Psychoanalytic Quarterly, LXXIII, 2004

A STUDY OF PRESCHOOL CHILDREN'S LINKING OF GENITALS AND GENDER

BY NANCIE V. SENET, PH.D.

The author describes a study that investigated what three- and four-year-old girls and boys know about the link between genital difference and gender difference by asking them to construct both a girl doll and a boy doll, using any of an assortment of anatomical features, including both male and female genitals. The results were interpreted as supporting the assumption of a normal early developmental period of psychological bisexuality; as contradicting the theory that when genital difference is discovered, girls are more distressed than boys about their genitals; and as evidence that both *girls and boys envy the genital of the opposite sex.*

INTRODUCTION

Children discover their own genitals at an early age and those of the opposite sex a little later. They realize, later yet, that there is a link between having a male genital and being a boy and having a female genital and being a girl. Implicit in this discovery, under normal conditions, is that they have the body of one sex and not that of the other. To be a boy means to have a boy body, and likewise for the girl. This linking of genital difference to gender difference is a cognitive milestone that impresses itself on psychological structuring from that point forward.

This paper reports the results of a study designed to clarify aspects of this developmental juncture. Several theoretical controversies are involved. First, in Freud's (1905, 1923b) theory of

psychosexual stages, three-year-olds enter into a period of genital primacy in which the anatomical difference between the sexes is discovered. That discovery impacts on and henceforth patterns a child's sense of being a girl or a boy. Cognitive-developmental researchers (Eaton and Von Bargen 1981; Emmerich et al. 1977; Gouze and Nadelman 1980; Kohlberg 1966; McConaghy 1979; Slaby and Frey 1975) differ with Freud and argue that sex difference is not meaningful for a child until a later age.

Second, early psychoanalytic theory assumed that, at ages three and four, the penis dominates psychological structuring for *both* boys and girls. In Freud's (1923b) view, the anatomical difference between the sexes is that of either having a penis or not having one. What is vital to a boy's sense of self as male is his fear of castration, and crucial to a girl's sense of self (not of herself as female, because Freud thought that that did not exist for a girl until puberty) is her envy of the penis. However, beginning with Horney (1924, 1926, 1933), revisionists of female developmental theory have asserted that, to the contrary, the young girl *is* aware of her own genital anatomy, and that this awareness furthers her positive self-regard and may enhance her identity as a girl.

Third, Freud (1933) also assumed that because the girl lacks a male genital, she has a more difficult time than does the boy in accepting her body as it is. Recently, many writers (D. Bernstein 1990; Krausz 1994; Mayer 1995; Richards 1992; Torsti 1993; Wilkinson 1991, 1993) have taken issue with this assumption and have proposed that girls' genital anxieties emanate from the structure of their own genitals, rather than from the lack of a male genital. A few writers (Fast 1990, 2001; Tyson and Tyson 1990) have even turned the tables and argued that, indeed, one gender may encounter more difficulty at the time of the discovery of sexual difference, but that the vulnerable group is boys rather than girls.

Both Freud (1933) and Horney (1933) charged researchers with the task of helping psychoanalysis to sort out the facts:

> [There] . . . are the very weighty conclusions with regard to the whole psychology of women, which follow from Freud's

> account of early feminine sexuality . . . . It seems to me that analytic experience alone does not sufficiently enable us to judge the soundness of some of the fundamental ideas that Freud has made the basis of his theory. I think that a final verdict about them must be postponed until we have at our disposal systematic observations of *normal* children. [Horney 1933, p. 59, italics in original]

The present study provided an opportunity to gather empirical data that might help to work out some of these theoretical controversies. I was interested in collecting evidence from preschool children about their nascent concepts of *girl* and *boy* as they relate to genital anatomy. To do this, I conducted an experiment with three- and four-year-old children. These were children who had been able to demonstrate at least a rudimentary understanding of gender (see section on "Design of the Study," p. 300). I expected that the research task would reveal the following: (1) whether or not children of these ages use genitals as a defining characteristic of gender categories; and (2) whether or not there are any differences between boys and girls in that respect, and/or with respect to the ways in which the genitals are employed in depicting a gendered body.

Literature relevant to this venture resides within both the psychoanalytic and the cognitive-developmental frameworks. I have drawn upon the riches of both these theoretical resources in designing this research and in interpreting its results.

DEFINITION OF TERMS

Sex and gender terminology is confusing. The words *sex* and *gender* are frequently used interchangeably, both in daily life and in professional literature. In this paper, *sex* refers to the biological, including anatomical, distinction between the sexes (Money and Ehrhardt 1996; Stoller 1976). *Gender* refers to the inner psychological representation of biological sex, but, parenthetically, it may be independent of biological sex (Money and Ehrhardt 1996). It should be kept in mind that, for the purposes of this research,

gender more specifically refers to the child's *early* conceptualization of gender as a mental category.

Masculine and *feminine* (like *masculinity* and *femininity)* refer to gender, while *male* and *female* refer to biological sex (Tyson 1996). Although the composite terms of *man, woman, boy,* and *girl* refer to gender, they also include sex. In actuality, sex and gender are inextricably interrelated. The distinction between the biological and the psychological may become especially blurred when what is being considered is exactly that interrelationship, as in this study. Additionally, because that interrelationship is the focus of this research, it has been necessary, for the most part, to limit the scope of my examination of gender specifically to that interrelationship, leaving out other important components of gender. Lastly, when I use the term *bisexual,* I am referring to body concept with regard to sexual anatomy, not to choice of sexual object.

LITERATURE REVIEW

Mental Development, Categorization, and Body Experience

Before age three, children develop a rudimentary concept of gender, consisting of mental categories comprised of gender labels coupled with culturally stereotypical gender characteristics (Leinbach and Fagot 1986). These mental categories grow out of the early structuring of a psychological organization via processes of categorization (Edelman 1987, 1989; Rosch 1978; Schore 1994). Evidence from cognitive-developmental research indicates that a three- or four-year-old child's ability to mentally organize perceptions so as to create meaning reflects a psychological organization that evolves out of a substrate of earlier global experiential categories and hinges on structuring experience via a process of categorization.

Mental organization in the earliest months coalesces through the infant's formation of global contextual categories that are based on the linking of spatiotemporally associated objects (Mandler and Bauer 1988; Mandler, Fivush, and Reznick 1987; Rosch 1978).

This categorization seems to occur not only on the basis of visual and tactile input, but also—and importantly—on the child's conflation of the kinesthetic experience of those objects with their spatiotemporal contiguity (Lucariello, Kyratzis, and Nelson 1992; Mandler and Bauer 1988).

Thus, early mental development, at least in part, proceeds from the structuring of patterns of kinesthetically and viscerally based information. The cognitive studies cited above actually provide further confirmatory evidence for the earlier work of Piaget and Inhelder (1969) and Spitz (1955), both of whom proposed that the infant's intellectual functioning originates in perception of body experience. These cognitive studies also appear to lend support to their assumption that body experience, including the experiencing of one's own anatomy, is a crucial element of early psychological organization.

Historically, psychoanalysis has emphasized the importance of body experience for psychological development (Freud 1923a). Representations of that body experience are considered to be crucial elements, intertwining with a myriad of other formative influences, in the creation of the fabric that is each child's unique identity (Hartmann 1950; McDevitt and Mahler 1989; Schilder 1935). When a child is able to recognize genitals as distinct anatomical features, their inclusion in the body schema enhances body representation as a whole (D. Bernstein 1990; I. Bernstein 1975; Blum 1976; Fast 1984; Greenacre 1950, 1971).

The Relationship of Body Experience to Gender Conceptualization

Anatomy differentially shapes the ways in which girls and boys learn about their bodies. Consequently, genital difference, in and of itself, crafts gender differences (Erikson 1951, 1964; Horney 1924, 1926, 1933; Tyson and Tyson 1990). Avenues for experiencing, exploring, and generating mental representations of one's body other than visual cues are especially important for the girl as she learns about body structure. Richards (1992) suggested that in girls, self-representation and body image are based on body ac-

tivity rather than on visual images alone. Tactile and kinesthetic perceptual modes furnish her with valuable paths for self-discovery (Irigaray 1990; Kalinich 1993; Kestenberg 1982; Richards 1992). These modes play a crucial role in the girl's ability to psychologically represent her genital anatomy, to experience it as an integral part of her body, and to establish her sense of herself as female and as feminine (D. Bernstein 1990; Krausz 1994; Mayer 1995; Torsti 1993; Tyson 1994; Wilkinson 1991, 1993).

Cognition and the Genital Basis of Gender

A child's sense of self as being male or female and as belonging to a particular gender, i.e., the early evolution of gender identity, is closely tied to the overall level of the child's cognitive development (Kleeman 1976; Silverman 1981). Cognitive studies reveal some details of the interaction between the maturational level of cognition and gender conceptualization. As early mental categories are formulated, they tend to be defined in terms of prototypes that capture the attributes most representative of items within the category and least representative of items outside of it (Rosch 1978). Thus, when the earliest gender formulations emerge, the ability to label others according to gender seems to be related to the use of stereotypical surface features as cues for recognition. Children under thirty months seem to need the presence of a prominent, socially determined gender characteristic (e.g., hair length, clothing) in order to be able to assign a person to a gender category (Leinbach and Fagot 1986). Anatomy at these ages does not appear to be used as a gender cue. Even though by thirty months, most children can reliably use gender labels for self and others (Thompson 1975), this ability does not embody the ability to understand the genital basis for the gender categories. At that age, when a child uses a gender term, it merely reflects her or his ability to use language to name an object (Emmerich et al. 1977).

Thus, for the toddler, gender exists solely as a taxonomic category. Studies have indicated that for the child younger than thir-

ty-six months, as gender categories are established, they reflect embryonic conceptualizations that are loosely tied to surface appearances (Leinbach and Fagot 1986; Thompson 1975). Gender is a fluid concept at this age, in that it does not take genital difference into account. It can be applied whimsically. But at the point at which children link genital difference to gender difference, their concept of gender is potentially imbued with deeper meaning and is anchored to an immutable personal quality.

It should be remembered that recognition and understanding of the link between gender and genitals occur while children are still relatively cognitively immature. That immaturity affects not only the way in which the genitals themselves are perceived, but also how that linkage is conceptualized. Characteristic of three- and four-year-old children is their fluidity of thought, reflecting age-appropriate, indistinct boundaries between reality and fantasy. Young children think syncretically (Piaget 1976; Werner 1980). Thought processes at these ages reflect a creative synthesis of motor-emotional and sensory factors. Werner (1980) describes this as follows:

> [The child's] . . . experience of a doll does not need to contain a head with two eyes, a nose, a mouth, and so on. On the contrary, it may be assumed that the perceptual experience of the doll is made up correlatively of both factual attributes and inner motor-affective needs and impulses. The affective and motor behavior of the child impresses itself on the world of things and fashions it. [p. 65]

Because of this fluidity in thought, the child's early concept of gender as related to anatomy does not necessarily conform to the body's actual anatomical configuration.

Related Studies

Although clinical work with young children has shown that they are aware of the anatomical difference between the sexes and are significantly affected by it, investigative research to corroborate that awareness and to clarify its influence on psychological develop-

ment has been scant. Several observational studies have shown that children from about fifteen months of age are aware of genital differences and engage in directed genital play (Dillon 1934; Kleeman 1965, 1975; Mahler, Pine, and Bergman 1975; Roiphe and Galenson 1981).

Several other studies have dealt with how and when very young children link sexual anatomy with gender. De Marneffe (1997) found that at eighteen months, toddlers could label themselves as a boy or a girl, but could not reliably label anatomically correct dolls according to gender. Even when these children, who were between the ages of fifteen and thirty-six months, knew which doll was genitally similar to them, they still had difficulty labeling the doll a *girl* or a *boy*. De Marneffe concluded that although the children had learned the gender names assigned to them, they did not have a grasp of the relationship between the gender term and the corresponding genital anatomy.

Earlier, the cognitive-developmental psychologist Kohlberg (1966) initiated research into children's linkage of sex and gender when he argued that, although the three- to four-year-old child has an awareness of genital differences, she or he does not use those differences as a criterion for gender categorization. It is not until age seven, in his view, that genitals acquire a centrality in gender categorization. When that occurs, however, it enables the child to view gender as an invariant or a constant.

A series of studies designed to test gender constancy in very young children—i.e., the stability of the concept of gender—seemed to confirm his thesis (Eaton and Von Bargen 1981; Emmerich et al. 1977; Gouze and Nadelman 1980; McConaghy 1979; Slaby and Frey 1975). Incredibly, all but one of these studies (McConaghy 1979) did not use genitals as a gender cue. However, two other researchers, using either photographs of nude toddlers or anatomically correct dolls in gender-recognition tasks, found that children as young as thirty-six months do employ genitals to designate gender (Bem 1989; Miller 1984). Still, Kohlberg's belief that children younger than seven see stereotypical surface features (e.g., length of hair, clothing) as the essence of gender, rather than

genital difference, continues to be invoked, even within psychoanalysis (Coates 1997).

Although both Bem's and Miller's studies showed that children as young as three do link genitals with gender, their research did not give the children a way to indicate which genitals were being used as cues. The doll bodies and photographs that were shown to the children already contained either male or female genitals. The children had no way of indicating whether or not they were using both male and female genitals to designate gender; it was possible that only one genital had been used as a gender cue for both the male and the female categories. For example, the children might have recognized the penis on the boy doll and correctly labeled it a boy, and then determined that since the other doll or photograph did not have a penis, it was a girl. The children might also have recognized that the female genitals made the figure a girl. The important issue of the role of each of the genitals in early gender recognition and conceptualization remained unaddressed in these studies.

OVERVIEW OF THIS STUDY

In this study, preschool children were asked to place body parts, including genitals, onto a doll to make it gendered. It was a task that confronted them with both genital difference and gender difference, and challenged them to consider the linkage between the two. The ways in which the children used the body parts to construct gendered dolls were expected to meaningfully reflect their ideas about that linkage. Additionally, because boys and girls have basically different anatomical ground plans, it was expected that these anatomical differences would differentially affect their gender constructs.

Hypotheses

Four hypotheses were tested. I had expected that: (1) the children would use the genitals more often than not to construct a

gendered body; (2) the male genital would be used more often by both boys and girls to construct the boy doll than would the female genital be used to construct the girl doll; (3) the female genital would be used less by boys than by girls to construct the girl doll; and (4) bodies constructed by boys would show sexual ambiguity more than would bodies constructed by girls—e.g., genitals of both sexes on either the boy or girl doll.

DESIGN OF THE STUDY[1]

Participants

The research sample consisted of sixty-two children, thirty-two boys and thirty girls, who ranged in age from thirty-eight to fifty-nine months (M = 46 months). Thirty-nine were three-year-olds (boys: n = 21; girls: n = 18), and twenty-three were four-year-olds (boys: n = 11; girls: n = 12). The children were recruited from preschools in central New Jersey suburban communities. They were predominantly from white, middle-class families and lived with both parents.

Stimulus Material

The children were asked to construct a girl and a boy, using Velcro-backed anatomical features that they could place on a doll body devoid of anatomical characteristics. This method contrasted with previous gender research in which children were asked to identify the sex of a preconstructed, anatomically correct doll. Free use of both genital and nongenital parts provided the children with an opportunity to express through anatomy their ideas about what makes a girl a *girl* and what makes a boy a *boy*. The task was akin to working on a puzzle, and was introduced to the children in that way.

These custom-made dolls had child-sized bodies (seventeen inches tall), and were made of a soft stuffing material covered with

[1] For a more detailed description of the study's methods, see Senet 1997.

a light beige, polyester-knit "skin"; each had an anal opening and hands with fingers. Both boy and girl dolls had the same short, curly, dark brown hair. On both, Velcro similar in color to the body was sewn across the width and length of the face and down the front torso to the pelvic area.

There were ten removable, Velcro-backed parts for each doll. The nongenital parts consisted of two eyes, two ears, two nipples, one mouth, one nose, and one bellybutton. The male genital consisted of a circumcised penis with scrotum, and the female genital was a vulva with labia major and minor, clitoris, and vaginal pocket. The dolls were specifically designed to portray a child's body rather than that of an adult; accordingly, they had no secondary sexual characteristics, such as pubic hair, chest hair on the male, or breasts on the female. The doll bodies were constructed identically except for the genitals, and were presented without clothing so that there were no stereotypical cultural gender cues, such as style of clothing or hair length. Thus, secondary sexual characteristics and stereotypical cultural gender cues were eliminated as possible confounding variables in this research. Although such variables are likely important to children's ideas about gender, they were not included as dimensions of this study, nor is their influence discussed in this paper; the purview of this study was limited solely to the significance of the genitals for early gender categorization.

Procedure

All interviews were conducted in the child's home. I gave the parent a short questionnaire to fill out about the family structure, and then I engaged the child in play with regular twelve-piece puzzles. The parent remained in the room throughout the research procedure, and each interview was videotaped. The tapes were later viewed as an aid in scoring, as well as for reviewing the verbal remarks and gestures of the children as they played with the dolls and completed the tasks.

At the start of each interview, I asked the child, "Are you a boy/girl?", first phrasing the question to conform to the child's

gender and then repeating it using the opposite gender. This assessed whether the child knew his or her own gender and could correctly use gender labels. Only one child answered "yes" to both questions, and although that interview proceeded to completion, the results were not used. Thus, the final sample of sixty-two children included only those who had correctly identified themselves as to gender.

I then showed the child fully assembled girl and boy dolls, placing them on a table at which the two of us would work. I told the child, "These are special puzzles. The pieces come off and can be put back on." After demonstrating how this could be done by using the lips of one of the dolls, I said, "Now I'm going to take all the pieces off." All twenty body parts (ten from each doll) were put in front of the child and were available for the child to use to complete each task.

One doll body was then placed in front of the child as I said, "Here is the body-puzzle. Please make it a girl [or boy, gender corresponding to the sex of the child]. Use the parts that you need and tell me when you're done." When finished, the child was asked to name each part used. The parts were then taken off the doll and placed alongside the unused parts, again making twenty parts available for use. The child was next asked to make the doll a boy (or girl, gender opposite that of the child), and again, when finished, the child was asked to name each part used as well as those not used.

I attempted to follow this protocol as closely as possible. However, in order to engage these very young children in working on the research task, I had to be flexible. I became involved in the doll play to a degree that varied with each child. Some children worked quietly without asking for help from me, while others needed to be coaxed to work on the task. Some wanted me to play with them as they worked. They asked me questions about the doll or the parts, or wanted help from me, or became playful and silly. Some children involved others in the room: parents, siblings, and friends, even a pet cat in one case.

Part way through the study, I realized that some of the children were calling their construction a "silly" boy or girl; and in-

deed, it would be silly looking. After a child who had made this kind of doll was finished, I would ask her or him to make another one and to now make the girl or boy look real. Only the original construction was used for scoring, however.

Scoring and Statistical Tests

The following information was recorded for each doll construction: the specific parts used, number of parts used, sequence in which they were placed on the doll, and body location where parts were placed. The genital was considered to be in the correct body location if it had been placed on the lower half of the front torso. The name that had been given for each body part was also recorded, but not used in the scoring. Each child's use of parts and body-location placement of genitals on both doll construction tasks was converted into scores for seventy-two genital-use variables. Using chi-square (χ^2), the data from these variables were analyzed by age and gender categories, as well as by two demographic categories (religion and siblings) for which the sample was heterogeneous. When sample size was small enough to result in a 2-x-2 contingency table with cells having an expected frequency of less than five, the chi-square statistic was adjusted using the Yates continuity correction. An alpha level of .05 was used for all statistical tests.

RESULTS OF THE STUDY

Genitals as Indicative of Gender

The majority of children in this study knew that genitals (1) belong on a gendered body, and (2) can be used as a defining feature of gender. Although each gendered doll came with ten removable parts, the actual constructions made by the children could contain anywhere from one to twenty parts (ten from each doll). In most of the constructions, the children used from eight to twelve parts (girl doll: 89%; boy doll: 92%), rather than simply putting on

all available parts. The genitals were included as one of those parts 74% of the time. Moreover, the genitals were placed on the dolls as one of the first seven parts 71% of the time.

Taken together, these results suggest that purposeful inclusion of the genitals occurred in both doll tasks. Moreover, in a preponderance of constructions, the children used the gender-consistent genital (although in some of these cases, the opposite-sex genital was also used) and placed it in the correct body location (girl doll: 66%; boy doll: 74%).

The Use of Both Male and Female Genitals

In constructing their conceptual world, young children give preeminence to an object's highly visible surface features (Gopnik and Meltzoff 1987; Rosch 1978). Because boys' genitals are a protruding body feature, while those of the girls are mostly hidden, I had expected that the boys in this study would be less likely than the girls to use the female genital in their girl doll construction. But, to the contrary, there were no significant differences between the girls' and the boys' constructions in this respect. Moreover, the majority of both boys and girls constructed girl dolls by including a female genital (76%) and boy dolls by including a male genital (79%).

Doll Constructions as Genitally Realistic

Although the expected differences between girls and boys in the frequency of use of the female genital on the girl doll did not occur,[2] differences between the sexes did occur on a particular kind of doll construction created by some children. These were constructions that were genitally realistic: only the appropriate genital was used, rather than a combination of male and female genitals, and it was placed in the correct body location. Out of the total sample, 26% of the constructions met these criteria. Interestingly, it

[2] See my third hypothesis, p. 300.

was the girls rather than the boys who made these doll constructions (see Table 1, below). More girls (37%) than boys (16%) constructed genitally realistic girl dolls, χ^2 (1, N = 62) = 3.58, p = .05; ϕ, p = .05. And more girls (53%) than boys (25%) constructed genitally realistic boy dolls, χ^2 (1, N = 62) = 5.24, p = .02; ϕ, p = .02.

Table 1

Genitally Realistic Boy Doll and Girl Doll Constructions

Genitally Realistic Doll	Gender of Child	
	Boys (*n*) %	Girls (*n*) %
Girl	(5) 16 *	(11) 37 *
Boy	(8) 25 **	(16) 53 **

Note. Percentages are based on the following sample sizes. Boys = 32, girls = 30.
* p = .05, ** p = .02.

Sexual Ambiguity in Body Design

A child could create ambiguity in the sex of the doll in two ways: (1) by using the genitals of both sexes, or (2) by using the genital of the opposite sex only. Approximately one-half of the total doll constructions were ambiguously sexed (girl doll: 56%; boy doll: 48%). It was on these kinds of constructions that other significant differences between girls and boys occurred. Differences between the girls and the boys had been expected because it had been assumed that girls would have a greater familiarity than boys with the genitals of both sexes. However, more three-year-old girls than boys, χ^2 (1, n = 39) = 3.72, p = .05; ϕ, p = .05, created sexually ambiguous girl dolls, but more four-year-old boys did so than girls, χ^2 (1, n = 23) = 5.24, p = .02 (see Table 2, next page). These differences were statistically significant.

Table 2

Sexually Ambiguous Girl Doll Constructions

	Age of Child	
	3 years	4 years
Gender of Child	*(n)* %	*(n)* %
Boys	(10) 48 *	(8) 73 **
Girls	(14) 78 *	(3) 25 **

Note. Percentages are based on the following sample sizes. 3-year-old boys = 21, 3-year-old girls = 18, 4-year-old boys = 11, 4-year-old girls = 12.
* p = .05, ** p = .02, Yates, p = .06.

Boys more than girls used both genitals simultaneously on the boy doll (see Table 3, facing page). When a boy made a sexually ambiguous boy doll, he most frequently used both genitals simultaneously, rather than only the female genital. The girls, however, were just as likely to give the boy doll only the female genital as both genitals. This finding—that boys more than girls used both genitals simultaneously on the boy doll—reached the level of statistical significance, χ^2 (1, N = 62) = 3.75, p = .05; ϕ, p = .05.

Among the three-year-olds who made a sexually ambiguous girl doll, the overall trend was for both the boys (seven out of ten) and the girls (ten out of fourteen) to use both genitals simultaneously, rather than only the male genital. Within the four-year-old sample (see Table 4, p. 308), however, boys (75%) continued to use both genitals, while girls (33%) did not do so. The difference was statistically significant, χ^2 (1, n = 23) = 5.79, p < .02. Adjusting for the small four-year-old sample using the Yates continuity correction, this finding remained significant, χ^2 (1, n = 23) = 3.81, p = .05.

In creating sexual ambiguity on the boy doll (see Table 5, p. 309), four-year-old girls used the female genital alone. The four-year-old boys, however, continued to use both genitals simultaneously. This difference was statistically significant, χ^2 (1, n = 23) = 5.79, p < .02; ϕ, p < .02. The numbers were small, however.

Table 3

Percentages for Use of Both Genitals Simultaneously in Girl Doll and Boy Doll Constructions

		Gender of Child		Age of Child	
Doll with Both Genitals	% Total Sample $N = 62$	% Girls $n = 30$	% Boys $n = 32$	% 3-year-olds $n = 39$	% 4-year-olds $n = 23$
Girl	39	37	41	44	30
Boy	37	27 *	47 *	41	30

Note. * $p = .05$.

Table 4

Comparison of Sexually Ambiguous Girl Doll Constructions

	Age and Gender of Child			
	3 years		4 years	
Genitals Used On Girl Doll	Boys *(n)* %	Girls *(n)* %	Boys *(n)* %	Girls *(n)* %
Both Genitals	(7) 70	(10) 71	(6) 75 **	(1) 33 **
Male Genital Only	(3) 30	(4) 29	(2) 25	(2) 67

Note. ** $p < .02$, Yates, $p = .05$.

Table 5

Comparison of Sexually Ambiguous Boy Doll Constructions

	Age and Gender of Child			
	3 years		4 years	
Genitals Used On Boy Doll	Boys *(n)* %	Girls *(n)* %	Boys *(n)* %	Girls *(n)* %
Both Genitals	(9) 82	(7) 88	(6) 86 **	(1) 25
Female Genital Only	(2) 18	(1) 13	(1) 14	(3) 75 **

Note. ** $p < .02$, Yates, $p = .05$.

DISCUSSION OF THE RESULTS

The research findings in this study generated data that impact on three aspects of gender development: (1) young children's ability to conceptually link genitals and gender; (2) differences in that process between girls and boys; and (3) preoedipal bisexuality.

First, with regard to the linking of genitals and gender, both the three- and four-year-old children in this study appeared to have grasped that there is a genital basis to gender. Second, the boys in this study, at both ages three and four, had more difficulty than the girls in making genitally realistic doll constructions. And third, the sample as a whole—with the exception of the four-year-old girls—created bisexual bodies. Many of the children imagined that gender does not exclude having genitals of the opposite sex. A fantasy or basic notion that the body can exist as a bisexual one was prevalent.

Genital Basis of Gender

Characteristic of their level of cognitive development, the children's crafting of the doll constructions seemed to reflect in part a primitive thought process that conflates wish with perception. Their doll-body designs could be described as revealing a free flow of play with ideas, wishes, fears, and so on, without regard for logical contradictions. These designs probably reflected each child's emotional and fantasy life as much as the recognition of anatomical difference between the sexes.

Even so, statistical evaluation of the use of genitals in doll constructions yielded a picture of their purposeful inclusion. Moreover, other nonstatistical evidence from the study indicated that the children possessed discrete factual knowledge about sexed bodies and gender difference. As reported earlier, I asked some of the children who had made a doll with unrealistic anatomical configurations to construct another doll, and this time to make it look like a real boy or girl. These children most often responded by making the construction look more realistic. In other words,

they had a factual grasp of girls' and boys' anatomy and could make their girl and boy doll constructions look realistic, including genitally. However, without adult prompting for performance strictly in conformance with a realistic body schema, these children's approach to the research tasks was imaginative. But even when children in this study made wholly unrealistic doll-body constructions, their choices with regard to genitals appeared to be intentional rather than random.

Some examples may help to clarify what I mean. Kristin, three years old, used all twenty parts on her girl doll. Nonetheless, she placed the vulva in the correct location and gave it a genital name. Three-year-old Tommy used nineteen parts on his boy, including both the vulva and the penis. When I asked him to make a girl, he immediately quipped, "But no penis." True to his word, he constructed a girl using all available parts except the penis.[3]

A number of children seemed to be playing with anatomical possibilities, but nonetheless demonstrated that they understood the link between genital difference and gender difference. Katie, three years old, placed two eyes on the face of the girl doll, followed by the vulva where the mouth should go, and then ears. Although she considered giving her girl a penis, in the end, she decided to leave it off. When she was finished, I asked her, "Is this the girl?" "Yes," she answered, pointing directly to the vulva perched on the doll's face.

Robert, a four-year-old boy, used both male and female genitals on his girl doll and boy doll. After the interview was completed, his mother, who had been watching, asked him, "Does a girl have a penis?" Quickly and confidently, he answered, "No."

Three-year-old Rachel made her girl with a penis. She placed it in the genital area and correctly named it. She did not give her girl a female genital. Next, she made a boy without a male genital. But as she began designing her boy, the very first part that she picked up was the vulva, which she placed in the correct body

[3] The male genital body part consisted of both the penis and scrotum, but for brevity's sake, throughout this paper, I refer to it as a penis.

location. She evidently knew that the vulva doll part was a genital, but for some reason, had chosen to construct her girl doll without it, as she had also chosen to construct her boy doll without a penis.

Patrick, three years old, used all twenty parts for both his boy and his girl dolls. He constructed his boy by first putting two eyes on the face and then putting the penis in the correct location. From then on, with his eyes repeatedly darting to his mother's face and then away, he became silly and giggly, sticking the other parts all over the torso. He named the penis correctly, but then made up silly names for all other parts. He began his girl doll next. The very first part he gave her was the penis, placed in the correct genital location. Now even gigglier, he announced to his mother, "Look, I made a penis for the girl."

Consonant with the primitive thinking of children of this age, their inclusion of genital difference into the dolls' gender schemas did not mean that true-to-reality body structure would necessarily be reflected. Nonetheless, relatively high percentages of the constructions (35% of the boy dolls and 26% of the girl dolls) were made genitally realistic. This finding in the context of these children's cognitive level of functioning evidences the powerful pull of their awareness of the genital basis of gender. The results as a whole affirm such awareness, refuting Kohlberg's (1966) contention that children younger than seven do not understand the link between genitals and gender.

Girl–Boy Differences

The girls' and boys' performance on the body construction tasks differed significantly in some respects. The girls more than the boys created sexed bodies for the gendered dolls by way of accurate usage of the genitals. This outcome issued from the data in two ways. First, at both ages three and four, the girls made more genitally realistic boy and girl dolls than the boys did. Second, 47% of the boys had crafted their boy dolls with both genitals, while only 27% of the girls constructed their boy dolls in that way.

To restate these differences, one could say that, on the whole, the girls in this study were more able to accurately convey their comprehension of the significance of genitals to gender, and perhaps had a better grasp of body structure as it relates to sex and gender difference.

The girls' greater proficiency in the body construction tasks was similar to results obtained in other, related studies. Mortensen (1991) asked children of ages five to thirteen to draw three pictures of people: one of each sex and one of him- or herself. She reported that boys more often than girls drew figures whose sex was unrecognizable by the raters. After age seven, all drawings made by girls could be recognized as to sex, but the boys continued to make sexually ambiguous drawings up to and including the age of thirteen.

Reviewing body-image research with preschool children, Fisher (1964, 1986) found that girls often manifested superiority over boys in mastering body-image tasks. Preschool girls showed a greater awareness of their bodies and more quickly mastered body spatial coordinates. On figure-drawing tests, when requested to draw a person, girls responded by drawing a figure of the same sex as the self at an earlier age than did the boys. Also, at an earlier age than the boys, girls incorporated details into their drawings that clearly distinguished the sex of the figure.

Although the notion that preschool girls are more cognitively mature than boys might provide a beguiling explanation for these boy–girl differences, existing research yields no confirmation for this view. Maccoby (1966), in a survey of research on sex differences in three- to five-year-olds, found no consistent differences between girls and boys in cognitive abilities.

The children in the present study were not tested for differences in level of cognitive functioning. However, in de Marneffe's (1997) study, which investigated two-year-old children's recognition and labeling of preassembled anatomically correct dolls, greater proficiency on some tasks was also found among girls. Since de Marneffe had tested the children for their level of cognitive functioning and had not found any differences between the

girls and the boys, she concluded that their differences in performance on the gender tasks could not be accounted for by differences in cognitive maturity.

Overall, these research findings create a picture that is the opposite of Freud's (1925, 1931, 1933) portrait of little girls. He argued that at the time of children's discovery of the anatomical difference between the sexes, it is girls, rather than boys, who are confronted with a daunting, perhaps even insurmountable, psychological task on account of the nature of their sexual anatomy. More recently, others (D. Bernstein 1990; Krausz 1994; Mayer 1995; Richards 1992; Torsti 1993; Wilkinson 1991, 1993) have argued that contrary to Freud's belief that a little girl must struggle to accept her body as missing the prized male genital, the task at hand for a girl is rather to find solutions to the genital anxieties intrinsic to the possession of her own female anatomy.

However, only a few have argued the reverse of Freud's position, observing that it is young boys who potentially have more difficult developmental tasks because of anxiety stirred by the nature of their own sexual anatomy. Tyson and Tyson (1990) contend that forming a genitally intact, confident sense of body self might be easier for girls than for boys because a girl's body structure inherently provides her with a greater sense of protection against genital injury. Boys, unlike girls, have genitals that are protruding appendages, and as a consequence are seemingly vulnerable. Fast (1990, 2001) argues that for a boy, matters of sex difference and of separation-individuation may readily become fused and impair his ability to adequately deal with sex difference at that developmental juncture. According to Fast, girls' and boys' issues diverge at the time when they recognize sexual differences. While the girl must recognize herself as sexually different from her father, who is usually not her primary caretaker, the boy must see himself as sexually different from the mother who *is* his primary caretaker, an inherently confounding circumstance.

The design of the current study did not allow for the gathering of data that would have more clearly revealed why the boys' body designs were not as accurate with respect to genitals as those

of the girls. One might speculate, though, that a confluence of elements, such as girls' and boys' possession of distinctly different sexual anatomies, as well as the differing nature of their early identificatory processes, affected their execution of the research task. Much has been written about gender differences in early identificatory processes (Benjamin 1995; Chodorow 1979; Dinnerstein 1976; Fast 1984; Tyson and Tyson 1990), so I will not repeat it here. On the other hand, little has been said about the effect of genital difference per se on the ability to psychologically incorporate sex difference.

Perhaps the hidden nature of a girl's genitals gives her an advantage in articulating gender via anatomy. Boys and girls learn about genital anatomy, their own and that of the other sex, differently. A girl can establish familiarity with her own genitals via kinesthetic cues (D. Bernstein 1990; Irigaray 1990; Kestenberg 1968; Krausz 1994; Montgrain 1983; Richards 1992; Wilkinson 1993) that are not available to a boy as he tries to apprehend the differences between a girl's body and his own. Girls not only can *feel* the movement associated with their own genital sensations, but can also *see* the motion of the male genital. Thus, the motorically interesting features of the male genital may add another dimension to the girl's understanding of it, while no similar element is provided for the boy as he tries to understand a girl's sexual anatomy.

Some of the children in this study alluded to the importance of motion for their grasp of genital anatomy. The ways in which they creatively labeled genitalia referenced their motor and kinesthetic aspects. The male genital was called a "tickle" by one four-year-old girl, a "vacuum cleaner" by a three-year-old boy, and "they-sail-on-the-ocean-in-a-boat" by a three-year-old girl. Another four-year-old girl referred to the female genital as "pee-to-get-out."

For the boy, reliance on what he can see for information about the body of the opposite sex will not give him as clear a grasp of female anatomy as the girl may be able to glean about male anatomy. The female genital, a complicated configuration of folds and openings, is not as visually salient or comprehensible as that of

the male genital. Although the girl is confronted with hurdles as she tries to grasp the features of her own genitals, for the boy, apprehending female genitalia and sex difference might well be a more daunting task. It would follow, then, that girls can learn more about the unique features of the protruding male genital than boys can about the mostly hidden female genital. If so, I would argue that this situation creates some advantages for the young girl, facilitating her ability to articulate body structure, enhancing her understanding of sex difference, and promoting more realistic body concepts than those of boys of the same age.

Excerpts from several children's interviews in my study will hopefully enhance the statistical picture of girl–boy differences yielded by my research. For example, three-year-old Johnny verbalized his difficulty in constructing the girl doll. He had confidently created the boy doll using fourteen parts, including both genitals. Although he had used the female genital on his boy, he had called it a "peepee," indicating that he knew it was a genital. When I asked him to make a girl, however, he began to do so tentatively. He put on the eyes and the nose. He placed a third eye on the face as a mouth and commented, "I'll make a funny girl," and then immediately put the doll aside, indicating that the construction was completed. Afterward, I suggested that he make the girl look real. He paused, and then responded in a lowered voice, "I don't know how."

In contrast, Elizabeth, three years old, got right down to business and had little trouble in completing both dolls. "This one's a boy and this is a girl—right?" she announced, as I took out the preassembled dolls and placed them in front of her. She proceeded to work on the tasks with little hesitation. Her girl doll was made with eight parts. The only genital she gave her was the vulva, which she placed on the lower torso and called a "peepee." Then she started on her boy. The first part she picked up was the penis; she accurately placed it on the lower torso.

Donald, also three years old, seemed delighted when he saw the dolls. But rather than freely engaging in the task, he moved back and forth between his own body and the doll body as he

worked on his boy and girl constructions. He gave his boy doll both genitals. He used the vulva on its face, naming it a mouth, and next correctly placed the penis on the lower torso. He could not name it, however, instead pointing to his own penis. His girl doll was constructed with only the male genital. When asked to name that part, he pointed to his own genital, but said, "She is like my Aunt Joanne." When he placed the nipples and bellybutton on his dolls, he pulled up his shirt to show me where they were on his own body. He seemed to be using his body as a prototype for both sexes, but his reason for doing so was unclear. Was it that he did not understand the link between genitals and gender? Was he defensively denying the girl her own genital? Did he not know what the female genital looked like? As is often the case, research leads to many more questions than answers.

Although most of the three-year-olds, both boys and girls, did not use the genitals accurately to create sexed doll bodies, by age four, the girls were handling the task with aplomb. The boys, on the other hand, continued to create genitally unrealistic bodies. It might be that the acquisition of the capability to conceptualize gender as a category related to genital difference was a more prolonged event for the boys than for the girls in this study. Could it be that by age four, the girls had been able to integrate genital difference into their concept of themselves as gendered in a way that enhanced and further stabilized their identities, while the boys at that age lagged behind in such an achievement?

Bisexual Bodies

A little over one-half (53%) the children in this study constructed sexually ambiguous doll-body designs, even though, as previously discussed, there was evidence that they were cognizant of the anatomical difference between the sexes and the genital basis of gender. A majority (66%) of these constructions were created by the use of both genitals simultaneously. Less commonly (34%), the children used only the genital of the opposite sex, i.e., the girl doll had only a penis, or the boy doll only a vulva.

The propensity for these three- and four-year-olds to fashion bisexual body designs for both boy and girl dolls is an intriguing statistical finding that potentially supports two assumptions of psychoanalytic developmental theory: (1) that young children wish to be both sexes, and (2) that genital envy exists at a young age. What follows is a consideration of these two assumptions, coupled with vignettes from my interviews that might be seen as illustrative of those concepts. The specific psychic factors that might underlie the construction of these doll bodies as bisexual, though, can only be a matter of speculation, inasmuch as the data is limited.

The Wish to Be Both Sexes. Kubie (1974), in noting the pervasiveness of children's denial of the anatomical difference between the sexes, saw this as defensive against a drive in both girls and boys to become both sexes. He argued, however, that children's desire to have what the other sex has is not a wish to give up one's own sex, but to supplement it with that of the other. Fast (1984) also recognized the prevalence of this wish, considering it central to the evolution of identity in young children. She argued that the childhood fantasy of possessing a sexually complete, bisexual body is an attempt to buttress a faltering illusion of omnipotent limitlessness after the discovery of sex difference.

Bearing in mind these arguments, the children's doll-body creations that playfully disregarded sex difference might be indicative not only of the wish to possess the genitals of both sexes, but also of ambivalence about acknowledging genital difference, as well as a defensive denial of the body limitation inherent in that difference. Excerpts from the interviews of a number of children in my study will perhaps underscore these possibilities and illustrate some of the choices being made as these preschoolers fashioned ambiguously sexed body schemas.

For three-year-old Carla, sex difference was acknowledged and clearly indicated on her boy doll, but it is possible that her desire for both genitals and her struggle with that desire was played out in the construction of her girl doll. She plunged into the task of making the girl doll as soon as the body parts were

placed in front of her. "Which one is the vagina?" Carla wanted to know. After briefly rummaging through the parts, she found the vulva and placed it correctly in the genital area. Then she picked up the penis. "What is this?" She placed it on the upper right torso and exclaimed, "I need another one like this." When she could not find another one, she moved it to the center, in line with the previously positioned vulva. Although she ignored sex difference in adorning her girl doll with both genitals, she did not do the same for her boy doll, which was limited to the genital of his sex.

Victor, a four-year-old boy, seemed to be struggling to admit sex difference while still holding onto the fantasy of anatomy not limited by that difference. He constructed his boy doll by first placing the vulva in the genital area and next putting a bellybutton inside the vulva. Then, finishing his genital masterpiece, he placed the penis on top of the other two parts. He called his anatomical invention a "weenie," saying that the boy "looked funny with the things on." As he started his girl doll, he told me, "Girls don't have weenies." He then proceeded to create a similar genital combination, except that he used the nose instead of the belly button inside the vulva, again finishing it with a penis on the top. He distinguished this genital from the one he had created for the boy doll by calling it a "crooked weenie." His unique genital designs and his acknowledgment of genital difference, while simultaneously denying that difference, could perhaps be interpreted as his expressing via the doll bodies that he could not so easily relinquish what was unique to the other gender.

Three-year-old Sally hesitated, at first, as she created her girl with the usual eyes, nose, and, mouth on her face and then a bellybutton in the genital area. "I need help making this girl," she implored. Picking up the penis, she asked, "Does this go with the girl?" Encouraging her to continue, I said, "You tell me what you would like this girl to have." Sally chuckled with delight. "A penis," she answered, placing it on the doll on top of the bellybutton. "I'll make her funny. I'll make a girl with a penis. See, the girl has a penis." Then, looking dismayed, she took off the eyes,

saying, "These are *boy* eyes. She needs girl eyes." She replaced them with two others. Next, Sally worked on her boy doll. She completed it by placing a bellybutton in the genital area and then the penis on top of that. She showed it to her 21-month-older brother. Playfully taunting him with having eliminated the sex difference, she now clarified the genital combination that had also been previously placed on the girl doll. "He has lipstick, Charlie, and he has earrings, and the boy has a vagina. The vagina is underneath the penis."

Four-year-old Josie, too, struggled with how to proceed with her knowledge of anatomical difference. She at first attempted to deny that the girl doll should be constructed without a penis. Afterward, she renounced the desire for the girl to possess what a boy has, instead offering her own girl body as a universal prototype: "Everybody must be just like me" (Mayer 1985). She constructed both the boy and the girl with the female genital only. She toyed, however, with giving the girl a penis. After designing the girl's face, she picked up the penis, looked at it, and asked, "Where does this go?" Without a pause, she continued, "I'll make it an earring." After placing it on the girl's ear, she looked through the pieces in front of her and said with dismay, "I can't find another one, another one just like that, another earring!" After looking through the parts a few moments longer, she took off the penis and declared, "I don't want it on." Next, she picked up the vulva and asked, "What's this?" "What do you think it is?" I inquired. Josie answered, "I don't know," while placing it correctly in the genital area.

Genital Envy. If indeed these children's doll designs revealed their desire to be both sexes, a concomitant of that desire would quite possibly be an envy of the genital that one does not have. Genital envy, as with other psychological concepts, refers to a complex phenomenon that includes emotional and cognitive determinants. This concept can be viewed from both these vantage points. With respect to cognition, envy of the genital of the opposite sex is perhaps fueled by the very nature of the preschooler's thought processes. Cognitive immaturity, typified by syncretic and

diffuse thought, prevails. The young child's perceptual organization is characterized by qualities of the whole (Werner 1980). Each part is assumed to contain the entirety of the object. Thus, the opposite-sex genital is not only a body part different from that of one's own, but may also embody all that is differentially attributed to the other sex. Perhaps, to possess that other genital is to have all that personifies that sex.

In considering possible emotional determinants of genital envy, we are confronted with a curious state of affairs. Psychoanalysis has barely acknowledged the existence of envy of the genitals of *both* sexes. Genital envy has been assumed to be synonymous with penis envy. Much has been written about penis envy theory, and we are all familiar with it; a brief summary of the relevant literature should suffice. For Freud (1923b), recognition of sex difference meant that children were confronted with the castrated state of girls. As a result, boys' fear of their own castration intensifies, and girls, realizing that they are missing a penis, are envious of it. In this way, he introduced penis envy as a key factor in girls' development and subsequently established it as the bedrock organizer of femininity (Freud 1925, 1931, 1933).

Others argued that, rather than bedrock, penis envy should be viewed as a conflation of secondary conflicts and/or defenses. Horney (1924) proposed three components: jealousy on account of the ready visibility of the boy's organ; hindrance of the girl's exhibitionistic tendencies because her genitals are mostly hidden; and suppression of the girl's wish to masturbate, contrasted with her belief that boys, because they are allowed to hold their penises while urinating, have permission to do so. Jones (1935) regarded penis envy as a regressive defense against the oedipal wish for father's penis. Klein (1928) also conceptualized it as defensive: an idealization of father's penis, as the little girl turns away in frustration and hate from her first object, the maternal breast.

More recently, writers have offered a myriad of possible dynamics related to penis envy. It can be seen as a metaphor serving to express intertwined but separate issues from various levels of development that articulates a narcissistic injury incurred

at the time of the discovery of the genital differences between the sexes, as well as a later regressive effort to resolve oedipal conflicts involving envy (Grossman and Stewart 1976). When a girl notices that she lacks something that the other sex has, a penis, her envy for that part can become a metaphor for desire, as well as a communication of her sense of other lacks (Wilkinson 1991). Penis envy can express a girl's feeling of being cheated because of parental failure to explicitly acknowledge the vulva (Lerner 1976). It can serve as a revolt against the omnipotent mother (Chasseguet-Smirgel 1976), or may express a fear of losing mother because of lacking what is needed to genitally gratify her (Lax 1995), or compensate for too early a traumatic disappointment with mother (Torsti 1993), or it might function as a defense against identification difficulties with mother (Torok 1970) or the lack of a relationship with father (Elise 1998).

Research observations seem to confirm the verity of penis envy theory's supposition that a girl is distressed at what she does not have at the time of discovery of the anatomical difference between the sexes (Mahler, Pine, and Bergman 1975; Roiphe and Galenson 1981). Observational data from some of the girls in the present study could be used as supportive evidence of penis envy as well. For instance, Caroline was one of the three-year-old girls who constructed her girl with both genitals. After beginning to make the girl, she hesitated, and I encouraged her, asking, "Does this girl need any other parts to make her a girl?" "Yes," she answered, placing the mouth correctly, followed by the vulva above one of the eyes, referring to it as an eyebrow. "Does she need anything else to be a girl?" I inquired. "Yeah!" "What does she need?" Picking up the penis, Caroline showed it to me, exclaiming "This!" "She needs that?" I asked. Caroline answered wistfully as she placed it on the upper torso, "I hope."

But to interpret this data solely as confirmatory of penis envy would be incomplete and inaccurate. Carla, Sally, Caroline, and a significant number of other girls in this study wanted their girl dolls to have penises *in addition* to the female genital, not *instead* of it. As Fast (1990) stated with eloquent simplicity:

> Denial of sex difference in both boys and girls is expressed in notions of being bisexually complete rather than in being male. Envy and demands for restitution occur in both boys and girls. In both, they concern ideas about others' unlimited sex and gender characteristics rather than their exclusively male completeness. [p. 111]

Thus, Fast believes that the little girl's wish to have a penis is reparative to the narcissistic injury imposed by the recognition of genital difference, and that it reflects a desire to retain an illusion of body completeness.

On the research task, three-year-old Patricia made her girl sexually ambiguous and her boy with no genitals at all. She adorned her girl with all twenty parts. The vulva was placed in the center of the torso and the penis (referred to as a hand) on the arm. In the genital area, she placed a bellybutton and named it a penis, perhaps underscoring the presence of that genital. Next, she made her boy doll. He was devoid of most parts, for she gave him only four—all of them eyes, placed on the torso. I could not help but wonder whether Patricia had seized the interview situation to poetically depict her fantasy of body completeness: "All eyes on the girl with a vulva *and* a penis, the girl who has everything!"

One interpretation I have offered for the large number of doll bodies designed with both genitals has been that a wish to be both sexes, i.e., to possess what the other sex has, is perhaps a common occurrence among boys as well as girls. Historically, however, the possibility that boys may envy female genitalia has essentially gone unnoticed. Neglect of what might be called *vulva envy* is remarkable. Attention has been drawn instead to girls' envy of the penis and boys' envy of breasts and women's childbearing capacity (Dinnerstein 1976; Fast 1984; Horney 1926; Klein 1928; Kubie 1974; Lax 1997). This saga began with Freud (1905), who considered psychological bisexuality to be a universal feature of the psyche, yet believed that it was only girls who wish to possess the genitals of the opposite sex. It should be remembered that he assumed that both boys and girls saw nothing but an anatomical anomaly—a missing penis—when they looked at the vulva (Freud

1923b, 1925, 1931). Such a position is a denial of the existence of an intact, uniquely female genital.

The possibility that boys might be envious of the female genital per se has continued to be excluded from consideration by all but a few writers. Little Hans's first plumber fantasy was revisited by Silverman (unpublished), who wrote that "the wish to obtain his father's and/or his mother's powerful genitals" is another way to interpret the fantasy. And Bettelheim (1962), describing his observations of adolescent initiation rites, argued that these rites originate more as an attempt at mastery of the envy that one sex has of the other than as a rite of passage demarcating childhood from adulthood. In a rarely cited work, he wrote, "Girls undoubtedly suffer from penis envy, as boys do from vagina envy" (p. 141). Bettelheim supported his thesis with clinical data and with striking evidence from male subincision rites practiced in some primitive cultures. In those rites, either the whole or part of the penile urethra, along the under surface of the penis, is slit open. The wound is called a *vulva* in tribes of central Australia and a *vagina* or a *penis womb* in New Guinea tribes.

An indirect approach to examining vulva envy is by way of literature associated with the dread and fear of that genital. In her exploration of psychoanalytic themes in the movie *Basic Instinct*, Richards (1998) suggests that the image of Medusa momentarily flashed on a TV screen in the lead male character's room is crucial to the basic theme of this murder mystery. That image brings to mind the image from a previous scene of the suspected murderess displaying her vulva, thus linking the danger of Medusa to the danger of women. The major theme, Richards concludes, is an assurance to men that "by avoiding beautiful, powerful women, they can avoid death" (p. 279).

Richards's argument implies that Medusa symbolizes the terror of the vulva as the power of woman, not as the terror of a mutilated male genital. Yet Medusa is the very myth that Freud (1922) used to corroborate his supposition that the female genital is horrifying to boys because it is castrated, and as such, it verifies the possibility of their own castration. Instead, that myth might attest

to male recognition and envy of a distinctive female genital. To Freud, "The terror of Medusa is . . . a terror of castration that is linked to the sight of something. Numerous analyses have made us familiar with the occasion for this: it occurs when a boy, who has hitherto been unwilling to believe the threat of castration, catches sight of the female genitals" (p. 273).

A more thorough study of Medusa lore suggests that, to the contrary, the terror of Medusa had more to do with fear of her potent femaleness than of her penislessness (Balter 1969). Medusa's history, culled from poetic legends dating back to Paleolithic cultures, identifies her as the serpent goddess of the Libyan Amazons, representing female wisdom, and as the Destroyer aspect of the Libyan "Triple Goddess," who was revered as mother of all the gods (Graves 1948; Walker 1983). As Anath in ancient Syria, Egypt, and Libya, the goddess was worshipped in sacrificial rites, during which she was fertilized by the blood (not the semen) of males. Anath then hung the shorn penises of her victims on her goatskin apron or aegis (Walker 1983).

Later, the classical Greeks revised the earlier poetic tales that venerated the goddess in order to assemble an array of deities more in conformance with their patriarchal social order (Balter 1969; Baring and Cashford 1993; Gimbutas 1982; Graves 1948). In so doing, they changed Medusa from a castrat*ing* goddess to a hideous, castrat*ed* creature. In their story, the "Destroyer" was herself destroyed at the behest of a cunning male potentate. But the original Medusa of earlier civilizations embodied woman as potentate. Female anatomy was seen as a link to the superior forces of nature. Supplemental to this point of view is Horney's (1932) essay on dread of women, in which she argued that male devaluation and dread of the female genital arises primarily out of male fears of genital inadequacy, and only secondarily from castration fears.

The weight of the statistical results from my research study supports the argument that a majority of the children interviewed considered the vulva to be valuable and desired. It would have been felicitous to have had further substantiation of this interpre-

tation via the children's verbal responses but most of the children did not verbalize their thoughts, and so did not explain their choices for the body designs. I can present some details, nonetheless, from the interview of one of the boys that might provide additional corroborative evidence, as follows.

Four-year-old Keith was able to use words to tell me what was on his mind as he worked on the research tasks. He was exuberant when I showed him the fully assembled dolls, but he had difficulty in carrying out the research task. He was interested in doing one and only one part of it: his attention was riveted on the female body, especially that genital. When I showed both dolls to him, he immediately took the vulva off the girl doll and shouted, "Ooh, it's got a peepee! Gonna make girls." "First, make a boy," I said. He pointed to the other doll body, also now devoid of parts, which had been put to one side, and asked, "Is that one a girl?" I again said, "First, make this one a boy." Taking the doll body in front of him, he placed two eyes on the face and then picked up the vulva and put it in the doll's genital area. He then put the two nipples on the upper body, calling them "boobs," followed by the mouth on the face. Next, he picked up the penis: "What's this?" "What do you think it is?" I queried. He answered, "I don't know —uh—a sock," and he attached it to the doll's foot. As soon as he finished the boy doll, Keith grabbed the other doll body and said, "I'll make the girl now." The first part that he picked up was the vulva. He placed it correctly in the genital area and then jabbed it, saying excitedly, "I'll punch the peepee." Like the boy doll, the girl doll also got a penis on her foot.

Although another four-year-old boy, Joey, did not speak, perhaps his manner of executing the tasks, as well as the body designs themselves, spoke for him, possibly indicating his desire for and envy of the vulva. He worked quietly; his demeanor was serious. He made his girl doll accurately and genitally realistic, placing the vulva in the correct location and correctly naming it. He had also used the correct number of parts (ten) for his boy doll, so that its overall appearance was realistic, except for one thing: he had used only the vulva as a genital. He constructed his boy

first with a nose, followed by a bellybutton. He then picked up the penis and placed it momentarily on the torso, but took it off, replacing it with the vulva in the correct genital location.

In this study, the responses of three- and four-year-old boys did not support Freud's conclusion that boys' primary reaction to the sight of the vulva is terror because they see it as a castrated male genital. What appeared to be interest—and perhaps even desire, more than fear—prevailed; these boys seemed interested in the female genital and used it. They adorned their male as well as female doll creations with it. In fact, significantly more boys than girls gave the boy doll a vulva. Also, many of the children, both girls and boys, advantageously used the research interview to learn more about the female genital. Alive with curiosity, they turned the doll task into an investigative opportunity. They thoroughly explored the part that was the vulva, holding it, poking fingers into the folds and vaginal opening, and looking at it every which way.

This research with a nonclinical sample of children has allowed a glimpse into one of the elements of the complex phenomenon of psychological bisexuality. Approximately half the girls and boys appeared to want the genital of the opposite sex, and most of those wanted it in addition to their own. Perhaps at this point in their young lives, in the wake of having recognized that there is a world of others—some of whom are bigger and more powerful and all of whom are differentiated by sex and gender—the genitals, now recognized as the basis of sex difference, can become a symbolic source of all generation and gender differences. It might be that through a fantasy of possessing both genitals, preschool children attempt to bolster their now-faltering illusions of omnipotence and wholeness. It might also be that these bisexual fantasies, arising at such a very young age, continue either consciously or unconsciously throughout life. Although I am aware that these possibilities are conjecture about interesting, albeit rather limited, data, my hope is that they will stimulate further research as well as additional interpretations.

CONCLUSION

A group of white, middle-class preschool children from several suburban Northeast communities provided fertile ground for the empirical testing of an aspect of gender development. This study investigated how three- and four-year-old boys and girls deal with the anatomical difference between the sexes. It yielded three main findings:

- First, the children understood the genital basis of gender. This research provided a straightforward demonstration of the children's awareness of the link between genitals and gender, a link that has not always been recognized as existing at these ages. It also provided a glimpse into the influence of their immature level of cognition—typified by syncretic thought in interaction with their primitive emotions and desires—on their emerging conceptualization of gender. Although the children purposefully included genitals in their gendered doll constructions, those body designs were for the most part fanciful. Recognition of the link between body difference and gender difference was manifest but contextualized within the primitive nature of thought and emotion typical of this age.

- Second, girls—cognitive immaturity notwithstanding—were more able than boys to articulate gender via anatomy. Using genital difference to enunciate gender difference appeared to be a more difficult process for boys at these ages. This finding contradicts the belief that it is young girls who have more difficulty in dealing with the anatomical difference between the sexes.

- Third, a majority of the children created both their girl and boy dolls with the genitals of both sexes simultaneously. These bisexual doll bodies were not construc-

ted by chance. Their prevalence was interpreted not only as a reflection of cognitive immaturity, but also as an indication that these children, although aware of genital difference, were reluctant to embrace the idea that to be either a girl or a boy means to have the anatomy of one sex and not that of the other. Recognition of genital difference did not mean that these children acquiesced to the bounds of reality that normally limit body structure to the genital of only one sex. It was proposed that perhaps both the girls and the boys desired and envied what they did not possess, and so created fantasy bodies capable of being both sexes.

Acknowledgment: The author wishes to thank Dr. Marilyn Freimuth for her invaluable help with this article.

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218 Elberon Avenue
Allenhurst, NJ 07711

e-mail: nsenet@earthlink.net

Psychoanalytic Quarterly, LXXIII, 2004

THE ANALYST'S TRUST AND THERAPEUTIC ACTION

BY KENNETH A. FRANK, PH.D.

The analyst's trust, a neglected topic in psychoanalytic discourse, participates in therapeutic action—through the analyst's emotional openness, "unobjectionable positive countertransference" (see Fox 1998), the holding environment, and the promoting of adaptive internalizations, among other ways. When the analyst's trust—in the patient, in the analyst's self, and/or in the psychoanalytic process—fails, crucial interactions may occur, capable of destroying treatment, or alternatively, of restoring mutual regulatory functions and potentially leading to important mutative processes. Patients benefit from analysts' becoming sensitive to, having useful ways of thinking about, and working with their states of trust and distrust. The author presents clinical examples to illustrate these points.

INTRODUCTION

Psychoanalysts of all orientations have long acknowledged the importance of analysts' and analysands' mutual trust (Balint 1952; Blum 1983; Fox 1998; Horner 1983; Kanzer 1972; Wolf 1979, 1993, for example). In fact, the degree of mutual trust that exists is probably as valid an index as any of the overall quality of the analytic or any other relationship. Understandably, however, it is the patient's, and not the analyst's, trust that has received past attention (Dewald 1976; Isaacs, Alexander, and Haggard 1963; Loewald 1970, 1977, among many others). The historical model of the generic analyst concentrated heavily on the patient's experience, at

times calling particular attention to the patient's trust or distrust, but took the analyst's trust more or less for granted, omitting it from substantive psychoanalytic discourse.

Interest in intersubjective aspects of psychoanalysis has grown progressively since the 1980s (Wallerstein 1998). As Jacobs (1996) pointed out, the contributions of many authors, including Boesky (1990), McLaughlin (1987, 1995), Poland (1986), Renik (1993), Sandler (1966, 1987), Schwaber (1995), and Smith (2000, 2002), amply testify to the fact that this dimension of analysis is being integrated into contemporary classical theory and technique. Although, traditionally, analysts were encouraged to strive to expect *nothing* of patients (Chused 1991), as part of a stance guided by the psychoanalytic triumvirate of anonymity, neutrality, and abstinence, awareness of intersubjective factors has caused us to recognize the impossibility of suspending or concealing our personal expectations and other individual expressions in a relationship as intense as a psychoanalytic one (e.g., Aron 1996; Boesky 1990; Frank 1997). Moreover, in an atmosphere in which the introduction of intersubjective considerations has stimulated many new ideas and raised many problems for analysts to consider, it has been pointed out (Gill 1994; Renik 1993, among others) that there are dangers in striving to achieve certain traditional analytic ideals.

Intersubjective considerations generate interest in the conscious and unconscious qualities and actions of individual analysts, how analysts as well as analysands understand and express their conflicting expectations and needs, and, especially, how analysts beneficially negotiate and constructively integrate these personal factors in the analytic relationship (S. Pizer 1998; Smith 2000). Recent papers (Davies 1999; Kantrowitz 1997) have alluded to the role of the analyst's trust. These articles, and the scarcity of others related to this neglected topic, suggest the timeliness of analysts' beginning to consider systematically the role of their own experiences of trust and distrust in analytic treatment.[1]

[1] A conscientious computerized search of the psychoanalytic literature turned up *no* articles devoted to the topic of the analyst's trust per se, but only the indirect references cited.

DEFINITIONS, COMPLEXITY, AND MULTIPLICITY

Ordinarily, the analyst operates within a range of benign positive feeling for the patient—what has traditionally been called "unobjectionable positive countertransference." This conscious, relatively unconflicted caring for the patient and concern for the patient's best interests has been seen as an essential aspect of the psychoanalytic process.[2] As I will elaborate, that realm of analysts' experience importantly involves trust, which usually does not become a *conscious* treatment consideration of the analyst. Accordingly, when we ask ourselves, "Do I trust this patient?" the reflexive answer is apt to be something like, "Yes, of course I do."

But when one grapples in earnest with this question, attending to the specific nature and subtle variations in one's experience, the reply becomes much more complicated. Attempting to identify, track, articulate, and interpret trusting and distrustful feelings toward one's patients brings awareness that trust is hardly a constant or an all-or-none condition, but involves shifting nuances and shadings of feeling states that arise uniquely in each treatment relationship and vary over time. Many questions can be raised. For example, what actually is meant by the analyst's trust? How is it similar to, and/or different from, other forms of countertransference experience? In other words, is it, like distrust and other affective experiences of the analyst, most productively considered and dealt with as an ordinary form of countertransference data? Or is it best regarded differently—as an essential ingredient in the analytic equation and a *prerequisite* of effective analytic engagement? Or can it be both?

If taken as countertransference data, what issues are involved in analysts' management of *problematic* feelings of trust, and, especially, of distrust? Since analysts do not usually discuss their feelings of trust and distrust openly with patients, are these feelings

[2] I will say more about the unobjectionable positive countertransference later. Also, see Fox (1998) for a review of this concept.

otherwise communicated to patients, and if so, how? What are the sources—in the patient, the analyst, and in the psychoanalytic interaction—of temporal shifts in the analyst's states of trust and distrust? More specifically, what verbal and nonverbal, conscious and unconscious, information are these internal and interactive shifts based on? Finally, if a crisis (or crises) in trust has occurred, what have been the short-term and long-term consequences? These are but a few of a host of questions related to this complex topic, questions that an intersubjective framework permits analysts to productively explore.

In speaking of the analyst's trust, I refer mainly to the analyst's conscious experience of *safety and relative emotional comfort* in engaging in the psychoanalytic task and its inherent uncertainties. Intrinsically, this trusting state requires the analyst's belief in the benignancy of the patient, a belief that, while typically following a variable course, is associated with ultimate confidence that the patient will remain a dependable ally in the process. These favorable perceptions of the patient bolster, and in turn are bolstered by, the analyst's faith in the analytic process itself, and provide the analyst with reassurance of his or her ability to manage that process constructively with this patient. Hence, the analyst's trust, as I am discussing it, encompasses three inseparable domains: trust in the patient—my primary concern, trust in the psychoanalytic process (Bion 1970; Coltart 1992; Eigen 1981), and in the analyst's self (Bollas 1983; Bromberg 1994; Davies 1996; McLaughlin 1987; D. Stern 1997; Tyson 1986), all interacting with one another in complex ways, as well as with the patient's reciprocal trust, to contribute to the analyst's experience of safety. Distrust, the opposite of trust, is associated with sensed danger and emotional discomfort; the analyst experiences uncertainty and threat in relation to the patient, self-doubt, and misgivings about the developing process.

Aspects of the analyst's trust and comfort, like distrust, and the analyst's struggle with them, are important elements of the treatment experience for both parties and influence interactions and outcome in complicated ways. They involve meanings, judgments, and predictions that are based on each analyst's individual psy-

chology, as well as on interactive influences, among other factors. They encompass a multiplicity of conscious and unconscious perceptual, cognitive, affective, and attitudinal processes, all active in the analyst's shifting internal states and expressed through actions and interactions. The multiplicity of conscious and unconscious perceptual, cognitive, affective, and attitudinal elements and associated action propensities composing the analyst's shifting states of trust and distrust cannot be readily parsed.

For example, it is virtually impossible to separate trust in the patient from that in oneself, from the patient's reciprocal trust, or from trust in the analytic process with this patient—especially since, unlike that of patients, the analyst's trust is not typically discussed during treatment. The analyst's trust nevertheless plays an ongoing, influential role—in very obvious ways, as when contracting with a suicidal patient over matters of safety, and in subtler ways, such as in trusting a patient who, one has learned, has been withholding important details about his or her past and present life, while nevertheless questioning the analyst's trustworthiness. Being contextual, trust is based on, while also affecting, interpersonal interactions and people's readings of them.

Because it involves attributing personal meanings to inherently ambiguous and dynamic interactions, trust can be fragile. Analysts may become aware of the significance of their trust only when it is under attack or otherwise breached, and a lack or violation of it is felt: the patient unrelentingly attacks the analyst's character, intentions, and goodness; the analyst discovers that a patient has deliberately withheld relevant material; the patient confesses that he or she has been actively but covertly involved with serious drug abuse, an extramarital affair, or even unilaterally has sought outside consultation about the treatment; or, after working through what the analyst believes to be important issues of intimacy and commitment with a patient, the patient "disappears" from treatment—to mention a few examples. While of course attempting to moderate their feelings, analysts react to such breaches in a variety of idiosyncratic and sometimes extreme ways, based on their own conflicts. Different analysts might respond to simi-

lar developments with varying, transference-based feelings, such as hurt, disappointment, betrayal, anger, condescension, even a desire for retaliation, or a retreat to a withholding, judgmental position.

The relationship between the analyst's and the patient's trust forms a subtle and complex treatment dimension, interesting in its own right, and its reverberating effects color the interaction, determining what is said and done, and how, by both partners. For example, when an analyst anticipates that a patient perceived as trusting will be able to grasp the positive intent of his or her communication, and also will be motivated to put the intervention to constructive use, then the analyst, feeling relatively secure, expresses him- or herself in ways very different than when feeling less trusting of the patient and the patient's reactions. Working comfortably in trusting ways, analysts might express themselves casually—in a word, a gesture, or even humor. But when trust is strained, as when the analyst expects that a distrustful patient might negatively misread the analyst's intentions or sabotage his or her well-intended comments, then the analyst might become—depending again on individual character—more circumspect, or perhaps forceful, among other reactions. Thus, not only open explorations, but also subtle differences in metacommunication arising from interactions involving trust or distrust, shape the evolution of the analytic interaction and the patient's conflicts.

Operating most comfortably, analysts are able to trust that their patients are attempting to discuss openly whatever seems to them consequential, especially reactions to the analyst, following the fundamental rule of psychoanalysis—while also striving consistently to understand patients' conscious and unconscious difficulties in doing so. One way of looking at the role of trust and the analyst's task, therefore, is that the analyst must approach the patient with a "fully" trusting sensibility, yet at the same time, because the analyst's experience is always subject to unconscious conflicts, fantasies, and expectations, the analyst must also be willing to question whatever is taking place, including his or her own sense of trust (Smith 2002).

TRUST AS A STATE

It is a valid if disconcerting observation that some of our analyst colleagues seem more generally distrustful than others, an observation suggesting that trust can be viewed as a relatively stable personality trait and distrustfulness as a psychopathological one. Moreover, all people, including analysts, of course, have areas of personality integration as well as vulnerability, and analysts' individual vulnerabilities—and thus their conflicts and defenses affecting the ability to trust—come significantly into play in a relationship as potentially intense and intimate as a psychoanalytic one.

While it could be considered a psychological trait of the analyst, the trust of the analyst is most usefully considered, as in the instance of patients, in terms of a variety of *states*, shifting moment-to-moment in the interaction with the patient, including the sources of these feelings and the ways the analyst experiences, manages, and expresses them. A primary task of the analyst thus becomes the examination of temporally shifting nuances and shadings of his or her experiences of trust and distrust—a project that reveals trust as an infinitely varying state in every analytic relationship, as in all relationships.

THE ANALYST'S TRUST AND THERAPEUTIC ACTION: UNOBJECTIONABLE POSITIVE COUNTERTRANSFERENCE AND THE HOLDING ENVIRONMENT

The analyst's trusting sense of safety and comfort with the patient makes a significant contribution to therapeutic action, as part of a benign positive feeling for the patient and also as a factor in the holding environment. A caring for the patient and concern for the patient's best interests are facilitated by, and facilitate, the analyst's sense of safety, and as noted, have been seen as essential aspects of the analytic process (Fox 1998). Counterbalancing analysts' awareness of their patients' psychopathology, limitations, and resistance are analysts' trust in the analytic process itself, which sup-

plements their faith in and hopefulness regarding their patients and their patients' potential for growth (see Cooper 2000). Provided that these sentiments of the analyst remain objects of the analyst's self-examination, and reflect a reasonable assessment of the patient's potential, the analyst's trust of this sort seems to be an ingredient of the work that facilitates its progress.

Much has been written about the holding environment—the analyst's affective presence and provision of an emotionally protective space that enables the patient to tolerate analytic disruptions (Bollas 1987; Meissner 1996; Modell 1976; Slochower 1996; Winnicott 1960b). The analyst's trust plays a significant role in shaping the holding environment, and in turn is supported by it, thereby providing significant benefits to the treatment. The ability of the analyst to sustain a positive, trusting feeling and to participate in a stable holding environment is compromised when the analyst is struggling with feelings of unsafety and distrust. For instance, some patients may openly negate the analyst's sense of self or attack the analyst with the intent to destroy his or her trust in them and the process; in such a case, the analyst may even be unable to recognize and assimilate the patient's experience, let alone sustain an essential experience of trust. As one would expect, when personal anxieties and conflicts cause an analyst to lose confidence in a patient's potential, the analyst undermines the patient's confidence and growth.

Because the patient knows the analyst is aware of the patient's unwanted qualities, the analyst's experience of comfort and safety with the patient can convey a trusting experience that affirms the patient's sense of his or her essential goodness, personal worth, and potential. The analyst's faith of this sort offers the patient hope, facilitates the expression and integration of disavowed aspects of the patient's personality, and bolsters self-esteem and confidence, while offering unspoken reassurance against fears of humiliation, retaliatory harm, abandonment, and loss of love—issues that patients often encounter during analysis. The patient's perception of the analyst's experience of comfort and safety can also mitigate guilty feelings and self-condemnation that may be

aroused as patients become aware of and explore their unacceptable negative qualities and aggressive feelings that are potentially threatening to the other, such as hostility, greed, and envy.

The patient's sensing of the analyst's authentic faith in him or her, and especially in the person the patient can become, conveyed affectively but not necessarily explicitly by the analyst, has further consequences beneficial for the patient. It has been observed that as patients internalize interactions with their analysts, they also internalize their analysts' image of them. Loewald (1960), for example, noted that "as in sculpture, we must have, if only in rudiments, an image of that which needs to be brought into its own . . . holding it in safe keeping for the patient to whom it is mainly lost" (p. 18). In holding and facilitating that image of and for the patient—an image shaped by the analyst's focus on the patient's "emerging core" (p. 20) (corresponding to Winnicott's [1960a] "true" self) and reworked by the analyst's own psychology—the analyst conveys faith that the patient can achieve it. Thus, according to Loewald (1960), "the patient, being recognized by the analyst as something more than he is at present, can attempt to reach this something more" (p. 27). This tenuous, reciprocal relationship, involving the hopeful analyst and the potential of the patient, represents the germ of a new relationship through which analysts' basic trust in their patients can favorably influence patients' changing representations of themselves and others.

FURTHER CONSIDERATION OF THERAPEUTIC ACTION: FEELINGS OF SAFETY AND EMOTIONAL OPENNESS

The patient's need for the analyst's provision of conditions of safety has long been acknowledged in technique (Greenberg 1986; Levy and Inderbitzin 1997; Sandler 1966, 1987; Schafer 1983). Yet, although analysts' trustworthiness as experienced by patients has been noted as a factor in the holding environment, little attention has been given to the ways analysts' own experience of safety, and thus trust, play a role. Indeed, the analyst's experience of safety

has been discussed very little and mainly in terms of the frame (Levenson 1992; Meissner 1996), as creating conditions enabling the analyst to perform the work. But analysts have safety needs beyond those addressed by the frame—needs that can be met only through interactions, and that are at play on an ongoing basis. Davies (1999) was aware of this consideration when she noted that:

> Out of the myriad of possible directions at any given point involving clinical choice, we [analysts] will often be unconsciously directed in pursuing aspects of the clinical encounter that we hope will optimize our own sense of safety, creativity, and the rich efflorescence of unconscious process and play. [p. 188]

Although the asymmetry of the relationship means that the analyst is by definition in a "safer" position than the patient, therapeutic action requires the analyst to remain emotionally available, involved, and willing to engage, and hence, to be at times deeply moved, even disturbed, and thus vulnerable. The analyst, once involved in this way, engages in an emotional risk, and without that risk no psychological change can take place (Kantrowitz 1997). The analyst's self-protective pursuit of safety is associated with the need to cope with the possibility of overwhelmingly fragmenting anxiety, humiliation, or harsh retaliation, inimical to an experience of trust. Based on their need for safety, analysts' expressions of self-interest, both inadvertent and sometimes deliberate, are inevitable (M. Slavin and Kriegman 1998), and can possibly interfere with and/or facilitate the work.

Empathic attunement, the cornerstone of the analytic method, depends on the analyst's remaining emotionally open and thus vulnerable to the patient's affects, imagery, hopes, and fears, as well as the analyst's own. As Kantrowitz (1997) noted, true emotional openness, seen as crucial for change, is not undertaken lightly by analysts, but requires trust in one's own capacity to withstand the intensity of the patient's affects and whatever associated fantasies, wishes, and fears they may arouse in oneself. Likewise, the analyst's authenticity depends on an ability to remain emotionally

open while striving to be as sensitive as possible to both his or her own and the patient's internal processes. A conscious experience of trust and relative freedom from anxiety reflect that an individual's conditions of safety are being met. When we function this way as analysts, we come to experience a greater freedom to be spontaneously and authentically ourselves, thereby gaining greater comfort, freedom, and fuller access to our own, and therefore to patients,' creativity, imagination, and playfulness in the work.

The need for the analyst to pass certain tests of the patient in order to facilitate the patient's trust is a well-documented phenomenon (Blum 1981; Garcia 1992; Weiss and Sampson 1986). Heretofore, however, we have not considered that patients, too, in order to facilitate analysts' best work, must pass certain tests of analysts—that is, must respond in ways that, from each analyst's individual perspective, enable the analyst to find and sustain (and when it is lost, to *regain)* an experience of safety and consequent emotional openness.[3] To give a very general example, one analyst might prefer that an analysis proceed in an atmosphere of subdued aggression, while another, in order to feel secure, might prefer that aggression be brought out in the open. Whenever the analyst's trust in the patient is seriously threatened, it poses a crucial challenge to the relationship, and the treatment is placed in jeopardy.

MANAGING DISTRUSTFUL FEELINGS: REGAINING PERSPECTIVE, WORKING WITH ONE'S OWN AND THE PATIENT'S PSYCHOLOGY, AND ANALYTIC "NEUTRALITY"

Once it is acknowledged that the analyst's basic trust in the patient plays a role in therapeutic action, and analysts are sensitized to

[3] The analyst's need for the patient to pass certain tests will be further elaborated in this paper, especially in the section entitled "Deepening Trust, Crises of Trust, and Trust's Restoration," p. 353, and will be illustrated by clinical vignettes.

shifts in states of trust and distrust within themselves, the crucial nature of analysts' having adequate ways of managing problematic feelings, especially of distrust toward patients, becomes apparent. At times, the sources of an analyst's conscious experience of distrust can be clear. Some patients are plainly litigious, for example, or blatantly need to undermine the analyst's benevolent feelings toward them. The task of analyzing such countertransference feelings can be complex, especially under intense conditions, with feelings of trust and distrust simultaneously being shaped both by patients' influence and by analysts' own resonating psychodynamics and conflicts. Here the work includes attempting to understand one's own reactions as well as those of the patient, undertaken in conjunction with the use of particular clinical theories (or combinations of them) that an individual analyst favors.

The analyst's experience of distrust with a patient, while elicited in ways similar to what occurs in outside life (that is, related to the analyst's individual conflicts, sensitivities, disappointments, hurt feelings, threatening fantasized expectations, and the like), is managed very differently in analytic sessions. Extra-analytically, one can more readily avoid and defend against such negative feelings. But in sessions, analysts must attempt to remain open and receptive, to contain and analyze the full impact and intensity of negative feelings, including distrustful ones, and to find ways of expressing them constructively.

The challenge to analysts is perhaps the greatest when dealing with borderline or otherwise primitive patients who are experiencing intense negative transferences and whose mental operations involve projective identification, splitting, and hateful or envious feelings. Losing perspective, the analyst may respond to the patient's unconscious and preconscious pulls to participate in enactments, causing the analyst to feel and/or to act like pathogenic persons from the past—a development that is inimical to both parties' experience of trust. In the midst of traumatic reenactments, with the analyst's own resonating psychodynamics mediating and organizing disturbing negative experiences of and with the patient, boundaries may collapse, obscuring the analyst's abil-

ity to distinguish what is attributable to his or her own and to the patient's psychology. The crucial ability to remain constructively trusting of, and trustworthy for, the patient is thus compromised. It is in part because many such patients lack basic trust in others (the analyst), and thus make it difficult for others to sustain trust in them, that their treatment becomes so difficult.

In working to restore a facilitating experience of trust that in the analyst's judgment falls within the boundaries of acceptable positive feeling for the patient, the aim is obviously not for the analyst to avoid distrust or to simulate or "fake" trust with the patient, but rather to process these feelings in order to achieve an internal, affective shift that returns the analyst to an *authentic* state of trust that is beneficial. There are many ways that analysts' theoretical dispositions, transference analysis, and self-analysis combine in working to regain appropriate trust—too many to summarize here; but there is value in considering some aspects of this process.

In common with the condition analysts have traditionally called analytic neutrality, regaining trust involves regaining perspective. Meissner (1998), who saw neutrality as an essential element in the therapeutic alliance, defined neutrality as a subjective mental disposition that enables the subject (analyst *or* analysand) to adopt an objectifying, evaluative stance toward either inner experiential states (thoughts, feelings, attitudes, reactions) or interactional experiences with others, allowing a degree of affective or cognitive perspective; this in turn enables the subject to begin to discern meaning and intent in his or her own behavior or that of others. According to Meissner, then, analytic neutrality is a mind-set allowing the analyst to maintain therapeutic perspective in whatever reaction, response, or intervention is chosen with respect to therapeutic usefulness. Neutrality, in this view, provides the ground for continual estimation of what is in the best interest of the analysis.

The internal processing involved in regaining benign trust is similar in respects to the processes Meissner described; yet the primary objective of such processing, in the light of the intersub-

jective dimension and especially of an understanding of the role of the analyst's trust, is not the achievement of a state of literal objectivity or equidistance (what analysts traditionally have taken from Anna Freud [1936] to mean neutrality), but rather the restoration of a more fully trusting sensibility that is judged by the analyst to be therapeutically beneficial.

Although it is an error to attribute the analyst's experience entirely to the patient's psychology, virtually all analysts have come to understand their shifting and especially disturbed states, such as distrust, as related in part to the patient's inner world. Therefore, they treat their experience as sources of information about patients and interactions. Working with it as a signal, one hypothetical analyst might understand an experience of distrust mainly as the complement of the patient's unconscious, internalized object representations. For example, that analyst might gain therapeutic perspective and insight into this state through reaching an understanding of the role of the patient's unpredictable, threatening, or abusive father, now internalized by the patient, and, figuratively speaking, holding the analyst at his (the patient's internalized father's) mercy (a reaction that would, of course, relate to the analyst's own conflicts in this area). Another analyst, understanding the patient through a different theory (or theories), might regain trust by "remembering" the threatened child within the patient that acts through aggression to protect the patient's fragile, emerging self (S. Stern 1994).

Other potentially productive forms of analysts' internal work with their distrust include understanding patients' dissociated self-states that analysts may experience and that take part in therapeutic action. Thus, Bromberg (1994) explained, "Change points occur when . . . the patient's dissociated experience that the analyst has been holding as part of himself is sufficiently processed between them for the patient to begin to take it back into his own self-experience little by little" (p. 545). Still other analysts (Ehrenberg 1992, for example) might work actively with such feelings by expressing them openly to patients once they are sufficiently processed.

However it is achieved, the analyst's recovery of an authentically trusting state participates in therapeutic action in several ways: it conveys the analyst's commitment to untangling and transcending the danger of old experience (J. H. Slavin, Rahmani, and Pollock 1998); it enables the analyst to regain emotional openness or constructive availability (Fosshage 1992); it is experienced and may be internalized by the patient as a mature, adaptive model for dealing with perceived danger and distress. In the section entitled "Deepening Trust, Crises of Trust, and Trust's Restoration," p. 353, I will discuss in detail how the analyst's recovery of trust plays a role in therapeutic action.

SELF-REVELATION, THE ANALYST'S VULNERABILITY, AND "BLIND" TRUST

The emotional stakes are high for analysts because, on some level, like their patients, they need authentic affirmation. McLaughlin (1995) made this point when he wrote:

> What each of us (analyst and analysand) needs from the other, whether on the couch or behind it, is at depth pretty much the same. We need to find in the other an affirming witness to the best that we hope we are, as well as an accepting and durable respondent to those worst aspects of ourselves that we fear we are. We seek to test and find ourselves in the intimacy of the therapeutic relationship, to become known to and accepted by the other, in whose sum we may more fully assess ourselves. [p. 434]

It is for this reason that few analytic moments test the analyst's trust or bring feelings of distrust more sharply into focus than moments when analysts are confronted with the option of openly and directly revealing their personal experience to patients.

The analyst's being deliberately self-revealing remains a controversial topic within psychoanalysis. Depending on one's theoretical commitments, sound arguments can be posed either for

or against this practice (Jacobs 1995).[4] Self-disclosure has been discussed in three categories—inadvertent, inescapable, and deliberate (B. Pizer 1997). All three forms are related to analysts' vulnerability but differently to their experience of trust or distrust. I limit the present discussion to disclosure that is conscious and deliberate, the form most related to active technique, because that form, involving active choice, most directly piques analysts' issues with trust. However, unconscious, inadvertent self-disclosures could equally reflect the analyst's state of trust (or distrust).

There are patients with whom, and moments when, analysts might feel inclined to share their experience, and others when they might not.[5] Sometimes, the analyst has the opportunity to consider acts of self-revelation beforehand, evaluating them with at least some sense of their likely impact, based on a tentative understanding of the patient's dynamics, transference, and the analyst's self-awareness, and how a specific revelation might correspond with new experience (versus old, or enactments), among other clinical considerations. However, the inclination to share often occurs to the analyst unexpectedly, and a delay for reflection could mean sacrificing spontaneity and the moment of greatest impact. Further, one can never have advance or complete knowledge of the sources of the inclination to share, what it may have to do with one's own as opposed to a patient's needs, or most important, what effect it will have on treatment.

Disclosing sexual feelings toward patients in any form has been a lightning rod for analysts' concerns about self-disclosure. Although it is not a priority of mine to engage in that debate in this

[4] The topic of analysts' self-disclosure, especially of sexual feelings, is provocative in its own right, and is discussed as relevant to one of the case examples that follow. The reader interested in exploring these topics more extensively might wish to refer to the articles cited in the text, and, additionally, to an issue of *Psychoanalytic Inquiry* (see Bornstein 1997) for a compilation, and to Frank (1999) and Jacobs (1993, 1999) for reviews.

[5] I refer broadly to a variety of possible levels and ways of revealing one's thoughts and feelings, and, in addition, to analysts' selectively discussing relevant aspects of their outside lives or personal histories that they judge to be potentially useful.

paper, I will summarize the controversy very briefly because I later report a case involving a crisis of trust that developed following such a disclosure. Many analysts oppose such sharing altogether (Maroda 1991, and especially Gabbard 1994, 1996, 1998). Gabbard reasoned forcefully that expressing sexual feelings is a special case of self-disclosure that is perilously close to violating the incest taboo. He believed that, unlike other feeling expressions of the analyst, such as anger, but like affection, the analyst's expression of erotic feelings may imply some form of action, at least from the patient's point of view, and thereby compromise the crucial atmosphere of safety. As Coen (1994) pointed out, some analysts have even questioned analysts' entertaining such *feelings*, let alone expressing them.

Other analysts, emphasizing the inevitable, natural presence of such feelings in mature relationships, as well as the developmental role of coming to terms with sexual forms of self-expression, have noted the value of judicious expressions of this type (Davies 1994, 1998; Fitzpatrick 1999; Frank 1999; Hirsch 1994; Knoblauch 1995; J. H. Slavin 2002; J. H. Slavin, Rahmani, and Pollock 1998). Some of these writers (Davies 1994; Frank 1999; Hirsch 1994, for example) have reasoned that feelings of attraction and their expression to patients must not be regarded differently than any other feelings or forms of self-expression; they must be processed for meaning to the extent possible, and their expression evaluated on a situation-by-situation basis. A very different and refreshing way of regarding analysts' sharing of sexual attraction, one related to a case I later discuss, was proposed by J. H. Slavin (2002). He reasoned that when a patient's innocent sexuality has been lost, it must be found with the analyst: "The patient needs first and foremost the appreciation of the analyst, including, when it occurs, the analyst's sexual appreciation" (p. 74).

Without having established guidelines to follow, and not knowing exactly how a particular patient will react, analysts must often leave decisions about disclosure largely to "blind" trust. In an interview that was published posthumously (Hirsch 2000), Wolstein, a forerunner of privileging countertransference disclosure in ana-

lytic technique, said his actual willingness to reveal himself to patients was dependent on a number of considerations unique to each treatment relationship, especially his personal experience of trust with the patient. He stated, "The critical question to me is, can I go defenseless into the relationship and feel undefended . . . Whether I can be undefended and spontaneous is a basic issue of trust" (Hirsch 2000, p. 189). Wolstein also observed that the patient needed first to reach a point of "real connectedness" (p. 189) (as opposed to defended or destructive relating) for the analysis of countertransference to be mutually meaningful.[6]

Other factors also make it difficult for analysts to trust the open sharing of their experience with patients. For instance, although analysts' uses of the self, including deliberate self-revelation, have become progressively integrated into clinical theory and accepted in practice (see the issue of *Psychoanalytic Inquiry* introduced by Bornstein 1997; and Jacobs 1993, 1999)—and even viewed as part of therapeutic action (Pollock and J. H. Slavin 1998)—the ideal of analytic anonymity nevertheless continues to exert a powerful influence over clinicians. It has been difficult for many analysts to overcome a tradition opposing their actively revealing themselves and to step beyond traditional technique and into a realm of heightened personal vulnerability, with no assurances that their boldness will be rewarded by beneficial effects. Moreover, the traditional requirement of analysts to remain incognito is indirectly supported by some current interpretations of holding that tend to stress the dangers of impingement and thus of interaction, and by other views that encourage analysts' indulgence of patients' developmental needs to idealize them.

These conventions can serve to provide justification for, and thus to reinforce, a cautious attitude that ultimately may serve the analyst's self-protectiveness or theoretical preferences, but not nec-

[6] Hirsch (2002) later clarified that Wolstein used the terms *transference* and *countertransference* to mean what current analysts call *subjectivity* and *intersubjectivity*. He noted that Wolstein eschewed metapsychology and believed that the unconscious could be discovered in a liberating atmosphere in which an optimally free exchange of analyst's and analysand's impressions of one another took place.

essarily the patient's needs. As a consequence, many analysts hesitate to act when the possibility of deliberate self-revelation presents itself. Undoubtedly, open sharing with certain patients, such as primitively organized ones, can be extremely problematic. However, as I show later in one of my case examples, despite assertions to the contrary, analysts' deliberate self-revelations can also enlarge the potential space that is so often seen as essential for therapeutic action to occur.

In addition to more strictly clinical considerations, analysts' opening themselves to patients involves strong and potentially limiting personal reservations. An analyst might be concerned with being seen as foolish, vulnerable, self-important—or even as lecherous in the instance of revealing feelings of attraction, for example, and be reluctant to reveal certain information felt to be self-diminishing, stigmatizing, shameful, or humiliating. Such feelings of distrust in the analyst are especially pronounced in the early stages of one's career, when they can be associated with extreme fears, even fears of being exposed as a fraud (Ditrich 1991). Privacy considerations—whether one wants a piece of personal information to be shared with others in addition to a particular patient—also play a role. Although, unlike the analyst, the patient is not required to maintain confidentiality in relation to anything learned about the analyst or what transpires between the pair, the manner in which the patient deals with the analyst's spontaneous material undoubtedly affects the analyst's sense of trust and freedom in the analytic setting and consequently his or her openness and willingness to be self-revealing. As Kantrowitz (1997) observed, analysts are more apt to disclose when they trust patients' capacity to express freely the thoughts, feelings, and fantasies stimulated by the analyst, the analyst's interventions, and the analytic situation.

DEEPENING TRUST, CRISES OF TRUST, AND TRUST'S RESTORATION

The potential for analytic change is maximized as patient and analyst, working together along a deepening, if irregular, spiral of

reciprocal trust, *both* come to feel safe enough with one another to progressively relax the self-protectiveness that prevents their vulnerability to, and thus recognition of, the other. The patient is enabled to express, in order to work through, transference with greater openness, fullness, and intensity, once the analyst's essential trustworthiness has been accepted (although it is repeatedly tested throughout the encounter). As patients' transferences are worked through, reciprocally, the analyst ordinarily comes to more fully know, respect, and thus trust the patient, and consequently to unconsciously move closer and to become more open and vulnerable (Kantrowitz 1997). When that happens, the analyst, like the patient, experiences a greater "willingness to be known" (Frank 1997), which, while to some degree conflictual, facilitates mutual recognition and an intimate meeting of two individuals who together can live through an insightful new relationship that benefits both. As Frankel (1993) clarified, intimacy "implies the desire to know, and the capacity to accept, all one may find in oneself and in the other" (p. 229).

Breakdowns in trust followed by their restoration may mark moments when "the grip of the field" is broken (D. B. Stern 1992) ---that is, when transference and countertransference have been breached, if even for a fleeting moment, so that, as Stern put it, "the analyst or the patient comes upon a new way of seeing the other or himself that opens new possibilities of interaction, which themselves then need to be described" (p. 359). Building on this idea, Gerson (1996) noted that "the analysis proceeds through the gradual and arduous accumulation of such moments, and the safety they contain, into an ever-widening arena of clarity and potential space for both patient and analyst" (p. 631). Such moments (seen by Gerson [1996] as the achievement of the truest sort of "neutrality") are significant as markers of analytic progress, manifesting the pair's emergence from the grip of rigid relational paradigms that have constricted both parties' living to their trust of new and more flexible ways of experiencing the self and others.

Characterized by the analyst's as well as the patient's acquisition of deepening trust, these interactions reflect movement toward mutual recognition and can provide ground for the pair's collaborative and improving estimation of what is in the best interest of the analysis and of further personality growth.

Deepening of the analytic process thus proceeds apace with the analyst's achievement of a deepening trust in the patient. Discordant moments inevitably occur between patient and analyst when mutual requirements for safety collide. These moments, when the prepatterned needs and actions of one of the parties conflict with and violate the conditions of safety required by the other, spur the negotiation of discord and, as Greenberg (1995) noted, set the stage for interpretation. They portend change, requiring the pair to find ways of negotiating their conflicting needs —--ideally, within the context of enlarging self-awareness. As discordance occurs and interactional patterns shift away from familiar ones that formerly permitted experiences of relative mutual safety, states of tension and distrust may grow. These negative states at first signal conflict to the analyst, and then diminish as the pair works toward reestablishing a state of concordance through the formation of a new relational integration that is freer of the residue of the past. Here we see one of the ways that distrust, in its signal function, can play a positive role in analysis. (Reciprocally, the analyst's trust can sometimes play a negative role—as in a problematic example discussed later, or by the analyst's burdening the patient with the expectation that he or she will be "trustworthy," among other ways.)

Because the frustrations and complexities of the psychoanalytic process are great, and trust is often fragile, it is not unusual to encounter crises of trust. The recovery of mutual attunement involved in the restoration of conditions of mutual safety and trust has been viewed from a number of theoretical perspectives and seen as playing an important role in therapeutic action (Beebe, Lachmann, and Jaffe 1997; Benjamin 1991; Fonagy 1993; Kohut

1971; Wolf 1993). Understandably, in considering these mutual processes, authors typically have emphasized *patients'* experiences from different angles. However, it is also the case that in moments when *analysts'* trust—in their patients, themselves, and/or the psychoanalytic process—is tested or breaks down, crucial interactions can occur that are capable either of damaging treatment, at times irreparably, or, alternatively, of restoring mutual regulation and advancing treatment, sometimes powerfully.

As illustrated in one of the cases that follow, that of Everett, when the restoration of trust fails, treatment crises may worsen, leading to both the patient's and the analyst's discouragement, and possibly even to a treatment breakdown. But over time, the episodic loss of mutual trust followed by its restoration may result in trust's growth and progressive deepening, as seen in two other cases (of Linda and especially of Alice). The analyst and patient alike must be able to develop a sense of faith in the relationship (and when it is lost, to regain it)—that is, a shared sense that "we" have the ability to recover and continue "our" work together despite, or even because of, such disruptions. Recovery often involves the difficulty of overcoming the analyst's as well as the patient's unresolved conflicts, and thus is concerned with repairing the analyst's as well as the patient's threatened belief in the other's trustworthiness and the viability of the relationship.

Maintaining reciprocal trust involves mutual regulation, and overcoming breaches in trust calls on reparative processes that require the patient to help the analyst help the patient. These mutual processes come to the foreground when repairing empathic ruptures and during other crises, but tacitly provide an ongoing regulatory background for the relationship at all times, serving to maintain an ambiance of mutual safety and optimism that allows analyst--patient interactions to deepen constructively. This regulatory-reparative process, concerned with the maintenance of mutual trust and itself an element in therapeutic action, can often form the leading edge of analytic change, with deepening trust and openness both resulting from the pair's transformation of old experience into new, and acting as a precondition for further such developments.

TRUST AND PROBLEMATIC COUNTERTRANSFERENCE: A CAVEAT AND EXAMPLE

The constructively functioning analyst's conscious experience of trust may seem to him or her well within the boundaries of benign positive feeling for the patient; yet the analyst must be willing to actively consider the various unique and unconscious meanings simultaneously occurring as part of that experience as potentially problematic. States of *dis*trust, associated with notable negative affect and other elements of conflict, can more readily than trusting experiences act as indicators of "signal conflicts" (Smith 2000), to be observed and scrutinized by the analyst and used as data for understanding the patient and the interaction.[7] However, experiences of *both* trust and distrust can be used by analysts as a gauge of states within themselves, their patients, and within the interaction. Trusting states, although playing an essential role in therapeutic action, can also result from conflict and become sources of difficulty for the analyst.

Consider a vivid example of a *problematic* trusting state that occurred while I was working with a patient in once-a-week analytic therapy early in my career. The patient was a challenging, borderline woman with whom I experienced an unusual degree of emotional reactivity. She would often treat me in ways that felt abusive, and at times I found it necessary to steel myself against her vicious assaults. Over time, she seemed to become increasingly capable of exposing her considerable sense of emotional vulnerability to me and, as well, of tentatively expressing her appreciation of my efforts on her behalf. In response, I felt a growing warmth toward her and the glimmer of a beginning mutual trust that I was all too willing to nurture, believing it to reflect the development of a new and positive phase in the relationship.

[7] Smith (2000), in his clinical example, emphasized his irritation as an affective signal. But any disturbance associated with conflict, and certainly the analyst's distrust (or, under certain circumstances, even trust), can also act as an indicator of signal conflict.

In the midst of this extended period of mutual good feeling and calm, which seemed to me a joint achievement and evidence of our progress, the patient requested that I act as her advocate in an outside situation. Specifically, she was having employment difficulties, and, believing it would be very helpful to her, she requested that I write her a supportive letter. At the time, I realized that her request threatened the ordinary boundaries of the analytic relationship, but there were extenuating circumstances, and I thought such a letter might actually help remedy the very real and serious reality problem she was having. Further, the patient ordinarily asked very little of men; she was extremely suspicious of them and convinced me that in the past, she had been very badly treated by members of my sex. I considered the interaction as a possible enactment, even explored the historical roots of her wish for rescue, but came to see her request mainly as a test of my trustworthiness occurring in the context of the growing mutual trust between us. After considerable exploration, I decided to obtain her written authorization and wrote a carefully worded letter of support. I hoped to be practically helpful to her in the context of an emotionally reparative experience.

I knew the course I had chosen was unconventional, but at the time I wanted very much—too much, I later realized—to be "helpful" to my patient, and this intervention held appeal based on my emerging theoretical position and a young practitioner's willingness to explore an "action-oriented" dimension of treatment, an approach that later became subject to a considered refinement (Frank 1999). Predictably, as I recognized in retrospect, the patient turned my letter to her detriment, using it skillfully, if unconsciously, to complicate her situation. Subsequently, she excoriated me as being "just like all men"—uncaring and destructive toward her. My growing trust and feeling of safety and comfort with her had been misguided—the result of many internal and interactional pulls.

Only after considerable time had passed did I truly appreciate that the interaction involved a powerful enactment, one so

compelling as an echo of my childhood past that it later seemed it should have been obvious to me, especially since my experience of trust with the patient felt consciously conflicted. It involved my wishful attempt to overcome fear of an unpredictable and sometimes emotionally abusive childhood figure, whose closeness and affection I had desired and actually gained at times by being "good" (considerate and giving). It is difficult to assess the overall impact of my actions on the treatment, which ultimately had a favorable outcome. However, I undoubtedly had misread the situation, being blinded by a desire to be helpful that was, unknown to me at the time, unduly motivated by self-reparative needs and requirements of safety of my own—specifically, my wish for a benevolent rapport with my patient. The event proved to be an important lesson on many levels. One was that, although it can provide a solid foundation for so many constructive processes in an analysis, the analyst's trust does not serve as an infallible guide.

FURTHER CLINICAL EXAMPLES

To further illustrate my main points, I will discuss three additional cases. The first two were originally published by Stuart Pizer (1998). The first of Pizer's cases describes a treatment breakdown that can be understood in terms of the patient's attacking and profoundly damaging the analyst's trust. The second is a brief, contrasting vignette, describing a patient whose actions met the analyst's safety needs, passed his tests, and supported and advanced his trust. S. Pizer (1998) originally discussed these two cases to illustrate the "nonnegotiable" in psychoanalysis—those moments when the analytic process reaches an impasse, as when a patient and analyst become hopelessly locked in repetitive enactment. Although Pizer did not do so, in considering the nonnegotiable, I will focus on the analyst's trust, experience of safety, and the patient's passing of the analyst's tests. The third case I will present, drawn from my own practice, highlights a failure and later recovery of the analyst's trust.

Everett

Everett (S. Pizer 1998, pp. 97-106) consistently disparaged his analyst, acting in ways the analyst experienced as taunting and abusive. Everett's history was that of a lonely child who had been the victim of humiliation at the hands of two much older sisters and a competitive father. The father's volatile temper and sense of humor often felt to Everett "sadistic and undermining." Everett found reparation in his mother's support, which typically was offered when the two were alone together and at the price of his becoming his mother's ally in her feeling of being abused by her family of origin. Everett took solace in his mother's pride in him and felt he had to shine for her.

Pizer described having enormous difficulty successfully holding, processing, returning, and thereby making use of his reactions to the abuse Everett heaped on him. From the beginning of treatment, Everett caused Pizer to bristle as he told him he felt compromised by being stuck with an analyst he saw as of a lower echelon than the patient's father-in-law, who was a training analyst, or his wife's therapist, who was the referral source and a former supervisor of Pizer. Yet, as Everett explained, he felt that he had no choice but to remain with Pizer; his wife would leave him if he failed to make a go of it.

Pizer described a prolonged interaction during which he experienced Everett as acting in blatantly and disdainfully taunting ways and trying to "dismantle" him. The patient faulted his analyst's every intervention and even his stance, comparing Pizer unfavorably to the father figures whom he saw as superior. Openly doubting Pizer's ability as a therapist, he successfully prevented him from feeling good about himself, about Everett, or their work together. Thrown back on feelings of self-doubt, Pizer found himself "hating" Everett's father-in-law.

Everett's barrage continued relentlessly throughout the course of treatment. He accused Pizer of "showing off"; asking "typically shrinky" questions; being unwilling to listen; being uptight, bland, and unwilling to adventure; overvaluing conventional niceness;

being righteous and controlling; making pronouncements; and being insecure. On one occasion, Everett demanded empathy and Pizer felt he provided it, only to have it denigrated by the patient as motivated by Pizer's need for self-aggrandizement. Pizer attempted repeatedly—to no avail—to interpret to Everett how his denigration of his analyst's empathy had the effect of shutting it down and ultimately depriving Everett of the empathic response he desired. In other ways, too, Pizer's attempts to help Everett, including interpretive efforts, were rejected and devalued, causing Pizer to become increasingly angry and to further doubt himself and his method. Exercising restraint, he took a "wait-and-see" attitude, struggling to contain his negative feelings while trying to understand what was going on with Everett and between the two of them.

Matters deteriorated dramatically when Everett announced that he was having an extramarital affair with his secretary. He took Pizer's refusal to have a joint session with him and his secretary as confirmation of the analyst's "uptightness," "rigidity," and "narrowness." On subsequently learning that Everett was developing an illegal plan with his secretary to embezzle money from their nonprofit employer, Pizer could no longer contain his feelings. Telling Everett that he was "shocked," he virtually insisted that his patient delay taking action in order to first examine his motivation for placing himself "in harm's way." Everett reacted by continuing his attack, accusing Pizer of "really losing it." He insisted that, as he had always said, Pizer was controlling and could not contain his feelings, but had to indulge himself by disclosing his shock.

At this point, Pizer reached his limits, which he asserted by telling Everett he was doing so to protect himself and the treatment. In effect, he told Everett that he found this behavior personally abusive and believed Everett realized what he was doing. Admitting—while also trying to contain—his own anger, Pizer pointed out that in the past, he had accepted and tolerated Everett's anger, but that it seemed to be a barrage that lacked any exploratory process. Pizer insisted, "I'll accept your anger, but I

won't take shit." Responding challengingly (and perhaps triumphantly), Everett retorted, "You've really lost control. This isn't therapy anymore. You're just being angry with me. You're so righteous. But, admit, you're really out of line" (pp. 104-105).

A further failed attempt to resolve this crisis bogged down in a struggle that Pizer saw as Everett's being "fixed on his dread of humiliation and hell-bent to humiliate me." For Everett, according to Pizer, it had come down to either his (Everett's) being crazy and impossible or Pizer's admitting that he himself had lost it.

Linda

Pizer (1998) reported a contrasting case (pp. 121-126), one in which he was able to trust the ability of his patient, "Linda," to accommodate to and support him in his internal struggle to endure her rage, which was at times so extreme as to be viscerally trying for Pizer. Like Everett, Linda was verbally assaultive, but the analyst achieved a mutually sustaining trust with her that contributed to favorable results. Here is how Pizer characterized his interaction with Linda—which I would see as their engaging in a form of mutual regulation involving each partner's passing of the other's test:

> Our relationship was able to contain both our experience of Linda's raw rage and her experience of my struggle to live with it . . . For all the harshness of Linda's aggression toward me, Linda was herself engaged in a precarious and subtle collaboration to keep our therapy alive and make it work for her. [p. 123]

In addition to her rage, Linda also offered Pizer sufficient empathy and consideration to earn and sustain his trust ("Even as she excoriated me, she gave me time to take in her message or catch my breath" [p. 123]). Unlike Everett, Linda passed the tests Pizer required to prove herself a trustworthy collaborator in the work. Notwithstanding her vicious assaults on him, and unlike Everett, she was able to affirm the good in Pizer and his positive

impact on her, and she conveyed her appreciation of his efforts on her behalf ("Linda could indicate to me that I had reached her with some meaningful communication" [p. 124]). Reciprocally, Pizer was able to maintain his belief in the good in her and to trust her. Interactions of this sort helped Pizer—and help all analysts—to successfully hold and process, and thereby to return and make use of, the distress created by patients' attacks on analysts' safety and trust. In addition to her need to inflict harm on him, Linda also supported her analyst's trust in her by assisting him with his own therapeutically crucial, internal efforts to survive.

Returning to Everett, ultimately, Pizer came to see the crisis as nonnegotiable: "It seemed beyond the two of us at the moment to explore [the] issue and its short circuit" (p. 105). Feeling that both parties needed to be protected from this "scorching intensity," Pizer suggested an outside consultation with another analyst. He offered some prospective consultants' names, but Everett chose to take a referral from his father-in-law, and then left treatment without resolving the critical difficulties involved in this transference-countertransference crisis.

Understandably, Pizer finally "lost" (to use Everett's term) trust in his patient's benignancy and ability to remain a dependable collaborator in dealing constructively with his unyielding abusiveness. In working with Everett, any analyst would be faced with a difficult challenge—to struggle with and survive the patient's relentless attacks on the analyst's shortcomings (sometimes felt as very real by the analyst), without benefit or expectation of any affirmation or even tolerance from the patient. Tragically, in self-protectively enacting the internalized role of abuser, Everett brought about the very outcome he sought to prevent, for in Everett's view, Pizer, like his volatile father, "lost it."

However, not every analyst would necessarily experience the same quality or measure of distress and difficulty with Everett; others might react differently—with more or less frustration. To his credit, Pizer was quite candid in reporting this case—more forthcoming than analysts ordinarily are. Yet in order to clarify

an analyst's particular vulnerability to a patient and the specific tests he or she failed, we must know even more about that analyst's psychodynamics and self-analysis and how his or her conflicts interact with the patient's. We also can see in this example how the analyst's failure of trust in the patient developed inseparably from that in the process and his ability to effectively perform the work with the patient.

Alice

A third clinical example, drawn from my own experience, illustrates, especially, how an unusually transparent lapse in the analyst's trust was repaired in a manner that advanced and deepened the analytic process. Though confounded by an unusual act of self-disclosure, the process described still has value as an illustration of the role of the analyst's trust.

At the time of the events described, Alice was in her third year of an analytic therapy that had been conducted once and later twice a week, seated face to face. A divorced, middle-aged woman, Alice originally sought treatment for strong anxiety associated with a suspicion that her father had sexually abused her during childhood. Her fear was stimulated by an older sister's allegation of such abuse, which months later the sister retracted, explaining it as a distortion that grew out of her own ongoing analysis.

Our early explorations revealed that Alice's father, an alcoholic, was indeed unpredictable, and because he could not effectively regulate his feelings, especially sexual ones, had many extramarital affairs. These affairs, known to my patient, eventually led to the parents' divorce during Alice's early adolescence. As treatment progressed, Alice gradually abandoned her concern, initially so frightening to her, about past sexual abuse. She concluded with reasonable comfort and certainty that there was no realistic basis to substantiate that possibility, either in relation to herself or her three sisters. Whatever the actuality, the patient's early explorations suggested that her fear about abuse was rooted

in fertile soil—her deeply conflicted desire for her father's affection and approval in the paradoxical context of his overtly sexualizing virtually all his relationships with females, while lacking any enthusiastic interest in Alice. Her difficulties were worsened by the superficiality and emotional inaccessibility of her narcissistic mother—initially described disdainfully as an attractive "geisha" who pandered to males—who, being "weak-willed," failed to provide Alice with an adequate feminine role model. In advancing her self-awareness through transference and countertransference analysis, I understood my role with Alice as balancing between being sensitive to and offering certain essential experiences missed in early childhood, and promoting more mature forms of mutuality and intimate bonding.

In first establishing our relationship, Alice at times became infuriated with me. Setting high standards and cutting me little slack, she would become enraged over something I said or did, and on a few occasions, stormed out of my office in mid-session. Phoning a few hours later in a calmer state, she would apologize, sharing her recognition that her reaction was extreme, while insisting that I take responsibility for my part in provoking her behavior. In the next session, we would clarify how she had experienced an unintentionally insensitive comment of mine—usually something that had seemed to me innocuous or even positive, but that through the lens of her early, traumatic experiences of rejection had caused her to feel unwanted or rejected. A growing sense of mutual trust seemed to develop as we came to understand these episodic disruptions more fully and mutually acknowledged our own contributions. Thus, mutual recognition was advancing as Alice was helped to move beyond her initially idealized expectations of me, and I was helped to become more sensitive to her. As our work progressed, we developed an increasingly trusting, open rapport and had wide-ranging explorations of many—sometimes uncomfortable—topics.

Over time, I grew to experience a strong affection for Alice. I admired much about her—her values, integrity, intelligence, the way she expressed herself, her wit, imagination, and unfaltering

commitment to her children's as well as her own personal growth, among other qualities. Appreciation of her physical being—my physical attraction to her—seemed a natural part of the package. For the most part, my feelings of attraction blended quietly with a constellation of other positive feelings, forming a comfortable, positive affective tone that seemed to me benign. Sometimes, depending upon her demeanor and the content of sessions, these feelings of attraction could intensify and come to the foreground. I was surprised when occasionally I found myself having the unusual experience of feeling quite uncomfortable with these feelings, as though I were doing something wrong in feeling as I did. I recognized that this uneasy, disapproving state, unusual for me in this setting, had important meaning that would need to be clarified.

The intensity that Alice first experienced with me was consistent with her history with men, which involved episodes of intense disappointment and anger over felt rejection, associated with failed expectations. When she met a man with whom she began to become romantically involved, I was hopeful that we might gain an opportunity to explore some of her conflicts over intimacy, including, based on our relationship, not only how excessive expectations and disappointments interfered with her forming a positive emotional attachment, but also her sexual inhibition. Sometimes, when it seemed appropriate, we had probed relevant parallels in our own relationship, but earlier attempts to discuss sexuality became superficial and were inevitably truncated.

After some time passed, Alice began to discuss conflicts about exposing her body to her lover and her sexual anxiety and avoidance. I was aware of my own attraction to her, as mentioned, and sensed that she might have similar feelings or curiosity about what I felt toward her in this regard, but if so, she avoided and played down such interests. As we further explored her sexual avoidance with her partner, I began to wonder about the possibility of opening up this matter in our relationship. I first rejected the idea, considering the controversy over analysts' sharing their feelings at all with patients, especially those of attraction, as

noted earlier. I was also particularly sensitized to the possibility of Alice's vulnerability in relation to these concerns, given her presenting complaint concerning her father's possible sexual abuse of her. Thus, I approached this conversation circumspectly.

Following a discussion about her outside relationship and her difficulty experiencing and expressing sexual feelings, I decided to go ahead and broach this aspect of the analytic interaction with her. I introduced my observation that although she and I had engaged in wide-ranging discussions and seemed to have developed considerable openness in our relationship, I could not recall our ever having spoken openly and directly about the matter of mutual attraction. I must have intimated during that conversation that such feelings seemed to me quite natural, because in a confrontational manner that struck me as motivated in part by her need to deflect my question, Alice asked me whether, "since they are so natural," I had experienced such feelings toward her.

Initially, I responded by asking her what she imagined, and then, based on her reply, explored the basis for her doubting that I could possibly feel attracted to her. This "virtual" self-disclosure (Cooper 2000) did not satisfy her, and she continued to pressure me to discuss my actual feelings. Finally, I stated that I did experience her as physically attractive. Not to say so, it seemed to me, would begin to feel like playing hide and seek, and could be experienced as a phobic avoidance that reinforced her own. Having always struggled with a sense of herself as an "ugly duckling," Alice was incredulous at first, dismissing my remarks as inauthentic and manipulative. Accusingly, she said, "You'd have to say that to any woman patient." We overcame that self-protective belief fairly quickly, as I helped her remember that I had earned her confidence in my honesty.

Alice then became anxious and offended, hearing my feelings as superficially based and as sexually objectifying her. Equating the verbal expression of feeling with the danger of taking action also made her anxious. We explored her reactions carefully, and significantly, we came to understand them transferentially as being based largely on her father's history of impulsivity and her moth-

er's compromised femininity. Sexuality felt dangerous to her, demeaning, and was to be avoided; to desire a man, or to want him to be attracted to her, would place Alice in jeopardy—of rejection, debasement, or of sexual responsiveness. In clarifying her responses to my disclosure, we closely examined the transference-countertransference interaction. As part of that discussion, I spoke straightforwardly and specified the many fine qualities I saw as the basis for my attraction to her.

Gradually, Alice came to feel more comfortable, indeed, affirmed, as she grasped that my feelings were an authentic expression of appreciation of her as a whole person. However, something extraordinary (for me) then occurred. When Alice did not come to an appointment following one in which we discussed her new ability to accept and even appreciate my expression of attraction to her, I became quite anxious. I waited for half an hour or so for her to arrive—an uncomfortable period spent in imagining that my openness might have been a mistake, possibly even retraumatizing her in some way that was related to her father and causing her to take flight from treatment. Revealing my loss of trust in her, I even imagined her disparaging me to others and their judging my behavior, actually undertaken cautiously and after considerable deliberation, as narcissistically motivated and/or a seductive lapse in control. In an act that I recognized as motivated by my conscious anxiety (that is, my feeling unsafe), I phoned her at home. She received my call calmly. I said, "I wonder if we got our times crossed." And indeed we had: she explained that she was not due in my office for half an hour—at her usual appointment time. Surprised, I checked my appointment book and discovered that I had been expecting her in the hour of the person I usually saw before her, who had cancelled, which I had forgotten.

In this interaction, an idiosyncratic, serious failure of my trust in both my patient and myself had occurred—a transparent one that was evident to me in my fantasies of failed clinical judgment and of her leaving and disparaging me, and to her in my anxious confusion. Later, when she came in and we questioned the confusion apparent in my phone call, my own comfort would have dic-

tated that we concentrate solely on her reactions to it. I might have offered some partial truth like "I just got confused." But clearly, something extremely important had happened between us, and in the context of the rapport we had achieved, to not explore and clarify this significant development with her seemed to me not only a missed opportunity, but also evasive and even disingenuous.

There were many ways that I might have chosen to pursue the exploration, of course, some more personally revealing than others. Although I felt vulnerable, I chose to tell the patient much of the truth as I understood it—that apparently I had misjudged the appointment time out of anxiety that my sharing had somehow been harmful to her in a way related to her father and had driven her away. I thought that disclosure might provide a starting point for a further discussion of the interaction, her sexual avoidance, and anxiety. Surprising (and relieving) me, she took a very direct, reassuring position. She seemed mildly annoyed that I had "sold her short," and told me that my anxiety over harming her with my sharing seemed unrelated to her experience. She assured me, to the contrary, that she had come to trust and even appreciate it as personally affirming. After all, she noted, who knew her better than I did? She described a dream from the night before that seemed confirmatory—of moving happily, comfortably, into a large house and furnishing it beautifully. In the dream, she felt revitalized, secure, and expansive.

To my embarrassment, we both recognized that my confidence in my understanding of her psychology and my trust in her inclinations toward me, as well as my own toward her, had been shaken. Because unconscious conflict and incomplete understanding of my own participation were clearly at play, I explored my historical transference and countertransference both independently and together with a close colleague, and gained some understanding of the personal sources of my reactions. As best I could understand, they were based on conflicted, erotized adolescent interactions involving my older sister (an understanding I did not share with my patient). Without going into further depth

and detail about my personal historical transference here, which I hope the reader will understand, I will say that important to the clarity I reached was a recognition of my defensive failure to appreciate her growth and maturity—that is, to fully trust the mature sexual appreciation that had developed between us. In my anxiety, I had focused on her child self as being unable to participate in a more mature form of intimate bonding. This was a serious misreading of the patient.

Two additional factors aggravated matters. I will discuss them because I believe they also affect many other clinicians detrimentally. The first was the psychoanalytic taboo against sharing erotic feelings with patients, noted earlier (Gabbard 1994, 1996, 1998). As discussed, that prohibition, while definitely having cautionary merit, has been grossly overstated in the opinions of many commentators (Davies 1994, 1998; Fitzpatrick 1999; Frank 1999; Hirsch 1994; Knoblauch 1995; J. H. Slavin 2002, for example). This bias can cause not only countertherapeutic inhibition in practitioners, but also irrational guilt and even phobic dread.

A second factor combined with the first to contribute to my anxiety and lapse in trust. It arose from the particular way I had understood Alice within the framework of psychoanalytic theory. At certain times, my thinking is influenced by developmental analytic conceptions of the analytic relationship derived from attachment and self psychology models. While early in treatment, these developmental formulations constructively informed my thinking and ways of working with Alice, they were no longer the most appropriate frame of reference at this stage. Although I disclosed my feelings of attraction reflectively and never for a moment doubted my self-control, this theoretical leaning predisposed me to consider the possibility that my expression of feelings of attraction to her might have constituted a crossing of boundaries, an enactment of abuse of her child self—although she was, as it turned out, and as my clinical judgment had initially told me, quite capable of addressing and grappling with these feelings on a mature and beneficial level. Alice's readiness to do so was further substantiated by our subsequent discussions; for instance,

she clarified how understandable my "misjudgment" was (my term with her), given that she herself felt fluidity in her experience as a girl/woman.

My sharing my feelings of attraction with Alice and the work surrounding it seemed to contribute to an enhanced sense of her sexual agency. As termination approached, she reported that she was able to experience herself as a more sexual and sexually appealing woman. Hence, it appeared that we had successfully worked through some part of her significant historical transference based on her relationship with her father, who acted out sexually with other women but did not appreciate her, and that caused her at first to experience my revelation as sexually threatening. In expressing her gratitude to me as we approached termination, Alice emphasized how important that act of sharing had actually been to her, including my "panic" over it (her term) and the work that followed. She explained that it offered her a "precise corrective" (also her words) for her difficult relationship with her father. (She was not a psychotherapist.) She clarified that what was so helpful to her was that we discussed not only what *should* or *could* be (that is, fantasy alone), but what our relationship *truly was*, involving mutual attraction associated with conflict and her anxiety over taking action.

To Alice, it was important that I had not deliberately offered her an artificial experience intended as the curative opposite of the traumatic one with her father; rather, spontaneously, elements of enactment developed that echoed her relationship with her father, but that were faced, managed, and ultimately resolved more satisfactorily. Alice said she appreciated this sharing in the context of my overall openness and "humanness" with her, which she contrasted with the mystification and avoidance of feelings that she experienced in her childhood family and in earlier attempts at psychoanalysis. She said she had learned that directness and openness, though not always easy, were possible and could be managed safely.

My candor with the patient about my lapse in trust and our working together to repair it played a significant role in achieving

a favorable outcome. Alice understood and explained to me that although in the beginning of our relationship, she had experienced considerable idealization and magical thinking in relation to me—viewing herself in retrospect as an awestruck child—as she learned more about my realistic strengths and limitations and the realistic possibilities of our relationship, she grew to feel a sense of shared responsibility as a mature partner. Thus, she said, I, like her, deserved respect for my sharing, including my anxiety over it. Ending therapy, which in prior years she had regarded as a rejection too painful even to consider and as necessarily nullifying all that might potentially be achieved, had become a realistic possibility.

Although at first, Alice and I were both upset by my sharing and the crisis of trust that followed, after exploring these developments openly and directly, we both emerged with a stronger and more realistic trust in one another, in our relationship, and self-trust. Paraphrasing McLaughlin (1995), we reached a synergism within our relationship in which both of us transcended old expectations and found expanded dimensions of ourselves.

CONCLUSION

The analyst's trust, in contrast to the patient's, has received very little attention in the past—either in the literature, or—at least explicitly—-in the consulting room; yet it plays a major psychoanalytic role. In articulating their own positions, practitioners may find themselves inclined toward either of two opposing views of the analyst's trust: some may regard it as a countertransference state, and thus as a source of information no different than any other experience of the analyst; while others may view it as a unique and essential relational ingredient in the analytic equation that is "beyond analysis" or "beyond scrutiny." This characterization of extremes reflects very different notions of the nature of the analytic process and therapeutic action, of personality functioning, and indeed of the nature of human beings.

I have described how the analyst's trust forms an essential precondition of the analytic process that must be actively managed

and must deepen over a highly variable course as part of therapeutic action, yet can also be problematic in the traditional sense of countertransference. The narrow definition of the analyst's trust that I have formulated, focusing on the analyst's experience of safety and feelings of comfort, captures a fundamental meaning that is useful. But that definition must not, through its inherent reductionism, oversimplify or discourage exploration of the multiplicity of forms and manifestations, preconditions, and consequences of the analyst's trust or the many phenomena related to it. For example, this definition emphasizes that which is conscious; but when examined closely, the analyst's (like the patient's) experience of trust (and distrust) is, of course, highly complex and fluid, with much of it being unconscious and conflictual.

Trust, like distrust, can be problematic. In addressing the complexity of the analyst's trust, I have called attention to the inseparability of trust in the patient from that in the analytic process, in oneself, and the patient's reciprocal trust. I have noted how the mutual regulation of patients' and analysts' trust serves both to safeguard and deepen the developing psychoanalytic relationship, promoting the analyst's as well as the patient's emotional openness, and sustaining the analyst's affirming, empathic presence. I have described trust as necessary for the analyst to be able to have faith in the patient and the patient's potential for growth; such faith, which engenders shared hope, also plays a role in therapeutic action. Through case material, I have shown that the analyst's loss of trust can devastate treatment; yet its mutual regulation and, especially, the process of its restoration contribute significantly to therapeutic action.

Acknowledgments: The author wishes to thank Stuart Pizer, especially, and James Fosshage, Clemens Loew, Richard Rubens, and Bonnie Zindel for their thoughtful feedback on earlier drafts of this paper.

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330 West 58th Street, Suite 200
New York, NY 10019

e-mail: Ken_Frank@msn.com

Psychoanalytic Quarterly, LXXIII, 2004

PLAYING AND WORKING THROUGH: A NEGLECTED ANALOGY

BY EUGENE J. MAHON, M.D.

The author proposes an analogy between certain features of playing and aspects of working through. Conceptualizing psychoanalysis as the process whereby unconscious fantasy is uncovered and then subjected to rigorous scrutiny, and building on Freud's (1908) insight that play is the same as fantasy—with the essential difference that fantasy links itself to real objects in play, such as toys and playthings —the author proposes that play can be thought of as not merely symbolic, as a fantasy bearer, *so to speak, but as a* fantasy tester *as well. In the process of working through, some analysands attach their unconscious fantasies not only to a transference object, a primary libidinal object, or a significant loved one, but also to actual props within the analytic setting (a Kleenex box, for example), making the analogy with play even more obvious and palpable.*

A comparison exists between playing and working through that is not immediately obvious. While both deal with fantasy and reality, the connective tissue that links the two concepts is elusive, and the analogy I am proposing has therefore been neglected, in my opinion.

A child at play is involved in an investigation of the interface between his or her internal world, which is at once magical and

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An earlier version of this paper was presented as the Annual Anna Freud Lecture of the New York Freudian Society in March 2003 in New York.

"Gothic," and an external world that has a mind of its own, so to speak. This is frustrating, to say the least, but of course, it is also the great meeting place of the two principles of mental functioning: pleasure and reality, facing off on a psychological turf that will determine the nature of compromise throughout development, a compromise that will have a bearing on the mental health of the player for a lifetime. Play, despite its repetitive nature, is the opposite of repetition compulsions of the id, which stubbornly try to maintain psychic inertia. Play is a persistent trying on of the garments of the phenomenal world, until the right fit is selected. This metaphor of trying on (Neubauer 1987) is apt only if we imagine the wardrobe of the phenomenal world as so extensive that the trying on and fitting could represent a lifetime's enterprise.

Working through refers to the psychoanalytic work that must be done side by side with interpretation in order to ensure that insight becomes practical and leads to change, thus having a real impact on the quality and character of life. If transference and interpretation capture genetic insights from the past and make them palpable in the analytic situation, working through puts the insights through their paces in the actual experiences of daily living.

Both play and working through have been written about extensively. I will not review all the literature here, but will instead emphasize an analogy between play and working through that I will then try to explicate, with the aim of shedding light on both topics in the process. The analogy that recently occurred to me was undoubtedly triggered by the interface between child analytic process and adult analytic process, which has informed my professional life for many years. Freud had many groundbreaking, insightful things to say about play, but my analogy deals with only one. He wrote:

> The opposite of play is not what is serious but what is real. In spite of all the emotion with which he cathects his

> world of play, the child distinguishes it quite well from reality; and he likes to link his imagined objects and situations to the tangible and visible things of the real world. This linking is all that differentiates the child's "play" from fantasizing. [1908, p. 144]

This linkage between internal fantasy life and real objects in the play space (made up of toys, stuffed animals, and so on) is the hallmark of childhood play, as Freud's emphasis suggests.

If play is internal fantasy life trying to find a foothold in the practical world of external life, using playthings to represent itself to itself, so to speak (the better to get to know itself!), isn't working through unconscious fantasy come to life through the ministry of transference and transference neurosis, with the aim of finding a foothold in the new experience of living out the rest of one's life according to a new contract? In this new covenant, fantasy repudiates certain features of itself while retaining others, the repetition compulsions of the id surrendering their energies to the new dynamism of working through. In other words, if play is fantasy seeking a practical expression for itself with props and playthings, don't working through in analysis and the uncovering of unconscious fantasy also seek an expressive culmination in the revised experience of everyday life? If insightful analysis can "predict the past" as Hartmann and Kris (1945, p. 21) so felicitously expressed it, the working-through aspects of analysis refuse to sentimentalize the past, but instead insist on reclaiming it by reworking it so that genuine affect can prevail, the past contained in the character of the future as historical witness rather than caricature.

Now that I have introduced the analogy between playing and working through, I would like to push it to its limits to see whether, under intense scrutiny and pressure, it will yield any new insights into the nature of the therapeutic process in child analysis and adult analysis. But first, I would like to describe play and working through in more detail, so that this analogy, emerging out of a context, may be even more convincing.

PLAYING

Playing must be as old as civilization itself. If civilization begins with the renunciation of instinct, as Freud so insightfully characterized it, play must surely have been one of the early stepping-stones that helped *Homo ludens* become *Homo sapiens*. In *The New Golden Bough*, Frazer (1959) argues that the "oedipal" rituals at Nemi (close to Rome) that depict the killing of the king and the crowning of the successor at regular intervals can be traced from their origins thousands of years ago to their many current derivatives that survive as rituals and ceremonies today. One derivative deals with childhood play: the wren-boys of Connaught in the west of Ireland, who reenact the hunting and killing of the wren every December 26, St. Stephen's Day. With a wren or a model of one in a cage, they march through the villages and towns, singing, "The wren, the wren, the king of all birds, St. Stephen's Day was caught in the firs. Up with the kettle, down with the pan. Give us a penny to bury the wren." It is unlikely that the chanting wren-boys are at all aware of the oedipal significance of the "dead king" of their singing, or that their song refers back to a ritual from thousands of years ago.

A similar emphasis on tradition and playing is mentioned in *The Lore and Language of School Children* (Opie and Opie 1959). The authors suggest that some of the chants children use in play may date back to the time of Nero. This lineage suggests an abiding intellectual and cultural urgency that defines play as serious rather than frivolous, despite the undoubtedly countertransferential adult dismissals of it as "merely child's play." Montaigne (1533-1592) saw no conflict between "serious ideas" and "games" (2003, p. 812), and commented that Socrates "never refused to play at cobnut with children or to ride a hobby horse with them and he did so gracefully; for all actions, says philosophy, are equally becoming and honorable in a wise man" (pp. 1038-1039). Shakespeare (1606) refused to sentimentalize play, comparing the sadistic play of wanton boys with flies to the mischief of the gods, who "kill us for their sport" (IV, I, 37).

This historical preamble is not meant to be exhaustive, but simply to emphasize that, while play has not been ignored by anthropology, academic psychology, or by literature in general, Freud's (1908, 1920) insights were nevertheless revolutionary in proposing that children have unconscious minds—and a sexual life, to boot—and that these are manifest in their play, provided that one trains one's eyes to see what is in front of them. Freud's groundbreaking ideas were actively exploited by the first generation of child psychoanalysts (Hermine von Hug-Helmuth, Melanie Klein, Anna Freud, Berta Bornstein, D. W. Winnicott), who applied Freudian insights *directly* in their analyses of children (ironically, Freud himself did not initially believe that direct analysis of children could be accomplished, instead treating Little Hans via the father).

So unique was the new Freudian window on play that controversy arose as to whether play was the equivalent of free associations and could be interpreted directly as such, or whether play was an expression of the child's ego and its defensive efforts at compromise and mastery—requiring that it be approached "ego psychologically," with no aspect of its multiple functioning being ignored, on the one hand, or too wildly interpreted, on the other. These controversies, like most intellectual disputes in psychoanalysis, have not been resolved. But there is no controversy, however, as to the central role of play in the practice of child analysis, regardless of the theoretical persuasion of the individual practitioner.

The genetic epistemology of Piaget (1962) has influenced the child analyst in profound ways as well. I will emphasize only two of Piaget's many ideas, assimilation and decentering, since I believe that they are the most germane to my argument. For Piaget, cognitive development advances as a child learns to decenter the self from a perceptual immaturity that would hold the child back from the threshold of the next developmental stage. An example will make the concept clear: a little boy who believes that six baseball bats are numerically larger than six toothpicks does not have the conceptual abstraction of numbers figured out yet. He

is seduced by the size and bulk of the six bats, convinced that the perceptually larger must be greater than the conceptually smaller; in short, he is perceptually bound. Soon, however, he will decenter his perceptual egocentricity from this cognitive puzzle and come to grasp the aesthetic beauty of a conceptual world in which the abstract number *six* is constant, even when perception might seem to favor the weightier, bulkier baseball bats over the diminutive toothpicks.

Decentering, for which there is no exact psychoanalytic equivalent, does, however, invite analogy. Piaget stresses the cognitive act of getting out of one's own way, so to speak. Initially, a child, confronted with "reality," imagines that the mind invented it, the child's *mind* the center of a solipsistic universe. The six baseball bats *have* to be numerically larger than the six toothpicks. A perceptually bound conviction would never give way to conceptual abstract truth (six is abstractly six, size of items notwithstanding) if the child did not decenter perceptual narcissism from the assessment of the more abstract, conceptual reality of which he or she is initially ignorant, by virtue of developmental immaturity.

While the cognitive seems to decenter as a matter of developmental course, the affective, the instinctual, and the unconscious do not. The entire child or adult psychoanalytic enterprise could be conceptualized as an attempt to understand the psychological inertia, the infantile omnipotence, the adhesiveness of the libido, the seductive appeal of unconscious fantasy that arrests itself where it will, the entropy inherent in death wishes (as Freud would stubbornly argue to the end of his days), and the like—and, having understood the tyranny of this repetition compulsion, psychoanalysis seeks to lead the mind away from it, through play in child analysis and through working through in adult analysis.

All of these issues (historical, theoretical, clinical) could be pursued at great length, but I have emphasized only one of Freud's insights in the interest of making the analogy between play and working through as uncluttered as possible. His observation about play, fantasy, and the reality of playthings to which the child attaches fantasies is one of those seemingly obvious dis-

tinctions that genius discerns, later becoming a well-known component of received reality as the history of ideas co-opts the formerly unknown into the canons of culture. What Freud captured here with seeming simplicity of diction is, I believe, quite profound. After all, he revolutionized the concept of childhood by insisting that it harbors polymorphous perverse sexuality in its fantasies, and then he says that in play, the child reaches for the reality of props and playthings, external pegs on which to hang this internal, sexually conflicted psychic world. Why? Freud is in a theoretical hurry to make an analogy of his own between the creative writer and the child at play. But if we ignore Freud's analogy (beautiful as it is) and instead momentarily invoke Piaget, we can argue that the child is assimilating the phenomenal world in play, *acting* on the world—the better to realize it and to conceptualize it, initially making the self the center of it, but then decentering from it in a cognitive advance.

Freud complicates this cognitive story when he imagines the polymorphous perverse fantasy trying to anchor itself in play with things and gadgets, as though the externalization of such fantasy could momentarily keep it at arm's length before it gets internalized again, perhaps a little safer now that it has been wrestled to the floor by the child's psychic activity. This is assimilation with a Freudian spin. Piaget might reject this way of reconceptualizing his argument, but I think child psychoanalysis would not. The child analyst, while armed with all that academic psychology teaches about play, also sees play through Freudian eyes, and consequently, for the child analyst, play is a complex, multiply determined phenomenon with a manifest face and a latent underbelly that likens it to a dream enactment—or, more correctly, a fantasy enactment.

A four-year-old child whose mother has died (to be presented in greater detail later in this paper) has a habit of playing with an airplane made of toothpicks and masking tape. To uninformed eyes, he is playing with an airplane. But to a child analyst, he is "killing" his mother, "killing" himself, mourning the dead object. From another perspective, he is trying to learn how to fly the trau-

matized remains of himself in the wake of his mother's death, trying to erect some phallic adaptation in the face of anxiety and guilt, which threaten to ground his engines on the developmental runway before they can become airborne. In other words, play to a child analyst is a psychic product that must be approached as a multiply determined compromise that can be viewed structurally, topographically, or dynamically, its conflicts informing the psychoanalytic situation and requiring the interpretative tact and timing that all analytic products and their contexts demand.

WORKING THROUGH

The Hollywood silver-screen caricature of psychoanalysis suggests that the free-associative process invites an interpretation that releases a hidden childhood memory, and in one eureka of insight, the constipated mind is enematically relieved and cured! The concept of working through is reality's dismissal of this magical and simplistic distortion of analytic facts. The psychological inertia that makes this caricature so laughable and unrealistic would preoccupy Freud for most of his scientific life. And speaking of psychical inertia, we might recall Freud's comment that

> . . . if we search for the starting-point of this special inertia, we discover that it is the manifestation of very early linkages—linkages which it is hard to resolve—between instincts and impressions and the objects involved in these impressions. These linkages have the effect of bringing the development of the instincts concerned to a standstill. [1915, p. 272]

The work of analysis could be characterized as the study of all linkages, conscious and unconscious, and their relation to each other. I am stressing the linkage between fantasy and a child's playthings that is the hallmark of play, and I am also stressing the linkage between unconscious fantasy made conscious in the analytic situation and the influence of such unconscious fantasy on the activities and details of behavior in everyday life—the de-

rivatives of the unconscious in day-to-day details of the human condition, if you will. I believe that the analogy between playing and working through represents a linkage that not only brings child psychology and adult psychology into an alignment that it would be shortsighted to ignore; in addition, it suggests that the deepest linkages of the mind (such as death wishes, for example) are linked to the details of living through neurosis. The two-way traffic between the two is a linkage that interpretation and its down-to-earth ally, working through, doggedly maintain in analysis, session after session. As Freud (1914) put it, "we must treat . . . illness not as an event of the past, but as a present-day force" (p. 151).

If the transference as a playground (Freud 1914) was Freud's laboratory, working through was an experimental launching pad where hypotheses had to be tested in order to develop wings and to contribute to the flight patterns of the future. Freud (1914) insisted that reclaiming the past must influence the future:

> The analysand must find the courage to direct his attention to the phenomenon of his illness. His illness must no longer seem to him contemptible but must become an enemy worthy of his mettle, a piece of his personality which has solid ground for its existence and out of which things of value for his future life have to be derived. [p. 152]

Specifically addressing the topic of working through resistances, Freud (1914) wrote:

> One must allow the patient time to become more conversant with this resistance with which he has now become acquainted, to *work through* it, to overcome it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis. Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance; and it is this kind of experience which convinces the patient of the existence and power of such impulses. [p. 155, italics in original]

Twelve years later, Freud (1926), returning to the topic of working through, would be even more specific about the origin of the psychic inertia that working through was up against:

> After the ego has decided to relinquish its resistances, it still has difficulty in undoing the repressions; and we have called the period of strenuous effort which follows its praiseworthy decision the phase of "working through". . . . After the ego's resistance has been removed, the power of the compulsion to repeat—the attraction exerted by the unconscious prototype upon the repressed instinctual process—has still to be overcome. There is nothing to be said against describing this factor as the *resistance of the unconscious*. [pp. 159-160, italics in original]

In 1937, Freud would return again to this deepest stratum of resistance (the attraction exerted by the unconscious prototype upon the repressed instinctual process), defining it variously as adhesiveness of the libido or, in a darker mood, as a psychical inertia that must represent the workings of the death instinct. In that context, I believe it is cogent to argue that working through therefore represents the agency of the life instincts, a refusal to "go gentle into that good night" (Thomas 1952, p. 942) or to succumb to the seductive attraction that the id's compulsions seem to offer. In working through, the ego insists that it will doggedly pursue the return of the repressed in every linkage possible, and that, in the tiniest details of everyday life, it will seek linkages to the vast unconscious tracery that got them started.

If Freud seemed willing to embrace the death instinct conceptually as bedrock mental inertia and entropy, his own concept of working through suggests the contrary, and the latter is the emphasis and implication of this paper. I am suggesting, for instance, that an analysand's embrace of the death instinct can be played with or worked through as aspects of a dialogue between the ego and the attraction exerted by the unconscious prototype. In other words, if transference *works* the genetic past *into* the analytic relationship, where it can be insightfully studied, it needs to be worked out and worked through also in the here and now of

life *lived*, so that it becomes genetic in a new way, no longer shaping neurosis but instead modifying the future before it happens. Working through could be conceptualized as not only work with resistance *in the transference*, but also as work with resistance *to the actualization of change* in the analysand's day-to-day life. That these are not mutually exclusive enterprises is obvious to any practitioner who tracks transference not only as it appears in the immediacy of the consulting room, but also in its subtle displacements in the traffic of everyday life. Much as the unexamined life is not worth living, the unlived analytic life is not worth examining unless working through can crack the mold of neurosis and create new paths of adaptation.

My topic is linkage of various kinds: the linkage a child at play makes between inner fantasy and the reality of props and playthings, the linkage between insight and unconscious fantasy made conscious in the adult analytic situation, and the linkage between play and working through itself, which I would like to first explicate clinically by describing two case examples (one from child analysis and one from adult analysis), and then more theoretically by way of discussion.

CLINICAL CASES

Play and Working Through in a Child Analysis

Luke, the four-year-old referred to earlier who recently lost his mother to malignant melanoma, depicts his dilemma in an analytic session. An airplane constructed of toothpicks and masking tape, about to make its maiden voyage, is grounded to the runway by layers and layers of tape adhering to its surface, making liftoff impossible. Child and analyst have applied a voluminous amount of tape in an orgy of flight control, while questions expressing the airplane's desire for liftoff have been met with applications of even more tape. Eventually, another plane is built of toothpicks and masking tape, and a long piece of wire that connects the grounded plane with the unbridled plane makes liftoff possible. The exuberance that follows is extraordinary. Both

planes, interconnected, manned by the boy who once seemed passive, take flight in a Kitty Hawk of emotion analogous to what the Wright brothers must have felt on that fateful day in 1903. The analyst, who thought that the grounded plane represented Luke's state of passivity, was surprised many months of analytic process later when the child referred to the "masked" (masking-taped) plane as the cancer-ridden mother who could not fly.

Play straddles these disparate interpretations, one could say, and countertransference forms the bridge between two meanings as one human in distress leans on another. That the adult other in this communicative experience understands that the child is working through the childhood expression of grief—hiding his teeth behind the masking tape of play, so to speak—is surely crucial, if the insights of understanding are to render the masks of distortion unnecessary in the long run. I have used *working through* here in the same sense as *play* in order to capture the activity of the child's mind as it engages in analytic process and addresses the problem of grief.

That the airplane can represent either the cancer-ridden mother who cannot "fly," or Luke's own sense of paralysis as he addresses his loss of her, is a tribute to the ability of play to convey multiple aspects of the conflict that the child is attempting to represent and master. In his play, Luke is at his most adaptive. At other times, he holds onto his bowel motions, reluctant to think of himself as a big boy who could flush them away. Death is perceived on one magical level as a force that sucked his mother into the toilet bowl and destroyed her.

Freud believed, as noted earlier, that play and fantasy are equivalent, except that in play the child links his or her fantasy to concrete objects in the real world. This linkage is what makes child analysis possible, one could argue, since analyst and child use the floor and playthings, rather than the analytic couch, to set in motion the regressive and progressive dramas of play. Having played with airplanes for many weeks, Luke was able at times to reflect on his play. A plane that flew out of control again and

again was characterized as a plane whose mother did not teach it how to fly. The stark reality of the mother's neglect of her son as cancer claimed more and more of her maternal competence, not to mention the ultimate abandonment signified by death, entered the playroom at such moments. The plane's anger and sadness at not being taught how to fly could be addressed—not all at once, but as much as could be tolerated, as the child displaced his affects onto the inanimate object to better understand his loss of the animate one.

Resistance is the great force that working through tries to overcome, but the act of overcoming is an act of sympathy for the resistance, since resistance, after all, is not merely adhesiveness of the libido, but also the factor that constitutes half the human soul —the half that is ashamed, afraid, unable to muster the courage to be self-assertive, that turns away from power and dignity and instead embraces self-pity and masochism, that believes safety can be achieved only through self-hatred and renunciation. After months of analytic work with Luke, he was able to watch his aunt feeding her young child without turning away and sulking, saying simply, "I wish *my* mother were not in heaven"—indicating that affects of yearning and envy could now be expressed rather than acted out regressively. Something had been worked through, using airplanes as the linkage between displacement and insight, between play and reality.

A similar piece of working through appeared more directly in the transference in this case: at the end of the hour, Luke would bar the door, forbidding the analyst from bringing the session to an end. The mother may have made an exit beyond his control, but the mother of transference could be controlled in a playful endgame in which the area in front of the playroom door was strewn with playthings, a barricade that made exit impossible. Furthermore, the physical weight of the child against the door would impede the analyst's efforts to open it, and negotiation was necessary in order to bring the hour to an end, often quite a few minutes behind schedule. The barricade was interpreted as an

act of love and hate, like the other communication about the grounded plane and the neglectful mother, and eventually the script underwent a significant change: When the analyst went to open the door at the end of the session, the barricade was cleared by the child. "Let me clear the way for you," he said. The analyst was surprised and impressed that Luke had reclaimed a new sense of self-confidence, in which one person's leaving another was no longer experienced as the equivalent of death.

This piece of child analytic process would be hard to make sense of without utilizing the concept of working through. Grief, sadness, anger, and love, instead of being acted out in regression, had been played out and worked through in the progressive enactments of play.

Play and Working Through in an Adult Analysis

Ms. K, aged thirty-eight, in the middle of a productive but very painful analysis, tried to "play" with the idea that her sense of self had always been compromised by her habit of swallowing aggression, rather than spitting it out in adaptive, communicative expressiveness. Married, with a gifted child (who exuded all the self-confidence Ms. K herself lacked), accomplished professionally and interpersonally, she nevertheless felt confounded, perplexed, and illegitimate at the core of her being. She felt like "coral attached to a reef." Safety resided in clinging, not branching out on her own into uncharted waters.

She had dreamed of coral as a child and imagined it not as an inert secretion, but as a living creature—beautiful, magical, but nevertheless afraid to leave the reef. Aggression in her psychic philosophy was not a commodity to be processed and used adaptively in the service of assertive living. The projection of it seemed so essential that any insight into the act of projection itself was an alarming prospect, not an imaginable achievement. "I could never even imagine it," she declares, totally unaware of her aggressive internal assault on the machinery of imagination.

After a long period of interpretation and reinterpretation, transference and enactment begin to tell an alternative story. One day, Ms. K entered the office smiling, and on her way to the couch, pulled a Kleenex from the tissue box. The analyst offered to place the whole box of Kleenex closer to her as she lay on the couch. The analysand chided the analyst for his excessive politeness, experiencing it as an act of hostility. The coral was leaving the reef, finally—developing some teeth of its own and snapping sarcastically with them. An opportunity for play and working through had presented itself.

The "Kleenex box incident," as it came to be tagged over time, was only one such analytic instance of something palpable, some detail that transference neurosis could "exaggerate" in the service of investigation and working through. "But there are so many details, so many incidents, thousands of them!" Ms. K observed, with a mixture of exasperation and wonder. One essential point of this paper is that indeed there are, and since such details and incidents are the external accompaniments of internal intrapsychic events, these details in the living of everyday life highlight the same conflicts and new attempts at resolution dealt with in the analytic situation. Insight needs to be tested against these incidents in real time, for insight develops its teeth as it engages these real-life events. If "God and the devil are in the details," human compromise that attempts to integrate and humanize these supernatural imagoes is in the details, too.

Working through ensures that insight is not shelved, as Valenstein (1983) reported, but is instead put to use in the flesh-and-blood "incidentals" of actual living. The word *incidental* has an additional significance in this case; it was a favorite word of Ms. K's to describe what she believed was totally lacking in the analytic situation: spontaneous affect on both sides; unrehearsed, "incidental" experience—not the contrived, manufactured affects the free-associative process dared to call "real."

"It's *mechanistic*," she would explain, another favorite word for artificial Freudian discourse. Interpretations reduced the mind to

merely its mechanisms. Resistance was the only recourse of a belittled, exasperated, mistreated mind. And resistance there was—formidable at times. It was worked through over time, as analyst and analysand came to appreciate the elemental anger housed in it, a genetic rage at mother and father that was never adequately expressed. Father had been completely absent, a void about which the analysand had no curiosity. This total lack of curiosity, which represented hatred and dismissal, as well as defensive disavowal, was interpreted and worked through over time.

A crucial aspect of Ms. K's noncuriosity about her father was a protective wish not to overtax her already burdened mother. This protective fantasy turned the young child into a responsible overseer of mother's needs, a total reversal of what the child needed for her own development. These aspects of interpretation and working through with Ms. K during long periods of resistance are very germane to my topic, and could be described in greater detail, but I want to return to the word *incidental* and to report a phase of working through that I believe will illustrate my points even more clearly.

The concept of a biting superego as the repository of much rerouted genetic anger had been developed and interpreted with Ms. K mostly through transference. The analyst would surely turn away from her, abandon her, never love her, even retaliate against her if sexuality or rage were expressed openly. Her husband's critical character and aggressive, competitive nature corroborated these internal convictions. But she knew it was her own character that was the issue, not his, even though collusion often blurred the psychological goals she set for herself. She had no teeth, never did, never would. But irony was about to play a trick on her: another analytic "incident" was about to happen. She had placed her handbag beside the head of the couch when she lay down. When she got up to leave, one of the clasps on the handle of the bag had attached itself to the fabric of the couch. Her bag had "bitten" my couch, the clasp having sunken its teeth firmly into the fabric, and it took what seemed like ages to disengage.

In the next several sessions, and indeed at intervals throughout the subsequent analysis, the incident in which Ms. K's bag bit my couch became a symbol of all she would like to work through, but was in despair about being able to accomplish. Criticizing me about the Kleenex incident had been almost unbearable to her. If she asked where I would be on vacation in summer and I did not answer her, rage and hurt sent her into despair. She knew it was exaggerated; her hypersensitivity astonished her at times. Could it really be all about childhood, her absent father, her overburdened mother?

The analysand's lack of curiosity about her father was an identification with, and idealization of, a mother who seemed to need no man in her life and who implied that her daughter would do well to follow suit. Ms. K, despite her marriage, had tried to maintain this fantasy of union with an all-sufficient woman as her unconscious goal. It was a kind of symbiosis, and it could only be imagined or achieved through utter existential happenstance. This was the fantasy that lay behind the word *incidental:* a casual, spontaneous, affective union with the other, not set up by desire or agency. This was the baby before teeth pushed their way through gums, a pre-Kleinian baby—blissful, symbiotic, conflict free, like coral in its reef, safe, undifferentiated. The irony that forced itself upon this most literate woman was that the word *incidental,* while not etymologically related to teeth (the root is *cadere,* to fall, not *dent,* for teeth) did lend itself by sound association to *dental,* describing the very aggressive orality that her fantasy had fought so hard to conceal!

She was aware now that her passivity and sense of illegitimacy were based on an unconscious fantasy that pictured her without agency, a self without teeth. But what to do about it? She sensed that she must *play,* an activity she could not remember as part of her childhood repertoire. But playing meant engaging with the analyst and others, and engagement meant danger, since in her definition of object relations, the other was the repository of all the sexuality and aggression the self felt impelled to disown. The

other could therefore co-opt the self—harass, enslave, seduce, and engulf it, and the self, without any sense of *I*, could not lift a finger or use any teeth to save itself.

An interpretation from the analyst suggesting that Ms. K's conscience had run off with her teeth, and that the self was now afraid to retrieve them, sent a shudder through her as if the very thought of teeth was alarming. But she began to stand up for herself, to practice having teeth, to play. When her husband chided her for drinking a glass of port, implying she was alcoholic (she certainly was not), she immediately quipped, "Don't confuse me with your business cronies. I'm enjoying my port." This felt to her like putting her head in a lion's mouth, but she knew her life, her new analytic life, depended on it. Her husband apologized. Maybe teeth were useful after all.

In the transference, Ms. K became more competitive. She complained that many of my other patients seemed old. Was this a measure of how long I held on to them, unable to cure them, given my incompetence? This was unusual; next to mother, I had been enshrined, untouchable. Since some of the other analysands were not as old as this misperception seemed to insist, Ms. K became aware that she was killing them off, claiming me all for herself. These new teeth she was experimenting with came with new insights that were disturbing and liberating all at once. She described the changes she was trying to integrate into her character as "mundane," but the word had a positive meaning for her, since she so often felt like a disembodied spirit; to be mundane or incidental—that is, of this world—was a significant goal for her. She thought of the work we were doing as an attempt to "reform" her, and this word, too, meant something positive to her: to reshape, restructure, reconfigure the whole armature of the psyche. But she was aware of the irony embedded in the word: that *reform* also meant changing a criminal sense of self into a new, less guilt-ridden vision of psychological reality.

Transference and genetic recall were intimately connected at this stage. The analytic process, productive as it was, could seem

like a mandate to *produce*, the anal imagery making the analysand wince visibly on the couch. She was bitter that precocity and a Protestant work ethic "came with mother's milk," as she put it. In such a developmental whirlwind, there was no time, no room for play. Learning to play now "will take some work," she quipped, with playful, sardonic humor.

A dream description from this phase of the analysis was extremely productive: "I am swimming in a heart-shaped swimming pool. But I am dropping cement as I swim and soon my swimming space becomes smaller and smaller." Ms. K had awakened from this dream angry, for once, at its implications. She felt sure that the dream had been triggered by a recent analytic session in which she imagined stepping out of her swimming pool, showing me her pink toenails, and envisioned my admiration of her, "the equal of your admiration for your wife, perhaps even greater." This daring, spontaneous fantasy had been reported in the previous session with excitement and fear, but also with a sense of analytic achievement. The dream seemed to be an unconscious undoing of her courage; and anger at her own dream work seemed to be her first association.

When all the elements of the dream were analyzed, Ms. K realized that she was deeply afraid of the working through upon which she was embarking; but she realized that her fear could be analyzed, too! "I can dream without cramping my style. If I analyze it, I can confine it to dreams and swim better in my waking life." Maybe there is no more fitting metaphor than this to depict the suffering and triumphs of working through.

In line with the thesis of this paper, one could argue that the retrieval of the unconscious fantasy of "I am coral attached to a reef; it is not safe to individuate and swim on your own terms through life's waters," and a concomitant fantasy, "a woman should not need a man; men are abandoners who are not to be trusted: they have no sense of accountability" became the hard-won insights of an intense analytic process, but we found that making them conscious was not enough. They had to be examined within the

transference and within the incidental details of life outside the consulting room.

When Ms. K asked the analyst, "Where do you find the patience for all this?" (referring to endless repetitions of conflicts and attempted resolutions), she was not only marveling at the idealized analyst/mother; she was also identifying her own impatience with herself, an identification with the father who had impatiently abandoned ship, "never to be seen or heard from again." The identification was defensive, of course, and Ms. K came to realize that it protected her from a furious dialogue with her absent father. Her total lack of curiosity about his whereabouts was not only an identification with the mother who forbade curiosity, but also a disavowal of the object of her love and hatred in the service of avoiding a stormy dialogue.

As she arrived at such recognitions, Ms. K often said to the analyst, "You are crucial. My relationship to you is essential if this is to work." Sometimes she wept as she said this. Through her tears, she was angry, hopeful, and loving, all at once. The analyst acknowledged an understanding of how crucial he was, since the analysand was picturing him as both the sustaining coral reef and as the abandoner. It was hard for her to picture him as a reliable human being who worked hard with her to understand the nature of the traps she had set for herself, eventually releasing her from them through analysis.

If we view Ms. K's question of "where do you find the patience for all this" as a pun—"where do you find the patients for all this"—an additional irony is revealed, an irony of intense abandonment that yearns to be "found" in the transference and elsewhere. Ms. K knew that she must work all this out with the analyst, but she also had to work it out with her husband, child, her aging mother, her colleagues, and friends. At this stage of the analysis, one could say that the coral had left the reef, swimming mostly in individuated waters, but carried cement with her just in case!

Working through is the yardstick that assesses the swimmer's progress (not to mention the many meanings of cement!). In

fact, I believe it was the working through in Ms. K's analysis that allowed a new metaphor to emerge, a metaphor that went completely beyond the coral-reef conceptualization. She imagined the analytic relationship as a space in which she would have a voice equal to the analyst's, a space of mutual respect that would promote a new dialogue in which no emotion would have to be disavowed. When this new metaphor of the analytic space or analytic dialogue dawned on her, she came to her session with an affect of analytic achievement and triumph, a newfound sense of courage and presence. As all the components of this state were examined from the here-and-now angle, as well as from the perspective of the genetic past, Ms. K suddenly accused the analyst of *changing the subject*. What she meant was that focusing on genetic aspects meant a flight from the intimacy of the here and now, that I was the victim of my own countertransference, and that changing the subject in that way hurt her feelings deeply.

I am making this interaction seem more simple than it actually was. In fact, it took a good bit of interpretation and working through to get things out on the analytic table, so to speak, but the point I am stressing is that the whole discussion embodied the nuts and bolts of the analytic activity that goes into the labor of working through. In other words, when coral that seems to need to cement itself silently and desperately to a reef begins to develop autonomy and to indignantly declare that one party to the analytic dialogue has changed the subject, the previously passive discourse has taken an active, assertive tack that highlights the complexity of working through, which is the painstaking work of identifying *the subject*, not only its genetic origins and their representation in the here and now of transference, but throughout all the vicissitudes of displacement as well.

When an analyst, connecting the immediacy of transference with its pedigree in the past, is chided by the analysand for changing the subject, one could argue that the great topic of *change* itself is being addressed, is being worked through, as the analy-

sand dares to criticize authority in a way that would have once been unthinkable. Ms. K never felt safe playing as a child; in fact, the concept of it made her shudder on the couch, as if its precarious premises (as Winnicott implied when he commented that play is always precarious) could shatter the small island of static stability she needed to cling to. Even though working through has been called *suffering through* by Waelder (1932), and one can certainly agree that some aspects of working through are painful enough to warrant that description, there is also a playful quality to working through as new ideas are experimented with and "tried on," as Neubauer (1987), using a sartorial metaphor, has so felicitously characterized it. I suggest that Ms. K, a child who never played, learned how to play as an adult in the analytic playground of transference, fantasy retrieval, and working through.

DISCUSSION

Psychoanalysis, after an initial brief naiveté that envisioned the unconscious surrendering its insights to the powers of interpretation without much fuss, quickly settled into the sobering realization that each analysis would amount to the painstaking study of a conflict between insight and resistance that might be terminable in some instances and interminable in others. If resistance is defined as both descriptive and dynamic, and if working through describes the analytic labor that attempts to break down this formidable fortress, it is clear that the complexity of such a project could never be fully addressed in a single paper. The analogy between play and working through, therefore, can only be considered an attempt to highlight one aspect of the topic and to add developmental and comparative emphasis that may have been overlooked in the past.

To be more than an intellectual exercise, an analogy should throw new practical as well as theoretical light on the topics being compared. I believe that, in bringing together play and work-

ing through, comparison and contrast can highlight unique features of both.[1]

The starting point of the analogy between playing and working through is Freud's lucid focus on one central feature of play —that is, its relationship to fantasy, its unique connection of the internally fantastic and the externally practical world of toys and playthings (the props of reality, as I have called them). I have used this insight of Freud's to bring attention to one aspect of working through that I believe has been neglected. Working through, according to Freud, reflects the analytic labor that addresses resistances preventing interpretation of psychic conflict from being effective all at once. A single interpretation, however accurate, given the complexity and multiple determinants of the defensive stronghold it attempts to assail, cannot expect to be successful in one fell swoop. And indeed, after the initial excitement of insight wears off, the analysand senses that repression and a host of collaborative defenses have rallied to undo the gains of partial revelation.

Freud, as alluded to earlier, cautioned the practitioner against despondency, arguing that disenchantment has to be part of the clinical process as resistances are worked with. If in 1893, Freud was aware of *working over*—an almost preanalytic intuition of the healing power of free associative thought—his concept of working through, reached several years later, is not only a measure of how sophisticated his thinking had become in twenty years, but also of how sober and patient the years of analytic labor had made him in the face of mental inertia and stubbornness, as insight and resistance fought each other tooth and nail!

Resistance, and its deconstruction in the act of working through, have become core concepts in psychoanalysis, and preaching to

[1] Ironically, the etymology of *analogy* and *neglect* exposes a common verbal root *(legere,* legend), which essentially means *to gather together* in the case of analogy, or not to gather together in the case of neglect *(neglegere).* By bringing together what had not been appreciated earlier (playing and working through), neglect is redressed and a heuristic pathway of intellectual and clinical associations is advanced.

the already converted is not the focus or function of my analogy. What I want to stress is one feature of working through—and indeed, a feature of play as well—that may have been neglected in both. I believe the proposed analogy is the key to this insight. If in *play*, a child learns to be practical by forcing magic to the ground, where it can be wedded to reality (relatively speaking), then in *analysis*, an adult analysand must also take unconscious fantasy and harness it to the reality of practical experience in day-to-day life. The classical concept of working through suggests that resistances to the acquisition of insight have to be worked with, and the workplace par excellence is the examining room that the transference-countertransference situation makes available throughout the length and breadth of the transference neurosis that analysis promotes. Surely, the analyst's interpretation of transference distortions and the analysand's developing capacity to collaborate on the deconstruction of such distortions, as well as their subsequent replacement with insightful, new reality testing that restores as it retrieves the analyst's identity from these distortions, are among the most impressive and convincing aspects of the analytic enterprise.

Another way of describing this most elemental feature of psychoanalysis is to suggest that unconscious fantasy guided along free-associative steppingstones inevitably makes its way to the person of the analyst. The certainty that it will find the personhood of the analyst as a resting place is, after all, one of the unique qualities of transference, as both resistance and revelation all at once. Free-associative explorations take refuge in transference when they dare not proceed any further in a given analytic session! If play must link itself to concrete objects to represent fantasy to itself—"holding as 'twere a mirror" up to the nature of an interior world by giving it a bit of substance in the concreteness of actual and moveable playthings to hold on to—free associative thought must latch itself to the person of the analyst as a comparable act of resistance and revelation. So far, there is nothing new in this depiction of analytic process, except perhaps the

emphasis on unconscious fantasy and its need to link itself to transference, the better to both hide from and look at itself simultaneously.

The relative emphasis I am proposing would suggest that it is not only the person of the analyst who gets invested with these defensive displacements, but also a whole world of objects, animate and inanimate. That a transference interpretation can eventually gather all these scattered elements of unconscious fantasy into their relevant meaning in the analytic relationship does not mean that we can lose sight of the clinical fact that transference alone cannot be, and need not be, the only receptacle for so much emotional reality all the time. In child analysis, this has been obvious from the beginning. In fact, in 1928, Anna Freud argued that children could not use transference as effectively or as generally as adults can, since children *live* with their primary objects and cannot be expected to divest such immediate familial presences of their psychic energies in the displaced manner that adults do. That Anna Freud changed her mind (relatively speaking) over the years does not mean that child analysands use transference as uniformly or as intensely as do adult analysands. It does suggest a developmental relativity, however, that reflects the clinical differences between these two technical modalities.

A classical vision of adult analysis tends to accentuate its differences from child analysis, as if props and playthings had no place beyond the playroom, as though an analytic couch invites a regressive, free-associative verbal process while the nonverbal, the transitional, the actively playful must be ignored. There are undoubtedly adult analyses where the associative process and transference exploration carry almost the total burden of meanings generated throughout the treatment. But if analysis is conceptualized as the unearthing of unconscious fantasy and the subjection of those fantasies to relentless, "scientific" reality testing (and surely this is only one conceivable definition that does some violence to the complexity of the total picture), it is unlikely that unconscious fantasy emerges from the mind, enters the free-associa-

tive pathways, latches itself onto the imagined persona of the analyst via transference, and then never makes an appearance in the displacements of friendship, marriage, child rearing, academic life, the workplace, sports, and all sorts of playful activities with inanimate objects—from chess pieces to artifacts to fetishes to playthings.

If "all the world's a stage and all the men and women merely players" (Shakespeare 1599, II, vii, 139), one could make a case that actors on stages use props to embellish or enhance dramatic dialogue or action. Think of the mileage Shakespeare gets out of a handkerchief in *Othello,* or the mischief with which Ionesco can invest household furniture in *The Chairs.*

For that matter, think of the use Ms. K made of Kleenex or a handbag. Ms. K's hunger for "incidentals," her yearning for spontaneity in human affective experiences, could reflect a hunger for play that seems to have gone unsatisfied in childhood—no doubt for extremely complex reasons of both internal psychic dimensions and external environmental ones. Her mistrust of the programmatic, her distaste for analysis that seemed "mechanistic," fed a powerful resistance that experienced transference and free-associative wordplay as contrived rather than truly emotional or spontaneous. This resistance was complex, genetic, and multiply determined, but it was ironic that one component of its undoing was indeed triggered by the accidental (or the *incidental)* in the form of the Kleenex incident or the handbag incident previously described. Could one fairly say that, when an opportunity for playing presented itself—belatedly, to be sure—in the form of these unforeseeable incidents in the midst of a transference neurosis, an old genetic symptom could be addressed and even redressed through the work of analysis?

There is no need to further elaborate this relative emphasis I am placing on the inanimate object in adult analysis, other than to stress an obvious developmental component: Prior to Winnicott's (1953) discovery of the meaning of the transitional, surely blankets and other inanimate objects had emotional significance

in the lives of infants and children, but this significance often went unnoticed. Winnicott's insight emphasized, of course, the olfactory and tactile *presence* of the mother in the *absence* the inanimate object would otherwise have represented, if the scent of the mother and the feel of the mother-scented cloth (not to mention the drool-scented body smell of the burgeoning self) did not provide a protosymbolic connection with her. A similar point could be made about all subsequent playthings. It is their parental, familial context that makes them useful to children as displaced, sublimated but intimate links to primary and sustaining libidinal objects. Children with impoverished family lives, with little connection to primary love objects based on chaotic social circumstances, do not play very much. To invest the inanimate with meaning, the animate emotional connection must exist first.

If the transitional object is thought of as an initial developmental prop, a sustaining link to mother in her absence, all subsequent inanimate objects that children play with and invest with meaning, from the transitional to the oedipal, could also be thought of as developmental props—more complex and conflicted, to be sure, but developmentally crucial nonetheless. All these inanimate objects reflect the developmental context of the parents and peers who nourish children as they engage in experience, conflict, and compromise. One would never isolate the world of play from the backdrop of primary objects that are central to its very existence.

Props assist an actor on stage: they do not interfere with the script, but rather enhance it. In child and adult analysis, one might postulate that props of various kinds—airplanes, Kleenex, and handbags, for example—assist analysands in the elucidation of their associations, in the flushing out and fleshing out of unconscious fantasy. One could argue that some analysands need props more than others, and that there may be complex characterological, genetic, and even diagnostic implications to such differentials and preferences. In working through resistances, one may

have to be aware of the meaning the inanimate holds, not only for certain children but for certain adults as well.

I have presented clinical excerpts from two analyses to support the central analogy of this paper. Excerpts provide emphasis, which is all I want the analogy to accomplish. Working through is a most complex process. When Freud noted that the opening moves of analysis could be delineated, as could the endgame, but that the rest of analysis—what comes between initiation and termination—defies precision or exegesis, one might speculate that he was referring to the cat and mouse of insight and resistance, the ins and outs of interpretation and working through. My analogy brings a certain emphasis to a specific aspect of working through. In fact, I emphasize a certain feature of play, neglected in and of itself, perhaps, to highlight the particular aspect of working through under scrutiny.

Let me be clearer: play is often conceptualized as symbolic play, as if its only function were to communicate symbolically. If this were play's only function, I suggest that language as symbol bearer is far more complex and expressive. But if we characterize play as not only fantasy bearer, but fantasy tester as well, an important aspect of its developmental function becomes clear. A child seems to need to enact inner drama with actual props, to become the stage manager and director of his or her own externalized interiority. Why? I would like to suggest that, while it is the symbolic content of children's play that has so fascinated adults, it is the nature of the activity itself, the aim-experimentation or aim-investigation of it, that should be emphasized as equally significant, if not more so, than the symbolic content—which, after all, could be expressed in language or thought without the actual enactment.

In this definition of play, action or aim (to use the Freudian word for it—I am borrowing from Freud's early use of *source*, *aim*, and *object* in his description of the vectors of instinct) is highlighted and the concept of aim itself, the action that brings about satisfaction of the instinct, is not considered a given, but rather a

phenomenon that must be considered in its own right. The ego thereby considers and reconsiders its activities ("Shall I break this toy?" "Shall I cut the eyelashes off this doll?" "Shall I bury this airplane under a ton of masking tape and never let it fly again?"—and so on). I would like to argue that it is these activities of the child with real play objects that will eventually convince him or her that magical thinking can be modified into more realistic thinking as limitless thought and fancy wed themselves to the practical necessity of finite human action. Magic is humbled, perhaps, but it is also made more serviceable.

I believe that what we call the magic of play is really a child's attempt to retrieve magical activity from its internal, unconscious hiding places in fantasy, fear, phobia, character traits, defenses, somatic symptoms, or whatever, and to enact this magical activity in the little theater of play. Once muscled into a manageable shape and size, given a local habitation and a name (as Shakespeare put it in a very different context), the magical component of the action is removed in the titration of play, and one is left with human action itself—a serviceable activity that cannot hallucinate a breast, perhaps, but it can tug on the mother's arm and ask for a milkshake! It is this "education" of action that I am stressing, not only in play, its first great theater of operation, but in working through, the adult extension of the concept of play that makes it possible for analytic insight to become practical.

In working through, as I define it (not idiosyncratically, I hope, but rather as an old concept in slightly new linguistic clothing), action again takes center stage as unconscious fantasy, revealed not only in the great theater of transference, but also in all experience beyond the proscenium of that great stage. Unconscious fantasy is thereby dissected and deconstructed as it holds a mirror up to itself and sees the magic that informed, indeed misinformed, its vision of reality. In the revised images of this analytic mirror, working through insists that if fantasy influences reality, reality can also influence fantasy.

I believe we could argue that the play described in the treatment of Luke, the first patient presented in this paper, puts his magic and his internal fantasy life into an externalized perspective, one that allows him to plaster a small object to the surface of a table and rescue it from its grounded, plastered state when he sees fit. That the airplane can represent so many factors—the mother's death or resurrection, the boy's anger or guilt, or the boy's castration anxiety, passivity, or masochism—is a measure of the multiple functions, the multiple meanings of play, and the myriad of interpretations possible as analysand and analyst work together to clear the runways of development. If magic is the fuel of childhood, like all fuel, it is relied upon by engines—the engines of reality—even as those engines transform it.

Similarly, in Ms. K's case, the coral weaned itself from the cement that bound it to the reef, creating a new space in which democratic dialogue replaced tyranny, and freedom of speech took over from submission. But freedom of speech means having to deal with affects and conflicts that coral need not concern itself with. The magic of neurosis comes with pseudoguarantees that individuation and autonomy cannot promise—and that working through insists on exposing.

Taking action on the new stage that analysis has created allows the old stage of Gothic, magical, primally distorted logic to fall into disuse. In a sense, neurosis consists of internalized, imploded magical action that distorts the ego's vision of reality, and working through is the execution of a new, postneurotic blueprint of action that is not magical at all, but inherently realistic. Ironically, it is this kind of new action—psychoanalytically informed action, as Valenstein (1983) termed it—that exposes the old magical, unconscious, neurotic action language, insisting on its demotion and removal from an executive seat of power.

I am suggesting that a child's play is the relentless, dogged attempt to make fantasy practical. Perhaps this is what Montaigne's insight was designed to emphasize in suggesting that, as alluded to earlier, the playful and the serious can be coincidental. I pro-

pose, in fact, that the quality of a child's ego that attempts to educate fantasy in a theater of action is very similar to the practical quality of working through that I am highlighting. I believe that Ms. K, for instance, had been the victim of an unconscious fantasy for most of her life—a fantasy that convinced her that aggression is unspeakable, that its teeth are cannibalistic and murderous, and that repression, reaction formation, depression, and passive character traits are absolutely obligatory as defenses to hide such teeth at all costs. The psychological price of this process is extraordinarily high, of course—a faintly perceived insight that keeps the motivational wheels turning in spite of extraordinary resistance!

The free-associative process and the magnet of transference might have lured this fantasy into awareness in another analysand. But in this instance, props and "incidentals" seemed essential, finally enabling the perplexed ego to use Kleenex and a tenacious handbag to confront resistance—not theoretically, but actively and affectively, as the here and now conspired in mischievous ways to tweak the nose of the genetic past and force it to play! To overemphasize the Kleenex or a handbag as accidentals or incidentals would miss the point of the analogy completely; what I wish to point out, rather, is the dogged nature of the ego that seizes the incidental, and in collaboration with transference and a free-associative process, makes off with an insight that transference resistance or a temporarily stalled flow of associations could not provide alone. This collaborative effort between free association, transference, and "incidental" experience can be compared to play in the sense that it uses props to link one kind of qualitative mental experience with another in the service of psychological exploration. If this kind of play in childhood contains an aspect of working through, as argued earlier, it could also be argued that this kind of working through of resistances in adult analysis, using the accidental or incidental as stage props, has a playful quality, even though the analysand might not experience it as such in the context of a transference neurosis.

In Ms. K's case, the incidentals of Kleenex and a biting handbag were useful in deconstructing the magical power of an unconscious fantasy. Furthermore, the changes that occurred in her relationships with her husband and friends were not only a direct consequence of analytic work with resistances in the context of the transference neurosis, but were also influenced by the experiences themselves. When Ms. K challenged her husband's criticizing her for drinking a glass of port, the actual experience became an exercise in de-fanging the unconscious tyranny of genetic teeth in the here and now of an actual confrontation with a most significant object in her life. Fantasy met reality in these actualities of working through, which were, of course, described to the analyst in the context of transference and had intense transference implications, but they were also real experiences in and of themselves and need to be recognized as such. If, as James Joyce (1916) implied, the human mind goes "to encounter . . . the reality of experience" (pp. 252-253) millions of times, the process of working through can use extratransferential as well as transferential experience to guide it toward its goal. That goal, after all, is not merely to encounter the reality of an experience called *transference neurosis*, but rather to use that transference neurosis and all other experience to free the mind from unconscious fantasies that would ensnare it.

The analogy I have proposed seems so obvious when examined in detail that raised intellectual eyebrows may greet the carriage of so much coal to Newcastle with sarcastic acclaim or mock surprise. In my defense, I can only suggest that the entire canon of received wisdom—the history of ideas as surprises that no longer surprise, once enlightenment has taken hold of them—nonetheless *began with surprise* when ignorance first met its startled self in the mirror of experience. Historical hindsight does not prepare one for the intellectual jolt experienced in reading Ferenczi's "A Little Chanticleer" (1915): the author implies that once the child (Arpad) became bored, broke off his verbal dialogue, and returned to play, he could no longer be communicated with! Here a clinician as astute and intellectually playful as Ferenczi turns down an op-

portunity to play! Given the year in which the book was written, however, one needs to remind oneself that the "obvious" psychoanalytic properties of play had not yet been discovered.

When Freud first intuited the unconscious meaning of play in his grandchild's *fort da* activities—or the linkage between fantasy, play, and playthings—in 1908, the intellectual surprise of the discoverer and his first audience must have been palpable. The obvious was forced to reveal the obvious secrecy it had made off with and concealed in broad daylight! The connection I have made between play and working through is similarly obvious, one could argue, but if the analogy, as I have outlined it, exposes the uncanny condensation of reality and fantasy that all human experience is and perhaps remains, no matter how successfully it is worked through, then the obvious will have reluctantly revealed its hidden subtleties once again.

By conceptualizing psychoanalysis as the process of uncovering unconscious fantasy and subjecting it to rigorous interpretation, by emphasizing play as fantasy tester as much as it has been extolled as fantasy bearer, and by focusing on a particular active ingredient in working through, I have undoubtedly narrowed the focus of all three of these elements, in order to peer through the particular lens of analogy that I propose. Ironically, my thesis gains additional support from a similar analogy that Freud used in a totally different context. In 1915, in a letter to Ferenczi, he concisely and memorably described the "mechanism" of his scientific creativity as the "succession of daringly playful fantasy and relentlessly realistic criticism" (Falzeder and Brabant 1996, p. 55). Somewhat irreverently, I would like to suggest that the *extraordinary* mechanism of Freud's creative genius can be compared to the *ordinary* mechanism of neurosis and working through, in the sense that neurosis can be compared to a compendium of internal fantasies that compromise the wingspan of psychological life, whereas working through is comparable to a process of persistent, realistic assessment that paradoxically grounds fantasy in reality, thereby setting it free. In a sense, play is the working through of

childhood, and working through is the newfound play of adulthood, both informed by fantasy and "relentless, realistic criticism," as adaptation and compromise try to wean themselves from self-deception.

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6 East 96th Street
New York, NY 10128

e-mail: Ejmahon@aol.com

Psychoanalytic Quarterly, LXXIII, 2004

ON PSYCHOTIC TRANSFERENCE AND COUNTERTRANSFERENCE

BY THOMAS MÜLLER, PH.D.

Following a brief discussion of the primary types of psychotic transferences, viewed from a theoretical position combining ego psychology with an object relations approach, the author presents detailed clinical material illustrating these transferences. The analyst's countertransference in work with such patients is also discussed in depth, including its use as a unique window into the patient's inner world.

INTRODUCTION

I suggest that psychotic transferences fall into four main categories, each of which includes several subcategories (Müller 1994), as follows:

1. Paranoid psychotic transferences, expressed by:
   - bodily centered or hypochondriacal presentations;
   - latent manifestations; or
   - overt fears of persecution.
2. Narcissistic psychotic transferences, expressed by:
   - symbiotic object relations;
   - the presence of an ideal selfobject;
   - omnipotent traits; or
   - autistic traits.
3. Confusional-state psychotic transferences, expressed by:
   - prepsychotic developments that announce an imminent psychotic regression;
   - evidence of total dissipation; or
   - fusion of self- and object representations.

4. The various affective psychotic transferences, including the presence of:
   - manic states;
   - psychotic superego and ego-ideal developments; or
   - separation conflicts.

Each of these distinct transferences provokes specific countertransferences in the analyst. Combinations of various subcategories are not only possible but common.

To illustrate how these transference paradigms may be played out and, especially, how the analysis of countertransference may be helpful in observing and moderating them, I will discuss three clinical cases: Ms. A, who evidenced a paranoid psychotic transference that included narcissistic-omnipotent features, and whom I saw in analytically oriented psychotherapy, three times a week; Mr. B, whose transference took a narcissistic-symbiotic form with features of the ideal selfobject, and whom I treated at a day hospital in four or five 25-minute sessions per week; and Ms. C, who exhibited a narcissistic-autistic form of transference, including confusional states, and whom I saw for three sessions a week in psychoanalytically oriented psychotherapy. All three were seen vis-à-vis.

THE EGO PSYCHOLOGICAL/ OBJECT RELATIONAL POINT OF VIEW

Before presenting the clinical material, I will give a short summary of the ego psychological/object relational approach to psychotic disorders, including schizophrenia, affective disorders, and monosymptomatic psychoses. From this theoretical point of view, clinical experience suggests that three interdependent factors may be responsible for the development of psychic structures in early life: internalization and defensive handling of infantile, phase-specific object relations; the reality of primary objects; and traumatic events. These structures can influence the individual's experiences in object relations throughout the course of a lifetime. It follows, therefore, that in the analytic situation, we may observe those structures of object relations that have most influenced the development of conflict in the patient's past.

Thus, transferences can be regarded as variations of conscious and unconscious structures of object relations in the here and now of the analytic situation—structures that were internalized during the infantile there and then. From an examination of the patient's transferences, we may draw conclusions about his or her unconscious self and object representations as they constitute his or her inner world. The patient's experiences, affects, fantasies, and thoughts resulting from these internalized and displaced structures are activated in the analytic situation, and the patient attributes them to the analyst and the analytic situation (Haesler 1991; Kernberg 1987)—being usually aware, at least on some level, of the "as-if" nature of these attributions.

The ego psychological/object relational point of view may also be helpful in understanding the psychic structures of psychoses, which coexist in an interdependent relationship with physiological and genetic factors. Psychotic disorders may therefore be viewed as a psychosomatic disease of the brain. Theoretical and clinical research on psychotic personality organizations conducted from this viewpoint (e.g., Bion 1957; Burnham, Gladstone, and Gibson 1969; Feinsilver 1986; Freud 1940; Frosch 1983; Grotstein 1983; Jacobson 1971; Kafka 1991; Katan 1954; Kernberg 1986; Kutter and Müller 1999; Müller 2000; Ogden 1982; Pao 1979; Volkan 1995) has suggested that a psychotic human being's self is not made up of uniform and homogenous structures, but rather consists of parts of the personality that are organized at different structural levels. Furthermore, the psychotic parts of the personality may vary in structure and dynamics (as with the multiple psychotic personality described in Kafka 1991). The psychotic parts of the personality lend themselves to the formation of stable and long-lasting psychotic personality organizations.

Nonpsychotic parts of the personality are constituted by internal object relations that are based on the internalization of a self-representation, one that has developed in relation to a representation of the object as shaped by a dominating affect (Kernberg 1984). Psychotic parts of the personality, as well, are not constituted simply by drive or defense operations, or by conflicts between the ego

and reality, but rather by a process I describe as follows: For many reasons, including biological and psychological factors, the developing personality has difficulty bearing frustrations and conflicts with inner and/or outer reality. The personality does not react by thinking (Freud 1911, 1915), but instead experiences "organismic panic" (Pao 1979) and "nameless fear" (Bion 1962). In order to protect the personality against this fundamental terror, the self takes refuge in pathological splitting that may lead to the fragmentation of parts of the personality (Bion 1962; Steiner 1993). As a consequence, fragmentation of self, objects, and affects occurs.

Whereas some psychotic patients remain in this state of fragmentation and pathological splitting, others succeed in activating more "mature" psychotic defensive operations, such as introjective and projective identification. These omnipotent and concrete defense mechanisms are motivated by the impulse of the self to survive mental catastrophe, while fusing the fragmented images into all-good and (split-off) all-bad selfobject units. These fused units remain in conflict with each other, with the nonpsychotic parts of the personality, and with outer reality. At first, such psychotic operations seem to lead to a certain stabilization of the personality, offering the self a sort of pseudocoherence.

The fused and split-off units are neostructures that do not only remain fixed in regressively recathected, normal infantile developmental phases, but are also diffused to nonintegrated parts of the self and to pathological developmental phases (Grotstein 1983; Volkan 1995). The function of these fused and split-off selfobject units is to disavow the separation and difference between the self and objects. Thus, they represent a lack of differentiation and separation between self- and object representations and affects, including a loss of reality testing, restricted self-reflective ability (the observing ego, synthetic ego functions, and so on), and the loss of identity and of body sense. Furthermore, these fused and split-off selfobject units reflect a loss of the symbolic dimension, defined as a triangular relationship between self, object, and the third object. Thus, psychotic transference loses its metaphoric structure—i.e., the as-if character of the patient's attributes has vanished.

Because the lower structural level of psychotic personality organizations differs fundamentally from the lower level of borderline and narcissistic personality organizations, psychotic transferences must be distinguished from psychotic reactions or episodes indicative of borderline or narcissistic personality disorders. The latter occur only within the analytic situation and can be dissolved by interpretive work that addresses their defensive structure (Kernberg 1984). By contrast, interpretation of the defensive structure of psychotic transference can sometimes lead to its transitory intensification, since all interpretation is characterized by a symbolic and metaphoric structure, and psychotic organizations are essentially a defensive position against the recognition of separation between self and object (including the depressive position and the oedipal triad).

Within this proposed framework, *countertransference* encompasses all emotional reactions of the analyst (the *totalistic* approach). These complex mental reactions derive from different sources. We may distinguish *subjective countertransference* from *objective countertransference*, and both may be conscious or unconscious. Usually, subjective countertransference refers to the analyst's personal equation (Freud 1933), being primarily independent of the patient or the process; but in certain cases, it may develop in relation to the patient or the process, and in those instances indicates the influence of the analyst's personality on the process (Ogden 1994; Renik 1993; Searles 1965). The objective countertransference derives from the analyst's mental or behavioral reactions to the patient and/or the process. During treatment with schizophrenic patients, countertransference most often derives from the psychotic transference of the regressed patient. Working through the countertransference means to distinguish its various sources in order to gain crucial data regarding the patient's reactualized object relations and defensive movements in the here and now. Of greatest clinical value are the analyst's concordant identifications with the patient's self-representations and his or her complementary identification with the patient's object representations (Racker 1968). As in psychotic states, self- and object representations do not exist separate-

ly; concordant and complementary identifications may also refer to fused and split-off selfobject units (and, therefore, these terms are used here in a slightly different sense than Racker used them).

Technical considerations within the suggested framework include the questions of what is helpful and in what way to which patient. The appropriateness of treating psychotic patients with psychodynamic psychotherapy has been met with skepticism since the time of Freud (Michels 2003; Willick 2001), but detailed clinical research (Alanen 1997) and empirical statistical research (Gottdiener and Haslam 2002) have validated its efficacy. In my own clinical experience, the consideration of whether to utilize psychoanalytically oriented therapy with a psychotic patient (especially a schizophrenic one) has been preceded by a consideration of whether the patient would be helped more by sealing over or by integrating the psychotic parts of his or her personality (Müller 2001). In the latter case, several basic principles may be helpful to keep in mind in working through psychotic transferences and countertransferences. At certain stages and with certain patients, it may be necessary to establish a relatedness (Searles 1965) that takes into account the patient's narcissistically injured and incoherent self, with a repudiation of the typical emphasis on interpretation of selfobject difference and separateness; instead, concentration on reality testing, the naming of emotions in the here and now of the therapeutic relationship, and the sorting out of thoughts and experiences in object relations may be beneficial.

To a certain degree, the analyst functions in the service of the patient as a narcissistically cathected selfobject, in order to offer the patient the possibility of identification with the analytic and therapeutic functions (Volkan 1994). The analyst thereby respects the patient's need for idealization, sometimes over long periods (Alanen 1997; H. A. Rosenfeld 1987). Throughout the treatment, noninterpretive elements, such as the analyst's tone of voice, timing and mode of interventions, and so on, are of major importance. Over long periods, psychotic projections must be contained and processed internally by the analyst, who should be able to think under fire (Bion 1962). If the patient has narcissistically cathected

the treatment and the analyst, the working through of the psychotic position—with its defensive operations and object relations that unfold within the transference from the very beginning—requires full attention. The general aim is to strengthen the nonpsychotic parts of the personality and to establish a mental space for the development of symbolic, triangular thinking (Bion 1962; Winnicott 1965).

A CASE OF PARANOID TRANSFERENCE

Ms. A

The following description of the treatment of Ms. A highlights the various dynamic and structural aspects of a specific paranoid form of psychotic transference and countertransference. This vignette illustrates a way to help a patient overcome a paranoid attitude and move toward a more depressive state.

A 36-year-old, married woman, Ms. A had suffered from a schizophrenic psychosis, paranoid type, since the birth of her only daughter four years earlier. She had had several hospital stays and was unable to work at the time she began treatment. Her mother had been in both in- and outpatient psychiatric treatment for decades. During the Nazi occupation, Ms. A's maternal grandmother had made a secret of her daughter's (the patient's mother's) mental illness in order to survive. Suffering from alcohol abuse, the patient's father had left the family when the patient was nine, after constant quarreling with both his wife and the grandmother. Four years later, Ms. A's grandmother died. Ms. A, then thirteen years old, had to take full responsibility for her insane mother until the mother's death in the late 1970s.

An important event in the analytic process occurred after two years of treatment, when—for the first time—Ms. A developed a degree of insight into the existence of the psychotic parts of her personality, which she had denied until then. This insight was subsequently often threatened and even temporarily destroyed by her persistent conviction of being persecuted by the Gestapo. Nevertheless, a reliable therapeutic relationship was established. A con-

stantly recurring theme in the treatment was the patient's guilt at not having looked after her mother well enough, with the deep, unconscious meaning that she herself had actually caused her mother's illness; this was itself a defense against her hatred of her schizophrenic mother. After one year of treatment, she was able to return to her job.

In the particular session to be reported, Ms. A ran into the treatment room, beside herself with rage. All day long, the Gestapo had tried to catch her and take her away from her little daughter. Filled with terror, she exclaimed that the treatment room must certainly be full of hidden Gestapo microphones. Suddenly, she cried out furiously: "It is *you* who is to blame for it!" She continued, still enraged: "You offered me a psychoanalytic book in order to increase my self experience!" It developed that she had read a section of the book the previous night. Her husband had tried to have sex with her, which she had angrily refused; then he had blamed her, and an argument ensued about the couple's parrot. She had never liked this bird, she continued in anger, referring to all the dirt and the noise it made in the night. Her husband, who had bought the parrot, forced her to look after it; he would go off to work and she would have to care for the disgusting beast, feeding it and letting it out to fly, then catching it and returning it to its cage. Ms. A went on to shout that she hated the parrot and her husband, that I was to blame, and that she both wanted more psychoanalytic books and wanted to break off the treatment with me.

She stopped abruptly, staring at me in anger and hatred. (At this moment, I did not know what else had occurred the previous night: that she had gone to bed without catching the parrot, and the bird had flown against a wall and broken a wing.) I felt overwhelmed by Ms. A's confusing story, understood quite nothing, and experienced pressure to explore the reality of her story, but also felt paralyzed by her reproaches. At the same time, I was angry with her husband: why didn't he control his sexual wishes? Couldn't he stop blaming the patient, by which he was threatening her psychic balance? Should I phone him and tell him not to wor-

ry his wife with his sexual desires and to look after the parrot himself? At the same time, I was concerned about the patient's little daughter and felt some pressure to actively care for this child, in view of the mental state of the mother and the constant parental quarreling.

Before pursuing these thoughts any further, I felt compelled to tell the patient that I had never recommended any psychoanalytic books to her. Ms. A laughed disdainfully at this. Then she observed that whenever I did not have all the facts, I tried to impose my thinking on her. Full of hatred, she insisted that I was to blame for all the mess she had experienced, both last night and today, and that she would not allow me or anyone else to succeed in "changing her polarity." I felt the impulse to console and soothe her because I thought—as I often had before—that she was capable of whipping up her rage to the point of entering an addict-like state. I felt a growing anger because I did not want to be likened to the Gestapo; but Ms. A seemed to be hardened and locked away from me. I perceived an irresistible internal pressure to interpret her delusional convictions and closure. The more I interpreted, however, the angrier she became, and a heated argument arose between us around who did or did not recommend which books, who was to blame, what was the use of the therapy, and so on.

Although I saw that the situation had begun to slip, I found myself unable to stop this turn of events. I felt insecure not only about the therapeutic situation, but also about my analytic identity. Suddenly, I began to recall difficult situations from my own analysis and supervision, and somehow, I managed to stop interpreting. I sat back and waited. Gradually, I began to succeed in reflecting on the situation, and I formed the impression that many aspects of the patient's infantile experience, as well as of her delusional baseline state, had just been explicitly expressed between us. I concluded that, most probably, she had experienced my interpretations as persecutory; that she was in need of being understood by me but not of understanding herself; that I had interpreted too fast in regard to her inner situation; and that perhaps

the motive for my interpretations lay not only in the effort to understand what was going on, but also in the need to get rid of my unbearable feelings.

I tried to talk to Ms. A about how she might have experienced me in this interaction between us. She immediately became less accusatory and quarrelsome, though she still observed me with some distrust. I asked myself whether she might have become confused the previous night because she longed for intimacy with her husband, yet at times, saw him as her main persecutor. Could my irritation toward her husband be the result of her motivation to get rid of her sexual wishes and mad parts by projecting them into him and into me? Had she projected her own unbearable feelings of guilt into me—feelings that resulted from her sexual wishes and her neglect of the parrot (perhaps a symbol of her mother)? Or did the reproaches I felt come from *my* feelings of guilt, stemming from the bad and dangerous treatment she was receiving from me? Did I feel as guilty toward her as she did toward her mother? Had she looked for me (in the psychoanalytic book) *after,* and not before, the quarrel—in order to control her anxiety and confusion, and had I abandoned her by leaving her alone with the "parrot," her husband, and her anxiety, just as her father had done when he left the family?

After some time, I suggested to Ms. A that last night something horrible must have been happened, something that made her feel under great pressure. Part of her seemed to have become overwhelmed by wishes and feelings of guilt, and had become confused and anxious. Again, the patient looked at me with hatred and anxiety. Then she said that she thanked God she had a different name from mine, because if she were to look in the telephone directory and think about how many listings for "Müller" existed, it would drive her mad. Taken aback, I again felt desperate, and found myself thinking despondently that even a minimal level of insight and tolerance for selfobject separation could not be sustained through the end of the session. Perhaps Ms. A's delusions really did lack any meaning and were merely the expression of some sort of deficiency syndrome.

Then, however, I remembered other, similar situations of doubt and discouragement in the course of her therapy, and the fact that in spite of these feelings (or because of them?), she had developed and progressed both in and out of treatment. I then suggested to her that she might be anxious that she would lose herself if she received something from me, that I could then invade her and take possession of her thoughts and feelings. She did not stop looking at me with distrust, but again seemed more quiet. Then I said that perhaps it helped her to identify the guilty and the bad that she had experienced last night and today in me, in order to get relief from all these unbearably horrible feelings and thoughts and to clear up her inner confusion and anxiety. And that perhaps, at the moment, this was the only way to show me how she felt. She became even more quiet, and after a while, she asked, "Do I abuse you?" I observed that she might feel guilty about depositing her unbearable feelings in me, being scared that I could not bear them either. Later, she said she wanted to visit the doctor with her parrot.

Discussion

One form of paranoid transference may unfold at the climax of the negative transference, as was the case with Ms. A. She completely identified the analyst with persecution and attack. In such cases, the patient may impose an interdiction on the analyst to say anything, or may reject all the analyst's comments, because the patient experiences every utterance of the analyst as a concrete attack (e.g., when Ms. A was convinced that the analyst would "change her polarity"). This form of transference can become so intense that patients like Ms. A cling to their rage against the analyst with a kind of addict-like, frenzied pleasure; during other periods, the patient unconsciously fears both his or her own attacks and the analyst's retaliation, and tries to break off the treatment.

Such a transference may develop out of the patient's attempt to get rid of aggressive, sadistic, self- and/or object representations by assigning them to the analyst through a psychotic version of

projective identification, creating fused, destructive selfobject units (e.g., the analyst perceived as a Gestapo object), which—either in the shape of the analyst or the treatment itself—persecute the patient. Especially in this form of paranoid relation, projective identification can have different meanings: the patient tries to protect him- or herself from unbearable inner experiences, such as feelings of loss (e.g., Ms. A's probable feeling of being left alone with her mad inner objects the previous night); fear of inner destruction of good self- and object representations (e.g., fusion of the parrot and Ms. A's daughter into ideal selfobject units); dependency on the analyst; and difference and separation of self and objects. In short, to protect against depressive experiences and recognition of the oedipal, triangular position, and to avoid the confusion of his or her inner world by splitting self- and object representations, the patient fuses such representations into oppositely cathected units and projects or introjects them. Projective identification can also function as a means of communication (H. A. Rosenfeld 1971a, 1971b): the patient may take the risk of showing his or her analyst the mad introjects, in the hope that the analyst will be able to hold, contain, and repair them—as Ms. A did, unconsciously demonstrating her confidence in the analytic relationship, in order to let the analyst participate in her inner catastrophic experience.

This form of transference can change quickly. In his or her own opinion, the patient has succeeded in getting rid of the mad introject by projecting it into the analyst and controlling it there. The patient then becomes convinced that the analyst is mentally ill and therefore dangerous. At the same time, the patient continues the therapeutic relationship, not only in order to attack the analyst, but also to deposit unbearable feelings, object relations, and parts of him- or herself (e.g., Ms. A's sense of the Gestapo or the meaning to her of the psychoanalytic book). In this manner, the patient establishes a relation with an object that is pathological, but is nevertheless needed by the patient as a mentally healthy container. This object relation seems to be a reactualization of the infantile situation, in which the patient was the prisoner of a horri-

ble paradox: he or she then had the conviction of needing to heal a real or fancied mentally ill parent, because only a healthy object could serve as a container and could function in the service of primary identification. That is, the patient had to be the container *for* the parent in order to be contained *by* the parent, but could be the container only in conjunction with the experience of being contained (as might well have been Ms. A's childhood feelings while living with her ill mother).

This deeply unconscious relation to an object, with individual variations, is central for most schizophrenic patients. It may have several sources, e.g., the real loss of a holding and containing relationship, or the attempt at reparation because the patient believes he or she has destroyed the object. This unconscious object relation may develop within the analytic situation via different forms of transference, often after real events, such as an illness or vacation of the analyst.

In concordant identification with a paranoid transference, the analyst may feel like the patient's dustbin, and as though his or her analytic identity is threatened. (In the case of Ms. A, this was manifested by the analyst's confusion in attempting to understand the patient at the beginning of the session.) Under the pressure of the attacking patient, the therapeutic ego splitting of the analyst is threatened by possible fragmentation and by loss of the inner autonomy required to maintain the triangular position and to be free enough, if necessary, to take the position of the object or the environmental mother (Winnicott 1965). Furthermore, this position can easily turn into a masochistic submission, resulting from the analyst's unconscious conviction of guilt at having failed completely in the work with the patient—and even more, the feeling of having done more harm than healing, as the patient may explicitly claim (as exemplified by Ms. A's analyst's feelings of desperation and guilt at being identified with the Gestapo). The analyst's submission may also result from his or her attempt to soothe the patient's aggression (for example, when the analyst tried to calm down Ms. A about the alleged loan of the book), combined with the analyst's resort to further interpretations or to limit setting. The

analyst may then overlook the patient's narcissistic, frenzied pleasure while enacting this rageful transference, and thus fail to protect him- or herself from the patient and the analytic situation.

If pressure from the patient is strong enough that these identifications seem to be compulsively acted out in complementary identification, we may observe vengeful counterreactions in terms of inappropriate restraints or an aggressive style of interpretation (i.e., an intellectualized or invasive one), as were present at several points in the analysis of Ms. A. Or the analyst may feel the urge to get rid of the patient, either by breaking off the treatment or by forced hospitalization, or by internally withdrawing from the patient, such as when Ms. A's analyst viewed her behavior in nineteenth-century, Kraepelinian terms—that is, as merely an expression of genetic defects. Such a counterreaction may lead to an augmentation of the analyst's guilt (about failing in the treatment or doing harm to the patient), and the analyst then easily falls into the trap of stirring up the negative paranoid transference, either by keeping quiet (e.g., not analyzing transference with the patient in due course), or by appearing to restrain the patient, since the patient will probably find either position to validate his or her deep-rooted distrust. Very often, the analyst may experience an impulse to act out aggressive selfobject units with a third object (the patient's family members, an institution, or colleagues—such as when Ms. A's analyst internally blamed her husband for upsetting her with his uncontrollable need for sex).

A CASE OF NARCISSISTIC TRANSFERENCE

Mr. B

The following clinical material is taken from the psychoanalytically oriented inpatient treatment of Mr. B, who suffered from paranoid schizophrenia, and demonstrates some of the dynamics of typical narcissistic forms of psychotic transferences—e.g., psychotic symbiosis and ideal selfobject transference.

When I first met Mr. B, an attractive and intelligent 30-year-old, he had been ill for more than ten years. He suffered from auditory

hallucinations with sexual and aggressive contents; for example, he saw himself as Agamemnon, raping women and devastating large areas, even whole civilizations. As I came to know during his treatment in a day hospital, Mr. B lived with his constantly quarreling parents. His mother blamed his father for abusing alcohol, and his father blamed his mother for spoiling their son. The family atmosphere seemed to be characterized by an acute lack of boundaries. During our discussions, Mr. B had aggressive outbursts against both parents, with each rage attack subsequently leading to involuntary inpatient treatment. Thereupon, the parents would decide to "try it again"—i.e., to postpone divorce—because they found it impossible "to abandon our son." As soon as Mr. B would return home from the hospital, however, new quarrels arose.

This vicious cycle had persisted for several years, causing the failure of quite a few treatments, and continued during Mr. B's first day hospital course. To further complicate matters, his inpatient therapist of long-standing suffered from alcohol abuse, and Mr. B was forced to interrupt his treatment when the therapist entered a withdrawal program at another clinic. Mr. B reacted with the delusional conviction that the therapist was his father, and insisted on visiting him at this clinic. He then stopped all treatment, claiming that "I don't need my father [i.e., the therapist] any longer," and shortly afterward, tried to commit suicide because voices had commanded him to "end my rotten life." After being rescued, Mr. B agreed to undergo treatment in our day clinic. Initially, the staff and I tried to direct—and thereby limit—the transference, as much as possible, to our day hospital team. Although this turned out to be quite difficult, the harmful acting out between Mr. B and his parents could be thereby gradually reduced. Regular family therapy sessions were also helpful.

From the very beginning of his day hospital treatment, there was a growing irritation toward Mr. B on the part of our team members. Some thought him too ill for a day treatment setting and argued for his return to inpatient status. One female staff member was angry because the patient followed her—"like a shadow," as she put it—gluing his gaze to her eyes and lips and imitating what-

ever she did. Other team members recommended a reduction of Mr. B's neuroleptic medication, considering him healthy enough to switch to outpatient treatment. Either day hospital or inpatient treatment would likely lead to a fixation of his illness, they felt, because he would be continually nursed and pampered like a baby. Furthermore, these team members blamed other members of the team for exploiting the patient for their own needs. Still others were afraid that Mr. B might commit suicide while away from the hospital, and in reverse, blamed other team members for not holding and caring for him enough.

During some periods, these discussions changed to mutual reproaches and the working capacity of the team was threatened. The team's various attitudes reflected Mr. B's mood and behavior as evidenced in the course of the treatment. Although he repeatedly sought the help of a particular nurse in regard to his physical complaints, accepting her assistance, he adopted a distrustful and hostile attitude toward the team as a whole. He felt persecuted, imprisoned, and forced to undergo treatment against his will, experiencing most of the rules and boundaries as means of humiliating him, and he was convinced that the team was manipulating his medication. In spite of these beliefs, however, he improved considerably, especially with respect to his chronic and severe illness; and this occurred without any change in medication from the time of his earlier inpatient treatment. Tension decreased in his destructive relationship with his parents, with the outcome that the vicious circle of parental quarrels followed by involuntary hospitalizations was finally broken. He never missed a day treatment session, the suicidal impulses diminished, and he even started to deal with the realities of his day-to-day life (his job, getting his own apartment, and so on).

Mr. B's relationship with me, his day treatment therapist, was characterized by a completely different attitude from that toward the rest of the team. During our sessions, we achieved a kind of understanding without words. Mr. B often appeared friendly; it seemed that his outlook was pleasant enough and he experienced a sort of well-being. Sometimes he praised my solidity, incorrup-

tibility, sympathy, and insight, while simultaneously complaining about the team's manipulative behavior and exploitation of him, which reminded him of his former therapist. At such moments, I often experienced the "sweetness of [an] omnipotent . . . or saintly feeling" (Eissler 1951, p. 147), and sometimes, I found myself justifying his attitude toward the team as stemming from his relationship with "difficult" parents and a "strange" inpatient therapist, telling myself that he needed to idealize me in order to experience a corrective emotional object relation. I also focused on his social improvements. I caught myself having the fantasy in team sessions that the other caregivers were really behaving too rigidly and lacked a deep understanding of the patient.

At other times, however, I had the feeling of being Mr. B's hostage. As soon as I made a remark other than one of agreement—e.g., if I tried to share my thoughts with him on what was going on, or even merely questioned what he had said—the harmonious atmosphere immediately changed. Mr. B would grow restless and distressed, sometimes angry or confused to a degree that it was impossible for me to process the contents of the session. This lasted for some time, and once I sat back and again became compliant with what he put forth, the sense of harmony returned. In contrast to my "sweet feelings," this experience led to an inner sense of paralysis and to a great deal of anger on my part, as I asked myself whether the patient was rewarding my keeping quiet with symptomatic and social improvement. Furthermore, I felt an impulse to support the team and was suspicious that Mr. B might set up its members against me or manipulate me in some other way. I found that my thoughts frequently led to feelings of guilt and inadequacy. I asked myself if I had overtaxed the patient by not having sufficiently contained his symbiotic needs and idealization. Shouldn't his symbiotic, psychotic object relation be left unquestioned as a defense against his anxiety, in order to avoid the development of a destructive relationship with me like the ones with his father and his former therapist, which had forced him into suicidal behavior? Was I confusing or locking him in with unrealistic therapeutic aims and efforts? Would I run the risk of ruining our

good beginning if I confronted him with my thoughts? Did I wish to protect myself from what the team had to experience with him, trying to rationalize the situation by explaining theoretically that it fit best for me? Sometimes I felt that I was overtaxing myself in trying to connect all these possible levels of meaning.

During this period, a session occurred that began with Mr. B's stepping very cautiously into the treatment room, as though he were trying not to touch the ground. He sat down, kept quiet, and looked around, as if he were visually palpating the office. Then he glanced out the window to the opposite building, looked back to me in fear, and began to grow restless. I followed his gaze and noticed a child sitting on a bench outside the window. Before I could formulate a comment, he said to me: "One has great responsibility." I tried to sort out the situation, wondering to whom he was referring—the child, himself, me, the team, a combination of these? Must he fight suicidal impulses or murderous wishes toward me or the team? I remembered the splitting mechanisms operative in team discussions; did they reflect the patient's actual object relations, consisting of different selfobject units of the patient and his family, reenacted as completely split-off psychotic transference? Or did they express our own problems as clinicians, concerning the economic situation of our day clinic or our realistic limitations with this patient?

While I reflected upon these issues, Mr. B observed me with great fear, and I got the impression that if I moved or said anything "wrong," something horrible might happen. At last, I offered my thoughts, telling him that he might feel panicked because of what he was seeing and hearing here in the session. Perhaps this panic might result from memories aroused in him by the sight of the little child. Perhaps he asked himself whether the day clinic could hold him or would throw him out, and whether I was fully conscious of my responsibility toward him, because I had noted that if I changed my sitting position or used words and thoughts different from his own, he experienced this as a change.

Mr. B then grew even more restless, saying, "I cannot stand changes to me." I then offered that he might experience "changes"

in me, his therapist, as changes in his own self, and the reason for this might be his fear that such changes could threaten his relationship to the team and me, because he might get angry with me and would then be afraid of my revenge, and finally, he would be able to rescue himself only by committing suicide. Subsequently, in the following session, Mr. B talked more about "changes in myself"; he commented on the wind, the movement of the door, passing cars in the street, people's glances—all those "changes" that he concretely viewed as secret signs that something horrible was about to happen, and therefore, he was forced to prevent such changes by means of his thoughts.

Discussion

In the *psychotic symbiosis,* patients like Mr. B are looking for the omnipresence of the good—the almighty, admirable—object, to introject a good object representation into the good self-representation, leading to a fused, ideal selfobject representation. The fused bad selfobject units are split off and externalized (in the case of Mr. B, this was expressed in conflicts with the team and splitting of the team into good and bad members). Clinically, this defensive operation can be seen when the patient claims, frequently without using words, that the analyst or another member of the staff (such as Mr. B's favorite nurse) must be always available, as though the person were as necessary for the patient as air to breathe; this person must fulfill the patient's needs and impulsive bodily desires in a concrete way in order to ensure the patient's well-being. The analyst is no longer experienced as a separate person, but as an extension of the patient's psychic and somatic self.

One function of this transference lies in the patient's efforts to avoid recognition of aggressive and anxious feelings within the therapeutic relationship, which could lead to the development of paranoid interactions. Another unconscious meaning can be seen in the patient's endeavor to establish and maintain an object relationship that makes it possible for him or her to experience what was missed during infantile development (Bion 1962; Kohut 1971). If

this form of psychotic symbiotic transference persists for some time and intensifies, the patient may arrive at the delusional conviction that everything he or she wants will be provided by the ideal object (and perhaps the analyst's real behavior may contribute to this delusion). The relationship will then suddenly change, and the patient becomes deeply afraid of being controlled by the introjected, ideal symbiotic object and of losing the self; or, alternatively, the patient's unconscious feelings of guilt, resulting from intense symbiotic needs, may escalate and promote a vicious cycle.

In concordant identification with such symbiotic needs and wishes, the analyst is apt to feel very close to the patient, and may be convinced that he or she has an uncannily precise understanding of the patient, as though the two of them exist in a kind of fusional state of dual union. As a consequence, the analyst may experience feelings of elation from time to time. In effect denying the reality of the distinction between self and objects—and the presence of polarizing negative feelings—the analyst then begins to take part in the patient's defensive movements. Such a relationship may be established either unconsciously or with the analyst's awareness of it; in the latter case, the analyst may rationalize it with the argument that the (severely traumatized or deprived) patient is in need of a concrete, corrective emotional and/or analytic experience. (An example is the analyst's defense of Mr. B against the "cold and cruel" attitudes of both the patient's relatives and some of the staff.) The analyst may thereby come to contribute to a fixation of this kind of transference. Although psychotic patients are often in existential need of a concrete containing and holding experience by the analyst during the course of treatment (Alanen 1997; Searles 1965; Winnicott 1965), these needs must not be intermingled with the establishment of a narcissistic symbiotic relationship, resulting from pathological symbiosis and its acting in by both patient and analyst.

In complementary identification with this form of transference, the analyst may be afraid of becoming engulfed in the existence of the psychotic patient, without the right to his or her own,

separate existence. (In Mr. B's case, this manifested in the analyst's feeling that he was the patient's hostage.) To defend against such fears, the analyst may adopt a kind of superego position or compulsive separation (e.g., unkind rejection of the patient, very strict limit setting, quick and invasive interpretations—all of which could at times be observed in Mr. B's treatment). Such a stance may well exacerbate the patient's symbiotic needs. Countertransference aggression may sometimes be enacted in the form of a (pseudo)concern that the patient may commit suicide (e.g., the team members' countertransference in the case of Mr. B).

During *ideal selfobject transference*, the patient feels empty or as though life is worthless when away from the analyst, and may develop a fear of death or other deep distress if the analyst tries to resist the patient's grip. Clinically, we can observe this behavior during prepsychotic states, when the patient fights fears of a psychotic breakdown with the help of idealization and awe of the object. It may also be seen when, in the course of treatment, the patient expresses aggressive, hypersexual, or envious parts of his or her personality (in regard to the analyst's real or imaginary behavior, autonomy, and capacities to feel, think, and analyze), and urgently tries to deny them. In contrast to symbiotic narcissistic transference, established and maintained by the introjective identification of an ideal selfobject representation, the patient here uses different variations of projective identification. He or she projects self- and object representations into the analyst, creating a highly idealized, fused selfobject unit, which for the patient does not merely represent, but concretely *is*, the ideal object, and which becomes the container of all hopes and even the life of the patient. (Examples in Mr. B's case were the patient's idealization of the analyst and the patient's reaction to seeing a child on a bench while looking out a window in the presence of the analyst.) The patient thus remains identified with his or her ideal selfobject and participates in the analyst's good capacities. However, this kind of relationship may easily bring about anxiety about being imprisoned within the object, robbed of all separation and individuation (e.g., a fear that Mr. B developed at one point of being un-

able to move without falling down). As a defensive reaction, a paranoid transference may arise, because the patient thinks the ideal object is responsible for his or her catastrophic situation; the patient may even feel that the object has seduced him or her into this ideal selfobject relationship—not to relieve the patient's distress but to exploit the patient and to satisfy the object's own needs.

In complementary identification with an idealizing transference, the analyst may feel him- or herself to be the most important person in the patient's life. The introjection of the patient's idealization can lead the analyst out of defensive and protective reactions and into heroic efforts, in order to save the patient and provide the opportunity to live a life beyond psychosis. The idealization also serves to protect analyst and patient from both the feared hatred of separation and envy within the therapeutic relationship and the recognition of realistic limits of the therapeutic efforts. (This is exemplified by the analyst's experience of "sweet sensations" [Eissler 1951, p. 147].)

In concordant identification, the analyst may feel anxious and desperate in the face of the patient's total dependence on him or her. This recognition of dependence can awaken a fear in the analyst of being devoured by the patient's psychotic needs and greed —a fear that may lead the analyst to harshly reject idealization by seeking shelter in neutrality and abstinence and by remaining distant from the patient, e.g., with an intellectual style of interpretation. The analyst may even actively try to destroy the patient's need of idealization of the object, without taking into account the patient's narcissistic vulnerability or what the patient is able to work through at a given phase of treatment.

It is especially by means of the symbiotic and ideal selfobject transferences that the patient shows the analyst the kind of relationship that, in the patient's past experience, has taken a traumatic turn or has been completely absent—a relationship with an ideal selfobject that would have been of existential necessity for primary identification. Besides the deep longing and desire for this ideal selfobject, the continuing failure and disappointment in such relationships are also part of the patient's attempts to stabilize

his or her narcissistic defenses. If this defensive construction goes unrecognized, and if the analyst allows him- or herself to be seduced over a long period into the role of the healing hero, then all the analytic efforts will only reproduce those disappointments and failures that characterized the patient's past relationships and inner life. If both analyst and patient eventually come to know in the course of treatment that the desired, magical healing remains unsatisfied, the analyst may try to protect both of them from deep disappointment—with the possible consequence of the well-known burnout syndrome: the analyst is perpetually caught within the experience; the patient is stealing his or her alive, good, and healing capacities; and all the analytic effort is doomed to be fruitless.

A third and somewhat different narcissistic transference is characterized by *psychotic omnipotence*. The patient treats the analyst in a cold, arrogant, derogatory, and condescending way; or he or she tries to make the analyst look ridiculous, attempting to deny or triumph over the analyst's helpful efforts while also denying all the self's needs. This transference takes root because the psychotic parts of the patient's personality succeed, at least temporarily, in capturing and exploiting the nonpsychotic parts of both the patient's own personality and the analyst's self. The psychotic parts hold absolute control over the objects, nourishing themselves by psychically or socially exploiting the objects, at the same time denying this because of feelings of guilt and envy. The psychotic parts of the personality also try to maintain the psychic equilibrium by wrecking all interpersonal relationships (as evidenced by the repeated failures of Mr. B's treatments).

This form of transference holds sway when the patient's psychotic parts succeed in defeating the efforts of the analyst and of the patient's nonpsychotic personality parts. Often, it serves as a defense against the symbiotic and ideal selfobject transference, and most often develops if, as treatment progresses, the patient can no longer deny and abolish the reality of differentiation and separation, beginning to experience real feelings of dependency on the analyst. The patient then uses psychotic omnipotence to counteract his or her feelings of deep and split-off envy, which now

threaten to poison the therapeutic relationship. This situation is exacerbated if the patient gets the feeling that he or she has been deceived by the analyst in the past. In this type of transference, the main defense is the mobilization of a grandiose, narcissistic self-object unit (a fused selfobject unit constructed from representations of the real and ideal self and the ideal object), cathected with destructive narcissism (H. A. Rosenfeld 1971a, 1971b; Steiner 1993).

In concordant identification with this type of transference, the analyst may have to fight feelings of meaningless and inferiority, and feels an internal push to turn away from the failure of therapeutic efforts. In this way, the analyst may sink deeper into a sado-masochistic and exploitative or manipulative relationship with the patient. The analyst may feel abused, betrayed, and spit out by the patient. In complementary identification, the analyst may have aggressive-sadistic impulses and fantasies of humiliating the patient by showing him or her that there is no way out of psychosis without the analyst's help. The analyst may experience vengeful impulses and feelings of injury, fostered by the patient's having first praised him or her to the skies, only to later reject the analyst; such impulses can lead the analyst to internally withdraw from the patient. Counteraggression can often be observed in the analyst's diagnosing the patient's defects, or in the analyst's rationalizing intense interpretations as part of the necessity to confront him or her with reality. The analyst might even develop the unconscious fantasy of keeping the patient in a psychotic state, in an effort to maintain his or her position of omnipotence.

A CASE OF MUTE AUTISTIC TRANSFERENCE

Ms. C

In the following account of the case of Ms. C, who suffered from schizophrenia, catatonic type, a fourth variation of the narcissistic psychotic transference is illustrated: the *mute autistic transference*, discussed here particularly in relation to countertransference.

I became acquainted with the then-28-year-old Ms. C in medical consultation. "She doesn't want to live any more," her nephrologist

told me. She was seriously compromising her nephrological and psychopharmacological treatment; several times, she had arrived at the clinic too late for her dialysis session, and once the team had to pick her up at her home. Recently, they had observed Ms. C screaming at the dialysis machine, after which she suddenly lay down, not moving for hours and not reacting when addressed.

Ms. C had suffered from obstructive nephritis from birth, requiring several hospital stays during early infancy, and at the age of twenty-two, she had begun hemodialysis. At twenty-three, she had been hospitalized psychiatrically for a schizophrenic illness, catatonic type. At twenty-five, she received a transplanted kidney, which subsequently turned out to be infected with cancer and had to be removed. She then resumed dialysis.

I learned all this from the clinic documents, not from the patient herself, because she hardly talked about herself, her past, or her present life. Some time after beginning psychotherapy, she was started on neuroleptics and regularly attended dialysis sessions —but with continued screaming at the machine and sometimes even beating against it, after which she would again become mute. Both in and out of the sessions, she often seemed to be deeply confused, e.g., she would come to an appointment too late or on the wrong day. She never canceled a session, however. Most of the time in sessions, she was mute and seemed to be shut in a shell; she was stiff, sometimes exhibiting what appeared to be automatic behavior or making strange faces. If she spoke at all, it was difficult to understand her because she tended to utter only obscure words, repeating them over and over. Therefore, even after the treatment had gone on for some time, I still had no understanding of what (or even whether) she thought about the facts and meanings of her mental or somatic disease.

In the session to be reported, Ms. C arrived fifteen minutes late. She unfolded her jacket and laid it on the couch with the hood lying on the pillow, sat down, and stared mutely at the hood, so that I felt as though I were in the company of two empty jackets. I tried to attune myself to the situation, but soon became drowsy and experienced a feeling of being stalled—a familiar sen-

sation in my meetings with Ms. C. At the same time, however, I felt bewildered, and as though I were part of a strange arrangement of obscure meaning. I asked myself whether the patient knew where she was and what kind of treatment was taking place, whether she remembered me or our last session, and felt the impulse to put these questions to her aloud. Then I thought that this uncertainty might again endure for the whole hour, and I felt some anger and a determination to know something from her—anything—and thought of forcing her to talk to me in order to at least see some evidence of her vital signs. At the same time, I felt helpless because most of the time, Ms. C continued to react in this dead way, no matter whether I shared her silence or whether I spoke.

Again, I asked myself if the patient suffered from amnesia or a brain disease, although this had been diagnostically excluded several times. More and more, I experienced the obligation to share time with this lifeless person as unbearable; the more I grew dissatisfied, the more I had difficulties in concentrating and tuning in to her and the situation; finally, I felt blocked. At last, in desperation, I tried to share my thoughts with her, saying that she might be in great need and distress as a consequence of her experiences up until then with her nephrology treatment (the kidney transplant and subsequent removal, uncertainty about whether the cancerous implant had infected other organs, the long waiting period before again being put on the transplant list, her experiences in dialysis, and so on). Perhaps this had led to a feeling of inner death, I commented, and she had to protect herself from such horrible feelings by abolishing memory in order to carry on without such feelings and thoughts.

Ms. C remained mute, but exhibited strange facial expressions and hand gestures that appeared to reject my comments. I thought she might be drawing back from my thoughts because she feared coming in touch with the horrible anxieties she had tried to project into me. I asked myself whether I might have said too much in my attempt to find vitality in her. Furthermore, I felt pressured because I knew that her nephrologist would not

put her on the kidney transplant list if she (or the psychotherapy!) did not succeed in stabilizing her psychic equilibrium. But I also felt some anger because of her negative behavior, and I asked myself whether she might have felt forced by her nephrologist to come to treatment with me, when she herself did not want it at all. Did she fear psychotherapy in the same way she apparently feared and disliked dialysis?

After a silence, Ms. C spoke, but I could make out only some of her words: "Problems . . . [repeated several times] . . . the dialysis machine . . . the food . . . all problems . . . everything is gluing . . . what is needed is a lamp . . . ." Then she fell back into a fixed silence. I remembered her nephrologist mentioning that Ms. C sometimes used a little lamp to observe the dialysis machine's data. I wondered if she understood the purpose of dialysis and how it works. I explained to her its medical function (to detoxify the blood, with the attendant strict limitations on the patient's food and drink, and so forth), but she failed to react at all to this.

I then asked myself whether Ms. C was perhaps afraid of fusing with the machine during dialysis (a kind of "gluing"), or perhaps with me during sessions, because such fusion was a threat to her sense of self. I told her that I understood dialysis might be a horrible situation for her, combined as it was with her sense of not knowing what was real and what was unreal, as well as not knowing what was going on with her body. At this point, for the first time during this session, the patient looked at me, something she had hardly ever done. Then I tried to describe what I felt might be her dilemma: on one hand, she needed the dialysis to keep her alive, to detoxify her body; but on the other, she feared it because she was restricted and dependent on the dialysis machine; it was something that controlled her, and she could not control it. I wondered if she experienced the dialysis machine as alive? And perhaps she might have the feeling that the machine was sucking her out, like a vampire, and therefore, she had to closely monitor its operations with a lamp, in order not to be killed by it, and she had even considered stopping dialysis altogether.

As Ms. C kept looking at me attentively, I felt encouraged to continue. I said that perhaps her relationship with me might feel like a dilemma, in that she felt she must remain mute and maintain a fixed gaze because she feared that I could take away her thoughts. That is, she was afraid of something similar happening here to what had happened with her kidney transplant: she had sought and was offered help in that regard, but what she got was a bad kidney, just as she might be getting bad psychotherapy from me. So she tried to turn off both my words and her own thoughts, even though she needed help in clearing up her inner confusion.

To my astonishment, the patient looked at me very clearly and directly, and spoke in a way that was not at all confused, but on the contrary, cohesive and coherent. She said that yes, what I had described could well be true, and in fact, she had just thought about this the previous day. She was fed up with this dialysis—it went on for such a long time! Nobody had ever told her how much she was allowed to drink and eat; instead, there were always reproaches from the nephrologist! With growing anger, she expressed the delusional conviction that the dialysis machine had somehow given her a cancerous kidney in order to keep her on dialysis. She stopped speaking suddenly, but continued to observe me closely, and then asked if I could read her mind. I told her that she might be anxious about losing herself inside me because she feared that I could take away her inner self in order to keep myself alive, just as the machine had. For the rest of the session, she maintained clarity in her thinking; she talked about her blood pressure, which she felt to be too low, and her heartbeat, which she thought was too fast.

In the next session, however, Ms. C fell back into muteness, as she had many times before, interrupting this acute withdrawal only with a few obscure words. I experienced her as like a person who is buried alive under a collapsed building, desperately trying to attract my attention. One of the reasons that I was able to persevere in keeping contact with her (though only barely) may have been that many of the interpretations I offered, apart from

the plausibility of their content, were also aimed at the creation of an alive therapeutic atmosphere and at defending against the unbearable feelings described above. I felt caught in an impossible situation in which I had to function as a sort of dialysis process in reverse, in order to keep the patient alive and to maintain my psychic equilibrium. In an unconscious identification with her, I fell into an autistic and at the same time omnipotent position, with the consequence that she felt overwhelmed and overtaxed in attempting to maintain her containing capacities; as a logical consequence, she would again withdraw. In addition, I had barely any knowledge of her anamnesis, and therefore, I could not offer reconstructions that might have helped us understand the enactment.

Discussion

A fourth paradigm of narcissistic psychotic transferences is represented by *autistic transferences*. Descriptively, these can range from pseudoadaptation, which masks an encapsulated psychotic part within the personality (a sort of "bookkeeping by double entry" process), to severe catatonic and stuporous behavior, in which nonpsychotic parts of the personality are locked away behind an autistic wall (D. Rosenfeld 1992). Such patients behave "negativistically," presenting dead material in sessions or speaking in stereotyped and automatic ways. Sometimes, speech and thoughts are fragmented. They seem to exist in dreamlike states or to behave as though frozen, and seem to have great difficulty in maintaining both psychic and physical vital functions (as was evident in Ms. C). Some patients manage to describe such catatonic and mute states during a later period of treatment, in which they characterize themselves as having felt derealized, depersonalized, without bodily feelings, empty, and burned out. Others report having had intense delusions.

This transference paradigm gives a clue to the patient's experience of severe narcissistic threat. It serves several defensive purposes: first, in order to rescue the fragmented self from a com-

plete breakdown into catastrophic fears, the patient commits a sort of psychic suicide (Racamier 1980), trying to eliminate his or her scattered and defective self from all self- and object representations, as well as from all meaning and affects. The patient's entire life seems to be projected into other objects or split off and encapsulated within the mental apparatus (Hopper 1991) or within the analyst. The patient tries to survive by maintaining contact with other objects (H. A. Rosenfeld 1971a), frequently becoming extremely dependent on the analyst's capacity to understand him or her. Another defensive motivation lies in the patient's efforts to abolish all experiences of time and space within the therapeutic relationship, since these could engender painful feelings. The autistic and catatonic relationship may also stem from the patient's impulse to control the threat of confusional states and the seduction of symbiotic desires within the analytic situation. In addition, autistic and catatonic transferences sometimes fulfill the function of defending against severe paranoid transferences: the patient tries to take care of the analyst by reintrojecting a mad introject (in the patient's unconscious view, this may include the mad parts of the analyst's self) and locking it up (through attempts to serve as a container and holding object for the analyst).

If the analyst manages to remain open to projections in the *concordant identification,* he or she may feel a lack of interest in the analysis, boredom, somnolence, or even a state of hypnosis (as evident in the countertransference in Ms. C's treatment), all constituting reactions to the patient's unconscious attempts to attack the analyst's life functions (feeling, thinking, and analyzing). The analyst may then experience a sudden change of feelings in which he or she is caught up in affects and fantasies of internal death, and may be filled with despair and a sense of helplessness at not being able to reach the patient. At other times, the analyst may feel tortured when in the company of the lifeless patient, who indeed appears to be an inanimate marionette, dominated by unknown influences. The analyst may get the impression that the patient is extremely sensitive and fragile, deserving of the greatest caution. In inpatient treatment settings, such feelings may be

bolstered by treatment team members who insist on further diagnostic procedures, because the severity of catatonic symptoms is regarded as apt to result from exclusively somatic sources.

Since such emotions are difficult for the analyst to contain, they may be quickly transformed into complementary identification: the analyst notes that psychotic symptoms seem to be retreating or even vanishing, and begins to focus on the patient's successful adaptation. This complementary position grows out of the wish to animate the lifeless patient, to convince him or her to talk to the analyst about past and present life circumstances, relationships, fantasies, and affects, in order that the analyst may construct or reconstruct meaning (seen, for example, in the analyst's efforts to translate and give meaning to Ms. C's words and behavior—ultimately, to keep the relationship with her alive). If these efforts fail over a period of time, and especially when the analyst observes how quickly the autistic and catatonic behavior can change into intense greed and hatred, the analyst may become gripped by a sense of irritation, expressed in the diagnosis of psychic defect and often combined with the suspicion of some kind of oligophrenia, and/or the analyst's impulse to write off the patient as incurable. In the case of Ms. C, this was exemplified by the fact that the staff of her inpatient unit attempted to have her transferred to another unit.

THE PSYCHOTIC TRANSFERENCE OF CONFUSIONAL STATES

Confusional states can take root in the patient's thoughts, feelings, and behavior with respect to person, time, and space. As was seen over a long period of Ms. C's treatment, such patients more or less lose all sense of continuity in themselves and their lives, in their bodies and in the outer world. They often find themselves in a kind of transitional state in-between awakening, dream life, fantasies, and delusions, unable to distinguish among these. Formal thought process and contents of speech, affects, and sometimes even the totality of the mental apparatus seem disorganized

and confused. Often, psychopharmacological treatment yields no substantial improvement in these symptoms. In some cases, the transference is characterized by the patient's absolute dependence on the analyst's understanding of his or her thoughts and feelings.

I propose the existence of three different categories of confusional states:

1. A less severe state of confusion, characterized especially by the patient's ability to quickly switch between psychotic and nonpsychotic mental functioning. This may represent part of a prepsychotic developmental process, foretelling an approaching psychotic regression. Boundaries between the self, inner objects, and outer objects, as well as between drives and affects, begin to break down because of the intensification of psychotic defense mechanisms against unbearable experiences and emotions. In the analytic situation, this type of confusional state may serve as a protective mechanism against symbiotic or paranoid transferences.

2. Intense and chronic confusion prior to expressions of a delusional state, which may indicate the self's catastrophic inner situation of total dissipation and fragmentation.

3. Confusional states that unfold in more advanced stages of treatment, when the patient, with the analyst's help, tries to separate, differentiate, and integrate selfobject representations that were previously split, leaving the patient unable to use the more "mature" psychotic defense mechanisms of introjective and projective identification.

In complementary identification with the patient's confusional states, the analyst may be concerned about the patient and experience pressure to carry out essential ego and superego functions in the patient's stead. However, if the analyst confines him- or herself to continual, simple translation of confused thoughts and feel-

ings, without trying to interpret possible causes for such confusion —i.e., if the analyst fulfills only the functions the patient assigns to him or her—-further confusion may result, because the patient becomes less and less able to differentiate between him- or herself and the analyst. The patient's regressive dependency needs and unconscious feelings of guilt may therefore even be fortified. Furthermore, the patient may become convinced of a loss of the self, since the object is carrying out all important mental functions in place of the patient. In such cases, the patient may form the impression that the analyst is exploiting the patient's needs and dependency for the analyst's own benefit.

Distinct from the foregoing situation is that in which the patient's nonpsychotic parts feel very relieved if and when the analyst succeeds in naming the causes of the patient's confusion, because that part of the patient's personality always hopes that the analyst will take hold of the healthy parts of the self and strengthen them against the psychotic parts. In other situations, the analyst may face the challenge of trying to get the patient to fill the transitional space with his or her own fantasies and feelings, with the possible consequence that the patient cannot create the subjective object or explore the transitional space alone. In concordant identification, the analyst is likely to feel a diffuse sort of panic, being unable to understand the patient over a long period. Or the analyst may feel as though drowning or going crazy. To protect against these feelings, the analyst may make intense efforts to take hold of and direct the treatment during sessions, such as by making quick and invasive interpretations, in an attempt to fill the gap caused by the missing sense of meaning between analyst and patient.

CONCLUSION

From a treatment perspective, an essential question follows from these considerations: What destabilizes psychotic organization and what stabilizes nonpsychotic parts of the personality? From the perspective of the development of acute pathology, one must ask

the inverse of this question: What stabilizes psychotic organization and what destabilizes nonpsychotic aspects of the self? Is it possible to identify those incidents or causative situations that provoke destabilization of nonpsychotic mental functioning and recharge prepsychotic defense mechanisms, as well as those that stabilize and keep up psychotic defenses and object relations? Can such information be used predictively? It might be of considerable clinical advantage if the analyst, treatment team, family members, and/or the patient could use this data to signal the necessity for early intervention (Altman and Selzer 1995). I shall discuss below some of the relevant incidents and attitudes that are observable within the therapeutic relationship, initiated by either the patient or the analyst.

Concerning the analyst, certain aspects of unconscious subjective and objective countertransference, if unrecognized, may be enacted in the treatment, leading to therapeutic impasses (H. A. Rosenfeld 1987) and misalliances (Langs 1976). The analyst's enactment may function as a repetition of the patient's traumatic infantile situation. Clinical examples of the analyst's *objective countertransference* have been given in earlier sections of this paper. Potential problems resulting from unrecognized *subjective countertransference* are numerous, varying according to the analyst's personality organization. Of central importance is the analyst's unconscious regressive need to maintain the patient's psychotic structure. A narcissistic analyst may need to play the role of the grandiose hero who must heal psychosis, refusing to accept the realistic limits of treatment, because of difficulty experienced in repairing his or her own inner objects. A borderline-structured analyst may fight all psychotic bad and hateful affects and relations, while a hysterically organized one may feel stimulated and aroused by dramatic psychotic syndromes, and a compulsively structured analyst may perhaps attack and persecute psychotic symptoms. A phobic one will contraphobically look for psychosis or try to avoid it. Others may project their own psychotic parts into the patient and control them there, a process resulting from defenses against psychotic parts of the analyst's own personality.

In the patient, causative situations may take the form of unconscious fantasies, which are experienced and played out as concrete convictions in psychotic parts of the personality. Superordinate to all other such fantasies is the psychotic patient's need to maintain a delusional position of absolute power and omnipotence over the object. Within the therapeutic relation, this need can be observed in various forms, most clearly in continual unconscious efforts to make the treatment fail. In this manner, the patient tries to reverse the infantile traumatic situation and to manipulate and exploit, to drive crazy (Searles 1965, 1979), and even to destroy the object on whom the patient is desperately dependent. Furthermore, the real or imagined loss of the analyst often leads to psychotic regressions or further stabilizes psychotic organizations.

Another fantasy stems from the patient's suicidal impulses, which indicate an approaching destabilization of the nonpsychotic personality or the dominance of a psychotic organization. In order to deny all dependence on the object, the psychotic part promises the nonpsychotic part a life without pain, psychosis, bodily needs, or conflicts (H. A. Rosenfeld 1971a, 1971b). Still other fantasies are based on the patient's unconscious envy of the analyst, which lead to negative therapeutic reactions, whose aim is to deny the separation of the self from the object, as well as the existence of psychotic parts of the self. This occurs especially after periods of intensive working through, when the patient may give the impression of being healthy enough to end the treatment. In many cases, these negative therapeutic reactions may develop as a consequence of the patient's self-destructive superego (Bion 1962; DeMasi 2000).

In summary, I believe that the analyst's familiarity with the various forms of psychotic transference described above—especially when combined with recognition of the types of countertransference that they are apt to trigger, as also discussed above—can contribute to successful outcomes in clinical work with this challenging group of patients.

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Millöckerweg 2
D-63452 Hanau, Germany

e-mail: Praxis.Dr.Mueller@t-online.de

Psychoanalytic Quarterly, LXXIII, 2004

WINNICOTT'S RESPONSE TO KLEIN

BY ROBERT EHRLICH, PH.D.

The author suggests that, although Donald Winnicott presented some important criticisms of Melanie Klein's work, at times he tried to advance his perspectives too definitively without adequately considering her own. Because of this, he failed to acknowledge sufficiently that he was offering a model of human nature and development that could be revised. The fact that his differences with Klein arose in the context of a complex relationship in which each played numerous roles for the other, especially in the context of their affiliation with the British Psychoanalytical Society, periodically made it difficult for him to present his ideas more carefully and in his more characteristically open manner.

INTRODUCTION

Up until the present, the history of psychoanalysis can be described in part as a set of theoretical disputes between some of its major figures. The conflicts that Freud experienced with Jung and Adler, which he discussed in "On the History of the Psychoanalytic Movement" (1914), foreshadowed later conflicts between him and others, as well as future disputes between other important theorists.

One of these disputes is embodied in Winnicott's response to the work of Klein and some of her followers. The nature of this

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A different version of this paper was presented on May 11, 2002, at the Psychoanalytic Institute of Northern California, San Francisco.

response was based on an appreciation of Klein's work, as well as a critique that became more sustained as Winnicott grew older. For as he developed, Winnicott came to put forth his own theory of early infant development, which, while utilizing some of Klein's thinking, departed from her work in significant ways. In this paper, I will focus on the differences that he had with her regarding four major ideas: (1) the nature of the psychological development of the infant; (2) the idea of the death instinct and the nature of aggression; (3) the concept of envy; and (4) the role of the environment, especially the mother, in shaping the infant's inner life. The perspective that each took on these interrelated issues was very important in determining what, when, and how they intervened when working with patients. In this context, it is important to remember that from his critique of some of the features of Klein's work, Winnicott developed a way of working with patients that at times differed from her own.

Unfortunately, it became difficult for Winnicott to view his differences with Klein as incapable of resolution because of some of the phenomena that they encompassed: namely, those relating to the elusive inner world of the infant. The fact that their dispute was played out institutionally, especially in the British Psychoanalytical Society, intensified it. In this context, it might be useful to view Winnicott's contribution as part of what Flax, utilizing the work of Foucault (1977), calls "a discursive formation" (Flax 1993, p. 37). For Flax, this term refers to the way that available forms of knowledge are historically rooted and institutionally sanctioned. She calls psychoanalysis a discursive formation because she believes that it provides a set of models for understanding the nature of inner experience, and that these models are embedded in history and shaped by the institutional settings in which they are advanced.[1]

[1] In a similar manner, Wallerstein (1988) has referred to the way that Freud's work "has . . . eventuated in our present-day pluralism of perspectives with varyingly inconsistent psychoanalytic theoretical structures to which we differentially adhere, depending mostly, it should be added, not on grounds of inherent appeal, plausibility, or heuristic usefulness, but rather on where and how we were trained, and

Like Klein, Winnicott came to believe and tried to convince others that he had discovered certain truths about inner experience that could be applied transhistorically and transculturally. In doing this, he was perhaps not sufficiently sensitive to the way that his own ideas grew out of his personal experience and the institutions in which he was trained and worked, as well as the larger history in which these influences could be situated. Though his style of presentation often suggested considerable openness to ideas different from his own, Winnicott ultimately embraced a particular vision of human development that at times differed with that put forth by Klein. I would argue that despite his attempt to portray himself as a helpless victim of attacks by Klein and some of her followers, Winnicott periodically advanced his ideas with a degree of certainty comparable to that which he attributed to those who criticized his own work.

Today, this style of presentation is increasingly challenged, so that Flax (1993) suggests that, unless psychoanalysis comes to be transmitted as a set of theories and practices that are viewed as part of a discursive formation, it may not survive. As she puts it, given her concern with the degree to which analytic ideas are frequently put forth in a dogmatic manner, "intolerance of difference, disorder, and complexity or a wistful political innocence will doom the discourse of psychoanalysis to increasing marginality and obscurity in the postmodern world" (p. 58).

In his response to Klein, Winnicott became increasingly critical and even failed to appreciate fully the manner in which he had influenced her work. Though he often presented important criticisms of some of her major ideas, at times he failed to capture the

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where we then live and practice" (p. 10). I would like to indicate here that I was trained at a psychoanalytic institute committed to the idea of exposing candidates to diverse views on metapsychology and clinical theory. My interest in comparative psychoanalysis is in part the result of this training and, I hope, is reflected in this paper. In utilizing a variety of sources, such as letters, biographical studies, texts by Winnicott and Klein, and commentaries on the work of these major figures, I have tried to present a plausible perspective on Winnicott's response to Klein. I am aware that there are other plausible perspectives that could be brought to bear on the issues explored here.

complexity of her thinking. This does not invalidate his critique. But it does suggest that at moments, he engaged in a kind of thinking that occurs too often in the field of psychoanalysis: that is, the tendency to generalize in a manner that discounts or even distorts the views of others, while at the same time presenting one's own views as far more legitimate.

Winnicott (1969), then, occasionally appeared to lose a sense of what he eloquently referred to as the importance of acknowledging "the limits of my understanding" (p. 711). Though he made this comment in the context of his work with patients, I believe it is useful to consider it in relation to his critique of Klein. For with her, he was capable of advancing his ideas with an uncharacteristic sense of absolute certainty. Ogden (2001) has stated that "the most distinctive signature of Winnicott's writing is the voice. It is casual and conversational, yet always profoundly respectful of both the reader and the subject matter under discussion" (p. 301). Ogden adds that "there is an extraordinary intelligence to the voice that is at the same time genuinely humble and well aware of its limitations" (p. 301). But in his critique of Klein's work, I would argue that Winnicott presented his ideas as if they were incontestable truths, and therefore that he violated the spirit of psychoanalytic pluralism.[2] He appeared intermittently to engage in a battle for his very intellectual life that had significant emotional implications, and perhaps that is why the subtlety and complexity of his thinking can be undermined.

BACKGROUND

I suggest that Winnicott's struggle began with his initial exposure to Klein. Referring implicitly to his work as a pediatrician and his

[2] In speaking of psychoanalytic pluralism, I am referring to what Wallerstein (1988) calls "a pluralism of theoretical perspectives, of linguistic and thought conventions, of distinctive regional, cultural, and language emphases" (p. 5). I believe that it is important to use this diversity as a way to develop the field of psychoanalysis through a process of continual assessment of issues pertaining to metapsychology and clinical theory.

growing interest in psychoanalysis, he stated that it was "difficult for me because overnight I had changed from being a pioneer into being a student with a pioneer teacher" (1962a, p. 173). It was Strachey, his first analyst, who led Winnicott to Klein in a manner that might be called questionable: Strachey told him in a session that "you will not get what Melanie Klein teaches in my analysis of you" (Winnicott 1962a, p. 173). In addition, it is perhaps significant that Winnicott's mother died when he was twenty-nine years old, in 1925, just before Klein came to England a year later at the age of forty-four.

By 1927, Winnicott had become acquainted with Klein's work. He was especially impressed by her book *The Psycho-Analysis of Children*, published in 1932. He had additional incentive to read it since it had been translated by Strachey's wife (Kahr 1996, p. 58). Winnicott acknowledged the importance of the book, which corroborated in many ways his observations of infants, with whom he had worked for years as a pediatrician. In addition, he found Klein's attempt to describe the inner world of the infant enormously helpful in his work with children, as his practice became more psychoanalytic (Kahr 1996, p. 58). Early in his career, he was so absorbed by Klein's thinking that the paper with which he graduated from the British Society in 1935, on "The Manic Defence," was itself a response to Klein's work of that year entitled "A Contribution to the Psychogenesis of Manic-Depressive States."

His allegiance to Klein is also reflected in the fact that he sought to be analyzed by her after his relationship with Strachey ended in 1933. This set in motion a process in which each of them would come to assume various roles of questionable compatibility, if not mutual exclusivity. In this instance, Klein did not accede to his request because she wanted him to analyze her son, which he did from 1935 to 1939 (Kahr 1996, p. 60). She also wanted to supervise her son's analysis, which Winnicott refused to allow, although he was supervised by her on other cases for approximately six years during this period. At this time, he praised Klein "for her lack of rigidity" (Kahr 1996, p. 59)—not something that he would have been likely to do later, when their relationship changed.

In addition, according to Rodman (2003, p. 77), in 1936, Winnicott began an analysis with Joan Riviere, one of Klein's most important associates in the British Society.[3] This analysis lasted about five years and helped to place Winnicott so much within the Kleinian orbit that Klein "named him as one of five Kleinian training analysts" (King and Steiner 1991, p. xxiv). Moreover, throughout "The Controversial Discussions" that went on in the British Psychoanalytical Society from 1941 to 1943, Winnicott generally sided with Klein rather than with Anna Freud, although he "played a rather minor role" (Kahr 1996, p. 82) in the disputes because he had only recently graduated as an analyst. Furthermore, he assumed the role of confidante for Klein, who at times told him of her fears about the acceptance of her work (Grosskurth 1986, pp. 259-261). Her conviction about her own ideas led her to make a rather dubious analogy between the British struggle to remain free in the face of the Nazi onslaught and the attempt to preserve her work in the face of the opposition she encountered in the Society. Demonstrating the tenacity of her convictions, which would plague Winnicott in the future, she said, "Each of us, of those who have got most hold of it have to keep great vigil not to let it slip" (Grosskurth 1986, p. 260).

Nevertheless, even in the course of his analysis with Riviere, from whom he received considerable personal help (Kahr 1996, p. 67), Winnicott was beginning to develop his own ideas. When he indicated that he was interested in writing a book about the importance of the environment in shaping human development, Riviere became somewhat annoyed with him, according to his own account (Padel 1991, p. 336). I believe that this skirmish with his analyst foreshadowed Winnicott's later difficulties not only with Klein, but also with Anna Freud. Speaking of the rift between Klein and Anna Freud, Rycroft "has suggested" (Kahr 1996, p. 82) that Winnicott might have felt forced into the role of younger brother (as with his two older sisters). Just as he had to extricate

[3] Rodman's biography of Winnicott appeared after this article was accepted for publication. Therefore, I was unable to utilize fully his valuable observations.

himself from the pressures of his early home environment in Plymouth, England, Winnicott had to deal with "the partisan pull" (Kahr 1996, p. 83) of these women in the British Society. Ultimately, he at least partially did so by helping to create the Middle Group of British Independents. It was only after World War II, with Klein's publication of *Envy and Gratitude* in 1957, that their differences became so unbearable for Klein that, in Winnicott's eyes, she essentially rejected his work.

But even before Winnicott's response to *Envy and Gratitude*, the two had their differences. However, whatever their disagreements were early in his career as a psychoanalyst, they were not enough to lead him to indicate forceful opposition to her central perspectives or to claim that her understanding of infancy, however profound, was also limited. He came to this latter position slowly, as his thinking developed. For Klein, this amounted to a repudiation of her conception of infant development. Winnicott thought otherwise. He believed that he was describing phenomena that belonged to an earlier stage of development than that described by Klein. Even as he began to lay out his own differences with her, he was aware of the fact that it was Klein who stimulated him to think about the many ways that the mother might have an impact on her baby's inner experience (Kahr 1996, p. 60). He presented his position in 1945 in his paper on "Primitive Emotional Development," which in part spurred Klein to publish her own version of what went on during this earliest phase in her work, entitled "Notes on Some Schizoid Mechanisms" (1946).

After the war, their relationship became increasingly contentious, with Winnicott seeking approval not only from Klein but also from Riviere. He did not believe that he ever obtained anything even close to acceptance, claiming that Klein especially thought he had nothing of any real or original value to contribute to the growth of psychoanalysis. According to Winnicott, his ideas about the power of the environment in shaping the infant's life, particularly the importance of the mother and the bond that she helped to create with her baby, were not sufficiently developed in Klein's work; while according to her, he failed to acknowledge

that she had already adequately dealt with these issues. In this context, it might be useful to consider Rycroft's remark that the Klein–Winnicott relationship was "an 'exercise in mutual non-comprehension'" (Kahr 1996, p. 77). In addition, Winnicott's critique of Klein's conception of the death instinct and aggression, as well as of the significance of envy, was a constant source of irritation to Klein.

Despite his identification of limitations in her work, Winnicott continued to recognize Klein's extraordinary ability. His second wife, Clare, who in the 1950s was a candidate at the British Psychoanalytical Society, indicated that she wanted to undergo a second analysis and wished to work with Klein. Given the stormy nature of his relationship with Klein at the time, it is surprising that Winnicott did not try to discourage his wife from doing so. In fact, he not only supported her decision, but actually went to see Klein to speak on his wife's behalf, indicating that she "owed him a favour" (Kahr 1996, p. 92) because he had analyzed her son. Furthermore, Winnicott interceded on his wife's behalf again once the analysis was in progress. His wife had left a session early and in an angry manner because, according to her, Klein delivered a 25-minute interpretation of one of her dreams. As a result, Klein wanted to terminate the analysis based on what she believed was Clare's overly "aggressive" nature (Grosskurth 1986, p. 452). Winnicott intervened by speaking with Klein as well as with his wife, so that the analysis resumed.

From Clare Winnicott's standpoint, the analysis was less than satisfactory, since she believed, for example, that Klein "implanted her own theory on what you gave her. You took it or left it" (Grosskurth 1986, p. 451). It is tempting to agree with Grosskurth, who has wondered whether, throughout all of this, Winnicott may have been "trying to persuade Klein, through his wife, of some of his ideas, particularly about the importance of environmental factors" (p. 453). That he did not succeed in this venture makes his continuing admiration for Klein all the more impressive. For Winnicott spoke highly of Klein during the last years of her life. In his writing, including his letters, he constantly indicated his respect and

admiration for her. His harshest criticism he reserved for some of Klein's followers, who, he believed, were turning her ideas into dogmatic assertions that were not sufficiently tested by experience or open to revision.

WINNICOTT'S CRITIQUE OF KLEIN

In order to provide a basis for understanding how Winnicott misrepresented aspects of Klein's work while advancing his own point of view, I will turn now to his criticism of parts of her theory. Given the complicated nature of their personal and professional relationship, it is not surprising that Winnicott's thinking about psychoanalytic issues was not only constrained but also nurtured by Klein, whose ideas he used as a point of departure for his own work (Phillips 1988). He stressed the latter by suggesting that, in general, he absorbed the perspectives of others and was not particularly preoccupied with the origin of his ideas (1945, p. 145). But with regard to Klein, I would argue that he did not simply "gather" (p. 145) her ideas, as he did with others, but that at times, his thinking was limited by the way he approached her work.

The core of his response to Klein was that the role of the actual mother in the life of the baby tends to be underplayed in Klein's thinking, as she portrays the infant's search for gratification as occurring under the sway of the instincts. For Winnicott, one can understand the baby's earliest psychological condition only by fully exploring not only the power of the instincts in shaping inner experience, but also that set of conditions under which the infant literally comes into psychological existence under the care of the mother. Winnicott (1960) called this the achievement of "unit status" (p. 44), that condition of at least minimal integration in which one can assume the ego has begun to exist. It is then that the infant can start to psychologically metabolize its instinctual life, which in the beginning consists primarily of a state characterized by a continuum, ranging from quiet to excited moments, and under the best circumstances leads to an inner sense of "personal going on being" (Winnicott 1960, p. 47).

Therefore, Winnicott challenged Klein's conception of the earliest phase of infant development, which she believed was dominated by the need to control aggression as a manifestation of the death instinct (Klein 1932, 1935, 1940, 1946, 1952, 1957, 1958). Her attempt to utilize Freud's theory of the relationship between Eros and the death instinct was opposed by Winnicott. At one point, he uncharacteristically stated with great certainty that "Freud's one blunder" was "the concept of the life and death instincts" (1952d, p. 42). But Winnicott did not indicate that Freud (1920, 1923, 1930, 1933) often advanced his ideas about these instincts tentatively, as hypotheses, and as part of his metapsychology, which he repeatedly stated could be revised if other, more useful explanatory principles were found.

In his conception of human development, Winnicott stressed that, because of its undeveloped state, the infant at first exists in a state of unintegration. Its initial need is to feel rooted in its body, a condition that can only arise with adequate maternal care. Winnicott was convinced that the mother's principal task at this stage is to allow her baby's chaotic urges to be brought together through her attunement to its physical and emotional needs.

Winnicott believed that Klein did not sufficiently acknowledge the necessity for this kind of attunement on the part of the mother. Moreover, he thought that Klein's emphasis on the interaction of various manifestations of the life and death instincts within the baby prevented her from acknowledging the importance of the inner experience of the mother. According to Winnicott, it is not the infant's hatred that is critical at this stage, but the mother's—for her anger must arise, especially in the context of the demands placed on her by the baby. The infant's fate may hinge upon how the mother is able to tolerate her own aggression and still remain receptive to the infant's scattered urges during its state of unintegration.

For Winnicott, aggression is there from the outset in the condition of unintegration, but in a form different than that taken as development proceeds. He stated that for the newborn, aggression is primarily "oral erotism," which then "gathers to itself aggressive

components" (1950, p. 205). That is why Winnicott wrote that in the earliest months of life, "aggression is part of the primitive expression of love" (p. 205). At this point, the infant's state of development is characterized by a predominance of "unconcern or ruthlessness" (p. 206). Here the infant is unaware that the mother who is attacked during periods of excitement is identical to the mother who is available during relatively quiet moments (p. 206).

Winnicott's rejection of the idea of the death instinct was based on his belief that aggression is not initially destructive. In fact, he suggested that it is only under the condition of some rudimentary form of ego integration, which takes place as development proceeds, that the infant can experience anger. For Winnicott, then, in the earliest phase of infant development, "aggressiveness is almost synonymous with activity" (1950, p. 204). He also stated that we use "the term aggression sometimes when we mean spontaneity" (p. 217). For him, the biological roots of aggression lie in the fact that it is inextricably tied to "motility and erotism" (p. 217). Although he did not sufficiently acknowledge it, here Winnicott appeared to be drawing somewhat on Freud's (1923, 1940) conception of the natural fusion of Eros and the death instinct. While Freud (1911, 1931) was aware of the importance of the mother's care in the infant's life, and particularly of her role as an auxiliary ego, he explored more fully the power of the instincts.[4] With regard to the issue of the fusion of Eros and the death instinct, Freud (1923) underscored the underlying physiological nature of this process. In contrast, Winnicott (1959b) stressed the idea that the condition of fusion is fully dependent on the existence of an environment that is sufficiently "adapted to the needs of an infant" (p. 127).

Emphasizing the importance of this first manifestation of aggression in motility, Winnicott stated that it "makes the erotic ex-

[4] In speaking of the degree to which the infant is "a slave to the pleasure principle" and neglects "the reality of the external world," Freud suggested that both these factors raise the issue of just how the baby can survive. Freud (1911) then stated that, "The employment of a fiction like this is, however, justified when one considers that the infant—provided one includes with it the care it receives from its mother—does almost realize a psychical system of this kind" (p. 220 n).

perience an experience" (1950, p. 216). He linked motility and aggression repeatedly, and in this context, he wrote: "The summation of motility experiences contributes to the individual's ability to start to exist" (pp. 213-214). Here he pointed to the movement of the fetus, especially its kicking, which is the precursor of the infant's ability to "pour as much as possible of primitive motility into the id experiences" (p. 211).

Again, without any reference to Freud (1923), who detailed the consequences of defused aggression, Winnicott spoke of this condition which, he believed, was likely to emerge only with the birth of the infant. Stressing the external factor, he stated that "the amount of aggressive potential an infant carries depends on the amount of opposition that has been met with" (1950, p. 216). The opposition met with during the trauma of birth is critical here, which points to the power of the frustrating environment in eliciting aggression. That this opposition is a necessary part of human development was often indicated by Winnicott. Even the earliest feeding processes can be robbed of "zest" (Winnicott 1954a, p. 268) if the infant is satisfied too quickly or too thoroughly.

Nevertheless, he was more concerned with the condition in which the infant meets with too much opposition. In such cases, a sense of feeling impinged upon may result. Unable to find a place of rest, the infant may have difficulty sustaining a core of aliveness. When this occurs, motility may be used not so much to discover the world, but more in the service of withdrawal. It is in this context that Winnicott spoke of a self that may be primarily given over to aggression. He stressed the reactive nature of this aggression, stating that it is "not dependent on biological factors" (1950, p. 217), unlike Freud (1920, 1923, 1930, 1937) and Klein (1932, 1935, 1946, 1952, 1957), for whom the constitutional element was paramount.

I think that Winnicott also implicitly challenged the emphasis by Freud (1915, 1930) and Klein (1932, 1935, 1940, 1946, 1952, 1957, 1958) on the destructive power of aggression. For Winnicott believed—more so than both these figures—that aggression is essential to growth. Speaking of the importance of opposition, Winni-

cott stated that it can contribute to the infant's development if properly dispensed by the early caregiving figure. According to Winnicott (1950, p. 215), when the infant begins to become differentiated from the environment, its aggression is responsible for this process moving forward. Winnicott suggested that this process begins even in the womb. He spoke of the way that "the foetal impulses" push for "a discovery of the environment," and therefore create the basis for "an early recognition of a *Not-Me* world and an early establishment of the *Me*" (1950, p. 216). Moreover, the existence of some form of opposition coming from the environment allows aggression to achieve some measure of satisfaction. Winnicott indicated repeatedly that adequate attunement to the needs of the infant involves the creation of an atmosphere to allow for this.

It is within this framework that Winnicott criticized Klein's (1957) conception of the importance of envy in the earliest phase of infant development. Unlike Klein (1957), who believed that envy was innate and therefore present from the beginning of the infant's life, Winnicott stated that envy emerges later, once a degree of ego organization has been achieved. For him, " 'envy' implies an attitude, something maintained over a period of time" and "a perception of a property in the object, a property which is not a projection from the subject" (1959a, p. 444). In order for envy to exist, the infant must have achieved at least a minimal sense of separateness from the caregiver, something which, according to Klein (1952), exists from the beginning, but which Winnicott, like Freud (1923), claimed came about only through development. For Winnicott, in the beginning, the infant is completely dependent on its environment and therefore unable to be aware of its separateness. He did not believe that Klein explored this condition of dependence fully enough, which in turn led to her emphasis on envy as a constitutional given linked to aggression.

According to Winnicott (1959a, p. 444), Klein left out of her analysis of envy the importance of the role of the caregiver, particularly the manner in which the caregiver presented the world to the infant. More specifically, he stated that the infant can exper-

ience envy "for something good about" the mother if the latter "is tantalising in her presentation of herself to the infant" (p. 445). In using the word *tantalising* here, he was referring to a specific condition of deprivation that arises when there is a disruption of the relationship between mother and infant. Under the best conditions, "the creative element in the infant is met and the infant begins to perceive that there is something good external to the self" (p. 445). In this context, the mother must be sufficiently present and receptive so that her infant's projections of goodness can feel corroborated.

Envy arises when the infant feels that the goodness emanating from the external world "is not sustained so that to some extent the infant feels deprived" (Winnicott 1959a, p. 445). It is with this condition in mind that Winnicott spoke of the aggression linked to envy. The infant becomes enraged when its projections are not received by a mother who at one time was experienced as good enough. Winnicott even went so far as to suggest that when the mother's adaptation to the infant is extremely good, the issue of envy cannot arise. However, he added that even under the best of circumstances, not all the infant's needs can be met.

Winnicott's stress on the importance of the early caregiver led him to place special emphasis on the infant's capacity to move out of a condition of absolute dependence. His paper on "Transitional Objects and Transitional Phenomena" (1953a) was intended to explore this process. Here he once again responded to Klein, in part, and in a somewhat critical way. Padel noted that the article, along with everything that Winnicott wrote in the 1950s, was "addressed to Klein, as though [Winnicott] were trying to persuade her of his point of view, particularly about 'good enough mothering' and the importance of the environment" (Grosskurth 1986, p. 399).

Winnicott presented his ideas about the transitional object in an attempt to create a bridge between the inner life of the infant and that which is outside itself. Klein was not pleased with the fact that he did not sufficiently incorporate her ideas into the paper. She "wanted him to revise" it, which he declined to do (Grosskurth 1986, p. 398). In this essay, he stressed the idea that the infant's in-

ternal objects are very much affected by the quality of care that the mother provides. More specifically, according to Winnicott (1953a), "badness or failure" of the actual caretaker "indirectly leads to deadness or to a persecutory quality of the internal object" (sic) (p. 94). If Klein might have corroborated these views, it is still difficult to imagine that she would have accepted Winnicott's critique of her conception of the "good breast."

In speaking of the breast as the "first object," Winnicott (1953a, p. 95n) once again attempted to reconfigure Klein's terminology. In a letter to Riviere in 1956, he indicated that "unless [the mother] can identify very closely with her infant at the beginning, she cannot 'have a good breast,' because just having the thing means nothing whatever to the infant" (p. 96). In addition, he suggested that the term *good breast* should refer to "a technique. It is the name given to the presentation of breast (or bottle) to the infant" (1956, p. 96).

That "technique of mothering" is carried out, in part, by the transitional object that Winnicott conceptualized as a real possession, like a blanket, whose psychological place is an intermediate location between the infant's purely subjective internal world and the real, objective, external world (Winnicott 1953a, p. 95n). The transitional object serves as both a link to the mother with whom the infant is merged, and a gateway to the world outside, whose independent existence is experienced as threatening. The object serves both to ward off the dangers of separateness and to provide a modicum of safety from which the infant can link up with that which is different from itself.[5]

For Winnicott (1954a), the existence of this object helps bring the infant closer to the depressive position, where its "love and hate" (p. 263) can be brought together in relation to the same person. Here he echoed Klein (1935, 1940), who first introduced the term *depressive position*. However, unlike Klein (1952), who empha-

[5] I am indebted to Grosskurth (1986, pp. 397-398) for her extensive comments on the degree to which Winnicott's formulation of the idea of the transitional object is interwoven with his debate with Klein.

sized the power of the infant's "love-impulses" (p. 208) and the synthesizing capacity of its ego in describing the modification of splitting processes, Winnicott (1954a) stressed the role of "the mother's technique" in enabling the infant to tolerate the coexistence of "love and hate" (p. 263).

Winnicott was particularly concerned about Klein's (1935, 1940, 1946, 1952, 1958) suggestion that this highly complex process of integration could occur earlier in the infant's life than the age of five or six months. In addition, he challenged Klein's use of "the term depressive position" because he believed that it "seems to imply that infants in health pass through a stage of depression, or mood illness" (1954a, p. 265). Although he embraced her concept of the manic defense as a technique to avoid the anxiety attendant to the depressive position, he intimated that she did not indicate clearly enough the way in which the manic defense is often utilized. He cited as an example the "liveliness" of dancers performing in a "music-hall" (1935, p. 131).

In order to downplay the depressive element in the depressive position, Winnicott noted that a better term for this phase might be the "Stage of Concern" (1954a, p. 264), which, he acknowledged, was embedded in Klein's (1935, 1940, 1946, 1952, 1958) ideas about the reparative process. In his description of what occurs in this stage, he emphasized the achievement of the movement "from pre-ruth to ruth" (1954a, p. 265), again noting the necessity of an ongoing adaptation to the baby's needs. For Winnicott, central to the depressive position was the infant's ability to perceive that the mother who provides for its well-being is the same person who is "used and even attacked at the instinctual climax" (1954a, p. 267). It is with this foundation that the infant may develop the awareness that the mother has been able to survive its assaults (p. 268).

On this basis, Winnicott believed that it is during the depressive phase, and not earlier—as Klein (1932, 1946, 1952, 1958) would have it—that the infant experiences "the beginning of the recognition of the existence of ideas, fantasy," and "imaginative elaboration of function" (Winnicott 1954a, p. 267). Therefore, part of what Klein described as taking place in the paranoid-schizoid position

actually occurs, according to Winnicott, in the depressive position. For he indicated that it is only in the latter that the infant begins to develop anxiety about what is going on inside itself. The infant's belief that it has created a "hole" (1954a, p. 269) in the mother through its search for instinctual satisfaction is very important here.

But unlike Klein, who stressed the infant's reparative inclinations, Winnicott suggested that it is equally important for the mother to be able to accept all the infant's gestures of concern. He emphasized the interactive nature of this process, for as it takes place, "the infant becomes able to accept the responsibility for the total fantasy of the full instinctual impulse that was previously ruthless" (1958, p. 23). The infant can then develop a "sense of guilt" as well as the "capacity to give, because of the sorting out of the good and the bad within" (1954a, p. 270). Although Winnicott was aware that part of his perspective here was a restatement of Klein's position, he also suggested that Klein and her followers did not use words like *reparation* and *restitution* carefully enough; he noted that these "words which mean so much in the right setting . . . can easily become clichés if used loosely" (p. 270).

WINNICOTT'S MISLEADING REPRESENTATION OF KLEIN

I suggest that, although he thought he was presenting a very different perspective than Klein had about the earliest phase of infant development, Winnicott made observations that could be said to dovetail with some of her central concepts. I believe that in doing so, he omitted from his analysis certain ideas advanced by Klein, and that his criticisms of her can at times be misleading. Once again, the possibility for a genuine pluralism is undermined, as Winnicott is intent upon presenting his own perspective without adequately discussing Klein's views.

While he made it clear that he could not accept Klein's conception of the paranoid-schizoid position, Winnicott acknowledged that his own views about the earliest phase were "related to

that which Klein describes" (1952b, p. 226n). He stated that in the phase before the onset of the depressive position, "the baby is developing a memory system and a self-awareness that become available for projection" (1962b, p. 453). However, he did not describe in detail the content of this condition of unintegration, except to indicate that it consists of states of continuity and discontinuity, which give rise to comfort and discomfort, especially in the context of the possibility for impingement. Under the best circumstances, the infant lives in a pleasurable state, one that is at least partially derivative of "the life-force" (1950, p. 216). It is the existence of this force that suggests the degree to which the infant is governed by the instinctual, even if it cannot be experienced early on. Winnicott's reference to this force in the context of his emphasis on early "muscular erotism" (p. 216) points to Freud's (1923, 1940) concept of Eros, in which the nature and transformation of the sexual element is paramount.

Winnicott's idea of this force also evokes Klein's concept of the life instinct (1952, 1957, 1958), which is the origin of the infant's sense of the good breast. But Winnicott did not directly acknowledge his debt to Freud or Klein here. With regard to Klein, he stressed that he did not like the term *good breast* because he did not believe that the newborn baby, so dependent on its environment, can have any conception of good or bad. The possibility of imputing goodness or badness to anything, according to Winnicott (1971), can come about only when the infant has become a "unit," that stage "of 'I am' " which "is very closely allied to Melanie Klein's . . . concept of the depressive position" (p. 130).

What disturbed Winnicott a great deal was that Klein did not acknowledge sufficiently the undeveloped state of the infant's ego. For example, Winnicott challenged Klein's (1946, 1952, 1957, 1958) belief that the baby of three months has an awareness of its internal world. Winnicott (1963) went so far as to say that in the earliest period of the infant's life, "the word internal cannot be used in the Klein sense" because the baby is too psychologically joined with the mother to allow for the kind of differentiation that is the basis for the use of the "mental mechanisms of projection and in-

trojection" (p. 185). He stated that, in her conception of the early ego, Klein overvalued certain processes that one would associate with a more developed person (1954b, pp. 57-58).

I think that Klein might have done that, but not to the extent that Winnicott suggested. Klein (1946, 1952, 1958) acknowledged the degree to which the infant's earliest days and months could be characterized as a fluid, unintegrated—if not chaotic—state. In fact, she acknowledged just how "helpful" was "Winnicott's emphasis on the unintegration of the early ego" (1946, p. 100). Although, unlike Winnicott, she did not conceive of the condition of primary unintegration as a lasting source of creativity, she implied her debt to him again when she stated that "the early ego lacks cohesiveness and that a tendency towards integration alternates with a tendency towards disintegration, a falling into bits" (p. 100). It is in part because of this description that she utilized the term *paranoid-schizoid* to characterize a dimension of the infant's early experience. But Winnicott did not like this expression because of its emphasis on certain processes that he believed occurred later in infant development: namely, projection and introjection. Nevertheless, in his discussion of the dangers of impingement, he did speak of the possibility of the pervasiveness of paranoia for the infant and the use of schizoid defenses before the depressive position is reached. Unlike Klein, he discussed these issues almost entirely in the context of the failure of the mother to respond to the needs of the infant.

According to Winnicott, adequate adaptation to the baby's needs in the beginning allows for a condition of "undisturbed isolation" (1952b, p. 222) and the possibility for a natural discovery of the environment. Failing this, the infant may become a "reactor" to "impingement" (p. 222). In this context, Winnicott stated that the baby may experience a breakdown of its sense of self, which can be recaptured through a "return to isolation" (p. 222). He added that no infant experiences perfect adaptation to its needs. Therefore, impingement is ubiquitous, but ideally, it is modulated. It is surprising that Winnicott (1952b) placed so much emphasis on the role of "intellectual processes" (p. 225) in allowing

the baby to overcome these inevitable failures, given his characterization of Klein's view of early infancy. For he noted that "intellectual understanding converts the not-good-enough environmental adaptation to the good-enough adaptation" (p. 225); but he did not elaborate on the nature of these "intellectual processes" (p. 225) in the earliest stage.[6]

Winnicott did draw on Glover's conception of the existence of ego nuclei to develop his own ideas about how the infant begins to feel unified (1952b, p. 225). He stated that "the moments of the gathering together of the bits" of the self are "dangerous," and that this "integration activity produces an individual in a raw state, a potential paranoiac" (p. 226). Although his reference to feelings of persecution here echoes Klein, his understanding of their origin differs. Unlike Klein (1946, 1952), who accounted for the emergence of feelings and fantasies of persecution by stressing the role of innate aggression and the way it is projected, while at the same time acknowledging the impact of a frustrating environment, Winnicott focused almost exclusively on the role of external sources of persecution. He then challenged Klein's emphasis on the existence of oral sadism at the onset of the infant's life; for him, oral sadism emerges later. It is the traumatic birth experience itself, he noted, that in some "paranoid cases" "placed a pattern on the infant of expected interference with basic 'being' " (1949a, pp. 190-191).

Like Klein (1946), Winnicott acknowledged that it is in reaction to a paranoid state that the infant then sets up schizoid defenses. But for Winnicott, the purpose of these defenses is to prevent the attainment of "unit-status" (1952b, p. 227), something that Klein (1958) took for granted as existing in at least a rudimentary form in the beginning of the infant's life. In addition, Winnicott departed from Klein in his understanding of early splitting pro-

[6] Winnicott indicated that when impingements are excessive, the infant may resort to "over-activity of the mental functioning" (1949b, p. 246), which gives rise to "confusion" (p. 247) or to the use of cataloguing. Speaking of "reactions" that "can be *catalogued*" (p. 247, italics in original), he cited the experience of birth, which can be so traumatic that the infant will record in memory "every reaction disturbing the continuity of being . . . in the correct order" (p. 248).

cesses. With regard to early splitting, like Klein, he stated that the infant is not aware that the mother who is attacked in moments of frustration is the same person who provides. Yet in making this observation, he differed from Klein, since in speaking about early splitting (as well as projection and introjection), Klein (1952) elevated in importance the immaturity of the ego and the power of the instincts. In this context, according to Winnicott (1960), she did not take into account sufficiently that which results from a "failure of environmental provision" (p. 50).

In addition, Winnicott did not believe that the early process of splitting can be registered by the infant in any significant way. For him, in the earliest phase, what is registered by the infant is confined to momentary states of being that possess some continuity but consist primarily of raw sensation. Under certain conditions, then, the infant may retreat to "a world of magic" (1952b, p. 227). But Winnicott never really elaborated sufficiently on the nature of the processes of which this consists, other than to indicate the way that it becomes revealed, presumably later in the chaotic and frantic nature of the child's "play" (p. 227). By contrast, for Klein (1946, 1952, 1958), the earliest processes of splitting, projection, and introjection are evident in the infant's fantasy world, a concept she used to cover a series of complex operations that are unconscious and concretized as bodily processes.

Absent from Klein's vision, Winnicott reiterated, was sufficient sensitivity to the quality of care provided by the infant's mother, with whom, he believed, the infant is merged. Nevertheless, in claiming a degree of separation for the infant in the beginning, Klein was not oblivious to the fact that the infant is helpless and totally dependent on its earliest caretakers. In fact, I would agree with Likierman (2001), who suggests that Klein made use of Winnicott's ideas about the importance of the environment "in her concept of the primary good object," which is not only the result of instinctually rooted fantasy, but also depends on "external nurturing" (p. 168).

Indeed, Klein (1952) echoed Winnicott when she spoke of the fact that "the very young infant responds to his mother's smile, her

hands, her voice, her holding him and attending to his needs. The gratification and love which the infant experiences in these situations all help to counteract persecutory anxiety" (p. 201). In addition, in referring to the early relationship with the mother, Klein (1952) stated that the primary object, "the breast, inasmuch as it is gratifying, is loved and felt to be 'good' " (p. 200). Conversely, when the breast "is a source of frustration, it is hated and felt to be 'bad' " (p. 200). In general, to the extent that the external world is frustrating, beginning with the anxiety attendant to the experience of birth, Klein indicated that aggression and persecutory anxiety are reinforced. Furthermore, she stated that it is "gratification by the external good object" that "helps to break through" "states of disintegration" (1946, p. 103).

These statements by Klein suggest that Winnicott did not sufficiently acknowledge the manner in which she took into account the role of the environment in shaping the infant's life.[7] Winnicott was extremely critical when he wrote that Klein "disqualified herself from describing infancy itself," since she focused so heavily on "primitive mechanisms" within the infant, therefore engaging in "an implicit denial of the environment" (1962b, p. 448). He was equally dismissive in referring to her understanding of the nature of aggression, stating that her "attempt" to speak of its "early history" "was doomed to failure since she tried to state it apart from the question of the behavior of the environment" (1962b, p. 454). I would argue, however, that although Klein certainly emphasized the power of innate aggression, her discussion of this issue was complicated by her awareness of the way this phenomenon had to be understood in the context of other influences upon the individual, particularly "the intricate interaction between internal and external factors at any given time" (Klein 1952, p. 223). Too often, then, in his analysis of Klein, Winnicott did not point to her realization of "the bewildering complexity of the processes which oper-

[7] As part of his attempt to understand the relationship between Klein and Winnicott in the context of their "elective conceptual affinity" from 1935 to 1951, Aguayo (2002, p. 1136) commented extensively on the nature of Klein's acknowledgment of the impact of the environment on the baby.

ate, to a large extent simultaneously, in the early stages of development" (Klein 1952, p. 198).

THE PROFESSIONAL AND CLINICAL CONTEXT

Winnicott's difficulties with Klein had great significance for him in the context of his membership in the British Psychoanalytical Society. Although he helped to maintain the cohesion of this organization through the creation of the "Middle Group," he was deeply troubled by what he believed to be Klein's unwillingness to respect his views and her desire to create a band of loyal followers. He even called her a "Eureka shrieker" because of "her tendency to regard every insight as the ultimate truth" (Grosskurth 1986, p. 400). Goldman (1993) suggested that perhaps Winnicott thrived on this perception of her (p. 201). Citing Winnicott's conception of aggression as an integral part of the "process of differentiation and self-definition," Goldman (1993) adds that "Winnicott knocks up against Kleinian doctrine, strikes at it, tears it down, and, in the process, appreciates its resilience, yet establishes his own distinct identity" (p. 201). I would suggest that Goldman underestimates the extent to which Winnicott's battle with Klein was perhaps a reflection of his continual attempt to differentiate himself from her.

In his work after 1950, Winnicott indicated that Klein and her followers tried too much to control his thinking. He often spoke of the propagandistic tone and rigidity of Klein and her supporters, which were especially evident to him during the meetings of the British Society. Writing to Segal in 1952, Winnicott indicated his concern with the way that Klein's ideas were "put forward aggressively and then defended in a way that can only be called paranoid" (1952a, p. 26). Segal acknowledged that Winnicott was "marginalized" by Klein, in part because of his use of such "active techniques" as "feeding patients milk and wrapping them in blankets," which helped set in motion "primitive transferences rather than analyzing them" (Aguayo 1999, p. 55).

But Winnicott believed that the nature of the processes experienced by the infant in the earliest months of life necessitated a reconceptualization of psychoanalytic technique. For him, that which is earliest in psychological development is essentially unrepresentable at the time that it occurs. Since he challenged Klein's (1946, 1952, 1958) belief that the infant utilizes elaborate projective and introjective processes from the beginning of life, he developed ideas about technique that emphasized the importance of creating an ambience in which early inchoate processes of a sensate nature could be reexperienced. Central to this was the necessity for the analyst to use language only minimally, in order to allow for the emergence of the earliest condition of unintegration in which "unit status" had not yet been achieved. In his later work especially, Winnicott emphasized the importance for the analyst to avoid speaking in full sentences or even to remain silent in order to facilitate this. He believed that this was particularly important with patients engaged in an arduous process of differentiation, which might involve subjecting the therapist to repeated "attacks" (1969, p. 714). According to him, in these instances, it is imperative that the therapist not retaliate. Here he implicitly challenged Klein (1946) and her followers, who were generally committed to the continual interpretation of aggression. By doing so, they would be breaking up a "natural process," he suggested (1969, p. 711).

It is not that Winnicott ever gave up believing in the use of the Kleinian model of interpretation with regard to the importance of projective and introjective processes. But according to him, for some patients, this model was inadequate because it failed to do justice to what had happened earlier in the patient's life. Nevertheless, Winnicott's work never received the hearing that he almost desperately wanted from Klein and her followers. In an extraordinary letter to Klein on November 17, 1952, he indicated his distress about her "need to have everything that is new restated in your own terms" (Winnicott 1952c, p. 34). Having sought support for what he believed was a "creative gesture" (p. 34) in his paper on "Transitional Objects and Transitional Phenomena," he was

deeply disappointed in her refusal to respond positively. He indicated that he "cannot make any relationship through this gesture except if someone come to meet it" (sic) (p. 34). He was very much aware of the "personal" (p. 37) nature of his distress here, since he recognized that the failure to have his gesture met had also occurred in his analyses with Strachey and Riviere.

With regard to the acceptance of the creative gesture inherent in his paper, Winnicott could say that it was "something which I have no right to expect from your group, and it is really in the nature of a therapeutic act" (1952c, p. 34). Despite his distress, in the same letter, he continued to show his admiration for Klein. But he believed that her work was being misused by some of her colleagues, who employed what he called "internal object clichés" (p. 34). Similarly, in a letter to Bion, Winnicott spoke of the tendency by followers of Klein to repeatedly use words like *projective identification* and *envy*, suggesting that this was akin to the "plugging of theme songs" (1955, p. 92).

It is tempting to believe that the last section of Winnicott's paper on "The Depressive Position in Normal Emotional Development," which was read before the British Society in 1955, was in part a response to just this problem. Speaking about the concept of the "good breast," Winnicott (1954a, p. 276) appeared to be concerned about Klein's tendency to emphasize the importance of its internalization. Therefore, he spoke of a "good breast introjection," which "is sometimes highly pathological, a defence organization" (1954a, p. 276). According to him, given the nature of early "inner chaos and the ruthlessness of instinct," there is always a temptation to idealize the breast, "based on selected memories, or on a mother's need to be good" (p. 276). Even though he appeared to be simply restating Klein's ideas about splitting, he referred to "good-breast" (p. 276) advocates. He warned analysts to guard against allowing themselves to be so idealized as to be "advertised" (p. 276) by their patients.

While he did not refer directly to Klein and her followers in this passage, it is possible that Winnicott had some of them in mind, given the setting and the year in which he made this presen-

tation. A few years earlier, he had written to Klein that "some of the patients that go to 'Kleinian enthusiasts' for analysis are not really allowed to grow or to create in the analysis" (1952c, p. 37). He was especially concerned that rigid adherence to Kleinian theory by the analyst might result in the patient's being forced into a particular mold. He complained that in a case presentation, one analyst

> . . . simply bandied about a lot of that which has now come to be known as Kleinian stuff without giving any impression of having an appreciation of the processes personal to the patient. One felt that if he were growing a daffodil he would think that he was making the daffodil out of a bulb instead of enabling the bulb to develop into a daffodil by good enough nurture. [1952c, p. 35]

In order to guard against this problem, Winnicott stated, throughout the 1950s, that it would be useful to "destroy this language called the Kleinian doctrine" (1952c, p. 35). He was quite critical of some of Klein's followers, who, he believed, embraced her ideas with sectarian passion. This had implications for Winnicott professionally, since some of her supporters in the British Society told their students not to take classes with him (Kahr 1996, p. 77). He saw the danger of her group's turning into a "coterie" that would develop "a system based on the defence" (1952c, p. 35) of her position. The result, he warned, could be "a real danger to the diffusion of [her] work" (p. 35).

According to Winnicott, for Klein's ideas to remain alive, they had to be rediscovered anew by each person who encountered them. It is not surprising, then, that he was drawn to people like Bion and Meltzer, whose work, according to Winnicott, reflected a creative use of Klein's thinking. But for too many of her followers, he reiterated, her work was tantamount to doctrine. He became especially critical of a remark made by Riviere in the "General Introduction" to *Developments in Psychoanalysis* (1952); there she stated that Klein's work was so systematic that it "takes account of all psychical manifestations, normal and abnormal, from birth to death, and leaves no unbridgeable gulfs and no phenomena outstanding without intelligible relation to the rest" (p. 11). Winni-

cott was "shocked" by this comment, which "implied that the Klein system of thought had covered everything so that there was nothing left to be done but to widen the application of the theories" (1956, p. 97). He believed that any system that claimed to be totalistic was suspect, for he stated that there is no "jigsaw of which all the pieces exist" (1952c, p. 35).

Unlike some of Klein's supporters, who, according to Winnicott, "speak as if they knew everything" (1953c, p. 54), he was often tentative in the way he expressed himself. He distinguished between "scientific statement" and "the statement of a political position" (1952a, p. 27), in order to underscore his belief that this attempt to advance Klein's ideas as an incontestable version of the truth was not wise. In letters, he complained to Rosenfeld and Bion that Klein and her followers often tried to advance their work in a manner that was too forceful, and that did not allow for a consideration of its problematic features (Winnicott 1953b, 1955).

As he grew older, his despair deepened. In 1956, he complained to Riviere that "you gave me to understand that both of you are absolutely certain that there is no positive contribution to be made from me to the interesting attempt Melanie is making all the time to state the psychology of the earliest stages" (p. 94). Finally, I would suggest that he seems to have retreated into a hardened position of his own when he claimed that Klein had little understanding of the earliest phase of infancy. He wrote that speaking to Klein about this phase was like "talking about colour to the colour blind" (1956, pp. 95-96). In this instance, he apparently lost sight of his own perspective that in psychoanalysis, theory building and therapeutic practice are both forms of play, in that they are open to continual revision.

It was Winnicott who, according to Klein, said that "no one has a monopoly of the truth" (Grosskurth 1986, p. 451). Klein agreed. Yet, given the way they approached their own work as well as each others,' I believe that at times, they belied this assertion. Even Winnicott, who prided himself on his openness, became increasingly unable to view his differences with Klein as a dispute that might not be resolvable in a clear and unequivocal way.

CONCLUSION

In the end, I believe that Winnicott's response to Klein suggests one of the dilemmas embedded in the history of psychoanalysis: namely, the belief held by many that a particular set of ideas with universal applicability can adequately encompass the complexity of inner experience. It is disturbing that Winnicott became so immersed in his own perspective that at times he did not accurately present Klein's views, even as he was criticizing her.

In contrast to the tone that he often adopted in his critique of Klein, in general, Winnicott did not present his ideas with such certainty that one is left with the feeling that they could not be contested. In an unfinished paper, he acknowledged that a genuine "scientist" "knows that no truth is absolute or final, and that it is the thinking and the feeling and the freedom to speculate that counts" (1968, p. 460). But this is not evident at times in his response to Klein's work. I would argue that his critique of Klein suggests that at least here, he was too often certain that he was right. He may have been right. But the fact that his analysis of the limitations of Klein's work was based on elusive questions about human nature and human development makes his certainty suspect. In his own way, at times, he appeared to be advancing his ideas as strenuously as he believed that she was. That their differences centered on matters that could not be easily opened to verification, let alone firmly validated, did not enter sufficiently into his thinking.

Perhaps this points to the central limitation of Winnicott's response to Klein's work. In his critique of her thinking, he appears too often to be trying to replace one conception of early infant development with another one, without enough appreciation, which is present in so much of his other work, that he is presenting a perspective on inner experience that can be revised or jettisoned if another, more adequate perspective can be formulated. Interestingly, in the unfinished paper mentioned above, he suggested (though not without revealing his prejudices) that everyone

should consider whether Freud's idea of the death instinct and Klein's concept of envy are valid. This suggestion is a reminder of the need to continually reassess some of the central ideas that have been advanced within the framework of psychoanalysis.

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1724 Buena Avenue
Berkeley, CA 94703

Psychoanalytic Quarterly, LXXIII, 2004

QUESTIONING AUTHORITY IN THE PSYCHOANALYTIC CLASSROOM

BY DAWN SKORCZEWSKI, PH.D.

Psychoanalytic educators today, like their predecessors who trained them, struggle to maintain respect for and make use of candidates' various kinds of professional expertise while offering instruction in "the subject." But unlike their predecessors, today's educators teach in the wake of various challenges to authority and knowledge in recent decades from across the disciplines. Some of the most important work of teaching in this context begins when teachers recognize that they have assumed the position of objectivity in the classroom —that they have closed down the possibilities for open discussion—and figure out (with and in front of their students) what to do next.

It is 5:30 on a Thursday evening in early October. In a basement seminar room at a psychoanalytic institute, candidates and instructors remove copies of three articles from their bags. Two candidates and an instructor glance down, checking their beepers. One explains that he will probably be interrupted in the coming hour and a half. Another mutters something about being on call. All three nod, acknowledging something. The second instructor discusses his daughter's sleeping problems with the woman on his right, an M.D. with some knowledge of pediatrics. She offers a vivid description of her own daughter's sleeping troubles, marveling that it feels like yesterday, although she is describing events of five years ago. A natural silence follows, which seems to signal a mixture of the feeling that "this, too, shall pass," and that the students and teachers are ready to begin class.

One instructor gestures to the reading in front of him. He asks: "What did you think of the reading for this evening?" A dead silence falls over the room. The atmosphere seems to become more tense by the second. Several students glance uncomfortably toward yellow pads, fiddle with pens, shuffle through the articles. What had become of the feeling that preceded this question, the feeling that students and teachers are both people and professionals, with different kinds of expertise and inexperience, people who have much to teach and learn from each other?

What happened in this classroom, I would argue, is that individuals who behave as experts in their day jobs assumed very different roles once they became part of a "class." As "students," the candidates became passive, apparently looking to the teacher to tell them the correct answer to the question. As "teacher," the training analyst who was their colleague attempted to open a discussion in the classroom. Although he initially seemed interested in creating a dialogue among equals, one that respected and built upon multiple points of view, he immediately offered his own opinions on the reading when faced with an uncomfortable silence.

Freire (1973) might describe the silent students in this room as trained in what he calls the "banking concept" of education, in which students figure as passive receptacles of information that teachers deposit into them. The instructor, also no stranger to the banking-concept model of education, offered a "deposit" of his own thoughts on the subject. But the instructor's open (probably too open) question also signaled his desire to create a very different kind of classroom, a classroom that resembles what Freire calls the "problem-posing" model of education. For a problem-posing educator, "the teacher is no longer the one who teaches, but one who is himself taught in dialogue with the students, who in turn while being taught also teach" (1973, p. 354).

Freire suggests that in a problem-posing model of education, teachers and students together determine what we come to call "a class." This did not happen in the fictional vignette I offered above, but it does happen with some frequency at the psychoana-

lytic institute at which I have been an Affiliate Scholar for two years. In the pages that follow, I will explore a challenging and successful educational dialogue in a psychoanalytic technique seminar at the institute. First, I will sketch some "problem-posing" teaching strategies that worked in the seminar—strategies based on questions, open-ended inquiry, and respect for candidates' expertise. Second, I will discuss a particularly effective pedagogical technique that emerged in the seminar, when candidates began to address what was going on between them in terms of what they were learning together—the here and now of the group process in the classroom. Finally, I will discuss what happened when a teacher in this "problem-posing" seminar assumed the position of the privileged knower that he had clearly tried to avoid in his classroom. When a psychoanalytic educator assumes such a stance, he or she recognizes neither the expertise of students, nor the spirit of open inquiry that is the pedagogical goal. Some of the most important work of teaching in this or any problem-posing classroom begins, I will ultimately argue, when teachers recognize that they have assumed a position of objectivity in the classroom —that they have closed down the possibilities for open discussion—and start to figure out (with and in front of their students) what to do next.

PSYCHOANALYTIC EDUCATION TODAY

Educators currently teach in the wake of recent challenges to authority and knowledge from across the disciplines. In conversations about the clinical setting, theorists have challenged the analyst's ability to be an impartial or objective observer of the patient, and have instead emphasized the mutually reciprocal influence of patient and therapist. These discussions include attention to the ways in which the analyst's experiences and theories influence the direction of the treatment. (See, for example, Benjamin 1988; Cooper 1996, 2000; Hoffman 1998; Mitchell 1995; Renik 1996; Spence 1982; and Stern et al. 1998.) For those who are concerned about psychoanalytic teaching and learning, this work has led to

a proliferation of strategies designed to invite students to assume authoritative positions in classrooms, and to act as makers of knowledge in concert with their teachers.

And yet, reformers of analytic education fear that for all the emphasis on mutuality, dialogue, and relationality in the literature about the practice of psychoanalysis, those who teach about that practice might remain locked in what Kirsner (1996) calls a process of "miseducation," through which students are "moved into conformity with their teachers and analysts." A number of these writers, including Kernberg (1996), Sorensen (2000), and Power (2001), have argued that psychoanalytic education can stifle the creativity of candidates. Their strategies for reform range from changes in hierarchical arrangements at institutes, such as in the way that one becomes a training analyst, to curricular changes, including, for example, the ratio of recent psychoanalytic literature read to texts by Freud, to changes in the way that the case seminar operates. With the notable exception of Power's (2001) piece, which speaks directly to actual classroom procedures, these reformers do not address moment-to-moment interactions of students and teachers in analytic classrooms. I will attempt to do this in the pages that follow.

My own perspective on this subject is that of a person who has played nearly opposite roles in the fields of psychoanalysis and education. First, as Director of Composition at a small college, I teach and supervise more than fifty writing instructors each year. Second, as an Affiliate Scholar at an analytic institute, I have been a student in a dozen courses in the theory, technique, and clinical practice of psychoanalysis. Educational theory has many ways of talking about teaching, but academics in my field do not have sufficient concepts or language for talking about process between people, the moment-to-moment interactions that constitute what we call "a class." I began to take courses at the psychoanalytic institute to explore this language in analytic writing, and I have been delighted to discover its usefulness to my work as a composition theorist and teacher of writing teachers. But I have also been intrigued by the possibilities this language offers for the

teaching of analysis. It has first and foremost brought my attention to what I believe is a central dilemma of analytic education today: how can an educator who is committed to sharing authority in the classroom teach what he or she knows so well without becoming an authoritarian, banking-concept educator in that classroom?

Aron (1999) recognizes that psychoanalytic educators might feel pulled between banking-concept and problem-posing models of education as they shape their pedagogy:

> How can we say to a trainee that this is what *the* psychoanalytic response should be in a given situation, that this is *the* proper psychoanalytic intervention, based on *the* standard or model psychoanalytic technique, when we and the student know there are any number of other analysts and supervisors, often at the same institute, who would disagree and do things differently? [p. 3, italics in original]

In the psychoanalytic technique course I will discuss, the instructors indirectly answered Aron's question as they invited their class to think about and negotiate between multiple theories of technique, rather than recommending that students form allegiances to one or even several methods. Students tested theories of technique against one another and experimented with those theories as they analyzed their instructors' and each others' clinical vignettes. They were encouraged to make use of multiple and even conflicting theories as they discussed the clinical material. But most important, the class explored the ways in which the theories they read related to the expertise and experiences of the students and teachers, separately and together, both inside and beyond the walls of the classroom.

OVERVIEW OF THE CLASS

From the start, my instructors in the analytic technique course practiced and encouraged awareness of the relationships between students' various kinds of expertise and the theoretical concepts we were studying as essential to the understanding of technique, on

multiple levels. First, each week's readings included two, if not three, recent articles on technique. These articles contradicted each other, initiating a written dialogue among experts on the topic for the day. The articles also set a context that the class members might explore, debate, and make use of to situate themselves in relation to the topic. Students were encouraged to challenge the writers of these texts, as well as to take seriously their contributions to the study of technique. Topics covered a broad range, but were focused (and often controversial): "beginning an analysis," "neutrality," "interpretation," and "resistance analysis."

Second, the instructors regularly offered material from their own cases for the class to interpret; in this context, students and instructors were invited to act as experts together. A number of class sessions included reflections by one or both of the instructors on experiences with patients earlier that week, or updates on an interaction that had been discussed previously. The case material showed the instructors to be struggling as clinicians to make sense of what was happening between them and their patients. In sharing their own clinical examples with the class in an open and genuinely curious fashion, the instructors signaled the extent to which they valued the class members' expert opinions on the practice of psychoanalytic technique, even as they voiced their own expert opinions with each other and the class in the process of the discussions.

Third, the students in some ways participated in setting the agenda for the course. Although instructors sometimes began a class session with a question or comment, as the course progressed, the students initiated the discussion; they offered clinical vignettes or questions to direct the group to the day's texts. They also influenced the direction of the conversation by asking questions, referring back to something someone had said earlier in the course or asking the class to look closely at a portion of the text. In any number of ways, the class sessions offered technique as a matter to wrestle with in a lively and democratic fashion, and as requiring self-inquiry to facilitate further understanding. As the course progressed, students were directly and indirectly invited

to shape the ways in which they explored each of these aspects of practicing technique, as the instructors solicited their opinions and examples, and as they responded to the students from moment to moment in the discussion.

Power (2001) imagines this kind of classroom in her critique of "correct" models of technique in the case seminar when she recommends that technique should be a matter for dialogue rather than mastery:

> If a case seminar is organized to include *both instructors and candidates* presenting material, and if discussion is based on the *shared personal integrations* of all the participants derived from the unique aspects of individual cases, there will be inevitable disagreement regarding technique. This would preclude the presence of a "correct" or "right" way. [p. 637, italics added]

The intellectual struggle and disagreement that Power describes will be clearer in the vignette I am about to present, but I want to point out here that they were built into the course syllabus and into the organization of each session of my class. Students asked tough questions and grappled with contradictory theories of technique. Power also recommends that instructors present their own cases, to "offer seminar participants a different perspective on the instructor's authority and knowledge by grounding it in the ability to expose one's work, to reflect on it, and to tolerate confusion and uncertainty" (p. 629). From the first session of this course, when one or the other of the instructors offered clinical material and asked for the candidates' interpretations, candidates had the opportunity to debate the case, to identify the blind spots of a more powerful party, their teacher, and thereby to act as experts by offering their experientially informed recommendations to the teaching analyst. The candidates' astute readings of their teachers' cases were lauded both during these conversations, when an instructor would say, for example, "oh, right, I never thought about that," and after, when it was common for one or the other instructor to thank the class for its contribu-

tions to a change in the patient–analyst relationship that the instructor attributed to the class's input.

It was because of the democratic and challenging atmosphere in the classroom, I believe, that an unusual thing happened. After about three sessions, we began to discuss our past and present experiences in the classroom—including the *process* of class sessions—as relevant to the issues in technique that we were exploring. Students and teachers raised issues about what someone had said in a previous session, referred to an article or a patient presented in previous weeks, or made reference to a concept they had discussed in a particular way in a past session. Candidates increasingly offered spontaneous examples from their own sessions with patients, and patients, in a way, entered the discussion, which now included a number of different texts from different contexts.

When the candidates began to address what was going on between them in the here and now in terms of what they were learning together, I became fascinated by this aspect of the course; I had never seen this form of instruction discussed in either the pedagogical or psychoanalytic literature I had read. In fact, whenever I described it to colleagues who are teachers of teachers, they found it a remarkable and exciting idea to reflect on the process of interactions in the classroom as a way to teach teachers to think about their technique. As an educator, I interpreted this aspect of the course as evidence of the problem-posing method of teaching in practice from moment to moment in the classroom. I was also reminded that this highly self-reflective method of instruction involves as many risks as it does rewards.

Before I discuss a series of interactions that both threatened and strengthened the atmosphere of respect and robust dialogue in my class, I want to acknowledge that true respect and intellectual engagement should be business as usual in any classroom. It has been my experience that this is not often the case, despite the best intentions of very knowledgeable and considerate instructors. I believe this is because we all (students and teachers), to one degree or another, crave the certainty of a world in which everything makes sense, a world in which the "facts" can be explained.

Palmer (1998) argues that a classroom organized around certainty "portrays truth as something we can achieve only by disconnecting ourselves, physically and emotionally, from the thing we want to know" (p. 51). Perhaps our pull to the "objective" point of view in a classroom harkens back to our earliest training in classrooms that introduced us to the idea of education as a disembodied experience, a disciplining of the self in the service of the institution (see Foucault 1975). Because we learned to experience "the facts" as fixed and immutable when we were young, teachers and students are pulled to locate absolute truths in their pursuit of even the messiest human questions. It makes sense, then, that the best-intentioned efforts to avoid banking-concept methods of instruction can lead both students and instructors—as we shall see in the following example of classroom process—to moments of disconnection from the material they are exploring together.

LESSONS IN TECHNIQUE: A CASE FROM THE CLASSROOM

The sessions in the technique class I have been describing became increasingly challenging about halfway through the course, when members of the class saw fit to question the participation of both instructors and students in a particularly volatile discussion that had taken place in the third class session. As they processed their interactions in the fourth session, the instructors and students foregrounded and then reorganized their styles of relating to each other in class discussion. This problem-posing moment in the classroom was precipitated by the perception that one instructor had adopted a tone of certainty about a student's contribution to the discussion, was joined by other students as he did so, and thereby called into question the student's interpretation of psychoanalytic technique. After some thought and consultation with other class members, the "silenced" student decided to address the entire seminar about it in the following class session.

My account of the interactions in these two class sessions represents my own version of a series of moments from the third and

fourth meetings. As an educator of writing instructors and a visitor in the world of psychoanalytic education, I had my own reasons for being fascinated by the process of this class. I have attempted to instruct teachers in the construction of problem-posing methods in writing classrooms for over a decade, and have repeatedly encountered the frustrations and joys of employing this method with real students in real classrooms. Until I sat in a classroom at the analytic institute, however, I had experienced these dilemmas and pleasures only from the perspective of a writing teacher, a writing program director, and a teacher of teachers. When I began to experience what it was like to be a student in a problem-posing classroom from another discipline, a discipline in which instruction in process is at least as important as instruction in content, I began to experience what many of the students and teachers I have worked with over the years have described—the exhilaration and frustration of an educational world in which absolute truth and absolute authority no longer exist as truths, but are rather ideas to be explored and interrogated.

I asked the members of the class (including the instructors) to read my version of the vignette that I am about to present. They provided feedback, and I revised it in response. This experience emphasized for me that every reading of these two class sessions is itself an act of interpretation. I have attempted to be fair to all those who spoke to me about their versions as I drafted and redrafted this vignette, but I would nonetheless urge the reader to hear this as my story of what happened, and as such, it is one of any number of stories that might be told about what happened in these two class sessions. I would also like to ask the reader to attend less to the fact that something "went wrong" or was disrupted in this class than to how instructors and students repaired the group process, and even improved it, in response. I ask the reader to think about how they negotiated new ways of understanding the course material and each other from this experience, and how *this experience* of what I would call questioning authority became a model for them of what it might mean to practice analytic technique in a therapeutic context.

I am borrowing the concepts of "moments of interaction" and "disruption and repair" from an article entitled "Non-Interpretive Mechanisms in Psychoanalytic Therapy: The 'Something More' Than Interpretation" (Stern et al. 1998). Here, Stern and his coauthors address the production of knowledge in psychodynamic therapy, but I also find their concepts enormously useful for thinking about the production of knowledge in classrooms like the one I am trying to describe. The authors distinguish between two kinds of knowledge, "one is explicit (declarative) and the other is implicit (procedural)" (p. 904). The first kind, explicit knowledge, would, I think, include the "facts" I just offered about the technique classroom: the texts to be read, the topics to be discussed, and the case material offered. Far from neutral or objective, all of these facts "come with a point of view" (Cooper 1996). The organization of the syllabus, the choice of articles to be discussed, the decisions about what sorts of case material to be presented and by whom: all of these are forms of declarative knowledge.

The second kind of knowledge, procedural, includes "knowing about interpersonal and intersubjective relations, i.e., how 'to be with' someone" (Stern 1985, 1995; Stern et al. 1998); this is called "implicit relational knowing" (Stern et al. 1998, p. 905). This kind of knowledge includes the ways that students and teachers interact in classrooms—ways that, I believe, are rarely if ever discussed in psychoanalytic literature. In the story I am about to tell, students and instructors entered into a dialogue about this form of knowledge, even as they continued to construct ways of being together. In other words, they reflected on and continued to shape their classroom interactions by focusing on them as an object of study. This way of thinking about the learning process seems to me to be essential to the production of knowledge in problem-posing classrooms. If the content of a course focuses on mutuality in the patient–analyst dyad, for example, shouldn't the process of the class be similarly organized around students and teachers creating knowledge in dialogue together? And how can teachers and students do this without making this process a topic for discussion in the course? In the classroom I am describing, it became a topic for discussion.

Class Session One

The topic for the session I would like to focus on first was "interpretation." In preparation for this session, the six students in the class read the Stern et al. 1998 article previously discussed. We were also asked to read "'In the Neighborhood': Aspects of a Good Interpretation and a 'Developmental Lag' in Ego Psychology" (Busch 1993)—which I will discuss at greater length, since it has a particular bearing on some of my main points—and "Interpretation and the Method of Free Association" (Kris 1992).

The class began when a candidate I will call Mike spontaneously offered a vignette from a clinical session earlier in the day. Mike had seen a new patient for the second time. She told him that he reminded her of Mr. Rogers. "Tell me about Mr. Rogers," Mike said to the patient. The patient talked about her associations to Mr. Rogers, which were to playing sports. There are two kinds of players, she said. Some are hard-hitting and others just play for fun. She said she liked the ones who play for fun. "Like the mailman on Mr. Rogers," she added. "Mr. McFeely!" exclaimed Mike. Both the patient and Mike laughed.

One of the teachers of the class, whom I will call Instructor A, observed, "The patient was flirting with you, Mike." One student said that she was not sure why it had to be flirting. The other teacher, Instructor B, said, "The patient was being aggressive. Mr. Rogers is a wimp." Several students shook their heads; others nodded. One replied that she thought that many people had maternal associations to Mr. Rogers. We began to discuss our interpretations of Mr. Rogers. The class was wrestling with whether or not the patient was being aggressive as they explored their own associations to Mr. Rogers. Instructor B brought up a part of the day's reading, Busch's "In the Neighborhood" (1993), in relation to the question about how to interpret the patient's analogy. What did it mean to be "in the neighborhood" in this case, he wondered? Whose neighborhood were they talking about?

The class proceeded from a discussion of who Mr. Rogers is, to what the patient was trying to say to her analyst when she made

the distinction between rough play and playing for fun, to whether Mike's response to her really addressed what she was trying to evoke in him, to what was actually represented in the reading by Busch. In this fast-paced conversation about a patient's message to her analyst, one of the students in the seminar, Nick, said, "Let's just say, for the sake of argument, that we say to the patient, 'you are being hostile.'" A couple of people in the class laughed, as if this were a ridiculous thing to say to a patient. It was implied in the tone of the laughter, I think, that Nick was not aware of the consequences of such an interpretation, that he was naive—or unconscious, even—not to realize the damaging effects of such an accusation. (Tone, as we know, is very hard to describe, but it is an essential aspect of the implicit relationships in any classroom.) At the very least, it appeared that if indeed the patient was voicing aggression toward her analyst, Nick's comments did not take into account her need for defensive protection against the acknowledgment of that aggression (as later noted by Instructor B in a personal correspondence).

During the next half hour, as the class continued its inquiry into whether the patient's comment should be interpreted as aggressive, Nick somehow came to represent the position of the aggressive reader in the room. At one point, Instructor B, who had initially interpreted the patient's analogy as aggressive, turned to Nick and jokingly suggested that he was the kind of analyst who would confront a patient and "tell it like it is." The accusation was repeated at least twice, and at least one of the other students participated. At one point, when Nick's corner of the seminar table was gestured toward in relation to addressing a patient's hostile feelings, it became clear that Nick was having a strong reaction. He indicated his discontent by miming that he was being crucified by the class. Nobody took up his gesture for discussion, and it appeared that all assumed they were sharing a joke together.

After the class, Instructor B approached Nick and asked whether "the play about his technique was okay." Nick said yes, he took it as a sign of collegiality. But at least three of the seminar members worried that Nick was not really feeling okay about the way

the class had proceeded. They separately called him that evening to discuss the situation. All three felt that the class had perhaps become overstimulated in its discussion, and that in the midst of it, Nick came to symbolize a position rather than a person who could think about the issues in many ways. As one of the students who called Nick, I voiced my concern that my own playfulness in the classroom might have been unconsciously identified with Instructor's B's playfulness. His style as a teacher reminded me of my own, I told Nick, and I was concerned that I might have acted in concert with the instructor at Nick's expense. In any case, I was concerned that the balance of authority in the classroom had felt unduly tipped against Nick.

After he thought about it some more, Nick decided that he was not settled about what had taken place in class, and raised the topic for discussion in the next class session. He discussed his decision in advance with the classmates who had called him, and we supported him. I think it is important to note here that this student and his classmates felt comfortable in bringing an out-of-class discussion into the classroom. It suggests to me that the dynamics in the classroom supported such a move, that these students felt that it was their classroom as well as their teachers.' Although this may appear to be business as usual, my experience has suggested that such a direct challenge to an instructor's authority is actually quite rare in any classroom. Miller (1994) reminds us of this when he remarks that "the place of unsolicited oppositional discourse [in the classroom] is no place at all" (p. 390).

Class Session Two

The following class, for which the topic was "resistance analysis," began with Nick's asking if the class could discuss the process in the previous session. He said that, in retrospect, he felt uncomfortable with the way he had been responded to. The air in the classroom was unusually tense. Instructor B said, "Let's talk about this. Maybe we could think about the role of aggression in our process last week?" Some members of the seminar said that they

felt that the class had had an edge to it, and several suggested that they had participated.

Instructor A said that he agreed; he believed that this tone, in fact, had been a part of the group's process since the term began. Instructor A suggested that the class even seemed to be evading and resisting its own aggression in some of the ways that we talked about in relation to the texts we were reading. Both instructors waited for a moment for someone else to speak. Then Instructor B noted that more attention could be paid to the role of aggression as an everyday part of every interaction, including group process in classrooms. He pointed out that this might relate to one of the readings for the day on the topic of resistance. It seemed as though Instructor B was ready to move on.

Nick asked if the class could wait before turning to the reading. He said that he felt that the class was not adequately responding to what had happened the previous week. Students contributed more about their experiences of the previous discussion. I remarked that it was interesting that Instructor A's interpretation of the patient's comment about Mr. Rogers as flirtatious had completely fallen away once the "aggressive" reading became the topic of discussion. I thought to myself that it was easier for me to speak at this moment because I was, after all, a visitor in this room, and not an analytic candidate myself; I would not be evaluated. In addition, I was a teacher, whose interpretations of technique in the previous sessions were often voiced in relation to things I had observed in the classrooms of the teachers I supervised. In some ways, I held the position of a different kind of authority in the room, as an individual with a Ph.D. in literature, rather than one in psychology or with some other professional degree in mental health.

Nonetheless, I was not the last person to speak. My classmates next discussed how it had happened that aggression, both in interpreting the patient and in the style of discussion, had become such a focus the previous week. What might the conversation have been like if they had pursued the idea that the patient was flirting with the analyst, rather than voicing aggression toward him? Why

hadn't they done so? And did the fact that Instructor A, who had suggested this reading of the situation, became uncharacteristically silent in the previous class relate to this dynamic?

Together, the class developed a collective thought about the place of aggression in class the previous week. Perhaps the class had become uncomfortable with its aggression, and, as a way to manage it, had chosen Nick as a scapegoat. When Nick offered a hypothetical question about hostility, in other words, the class became organized around him as the hostile figure: his ideas became identified with him. Instructor B and the class reacted to Nick's comment in just the way that some members of the class had suggested his comment would affect the patient. In short, the group was in parallel process to the content of its session. This is what Instructor A had in mind when he said that aggression had been a part of the process of the class session. There were, in other words, at least three levels of unrecognized aggression in this class session: aggression toward Mike's patient, who might have been wounded by Nick's comment; aggression toward Nick, who was scapegoated by his classmates and teacher; and aggression toward the ideas put forward in the reading material, with which many in the class had disagreements.

Instructor B added another level of reflection to the group process. He volunteered that perhaps the class was responding to his personal style; he had in the past been experienced as blunt or too forthright in a classroom. I volunteered that I might have a too-blunt style of participating in discussion; I disagreed, in other words, that it was only Instructor's B's affect that had directed the conversation. After more discussion, and after Instructor B asked Nick and the class if they felt the issue had been fully discussed, the conversation moved easily to the topic for the day's session.

Both instructors and Nick thanked the group for attending to what had happened between them. Nick noted that this discussion had been useful to him on many levels, including a very personal one. He had often been accused of making much ado about nothing when he raised issues for discussion in his family of origin,

and he was happy that this was not the class's interpretation of what he had been doing this evening. Indeed, the class seemed grateful to Nick for bravely raising this issue, and for addressing an aspect of their process that might otherwise have become an "elephant in the seminar room."

READING CLASSROOM INTERACTIONS: FURTHER LESSONS IN TECHNIQUE

There are many ways of understanding these two class sessions, just as there are many ways of understanding what Mike's patient might have been trying to convey to her analyst when she compared him to Mr. Rogers. But I wish to illuminate what the interactions in and outside of this classroom suggest about questions of authority in the teaching and learning of psychoanalysis. We might say about this classroom situation that when Nick was targeted as *the aggressive reader*, he became the figurative student of both his classmates and his instructors. The other students joined Instructor B and became banking-concept educators, viewing Nick as an inept and naive reader of the patient being discussed. Despite his years of clinical experience and training in psychiatry, Nick was cast as a simplistic individual who had much to learn about practicing psychoanalysis, a novice who did not have his facts straight.

In session two, when Nick expressed his frustration at having been misinterpreted, he asked for a different understanding of his role in the discussion and in the classroom itself. He became a problem-posing educator, urging his classmates and teachers to rethink their relationships to each other, and simultaneously, to consider the knowledge that they were constructing about analytic technique. He indirectly suggested that the knowledge they were building together might apply to their relationships to each other in the classroom. Nick's insistence on further talk about his experiences in the classroom the previous week also drew the class's attention to the fact that this group of people was creating knowledge together, that if even one of the six members of the class

felt driven out of the conversation, the entire group would have a different relationship to the topics they were pursuing.

Nick suggested that the class's implied interpretation of him in the first session (as aggressive) was overdetermined. The class had heard Nick's comments only in the context of his first contribution to the discussion; everything he said after that was deemed insensitive to the patient's defenses. By raising the issue in the following session, Nick gave everyone an opportunity for wider interpretation. This wider view, which included his experience of what had been happening in the room, changed the group's understanding of what had occurred during the previous session.

Nick's comments in the second session also offered a very important and specific lesson about instructors who teach psychoanalysis. His insistence that the class revisit the previous week's conversation in some detail called attention to blind spots in the original discussion, in part produced by Instructor B's tone of absolute certainty. In the power relations in a classroom, Nick was a student in the class, no matter how much it felt like a democratic and open atmosphere. Given this power dynamic, it was a risk for him to ask the class to consider its process the previous week. He was raising the class's awareness to the fact that any instructor's opinion, when voiced in a classroom, carries more weight than that of any student, regardless of the situation. When an instructor speaks, he or she carries the institutional authority of the teacher, the authority inherent in the role. Although an instructor cannot escape this fact, he or she can consider what use to make of that authority—and in particular, whether or not to use it in ways that obfuscate the authority and expertise of others in the classroom.

Nick might never have raised the issue if the instructors in this seminar were not vigilantly aware of their uses of authority in the classroom. They illustrated their concern about how to use it in a number of ways. First, Instructor B asked Nick if he was okay with the first class. When Nick reevaluated the situation and returned to initiate a discussion of the previous week's conversation,

he was welcomed by both instructors (although the discussion admittedly caused no small degree of anxiety for them and the class members). That Nick felt able to initiate this discussion strikes me as significant; clearly, he felt that such a challenge to his instructors and classmates would be tolerated, or perhaps even welcomed. In other words, there was already room in the seminar for a dialogue that reformers of analytic education, such as Kernberg (1996) and Power (2001), have in mind when they try to work against hierarchical arrangements they have observed in classrooms at analytic institutes.

It also seems important for us to consider how the two teachers and the seminar members responded to Nick's request to process the third session. Instructor B contributed to the atmosphere of open and frank discussion when he attempted to understand the content of the previous session aloud. This was most particularly the case when Instructor B offered his personal teaching style as an object for discussion. When Nick related his own childhood experiences at the end of the discussion, he, too, explained how his past experiences made what happened in the room resonate for him on another level. Here, we can appreciate that the hierarchical order of a traditional classroom did not shape the interactions in this classroom. Instead, there was a give and take in which both the instructor and a particular student assumed positions of authority in the conversation, and in which both instructor and student drew the class's attention to how their personal histories shaped their interactions there. It was therefore a classroom in which what Tronick (in press) defines as *co-creation* figures prominently; students and teachers participated in shaping what they called "a class."

If we think about what I am trying to describe in terms of one of the articles that the class read for its third session, we can learn even more about this interaction. Busch's "In the Neighborhood" (1993), for example, might attribute part of what was happening in the room to the fact that "Universal trends from childhood . . . tend to pull the analysand [or in this case, the student] toward a regressive relationship where the analysand [or student] 'associ-

ates' and the analyst [in this case, the teacher] interprets" (p. 174). In the first class session, when Nick became the object of interpretation, we might say that Nick regressed. This may be true, for I would contend that both teachers and students experience regressive pulls in classrooms at any institution. But while teachers are pulled toward positions of absolute authority, students often gravitate toward meek silence. Appel (1999) explains that "both the desire for love and the anxiety of losing love are brought into the classroom . . . . Students enact earlier conflicts as they vie for the teacher's love" (p. 134). The situation I am exploring raises the possibility that teachers also vie for love in the classroom, although in most cases their "conflicts" are harder to see.

What if Nick had taken the more typical position of silence when he felt injured by what happened in his class? What if he had deemed his teachers' love more important than his own experiences and emotional responses? In that case, his experience might well have been invalidated or even unnoticed, even by himself. In the words of linguist Mary Louise Pratt, "If a classroom is analyzed as a social world unified and homogenized with respect to the teacher, whatever students do other than what the teacher specifies is invisible to the analysis" (1999, p. 592). Nick's supposedly naive interpretation of the patient's situation would have been "invisible" to the class's "analysis" if he had not vigilantly raised the issue in the following class session.

If we think about this vignette in relation to another article the class read that week, Stern et al.'s "Non-Interpretive Mechanisms in Psychoanalytic Therapy: The 'Something More' Than Interpretation" (1998), another level is added to our understanding of what happened. Both instructors and students were learning ways for teachers and students to "be with" one another apart from those allowed by banking-concept models of teacher–student relationships. Freire (1973) notes that in such a model of education, "the teacher confuses the authority of knowledge with his or her own professional authority" (p. 59). Freire refers to the ways that an instructor's ideas can become truths—or even "gods"—in the classroom.

Hoffman (1998) talks about a similar phenomenon in analysis when he argues that "the whole ritual of psychoanalysis is designed, in part, to cultivate and protect a certain aura or mystique that accompanies the role of the analyst" (pp. 151-152). Freire and Hoffman might have similar ways of understanding the mystique of the senior analyst as truth-sayer in the analytic classroom. The classroom I described, with its atmosphere of mutuality, disruption, frank discussion, and repair, contrasts with this characterization. Stern et al. (1998) would suggest that the interaction I described contained "special 'moments' of authentic person-to-person connection . . . that altered the relationship [in this case, between the teachers and the students] in this classroom" (p. 906).

I would also like to think about these interactions in terms of what Cooper (2001) calls the "return of the repressed positivistic." Cooper uses this term to explain what happens in social-constructivist theories of analysis when we try to analyze, as much as possible, the authority of the analyst as it plays out in the analytic relationship. He explains that this is an ambitious enterprise and inevitably a failed one. For no analyst can recognize and analyze away all authority (Cooper 2000). If we think about this "return" in the class sessions I described, we might note that even when a class is designed to encourage the discussion of multiple viewpoints, an instructor's tone of certainty and the use of remarks that have a dismissive tone can constrain a discussion, so that the ostensibly invited multiple points of view are not really welcomed. Nick, Instructor B, and the class members worked toward a fuller understanding of "how it happens in analysis and in classrooms that when we think we are doing one thing—for instance, encouraging multiple points of view—we may be doing just the opposite" (Walton 2001).

Educational theorists such as Spellmeyer (1993) warn that an educator's beliefs about the knowledge to be imparted do not necessarily correspond in any direct way to his or her uses of authority. In other words, despite the fact that an instructor believes that knowledge is context driven, dependent on the knower, and historically situated, that instructor might remain en-

trenched in ideas about "what is good for the students." In fact, Spellmeyer believes that teaching practices have actually not changed much at all, despite our recent focus on situated knowledges and shared authority in the classroom: "The theoretical debate about what to teach and how to teach it has not fundamentally changed teaching as a social practice—or rather, as a practice of socialization largely designed to reproduce our values and advance our objectives" (p. 239).

Spellmeyer expresses concerns that deeply held ideas about what is "correct" continue to shape the pedagogical decisions of even the most progressive instructors. Britzman (1999) adds a cautionary note from the realm of group education when she identifies "a reticence to investigate the difficulties groups have in making and encountering knowledge that allows individuals new experiments in working creatively and ethically with each other" (p. 332). The class that I have described might constitute just such an experiment.

The reader may have noticed that I did not engage in an exploration of other readings of what Mike's patient said to her analyst. There are multiple readings of this interaction, and I would speculate that not one of them could be determined as the correct reading without the presence of the patient, her analyst, and their analysis of what happened between them in the first session. In fact, the reader can probably think of countless situations in which discussions of what went on in the first two meetings of an analysis, or in any two meetings, have gone on for years. It is not that I am not interested in such discussions, or that my psychoanalytic technique course did not attempt to address the multiple meanings that might be generated in them; on the contrary, the fact that I can entertain so many ways to think about this interaction is a credit to the people who taught and participated in the class I took. In other words, I learned that it is as important to understand the ways in which an analyst and patient develop interpretations together, to consider what they use to think *with* as they think *about* these interactions, as it is to determine a "correct interpretation." This is not to say that our class created a rela-

tivistic world in which all interpretations are valid, or one in which one interpretation is as useful as another, but rather that our instructors helped us think about the act of making interpretations as at least as significant as the interpretations themselves.

I would like to return to the idea of "the neighborhood," which invokes both the title of Busch's (1993) article and the patient's comparison of her analyst to Mr. Rogers. Busch urges analysts to work to stay in the patient's neighborhood as they interpret the material. But whose neighborhood are we in when we say that the patient was flirting with her analyst in the above vignette? And whose are we in if we say she was being aggressive? Whose neighborhood is the classroom at the analytic institute in?

Anthropologist Unni Wikan (1990) remarked that "everyone's [living] room is feared by someone" (p. 55). Wikan draws attention to the fact that no space, including a classroom space, is uniformly experienced as safe or as dangerous by any group of people. Instead, I would suggest, people in a classroom work to create safety and take risks together, with the instructors leading the way. When the instructors discover through their students, as Instructor B did, that they have somehow disregarded or closed down the possibilities for creative exploration, it is their job to call attention to this and to decide, together with the students, what to do next. What happened next in the class I described was a more fruitful, open, and risk-taking environment than had previously existed. This was the work of a brave student and an equally brave instructor, and also of the other instructor and members of the seminar.

Whether we are in our offices or our classrooms, we produce versions of the truth in the service of our profession: truths that become so much like common sense to us that we no longer recognize them as versions at all. This is the inevitable result of professionalization itself, a process through which we learn to interpret the world from particular, institutionally authorized vantage points. Our interpretive abilities have value in the marketplace in the name of expertise, and our credentials advertise that expertise to patients, colleagues, and students. A humble approach

to our interpretive abilities can be hard to come by, particularly when we work so hard to achieve professional status. Renik (1996) explains that "we become most religious in our approach . . . when we pretend . . . that we are able to remain neutral and that our interventions describe revealed truth" (p. 515). Even when we are not "pretending" to know the truth, our personal experiences and beliefs are "enshrined in [our] theories" (Stolorow and Atwood 1979, p. 39); it is only through careful attention to others' reactions to us that these theories become accessible for analysis.

CONCLUSION

In my own experience as an authority in the classroom, I have observed that difficult moments provide me with opportunities to identify my own theories—or versions of the truth—as they are reflected back to me in my students' unexpected responses. The next step of the dialogue can be lost if I wrongly locate the source of misunderstanding or difficulty in the student's passivity or unpreparedness, or attribute it to "a bad day." If I can bear to look at myself through the lenses my students provide at these moments, I believe I have much to learn about how, despite my attempts to enter into dialogue with them, I can become deaf to my students' ideas in the service of my own. The class sessions that I described showed an instructor who, with his students' help, identified the mythologies of his teaching practices as he "heard them back" through the students. Any teacher's ability to hear rests on the willingness to recognize that a classroom is not one but many neighborhoods, that we instructors and our students—and all of our patients—inhabit many neighborhoods at once. When we are certain that we know which one we are talking about, we are always in danger of leaving somebody outside the gate.

Acknowledgments: The author would like to express her appreciation to the individuals who contributed enthusiasm and insight to this piece. For reasons of confidentiality, no names appear here, but their mark is on every page.

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Emerson College
120 Boylston Street
Boston, MA 02116-4624

e-mail: Dawn_Skorczewski@emerson.edu

Psychoanalytic Quarterly, LXXIII, 2004

CREATIVITY AND PSYCHODYNAMICS

BY CHARLES BRENNER, M.D.

In his great dictionary, Johnson defined the word *create* as to *form out of nothing*, to *cause to exist*. His spiritual descendants, the lexicographers who put together the latest edition of Webster's dictionary, likewise defined *create* as to *bring into existence*. Insofar as popular works of literature and dictionary definitions accurately reflect accepted usage, one may say that the words *create* and, by extension, creativity, are loaded words. They impute truly magical powers to those who do the creating: the power of making something out of nothing, the power of bringing into existence, as God is supposed to have done according to the opening of the book of Genesis.

In addition, the adjective *creative* implies a significant value judgment. It is complimentary. Shakespeare was creative. So were Newton and Einstein, da Vinci and Michelangelo. One would not ordinarily call Genghis Khan, Hitler, or Stalin creative, even though each was instrumental in bringing into existence an organization that profoundly affected the lives of millions. To call someone creative is to imply admiration and approval, not the reverse.

Few people and even fewer scientists today believe that something material can be created out of nothing. What do seem to appear from nowhere, what do seem to be literally brought into existence, are thoughts and ideas. They and the objects to which they give rise—literature, art, scientific theories—are what deserve the adjective *creative*.

Freud's first approach to the problem of creativity was his monograph on Jensen's *Gradiva* (Freud 1907). In it he wrote that a writer of fiction

> . . . directs his attention to the unconscious in his own mind, he listens to its possible developments and lends them artistic expression instead of suppressing them by conscious criticism. Thus he experiences from himself what we [psychoanalysts] learn from others—the laws which the activities of [the] unconscious must obey. [p. 92]

In the later article on Leonardo da Vinci (Freud 1910), Freud's conclusion is quite evident that unconscious, repressed wishes can influence normal thought and behavior, but, and the but is a big one, only or primarily in creative individuals, in artists and especially in great artists. In fact, the belief still persists that the greater the artist, the freer that artist's access to the normally hidden sexual and aggressive wishes of childhood and to the conflicts associated with them. When such wishes influence the thought and behavior of ordinary folk, as in the slips and errors of daily life, Freud considered them pathological—the psychopathology of everyday life.

The idea that creative artists have special access to wishes and conflicts of childhood origin that are inaccessible to uncreative individuals unless those uncreative ones are neurotic (return of the repressed from repression) poses a serious problem. One way to solve the problem is to postulate that one must be more or less neurotic, or even psychotic, to be creative. Since everyone, creative or not, has plenty of evidence of neurotic difficulties, it is not hard to adduce evidence that seems to support this thesis. One need only demonstrate evidences of neurotic compromise formation in creative individuals, which is not difficult to do. Unfortunately, however, one must at the same time assume that ordinary persons who are not creative have little or nothing in the way of neurosis troubling them, which is far from the truth.

Another solution to the problem is to equate creativity with neurosis and/or psychosis. Being creative is then viewed as the equivalent in an artist of a pathological compromise formation in someone who has neither talent nor capacity for artistic creativity. The creative act is thus viewed as an alternative to succumbing to mental illness, an idea that artists themselves not infrequently put forward.

Kris (1952) suggested still another possible solution, which he called *regression in the service of the ego*. His idea was that creative activity takes place in an altered ego state, one in which the creative individual has temporarily regressed to an earlier, less mature mode of mental functioning. The analogy would be to the sort of regression that Freud (1900) showed to be characteristic of mental functioning during dreaming. Just as a dreamer has access to the wishes and conflicts of childhood that are normally inaccessible during waking life, so a creative individual, Kris suggested, has equal or similar access to those wishes and conflicts during an act of creation.

I suggest that a better explanation than any of the ones just summarized is offered by recognition of the fact that conflict and compromise formation are ubiquitous in mental life (Brenner 1982). The part played in creativity by the conflicts originating in childhood sexual and aggressive wishes is no different from the part they play in every other aspect of mental life. Creativity is no different from everyday mental functioning with respect to its dynamics; what is special about creativity does not have to do with its psychodynamics. To put the matter more positively, everyone is creative all the time, every day. Every thought, plan, and action is a creative compromise formation, dynamically speaking, however mundane and ordinary it may be. Everyone, whether awake or asleep, produces a constant stream of compromise formations, each of which is a unique creation without being in the least creative in the accepted meaning of the word.

Creativity is not a word to be used lightly. It is an accolade. It is not to be bestowed on universal, everyday mental activity. Implicit in the concept of creativity is a value judgment, one adopted from the culture of society. What it signifies in our society is not just novelty of thought or action, or even thought and action that are unique as well as novel. It signifies in addition that the mental functioning of the person called creative is judged by the members of the society in which she or he lives to be *successfully* innovative. It signifies that the compromise formation(s) called creative are admirable and useful ones, ones that other members of society wish they could do, too.

To underline the point that the current, shared opinion about creativity is culturally based, it may be recalled that not all societies at all times thought highly of innovations, successful or not. There was a time in western European history when the ideal was to conform, to do one's duty to God and master, and to shun change and innovation. When Galileo proposed his innovative idea about the solar system, an idea that is today considered to be highly creative, his masters in the church judged him to be heretical, not creative, and would have put him to death had he not recanted. The same sort of variability in judgment is apparent in the field of art. At the time when Van Gogh was unknown and disregarded as an artist, a painter named Bouguereau was widely acclaimed as a creative genius. Fifty years later, none but a very few had ever heard of Bouguereau, while Van Gogh was a name on everyone's lips. What is deemed creative today may be looked on as banal tomorrow. What is unnoticed or despised today may inspire universal admiration and praise after the death of its creator.

In brief, creativity, like beauty, lies in the eyes and mind of the beholder, not in the psychodynamics of the individual who is called creative, however justified the appellation may be. It is the value judgment of one's fellow creatures that decides whether one is to be called creative or not. If one leaves that judgment to one side, everyone deserves to be called creative at every moment. As far as mental life is concerned, both men and women are creative by nature. Those who are honored by being *called* creative are the special few whose creative products are admired and prized, the special few whose creations are judged to be successfully innovative by the members of the society to which they belong. The dynamics of the creative process are just as present in the creation of a piece of pulp fiction as in the creation of *Anna Karenina* or *War and Peace*. What distinguish products that are rated as trash from those that are considered "truly creative" are their formal characteristics, not their dynamics. And the formal characteristics are, in large part at least, determined by societal norms. If there are any formal criteria of creativity (as we use the

word)—or, for that matter, of beauty—that are absolute in the sense of being independent of societal norms, they have yet to be convincingly demonstrated.

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35 East 85th Street
New York, NY 10028-0963

e-mail: Eandcbrenner@aol.com

Psychoanalytic Quarterly, LXXIII, 2004

WHO OWNS THE COUNTERTRANSFERENCE?

BY ARNOLD GOLDBERG, M.D.

A recent series of articles published in the *Journal of Clinical Ethics* (Harvard Ethics Consortium 2003) presents a published case study of a patient in psychotherapy, along with the responses of a number of readers, including a response from the patient himself.[1] The basic point of these essays has to do with the patient's consent for the publication of his case and the repercussions that ensued from his reading about himself from his psychiatrist's point of view. The latter report included a good deal of the psychiatrist's feelings about treating this patient, feelings that he had not previously shared with his patient and that turned out to be quite hurtful to the patient. Although the patient had given his consent to have his case published, this consent had been agreed to long before the case was written up, and indeed, the patient hardly remembered that moment of agreement until presented with the finished product.

The *Journal* includes essays by both the psychiatrist and the patient, with discussions by a number of ethicists who themselves seem quite committed to the dual task of allowing a patient to read what is said about him or her, while ensuring that such a reading will not be harmful or injurious to the patient. Most readers will probably conclude that the delicate effort at a balance to the problem has not resulted in a happy solution.

[1] I am grateful to Carlye Perlman for alerting me to this publication.

Some Background

I shall not review here the extensive literature on confidentiality of psychoanalytic publications, which has been adequately reviewed and discussed by Gabbard (2000) and Galatzer-Levy (2003). Rather, I wish to pose our particular dilemma as one between the stance of the International Committee of Medical Journal Editors (1995) and the Committee on Scientific Activities of the American Psychoanalytic Association (1984). The guidelines of the first, as summarized in the second, say that published information must be "essential for scientific purposes" (p. 440), and "the patient or proxy must give written informed consent for publication" (p. 441). This has the form of a law and is decisive.

The second group does not demand consent, but leaves it up to the author to protect the patient. Protection ranges from alteration or omission of material to thick disguise of the patient. The latter usually demands that no one other than the patient can recognize him- or herself as the one being written about. This takes the form of a calculation and a judgment.

Each of these two positions centers its attention on patient protection and gives the vulnerable patient the maximum concern, yet each has a status of its own and is set up in opposition to the other.

Ownership

The crux of the issue of revealing something about the treatment of a patient often comes down to a question of ownership. Although the property status of human tissue is controversial (National Bioethics Advisory Commission 1999), the *Journal* states that patients clearly have ownership of their stories (Joffe 2003), and so lay claim to privacy.

The narrative that is constructed in the formation and presentation of a case history is felt to belong solely to the patient, who must either give permission for its distribution or must be protected from any harm that could result from its publication. Thus, at one end of an imaginary line that we could construct, we would have the treatment—be it psychoanalysis or psychotherapy—as an

activity done solely for the benefit of the patient, with all issues such as property rights belonging to the patient. Midway on our imagined axis we can fashion a co-constructed narrative, which is both a product of two authors and an entity that would allow for a claim of dual or shared ownership. Finally, at the pole opposite to that of patient ownership, there could be a point that seems to belong to the therapist in its entirety.

It is often a poor analogy to place physical medicine alongside psychological treatment, but we surely can agree that (say) a surgical technique that is honed and perfected on one or more patients can be used effectively on future patients. That technique or knowledge is now the property of the surgeon, with all due gratitude to the patients who lent themselves to its development. So, too, in psychotherapy and psychoanalysis, each patient is a potential laboratory in which to develop our own skills until, over time, these become so much a part of a practitioner that she or he is hard pressed to point to its origin. The fuzziness begins in the middle; only at the extremes does clarity ensue.

Case Illustration

An interesting case in analysis presented a bit of clinical material that I felt had not heretofore been represented in the literature. I wrote up the case, with the major pertinent issues revolving around my countertransference reactions to the clinical material. I showed the written-up case to a consultant, who felt that this was a significant contribution and should be published. The wisdom of this conclusion is not the issue here, but the dilemma is. In truth, the value of most contributions is determined over time and cannot be readily apparent.

Although this case could be disguised from being identified by anyone but the patient, it could certainly not be concealed from the patient. If he or she were to read of my countertransference reactions, it seemed to me that it would be potentially harmful to the conduct of the analysis. Nor could I show the written case to the patient for consent to publish, since it might readily recapitulate the sad events written up in the aforementioned *Journal*.

In that case, the hurt and angry patient did return to his therapist to work out the derailment that had resulted from his reading of the case, and the therapist felt that both he and the patient had profited from this unfortunate circumstance. It seems that the harm can come at any time, even after termination. But one can hardly make a case for the supposedly ameliorative effects of a return's being universally true.

Stoller's (1988) advice is to let patients edit and disguise their own cases, but this advice is given in the form of a universal rule, and I have no doubt whatsoever that it would not apply to my patient and my countertransference. Nor was I eager to test my conclusion. Rightly or wrongly, I felt that thick disguise would destroy the point I wished to make, and I saw no way out. No solution seemed to fit.

Discussion

The benefit of the case presented in the *Journal* is that, for the most part, it represents a situation in which everyone would have been better off if the write-ups had never been seen by the patient. Of course, the best but not the only way to achieve this is never to publish anything save fiction or theory. Many potential but unwilling writers, or those who simply cannot write, take refuge behind this solution. Indeed, one often finds the most zealous defenders of patient protection to be filled with the ranks of the nonwriters. The other solutions available to solve the dilemma are nicely listed and discussed by Galatzer-Levy (2003), but he shows them all to have their own failings. In fact, he concludes his article by joining Gabbard (2000) in stating that all supposed solutions face difficulties.

If we move away from the very valuable point on the continuum that is devoted to patient protection and patient ownership, we may arrive at a point closer to one of therapist ownership, as in my countertransference, coupled with a possible benefit to future patients. The risk is clear. The answer is less so, but not beyond us. It begins with our dispensing with a commitment to any set of rules that govern all case presentations and publications. If

we embrace pragmatism, then we need to recognize that some patients should indeed be consulted beforehand, some disguised minimally, some disguised thickly, and perhaps some disguised not at all. Stoller (1988) may have carved out a group of patients who can edit their own cases, while others may delineate those who should never have to reckon with such publication. There is a grave danger in treating all patients alike, as well as in our taking for granted that a higher moral code exists to which we must all conform.

When Gabbard states that no approach is without its problems, he argues that a clinical decision must be made in each case regarding whether it is the best strategy to use thick disguise, to ask the patient's consent, to limit the clinical illustration to process data without biographical details, to ask a colleague to serve as author, or to use composites. Once again, the goal is to minimize potential harm to the patient while maximizing the scientific value of the contribution (Gabbard 2000). Those are excellent guidelines, but the above-noted *Journal* case and my own quandary seem to suggest that there is simply no way to know beforehand, no guarantee of achieving the goal anticipated by Gabbard. Not only is no approach without its problems, but the potential problem is not usually readily apparent in making one's clinical decision. Can it be that we cannot write without risk?

There is an interesting discussion by Derrida on ethical decisions, in which he affirms that every such decision requires confrontation of its essential, irreducible undecidability. Caputo (1997) summarizes Derrida's point:

> The opposite of "undecidability" is not decisiveness but is calculability. Decision-making, judgment, on the other hand, positively depends upon undecidability. So, a "just" decision, a "judgment" that is worthy of its name, one that responds to the demands of justice, one that is more than merely legal, goes eyeball to eyeball with undecidability, stares it in the face (literally), looks into that abyss, and then makes the leap, that is, "gives itself up to the impossible decision." [p. 137]

Alas, just as psychoanalysis is one of the impossible professions, it is also burdened with impossible decisions.

Conclusion

Most ethicists and moralists aim to form laws of behavior that cover all persons, such as is embodied in the golden rule of doing unto others as you would have them do unto you. However, most persons decide their behavior on a more pragmatic, ad hoc basis, and this may well result in behavior that ranges from the utterly selfish to the most altruistic. What psychoanalysts have learned is that all behavior is complex, much of it is unconscious, and so we are more often befuddled than confident about the meanings of behavior. Ethicists who promulgate universal rules may indeed do us more harm than good. Absolutes in psychoanalysis and psychotherapy are conveniences that can inhibit and blind us. We may profit more from devoting time to better categorizing our patients into those who may not care at all if they are presented as case material, those who care just enough to be disguised, those who would give consent if they could edit the case, and those who would forbid any sort of publication. This is not meant as a solution but could lead to a better clarification of the dilemma. It may simply not be true that from the point of view of others, confidentiality is an absolute privilege that must always be observed, or that privacy is a fundamental right of all patients. Rather, confidentiality and privacy may be proper objects of investigation—investigation that is waylaid by those who would claim certainty about the right way to behave.

The investigations that are necessary to better equip us to make a proper determination about privacy and confidentiality are probably not those that divide therapists and analysts as to their preferred procedures. As interesting as that research might be, it is not of paramount importance. What is needed is a clearer idea of how we balance the risk of disclosure with the need for disclosure. Both patient and therapist should enjoy rights to attain this balance. Analyses are co-constructions and lend value to each of the participants. We surely cannot devise a risk-free an-

swer while maintaining our credibility as scientists. Both obligations and ownership go both ways.

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122 South Michigan Avenue
Suite 1305
Chicago, IL 60603

e-mail: docaig@aol.com

Psychoanalytic Quarterly, LXXIII, 2004

THE SEDUCTION OF MONEY: AN ADDENDUM

BY ARNOLD ROTHSTEIN, M.D.

It is seventeen years since I reported my experience of conflict in working with a patient who attempted to seduce me with money (Rothstein 1986). First, he informed me that he had left me $250,000 in a recently written will; then he suggested creating a foundation that I would administer. Finally, he offered me a retainer of $20,000 per year after the termination of his analysis to ensure my subsequent availability. Treating all these seductions as fantasies, rather than collaborating with him in their enactment, proved beneficial in our analytic work.

Ten years after terminating his analysis, Mr. X developed a terminal illness to which he subsequently succumbed. After being diagnosed, he returned to treatment to work on his experience of dying. In our last session, shortly before his death, he hugged me, told me how grateful he was, and that he loved me. After his death, I found myself having a recurrent daydream: a lawyer called to inform me that Mr. X had, in fact, left me $250,000 in his will. This daydream emphasizes the ubiquity of interminable conflict and analysts' susceptibility to the seduction of money.

In the past decade, the movement to establish psychoanalytic foundations has gained momentum. Recently, I became aware that a patient currently in analytic treatment had become significantly involved with the psychoanalytic foundation of the institute with which her analyst was affiliated. This experience reminded me of the seductive offer of Mr. X to administer a foundation named the X-Rothstein Foundation. In 1986, I noted that

> I was aware of the powerful countertransference temptation to accept this seemingly rational and morally acceptable impulse toward generosity. I thought to myself, "This guy wants to make me one of the most powerful funding sources in psychoanalysis." However, the relationship of this seductive proposal to the earlier offer to be my benefactor was obvious. Further analysis eventually revealed more about its concealed intentions. [p. 297]

These experiences motivated me to write this brief communication. I propose that the data presented suggest that analysands' active involvement in psychoanalytic foundations, while they are simultaneously in ongoing analyses, may limit their work in the analyses of transferences. Furthermore, analysts' treating such activity as simply "grist for the mill" may be both self-serving and overdetermined. It is important to remember that analysands are unlikely to understand the importance of resisting the enactment of their conscious wishes to be generous. An alternative to treating such requests as grist for the mill is to treat them solely as fantasies. I emphasize that this technical approach offers the optimal possibility of analyzing their overdetermined unconscious determinants. Finally, I suggest that analysts can benefit from considering such temptations on the analyst's part in the same manner that they would consider the urge toward any possible boundary violation: as an indicator of the need for self-analysis and/or consultation with a colleague who is not affiliated with a psychoanalytic foundation.

These recommendations seem particularly appropriate when one considers the variety of meanings money has for wealthy patients, who are especially attractive to psychoanalytic foundations. These recommendations derive from the guidelines on analyzing transference-countertransference contained in Freud's final paper on technique, "Observations on Transference Love" (1915). They were remarkably helpful to me as I worked with my temptations to be seduced, exploitative, and self-destructive in my work with Mr. X.

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275 Central Park West
New York, NY 10024

BOOK REVIEWS

SEXUALITY, INTIMACY, POWER. By Muriel Dimen. Hillsdale, NJ: Analytic Press, 2003. 328 pp.

This volume consists of a series of essays published between 1989 and 2001. They are well written, with beautifully evocative metaphors, interesting clinical examples, and important personal references. They describe the journey Muriel Dimen has taken in her struggle with difference and inequity, that which lies on the surface and that which is hidden beneath, as well as that which is innate and that which is culturally determined. She has traveled from anthropology to Marxism to feminism to postmodernism and to psychoanalysis. The impact of each is clearly evident.

The author gives us a nonlinear compendium on psychoanalysis, social theory, and feminism, with a special focus on the problem of dualism. The nonlinearity of the project renders it soft-edged. One might possibly call it feminine if one were thinking in terms of dualisms and gender dichotomies. To write a hard-edged, linear, formerly-considered-masculine review of this book would therefore be difficult and, ultimately, inappropriate. Anyone looking for that here will find this review, in line with these essays, meandering.

Dimen's style is a mixture of the personal and the factual, the internal and the external, and the subjective and the objective. Significant authors in several fields are noted. I can only comment on the psychoanalytic references, as those are the ones with which I am most familiar. And in this realm, I can think of few significant contributors who are not referenced and few significant controversies not addressed. The style, if one needs to characterize it, is at one and the same time both obsessional and hysterical.

It is at the crossroads of social theory, psychoanalysis, and feminism that Dimen discovers an opportunity to explore sexuality, intimacy, and power. Traditionally, each field has focused on one

aspect of the triad: social theory on power, psychoanalysis on intimacy, and feminism on sexuality. Dichotomies have been established, with psychoanalysis and social theory interacting with and complementing each other. Dimen adds feminism to the mix. This book is about the confrontation of these three theories. It is also about moving from dualism to multiplicity.

It begins with a recounting of the author's personal journey. This is of obvious interest to the psychoanalytic reader, as it adds a personal note, as well as some depth of understanding of the journey and of the writer. It demonstrates the influence of culture and feminism and the significance of the idea that the personal is political. The hard edge of the multiple theoretical references and Dimen's engagement in multiple controversies with significant contributors is softened by the personal and the internal. Here we see gender multiplicity at play and at work.

Central to this volume is Dimen's emphasis on the position of dualism in our thinking and the need to replace it with multiplicity. Replacing *either/or* with *both/and* leads us to contingency, i.e., the idea that "it all depends." The problem with dualism, the author notes, is its dissolution into monism, revealing the underlying hierarchy. Only one of the two is right, natural, normal, or true, thus leading to the acquisition of power for the one and the concomitant loss of power for the other. The reference here to male and all that is considered masculine in opposition to female and all that is considered feminine, as well as to the privileging of heterosexuality, is explicated as the ideas evolve.

In pondering the shift to both/and, to multiplicity, Dimen utilizes Ogden's concept of the third, as well as Winnicott's transitional space—that which is internal and external, self and other, a space where distinctions are not made. It is a space for play and creativity in which multiple theories can interact, allowing for contingency and uncertainty. It is a space that does not demand resolution.

She goes on to note the dichotomous nature of psychoanalytic theory. It is here that I part ways with the tenor of this book. Multiplicity did not enter the psychoanalytic arena with feminism or

postmodernism. Psychoanalysis has been all about multiplicity, about living in the state of tension, ambiguity, and contingency that she advocates. Compromise formation and the principle of multiple function are long-standing cornerstones of both theory and clinical practice.

A multiplicity of dualisms in psychoanalytic thinking is noted: mind/body, body/object relations, oedipal/preoedipal, male/female, cognition/emotion—as well as the more recent addition of object relations and intersubjectivity. Here the author revisits dichotomies from which many of us have moved on, toward the "it-all-depends" mode. That is not to say that important remnants of this dichotomous thinking do not exist in psychoanalysis; clearly, there is resistance to incorporating the new (and no longer new) psychoanalytic ideas of femaleness, and to attempting to undo the idea that *male* is equivalent to person and *female* to not male, all of which has led to the multiple dichotomies of dominant/submissive, phallic/castrated, autonomous/dependent. A focus here would be a significant contribution. There is no need to take on so many of these other issues. Were Dimen to limit the number of fronts on which she advances her argument, she would make a clearer, stronger case.

The nature/nurture dichotomy that Dimen experiences as so burdensome to psychoanalysis is attributed to Freud's leaning on Darwinism to legitimize his new science. That which is natural, i.e., *man's nature*, became right, moral, true, and empowered. This, she believes, led to a gendered splitting of power and intimacy, a privileging of reproductive heterosexuality, and a limiting of sexual expression. She indicates that female sexuality and subjectivity were sacrificed in order to attain scientific legitimacy. The early feminist response was to revalue the qualities of nurturing and relatedness and to note the dichotomies of male and female, autonomy and relatedness, and the hierarchy attached to these attributes. The postmodern perspective added the element of multiplicity, reopening our thinking about sexuality and destabilizing gender as a concept. With this new way of thinking, gender could become multiple, emergent, individually unique. It became easier

to hear the female voice in its various registers. The authority of the personal experience was promoted.

This historical survey of the evolution of feminism is helpful in comprehending the contribution that it has made to psychoanalysis. Not all of the credit lies here, however, as advances in psychoanalytic thinking had also been ongoing via a rethinking of the concept of femaleness and of promoting the authority of personal experience.

Dimen is at her best when she addresses sexuality and gender, e.g., the psychology of gender and the social institutionalization of sexual difference. She counters the trend of attributing intimacy to the realm of the woman and power to the realm of the man. Gender identity is multiple and contingent, rather than unitary and determined. Her interest is on the social and psychological limitations placed on gender possibilities. She does not consider studies pointing to brain and body differences that ultimately might limit this omnipotentiality. To allow for this multiplicity of sexuality, psychoanalysis must not only give up Darwinian determinism, but must also turn to a consideration of desire. Desire is that which stands for lack, absence, longing, as opposed to need or demand. It is insatiable, a driving incompleteness. It is, in essence, the sexual drive.

In considering the sexual drive, Dimen notes the disappearance of the body from psychoanalytic thinking. This is attributed to its association with that which is female: feelings, sexuality, sensations, that which is inside. She suggests that our more recent increased interest in countertransference, enactments, and the impact of the person of the analyst relates to the increased participation of women in the field. Countertransference, she states, registers somatically and women are more comfortable in using their bodies. Patriarchy is blamed for the gendered split of body and mind, of nurture and aggression.

In an essay on aggression in women, Dimen expresses surprise at discovering that women are competitive with other women, that women are aggressive as well as nurturing. And there is a final essay in which she looks at “perversion,” claiming that this is more

than a diagnosis; it is an expression of disgust that we utilize in order to distance ourselves from an "other" sexuality. Here she takes on Kernberg and Chasseguet-Smirgel, calling for greater clinical openness to understanding our patients' choice of sexual fantasy or activity, thereby allowing for sexual diversity.

Sexuality, Intimacy, Power is an important book for the psychoanalytic reader, even though at times it is an aggravating one. It demands a reconsideration of the topics of gender and sexuality and their interdigitation with issues of intimacy and power. It suggests that with a less gendered dichotomy of intimacy and power and a greater openness to sexuality, we might attain a more ideal universe. Questions remain as to exactly how much of this is culturally determined and what the limitations to multiplicity may be. Their consideration, however, is vital.

In reading these essays, we are reminded of the importance of involving ourselves in other academic realms. We are also reminded that sociocultural forces need to be considered. We may not want to embrace all of what is written here, but it is important to listen and to ponder. We are enriched through its consideration.

RUTH FISCHER (BRYN MAWR, PA)

AFFECT REGULATION, MENTALIZATION, AND THE DEVELOPMENT OF THE SELF. By Peter Fonagy, György Gergely, Elliot L. Jurist, and Mary Target. New York: Other Press, 2002. 578 pp.

This scholarly and substantial book focuses on the relation of "developmental work" to psychotherapy and psychopathology. By developmental work, the authors mean both new development

research literature and the process in therapy of rebuilding faulty development. The authors seek to integrate their scientific knowledge of psychological development with their experience as clinicians, a daunting task. They redefine *attachment theory* creatively and less rigidly than heretofore: the early environment is seen not just as a template for all later relationships, but also as determining the "depth" to which the social environment may be processed, and as facilitating or undermining the individual's ability to process or interpret information concerning later mental states. The book is divided into three overlapping areas: the theoretical, the developmental, and the clinical.

Of special interest to me as a child psychoanalyst is the excellent, comprehensive review of the studies contributing to an unfolding developmental picture of the child's understanding of mental life, minds, and psychic reality versus external reality. How does the child come to develop subjectivity, to know about intentions, beliefs, and emotions? The authors sequence the steps along this pathway in clear developmental perspective, pulling together studies from cognitive science, developmental psychology, philosophy, and psychoanalysis in a beautiful presentation of cutting-edge research in the development of theory of mind. Yet at times they do not credit others who have written in this domain with different terminology. For example, Ritvo and Solnit[1] carefully studied the identificatory processes leading to affect regulation; Escalona[2] emphasized the subjective rather than objective environment of the infant in her concept of the baby's "concrete experience" of the mother; Pine[3] delineated the steps in early self formation; White[4] highlighted self as agent with a focus on efficacy;

[1] Ritvo, S. & Solnit, A. (1958). Influences of early mother–child interaction on identification processes. *Psychoanal. Study Child,* 13:64-94.

[2] Escalona, S. (1965). Some determinants of individual differences. *Transactions of NY Acad. Sciences, Ser. II,* 27(7):802-806.

[3] Pine, F. (1982). The experience of the self. *Psychoanal. Study Child,* 37:143-168.

[4] White, R. W. (1963). *Ego and Reality in Psychoanalytic Theory*. New York: Int. Univ. Press.

and Mahler[5] delineated affect regulation and mutuality, to name just a few.

And this brings me to a major problem I find with this book. How does one view the issues addressed by the authors in terms of a general psychology? The authors do not state clearly enough that they are describing pathology beyond the neurotic range. They are dealing with ego disturbances in reality testing—developmental and borderline pathology. The mental life development and reality disturbances in neurotic-range pathology are not really discussed or clearly differentiated, although the authors do cite Freud:[6] "What lie behind the sense of guilt of the neurotics are always *psychical* realities and never *factual* ones" (see p. 254 of the subject book; italics in original). Cases of disorganized attachment, abused children, and parents who are preoccupied because of their own history of trauma make up but a small proportion of the general population. Dividing people's histories into the broad attachment classifications does not do justice to the complexity and variation of developmental trajectories.

Too quickly, the authors assume that studies of attachment behavior can be directly linked to conclusions about the mental life of adult patients with borderline personality disorder. The paradox is this: after acknowledging that there are multiple discontinuities when it comes to a moving developmental picture of mental life and theory of mind development, the authors seem to suspend this model when it comes to attachment issues as explanations of adult pathology. How can continuities between a 12-month-old, a preschooler, a 6-year-old, an adolescent, and an adult be meaningful if the personality is as yet in such nascent form? How do we know that it is the earliest mother–child interactions that are determinative in later pathology?

Tronick describes some attachment researchers as "stuck in infancy" and as paying insufficient attention to changes and differen-

[5] Mahler, M. S. (1972). On the first three subphases of the separation-individuation process. *Int. J. Psychoanal.*, 53:333-338.

[6] Freud, S. (1912). Totem and taboo. *S. E.*, 13.

ces between the infant's and adult's emotional and cognitive capacities, states of consciousness, ways of making sense of the world, and possible meanings over the course of development.[7] Have these writers privileged data reflecting on the caregiver–infant dyad at the expense of other variables over time? The challenge is to find a methodology that will examine how psychoanalysis and empirical sciences can mutually inform each other. Lansky[8] suggests that we need a metascience to help us evaluate our efforts at synthesis per se.

Take, for example, my reading of this book's explanations of splitting. Citing Dennet,[9] the authors uncritically suggest that splitting follows naturally from a need for coherence, which is universal and elevated to a central organizing principle of the mind. Splitting may make sense in cases of children who suffer from extremes of trauma, such as sexual abuse—how can children put together that the parents who love them and look after their best interests also abuse them? However, the continuum of how one deals with mixed feelings and ambivalence needs to take less extreme cases into account via a more complex lens that is capable of examining mixed feelings—feelings that do not necessarily lead to splitting, but rather to a wide variety of differentiated defenses. Splitting has been defined in so many different ways that a more detailed delineation of its meaning requires careful consideration (i.e., Klein[10] in terms of positions; Kohut,[11] vertical and horizontal splits; Kris[12] in terms of observing ego; Stierlin,[13] splitting

[7] Tronick, E. (2003). "Of course all relationships are unique": how co-creative processes generate unique mother–infant and patient–therapist relationships and change other relationships. *Psychoanal. Inquiry,* 23(3):473-491.

[8] Lansky, M. (2003). Discussion of Peter Fonagy et al.'s "The Developmental Roots of Borderline Personality Disorder in Early Attachment Relationships: A Theory and Some Evidence." *Psychoanal. Inquiry,* 23(3):460-472.

[9] Dennet, D. (1987). *The Intentional Stance*. Cambridge, MA: MIT Press.

[10] Klein, M. (1946). Notes on some schizoid mechanisms. *Int. J. Psychoanal.*, 27: 99-110.

[11] Kohut, H. (1971). *The Analysis of the Self.* New York: Int. Univ. Press.

[12] Kris, E. (1956). On some vicissitudes of insight in psychoanalysis. *Int. J. Psychoanal.*, 37:445-455.

[13] Stierlin, H. (1973). Group fantasies and family myths. *Family Process,* 12:111-127.

within families). One needs to look more closely at the clinical context in which the splitting phenomenon occurs.

On the positive side, this groundbreaking book offers a crucially important clarification of issues on the establishment of external and psychic reality by looking at extremes—young children and very disturbed patients—in the tradition of Werner.[14] I look forward to the authors' discussion and application of their ideas to a range of mid-level psychopathology, such as the neuroses or less severe character disorders.

Using attachment theory so heavily is problematic. While four broad defensive strategies of being are delineated with attachment classifications—*open and direct* with affects and wishes, *avoidant* of feelings and wishes, *preoccupied* with feelings and wishes, or *disorganized* without a stable pattern of defense—there are so many and such varied strategies for coping that focusing on just four seems limited. It is my experience that most people are more mixed than unidimensional. Furthermore, security of attachment is just one variable in the personality; what about core intrapsychic conflicts and how they are handled, the nature of symptoms, the essentials of individuality, and psychic development? While the inner sense of security may be stable, it tells us very little about the meaningful life course and central organizing character traits constructed by a person.

Another of this book's problems is the assumption that attachment classifications and the internal working models derived from them are accurate accounts of actual events that operate out of consciousness, are resistant to change, and reflect the veridical mothering provided, without a further investigation of whether behavior has been shaped by defenses and their adaptive functions. Although Fraiberg[15] beautifully described defenses employed as early as three months of age, the authors of this book

[14] Werner, H. (1948). *Comparative Psychology of Mental Development.* New York: Int. Univ. Press.

[15] Fraiberg, S. (1982). Pathological defenses in infancy. *Psychoanal. Q.*, 41(4): 612-635.

believe that representations are based on observable patterns of the mother–baby exchange, and that they serve to regulate the emotion that arises from mother's success or failure in meeting the baby's attachment needs. Thus, representation seems limited to mental representation of self in relation to attachment. But if the mother is internalized along with the complex mesh of fantasy and affect that constitute the infant's experience of her and of important others, little room is left for the influence of wishes, conflicts, fantasies, idiosyncratic construals of meaning, temperament, biological capacities and limitations, cognitive styles, talents, strengths and weaknesses, the infantile mind-set, or primitive capacities for reasoning and understanding. The authors' near-singular emphasis on the early mother–child dyad risks the return to a postmodern version of the "schizophrenogenic" mother.

The writers suggest that attachment classification provides the tools for processing the social environment, a hypothesis that needs to be investigated; for example, are babies with secure attachments the same ones who do better on the false belief task? While secure attachment is a protective factor, it is not dynamic enough to define the complexities and variabilities of a developmental perspective. Mother's handling of attachment needs is not the only source of defensive style.

An alternative view of attachment classifications, albeit quite a bit more limited, is that of attachment classification as a general measure of ego strength, synonymous with basic trust, aspects of object constancy, and solid autonomous ego functions. The attachment patterns are like object constancy in the sense that an object representation is not a snapshot, but a sense of a whole relationship and of the shape of oneself, devised in order to hold onto the object. The individual tempers fear of loss of the object via organized defenses. One should talk of one's fantasies of safety, rather than of security itself. Some fantasies serve to temper anxiety, to allow for delay and good reflective ability, while others stimulate anxiety and a rush to action. Some may alternately serve both the purposes of delay and of action, depending on context and momentary contingencies.

The authors' model of psychopathology seems to derive from sequencing of their steps of the normal construction of a mental self—a developmental achievement, but too unidimensional as the focus for all pathology. To summarize in the most succinct way (these points are expanded throughout the book): The child must first learn that his or her internal experience is meaningfully related to by the parent (social affective biofeedback, in which affects are exaggerated and playfully fed back in manageable, containable form). The child has an "innate contingency detection module"[16, 17] and registers contingent responsiveness right from the start. The parent, giving marked affective feedback, helps the child decouple his or her internal state from physical reality, offering the child a sense of control over the experience. The exaggeration (markedness) signals nonconsequentiality. The infant repeatedly internalizes those of mother's processed images of his or her thoughts and feelings that provide containment. She is the infant's thinking system; by finding an adequate response to the infant's distress, she gives him or her a manageable vision of what the infant is communicating, and, by combining the infant's fear with irony, a contrasting affect, she gives him or her both the same and not the same, mirrored back, with the message that there is nothing to worry about.

At first, the child experiences his or her mind as a recording device—there is an exact correspondence between internal and external reality (psychic equivalence mode). Since it is so frightening for scary thoughts to be real, the child eventually finds the pretend mode (second year of life). The other who plays along (so that the child can find his or her mind in the other) can think of thoughts in play because they are stripped of the real connection

[16] Gergely, G. & Watson, J. S. (1999). Early social-emotional development: contingency perception and the social biofeedback model. In *Early Social Cognition: Understanding Others in the First Months of Life*, ed. P. Rochat. Hillsdale, NJ: Erlbaum, pp. 101-137.

[17] Watson, J. S. (1994). Detection of self: the perfect algorithm. In *Self-Awareness in Animals and Humans: Developmental Perspectives*, ed. S. Parker, R. Mitchell & M. Boccia. New York: Cambridge Univ. Press, pp. 131-149.

to the real world and people, to consequences and to implications. The two modes can be only gradually integrated through the close participation of another's mind that can hold together the child's pretend and realistic perspectives, giving rise to psychic reality in which feelings and ideas are known to be internal and yet in close relationship to what exists outside. The child's state, represented clearly and accurately, yet playfully enough so that the child is not overwhelmed by its reality, is the seed for the child's symbolic thought.

From the model of normal development comes the model of pathology. A deficient affective mirroring system undermines normal self agency, leading to impulsive dysregulation and developmental arrest at the psychic equivalence mode. The infant internalizes the parent's experience or defenses as a core part of the self, the alien self, when the child's distress is mirrored back without being mentalized or when the parent is unattuned. The child is stripped of communication that he or she can recognize and use; the mother has put forth an alternative reality not related to the infant's experience. The alien self is dealt with by externalization, giving the illusion of cohesion, control, and security. Or the child shifts to pretend mode through dissociation (splitting) as the only way to sever the connection between an internal state and an intolerable external world. The child cannot play with feelings that feel too real. Without *playing* with reality, the child does not learn that his or her experience is a version of reality or a representation that brings modulation.

One problem with this model is that, since the adult is no longer negotiating a series of adaptational and maturational changes, a model of development taking place under favorable circumstances—where maturation is at its height—cannot be applied to pathology without careful retranscription.

It seems that a model of treatment based on what a good parent does to help a child integrate the pretend mode and the psychic equivalence mode (equating thought and reality) can be used to guide the therapist, whose job it is to rekindle mentalization and enhance reflectiveness. Gradual integration of the two modes oc-

curs through the close participation of another's mind that can hold together the pretend and realistic perspectives, giving rise to a psychic reality in which feelings and ideas are known to be internal and yet closely related to outer reality. Just as the parent plays with the toddler, the therapist creates the frame for pretend play. Thoughts become accessible through the creation of transitional space. The analyst helps label and understand the patient's emotional states; the focus is not on unconscious intent, but on the emotional antecedents of enactments and on the emotions that cause disorganization. Transference interpretation is primarily a concrete demonstration of alternative perspectives of reality. Rather than preserving neutrality and anonymity, the therapist helps the patient to see him or her as a real person by allowing the patient to enter into the therapist's world. It is the therapist's task to make the expression of internal states safe by accepting the patient's transference experience, implying that the therapist does not have that experience, and thus acknowledging psychic reality, as well as providing the possibility of some distance and an alternate perspective.

But the authors of this book do not address the issue of integrating our basic task in analysis with the remedial work necessary for those patients who have not solidly established an inner subjective world. More specifically, Shapiro[18] reminds us that our basic task involves the centrality of the search for meaning: the unconscious meaning of the patient's actions, thoughts, and fantasies. If we switch techniques, we want to make sure we are not disrupting our search for meaningfulness of the intrapsychic repetitive patterns that lead to maladaptive behavior and unhappiness. Can using the transference in this way interfere with the search for meaning? The authors note that their kind of analysis is an emotionally corrective experience, since being in control changes and transforms negative affective memories through the reexperience

[18] Shapiro, T. (2003a). Whatever happened to meaning in psychoanalysis? Knowing the tides and having a map of the shoals. Paper presented at Western New England Psychoanalytic Institute, New Haven, CT, June.

of an unmarked mode with a positive sense of agency, safety, and emotional rewriting. The goal is to delineate the patterns of interaction, and to then identify and correct maladaptive models by activating alternative models of selectively interacting. Thus, though it may be that with any new endeavor, the new issues are emphasized and the old merely taken for granted, the authors of this book seem to have moved away from what psychoanalysis has uniquely contributed to the theory of mind: the view of behavior as mediated. As Shapiro points out, "the mediation process is what psychoanalysts study in the form of personally construed meaning units."[19]

The authors state that their conclusions

> . . . call for a reappraisal of the relative importance of aspects of technique in cases showing the kinds of early developmental failure that we have tried to describe. This means that certain more supportive techniques may shift from the status of parameter to mutative components, at least in the early stages of what is likely to be a prolonged analysis. [p. 477]

But it is not clear how the authors integrate the earlier, more supportive approach with later phases of a more traditional treatment. Clinical material to show how this transition occurs would have been useful in clarifying the relation between these newer modifications and our standard technical approaches. While the goal of treatment is to rekindle mentalization, at times, therapeutic action seems to bypass mediated inner life in favor of lived life, to the neglect of intrapsychic and unconscious fantasy. The authors acknowledge no need to articulate the fully complex past as a means of understanding present patterns. According to them, treatment focuses less on memories and ideas, but rather, the patient needs an interpersonal situation where the potential for reflective functioning can safely grow. Is this true for all, or a nec-

[19] Shapiro, T. (2003b). Use your words! Paper presented at the Amer. Psychoanal. Assn. Summer Meeting, Boston, MA, June.

essary first step with particular patients whose inner world has been severely compromised? The authors need to place such an approach in the overall framework of psychoanalysis.

To return to the concept of splitting, I cite my own split reaction to this book. On one hand, the authors have brought together research in the field of early mental life, subjective experience, reflective capacity, and affect regulation in such a way as to provide us with a moving picture of the complexities of development, applicable in so many different ways. They provide an excellent survey of early self development. They are convincing in their emphasis on the need for patients to gain a better understanding of the nature of mental states. They provide a rebuttal to those who claim that psychoanalysis is too disconnected from related disciplines, or that it does not provide a scientific basis for its concepts. The authors use their data to provide a creative addition to analytically oriented diagnosis and treatment issues that take account of weaknesses in the domain of experienced reality.

On the other hand, they have neglected some areas: aspects of the biological and the range and complexity of outmoded mental constellations. While they have highlighted attachment patterns, they give short shrift to the variety of unconscious fantasies that need to be articulated as a means of understanding present patterns. They do not address the problems generated by the changes in technique they advocate. It is when patients understand their active roles in the transfer of outmoded patterns to the unhappy present that they have the motivation and understanding to change.

If this book finds its place as an addition to, and not as an attempted replacement for, contemporary psychoanalytic texts—especially given the information it provides for some patients with certain needs—then it makes a significant contribution to the evolution (not revolution) of over one hundred years of psychoanalytic thinking.

WENDY OLESKER (NEW YORK)

ATTACHMENT THEORY AND PSYCHOANALYSIS. By Peter Fonagy. New York: Other Press, 2001. 262 pages.

This book offers a concise, useful, thought-provoking overview of attachment theory in the context of contemporary psychoanalysis, while also providing a meaningful background for the author's more recent publications. Few analysts possess the depth and breadth of scholarship that Peter Fonagy brings to bear in presenting his ideas. The clarity of his presentation is welcome, and the contents of this book are clinically relevant, research based, and theoretically rigorous.

Attachment theory has had a rather beleaguered history. It dates back to Bowlby's widely read and widely criticized work, which was carried out in the 1960s and has been greatly expanded since then. Many factors have played a role in the marginalization of Bowlby's contributions. Some infant and child researchers interested in Bowlby's work came from academic empirical sciences and observational research settings; they were not familiar, for the most part, with the fundamentals of psychoanalytic theory and practice. Bowlby's novel ideas often seemed questionable and difficult for them to embrace. Among psychoanalysts, Bowlby's attachment theory was first vigorously criticized and then largely ignored. Criticism came in part because of his unorthodox view that social bonds are a primary given (rather than derived from drive expression), and because he emphasized observation of the child's reality, rather than focusing on the inner representational world that was of interest to more orthodox analysts. He was criticized even more sharply for allegedly renouncing the unconscious and the centrality of the Oedipus complex, as well as for negating the importance of affects rooted in the infant's bodily experience and of those arising in the context of adaptation and socialization. He was also taken to task for viewing physical separation as the primary source of motivation, for underestimating the role of developmental stages of the ego in understanding the impact of attachment and loss, and for all but ignoring the importance of symbols and symbolization. In short, for many years, Bowlby's ideas were met with criticism and dismissal.

Fonagy believes that Bowlby's empirical observational work needs to be integrated into modern psychoanalysis. Neither traditional academic observational researchers nor psychoanalysts have fully appreciated the rich relationship that exists between attachment theory/research and psychoanalysis, according to Fonagy. He therefore presents his views on integrating the two so as to provide a context for discussion and research.

Fonagy begins with an extensive summary of the formative concepts and research findings of attachment theory. He discusses an array of points of convergence and divergence between attachment theory and Freud's model, the North American structural model, the Klein-Bion model, that of the independent school of British psychoanalysis, and the interpersonal relational approach. He proceeds to highlight in extensive detail the strengths and problems within attachment theory as they relate to the spectrum of modern, "great" theoretical perspectives. Additionally, he discusses the specific relevance of the work of Daniel Stern, and provides a synopsis of that of less well-known attachment theorists, such as Karen Lyons-Ruth, Morris Eagle, Jeremy Holmes, and Arieta Slade.

In a synthesis of ideas mentioned earlier in the book, Fonagy goes on to discuss the commonalities between attachment theory and psychoanalytic theory in general, and he draws attention to the benefits that attachment theory can derive from psychoanalytic insights. The author emphasizes, integrates, and differentiates among key conceptual approaches and controversies that define the cutting edge of current attachment theory and research. Along the way, he draws attention to his own conceptualization of mentalization and weaves this concept into a more general exposition of the theoretical fabric that defines the field.

Fonagy attempts to integrate experimental "social science" and clinical psychoanalytic theory in a way that seems to me sensible, justified, and to the point. He identifies many practicable tracks of research that could find a place in academic settings. I think his work can therefore contribute to greater credibility for psychoanalysis among thinkers in academic circles where analysis

has been marginalized or vilified for failing to conform to the rigorous procedural paradigms and epistemic metaphysics of modern science.

Within analysis itself, and particularly among those analysts espousing traditional structural theory, Fonagy's work can be seen as presenting a serious challenge to the limitations of one- and two-person psychologies; at the same time, it offers a context of mental systems theory from which neither intrapsychic nor social influences are excluded. Attachment theory is neither subsumed by nor does it subsume traditional analytic traditions.

Of course, *Attachment Theory and Psychoanalysis* does not purport to offer the final word on attachment theory or on comparative psychoanalysis. Much is left unsaid or is only touched on in passing when reference is made to specific ideas in the work of authors with other theoretical views. Furthermore, more extensive exposition of the concept *mentalization,* including its many clinical ramifications and its role in psychological development, must await future publications. Similar shortcomings are to be found in the author's summary overviews of the "great" psychoanalytic perspectives. His intention of highlighting attachment theory may provoke objection on the part of some readers, but, at least from my perspective, his exposition stimulates a range and depth of lively discussion of attachment theory that opens up clinical, theoretical, and research considerations in a way that the writings of few other contemporary writers do.

Fonagy has further explicated his ideas in two subsequent volumes that build upon this one: *Affect Regulation, Mentalization, and the Development of the Self* (coauthored with György Gergely, Elliot L. Jurist, and Mary Target, 2002) and *Psychoanalytic Theories: Perspectives from Developmental Psychopathology* (coauthored with Mary Target, 2003).

At this point, attachment theory is still evolving. While it does not yet represent a fully explicated or cohesive whole, its current key concepts, pivotal findings, and research approach are admira-

bly presented in *Attachment Theory and Psychoanalysis*—a tour de force written by one of our leading theoreticians and researchers. Because it is timely, clearly written, succinct, and stimulating, I believe the book will find a special place in the curricula of psychoanalytic training programs and on the reading lists of analysts for whom attachment theory has not had a place, or of those who may have ignored or depreciated it in the past. Fonagy plays a leadership role in psychoanalytic theorizing, and this book describes a cornerstone of his perspective.

GREGORY D. GRAHAM (HOUSTON, TX)

WINDOWS. By J.-B. Pontalis, trans. Anne Quinney. Lincoln, NE: Univ. of Nebraska Press, 2003. 142 pp.

J.-B. Pontalis is well known to readers on this side of the Atlantic from his many publications, especially his well-regarded *The Language of Psychoanalysis* (1973), coauthored with J. Laplanche, and from his many years as editor of *La Nouvelle Revue de Psychanalyse*. He may require little introduction, but nonetheless, we are provided with a very effective one in a fine translator's introduction to this book.

Windows does not lend itself very readily to review, just as it does not open itself to reading on conventional terms. We have here a series of brief and very personal essays or reflections, or what I would prefer to call musings. Each is but a page or two in length. There is no discernible sequencing or overall plan of organization of these musings; rather, they seem random or casual and unpremeditated. Each is centered on a particular topic, almost freely associative in character, and touching—at times directly and explicitly, at other times quite indirectly and diffusely—on matters of concern or relevance to psychoanalytic experience. The intent does not seem to be clinical or even theoretical, although occasionally, the author's attention turns to case material or to a particular patient. Rather, these little musings are more general

reflections on and about psychoanalytic experience and experiences—in the first instance, the author's own experience, and by implication, others,' yours and mine. They are focused psychoanalytic meditations, or perhaps better described as invitations to psychoanalytic reflection or meditation.

This perception leads me to say that this little book is better not read as one would read an ordinary book, going from chapter to chapter, starting at the beginning and continuing on to the end. The present volume resists that approach, lending itself to more casual perusal. Rather than reading it from beginning to end, the reader would do much better to consider the book a leisurely reflection on individual topics. These meditations or musings are better suited to the odd moments, the spaces of relaxation and quiet that may turn up in the course of an otherwise busy schedule. They call less for reading than for mulling or savoring; they invite musing in the reader in response to the musing of the author. The book succeeds in this by touching on elements of the analytic experience that all analysts share. I found scarcely a page on which there was not some common chord, some reminiscent turn of phrase or suggestion that stirred recollections or triggered a string of associations or further musing of my own.

So I recommend that *Windows* not be read, but rather tasted and mulled—as one would a fine wine rather than a *vin ordinaire*. I found it better to consult one topic at a time—the order matters little since they are all quite independent and self-standing: taken either in sequence or randomly, they are of equal merit. And I would add that one could make a case for the real benefit or value of these little essays by appreciating the extent to which the deeply personal musings of their author prompt or elicit a companion musing in the reader. So if one is open to moments of quiet self-reflection and sensitive musing—I almost said *reverie*—one has the opportunity in these pages of opening a window or windows to oneself. The exercise may be salubrious.

W. W. MEISSNER, S.J. (CHESTNUT HILL, MA)

AFFECT INTOLERANCE IN PATIENT AND ANALYST. By Stanley Coen. Northvale, NJ: Aronson, 2002. 290 pp.

"How Much Does the Therapist at Work Need to Feel?" asks Stanley Coen in this book's chapter 7, which bears that title. A great deal, he answers: he or she must be able to experience passions—both of love and hate—in order to explore them in the treatment. Several clinical vignettes detail the author's struggles with intense feelings, as well as his satisfaction when he succeeds in resonating with his patients. For example, he was surprised to find himself hating a patient, Ms. X (pp. 15-21). Presentation to a "peer supervision group" (p. 20) helped him understand that her surface presentation of love had been so gratifying that he had been complicit in camouflaging her underlying rage and hatred. Another patient (Prof. J, pp. 21-27) evoked hatred with his tenacious resistance to experiencing the neediness that he hid behind a facade of rigid rage and entitlement. Colleagues at Austen Riggs, used to working with hospitalized patients, helped alleviate the author's pessimism (p. 24).

As noted in the preface, *Affect Intolerance in Patient and Analyst* is the product of many years of work, which "incorporates, in thoroughly revised form, material previously published elsewhere" (p. v). It is comprised of eleven chapters and divided into three parts. Part 1 is entitled "What Makes Affect Intolerable for the Patient and Therapist?" Part 2 is "What Is the Therapist's Role in Helping the Patient Develop Affect Tolerance?" And part 3: "Helping Therapists' Affect Tolerance through Talking and Writing about Our Work." Illustrative clinical vignettes accompany such subtopics as "Barriers to Love," "How to . . . Bear the Unbearable," "Managing Rage and Hate," "Perverse Defenses," and "The Wish to Regress." Many of the chapters might be read individually.

Somewhat incongruous with the title of part 3, its third chapter addresses the application of child development research to adult treatment, while the fourth discusses two papers by Erik Erikson. Although these two chapters are interesting, the book

would be more cohesive without them. Their inclusion highlights the inherent difficulty in organizing a collection of papers under one title. The split focus of the book—the subject of affect intolerance in patient and analyst, and the subject of effective communication with colleagues—arises in part from the need to find a unified thread for a variety of papers.

Coen helps his patients to bear intolerable affect *"by experiencing with and for the patient"* (p. 158, italics in original). He views his position as akin to that of therapists who treat traumatized patients by attempting to "resonate deeply with the unbearable" (p. 171), and to "persist with feeling what the patient cannot feel" (p. 171). Feelings of empathy, outrage, love, and hatred toward patients are described. The treatment process with so-called difficult patients involves an oscillation between collaboration and disruption and is often quite lengthy. In one case, although he had been advised by colleagues to discontinue the seemingly endless analysis of a consistently rejecting patient, Coen preserved the hope of an eventual positive outcome. The reader is reminded that tolerating frustration is part of analysis for both parties.

The author describes himself as a traditional analyst who "tries to integrate the helpful clinical contributions of colleagues' relational, interpersonal, Kleinian and attachment theory perspectives" (p. 155). However, terms that imply tacit adherence to what has been characterized as a relational framework and that are used interchangeably in the book are: *treatment partners*, *treatment couple*, and *analytic couple*. The clinical vignettes also demonstrate that the author's theoretical framework is more accurately described as interactive than as what is usually called traditional.

For example, Mr. N (pp. 64-71; the *N* stands for *negative*) expresses rageful feelings by shouting in the analyst's face, bending his Venetian blinds, and lying about finances. This patient responds favorably to the analyst's empathic comments about his loneliness and neglect as a child, but the negativity continues. One day, the discouraged analyst relates a conversation with his

own grandson. He contrasts the attentive manner in which he, as a doting grandparent, has behaved with the neglect Mr. N experienced as a boy. Mr. N is then able to experience the analyst as "a new developmental object," and some working through occurs. Eventually, Mr. N "felt encouraged that he could take pride in a newfound capacity for caring feelings with me" (p. 70). He begins to be playful in the sessions, and brings in a poem. A relational perspective, rather than a traditional approach, informs the treatment demonstrated by this vignette.

A separate focus of this book is the need for collaboration with trusted colleagues. In the author's words:

> I think it is very helpful for us to talk and write openly—a major aim of this book—about our difficulties tolerating patients' rage and hatred toward us so that we can manage better such destructiveness, in ourselves and in our patients. [p. 63]

The importance of exchanging clinical material with other clinicians is reiterated numerous times throughout the book. Two chapters in part 3 are devoted to the subject of communication with colleagues: "Discussing Colleagues' Therapeutic Work" and "Why We Need to Write Openly about Our Clinical Cases." The history of psychoanalysis is replete with political bickering and, at best, we have had a conservative attitude toward new viewpoints. Therefore, although tangential to the topic expressed by the title of the book, attention to the teaching of communication skills is welcome. Our profession has been slow to accept the need for analysts—acute observers and careful listeners who we are—to be taught how to work with colleagues and to coherently present our thinking. Perhaps the recent introduction of workshops and seminars in case writing and supervision will improve these skills in the next generation of analysts.

The author's attempts to model fairness and tact in discussions of several panels and presentations are of limited success.

He states that a concentration on the presentation process through the lens of affects will facilitate tolerance of diverse theoretical viewpoints, yet he stridently sides with the relational presenters whom he perceives to be attacked. For example, we are told that a panel entitled "What in the World Is the Relationship?" (p. 153) became politicized. The majority of participants, described as traditional analysts, are also characterized as sharply critical of the relational presenter. Coen angrily and vehemently defends the viewpoint of the presenter, who emphasized her own affects and whose theoretical framework encompassed a frequent sharing of her feelings with her patients. This strong bias belies the author's admonishment to colleagues to maintain a nonjudgmental attitude. It highlights how difficult it is to avoid polarization and to maintain respectful communication across the probably theoretically incompatible differences among us.

In another example, a presenter, Dr. R, has dealt with his recognition of "homosexual tensions" (p. 95) between himself and his patient by self-analysis and interpretations, but did not bring the issue up as a topic for joint discussion. One Monday morning, Dr. R fell asleep in a session. Once again, Dr. R's theoretical framework led him to undertake self-examination, followed by directly addressing with the patient only the latter's reactions to his analyst's falling asleep. Coen says that the analyst should have considered the issue as a concern of the treatment couple and should have acknowledged to the patient his difficulty in connecting. The message suggested by this critique is that the therapist must engage interactively and in a self-revelatory manner in order to be able to fully acknowledge his own passionate feelings. Once again, a debate about which theoretical framework is "correct" has taken precedence over open communication of ideas about tolerating strong affects.

The strongest features of this volume are the discussions that focus on tolerating desire and rage, on bearing the unbearable, and on wishes to regress in both patient and analyst. In those

sections, the personal struggles of the author as analyst are enlightening and moving. As Coen aptly writes, we bring with us a heritage of emphasis on abstinence, in which acknowledgment of strong passions toward patients has been viewed as potentially the beginning of a slippery slope. The word *countertransference* has been used as a club with which to pronounce critical judgments upon colleagues. Patients have been declared unanalyzable even though, had we been better able to tolerate and contain their strong affects, they might have benefited from analysis.

The author observes that so-called younger analysts tend to be more accepting of their strong feelings of love and hate than are the older generation of analysts. They seem less burdened by the fear of being criticized for admitting that they are struggling with passions of love and hate aroused by the treatment process. Yet all of us avoid some patients and collaborate with others as we seek to manage our own needs and desires.

The main subject of this volume (i.e., intolerable affect in analysts and patients), and a beginning exploration of what to do about it, is thoughtfully and insightfully presented. *Affect Intolerance in Patient and Analyst* is appropriate for experienced clinicians as well as for students of psychoanalysis and psychotherapy.

SYBIL A. GINSBURG (ATLANTA, GA)

FATHER HUNGER: EXPLORATIONS WITH ADULTS AND CHILDREN. By James M. Herzog. Hillsdale, NJ/London: Analytic Press, 2001. 324 pp.

This is a strange, fascinating, wonderful book. In a manner of speaking, it is three books in one. First of all, it is, in a meandering, slowly developing way, about the topic that gives the book its title—*father hunger*. Second, it is about a topic that has been a particular preoccupation of the author for some time—*play*, both within and outside of the analyst's work space. Finally, it is about something that, to this reader at least, forms the haunting, overwhelm-

ingly dominant theme of the book, although I am not sure that the author is aware that it is the theme that dominates—the *Holocaust and its impact upon the offspring of its survivors.*

Herzog has been studying the role of the father in the nuclear family for a long time. When I was president of my local psychiatric society over twenty years ago, I invited him to speak to our group on that topic, and his presentation was very well received. His focus that evening was upon the father's role in diluting the intensity of involvement between child and mother, so that the child can have a chance to bud off, individuate, and stand on its own. The concept of *father hunger* has evolved out of that earlier interest. Herzog does not explicitly define father hunger, but, as I understand it, he is referring to the effect of a father's failure to fulfill his children's need for him to be an aggressive, powerful but loving paternal figure who facilitates his children's capacity to play with, get to know, and harness their aggressive endowment so that they can use it to fuel exciting libidinal expression and effective executive activity.

Herzog states:

> I am always trying to explore the ways in which the self, especially the masculine self, develops as a self-seeking entity using sameness and difference as a way of harnessing, knowing, and owning his own attributes, both facultative and problematic. [p. 2]

His book, furthermore, is "intended as a window on the processes of development, derailment, and repair as these are accessed, uniquely, in the analytic modality" (p. 3).

Herzog presents the case of Michael, a 50-year-old man who has a "good" marriage but has twice "fallen in love" secretly with men who have "idealized him as a father-mother" (p. 5). Each time that thoughts of the man he loved intruded into Michael's fantasies while he was engaged in lovemaking with his wife, it was in the "form of a present, benevolent, and supportive man" who "stood

for [his] unresponsive father" (p. 6). Herzog analyzes this in terms of hunger for the good father whom Michael was not fortunate enough to have had. Michael's father was actually a critical, sadistic, brutalizing tyrant, when he was not neglectful and abandoning.

Startlingly, however, Herzog seems to miss the significance for Michael of his father's Holocaust background! Michael reports dreams of a son in a concentration camp and of a son being beaten. He reports a compulsive need for sex (as a life force, I wonder?) every night, and he refers to his ejaculation as "shooting" (p. 3). He indicates that his special area of interest is Nietzsche, and he repeatedly employs German words and phrases—*nicht Gesicht*, *Weltanschauung*, and so forth. Michael attends a Holocaust meeting in Germany. He speaks of killing chickens and of chopping off their heads. He states that the only way his frequent lovemaking with his wife could end "would be if something terrible happened" (p. 14). Herzog states that "a sadistic aggressive component beneath the defensive invocation of the lovemaking seemed clear" (p. 15). The two men whom Michael loved had the German names *Hans* and *Erik*.

In a later chapter, Michael comes through even more clearly as dominated by the effects of the Holocaust. His father, who had been terribly scarred by his Holocaust experiences, repeatedly gave him "shots" and sadistically beat him up and beat up his mother. He once even broke Michael's bones, when he was a little boy, by throwing him against a wall. There are allusions to the way in which all of this affected Michael's oedipal conflicts while he was growing up. Perhaps Herzog deliberately postpones reference to the importance of the role of the Holocaust in generating Michael's neurotic anguish, but it is not at all clear in the opening chapters that he recognizes its powerful presence and central importance. I could not help but find this seeming oversight unsettling, particularly by someone whom I so much respect and admire.

Herzog, corroborating input from the patient, interprets two dreams that Michael had seventeen years apart (during his first

and second analyses) in terms of the concept of father hunger, i.e., as reflecting a boy who needs to be rescued by a father who, however, never makes an appearance. Herzog's central assertion is that "children need a father . . . the father's principal intrapsychic role [is] as the modulator and organizer of aggressive drive and fantasy" (p. 51). He cites Loewald's and Mahler's view that fathers "function as a protector against the threat of maternal engulfment" (p. 51), and he makes reference to Ernst Abelin's view of the father during the "late practicing and rapprochement phases" as "the organizer and modulator of intense affect paradigms" (p. 51).

Mothers begin differently in their interactions/relationship with their children than do fathers, Herzog states:

> The mother's initial stance is one of already being with and, in some sense, in. She perhaps needs to withdraw a little . . . . The father, on the other hand, needs to find a point and mode of entry into both the mother–infant dyad and his child's inner world . . . . Just as the mother must, in a sense, withdraw, he must, in a sense, intrude, penetrate . . . . The paternal mode of entry can constitute an intrusion . . . [and] mothers typically go about restoring order after their fathers' Kamikaze style engagements . . . . Where this sharing of roles does not happen, aggression does not become modulated. [p. 56]

In chapter 6, "Bart and the Killer Walrus," Herzog describes a little boy whose father (who had himself been puny as a boy and had to be hypermasculine to feel comfortable) encouraged him from the beginning to be aggressive as a synonym for masculine, while his mother restrained herself from intervening. Bart became a terror in the neighborhood. In analysis, Herzog presented himself as a father figure who helped a little boy learn how to control his aggression, and he encouraged Bart to do the same.

I have been impressed, while evaluating youngsters for several school systems over the past many years, with how often I have

encountered boys (and some girls) who have been traumatized by having been abandoned by their fathers. They are depressed, angry, and distrustful of authority. As a group, they tend to seek immediate or short-term satisfaction and do not appreciate the value of working hard to empower themselves through education, although some of them are quite intelligent. Far too many of these youngsters engage in antisocial and at times illegal activities, or are clearly headed in that direction. Herzog addresses this phenomenon as follows:

> The son whose father is not available, the boy who does not experience an answering male reality, both physical and affective, sets out to *steal* that which is not freely given or elicitable. Without a man's acknowledging his mind, tracking him, thinking about him, an array of problems in minding, mindedness, and employing the symbolic function ensues . . . . Deformation in the direction of I don't know how, I lack the equipment, and I can never learn predisposes to stealing and flows into disturbances in having to do it. [pp. 75-76]

Herzog's interest in *play* comes through repeatedly in the course of his (wonderful) clinical presentations, which involve children, adolescents, and adults. He offers intriguing (and very sensuous) material, for example, about his work with an adolescent girl (during a summer when she was fourteen, and then in analysis for four years when she returned to attend college in Boston). The second of the two chapters devoted to his work with this patient appears to have little to do with the topic of father hunger, but once again, it involves Holocaust survivor issues. We are told that the patient's preoccupation with a boyfriend's "butt" during the summer when she was fourteen—and with Herzog's "butt" during that same time—was connected with intense loving feelings for her German grandfather, eighty-eight years old at the time and deteriorating from Alzheimer's disease. The patient played music and sang during her first session with Herzog. At the time, her doing

so was puzzling and incomprehensible to him. During the later treatment, both that and the "butt" preoccupation become much clearer, when the patient explains:

> When I go . . . and dance with him [her grandfather], he sticks out his butt as though I'm supposed to admire it. He's eighty-eight years old. He was at Bergen-Belsen and then Auschwitz, and he is vain about his butt. [p. 105]

It is clear that Herzog was very much taken with his clever, dynamic, pretty young patient, who let him know that she found him very exciting and who shared his love for puns and plays on words. But there is a darker, hidden side to the mutual fascination that Herzog and his patient had for each other. In a very brief but very moving preface, Herzog dedicated the book and the professional work that led up to it to his maternal grandfather, who would not let his son go alone to Auschwitz, but voluntarily accompanied him there so that they would perish together. Herzog states in the preface:

> I never knew my grandfather, and horror of his particular circumstances and of the Holocaust generally defy comparison, but the identification with him is strong. To accompany, even in terror; to refuse to extract myself, even at a cost; and to try to help so that a person who requests my assistance, and with whom I have forged an alliance, need not do it alone—has been my guiding principle. [p. ix]

When I had gotten halfway through this volume, I found myself wondering, in fact, if the book might aptly have been titled *Grandfather Hunger*.

Via a dream that leads her both to clever word play involving the sequence *weasel—mongoose—man-goose*, and to a teasing, playful, exotic but also pained interaction with Herzog, this same patient comes to reveal that she viewed Herzog when she first met

him as "incredibly handsome, a blond, blue-eyed, six-foot-two-inch German" (p. 108). She informs him that her boyfriend that summer in Boston was also German. She indicates that for a long time, she has been drawn to German guys, and quickly jumps to saying: "My butt is a dead giveaway. It's a girl's butt" (p. 108). After a brief interchange between them about the phrase "a *dead* giveaway," Herzog asks her, "Are you saying that if someone sees that you are a girl, that it will be curtains for you?" (p. 109). She replies: "What you said is sort of interesting, I started thinking of the Nazis, how unspeakably terrible they were and that, if I had been in Europe then, they would have killed me just like they tried to kill Opa and did murder his wife and their three daughters" (p. 109). One of the daughters, it turns out, was named Manya Goosen; she fled from the Nazis and joined the partisans, only to be "turned in when they discovered she was a girl" (p. 109).

Herzog then shares a segment from a year and a half later in the same analysis, in which the patient lambastes him as a destructive, narcissistic sadist, as she speaks about people who torture and murder other people. Her associations lead her to her grandfather's experiences in Bergen-Belsen. She then reveals that in school, she has been watching films in which people do unspeakable things to other people. The course she is taking, she says, "is about the Holocaust, and now we're talking about why people do these things to other people and how a person gets to be able to do it" (p. 116). The chapter ends with the patient's recounting a story about a Jewish boy who runs to join his friends, who are being marched off by the Nazis, and ends up being shot after he scoots up a tree. The patient says, "I don't know why it came to mind, but it is something about being able to get away and then choosing not to . . . something about choosing to participate in one's own destruction" (p. 121)—(like Herzog's grandfather!). *Play* is prominent in this case report; father hunger is tangentially a factor; the *Holocaust* in Europe adumbrates all else.

In chapter 11, Herzog departs altogether from the subject of father hunger (although the clinical data revolve around the mor-

tal illness and death of a father). It is his fascination with the subject of *play and playing* that prevails—but once again, the effects of the Holocaust form a prominent topic. The central theme of the chapter is how difficult it can be, even impossible, to hold firmly to the cardinal rule in psychoanalytic work of resisting entreaties to have physical contact with the patient, in cases where the patient has been so violently brutalized in the past that words are not enough. (Can it be that we have not really left the topic of the emotional effects of the Holocaust?) Herzog ends the chapter by visiting theoretical notions about the way in which the "paternal rough-and-tumble play mode [might] allow experience with disruption, [so that it] . . . might help to construct *a protective shield against traumatization* [that could] . . . be the substrate for both resiliency and strength *in the face of actual onslaught*" (pp. 138-139, italics added).

Herzog goes from here to a chapter that begins: "Dr. C's story is an example of how trauma becomes transmitted from one generation to the next, how it becomes entombed in fantasy, and how that fantasy and its entombment can become embedded in erotic play" (p. 140). Historical calamity is here seen to impinge upon a boy's fantasy life in a way that becomes apparent in a very disturbing manner fifty years later. The patient has been referred to Herzog for treatment because of Herzog's "immersion in the study of the effects of the Holocaust on children of survivors" (p. 142). The clinical material that is presented has nothing to do with father hunger, but it is a fascinating account of the relationship between certain neurotic acts and symptoms and details of Holocaust traumatization.

In the chapter titled "Natalia and the Bacon Factory," Herzog does a major service by forthrightly and courageously exposing his own emotional sweeps and storms as he allows himself to rub emotional shoulders with children who have been so brutalized that they are raw and relatively unfiltered in their primitive hunger for contact with him. I can best demonstrate this by quoting Herzog's own words:

> When Natalia, playing Natty, jutted out her bottom toward me and saucily requested a swat, I felt like complying. I did not wish to hit her really hard as she suggested, but it seemed as though a love pat would be just in order. I felt like I could do this and it would continue the play. As the term love pat came to my mind, however, I knew that I could not do this so cavalierly, nor should I, as the conflation of aggressive and libidinal underpinnings was inseparable. [p. 177]

He goes on to say:

> Even as I tried words, with a freedom that Natalia's stance granted, I did not know that they would suffice. I wondered if Natalia would need an experience with a more controlled aggressive interaction, for example, a whack to counteract her experience with her father's out-of-control attacks on her body and spirit. Were this to be an actual requirement, how would the two of us negotiate it, and how would we disentangle such play from the concomitant sexualized itching and touching issue? [p. 178]

We also need to hear from Natalia:

> At about the time we stopped, Natalia said to me, "You know me better than almost anyone else does, and I know you better too. I know how you do things. That is very important. I know how we do it together, how it goes between you and me. I know you so well that I know how you smell. You know how I smell too." I thought that she was right. [pp. 179-180]

In the chapter called "Tommy and the Black Lion," we encounter an abundantly clear clinical example of Herzog's concept of father hunger. The patient, Tommy, is very angry with his perfidious mother, who has withdrawn from him as her star and is giving her precious "ma-milk" to his baby sister. Hurt and narcissistically deflated, he turns to his father for the "pa-gas" (gasoline) that powers the strong but dangerous automobile—"Night Rid-

er"—with whom he identifies (Herzog might not have been familiar with the television show "Knight Rider"). Tommy needs, Herzog tells us, to detach himself from his mother-self-with-mother orientation and enter into a self-with-father identification.

For some time after beginning the treatment, Herzog is mystified and befuddled by Tommy's symptoms and by what he is playing out in the sessions. By the eighth month of treatment, the third month of four-times-per-week meetings, Tommy was repeatedly calling his analyst stupid. Herzog tolerates this description of his own mystification, and he patiently and doggedly persists in his efforts to understand what is being conveyed to him. (While reading this, I recalled something Max Schur said during a course in which I participated while in psychoanalytic training: "One of the nice things about psychoanalysis is that if you don't get what the patient is telling you the first ten times, you'll probably get it the eleventh time.") Eventually, the issues become clear.

Toward the end of the second year of analysis, Tommy, now age seven, becomes terrified of "black lions." He explains that, "Black lions are really mean. They kill because they like to, not just for food" (p. 220). He explicates further: "He has no family. He is the only black lion . . . . That's what makes him so deadly and dangerous. He has nothing to lose . . . . It helps to have someone who is like you. Everyone knows that, stupid" (pp. 221-222).

Tommy makes Herzog into a knowledgeable, powerful, black lion doctor. Tommy himself becomes a ferocious black lion named Wrecks (Rex?) who does nothing but kill and eat people. It is the black lion doctor's job to help him tame himself and get himself under control. Via dreams and a preoccupation with whether the father of another little boy will spank him for disappointing him, Tommy makes it very clear that, like a lion cub, a boy needs a kind, understanding but firm father who will help him learn how to tame, modulate, shape, and make good use of his innate aggressive inclinations.

A little later, Herzog tells Tommy, as they are playing and talking together, "That's how a little lion learns to hunt. You know he needs a teacher." "Yeah," Tommy replies. "Someone who is like him and knows how it feels to run fast and then to jump and strike" (p. 227).

Other chapters of *Father Hunger* focus on children's dreams, fathering sons and daughters, the father–son relationship as a paradigm for male–male interaction, expectant fatherhood, teenage boys who have impregnated girls, and the theme of "father, aggression, anality, and the bottom" (p. 300). Rich clinical detail is provided from both adult and child analyses.

Chapter 19 contains extremely interesting material from seven consecutive analytic hours with a man who "had a problem with the modulation and organization of his aggressive drive and fantasy" and "elaborated its 'containment' in an anally organized structure" (p. 301) that produced perverse anal behavior. In the final, brief chapter, Herzog provides a follow-up on most of the patients whose treatment he has described in the book, amply demonstrating the efficacy of psychoanalytic treatment.

I recommend this book heartily, not only to those who are interested in the particular topics addressed in its pages, but also to those who enjoy reading about effective psychoanalytic treatment or who search for useful adult and/or child analytic material for teaching purposes. I am especially grateful to its author for providing an abundance of clinical analytic detail, in which he willingly exposes the human dilemmas and human frailties that play a part in his work as an analyst. It is a welcome antidote to the many psychoanalytic books and papers that present abstruse conclusions that are unsubstantiated by primary data or that depict perfectly calm, all-knowing analysts who never get ruffled and are always on target, correct in their brilliant interventions. Only human beings can analyze other human beings; and I am grateful to Jim Herzog for being very human and admitting to it.

MARTIN A. SILVERMAN (MAPLEWOOD, NJ)

PEP CD-ROM, Archive 1, Version 3. Published by Psychoanalytic Electronic Publishing, www.p-e-p.org.

My first reaction when invited to review the new PEP CD-ROM was that I am not competent to do so. I am an active consumer of the psychoanalytic literature, but basically computer illiterate. I am too coddled to have mastered the technology and use it only for e-mail. The coddling is done skillfully, and as far as I can tell effortlessly, by Russell Scholl, my administrator for the last fourteen years and a talented and proficient "natural" at computers. My second reaction was that, just as we use the PEP CD-ROM collaboratively, Russell and I should collaborate in writing this review.

It seems amazing that the whole system is so small—seventy-eight years of the complete text of the major psychoanalytic journals all in the space occupied by a small book! The shelf space saved is worth the price (although pretty soon, all the other things one would put on those shelves will be just as compact). Even more important, everything is retrievable and accessible—no more searching through volumes of *The Psychoanalytic Quarterly* only to find that my memory failed and the article I sought had actually been published in the *Journal of the American Psychoanalytic Association*, or that the article I remember reading thirty years ago was in fact published twenty years before that.

Russell installed the program (he will tell this part of the story in the following section of this review), and we sat down for my first lesson. I started where anyone would, looking up all my papers and all those that referred to them. It took seconds, and while there were no surprises on the first list, there were a number on the second. There were people I did not know and had never met who had cited me, and I could quickly and easily find them. I liked that. However, competitiveness soon won out over pride; what about some of my better-published colleagues? I learned (or confirmed) that they published much more than I, and cited me less often than I cited them. The truth hurts.

The disc has two basic characteristics—the more obvious is that it comprises a complete library of every article in eight major psychoanalytic journals, from their beginnings through 1998.[1] The second is that it contains an extraordinarily versatile search engine that allows the user to review every page of these journals while asking questions such as, "Where does *transference* appear in the same paragraph as *psychosis?*" or "Does Kohut ever refer to Sullivan?" The program not only answers such queries; it also generates interesting questions of its own that are now easy to answer, but would not have seemed worth the effort before. Paul Mosher's study of trends in the use of psychoanalytic concepts over time is an elegant example of how such a process can be invaluable[2] (and, since that study was published in 1998 and is based on an earlier edition of the PEP CD-ROM, it can itself be retrieved from this disc).

A single disc that contains all these articles is a miracle of the electronic age, but it is the search engine that makes the real difference. It supports a sort of dialogue between the user and the entire body of psychoanalytic literature, even making the vast literature that the user has never read available for study.

In addition to providing access to the literature and making it available for searches, the disc enables the user to print any article it contains. That means that readings for seminars, study groups, or personal use are instantly available in hard copy, without the need to find them in a library or on one's own shelf. This alone has more than compensated for the (high) cost of the discs —what used to be a major chore is now a trivial step.

In sum, the PEP CD-ROM is a remarkable library, a creative tool for systematic searching, a convenient source of paper cop-

[1] Version 4 of the PEP CD-ROM has become available since the writing of this review. It contains additional journals—a total of thirteen—through the year 2000, as well as twenty-three books, including *The Freud-Klein Controversies, 1941-45* (King & Steiner) and the Laplanche-Pontalis dictionary, as well as major works by Anzieu, Bion, Fairbairn, M. Klein, Matte Blanco, H. Rosenfeld, and D. N. Stern.

[2] Mosher, P. (1998). Frequency of word use as indicator of evolution of psychoanalytic thought. *J. Amer. Psychoanal. Assn.*, 46:577-581.

ies of articles, and a wonderful toy, all in one. Future versions may come to replace both journals and books. Get it and learn how to use it now; you will throw away your old journals.

ROBERT MICHELS (NEW YORK)

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For the psychoanalyst and the student of psychoanalysis, the PEP CD-ROM is an invaluable resource. With this disc, the researcher has at his or her fingertips a virtual library comprising the complete runs of eight major psychoanalytic journals from 1920 to 1998:[3] *Contemporary Psychoanalysis*, the *International Journal of Psychoanalysis*, the *International Review of Psycho-Analysis*, the *Journal of the American Psychoanalytic Association*, *The Psychoanalytic Quarterly*, the *Psychoanalytic Study of the Child*, *Psychoanalytic Dialogues*, and *Psychoanalytic Inquiry*.

Countless hours (not to mention shoe leather) can be saved by users of this disc.

This version of the PEP disc is actually a two-disc set: a setup disc and another that contains the database. Just as with the earlier versions, it must be registered shortly after installation or the program will cease to work after fifteen days. Licensing is required to prevent copying the software. I found the installation and registration process straightforward and the PEP support very responsive and helpful (via e-mail and by phone during prescribed hours each day). Once you have installed and registered the software, you may use the data disc as a regular CD-ROM, loading it into your CD-ROM drive each time you want to access the database, or, given enough available memory, you can copy the contents of the data disc directly to your hard drive. The latter facilitates speed and ease of use.

Included in PEP's "Help" feature (which comes with the PC version of the disc; Mac users must refer to the PEP website) is the "Quick Introductory Tutorial," a guide to get the neophyte up and running. I found it a most satisfactory primer and a fine in-

[3] See footnote 1 on the previous page.

troduction to the wonders of this disc. I also found that it took longer than the stated forty-five minutes to work through it thoroughly. The search software employed, Folio Views, is somewhat complex, and takes time and use to master. To get started, however, the Quick Tutorial is sufficient, and will take the user a pretty long way.

This is a great disc for browsing. Like poking around library stacks or strolling the aisles of a favorite used bookstore, the user is taken down unexpected pathways that lead to interesting volumes heretofore unknown. As with surfing the Internet, care must be taken to keep an eye on the clock lest an hour or three slip away while the user is immersed in the disc's engaging contents.

An easy introduction and a pleasant way to browse the disc is the "Quick Access" feature, which appears on the upper right-hand side of the screen when the program is opened. Quick Access provides instant access to tables of authors, journals, articles, and so on. For example, one can open the Table of Authors and click on an author's name, and a bibliography appears of all the articles by that author that are contained on the disc. Click on the title of any article in the list, and in moments, the text of the article is before you. The same is true of the Table of Journals and the Table of Articles. The program also features access to All Figures, All Tables, All Abstracts/Summaries, and All References. The last item in the Quick Access menu, "About PEP Archive 1," is a bit of explanation-cum-self-promotion that includes the following statement:

> The PEP disc contains a vast amount of information—over 32,000 articles and over 2,000 figures and illustrations that originally resided on more than 218,000 journal pages and 397 volumes. In hard copy, the Archive represents a stack of paper more than 22 feet high and weighing nearly a ton.

Impressive.

Aside from being a virtual 22-foot, one-ton library, the program's unique value is the versatility of its search capabilities, en-

abling the user to search by author, article title, year (or for articles appearing before or after a certain year), keyword, phrase, or journal—and, of course, by content. Its sophisticated search engine enables the user to search for multiple terms in close proximity to each other, e.g., words appearing within five, ten, or twenty words apart. It even allows the user to look for a word or phrase contained in the content of a reported dream. A search can be limited to certain types of articles (specifically, Abstract, Announcement, Article, Commentary, Profile, Report, or Review). One can also discover who cites whom, as Dr. Michels noted. Another useful search option is the "Limit search to checked branches" feature, which allows the user to handpick any number of articles to which the search will be restricted.

There are several "wildcards," permitting searches for different forms of a term, alternative spellings, synonyms, and so forth. For instance, typing in "prop*er" locates the terms *propagandizer, propeller, proper, proposer,* and so on. The program can also locate terms that were misspelled in the original journals (which have been transposed to the CD-ROM unchanged).

Hypertext links leading to helpful pop-up windows occur frequently in the articles. These include information about the author (at the beginning of each article), footnotes, references, and so forth. If the referenced article is contained on the disc, it may be accessed immediately with a click of the mouse.

There are flexible printing options that allow the printing of a single article, a series of articles, highlighted text, bibliographies, and so on. The latter can prove quite useful, since by checking "List bibliography from search," the user obtains a bibliography of the results of the search that can then be printed, copied and pasted into a Word document, or e-mailed to a colleague.

In addition to the CD-ROM, there is now a World Wide Web version of the PEP literature available, aimed at university libraries and other large institutions; it can be accessed by multiple users simultaneously. This is a major advance in making the psychoanalytic periodical literature available to students and faculty.

I have one caveat about the program. I use a Macintosh computer, and there are a number of idiosyncrasies with the Mac version of the disc. (PC users might say that the idiosyncrasy lies with the Mac.) The tutorial and PEP "Help" are designed for PC users, who are, of course, in the majority. A handful of differences in nomenclature and in the layout of the various search windows exists between the two platforms, so in places, extra work was required on my part to figure out what needed to be done to execute a given function on the Mac. Mac users must go to the PEP website for PEP Help; it is not on the disc itself. This is a disadvantage, especially if the Internet connection is slow or temporarily down. In future versions, it would be very useful if PEP Help can be contained on the disc itself, with a discrete PEP Help for Mac users on the website.

Despite the above-mentioned shortcoming, the PEP CD-ROM is a superb research tool and a must-have for psychoanalysts, students of psychoanalysis, and anyone with a serious interest in the field.

RUSSELL A. SCHOLL (NEW YORK)

ABSTRACTS

PSYCHE

Abstracted by Cordelia Schmidt-Hellerau, Ph.D.

56/57, July 2002 – June 2003

Focusing on Internal and External Factors as Two Perspectives in Clinical Understanding. Jörg Scharff. 2002, 56, pp. 601-629.

The author asserts that clinical understanding is guided by background theories. These can be categorized according to whether they focus more on internal or external factors, or, to put it differently, the way they relate to Winnicott's distinction between *created* and *found*. Using clinical material from various authors in three areas—trauma, borderline pathology, and neurosis—Scharff illustrates the defining features of these two approaches to understanding the patient, as well as the conflicting tensions between them, which must be reconciled in clinical practice.

One of several examples is a vignette taken from Britton. A four-year-old girl whom he treated had witnessed her parents having a fight, culminating in the father's physical attack of the mother, who then tried to commit suicide and was hospitalized. In playing with animal toys during her session, the child constructed two separate units divided by a barrier; on one side, she placed a pig family analogous to her own, with parents, herself, and her newborn sister. On the other side, she placed wild animals. The pig father attacked the pig mother while she was feeding the baby pig. The girl briefly touched the crocodile on the wild side and tried to heighten the wall between the two groups of animals. Britton interpreted to her that she was afraid her own furious

(oedipal) fantasies would get mixed up with what had happened in her family, and also that what she wanted to enact in play in the session would get mixed up with what she thought might happen at home. Without responding, the child got the crocodile over the wall and made it bite the mother and baby pig. Britton argued that in order to differentiate between her inner and outer realities—that is, her own aggressive thoughts and the aggressive behavior of her father—the child needed to own her wild and furious fantasies.

Scharff then outlines an alternative understanding, focusing on the incident as reality rather than on the girl's fantasies, acknowledging that it meant a trauma of loss in terms of parental protection (the mother wanted to suicide, the father was out of control, and the child did not exist for her parents at that moment). From this perspective, the wall the girl built did not symbolize a split between her good self and her bad self; rather, it was a protective dissociation enabling her to preserve, to a certain degree, the representation of "good enough" parents and to continue her oedipal fantasies with the "old" objects. Thus, the hole that was "beyond understanding" (of what had really happened in her family) could be momentarily filled with the analyst's comments, helping the child to eventually accept that she was not in control, but at times was even helplessly delivered to her objects.

Both perspectives are valuable. Britton suggested that ownership of the girl's guilt (helping her see her own anger) put her in a more powerful position. Scharff suggests that this constituted taking the second step before the first one. Alternatively, helping her work on her powerlessness and her heightened wish for safety and control would enable her to face her own potential for guilt.

Similarly, the author discusses two different ways of conceptualizing a clinical approach to borderline mentality: (1) focusing on the patient's destructive envy and his or her attack on the good breast (especially when the analyst is able to think independent thoughts or to relate to his or her own inner analytic objects); or (2) focusing on the patient's separation anxiety and defensive iden-

tifications with intrusive external objects (the patient's aggression enacts the object's aggression).

Scharff identifies differences between Meltzer's and Green's understandings of anal masturbation with regard to an absent/dead mother. Meltzer understood the child's equation of the mother's breasts with the child's own buttocks as a hostile response to mother's leaving and the child's subsequent interest in buttocks as self-nurturing. Conversely, Green understood anal masturbation as an act of fantasized nurturing of the dead object (mother) in order to preserve her forever. Being open to both perspectives is necessary in order to carefully distinguish between the healthy and malignant parts of the patient (cf. Rosenfeld). To remember that action stimulates *re*action (even though the latter is co-determined by inner factors) requires a constant shift in our attention between these two sides of an interaction and what they mean in the patient's inner psyche.

ICD-10 and the Issue of Natural Illness Units in Psychic Disorders. Anna Elisabeth Landis. 2002, 56, pp. 630-656.

The author distinguishes the classifying form of diagnostics, which treats illness phenomena as if they were intrinsically self-identical, natural objects, from the conceptualizing form of diagnostics, which regards human individuals as both identical with and different from their own selves. Proceeding from this dialectical viewpoint, Landis criticizes the itemizing approach underlying the ICD-10 and DSM-IV diagnostic manuals, urging in its stead a psychodynamic approach comprising past, present, and future axes. She emphasizes the dialectical complexion of the human psyche with reference to the dialectic between drive and repression, which she goes on to equate with the dialectic between the life drive and the death drive. With reference to Hegel, Luhmann, and Giegerich, and critical of Green's notion of *le negatif*, she emphasizes negativity as a theory-instigating element. From this vantage point, Landis criticizes standard practice in psychoanalytic diagnosis, contending that it fails to appreciate that

our allegedly subjective inclinations obey an objective law: that of the Other inherent in all subjectivity.

The Ego, the Analyst and the Analytic Relation. Some Reflections on Contemporary American Psychoanalysis. Cordelia Schmidt-Hellerau. 2002, 56, pp. 631-686.

In Germany, two major groups of contemporary American psychoanalysts are viewed with positive as well as negative prejudices: those who ascribe to ego psychology, on the one hand, and the relational analysts, on the other. After briefly tracing the inheritance of the former (Hartmann, Rapaport, Brenner, Arlow, Kris, Gray), as well as the emergence of the latter (the interpersonalists, the intersubjectivists, the relational school), the author muses on how the radical changes in thinking and in clinical technique that are characteristic of relational analysis have come about.

In discussing American ego psychology as it was practiced over decades, she mentions common complaints about (1) a coldness and unrelatedness in the "classical" analyst's stance; (2) a lack of elaboration and integration of the concept of countertransference (which profoundly connects the analyst with the analysand and the analytic process); and (3) a neglect of sexuality (including unconscious sexual fantasies and conflicts) in comparison to the emphasis on defense analysis and ego analysis.

In opposition to the scientific claim and ultimately unscientific nature of metapsychology, there was a revolt against Freud's metapsychological model of the mind, which discredited many proposed theoretical concepts. The author understands the more recent revolt against classical technique within the relational group (Renik, Hoffman, Aron) as a consequence and logical offspring of the rejection of metapsychology as a comprehensive theory of the mind. In this context, she outlines the debate on subjectivity versus objectivity (Hanly, Friedman, Smith). The focus on relatedness and the emphasis of the real relationship between analyst and analysand in relational analysis can further be understood as an opposition to the emphasized technicality of old-fash-

ioned ego psychology. Discussing different clinical vignettes (Brenner, Busch), she highlights the strategies of intervention, which are based on relating, or not, to a metapsychological model of the mind.

Collective Phantasms, Destructiveness, Terrorism. Werner Bohleber. 2002, 56, pp. 699-720.

The author investigates a territory hitherto largely uncharted in psychoanalytic terms: the convictions and motives acted upon by the perpetrators of the terrorist attacks of 9/11. He identifies the ideological/religious factor as a crucial component—an operative force behind the combination of a narcissistic ideal condition with terrorist mass murder.

After some general observations on the connections between religion, purity, and violence, with reference to Reik and Grunberger, the author enlarges upon the religious worldview and mentality of Islamic fundamentalism, discerning astounding similarities with ethnocentric German nationalism in the nineteenth century, and especially with radical nationalism after the First World War. These are (1) the myth of an ideal prehistory; (2) hostility toward Western principles and values; (3) the ideal of a homogeneous unity, sought through a process of eradicating all strange elements; and (4) a death cult that suggests that the greatest happiness can be achieved via sacrifice for one's country or religion. Working with the concept of *ubiquitous unconscious fantasies*, the author notes that these elements not only tend to be externalized, but are also captured and promoted by social agents (institutions, traditions).

Referring to an earlier paper on national socialism and anti-Semitism, Bohleber emphasizes the fact that unconscious fantasies based on the notion of a *nation* can become fascinating, but also release a huge amount of aggression and violence. He elaborates on three major groups of unconscious fantasy complexes: (1) Fantasies of being taken care of and sibling rivalry: Every stranger is experienced as an intruder, threatening the possession of the pri-

mal object and striving to live as a parasite in one's own territory; unconsciously, the stranger is identified with the rival sibling, destroying the idealized unity with a collective mother imago. (2) Cleanliness (which plays a major role in Islam) and the ideas about the other: Forbidden strivings are projected onto the stranger, individual differences within a group of narcissistically identified members cease to exist; thus, it is the other who pollutes or poisons everything that is clean within the group. In order to maintain this pure, narcissistic homogeneity, the different stranger needs to be aggressively persecuted; this kind of narcissism tends to become more and more radicalized. (3) Visions of unity and fantasies of fusion: As individuals regressively merge with the group, the group becomes an illusion of substitution of the lost primary object. Individuation is alien to the Islamic culture; the question of "Who am I?" is replaced by "To whom do I belong?" Thus, a worldview is created in which there is a huge symbiotic unity on one side, and split-off rivalry, competition, and pluralism on the other.

The article closes with some psychoanalytic observations on biographical material about two members of the circle close to the Al-Quaida terrorists.

Primal Seduction and the Lost Object. A Model for the Inscription of Drive into Freud's Theory. Wolfgang Hegner. 2002, 56, pp. 721-755.

Taking up the work of Jean Laplanche, the author urges the necessity for a reevaluation of drive theory. Against the widespread view that drive theory is outmoded, he advocates identification of, and engagement with, the still unexploited potential it contains. Crucial to such a rereading is the distinction between *instinct* and *drive*. The author recommends not viewing the concept of *drive* either in the sense of an axiomatic, biological/endogenous given or as a mere social ingredient. Along with Laplanche, he favors an understanding of drive as originating from the inevitable confrontation between the child and the unconscious

desire of the adults. In its intersubjective constitution, drive is seen as the "language of the other," subject to a lifelong, never entirely successful or conclusive task of translation.

A Longitudinal View of Early Development. From the Relational World of the Parents to the Ideational World of the Child. Kai von Klitzing. 2002, 56, pp. 863-887.

Starting with an overview of psychoanalytic theories on infant development, this article describes an empirical research project in which families and their firstborn children were studied from pregnancy to the fifth year, on the basis of a prospective/longitudinal research design. The study inquired into the connections between the parents' intrapsychic and interpersonal relational worlds and their representations, observable parent–child interactions in the early years, and relevant aspects of the children's individual development.

Most research projects on mother–infant dyads are based on and depart from the assumptions of attachment theory. This study focuses on an understanding of early development as an intrapsychic process of triadification and triangulation that is present as such from the outset. Referring to the work of Lebovici (1988) and Soulé (1982), who contrasted the fantasized interaction between the imaginary child and the parents with the real child's development, von Klitzing tried to assess the triangular relational competence of the parents before the child's birth. The results indicate that the relational space the child is born into has a crucial impact on the developing relational world of the child. Triadic competence is defined as the parents' capacity to anticipate and conceptualize their future family relationships. Significant connections are identified between parental competence in shaping relationships at the intrapsychic and interpersonal levels, the quality of early parent–child interactions, and important parameters in the behavior and ideational world of children of preschool age.

Accordingly, the author suggests that psychoanalytic developmental theory should devote more attention to early preoedi-

pal triadic and multiple configurations, and should understand the Oedipus complex as a culmination phase in the continuum of internal and external triadic-relation experiences.

Is Infant Research Irrelevant for Psychoanalysis? Remarks on a Controversy and on Psychoanalytic Epistemology. Martin Dornes. 2002, 56, pp. 888-921.

The author comments on the controversy between André Green and Daniel Stern concerning the relevance or irrelevance of infant research to psychoanalysis. This controversy pertains to a fundamental dilemma: Does psychoanalysis have to rely on external contacts? Or is psychoanalysis an autonomous discipline that regards data collected within the clinical setting as valid, while considering extraclinical validation as immaterial or impossible?

Green considers infant research irrelevant to psychoanalysis, because it is his view that the subject of analysis is not the infant, but the unconscious as it emerges within the analytic situation. For him, to reflect psychoanalytically on the specific ways in which the unconscious mind works is fundamentally different from reflecting scientifically on how the observed infant's mind might function. Green does not criticize infant research for its focus on the observable behavior, but rather for its conclusions (e.g., Stern's theory of *protonarrative envelopes*, which states that infants experience interactions as gestalts that are dynamically structured like a story). Green finds such conclusions speculative and no more scientific than Klein's ideas.

Stern disputes this position, believing that his theory takes into account as much of the scientific data as possible. Dornes concedes that, even though it is hard to prove that what the infant *perceives* (Stern's focus) is identical with what the infant *experiences* (Green's focus), there are at least some research results that confirm Stern's theory as more than speculation. According to Stern, infant research is different from psychoanalysis in that it tries to establish proof that is acceptable to all, not just to those who adhere to a specific theory.

Green emphasizes his concern that psychoanalysis will lose its specifics if it tries to connect itself too closely to science. However, scientists often emphasize their concern that psychoanalysis will lose its relevance for science if it insists on such specificity. Dornes believes that the disadvantages of an isolative attitude in psychoanalysis would be considerable, and therefore recommends the intensification of an interdisciplinary dialogue.

The Adult Attachment Interview and Psychoanalytic Understanding. A Clinical Dialogue. Anna Buchheim & Horst Kaechele. 2002, 56, pp. 946-973.

The authors state that, with its complex, text-near evaluation approach, the Adult Attachment Interview can broaden the horizons of psychoanalysts. In psychotherapy, to know about the way in which the mind comes to terms with attachment-related and traumatic experiences is especially important. This article compares and contrasts attachment theory and psychoanalysis, with special reference to attachment-theoretical assumptions about the development of pathology. There follows a methodological section on the Adult Attachment Interview and the general procedure for evaluation and formation of classification categories proposed in its design. With reference to two case histories, Buchheim and Kaechele delineate the similarities and differences between psychoanalytic / clinical and attachment-oriented / evaluative perspectives. Even though there is some convergence between these two vantage points, the authors concede that for all conflicts about issues beyond questions of attachment, the psychoanalytic approach proves to be the only suitable one.

Female Development in Menopause. Gertraut Schlesinger-Kipp. 2002, 56, pp. 1007-1030.

Psychoanalysis has paid comparatively little attention to the female climacteric. Classical positions dealt with it in terms of loss, deficit, and depression. Freud (1937), considering menopausal

women old, noticed various conflicts because he identified a reinforcement of drive activity in one case. Deutsch (1948) emphasized the importance of the preoedipal mother in dealing with those conflicts. Only Benedeck (1950) questioned the idea of an unavoidable climacteric depression; she suggested that women have to deal with the psychosexual integration of feelings and hormones in each cycle, requiring a focus on the developmental aspects of each phase in a woman's life.

Horney (1923) stated that both males and females have a primary and genuine knowledge of femininity; for her, the wish for a baby is primary, rather than secondary to penis envy. Langer (1964) made use of the fairy tale character of Snow-White in order to point out rivalry and hatred and the daughter's fear of triumph over her mother in adolescence, which might turn against her when she herself approaches menopause and becomes the destroyed maternal image. More recent psychoanalytic theories (Chasseguet-Smirgel, Kestenberg, Sies and Nestler, Hettlage-Varjas and Kurz) have conceptualized menopause according to internal mother and father images, the significance of inner bodily space, and changes in sexual and object relations.

The author emphasizes the aspect of female development in menopause that offers the chance for internal and external changes: the working through of unresolved separation conflicts and revenge fantasies and anxieties with the mother, longings of merger, the meaning of an empty inner space, and the end of an unconscious "daughter"-fantasy in relation to the father.

Folds and Fissures. Bioethics as a Challenge for an Ethics of Psychoanalysis. Rolf-Peter Warsitz. 2002, 56, pp. 1093-1121.

Defining ethics as a theory of social intercourse, the author sets out to rectify the foreshortened perspectives of present bioethical discussion by reestablishing the links with an overarching perspective on the human condition. This new view reflects a due and ample concern with the way in which the biological human substrate is embedded in social relations and conditions. Warsitz indicates how the conceptual imagery and elucidation patterns

pervading present-day bioethical discussion (e.g., human hubris, as well as delusions of omnipotence and the psychic and social price these exact in terms of regression to preoedipal conditions, neglect of generativity, narcissism, and so on) are adumbrated in the myths informing ancient Greek thought. In the central section of the article, the author explores the issues involved in an inquiry into the level of drive vicissitudes and object relations underlying ethics itself. The guiding notion operative in these investigations is that the humanity of the human animal incorporates as one factor the fantasies we entertain about ourselves and others.

Lost in the Maze of "Postmodern" Language Games? Readings of a Micrograph by Robert Walser. Marius Neukom. 2002, 56, pp. 1197-1226.

The author tries to investigate the impact of a literary text on the reader. One short text from the "Micrograph" series by Robert Walser was given to seven female and seven male readers, who were subsequently asked to respond to it spontaneously. With the help of a semistructured interview, the author collected answers that revealed countertransference patterns within the reader's unconscious reception of this text. Analysis of the narrative structure (based on literary criticism) uncovered emotionally significant theme complexes and the hidden offers of various roles that Walser had made to the reader in this text.

Editor's Note: In conjunction with the following abstract, the reader may be interested in Thomas Müller's article, "On Psychotic Transference and Countertransference," pp. 415-452 of this issue of *The Psychoanalytic Quarterly*.

On Psychotic Identification. Thomas Müller. 2003, 57, pp. 35-62.

The author examines the function and significance of psychotic identification, which encompass a range of archaic, self-protec-

tive / defensive operations and object relations. These features are common to all forms of psychotic personality organization.

In discussing Rosenfeld, who conceptualizes primary narcissism as an omnipotent object relation based on projective identifications, Müller emphasizes the seductive power of this psychotic defense: the patient uses a narcissistic withdrawal in order to defend against frustration, envy, and reactive aggression, as well as of the loss of a good object or of the idealized self. However, in consequence, the omnipotent, crazy self can end up not being differentiated any more from a more healthy self (confusion).

With an extended clinical example, the author elaborates on various functions and meanings of psychotic identification. This phenomenon embraces a series of archaic operations, such as splitting, introjective and projective identification, foreclosure, and denial, all as means to defend against the fear of fragmentation. This is the basic precondition for psychotic thinking, feeling, talking, and relating to objects. Paradoxically, psychotic identifications create a trap harboring two alternative ways of self-destruction: either a fusion with the ideal object (projective identification), which elicits the anxiety that the object will pay back this invasion and destruction, or a state of being overwhelmed by the object (introjective identification), which elicits the anxiety of being destroyed.

Traumatized Refugees and the Official Assessment Process. Psychoanalytic Perspectives. Franziska Henningsen. 2003, 57, pp. 99-120.

Traumatic experiences are fended off via dissociation, and hence frequently defy communication at the verbal level. This state of affairs involves hazards at the legal level, such as in connection with decisions about the right of residence for aliens. In this process, refugees may have to prove traumatization. If they have not been trained in dealing with traumatized individuals, officially designated experts, judges, and the staff of the relevant authorities may be unable to identify the trauma due to uncon-

scious transference processes. When transference-countertransference processes are not recognized, the applicant's distorted ego functions, severe thought disorders, defenses against the trauma, contradictory messages, and apparent lack of emotional involvement often lead to the conclusion that there has been no trauma.

Drawing upon clinical examples, the author shows how a modified psychoanalytic interview technique can reveal relational constellations and transferences conditioned by trauma, which can help refugees to verbalize their experiences. Henningsen appreciates the deep initial distrust of the fugitive, who may have experienced the whole application process as retraumatizing. In order to carefully evaluate the refugee's traumatic experience, the author suggests a procedure of several steps, which she demonstrates by example. This procedure allows for a growing trust between the traumatized and the evaluator. Initially, it is helpful to get an overview of the present situation of the applicant; here, breaks in the communication often reveal the dissociative processes typical of traumatized personalities. A second session addresses the pretraumatic life of the applicant; this is important in order to appreciate the whole personality of the traumatized individual. In a third session, the historical event (trauma) is addressed, which is necessary not only for the process of evaluation, but is also an important precondition for the trauma's eventual reintegration. The last session is devoted to discussing the joint experience and the evaluation.

Ferenczi's Presence in Margaret Mahler's Theory. With Some Thoughts on the Identity of German Psychoanalysis After 1945. Ulrike May. 2003, 57, pp. 140-173.

At the end of the 1960s, psychoanalysis in Germany was heavily impacted by both American and international influences. Between 1965 and 1975, half of all publications in *Psyche* were translations from American or British articles. Thus, German psychoanalysts up to this point mostly identified with the work of American analysts, including those who had emigrated from Germany,

and who in so doing had lost their roots. This identification delayed the German analysts' process of working through of the Nazi past, which only began after 1975.

This lack of roots or a sense of heritage is problematic in our field, since the context within which discussions take place is essential for the achievement of a comprehensive understanding. The author of this article states that, in reading our literature, we often fail to apprehend who is talking with whom about what (that is, the context). The fact that American psychoanalytic developments between 1940 and 1970 (Hartmann, Jacobson, Kohut) were presented in Germany in a condensed form within only a few years made it very difficult or even impossible to fully comprehend them.

In this context, May traces and acknowledges the impact of Ferenczi's concept of omnipotence on Mahler's concept of symbiosis. Mahler went to school at Budapest, where she met Ferenczi, who encouraged her to undergo her first analysis with Deutsch. Mahler continued her analysis in Vienna with Aichhorn and later with Hoffer, but did not feel accepted by the Vienna Group. Thus, for Mahler, emigration to the United States was painful yet liberating.

The author then traces the development of the concept of *ego*. Referring to Freud's paper, "On Two Principles of Mental Functioning" (1911), Ferenczi wrote his "Stages in the Development of the Sense of Reality" (1913) as a first theory of the ego's development (four steps from infantile omnipotence to a realistic sense of the world and one's own ego)—ten years before Freud's "The Ego and the Id" appeared.

Mahler's ideas of fusion and symbiosis drew on Ferenczi's notion of omnipotence, even though she rarely referred to Ferenczi directly. Ferenczi was disregarded among American ego psychologists, and Mahler considered herself an ego psychologist. May concludes that acknowledging Ferenczi's roots in Mahler's thinking makes her theories, as well as American ego psychology, more familiar.

Ego-ideal and Superego in a Modified Structural Theory. Rolf Fletscher. 2003, 57, pp. 193-225.

Modifying Freud's structural theory, Fletscher suggests giving up the spatial conception of the ego, superego, and id. He defines the self as the comprehensive entity of the whole person (mind and body), as well as the integrated totality of all affectively cathected self-images and representations. In accordance with Hartmann's views, the ego is seen as a complex of organized functions, but in contrast to Hartmann's conception, it is also viewed as an organ of the self. The ego ideal and superego are specifically emphasized self-representations. The differentiation between organized functions and organized presentations mirrors the difference between ego and self: The ego is an organization of functions, while the self is an organization of structuralized representations. Thus, ego ideal and superego are not spatially conceptualized within a psychic apparatus, exercising functions separately from the ego, but are instead affectively charged representations and activities within the ego.

The Sexual Breast. Friedl Früh. 2003, 57, pp. 385-402.

The author inquires into the reasons why the female breast is not regarded and not referred to as a sexual organ, despite the fact that arousal of the breast is an essential factor in female orgasm. She suggests that the trinity of sources of physical pleasure for women—vagina, clitoris, breast—cannot be acknowledged as such because the breast is a part of the body that is seen primarily as assuring the survival and nutrition of babies. Case vignettes indicate the intrapsychic conflicts, fantasies, and far-reaching uncertainties involved for both sexes in the dual significance of the breast: the world of motherly love, on the one hand, and of sexual pleasure on the other.

The Plank over the Abyss. Female Countertransference as a Source of Insight in the Treatment of a Severely Traumatized Woman Patient. Mechthild Zeul. 2003, 57, pp. 426-443.

A remarkable attunement of sensitivity and the awareness of physical similarities (as an integral part of the early mother–daughter relationship) between the analyst and her patient formed the foundation and starting point for the reconstruction of a patient's early trauma. This patient had suffered serious injuries in a severe car accident at the age of three, followed by a coma for a number of weeks. Confiscation of the analyst's body, her acceptance and translation of this need into words, were preconditions for the patient's development of a consistent sense of self. As the treating analyst, Zeul made use of her concordant and complementary countertransference in order to better understand the issues involved in the process. Thus, affective collusion in unconscious enactments could become a significantly helpful factor in reflecting on and understanding the affective roots of the patient's disorder.

Drive, Object, Space. Changes in the Psychoanalytic Understanding of Anxiety. Thomas Plänkers. 2003, 57, pp. 487-522.

New approaches to the psychodynamics of phobic symptom formations center around the meaning of psychic space and/or psychic three-dimensionality. This article takes as its point of departure Freud's energetic and psychological theory of anxiety, Klein's distinction between persecution anxiety and depressive anxiety, and Bion's discussion of various forms of anxiety from the point of view of preservation or restriction of psychic space.

The author emphasizes Bion's concept of geometrical (three-dimensional) development. Referring to the Latin meaning of angst/anxiety, angustiae = narrowness, he understands the occurrence of anxiety as related to the experience of either preservation of or loss of psychic space. This permits the framing of a geographical hierarchy of anxiety forms, as follows: Neurotic relationships (based on self-object differentiation) take place within

a triangular self-space; typical anxieties are depressive anxieties of loss and conscience or signal anxiety (alpha anxiety), as in castration anxiety and real danger.

In borderline or narcissistic personalities or perversions, where psychic self-object differentiation is not achieved and separation seems unbearable, pathological projective identification (used to intrude and control the object's space in order to avoid dependence anxieties and related conflicts and affects) creates a pseudo-triangular nonself space (a space within the mother), which stirs up claustrophobic, agoraphobic, or persecutory anxieties. In psychotic personalities, characterized by a loss of self and object, anxieties are catastrophic—nameless and traumatic, leading to panic attacks.

The author shows that this perspective allows for understanding and interpreting upcoming anxieties in the context of inner-psychic object relationships. Within the transference relationship, the patient gives voice to his or her inner objects, experiencing the analyst as part of his or her externalized inner objects. It follows that the analyst will participate in the anxiety experience of the patient. Plänkers emphasizes a small but crucial difference, however: transference means that the patient *lives in* the anxiety-provoking past (the patient does not merely repeat the past); thus, the interpretation is not a comment on the transference, but forms an element *within* the transference relationship. The interpretation (a third position agreed upon by analyst and patient) creates psychic space (three-dimensionality) and thus changes the experience of anxiety.