are not helped to understand this in depth. Here I wish that Lesser had discussed the idea that women tend to have more capacity

for social malleability of sexual expression, that is, more erotic plasticity, than men do.[4]

I agree that we should not jump to pathologize stability or fluidity. Nevertheless, we need to understand how such preferences might evolve and function in the individual psyche. Overt behavioral object choice, erotic feelings, and social identity may not be consonant and may have different meanings for the individual. We ought to remain curious about the factors expressed in those preferences. Friedman has suggested that relative plasticity in female object choice may be related to less androgenization of the female fetal brain, but that does not fit with his suggestion of increased fetal androgenization in some female homosexuals.[5] Biological factors may indeed affect object choice, but I maintain that object choice may be influenced as well by attachment needs, intrapsychic conflicts, identifications, social directives, and the internalization of cultural pressures for conformity. I also hold that some aspects of female object choice may acquire early (perhaps oedipal) fixity, but may pertain more to qualities in the object relation than to gender of the object. With any individual patient, we need to remain open to all possibilities and to work toward understanding current internal experiences and fantasies. This includes the possibility that some object choices have developed out of conflict resolution. There are always multiple meanings to any behavior, preference, desire, or fantasy, whether fluid or stable.

In this same section on theory, Schonberg's contribution studies the linguistically difficult writings of both DeLauretis and Grosz. These writers presented academic ideas about relations between bodies, lesbian sexual desire, and culture. DeLauretis revised Freud's concept of perversion, envisioning a particular lesbian, erotic subjectivity that is a product of culture: namely,

[4] Baumeister, R. F. (2000). Gender differences in erotic plasticity: the female sex drive as socially flexible and responsive. *Psychol. Bull.,* 26:347-374.

[5] Friedman, R.C. (2001). Psychoanalysis and human sexuality. *J. Amer. Psychoanal. Assn.,* 49(4):1115-1132.

one in which lesbians desire the (fetishized) lost maternal object. Schonberg challenges the assumption that lesbians form a coherent group, as well as the notion that desire rests on a deficient personal body-ego image. Grosz, too, envisioned the female body as constructed in our culture as a "lack" or as an uncontrollably leaking liquid, deficient in self-containment. Such a cultural construction, when internalized, interferes with female autonomy. Schonberg applies Grosz's views to her own (intersubjective) concept of a patient's unconscious, which interacts with the unconscious and real behavior of an actual analyst. She feels that this formulation allows multiple images to occur for both analysts and patients, and encompasses experiences that can include diversity in race and class. All the same, Schonberg faults Grosz's fixed idea about the psychic meaning of the female body; she considers that it is the personal meaning attributed to corporeal experience, rather than the physical experience itself, that is determinative. Many analysts would agree.

Other papers in the theory section of *Sexualities Lost and Found* include Orange's description of sexual desire as an integral part of women's capacity for subjectivity, and Blum's challenge to Kohut in regard to his de-erotization and pathologization of the homosexual object.

The book's third section, entitled "The Impact of Culture," contains a number of thought-provoking contributions. Richards presents a lively discussion of the poet Minnie Bruce Pratt. Using excerpts from Pratt's autobiographical poems, she describes Pratt's midlife evolution to lesbianism. Pratt's adult years included a long attachment to her husband and the use of that relationship to project aggressive impulses. A new midlife homosexual orientation encompassed acceptance of her own aggressivity and her own sexual agency. If Pratt were a patient, we might wonder about the connection between her inhibited aggression and her unsatisfactory marriage. Was her heterosexual marriage a conformist effort, lacking in intimacy and erotic agency? Was her midlife conversion part of her personal growth toward an ability to be alone and to discover and ex-

press independent erotic desires? We do not know whether Pratt experienced a shift in erotic fantasies along with change in the gender of her chosen objects. Was the erotic direction new, or had it simply been hidden? Here is an inspiration for more clinical study, in order to enlighten us about erotic patterns, fluidity, and female sexual autonomy.

Both Ercole's paper "Postmodern Ideas about Gender and Sexuality: the Lesbian Woman Redundancy," and Schwartz's paper, "It's a Queer Universe: Some Notes Erotic and Otherwise," are actually contributions to theory, although they appear in the section on culture. Both suffer from a lack of clinical material to illustrate their ideas. Ercole presents postmodern conceptualizations, including the social construction of identity, in which sexuality and gender are understood as performative acts rather than as stable categories resulting from developmental sequences. Gender and sexuality are comprehended as something we do, with elements of sexual theater, masquerade, and scripted performance. Undoubtedly, social pressures play a part in the formation and expression of identity, yet the ways in which social elements become part of identity or can produce internal change are not adequately explored here. As a clinician, I am unwilling to exclude the idea that development can involve conflict resolution, consolidation, and structuring, rather than infinitely new performative acts. The sparse clinical material in this article is weak, unconvincing, and reflects a directive style in the therapist.

Schwartz's essay employs concepts from queer theory to discuss the important topic of lesbian eroticism. Schwartz offers engaging ideas about the range of lesbian eroticism, but her paper suffers from insufficient clinical data to substantiate its claims. She asserts that lesbians experience less rigidity in the relations between identification and object choice than do heterosexuals: both being and desiring a woman occur. Lesbian eroticism encompasses multiple identifications and positions of desire, with diversity in eroticism and role playing. Phallic imagery can be incorporated without its signifying male iden-

tifications or masculine protest. Lesbian sexuality and bisexuality can also function as a resistance to fixed identities of gender role and object choice. Genital sex is not privileged; there is a continuum from sadomasochism and butch–femme relations to the presumably nongenital Boston Marriage. Fears of ruthlessness and aggression in oneself and one's partner may lead to avoidance of intense passion or "bed death." Schwartz initiates a discussion of ideas about lesbian eroticism, but she generalizes instead of providing vignettes or a clinical database. She does not distinguish primary lesbians from those who discover their preferred identity in adulthood. She also underestimates the potential range of fantasies and identifications possible in any form of female erotic expression. Finally, she does not differentiate what is special to lesbians as opposed to what is common to most women's sexuality. Other papers in this section on culture discuss lesbian passions expressed in popular music and the challenges faced by lesbian mothers, such as competition with partners over mothering.

The last section of the book is entitled "Twenty-five Years of Psychoanalysis in the Lesbian Community." One paper details sociological changes in the lesbian community. Another reviews a 1968 study of figure drawings of lesbian and heterosexual women from a postmodern viewpoint. The interpretation holds that gender and sexuality are aspects of social relationships rather than fixed developmental traits.

In summary, this volume presents various viewpoints and ideas about lesbian sexuality that stimulate a curious reader. I would have preferred that the editors furnish integrating summaries for each section, rather than a mere collection of individual essays. The book has led me to reflect on how little we know about the actual range of erotic fantasies in all women. This may derive in part from female tendencies toward social and interpersonal adaptation, sexual shame and inhibition of aggressive and sexual agency, and lack of empowerment to explore sexuality. Issues of power and dependency, longings for object relatedness, and needs for freedom and safety to ex-

press aggressive and sexual passions all cast their imprint on female eroticism. There is evidence that behavioral choices as well as fantasies are sometimes influenced by biological factors (neurohumoral, fetal, temperamental, genetic), as described by Downey and Friedman.[6] But clinical experience compels us to acknowledge that sexuality can be utilized and shaped by psychological imperatives, such as wishes to resolve developmental conflicts (including those related to attachment, preoedipal and oedipal stress), and needs to address here-and-now conflicts.

McDougall suggests in *Sexualities Lost and Found* that identifications and directions in the family can shape object choices. Trauma, conformist pressures, and developmental and adaptive needs are other influences. While lesbian patients occasionally give a history of atypical gender-role development, that is certainly not inevitable. Thus, multiple factors influence any erotic preference. The result is usually overdetermined. In a given patient, we have access to current conflicts, transferences, and fantasies about the past, and can usually only speculate about the mix of biological substrate, conflict resolution, identifications, and directions from the environment that resulted in a given object choice or provided impetus toward flexibility or fixity. The impact of maternal stimulation or suppression of female eroticism in infancy, the effects of familiarity versus strangeness in patterning of object-related erotic arousal in the early oedipal period, and the influences of latency and adolescence are all unexplored areas for future research.

I have noted previously that erotic fantasies themselves do not necessarily shift with women's midlife conversions. Plasticity in the choice of gender of the love object (clinically noted to be more frequent in women) may reflect diminished social opprobrium for female bisexual activity in the context of overt social conformity, social denial of female sexuality in general, and some specific contrasts to male development.[7] But perhaps fac-

[6] Downey, J. & Friedman, R. C. (1998). Female homosexuality: classical psychoanalytic theory reconsidered. *J. Amer. Psychoanal. Assn.*, 46(2):471-506.

[7] Friedman 2001 (see footnote 5, p. 503).

tors other than gender provide the fixed elements that contribute to sexual identity and choice for women. Downey and Friedman emphasize the need for intimacy to kindle erotic feelings in many women, as Kirkpatrick suggested.[8] Still, precisely what constitutes feelings of intimacy for women may be quite variable. The essential elements of erotic turn-on for an individual woman may be based on various specific qualities in the perceived or fantasized object relationship. Among these may be a ratio of familiarity to differentness; needs for a guarantee against abandonment; feelings of safety or danger; fantasies about one's body eliciting lust in or admiration from another; fantasies about caregiving, caretaking, or pregnancy; or, finally, aspects of power and agency (such as wishes for control, safety, or submission to power). Further clinical exploration would help us to understand more about the range of elements influencing female eroticism.

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[8] Kirkpatrick, M. (1987). Female homosexuality. Panel report: toward the further understanding of homosexual women. *J. Amer. Psychoanal. Assn.*, 35:165-173.

DEATH OF A "JEWISH SCIENCE": PSYCHOANALYSIS IN THE THIRD REICH. By James E. Goggin and Eileen Brockman Goggin. West Lafayette, IN: Purdue Univ. Press, 2001. 242 pp.

It would seem a fairly safe and commonsense assumption to believe that psychoanalysis as outlined by Freud was neither practiced nor preserved during the Third Reich. The period in German history from 1933-1945 could hardly be considered compatible with the type of free thinking and self-exploration required for psychoanalysis to exist, let alone to flourish. According to this book, however, even during the height of World War II, life in Germany included psychotherapy and a form of "cleansed" psychoanalysis designed to eliminate all aspects of its Freudian (i.e., Jewish) origins.

Now, thanks to the efforts of James and Eileen Goggin, we have a meticulously detailed account of the fate of psychoanalysis during the Nazi regime, one that enriches existing material while advancing a hypothesis that differs from that of the previous work by Cocks.[1] The Goggins, who are neither historians nor psychoanalysts by training, have devoted their energies to an exploration of what happened to the Berlin Psychoanalytic Society after Hitler's rise to power. Their motivation appears to reside in their true affection for psychoanalysis, as well as in their concern that the truth about German psychoanalysts who collaborated with the Nazi government will be lost in a sea of rationalizations about the "innocent" nature or good intentions of those who did so.

In the introduction to *Death of a "Jewish Science,"* the authors note that it was Cocks's book mentioned above that first introduced them to the subject (p. xi). Much of their research proves to have been in the service of correcting, if not refuting, Cocks's assertion that psychoanalysis survived and grew during the Third Reich due to the efforts of M. H. Goring in his role as director of the Goring Institute, into which the Berlin Psychoanalytic Society and the entire German Psychoanalytic Society (DPG) had been incorporated. It is far from surprising that they have been able to gather a large amount of data to support their assertion that psychoanalysis, for all intents and purposes, was eliminated during the Third Reich, since this was Hitler's expressed desire and intention.

Having attended the International Psychoanalytical Association's 1985 meeting in Hamburg, I am aware of the ambiguous role of Drs. Muller-Braunschweig and Boehm in negotiating the apparent "official" survival of psychoanalysis and the DPG during the Third Reich. At that meeting, a positive attitude toward Muller-Braunschweig's efforts seemed to be dominant. The in-

[1] Cocks, G. (1997). *Psychotherapy in the Third Reich: The Goring Institute.* New Brunswick, ME: Transaction.

teraction between Freud and Muller-Braunschweig around whether Freud should agree to the expulsion of all Jewish members of the DPG, in the form of a required resignation, was viewed as a legitimate dilemma for both Freud and Muller-Braunschweig. The accepted wisdom espoused at that meeting implied that Muller-Braunschweig's decision to accept Hitler's terms for the continued presence of psychoanalysis was a legitimate interpretation of Freud's instruction that he should do what he felt was best for psychoanalysis. The Goggins correctly question whether the decision to favor the survival of psychoanalysis as a science, despite the obviously unacceptable expulsion of Jewish psychoanalysts, could possibly be justified. The importance of their reevaluation is validated with the benefit of hindsight regarding what was to come in Nazi Germany. The authors mobilize data that leaves little doubt that psychoanalysis would have been better served had it been eliminated or banned from Germany during the years of the Third Reich.

According to the Goggins' documentation, Muller-Braunschweig and Boehm were ultimately involved in the use of psychotherapeutic evaluation as a means of eliminating individuals judged to be untreatable, and hence undesirable from the perspective of the Third Reich. Such individuals included recalcitrant children (who were sent to "safe homes," which were in fact facilities where they were murdered), homosexuals, and soldiers suffering from war neuroses (who were also executed). The idea that psychoanalysts continued to be meaningfully trained within a subdivision of the Goring Institute—when in fact its leader was an openly avowed member of the Nazi party who endorsed Hitler's goals—cannot be viewed as accurate.

Much of what the authors present in *Death of a "Jewish Science"* may seem self-evident, but it is still an important contribution when one considers that other historians have presented an inaccurate picture of psychoanalysts during the Third Reich, portraying them as dedicated to maintaining the practice of analy-

sis despite the impossibility of the political climate.[2,3] It makes a decided difference whether those German analysts who chose to stay on after the expulsion of their Jewish colleagues are viewed as an embattled group of right-minded individuals attempting to preserve psychoanalysis for the future, or are seen as opportunistic individuals who rationalized taking advantage of their supposed Aryan status to advance themselves.

A middle position located between these two viewpoints might entertain the notion that those who remained were initially invested in their own survival, as well as the survival of analysis. How could they have predicted what was to come? Both the senseless mass murder of European Jews and the total defeat of Germany were beyond comprehension in 1933-1935. And it is important not to forget that Germany's defeat was still far from obvious during the years 1939-1943. Increasing belief in the Third Reich and its paranoid view of the Jews undoubtedly would have influenced those analysts continuing to work in Germany during the years when victory appeared very likely. It might be appealing to think of those who remained in Germany as attempting to stand for reason and sanity during those years, but this is more likely than not a fantasy. Furthermore, the decision by non-Jewish analysts to leave Germany—such as Sterba, Grotjahn, and Kamm—indicates that it was far from impossible to make an ethical choice to give up a career in Germany on the basis of one's principles.

The authors of this book have done both psychoanalysis and history a service by employing a definitive argument and mobilization of facts to refute any opinion that psychoanalysis survived or grew during the Third Reich. They make it clear that analysis has unique characteristics that make it impossible for it to flourish in a totalitarian regime. In their view, it is an illusion

[2] Spiegel, R. (1975). Survival of psychoanalysis in Nazi Germany. *J. Contemp. Psychoanal.*, 11:479-492.

[3] Spiegel, R. (1985). Survival, psychoanalysis, and the Third Reich. *J. Amer. Acad. Psychoanal.*, 13:521-536.

to think that individual analysts can resist the pressures of the society in which they practice. This is an important point, even in societies neither as corrupt or as destructive as Germany was under Hitler.

Psychoanalysis, with all its potential for freedom of the individual to discover and express him- or herself, has frequently succumbed to the influence of societal values, even in a democratic nation, without any awareness that its theory was being influenced by the attitudes of its host society. One needs only to think of the decades of exclusion of homosexual individuals from consideration for psychoanalytic training in the United States to identify a confluence between psychoanalytic belief and the values of the overall society (in this case, its homophobia); this dismal chapter in the history of the American Psychoanalytic Association is still in the process of being undone and repaired. It is because the Goggins' book reminds us of our vulnerability to influence from the society we live in that it has value beyond the narrow scope of reconsidering the state of psychoanalysis during the Third Reich. Analysis never was a "Jewish Science" except in the minds of paranoid leaders and individuals who focused upon it as an object of hatred because of Freud's Jewish background. Furthermore, the privacy and intimacy inherent in the analytic situation have stigmatized psychoanalysis in other countries as well—countries where anti-Semitism has not been the predominant destructive factor, as it was in Germany.

In reexamining Freud's directive to Muller-Braunschweig to do whatever he felt would be best for psychoanalysis in the long run—that is, in regard to the question of whether to keep the DPG open while expelling its Jewish members—we might look upon that directive as reflective of Freud's priority at that time to keep psychoanalysis alive, no matter what. But we would then have to conclude that Freud's judgment in this area was faulty. Perhaps his hope that psychoanalysis would be widely accepted by the non-Jewish world led him to accept the forced resignation of all German Jewish analysts. In the ensuing decades, the survival of psychoanalysis would establish beyond any doubt its

independence from any religious group. But unfortunately, the outcome of Freud's stance was anything but helpful to psychoanalysis, which undoubtedly would have been better served had it been condemned and outlawed by the Nazi regime.

The authors of this book make it clear that, ironically, psychoanalysis has not only survived, but flourished in post-War Germany. Their explanation ties the inclusion of psychoanalysis in government and private insurance plans to the managed economy of modern Germany. Those interested in the status of psychoanalytic organizations in contemporary Germany, as well as the relationship of the IPA to other current German psychoanalytic groups, will find considerable material on the subject in a chapter entitled "Postwar Legacies."

Few books that have adorned my desk have elicited as much interest from my patients as this one. The title, *Death of a "Jewish Science,"* has a riveting impact, even though the younger observer has no idea what the Jewish Science might be or in what context it would be relevant. Readers of this book are ushered into the world of the Third Reich and the Holocaust. We learn that the degree to which Hitler and his followers were concerned with maintaining a non-Jewish version of psychoanalysis (that is, psychoanalysis without Freud) is surprising, given the relatively small number of analysts in 1933 Germany. The Goggins do not present an explanation for the Third Reich's preoccupation with psychoanalysis; it is possible that this was simply part of the rapidly growing and lethal anti-Semitism of that leadership, as well as its dedication to censorship. However, the attempt to rewrite psychoanalytic theory, to remove sexuality and the oedipal conflict as central elements of the theory, indicates that Hitler and his advisers may have received input from Jung and other anti-Freudian psychoanalysts. (The authors provide careful documentation of both Jung's anti-Semitism and his very active collaboration with the Nazi government; see pp. 70-78.) Jung's racist writing, with his support of the notion of an Aryan psychology superior to Jewish psychology, may have made psychoanalysis seem important to Hitler and the Third Reich.

While the Goggins present shocking evidence against Jung, they avoid making the connection between the Nazi preoccupation with "cleansing" psychoanalysis of Freud, on the one hand, and Jung's possible intention of triumphing over Freud in their long-standing rivalry, on the other.

Psychoanalysis did experience a vigorous rebirth in Germany following World War II. This reemergence was in part based upon those German analysts who survived the war through their involvement in the Goring Institute. Muller-Braunschweig, despite the deterioration in his character described by the Goggins, played a significant role in the reorganization of psychoanalysis and in the reaffiliation of at least some German analysts with the IPA. The authors of this book make it clear that, in light of the data they have uncovered, psychoanalysis in its true essence failed to exist during the Third Reich. Perhaps this statement, while true enough, minimizes to some extent the degree to which those German analysts who continued to practice found themselves taken over by the extreme actions of the Nazi regime. As the Goggins point out, it was the early, forced resignation of Jewish analysts in the DPG that led most, if not all, German Jewish analysts to leave Germany early enough to avoid the Holocaust. Many of these individuals were able to successfully relocate in the United States and South America, and from these locations, they have continued to make important contributions to contemporary psychoanalysis. Undoubtedly, their survival has changed the landscape of the field. Although it is beyond the scope of *Death of a "Jewish Science"* to consider the theoretical orientation of German psychoanalysis today, one has to wonder whether the survivors of the Third Reich—the refugee analysts who have so enriched psychoanalysis—are not essential contributors, through the medium of analytic literature, to the psychoanalysis that is so popular in Germany today.

This relatively short book succeeds in bringing the psychoanalytic reader in touch with a destructive period in the history both of the world and of psychoanalysis. It documents, in a fair

and balanced fashion, both the heroic efforts of individuals like William Langer, who responded to the plight of German Jewish analysts trapped in Germany, and the relative indifference of others, such as the unnamed head of the New York Psychoanalytic Society, who rationalized inaction on the grounds that there would be insufficient work to support these refugee analysts in the United States.

It is to be hoped that *Death of a "Jewish Science"* will be widely read by psychoanalysts, even those with little interest in the Third Reich, because of its implications and its cautionary note about the influence of societal and political forces on how psychoanalysis is practiced. The remarkable tragedy of those German analysts whose value systems permitted them to endorse the forced resignation of their Jewish colleagues serves to remind us all of the importance of ethical values over political systems.

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MISTAKEN IDENTITY: THE MIND–BRAIN PROBLEM RECONSIDERED. By Leslie Brothers. Albany, NY: State Univ. of NY Press, 2002. 108 pp.

A philosophical dictionary defines reductionism as:

> Any doctrine which attempts completely to translate one type of concept into another type, supposedly simpler, more basic, or with better empirical confirmation . . . . To reduce a psychological to a physiological theory is to show that the latter can in principle yield all the results of the former.[1]

Causal reductionism is again on the march in psychoanalysis, in the form of the growing influence and stature of neuroscience

[1] Ayer, A. & O'Grady, J., eds. (1994). *A Dictionary of Philosophical Quotations.* Oxford, England: Blackwell, p. 496.

in current psychoanalytic discourse. It has become fashionable to claim that psychoanalysis must incorporate, or even be grounded in, the findings of neurobiology in order to restore and maintain its scientific respectability. According to Alan Schore,[2] an ardent advocate of this objectivist turn, neuroscience is now in a position to complete the "Project for a Scientific Psychology" of the young Freud by being able to demonstrate that emotional states have localizable correlates (read: causes) in the brain. Analysts who wish to preserve psychoanalysis's dedication to illuminating worlds of personal experience will welcome well-informed criticism of this reductive trend.

No one is more qualified to undertake such a critique than the author of *Mistaken Identity,* Leslie Brothers, a psychiatrist knowledgeable in both psychoanalysis and philosophy and with extensive experience conducting neuroscience research. By virtue of her important contributions during the 1990s, she is widely recognized as an originator of social neuroscience, a move away from the focus on the isolated brain and toward a study of the brain in social context.[3] In the volume under review, she draws on the spirit of Wittgenstein, who viewed philosophy as performing a therapeutic function for human thought by clearing up the conceptual muddles created by misapplying "language-games" to domains of discourse to which they do not belong.

The book's central argument is that the bridging currently being done between mind-talk and brain-talk is scientifically unfounded. Brothers's aim is to show that neuroscience cannot independently support psychological narratives, but is merely window dressing for them. To that end she presents an incisive, systematic critique of what she aptly terms *neuroism*—the practice of uncritically gluing mind-talk and brain-talk together and using these collages as pseudoexplanations of psychological life.

[2] Schore, A. (1997). A century after Freud's project: is a rapprochement between psychoanalysis and neurobiology at hand? *J. Amer. Psychoanal. Assn.,* 45:807-840.

[3] Brothers, L. (1997). *Friday's Footprint: How Society Shapes the Human Mind.* Oxford, England: Oxford Univ. Press.

Neuroism is doomed to failure, according to Brothers, because neuroscience lacks a unified theory of how the brain works, and therefore does not really have anything to which to reduce psychology. Neuroscience is in a fledgling, pretheoretical, natural-history stage of scientific development, possessing large numbers of empirical observations but no guiding theoretical framework with which to integrate them. What neuroists do, Brothers contends, is take data generated in neuroscience laboratories and paste them together with conceptual schemes actually imported from psychology, so that the psychological concepts are decked with neuroscience data and thereby gain the appearance of being empirical entities. A covert bargain is struck whereby neuroscience borrows unifying theoretical narratives from psychology and psychology gains scientific status and respectability from neuroscience.

Brothers deftly exposes five interrelated devices used by neuroists like Schore to paper over the unbridgeable gulf separating mind-talk and brain-talk. First, they create stories amalgamating everyday mental language with neural language, stories that appear to bridge the mind and the brain because some of the phrases and words have both neurobiological and nonneurobiological meanings. Ignoring the fact that these meanings derive from very different contexts makes the distinction between neuroscientific and psychological meanings seem to vanish.

A second neuroist device is to draw an analogy between the linguistic structure of an everyday psychological concept and the physical structure of the brain, treat the analogy as if it established an identity, and then declare that the psychological concept is realized in the brain. A third device for erasing the distinction between psychology and neuroscience is the practice of writing neuroist stories in the style and technical jargon of scientific research articles. A fourth device for drugging the critical senses is to appeal to paradox and mystery whenever the mind-brain bridging does not work.

Brothers's exposure of the fifth neuroist device is perhaps the most damning. A neuroist writer can *seem* to be supporting

his or her claims by referring to neuroscience research, when in fact the cited research is entirely irrelevant to these claims, or has been rendered irrelevant because it has been superseded by more recent findings that are not cited. Such irrelevance will not be readily recognized by psychological or psychoanalytic readers, because typically they do not read and do not have the necessary background to comprehend the cited research papers. Brothers, by contrast, employs her extensive knowledge of neuroscientific research in a detailed critical evaluation of neuroists' misleading use of irrelevant citations to support their extravagant claims.

Mistaken Identity is a much-needed, powerful corrective to the current pull toward neurobiological reductionism—toward replacing faith in Freud with faith in the brain. Even more important, the book reminds analysts to be careful about language. Language encodes unconscious philosophical assumptions and commitments that have a profound impact on clinical work.[4] Brothers's brilliant critique is an important advance in the direction of making aspects of this philosophical unconscious conscious.

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[4] Stolorow, R. D., Atwood, G. E. & Orange, D. M. (2002): *Worlds of Experience: Interweaving Philosophical and Clinical Dimensions in Psychoanalysis*. New York: Basic Books.

THE SINGLE WOMAN–MARRIED MAN SYNDROME. By Richard Tuch, M.D. Northvale, NJ: Aronson, 2000. 310 pp.

The following quip by Helen Rowland, American writer, journalist, and humorist (1876-1950), was cited in a New Jersey newspaper, the *Star-Ledger,* on September 9, 2002, under the heading "Thought for the Day": "Nothing so annoys a man as to hear a woman promising to love him 'forever' when he merely wanted her to love him for a few weeks" (p. 23). Ms. Rowland did not know

when she penned these words that she was foretelling the publication of *The Single Woman–Married Man Syndrome,* a book about a particular type of extramarital affair to which her observation aptly applies.

The author, Richard Tuch, a psychoanalyst in California, describes a particular constellation that can lead to an extramarital affair. A man is seriously dissatisfied in his relationship with his wife but cannot confront and resolve the problems between them. He enters into an affair with a single woman, whom he expects to inflate his damaged ego, restore his wounded self-image, and soothe his injured pride. The woman who fills this role for him does so because she is acting out a neurotic, oedipal fantasy in which she hopes to wrest him away from his wife and thereby achieve an unconscious victory over her own mother. Each participant in the affair, Tuch observes, is destined to meet with disappointment.

The affair, we are told, derives from "complementary motivations and behaviors of two individuals that happen to fit together like matching pieces of a jigsaw puzzle" (p. viii). It involves

> . . . man's unique problems maintaining exclusive intimate attachments with women over time; women's unique inclination to employ masochistic adaptations in their relationships with men; married couples' varied styles of dealing with their differences; the relationship of power and control to the processes of domination, submission, and the act of surrendering; and the nature of the enterprise called "love." [p. xii]

The affair is a "relationship between two parties who have entered into an unconscious contractual agreement to get certain needs met via specific types of interactions" (p. xiv).

Tuch presents cogent arguments to support his understanding of what is involved in this type of affair, though this reviewer questions the validity of his generalizations about people. It might be more reasonable to say that Tuch's observations apply to underdeveloped people, rather than to human beings in

general. The individuals he describes do not come across as having achieved a very high degree of emotional maturity. I also have serious doubts about his contention that women in general are masochistic in their relationships with men.

Each of the two parties to the affair, according to Tuch, starts out feeling gratified by the affair. Eventually, however, each tends to feel controlled by the other, and the two become ambivalent about their relationship. Tuch contends that

> . . . husbands who are unable to retain their sense of dignity as they attempt to work out the differences they have with their wives are more prone to have affairs . . . . The affair serves to illustrate that the man is doing as he pleases rather that being "made" to submit to his wife's demands. [p. xix]

The single woman has to maintain secrecy about her supposed victory over the man's wife. She has to be on her best behavior and has to be available when *he* is available. He rarely has to suffer *her* unavailability. The extramarital affair is free from the everyday conflicts, resentments, and misunderstandings that typically arise in the life of a married couple. It is a fairy tale, which both participants believe to be true—until the time comes when the fiction can no longer be maintained. "No marriage can compete with so perfect an arrangement as this. The affair seems too good to be true. And so it is" (p. 12).

Resentment and conflict inevitably arise between the participants in the affair. It typically focuses, according to Tuch, on if and when the man will leave his wife. The man typically believes that he will leave his wife for the other woman, with whom he has a so-much-better relationship, but he never does leave his wife. Ambivalence reigns. He is unsatisfied and unhappy in his relationship with his wife, but "interpersonal conflict resolution is not his long suit. That is partly why he got himself into such a jam in the first place" (p. 13). "The single woman never seems to give up hope" (p. 13)—but if she sets a deadline, she never holds to it.

Although he does not actually say so, Tuch seems to imply that this scenario applies to extramarital affairs in general, or at least

to the vast majority of them. Undoubtedly, every psychoanalyst's and psychotherapist's clinical experience is unique, but in my own practice, I have more often encountered instances in which the underlying dynamics have been rather different from those the author describes. In fact, I have encountered the set of dynamics he cites far less often than very different ones. I have seen a good number of situations in which a man has fallen out of love with his wife and falls in love with someone else, who also falls in love with him. They drift into an affair that culminates in the man's divorcing his wife and marrying her. The second marriage often, but not always, proves to be a lasting one.

Another constellation I have encountered involves a man who, either out of convenience or as a result of youthful naiveté, has married a woman who does not excite him but who is socially appropriate and an adequate mother to their children. He stays with her, but enters into an ongoing love affair with a single woman who prefers an independent existence to the constraints of marriage and a family. A related scenario involves a man who loves his wife, but is so afraid of closeness with a woman that he has to control his relationship with women by dividing himself between one woman who runs his household and takes care of his children and another with whom he has a romantic, sexual relationship.

Yet another scenario I have encountered is that of a man with unresolved oedipal conflicts involving his mother who transfers them onto his wife. He becomes tumultuously entangled in a confused and confusing adolescent effort to leave her for another woman, although he cannot quite carry it out. I have also worked with men (as well as with their wives) who have no intention of leaving their wives, but whose narcissistic vulnerabilities make it impossible for them to resist a young woman who admires, flatters, and looks up to them. In other words, many different sets of dynamics can underlie an affair between a married man and a single woman.

It is my impression that in a certain social stratum, it is far from uncommon for a man to divide his life between a traditional

wife and family on the one hand, and the excitement of maintaining a mistress on the other. The psychology of the man and of the mistress in this scenario, I believe, is not nearly so simple as that depicted by Tuch in the "single woman–married man syndrome" that he describes. A degree of narcissistic, at times even sociopathic, entitlement appears to play a part in both parties, it is my impression, who are engaged in this particular scenario.

I have analyzed several men whose experiences with their mothers while growing up have made them extremely distrustful and wary of making an exclusive, loving investment in a woman who might turn out to perfidiously disappoint or abandon them. One patient, for example, had been raised by a psychotic mother who both terrified him and was unable to provide the kind of mothering a child needs. Another had been sent away by his mother to live with relatives at a tender age, when another baby was born. Several had been the result of unwanted pregnancies, for which their mothers never forgave them. Others had had very disturbed relationships with their mothers for a variety of reasons. These men could not or would not devote themselves to one woman, nor would they commit themselves to a binding marital relationship without demonstrating to themselves at the same time that they were free to go elsewhere when the spirit so moved them. They did not necessarily have problems with their wives, nor did they necessarily have problem wives. Their difficulty, rather, was that they had a problem with "the generic woman," as one of my analysands put it in connection with a recurrent dream image.

These men tended to harbor extremely ambivalent feelings toward women. Having either an ongoing, lengthy affair with another woman or having multiple affairs was in part an expression of rage at their mothers, which they had transferred or extended to their wives, especially after their wives became mothers. The affair(s) also provided an opportunity to be cruelly teasing, disappointing, and/or punitive toward the women with whom they were having extramarital relations, as well as to control—rather than being controlled by—both women in their

lives. Tuch scants these various aspects of the phenomenon of extramarital affairs—to my mind, critical ones—in his reductionistic approach.

Tuch provides a number of detailed illustrations of the constellation he is describing. Unfortunately, although he indicates that he has seen many instances of it in his clinical work, none of the material he uses comes live from his own practice. With one exception, the cases are drawn from the writings of other people, with all the drawbacks that that entails. The stories, for the most part, do not fit neatly into the scenario that is focused upon in the book, but are shoehorned into it in a rather procrustean fashion. The one illustration drawn from real life is the notorious affair that was in the forefront of the public eye at the time the book was written: that between Bill Clinton and Monica Lewinsky. But that relationship, even in Tuch's extensive account of it, does not seem to me to quite fit the single woman–married man syndrome outlined in the book.

The book illustrates both the positive and the negative features of attempting to create a hybrid work that can appeal both to a professional readership and to a more general one as well. Tuch attempts to provide something that will be useful to mental health professionals in their clinical practices, but at the same time, he tries to satisfy popular interest in the topic of extramarital affairs as well. A contribution to the understanding of unconscious determinants of involvement in extramarital affairs can certainly be useful to the clinician. It can also broaden the general public's understanding of this aspect of human behavior beyond the superficial, simplistic explanations of psychological issues that generally are available in bookstores and public libraries. Reaching out simultaneously to both a professional and a general audience, however, is likely to disappoint the former and confound the latter. I fear that, despite the best of intentions, that is indeed what this book does.

The book does have several appealing features, however. The central thesis is basically sound and is internally consistent, even though presented rather repetitively, as is so common in

psychological works addressed to the public at large. There are some good chapters, in which various components of the "single woman–married man" syndrome are examined in detail. An especially good chapter is the one that describes the Oedipus complex in general. These chapters are clearly written, in relatively uncluttered language, which makes them quite useful for a lay audience interested in understanding human behavior. It also has something to offer to a professional readership, although experienced psychoanalysts are likely to glean little that they do not already know about the topic focused upon in the book.

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PSYCHOTHERAPY WITH AFRICAN AMERICAN WOMEN: INNOVATIONS IN PSYCHODYNAMIC PERSPECTIVES AND PRACTICE. By Leslie C. Jackson and Beverly Greene. New York: Guilford, 2000. 298 pp.

This volume grew out of a 1994 focus group dialogue with a group of African American women attending the American Psychological Association meeting. In their experiences as graduate students, clinical trainees, psychotherapy patients, and supervisors, these clinicians had experienced a dearth of literature relevant to the special issues encountered in doing psychodynamic psychotherapy with African American women. The resulting book is a collection of fourteen chapters by African American women mental health professionals (twelve psychologists and two social workers) on various aspects of psychodynamic therapy with African American women. While the book's origins suggest that the original intent was to supply a needed body of writings for any mental health professionals working with African American women, the tone of the writing often seems geared toward educating non-African American therapists and supervisors.

The first four chapters deal with the new multiculturalism and psychodynamic theory, the interweaving of cultural and intra-

psychic issues in the therapeutic relationship, understanding the identity and context of the therapist and patient, and applications of the Stone Center theoretical approach for African American women. These chapters stress the need for therapists to develop an awareness of their own ethnocultural beliefs and attitudes and to educate themselves to the legacies of slavery, racism, sexism, stereotyping, and cultural aesthetics based on European standards of beauty. Chapter 3 ("Individual and Group Psychotherapy with African American Women: Understanding the Identity and Context of the Therapist and Patient") is particularly useful in outlining how therapists' assumptions and feelings about such issues as race, class, gender, sexual orientation, language, standards of beauty, assertiveness, and spirituality influence the course of psychotherapy. For example, Joan Adams points out the failure of most White therapists to appreciate the fact that certain differences between African American women and other patients are culturally normative, e.g., close extended family ties beyond age twenty-one, strong spiritual beliefs, and cultural prohibitions against revealing and discussing personal family matters. And while I was conscious of certain stereotypes applied to African American women, others outlined in chapter 4 (on applying the Stone Center approach) were less familiar to me, although easily recognizable once named: "Mammy" (the selfless although not-too-bright caretaker), the "Matriarch" (strong but controlling), "Sapphire" (bitchy and castrating), the "She-Devil/Jezebel" (impulsive and promiscuous), the "Welfare Mother" (controlling, lazy, and irresponsible), and "Superwoman" (a multitasking workhorse with no needs of her own).

Succeeding chapters address such special topics as African American lesbian and bisexual women, the African American supervisor, memories of racial trauma, psychoanalytic group psychotherapy with African American women, and moral masochism, among others. Particularly fascinating was a chapter on hair texture, length, and style as a metaphor in the African American mother–daughter relationship. Although "hair wars"

are hardly exclusive to African American mothers and daughters, they seem to take on added intensity here because racism has historically devalued African physical features, including hair texture.

One finishes the volume enlightened about many aspects of working with African American women in psychodynamic therapy, but notes a certain ambivalence on the part of some of the authors about the very enterprise of psychoanalytic psychotherapy with these patients. For example, Francis Trotman, in a chapter on feminist and psychodynamic psychotherapy, states, "Moreover, psychodynamic theory is notorious for its androcentric, heterocentric [sic], and White, middle-class ethnocentric point of view" (p. 264). Fortunately, most of the authors are more sanguine about the use of psychoanalytic psychotherapy with African American women, and the book makes a valuable contribution to a deeper understanding of issues encountered in working with them.

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ON FREUD'S "GROUP PSYCHOLOGY AND THE ANALYSIS OF THE EGO." Edited by Ethel Spector Person for the International Psychoanalytical Association's *Contemporary Freud: Turning Points and Critical Issues.* Hillsdale, NJ: Analytic Press, 2001. 184 pp.

This issue of the International Psychoanalytical Association Monograph Series considers Freud's "Group Psychology," which the editor, Ethel Spector Person, feels "does a half-turn, if not a whole new turn, in Freud's thinking" (p. xiii). John Kerr offers excerpts from the text as well as a contextualizing exegesis, particularly noting points of agreement and difference between Freud and his contemporaries, such as William McDougall and Gustav LeBon. The central question of "Group Psychology" is the relation between the individual and the leader of the group, and how this affects other group members. Insofar as these ties

are libidinal, how do they reconcile with self interest, and what is the nature of the identifications to which they lead? Moreover, how do fear and guilt come into the equation in group psychology? As Freud writes in his "Group Psychology,"[1] it is the vicissitudes of the ego ideal that lie at the heart of the group process, by which

> . . . the ego becomes more and more unassuming and modest, and the object of love becomes more and more sublime and precious, until at last it gets possession of the entire self-love of the ego, whose self-sacrifice follows as a natural consequence. The object has, so to speak, consumed the ego . . . . [p. 113]
>
> The functions allotted to the ego ideal entirely cease to operate. A primary group of this kind is a number of individuals who have put one and the same object in the place of their ego ideal and have consequently identified themselves in their ego. [p. 116]

In group psychology, the object of love is the leader, yet the new ground broken by Freud was the relationship between individual psychology and group psychology, an issue that would preoccupy a later generation of psychoanalysts, such as Kurt Lewin (p. 52 of *On Freud's "Group Psychology")*, Wilfred Bion (p. 53), S. H. Faulkes (p. 55), and Andre Ruffiot (p. 56), as well as Didier Anzieu. The latter studies the problem of group illusion where the group takes the place of the ego ideal of each member, as Freud saw the leader doing in hierarchic, collective organizations (p. 57). But in "Group Psychology," Freud already posited an irreducible social instinct, herd instinct, group mind (p. 70).

In his contribution, Anzieu presents the historical background against which this book was written, raising the question of whether the group dynamics of the IPA and other psychoanalytic

[1] Freud, S. (1921). Group psychology and the analysis of the ego. *S. E.,* 18.

societies provoked Freud's reflections on group psychology. Anzieu follows Freud's thought about how cohesion and dissolution come about within groups, noting the cohesive force exerted by Freud's writings upon psychoanalytic societies (p. 49) and the disintegration of this cohesion when ambivalent love for the leader and other members of the group turns to hostility (p. 50).

Robert Caper starts from the observation that a mind without links to objects is simply not a human mind, and thus, individual human psychology cannot be isolated from group psychology; moreover, the internal world of the individual is an internal object world (p. 62). Caper describes the psychoanalytic dyad as a combination of elements of organized and unorganized groups, composed of what Bion calls work groups and basic assumption groups (p. 68), a union of two bringing together elements of group process that are both primitive and sophisticated, which simultaneously eliminate and preserve separate identities (p. 69). This means that in the dynamic between analyst and analysand, the analyst does not behave in a way congruent with the archaic internal object that the patient is projecting onto him or her, which would deprive the patient of the opportunity to compare and contrast the patient's internal object with the external object of the analyst; this allows the analysand the chance to differentiate the internal reality of his or her fantasies from external reality (p. 74).

Abraham Zaleznik carries this line of reflection further, speaking of complex organizations (p. 88), and suggesting that, alongside identification and libido, self interest must be seen as extremely important in group dynamics and must be understood in reference to the formation of an internalized sense of power (p. 92). Andre Haynal proclaims the need to take seriously the history of fanaticism in connection with both religious and secular doctrines, as well as in the history of psychoanalysis, in a quasi-hypnotic submission to the leader's voice and the projection of our ideals and hopes onto that person, along with the impulse to expel those who go against basic principles (p. 119).

Haynal concludes with a presentation of Ernst Falzeder's family trees of psychoanalytic schools (pp. 121-128).

Yolanda Gampel analyzes our "millennial culture" in light of Freud's "Group Psychology," considering how "globalized capital creates a new transnational class of the weak linked by satellites" (p. 132) with media images preserving the myth of modern life (p. 133). Racism is the collective parallel to individual narcissism in its nonacceptance of the difference of the other (p. 134), whereas really, it "is only the other who is able to recognize the individual and grant him a place within the social sphere, however it is symbolized . . . through the mechanism of incorporation or internalization, both of which allow for identification" (p. 137). Gampel, in reference to shock survivors, describes a "radioactive identification," wherein, as in "radiation, an external reality enters the psychic apparatus" through social violence, "without the individual's having any control over its entry, implantation and effects" (p. 141).

The concluding contribution, by Claudio Eizirik, links the thought of Freud's "Group Psychology" to a line of thinkers extending to Otto Kernberg. Eizirik warns of the need to counter the illusory power of psychoanalysis with outcomes and verification studies, as well as permanent dialogue with other disciplines (p. 170). Indeed, psychoanalysis remains in a crucial relationship to illusion, as Freud recognized so long ago; but is it really the task of psychoanalysis to help us give up all illusions? This is the lesson taught to us by the history of psychoanalysis thus far, according to Eizirik, who notes:

> At the beginning of a new millennium and of our second century, we are now challenged to give up our illusions, to demonstrate to our surrounding culture that we answered its thirst for illusion with the partial belief in some illusions, but that we are now part of a structured, predominantly work group whose members are tied together with the same purpose of undoing illusions, our own and prevailing ones in our culture. [p. 171]

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ABSTRACTS

ZEITSCHRIFT FÜR PSYCHOANALYTISCHE THEORIE UND PRAXIS

(JOURNAL FOR PSYCHOANALYTICAL THEORY AND PRACTICE)

Abstracted by Cordelia Schmidt-Hellerau, Ph.D.

XVI, 2001, 1 – 4

The first issue of this volume presents the papers and discussions of the Congress of the Middle European Societies 2000 in Budapest. The subject of the Congress was Ferenczi's famous paper on the "Confusion of Tongues Between the Adult and the Child" ("The Language of Tenderness and of Passion"), published in the *International Journal of Psychoanalysis* in 1949. The second issue reappraises Freud's "The Interpretation of Dreams," 100 years after its initial publication, and explores new ways of understanding the function of dreams. The third issue focuses on trauma and its component parts of hatred and violence; while the fourth issue presents theoretical papers on Laplanche and affect theory.

"The Beauty and the Beast" Before the Primal Scene: On the Transformation of Speech Arousal. Eva Schmid-Gloor. No. 1, pp. 13-26.

Schmid-Gloor presents a severely traumatized patient who was subjected as a child to her father's sexually seductive and verbally assaulting behavior. She describes how the patient tried to verbally excite her in a pleasurable as well as scary way by using sexualized language, repeating the way her father talked to

her. Elaborating Ferenczi's concept of a two-phase process in the development of guilt feelings in traumatized patients, Schmid-Gloor includes a contemporary view of splitting, disavowal, and projective identification. She demonstrates that the patient's guilt feelings resulted not merely from her identification with the boundary-violating father, but also from the projective identification she was submitted to by her father. "After the sexual assault, the adult projects the unbearable part of his instinctual desires into the child and from then on treats her in a stern and controlling manner; thus, the child experiences herself as the 'container' of these impulses of the other; according to her view of herself as uncontrolled, instinctual, monstrous and dangerous, she develops the guilt feelings, which are avoided by the boundary violator" (p. 15). Schmid-Gloor differentiates between two psychic processes: in consequence of the denial of trauma and in order to preserve the pretraumatic good object, the aggression of the object is split off. At the same time, the child identifies with this aggression—a process supported by the projective identification of the adult that results in masochistic, self-punitive behavior. Schmid-Gloor shows how the fixation to trauma can become a defense against the patient's oedipal conflicts.

To Meet and to Miss Each Other in the Speech's Space of the Psychoanalytic Process. Jutta Gutwinski-Jeggle. No. 1, pp. 37-56.

Musing on the controversy between Freud and Ferenczi (trauma as a real event and/or as a fantasy, and its consequences for psychoanalytic technique), this author discusses the beginning of newer developments in psychoanalytic theory. Referring to Bion, she demonstrates that, in her work with a very disturbed obsessive patient, the weak ego was continuously overwhelmed by a primitive, destructive superego, which relentlessly worked to destroy any development within the analysis. Surviving and working through difficult countertransference anxieties, the analyst understood that the patient's effort to destroy her as a good object was a defense against guilt feelings, separation anxieties,

and an acknowledgment of the limitations of reality. His weak self needed to remain imprisoned by a destructive, narcissistic part of him, preventing his getting in touch with the pain of his longings and positive feelings. By pointing out these inner attacks on his weakened ego, the analyst helped the patient to allow more benign metabolic processes within the analysis to bear fruit.

The Differential in Psychoanalysis. Linguistic Confusion: Transferal – Translation. Thomas Aichhorn. No. 4, pp. 405-443.

This author links Ferenczi's work with Laplanche's seduction theory. He suggests that within the rapprochement of child and adult, "differential mechanisms" are set off, which arise during the initial seduction and produce the sexual unconscious. Aichhorn understands the identification and the translation of the adult's enigmatic messages as differential mechanisms, which produce designified signifiers and set off the drives. The work in psychoanalysis is seen as a never-ending de-translation, a suspension of the ideologies the ego formed in order to solve the initial riddles of the seductive messages.

What Is Still Alive of Freud's Theory of Dreams? Wolfgang Mertens. No. 2, pp. 123-148.

Mertens suggests that Freud's classical mechanisms of dream work, condensation, displacement and symbolization do not serve exclusively to disguise an objectionable dream wish, but also represent a ubiquitous kind of perception found in conscious processes as well. These mechanisms have been discussed within cognitive linguistics in the sense of classical tropes, as conceptual metaphor, metonymy, and synecdoche, indicating that dreams display the syntactical rules of language and cognition. However, as Mertens stresses, classical tropes do not account for the ontogenetically earlier pre- and protolinguistic emotional, actional, and conflictual contents of psychodynamic processes that

constitute a matrix for later cognitive linguistic acts. Thus, Mertens concludes that the classical mechanisms acknowledged within the research of cognitive scientists—condensation, displacement, and symbolization—cannot be replaced by a cognitive way of "translating" dreams. The psychodynamic specifics of the unconscious and the unspeakable experiences of the first year of life still require the psychoanalytic way of elaborating dreams via free association or Freud's concept of the dream work.

Nightmares, Dreams and Thinking Processes. Bernard Golse (trans. Martina Feurer). No. 2, pp. 194-206.

This author is concerned with the function of dreams in relation to the general working of psychic processes and memory. Referring to the work of Palombo (1976), he suggests that dreams serve the necessary function to store, integrate, and encode unfulfilled day residues within the epistemic network of our memory systems via multiple associative links. In this respect, dream work can be compared to the work of mourning: dreams work on a withdrawal from the activated object relationships by transferring the day residues of the procedural (action-oriented) memory into the declarative (long-term) memory systems. The malfunctioning of this process is displayed in the nightmares of small or autistic children and of patients suffering from traumatic neuroses. Here the day residue cannot be digested and integrated, but instead constitutes a permanent action program within the procedural memory (p. 200). Nightmares seem to indicate a failure in the binding processes that provide the transition from the original processes (pictogram) to the primary process (scenic elaboration or fantasy). Golse suggests that among other functions of the dream is that of ongoing repetition of the ontogenetically important steps of primarization of the (Ur-) significant within the psychical apparatus.

Notes on the Genesis of Trauma. Raymond Borens. No. 3, pp. 257-268.

Borens introduces the main subject of the third issue from a Lacanian perspective. Trauma, he states, is what will have turned

into a trauma *a posteriori*. Exposures to the desire or to the *jouissance* of the Other and to the presence or lack of signifiers are essential here, and help to distinguish between normal trauma, actual trauma, and destroying experiences.

Hatred and Revenge as Complications in the Adolescent Development. James Herzog (trans. Bettina Reiter). No. 3, pp. 269-284.

This author uses detailed material from the analysis of an adolescent, whose acting-out symptoms bore a close relationship to the biographical and theoretical interests of the analyst, to show how the discovery and working through of trauma could be understood only in connection with the development and working through of the transference.

Traumatizations and Unconscious Fantasies of a Female Patient with Multiple Holocaust Traumas. May Widmer-Perrenoud. No. 3, pp. 285-300.

Exploring the impact of traumatic experiences on unconscious fantasies, the author demonstrates how the interpretation of dreams helped to reveal the unconscious fantasies that impinged on her conflicts and traumata.

The Rhetoric of Trauma in Georges-Arthur Goldschmidt's Short Story "The Segregation." Marius Neukom. No. 3, pp. 347-364.

This author explores the mechanisms by which this story of a Jewish boy who survives the trauma of segregation elicit the involvement of the reader. These mechanisms can be identified within the framework of a reader response analysis and a psychoanalytic narratology.

Sensoriness and Violence: The Side of Good and Evil? Werner Balzer. No. 3, pp. 365-381.

Departing from Freud's view of the early ego as a bodily rooted "surface-being," Balzer focuses on the fate of the psychic inner space that evolves from the space between the growing ego and

the objects, as well as from the tolerance of absence and the possible negation of things. Sensory obtrusiveness threatens this transitional space. Being separated from and related to objects simultaneously seems to become increasingly precarious. The circularity of addictive excitations in place of symbolically transformed meanings favors adhesions to sensory surfaces with poor relatedness, an unclear differentiation between inside and outside, and splitting between meaningless presence and absent meaning, futile fullness and meaningful emptiness.

Affect: The Psychology of the Metapsychologies. Ahmed Fayek (trans. Johanna Pelikan). No. 4, pp. 491-520.

This author stresses the *affect* as the only concept that includes what he calls "the three metapsychologies" (dynamical, topical, and economical) and can thus be understood as a "psychology of metapsychology" (p. 492). He particularly focuses on the difference between the notion of affect as a "quantum" and the notion of feeling. The disappearance of this distinction is seen as the result of the rejection of the concept of *Trieb* and the dismissal of metapsychology, with its structure-generating concepts. As a consequence of this abolition of metapsychology, the different psychologies of the self (Kohut), the ego (Hartmann), the object (Klein), and the subject (Lacan) developed. For Fayek, psychology and metapsychology used to form a dichotomy that provided a logically consistent framework for psychoanalysis. Since then, new dichotomies have been developed, as, for example, between science and art (Fairbairn, Guntrip), clinical and abstract theory (Klein), biology and psychology (neo-Freudian), and objectivity and subjectivity (Renik). The problems with all these alternative dichotomies are rooted in a lack of clear definitions of their concepts. Fayek pleads for a return to Freud's texts, namely, his metapsychology and his concept of *Trieb,* in order to integrate rather then split apart psychoanalytic progress within a consistent, basic framework.

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A double issue on "Father–daughters and mother–sons" opens Volume 17; it assembles papers on difficulties in developing gender identity. The third issue is dedicated to "Politics, History, and Interpretation"; it is organized around Edward Said's speech, written as the Sigmund Freud Lecture in Vienna in May 2001. However, protest against Said as an "anti-Semitic chief propagandist of the Palestinian movement" led to his being uninvited. Instead, he presented his paper at the Sigmund Freud Museum in London in December 2001. This issue also presents the Sigmund Freud Lecture of Sudhir Kahar, presented in Frankfurt in November 2001.

Difference, (Symbolic) Castration, Gender: The Question of Gendering After Lacan. Heinz Müller. No. 1/2, pp. 7-22.

This author places the concept of castration at the center of Lacan's theory of the subject, as well as of psychoanalytic thinking in general. Müller emphasizes Lacan's concepts of *asymmetry* and *paradox,* both of which characterize the formulas for the position of man and woman: man is subjected to the phallic function; there is one man who is not subjected to the phallic function or to castration (referring to the father of Freud's primal horde); there is no woman independent from the phallic function; and not everything in a woman is tied to the phallic function (p. 18). The author wants to show the usefulness of these concepts for classical metapsychology, for a psychoanalytic definition of sexual difference, and for an extended understanding of Lacan's formulas for gendering.

On Anality in Women. Martha Eicke. No. 1/2, pp. 23-30.

Eicke sketches the developmental path of the female child into a woman under the perspective of her anality. The invisibility and untouchability of the female genitals and the fact that sensa-

tions of the inner body become conscious for the first time during the anal phase point to the specifics of her experience, which is crucial for developing a stable and well-integrated bodily self. Sensations within the stomach that are linked to experiences of need, relief, pleasure, and pain draw the child's interest to the questions of what goes on in her belly and how the products of her excretion are received by her mother. Early feelings and fantasies of power, mastery, and control, or of being persecuted, overwhelmed, ashamed, or plagued by these bodily events, are decisive for further development of her genital discoveries and experiences. Analysis of women with abdominal problems often reveals a depersonalized relationship to the bodily self. Within phases of a negative mother transference, these patients' struggles center around power and helplessness, idealization, and devaluation. This is especially crucial in work with bulimic patients, who suffer from a high degree of ambivalence toward their primal objects. They experience the loss of control over and separation from the mother as an offensive hurt. Then a replacement for the disappointing object/analyst is sought in food, which can be controlled by the patient herself. However, because food contains an aspect of the bad object, it has to be evacuated by forced vomiting. This reestablishes self-control and omnipotence against the overpowering rape of an inner object.

Psychoanalysis and Healing in the Eastern Traditions. Sudhir Kakar (trans. Regine Strotbek). No. 3, pp. 199-214.

In comparing elements of Eastern spiritual traditions with what psychoanalysis provides, Kakar likens the guru's empathy to Kohut's empathy. The author presents the case of a middle-class woman in an unhappy relationship with her husband, who suffered from depressions, physical and psychical weakness, and dark moods. When she and her husband enter Sai Baba's Ashram, the Swami (Guru) says: "Eventually you've come, I called for you with so much love" (p. 203). Hearing this stirs up an emotional turmoil, and the woman bursts into tears and sobs like a

child. Kakar says that this woman feels deeply understood, which is an essential part of healing in the Eastern traditions. Interacting with a Guru, which can continue over years, can activate all sorts of problems, e.g., oedipal conflicts, rage, and depressions, without leading to conscious insight. Here Kakar finds the greatest kinship with Kohut's concept of empathy. However, empathy in the Eastern Traditions leans toward a "mystical pole," while in psychoanalysis, it tends toward a more "intellectual" one. Kakar states that spiritual exercises can enhance the analyst's capacity to empathically identify with the patient.

Freud and the Non-European. Edward W. Said. No. 3, pp. 215-238.

The author focuses on the modernity of Freud's thinking, noting that Freud refused to define Jewish identity in a territorial, historical, or religious way, but instead emphasized the fragility of internally grounded identities by calling Moses, the founding father of Judaism, a foreigner—who at the same time created his own people, the Jews. Freud's "Man Moses" is here read as a typical late *oeuvre,* and is compared both to Beethoven's later compositions and to Joseph Conrad's work, the latter of which proved to be paradigmatic for African literature. The text emphasizes a non-nationalistic utopia for the Middle East, in which both the region's age-old peoples, the Arabs and the Jews, are advised to adopt a founding mythology that integrates the other as a basis for a peaceful future.