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OBITUARY

JACOB A. ARLOW (1912-2004)

Dr. Jacob Arlow died peacefully in his sleep on May 21, 2004, at the age of ninety-one. He had been gradually failing for months from prostate cancer and progressive myocardial disease. Fortunately, he was without pain during his last illness and lucid to the very end.

Dr. Arlow's psychoanalytic career spanned more than half a century. During that time, he was active in every branch of the profession and an outstanding figure in all. He contributed more than 100 articles to the psychoanalytic literature, as well as a highly regarded book of which he was coauthor, *Psychoanalytic Concepts and the Structural Theory*. The book remained in print for more than thirty years as the definitive exposition of the distinctions between the structural and topographic theories of Freud and of the reasons for preferring the former to the latter. His papers on unconscious fantasy and on empathy, the latter with David Beres, were also extremely influential in shaping the clinical thinking of many analysts. In addition, he made important contributions in the field of applied psychoanalysis, among which his piece on the ritual of bar mitzvah deserves special mention.

As a teacher, Dr. Arlow was highly regarded and in great demand throughout the world. While still a young man, he was appointed Turner professor at the Columbia University Center for Psychoanalytic Training and Research. He taught for many years at the New York Psychoanalytic Institute, where he was first a student, and then a member, a training and supervising analyst, a member of the Educational Committee, and from 1966 to 1968, he served as its president. His supervisees were legion. He also served for sev-

eral years as Chair of the Board on Professional Standards of the American Psychoanalytic Association.

In addition to the foregoing, probably Dr. Arlow's greatest influence on psychoanalytic education was in connection with his years on the Editorial Board of *The Psychoanalytic Quarterly*, of which he was Editor from 1971 to 1979. He did a superb job in this capacity, as many contributors to the *Quarterly* can testify.

As one would expect, Dr. Arlow received many other accolades as well. The list is so long that only a few can be mentioned. He served as president of the American Psychoanalytic Association, treasurer of the International Psychoanalytic Association, and an honorary member of the Michigan Psychoanalytic Society, where he did yeoman service during the years of transition between that society and its predecessor. The New York Psychoanalytic Society selected him on occasion as both the Freud and the Brill lecturer. In 1988, his colleagues honored him with a splendid jubilee volume titled *Fantasy, Myth, and Reality: Essays in Honor of Jacob A. Arlow*, edited by Harold P. Blum and others.

In his professional life, Dr. Arlow was formal and dignified. In his personal life, however, he was characteristically relaxed and a delightful companion, with great wit and a flair for light verse. He enjoyed the out-of-doors, often in the company of his beloved wife and four sons. He had an extensive knowledge of literature and went to the theater frequently and with great pleasure. He was also fond of languages and was especially fluent in Hebrew. In fact, he met his wife at a Hebrew-speaking summer camp, where both were counselors. Though neither was religious, they were zealous in their interest in matters Jewish, and Dr. Arlow's knowledge of the Jewish religion and of Jewish culture and history was legendary. In addition, he was for many years an active member of the International Association for the Study of Time.

Dr. Arlow was a very friendly man. He had many good friends in his personal as well as in his professional life, friends who greatly enjoyed his company, as he did theirs. He was a man beloved for

his personal qualities, as well as a towering figure in his profession. As Shakespeare wrote of Brutus:

> His life was gentle, and the elements
> So mix'd in him that Nature might stand up
> And say to all the world, 'This was a man!'[1]

We shall not soon see such another.

CHARLES BRENNER

[1] *Julius Caesar,* V, v, 73-75.

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FATHER HUNGER AND NARCISSISTIC DEFORMATION

BY JAMES M. HERZOG, M.D.

The author advances the hypothesis that paternal availability and the relationship between the mother and father are crucial components of evolving character structure in children. He proposes that a kind of narcissistic pathology featuring perverse sexuality may eventuate in the absence of paternal availability and in the presence of a disordered relationship between the parents. He also suggests that the ways in which aggression is or is not modulated and organized are crucial components of this evolving disorder, and that boys are more susceptible to its full manifestation and expression than are girls.

INTRODUCTION

Narcissistic deformation in childhood often features a contemptuous arrogance that reveals the absence of an effective paternal authority sanctioned by the mother, and often a concomitant demeaning of the father's modulating and organizing capacity by the mother, which is explicit. The child without a paternal authoritative helper is left alone in regard to his or her aggression, and displays a painful amalgam of self-generated efforts to organize and deploy this part of the self. There is often a conflicted identification with the demeaning mother as well. However, the dismissive boy is inclined to accept appropriate partial provisions of masculine paternal authority as these are proffered by the analyst. In the absence of such availability, the boy is en route to the development

of a perverse character structure in which the self is taken as object, and in which control of, rather than relating to, is the principal mode of interaction with others.

What, then, are the origins of object cathexes in childhood, and what are the factors that thwart such processes and interfere with a subsequent investment of the self with those relational bonds that were initially directed toward others? How does the development of hatred as a manifestation of the lack of modulation and organization of aggressive drive and fantasy figure into this process? Is arrogant and contemptuous control of and disregard for the other an invariable perversity that characterizes the appropriated sexuality of such children? Do many of the aforementioned features figure into the abortive attempt of the insufficiently parented child to construct his or her own version of the parental caregiving and sexual couple? Is the role of the father particularly crucial in this regard?

The psychoanalytic treatment of children offers a potentially important window on these complex and important questions pertinent to the development of narcissistic character pathology. Four analytic vignettes will be presented to demarcate the territory that I shall then discuss.

FELIX

Felix was four years old when he entered analysis. His father's analyst suggested an evaluation, as the boy was often sluggish and withdrawn, and occasionally belligerent, without obvious precipitant. Felix was the only child of parents in their middle thirties. Mother had been previously married; it was father's first marriage. Both were professional, although father came from an independently wealthy family and no longer worked. There had been an unsuccessful attempt to provide Felix with a sibling, and overwhelming difficulties in the parental relationship were now grossly apparent. Mother spoke of ending the marriage and father appeared defeated and depressed. "I am rendered impotent by her fury and scorn," he stated when his wife scathingly derided him.

Felix began his play with me by introducing the king of Spain, a most unpleasant autocrat with a fondness for sushi. He was a fascinating character, and it took me quite a long time, perhaps five or six meetings, to realize that the complexities and curiosities of his regal character had kept me from noting that I was being treated as quite extraneous to what was occurring. As I tried to make inquiries about the king and about his eating habits, it became ever more clear that there was no one else but the monarch himself in the royal household and the royal life. There was the ever-hungry, ever-eating regent, and that was all. My exclusion did not seem to be motivated by any particular hostility; rather, it was just that I was not there.

I resolved to stay interested in King Alphonso and his splendid isolation. This took some doing, because the king was only interested in his sushi. Every day, Felix described, was devoted to the selection of fish, the preparation of wasabi and soy sauce, and the ritualized consumption. I would ask about the fish, about the sushi cutter, about the rest of the king's day. No information was forthcoming, but the play continued. It was different each day in some small detail from what had transpired the previous day, but the broad outline of regal sushi eating remained unchanged. I learned that the fish were cut and consumed raw, that Alphonso cared not a wit as to how this felt to or for the fish—that in fact he could not comprehend this question, and, therefore, its mere utterance enraged him and made him hate the interlocutor.

I shared with Felix my growing awareness that there was something fishy going on. The king could not possibly be happy with this state of affairs. In fact, I said, he seemed oblivious and indifferent. This intervention was met with a blistering attack from Felix. Who was I to comment on matters pertaining to the court and the king? I was a lowly commoner and knew nothing. People had been eliminated for lesser offenses, Felix added. I was both startled and relieved by the vehemence of the response elicited by my intervention. I could get through to the patient, after all, and the response remained in displacement.

Felix was not finished, however, with this response. He sneezed violently, spewing mucous from his nose. He took a glob of it in his hand, waved his hand in my direction, and then put it into his mouth. I observed that what came out of and then back into his body, namely, the nasal mucous, had come very close to me. I resolved to watch for the aggression inherent in this gesture, which was aborted, and then I thought that Felix might not actually differentiate entirely between himself and me as he considered wiping his hand on my arm. Might it be that in my degraded state, I was simply a receptacle for the mucous, or might it be that this non-autistic boy actually regarded me as he regarded his mouth or pant leg with regard to the disposal of what had come out of him?

It is important to note here that body as usable in what might be considered dialogue with another was present, that the degradation of the other was joined, aggression was poorly modulated, and that the self-with-self conversation continued—or, more accurately, the self-with-body-part conversation went on, even as there appeared to be interaction with the other. I continued to reflect on the sneezing episode and how important it felt to me. It was not an isolated event. Each time that Felix sneezed or snorted and produced a nasal discharge, his hand would proceed in my direction. Sometimes he would do the same when his hand had been in his mouth or when he had scratched his behind. I came to be able to ask about this. Eventually, we were to learn that in some ways, I was being treated as if I were Kleenex, or possibly a part of himself —that he hated snot and also thought that it tasted all right, but, importantly, that Felix was also considering that I was more than the snot or the Kleenex, that I was also Dr. Herzog, that *we* played together and that I was helping him.

These were momentous happenings, and I was told that even King Alphonso noted that something out of the ordinary was going on. Felix thought that, having noticed this, the king might consider ending his not-so-splendid isolation and choosing a queen, and perhaps even going on to make a royal family.

I have come to recognize that children who have needed to withdraw object-related cathexes from interactive currency, as a

consequence of primary caregivers' inability to participate in an ongoing relational dialogue and trialogue, often elaborate syntactical material in play that resembles that which Felix adumbrated. Such children often react to the analyst's efforts to find out more with a "who-do-you-think-you-are?" attitude. The body is frequently involved, and a protoperverse object relationship is presaged—first with the self, and then with the other as both a self extension and as an other to be controlled. An amalgam of sexual and aggressive elements is deployed, initially in a poorly organized fashion and then in a more ritualized and organized way. Note, however, that the analyst can "get through," and that the child is open to such an intervention. Such openness, while still present in childhood, is often no longer available by the time an analyst meets an adult Felix.

Earlier, Eleanor W. Herzog and I (Herzog and Herzog 1998) suggested that a predisposition to developing a narcissistic personality disturbance might be occasioned by serious disruptions in the child's parental couple representation, which mirrored actual interactive reality. We reported on the analysis of a child, Ned, who manifested a narcissistic disturbance and who created a new parental couple by attending to the analyst and his wife as a necessary prerequisite to embarking on oedipal object relatedness. We proposed that self-with-mother and self-with-father representations, in the absence of self-with-mother-and-father-together representations, can potentially hamstring psychological development and skew it in the direction of narcissistic fixation. This conceptualization is moored in the conviction that preoedipal, triadic reality is a sine qua non for subsequent oedipal elaboration.

Since the time of our 1998 publication, we have collected seven more cases that appear to strengthen our suppositions, and that also feature this same effort on the part of the child to create a new self-with-mother-and-father-together representation. To this core conceptualization, I now append the notion that paternal functional absence, in combination with active demeaning of the father by the mother, may also predispose to narcissistic disturbance in the child, and that the appropriation of body functioning as a ve-

hicle for the control of the other, rather than as an interactive modality with the other, is the hallmark of such an environmental history (Braunschweig and Fain 1981).

MEL

Mel, referred to analysis at age seven, was almost completely incapacitated by his hypochondriasis and attendant school absence. Almost all of his days featured gastrointestinal upset and a feeling of being too ill to go to class. His academically oriented parents were at their wits' end about how to proceed. Mother, a neurologist, favored a diagnosis of depression and learning disorder and had sought pharmacological intervention; father, a philosopher, felt muddled and unclear about his son's declining course.

Mel was distracted and preoccupied at our first meeting. In the waiting room, he was writhing in his chair, complaining of abdominal pain and exhaustion. Entering the office, he rushed to the couch in order to rest. When I inquired about what was going on, he told me to be quiet and not bother him. I replied that he seemed very bothered and that I hoped that he and I together might figure out why. He looked at me with scorn. How could the two of us do anything together, he wondered. I was to learn that the idea of two people engaging together in any project was completely foreign to his *Weltanschauung.*

Over time, Mel let me watch as he worked on a project for school. It had to do with the life cycle of the lobster. Father lobsters fertilized thousands of eggs, which were later thrown by the mother lobster off her tail. The lobster parents could not stand each other; in fact, they hated each other and would promptly eat each other were they not to separate immediately after intercourse. The hapless embryos floated to the top of the water, where most were promptly consumed by hungry fish. Of the original thousands, three or four reached molting stage, and with the additional weight of their shells, descended to safer depths. Each lobster was totally on his own, with no relationship to either progenitor.

It felt like great good fortune when Mel named one of the lobsters Thermador and we began to follow him more closely. Therma-

dor liked really cold water and would struggle to find a depth that suited him, temperature wise. (I noted that the lobster's name appeared to mean *lover of warmth,* and awaited clarification as to what this might connote.) If the water was too warm, Thermador would develop a stomachache, which unfortunately featured a great deal of flatulence. The aroma of this gaseous discharge offended Thermador, and we came to appreciate that the lobster liked himself only if the surrounding water was very cool, if his stomach did not hurt, and if he did not expel malodorous gas. In fact, Thermador hated himself when he produced a gaseous stink.

Mel enhanced the story line he was elaborating by farting loudly as he described Thermador's dilemma. He seemed amused that I noticed this activity. For my part, I tried to decide whether it served our enterprise better to acknowledge the strong aroma that now pervaded the *spielraum* or to concentrate on the lobster and his predicament. Eventually, I commented that I might open the window as there was a strong smell in the room. "Tough shit" was Mel's reply. As the play continued, Mel devised a cure for Thermador's flatulence. Emergence in boiling water until he turned red seemed to do the trick. Mel said he hated how Thermador smelled and now he would smell no more. I noted that this hatred toward the lobster might also be felt for the farting self, and that there was no second chance, nor any concern, for the ongoing being of the other in this unmodulated rage.

I would like to suggest that Mel and Felix present in somewhat similar ways. Mel's "tough shit" was a more direct expression of disregard, and even contempt, than Felix's somewhat more modulated "who do you think you are?" But there is a family resemblance. I was soon to learn that Mel's parents were very unhappy with each other, too, and that in both families, the mother felt contemptuous toward her husband, and perplexed and perturbed by her son (though significantly more interested in him than in her marital partner).

Furthermore, the nasal discharge and the flatulence—the first with Felix, the latter with Mel—proclaim the appropriation of a body function into a seemingly relational matrix, which is in fact control-

ling rather than interactive. Lastly, note the presence of hate as an affect, which anneals unmodulated aggression with total disregard for the well-being or the going-on-being of the other. In fact, this affect appears to be directed toward parts of the self that are appropriated by developmental need and environmental lack, and that are often displaced in play; they are usually disguised as grandiosity or hypercathexis in the self presentation.

BASIL

I shall further illustrate this last point with a description of Basil, who entered analysis with me at the age of fourteen, in dire circumstances. He would not do his school work, was alternately hyperaggressive and impossibly submissive, and appeared to be headed in a direction that his headmaster called certain failure. Basil's father had been an industrial baron who drank himself to death; his mother, much younger than the father, was a movie star.

Unlike either Felix or Mel, Basil seemed to take an instant interest in me. He commented that I was big and that I had a big reputation and a big fee to match. He stated that his mother had told him how lucky they both were that I had time in my schedule to see him. He lounged on a chair as he made these comments, spreading his legs wide and scratching his crotch and butt frequently. These comments did not feel friendly, nor did he seem sincere. To myself, I wondered about the location and meaning of the scratching. It really came as no surprise when at the end of the first hour, he told me that I could kiss his ass for all he cared. I responded by saying that I knew that "kiss my ass" is a figure of speech, but I presumed that Basil was saying something important by employing it. I hoped, I said, that we might find out together what that was. I did not remark on the fact that he seemed to have quite a persistent itch in that area. He said that I was a "strange fag," and that he would come to see me again next week, "because I have to."

Basil and I continued our work together. He was often aloof; always dismissive. The theme of his ass and my interest in it contin-

ued. This decidedly homosexual focus seemed, however, distinctly nonsexual, or, more precisely, neither erotic nor object related. Basil would comment that his ass was moist today or completely dry. He might say that its aroma was strong or negligible. He would comment on the completeness or casualness of his wiping. All these remarks were made with a kind of leer and an implication that he was uncovering an uncontrollable interest of mine. I, for my part, tried to figure out why his body talk and what might be considered teasing seemed so blatantly to be something else. What was this something else?

This theme continued. Basil wondered if he could "get me" by bending over. I felt that getting me might be the point and asked about it. Basil was annoyed by my interest in his motivation. Eventually, we were to learn that Basil wanted to undo me, to make me beg for his ass, to be caught in my own desire and then to be at his mercy and controlled by him. "I know you want to rim me," he sneered. "I hate your fucking guts, you revolting faggot."

Here, the narcissistic evolution of a perversity seems clear. The other is to be controlled by a body part and thus not taken into account as a separate entity. Of course, Basil's selection of an entrapment mode reveals much about his conflicts and fixations, and perhaps his assessment of my vulnerabilities, but the overarching effort is to control the other and to prevent the emergence of real interaction or object relatedness. I, as analyst, struggled with how I might use both the material and Basil's stance to engage him.

Eventually, I said that I thought his evaluation of his ass and its appeal mattered, and that I thought that his efforts to involve me with that part of him were complicated. He responded that it was not about his interest, but about mine. I said I knew that he had said that, but that I thought that was an effort to keep me out, even though he was provocative in proposing that I wanted in. He said that I was incomprehensible and then that I was an asshole. I then said that in some way, I thought he was suggesting an asshole--asshole dialogue, although I did not yet understand the relationship between the symbolic part—that I, the analyst, was an asshole—and the anatomical part, his descriptions of the various states and qualities of his anus and buttocks. When I said this, I tried not to be se-

ductive or dismissive, but rather to take seriously his communication and to invite him to listen seriously to me.

Basil responded by telling me that I was an ass-wipe. Then he growled, "I knew you were just trying to eat out my butt." I wondered if my talking about the asshole--asshole dialogue had been premature, unwise, or just too much. I waited, somewhat apprehensively. Basil was cursing, now calling me a fucking asshole; then he got up from his chair and began to pace. His vocalizations continued, but seemed to become more organized. I waited. He looked at me carefully, and then his sneer lessened somewhat as he said: "Is this right, you are admitting that you are an asshole—'in the symbolic sense,' I think, is the way that you put it—and you are actually wondering why I keep talking about my asshole in the actual, I think you said, anatomical sense?"

"That is exactly what I am saying," I said, and I felt that we had perhaps turned a fateful and felicitous corner. Basil looked somewhat relieved. I know that I felt greatly relieved. "I think you can hear me, dude—maybe your ears are straighter than your butt," he said grudgingly.

Our course had become somewhat clearer. I was, perhaps, still being demeaned by the appellation *dude,* and someone's perversity was still rife; but there was also some recognition of my presence as a participant, not just an object. This seemed to be a promising change. We needed to learn more about why and how the other was an asshole. Did this reflect early experience with the ill and then disappearing father, or with the very present (perhaps too much so) celebrity mother—or was this a reference to disappointing aspects of the mother-and-father-together experience and the subsequent representation of Basil with both of them? Why was the self represented as a succulent anus that would entrap and control? How had we found a way to address these issues, and would this initial beachhead be maintained?

RALPH

Ralph came to see me at age three. His mother, Amanda, the CEO of a large company, complained about Ralph's sadism and his irre-

sistible physicality. She told me that she was divorced from her husband, but that since they had adopted Ralph while still married, her ex-husband was "sort of" the boy's father. "There is very little to him," Amanda stated in describing her former husband. She thought that it would be best if I were to see Ralph with her, because he might be afraid to be alone with "a man like you."

I wondered about this, particularly the meaning of "a man like you," but as Amanda seemed quite convinced that this was the way to proceed, and did not appear interested in my wonderings nor to brook disagreement easily, I concurred. I quite quickly was informed that Ralph's father was no good and that he would certainly have no role to play in whatever ensued.

In our four initial meetings, which occurred in the aforementioned format, Ralph barely acknowledged my presence, appearing preoccupied with the irresistible urge to hide under my analytic couch or to refuse to enter the play room at all. Mother barely seemed to notice the first situation, talking on with no reference to her son; she was immensely involved with the second situation, however, and would try to drag Ralph into the hour. I attempted to make contact with the boy in both modes, his hiding and his refusing. He did not respond.

Increasingly, I worried that Ralph would be put off by his mother's compelled flirtatiousness with me and her seeming incapacity to notice his disappearance, which alternated with her heated physical wrestling when he was reluctant to come in. I proposed that our next meeting occur without her. She laughed as though I were joking. "How can anything be without me?" she asked. I stuck to my guns and said that I was convinced that the time had come for me to see Ralph alone. "It will never work," Amanda stated. "You won't come and see this dangerous old man without me, will you, snookums?" she asked Ralph. I said again, "Let's try it next week, Ralph, and let's see if we can find a way together for us to learn what the dangers are and what we can do about them."

Mother had her driver bring Ralph the next week. The boy entered the playroom, took off his shoes, and threw them at me. I was astonished when he then said, "Fuck off, weirdo!" I had never

heard a three-year-old speak that way, and I wondered if it had been a mistake to ask his mother not to come. Transiently, I felt as though I could not manage without her. And over the next several meetings, we repeated a similar sequence: Ralph would partially disrobe, try to physically fend me off, and shout the same epithet. I tried to determine whether he was afraid or if something else was going on. In the sixth meeting without mother, Ralph shouted at me, "I don't want you here, you dangerous old man!" He then repeated, "dangerous, dangerous, dangerous!" "What does 'dangerous' mean?" I asked. Ralph did not answer.

We continued to meet, and I seemed to be getting better at anticipating when the boy would attack. I started to say to him that I could feel something coming. I hoped to interest him in my interest in what was building up inside of him. I remembered mother's words to the effect that there was nothing without her, and now wondered if there could be something with me. *How to be with* seemed to be the danger, and apparently a very great one.

We entered a phase in which the periods between attack featured solitary play on Ralph's part. He would find a toy and begin using it. He behaved as though my interest or interrogatories were inaudible. I persisted and sometimes constructed a parallel play. I hoped that there would be some area of intersection, but noted that this occurred only when Ralph attacked me or repeated the now-ritualized shout, "Fuck off, weirdo!" About once a week, his mother would call to tell me that she assumed that nothing was happening in her absence. "We'll do it your way," she continued. "I will not be coming in."

After about forty hours with Ralph, I decided to try a new tactic. I posted two rules in the playroom: (1) no actual hitting, and (2) we shall try to discuss what happens. Ralph's response to the rules, which I read to him, was: "Who says?" I responded, "I do." "You?" Ralph asked in his usual dismissive tone. "Yes, these are my rules and it is I who am saying so," I replied. I waited and watched what would happen. Ralph took off his shoe. I thought that he would throw it at me again. I said, "Rule #1—no actual hitting." Ralph asked, "Do you think I am deaf?" and threw the shoe in the opposite

direction. I felt very pleased with this development, and I said to Ralph, "It is clear that you can hear and that we are beginning to be able to understand each other."

I was not prepared for the next development. When Ralph returned the following day, he again threw his shoes away from me rather than toward me, and then he said, "My feet stink." Before I knew what was happening, he stuck both feet in my face. "That is a strong smell," I said. I was thinking about what this might mean when I noticed that Ralph had withdrawn again and was under the couch. "Why are you hiding?" I asked. There was no response.

I wondered about the smelly feet and their being put in my face. Was this a challenge to Rule #1 or Rule #2? What might happen next? I thought that this play on Ralph's part was related, but why did he disappear? The next day seemed even harder to understand. Ralph came into the room and began to drag me across the floor. I released myself from his clutches and asked, "What is going on?" He looked away and then hid again. I said, "Ralph!"—both searchingly and emphatically. At first, he did not answer. Then he said, "Ralph is here. Smell my feet." Then he asked, "Is anyone else here? I hate—*hate* you."

By the end of the hour, I had figured out that he was repeating behaviors from our initial meetings, which had featured his mother and him together with me. Dimly, I understood that something about self-with-mother had been evoked by my posting of the rules. This was either a regression or an elicited representation of dyadic reality. Was there also an unbearable intimation of a father, and with him, of triadic reality? I had hoped to provide something like this with my rules. I wondered why "smell my feet" was a part of this.

I thought of Basil and his butt. Was I seeing something *in statu nascendi* that Basil had presented in riper and more established form? I thought so—that here was the beginning of what could become a perversion; i.e., that the narcissistic dilemma could only be breached by a seemingly sexual relationship in which control was central and the biological format facultative. Was there also a suggestion that the sexualized, aggressive representation of self-

with-body-part or self-with-other constituted a desperate effort to create a third, an unrecognizable facsimile of the sexual parental couple through the eyes of a very young child?

Ralph continued to struggle in each hour. He seemed to speak with his body rather than with words. I tried to verbalize something of what I thought was happening, saying, "When I posted the rules, you stopped attacking me. But then you seem to have become very interested in the smell of your feet, and I wonder if you want to know if I am, too." Ralph listened, but said nothing. I continued this line of inquiry. Eventually, Ralph spoke. "If I can't keep you away by throwing my shoes at you, I don't know what to do." "Why must you keep me away?" I asked. "Dangerous," was the response, and then, "You are a weirdo." "Am I?" I asked. There was silence.

Then Ralph said: "I will make you smell my feet; they stink. I hate them, their smell; I hate you." "They do have a strong smell," I said, and added, "Feet often do." "Why?" asked Ralph. "Feet sweat and sweat has a strong smell," I continued. He looked calmer. "No, yes, really, everybody's? Yours, too?" "Often," I responded. "We understand each other," was his next comment. "Yes, "I said, "we are trying to do that. I wonder why it feels so dangerous to understand each other. It also seems reassuring that you and I might be alike in certain ways. I think that we can use our rules to make it safe."

Ralph nodded and did something extraordinary. For the first time, he put his shoes back on. I hoped that we could agree that sweaty feet have a strong aroma and that this biological reality would not need to be grievously appropriated as a substitute for relatedness and as a vehicle for perverse control. I knew that by stating that my feet could have a strong smell, too, I was offering a male–male alliance to Ralph, which I hoped would ease his isolation and help him to feel less vulnerable in regard to the danger and the wish for merger with his powerful mother.

DISCUSSION

So, Ralph and I, Basil and I, Felix and I, and Mel and I wrestled in various venues with the concept that the self is too much, too

strong, too little, too weak, in aroma, in impulse, in complexity, for it to be self-managed or co-managed. Instead, the self is to be foisted upon the other, as in "you do not exist," or it is played out in its more seemingly somatized, mucous management between Felix and me, the presence of flatulence and its odor between Mel and me, and then in a more sexualized form, "rim my ass" or "smell my feet" with Basil and Ralph.

I wonder if there may be a set of overlapping and interdigitating templates that involve a deficit in interactive co-management of self structures—templates that reflect actual interactive defects in either the self-with-each-parent realm or in the self-with-mother-and-father-together sphere. The resultant incapacity to modulate and organize plays itself out in what becomes—if there is no intervention—a progression toward a narcissistic personality disorder. Hatred as an extreme form of unmodulated aggression is omnipresent, and some representation of the parental sexual couple is, perhaps, unconsciously depicted in a desperate effort to create a useable third.

The self develops as an other, self-seeking structure. In actuality, I posit, the self develops as a self-with-mother, self-with-father, and self-with-mother-and-father-together, seeking structure. Distortions resulting from suboptimal availability in any of these spheres affect narcissistic development. Ways of compensating for nonreciprocal systems evolve, and always they contain the pain of what was not represented as the original insult and its subsequent elaboration. The provenance of each evolving narcissistic disturbance is clearly depicted in its psycho-architecture. A mythology reflects its region, as the poet Wallace Stevens (1972) wrote.

The self evolving without adequate interactive partners attempts to adapt. The adaptation that involves the taking of a body part or function as partial object, and then the use of deformed aggression as the mode of interaction, results in private perverse practices and in a seemingly sadomasochistic object relations schema. Note, however, that none of this is totally what it appears to be. It is a situation demonstrating the continuous necessity to differentiate the genotypic from the phenotypic. What is actually occurring is the re-

quirement that force be used to control both the self, and in some evolving way, the other, as simultaneously a part of the self and as something foreign to the self. The original other has had to be constructed from a less than adequate model, the mother-with-the-self, the father-with-the-self, and the mother-and-father-together-with-the-self. This construction is forced; it is a matter of necessity, eventuating from the lack of actual availability.

This forced construction extracts a huge cost from the self. It biases the capacity to recognize the reality of the other, and it prescribes a relational mode, which perpetuates this cost. This construction harnesses itself to the affect of hatred, and the course is set toward perversion of the self and perversion of the other. It is, of course, predicated on the reality of the child's not being recognized by caregivers to begin with. In the absence of an attuned mother and a modulating and organizing father, the self's regard for its component parts and functions is unattuned and unmodulated. It is as if there is a perverse intrapsychic structure that precedes the developing perverse interactive modus. These efforts are always aimed at self-righting, but they are inherently flawed and lack the necessary presence of the other in an ameliorating form; they are now destined to destroy the other as the primary form of being with. Pathological authority is constructed in lieu of viable and structuralizing paternal authority in the presence of endorsing and reciprocating maternal authority.

It is interesting to compare and contrast this formulation with Target and Fonagy's (2002) notion of the difference between an object's becoming a part of the self and the mind's developing the capacity to represent a relationship of self with other. They speak of *triadification* that occurs in a more or less felicitous fashion, reflecting both the mother's capacity or incapacity to recognize her child's mental functioning and her capacity or incapacity to recognize, permit, and convey the valued reality and separateness of the father's mental functioning to the child. Clearly, these conceptualizations of the developmental routings to mindedness are germane to the constellation of intrapsychic unfoldings that I am describing. They presage a narcissistic deformation and a rep-

resentation of self-with-father, self-with-mother, and self-with-mother-and-father-together that predisposes to malfunction, rather than to the optimal capacity to play, to love, and to work, both by and within oneself and with others.

In a series of earlier communications (Herzog 1995, 1998, 2000), I have suggested that the libidinal, aggressive, and narcissistic availability of each parent is affectively vital, and that such availability requires a physical component as well. Thus, mothers must actually *hold* their children, not just *feel* holding, and fathers must interact physically, too. I have suggested that neuronal development, including the elaboration of enzymatic systems necessary for optimal aggressive management, is contingent upon actual physical interaction, and I have illustrated this with reference to paternal involvement in regard to the important modalities of *scent* and *sting*. This is, of course, a putative schema, reflecting both clinical observation and very tentative neurophysiological theorizing. A child must take in the father's distinctive scent and actually feel the sting of his anger. (These olfactory and tactile aspects characterize self-with-mother interactions as well.) In all cases, the ways in which this is accessed by the child and provided by the father are heavily influenced by the mother's feeling about the physicality of masculinity, and thus the mother-and-father-together relationship is built into the availability and eventual meaning of these aspects of paternity. Again, in order to develop authoritative self structure, a boy must know the authority of his father and feel his mother's approval and endorsement of masculine selfhood; he must feel himself to be competent and effective in managing aggression and in constituting a legitimate conduit to interaction with others in the outside world.

In an earlier publication (Herzog 2000), I discussed Danny, a child analysand whose dilemmas and solutions had included an exploration of self-whacking. Danny contrasted this with a whack delivered by a father or an analyst who loved him and cared about his future development. Poignantly, he proclaimed that whacking his own bottom when he had been out of line was completely different from having his father do it. Panksepp's (1998) discussion of

tickling, which cannot be self-administered and requires the presence of an active other, reflects the same basic truth.

Danny also discussed the strong smell of the analyst after exercise; he revealed that the "dioderant" part of his fantasy life revolved around whether or not the actuality of the father's scent could be endorsed by the mother and thus be made available to him, or whether she could control its masking or actual ablation. In so doing, he was discussing the option of a related, biologically real father and mother who interacted with him and his biology, rather than the absence of these vital forces and the forced and perverse solution that their absence presaged: hatred of the self, masked as grandiosity, and control and denigration of the other. Such a related and available parent and parental couple maintain an ongoing relationship with the reality of the child before, during, and after any and all loving or disciplining interaction. Moreover, I posit that they facilitate the development of brain underpinnings and mind functions, which in their absence develop in a stunted fashion.

Narcissistic personality disturbance *in statu nascendi* reflects, then, in my formulation, a mind-brain organization in which unmodulated aggression is prematurely sexualized, and, in its reliance on unrelated force, reveals the only pathway at its disposal. Thus, the self is both strangely noncognizant of its borders and rough or indifferent with itself and with others. This calling upon available resources and appropriating them out of sequence and without environmental input makes biological sense and operates in accordance with the philosophical principle of Occam's razor. It mirrors the adaptations that we have come to recognize as part of the symptom picture of the child with a variety of learning and attentional disorders as well. Yet, for much of childhood, an openness remains that permits amelioration to occur through psychoanalytic input or environmental restitution.

Thus, child patients and nonpatients will seek paternal authority, maternal holding, and even, as in the case of Ned (see Herzog and Herzog 1998) and others, the creation of an alternative parental couple. Without success in the search for environmental alternatives (and often the child is actively hindered in this search by the

parental surround), adaptive mechanisms are foreclosed, and constriction threatens. This process is aided and abetted by the gratifications that the perverse character structure affords. With adolescence and the pubescent arrival of orgasm, actual constriction often intervenes. The Felix, Mel, Basil, or Ralph who actually comes by control of the other with his body effluents is ever less motivated to seek restitutive objects or actual interaction and relationship. The extreme manifestation of unmodulated aggression, alloyed with a diminished capacity to differentiate and value the ongoing nature of a relationship with a vital and essential other, and accompanied by the necessarily concomitant overvaluation of the self for defensive purposes—employed as an antidote to the self-hating aspect of unbridled hatred—increasingly cripple both the intrapsychic and the interactive repertoires of the afflicted individual. The analyst who can secure a beachhead with a child patient is increasingly less able to do so with a postadolescent analysand. Identifications from the child's past are almost always fraught with unavailability and narcissistic fragility, as well as tainted by the frankly perverse nature of the sexualized relational substitute that has evolved and must now be secreted away in order for any semblance of an adult--adult dialogue to occur.

I would like to assert that it is not accidental that I draw on male cases for this exposition. It is the particular vulnerability of the male child to paternal absence, and his imperative need for the mother-with-father-together representation, which skews the distribution of this disorder according to gender. It may also be that the male child's greater aggressive load, and thus his subsequently greater need for mentorship in regard to it, predisposes him to use unmodulated and then sexualized force on himself and on others in the absence of a modulating and organizing father. The problem of hatred for such boys is extreme, and the havoc that ensues as a result is incalculable, both for the boy himself and for all others who cross his path. Thus, boys may be more susceptible to the development of a narcissistic personality disorder in the absence of good enough mothering, good enough fathering, and good enough mothering and fathering together.

All of the constituents of this disorder are also more prevalent in male children: the development of a perverse pseudorelational schema, the appropriation of sexuality for control rather than mutual pleasure, and the restriction on the inherent playfulness of normative sadomasochistic relatedness under the aegis of unmodulated aggression. Violence, intrapsychic and interpersonal, the end product of unmodulated and unorganized aggression, is the ultimate disintegrative product of inadequate paternal authority. The mother must sanction her husband's—the child's father's—use of his own calibrated aggressive physicality in the service of their son's management of his own aggression, in order to prevent this disorganized outcome (Herzog 2001; O'Connell 2004). Paternal authority is best exercised and internalized as an aspect of triadic reality and relatedness. In such a context, the boy has the opportunity to experience self-with-father and self-with-mother-and-father-together, as well as self-with-mother. He thus learns how a boy and then a man manages himself respectfully by respecting the other and being respected by her or him. He also learns that self-respect is patterned on a triadic reality, which endorses his constitutional somatic and psychic endowment and its modulated and organized deployment. He can be self-centered and respectfully relate to others as well, with his maleness intact and guiding his way of relating and being related to.

Recently, exciting new work on the Y chromosome has explicated the ways in which the potency of maleness requires base exchange by a self-coiling mechanism in order to promote genetic diversity, and to repair and protect against what geneticists label Muller's Ratchet (Skaltetsky et al. 2003), which involves the inevitable decay of noncorrecting—that is, noninteracting and nonexchanging—genetic material. In such a situation, further growth and replication reflect and hypertrophy extant conditions and often contain defects that deform the organism, the essential notion being that no mechanism exists to compensate for derailed functioning. On the level of hermeneutic metaphor, it is not an exaggeration to state that maleness is both very potent and potentially very self-centered, and that the boy without an available and author-

itative father, an available and attuned mother, and a parental couple who function as a sexual and aggressive caregiving unit is vulnerable to the psychological equivalent of Muller's Ratchet, a narcissistic personality disturbance. It is this sector of the psychopathological spectrum that is disproportionately occupied by inadequately parented boys; and it is these same boys who can be reached and decisively aided by psychoanalytic intervention.

CONCLUSION

A child's capacity to play is his or her greatest developmental asset. Child analysts utilize this modality as a way of accessing unconscious process and mobilizing restitutive developmental forces that favor gyroscopic stability and an optimization of each child's endowment and environmental succor. Analytic treatment for children with unfolding narcissistic personality disorder is imperative. By using displacement, enactment, and interactive enactment, the three play modes that characterize the child's armamentarium (Herzog 1993), it is possible to reactivate developmental hungers that facilitate object-oriented progression. Ralph, Basil, Mel, and Felix can be reached and assisted in a manner that allows them to reaccess a fuller representational deck. This in turn enables a return to "full-deck functioning," which has as its core object relatedness, respectful interaction, and well enough modulated aggression (Herzog and O'Connell, unpublished). The absence of such psychoanalytic intervention, conversely, is associated with an increasingly "ceilinged" prognosis and an ever-evolving psychological morbidity. Perverse patterns of relating and self-regulation become increasingly resistant to interpersonal appeal, and the sexualized substitute for actual relating becomes more firmly ensconced. As with other malignant illnesses, when treatment occurs, it has a decisive impact on outcome and prognosis.

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TRANSCENDING BITTERNESS AND EARLY PATERNAL LOSS THROUGH MOURNING AND FORGIVENESS

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This paper provides an in-depth account of a clinical path to forgiveness following a complicated, delayed mourning of an early loss by a man now entering old age. The search for mourning and forgiveness in light of extreme bitterness in advancing age is highlighted. Despite the intimate connection between mourning and forgiveness, this paper attempts to highlight important differences in their dynamics and psychological aims. Forgiveness is conceived as work, unconsciously motivated, to safeguard and complement the psychological gains of mourning. The distinct features of forgiveness facilitating psychic reorganization, as well as the adaptive function of refusal to forgive as a defense against melancholia, are discussed. The paper concludes that in this case, the motivation for forgiveness was to repair a powerful narcissistic injury.

INTRODUCTION

The psychoanalytic literature on object loss during infancy and childhood is largely focused upon maternal absence as the result either of emotional detachment (Alpert 1959; Green 1986; Price 1994; Shengold 2000) or of actual abandonment due to desertion

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or death (Barnes 1964; Furman 1964; Perdigao 1999; Wanamaker 1999). While, certainly, such loss has a profound impact upon the psychic development of the child, the effect of paternal loss during childhood is also significant (Abelin 1971, 1975; Buirski and Buirski 1994; Burgner 1985; Herzog 1980; McDougall 1989; Seaker and Katz 1994; Sugarman 1997). This is even more true if the loss occurs before the child's birth (Neubauer 1960) or during early infancy (Burgner 1985; McDougall 1989; Siegman 1966), and if objects to ameliorate the loss are not available.

Children of both sexes suffer deeply as a result of loss of the father, though boys might be faced with greater difficulty in establishing identity consolidation and gender coherence, while also finding themselves in a too-close, binding relationship with the mother (Burgner 1985). They may also suffer guilt from seemingly scoring an oedipal victory. The impact of such trauma may be of lifelong duration, and causes difficulties particularly in resolving the mourning process, because the object of mourning has never been experienced in reality.

The case that I am presenting is noteworthy because the patient was able to come to terms with intense feelings toward the father he had never seen. I will attempt to show how the unleashing of a complicated, belated mourning process in analysis allowed the patient to become aware of his ambivalent feelings toward the man he assumed his dead father to have been, and how the working through of these feelings within the transference helped him not only to forgive his heretofore despised parents, but also enabled him to forgive himself. In this case, the delayed mourning and the psychological process that led to the forgiveness of the father were inextricably linked. The complementary nature of the dynamic relationship between mourning and forgiveness, as well as differences in the psychological aims of each, will be discussed.

CLINICAL MATERIAL

Background

Dr. D, a married physician in his mid-sixties, sought psychoanalysis for chronic hypochondriasis and somatization disorder,

which had grown worse since his retirement from practice about three years earlier. He was the only child of immigrant parents and had grown up during the Depression. His father died when the patient was eight months old, and in late adulthood, the patient came to strongly suspect that his father had suicided. However, this death was never explicitly acknowledged during the patient's early childhood, and in response to his questions, he was told that his father was away on a long trip. Despite his strong wish to accept this explanation in anticipation of his father's return, as a young boy, Dr. D did not know how to reconcile this story with his frequent visits to the cemetery, accompanied by his black-clad mother, who would cry profusely at a grave while he sat next to her, watching quietly.

Up to the age of ten, when his mother remarried, Dr. D not only shared the same room with her, but also shared her bed. Despite his superior memory, he could not remember anything at all about this room, but did recall frequent nightmares that ended only when his mother remarried and he got his own room. Throughout his childhood, Dr. D's mother was intrusively preoccupied with his health, hygiene, and bodily functions. Among other seductive behaviors, she would coach him to stand up on a chair and give her "honeymoon kisses." He felt ambivalent about some of these experiences, since he derived pleasure from being the only man in his mother's life. Simultaneously, he felt confused and deeply ashamed of his occasional erections during some of these interactions.

Dr. D described having been a docile, compliant, and fearful child who rarely cried openly or expressed his anger. He was always careful of not hurting or overburdening his mother out of a fear of losing her, too. However, with the onset of adolescence, he became a very angry boy who would constantly berate and quarrel with his mother, a behavior that he came to understand as a defense against his fear of feminization and, paradoxically, against his oedipal feelings. While he suffered from survivor guilt, he felt like an exception who had managed to get rid of his father and other siblings and remain the only man in his mother's life. He felt he

was destined to become a great man, a fantasy reinforced by his mother. A recurrent masturbatory fantasy that emerged in early adolescence was that of a beautiful, torturing queen, towering above him, who inflicted pain and observed him during various humiliating scenarios.

Dr. D was thrilled by his mother's marriage and did everything to please his college-educated stepfather, who, although not expressive of affection, took a serious interest in Dr. D's education and intellectual growth, which had been totally neglected up to that time. Soon Dr. D became his stepfather's close companion, and during their long walks together, he was taught about the worldliness and the elevated social class of white, Anglo-Saxon Protestants. He was reminded that for non-WASPs, like their family, the only ticket to recognition and respect in America was the pursuit of intellect. The patient eagerly embraced this view, and later came to see intellectualism as his passport to masculinity.

Nevertheless, as he entered adulthood, Dr. D felt a growing envy and hatred of WASPs, combined with a hopeless sense of exclusion, as well as being wronged and shortchanged—feelings that continued to consume him for many years. This theme, accompanied by a stubborn and relentlessly unforgiving attitude toward everything American (as well as toward all that related to his ethnic background or his unsophisticated biological parents) set the tone for an unending litany of injustice, inequity, and unfairness during his analysis with me—a non-WASP, female analyst, whom he could consciously relate to with a sense of kinship.

Course of the Analysis

Analysis began at three times a week and was increased to four times a week during the second year, when the patient moved closer to my office. The sequence of events that I will present took approximately two months to unfold during the second year of analysis. By this time, Dr. D's earlier aggressively tinged erotic transference had significantly toned down, and I was gradually able to unveil his relentless wish for reenactment of his sadomasochistic

sexual fantasies, during which he incessantly accused me of deriving pleasure in judging him, pitying him, and looking down on him, while simultaneously disparaging me for being no better than a prostitute for seeing other patients/johns. The recurrence of different variations of this theme, and the processing of my own irritation and angry countertransference, finally allowed me to wonder aloud whether he was talking about me or the torturing queen of his adolescent masturbatory fantasies. As the powerful flood of his erotic feelings toward me (mother) was unleashed and recognized, Dr. D felt deeply understood, and allowed me to help him overcome his conviction that the only way he could engage with me was through a sadistic sexualization of our relationship. It was within the ensuing (relatively) calm and benign positive transference that the events took place that opened the path to a delayed mourning and forgiveness of his long-dead father—and his subsequently devalued mother.

These events began in the context of my announcement of a five-day absence, which was initially met by Dr. D's sullen silence, and later by a relentless depreciation of God and ridicule of organized religion. When I confronted him with his sense of pleasure in rejecting God, he immediately acknowledged the displaced nature of his rage, and conceded that the ideas of *God* and *father* went together: "I feel a tremendous amount of anger at him [his father] for leaving me. That's what I'm mad at. I'm angry at everyone. I'm one son-of-a-bitch angry person. Then I get contemptuous and say my father was nothing more than a lowly tailor. That goes along with having a peasant mother."

Despite the transference implication of the patient's anger, I chose to stay with his immediate affective experience of his father. I said: "But he could still have loved you as a son."[1] After a few seconds of silence, the patient burst into tears as he talked about his need for the unconditional love of a father. For the first time, he questioned his prior conviction that he had been better off raised

[1] Although this was not a precise interpretation, it was sufficient to put the patient in touch with his repudiated longing for unconditional paternal love.

by his sophisticated stepfather, to whom he owed all his outstanding accomplishments, instead of by his "lowly" father, whose untimely death spared him from a provincial life.

Nevertheless, Dr. D's low tolerance for depressive feelings and his exquisite sensitivity toward rejection continued to manifest. For instance, when he saw me after this session (unbeknownst to me) in the hallway looking at my mail, he had the thought that "There she goes with her own life. She doesn't give a damn about me." He felt that he had exposed his vulnerability, and that I should have been wringing my hands to stay with it. My casually looking at my mail was an affront to him, which led him to believe that he truly did not want to know me outside of the consulting room. Then he accused himself of being irrational, ridiculing himself for having high expectations of me.

When Dr. D related these reactions to me, I remarked that he was worried I would take his comments to heart and become uncomfortable in listening to his hurt and upset. He lightened up and was able to continue: "Yeah, and on a third level, you appeared more accessible to me. I felt like saying to you that you look desirable in your sweater." I said: "You mean desirable but inaccessible." He agreed, adding, "Just the fact that I didn't know what to expect. My first impulse was how cute you looked, wanting to put my arms around you. It was sexual, and then I started to think, 'She doesn't care about me. Look! She's aloof, reading her mail.' This little episode reverberated with all my relationships with women. The aloof, inaccessible, desirable, perennially torturing queen!"

I commented that this sounded like a familiar scenario of his childhood, the constant state of overstimulation at having his mother next to him in the same bed—so accessible, and yet, in a torturing way, inaccessible. I then invited him to become more empathic with his plight: "Maybe you can appreciate how painfully you had to be reminded of the smallness of your penis in order to keep your desires at bay, and how, to this day, you have to rely on that smallness to avoid the fantasied incest that you simultaneously have a hard time giving up."

During the next three weeks before our break, Dr. D began to romanticize sorrow as an emotion deeper than joy. The idealization continued as he began to glorify not just sorrow, but also tragedy. He described the powerful appeal of *King Lear* as superior to the light entertainment of *A Midsummer Night's Dream;* he talked of how sorrow stimulates great, serious, and deep artistic work, of the moving beauty of Beethoven's last quartet before his death, the awesome Death March, and of the kinship he felt with flamenco music. Indeed, he wondered whether he really wanted to give up his sorrow at all!

As he continued to complain that the Western cultural world does not understand sorrow, he gradually realized that his own chronic sorrow preserved that part of himself that wanted to consciously hate the dominant culture of the American WASP from which he felt alienated. I pointed out the resentment he felt toward his father for not being around to make him feel grounded, and suggested that because he could not forgive his father's absence, he was projecting that loss onto the culture, constantly—reminding himself that he could never belong to the Anglo-Saxon world, nor could he identify with any other ethnic community.

I felt that Dr. D was sealing his fate as an orphan child, deprived of a strong and intact, symbolic family. As such, the hatred of his father displaced to WASPs also assuaged the guilt that emanated from his murderous wishes toward him. His sorrow further served his unconscious purposes in that his sense of hopelessness functioned as a way of denying his hostility toward his father. I commented: "It is as though you're saying, 'Look how much I'm suffering on your account [addressing his father, as well as me in the transference]. That shows how much I love you.' It sounds like you have to hang onto this sorrow as a way of not mourning the actual loss of your father." This interpretation helped Dr. D overcome some of his resistance, and with some trepidation, he resumed the mourning process.

As we approached the date of my departure, the patient reported having had a painful flare-up of his hernia, and wondered if he had created this pain as a way of avoiding his feelings of pain at

seeing me go. He was aware that, although we would miss only two of our regular sessions, a part of him had to fight back the thought that I was leaving him without good reason, and so he had had to come up with a justification for my absence. He had convinced himself that I would be absent for religious reasons, in observance of Ramadan, a Muslim holiday. But, as he explained, it was hard for him to see me as a religious person, and knowing that psychoanalysis is such a secular profession, he realized that it might even be irrational to cast me in such a light.

Recognizing this need to create a far-fetched justification for my abandoning him, Dr. D was able to get in touch with both his inability to cope with my absence and his fear and resentment of his dependency on me. He remembered, for instance, that his grandmother used to literally pull him away from his mother when she had worked all day and wanted to see a movie alone. His fantasy that I was going away for fun became unbearable, as it became associated with his pain at being excluded from his mother's fun. Thus, he had to imagine that I was taking off out of a sense of piety and not for fun, i.e., sexual fun. He wanted to insulate me from his anger, and felt that a good way out of the dilemma would be to have my sympathy by virtue of his physical symptoms. He then realized that he was consumed by fantasies of my being in a plane crash or becoming ill during my trip. It was only at the end of the session, when he saw the wall light announcing the arrival of my next patient, that he snapped, "You've got a busy morning today—I'm being sandwiched between two other patients."

In the following sessions, Dr. D's anger persisted, and he tried to mask it by alternately complimenting me and giving free rein to his sexual fantasies, which were tinged with subtle hostility or colored by outright devaluation of me. It was only when he shared a nightmare of someone's sticking a pin in his inner thigh, and his waking up from agonizing, sharp pain, that he was able to realize how angry he was with me. His sexual fantasies were his way of trivializing me and bringing me down to the level of a prostitute who had to share herself with others, both in and out of the office. He lamented that even these fantasies were a source of anxiety,

since he could not imagine, in light of our age difference, being able to satisfy my "enormous" appetite. He then alluded to a fantasy of biting off Napoleon's testicles and eating them in order to no longer feel so insignificant, small, and especially vulnerable, now that he was retired.

At this point in his account, Dr. D began sobbing, and admitted that he had been deeply touched when I suggested that the man he had known only as a humble immigrant tailor could also have given him the love of a father. The comment however, had also depressed him: "I didn't want to feel it because I dreaded accepting that it was a done deal." He became aware of a great sense of desolation, to the point of wondering what the point of being alive was with his father gone. In his newfound ability to empathize with his orphan-immigrant-child self, he had become philosophical; he marveled at how much of a tough veneer a man must put on in order not to appear like a vulnerable child, assuming his experiences were universal.

After his visit to the nursing home where his mother lived, on the way to his session, the patient reported that he felt closer to his mother because of me. He then added that no one else in the universe knew him as well as I did, and that he was convinced I could never forget him. He felt that this aspect of our relationship was more intimate than lovemaking. He was more accepting of what I could give, and did not deny our closeness on the basis of the boundaries of our relationship.

Dr. D's mourning continued after my return the following week. But his anger toward me was replaced by a sense of disappointment. He was disappointed in me for being a woman and therefore not a good substitute for his father. Now, in a significant way, he felt that my gender was an impediment in allowing him to transfer all his paternal longing to me. He lamented, "You're not my father and you can't take his place. He's the only one who can show me the way. Last week, when I felt his loss—my total anguish and sorrow—the thought of him was all that restored me to courage and manliness."

At other times, the patient complained that, because of my intellect and my insights, he could identify me only with his stepfa-

ther. Then, alluding to the fact that he had been told as a child that his father was not dead, but simply on a long trip, he said, "I feel like Ulysses' son, waiting for his father—except that my father will never return from his journey."

For the next two weeks, Dr. D did not miss any opportunity to cast me as impotent to help him with his despair. For instance, if he worried about aging, I would not be able to understand this because of our age difference. Or, if he was concerned about the stock market, it would be futile to discuss this with a woman: "Why do I have a sense that I'm talking to a wall? As a woman, what could you possibly know about the financial world? I bet you're like my wife, only good at spending money. I feel I'm talking Chinese to you! But if your husband were here, he would understand where I'm coming from."

I found myself irritated at being cast in this role, and a few times, I was ready to snap back, "What makes you think that my age or gender prevents me from understanding your problems, when you know quite well that I have understood all your struggles with masculinity in ways that you felt no one else could?" At other times, as a way of proving that I was not so powerless, I would catch myself wanting to give Dr. D subtle bits of advice, like: "If you hate your wife's bitchiness, maybe you should stop provoking her so much."

As I got in touch with my anger and frustration through these very tempting thoughts of confrontation, I started to listen to Dr. D differently. In his unending refrain about my impotence, I began to hear the despair of a lost boy—unanchored, adrift, and looking everywhere for his father, but unable to find him, turning away everyone else as poor substitutes. Hearing his anguish more clearly now, I began to feel empathy and compassion. I realized that in the transference, Dr. D was rejecting what I could give him as the intellectual stepfather, or even as the benign mother. Instead, he unconsciously wanted to recapture the hitherto disavowed experience of searching for a father who would never return, and thus he had to dethrone me from my position of power. Consequently, I chose to accept the role of the powerless ana-

lyst in the transference, and simply empathized with the little lost boy in him, freely and nonjudgmentally allowing him to express his sense of futility and loneliness.

The following week, Dr. D came into his session announcing an episode of hypochondriasis. He had forgotten a few things related to his finances, and he thought that he might be experiencing the onset of Alzheimer's disease. This newfound fear gave him yet another pretext to point out my inadequacy as a father substitute and the futility of my efforts to rectify his problems. I noted that he seemed to be using this fear of Alzheimer's to purge himself of the legacy of his stepfather's idealization of intellect, which had become a barrier between him and his biological father. Similarly, because of his respect for my intellect, I had come to stand for his stepfather, and therefore I, too, stood between him and his real father. I commented that he had to make both his stepfather and me impotent in order to stay in touch with his longing for his father, and, in this process, he was undoing his former devaluation of his father as a lowly immigrant.

Dr. D responded to my insights in a positive way, grateful that I had understood him so well, and he no longer rejected me as the wrong object in the transference. He declared that he had entered a new state of mourning, and had placed his father's picture on the mantelpiece as a way of resurrecting him. Although I was impressed by the speed of the patient's progress, I wondered if it were really quite so easy; perhaps he was trying too hard to reward me in his attempt to strengthen our bond following derision of me as a female.

At the next session, Dr. D came in with a big smile. My first name, he said, was very pretty, and made him think of Scheherazade in *The Arabian Nights*. He had been picturing me as a former university student, and imagined with compassion how difficult it must have been for me to study in English as a second language. He remarked, "I noticed the other day that you said *Alzheimer* instead of *Alzheimer's*." He added that he did not consider my error to reflect my intellectual abilities, but rather thought it was "cute." He felt he had glimpsed a side of me that I did not want to expose, saying, "You can't hide who you are from me."

I could not fail to see the patient's pleasure in catching my linguistic mistake and giving free rein to his voyeurism. During the prior session, I had wondered, given his effusive expression of gratitude for all I had done for him, whether he was not defending against a sense of envy at my ability to read him sometimes better than he himself could. Now, as he carried on, I noticed an even stronger exaggeration in his tone, which was certainly related to a feeling of empowerment or victory over me. Perhaps the new, daring quality of his expressions indicated that he no longer had to feel envious about my perceived superiority in the analytic situation, since the reality of my mistake had toned down his transferential need to perceive me as the omniscient analyst, in contrast to himself—the little boy locked out of the parental bedroom. It appeared that the error had humanized the two of us and our relationship. Consequently, despite the condescending tone of his reassurance, there was also an affectionate quality to his communication, leading me to conclude that he now felt himself in the superior position of bestowing forgiveness on me, and that he was gratified to do so.

I chose to focus on Dr. D's ability to forgive rather than on how he had arrived at a position of forgiveness (that is, via reparation of his sense of envy by catching my mistake). So I remarked, "I think it's interesting that you're comfortable with my mistake/imperfection. You are also quite empathic. Maybe I can be intellectual, in your eyes, but occasionally not so erudite. Perhaps the fact that this stuck in your mind is reflective of your attempt in here with me to integrate the goodness in your stepfather—the intellectual—with your father, the loving immigrant."

After I conveyed these thoughts to the patient, he reported the following dream:

> I'm in this house. There's this telephone pole that goes up right next to the house. The pole's on a wobbly foundation. It's about to fall and it does, creaking as it falls. It hits the roof at an angle; I'm apprehensive, concerned that it's damaging my house. But when it happens, it isn't so bad—the damage is reparable.

Dr. D questioned what this dream had to do with mourning his father's death. "First of all, the pole shouldn't have been there next to the house, and the base of it was not solid," he explained. "The feeling was of apprehension. A few days ago, I was telling my wife that as a man gets old, his erections lean at an angle and are not straight. In the dream, as soon as I said it was going to fall, it did so. I wasn't panicky; the house was damaged, but reparable. The pole was a utility pole; it could have been a telephone pole. In the dream, I said, 'Telecommunication has something to do with the intellect.' "

Then the patient exclaimed, "Now that you mention it, I think the pole represented my intellect. It was on such a wobbly foundation. It was like a childish way of erecting something huge without much foundation." Following these elaborations, Dr. D could understand why he felt so insecure as a man, relying only on his intellect to feel masculine. He realized that if he could come to terms with his father as a loving parent, he would no longer need to equate masculinity with intellectual acumen. Simultaneously, he recognized that if he could accept his own limitations, he would no longer expect godlike perfection in his father or in me.

In the following months, Dr. D's newfound ability to forgive in the transference took an interesting turn. It appeared that he was starting to rewrite his history. For every memory of an abusive act of his mother—who was the primary figure in his life and the target of his murderous fantasies in the past—he would conjure up a heart-wrenching memory of her hardship as an immigrant and a single parent. It seemed that being in a position to forgive had pulled him out of the victim mode of being an injustice collector. He was no longer focused on his own wound—perhaps because it was no longer an open wound. As he shifted his focus to the wounds of others, he stopped feeling crushed by parental flaws and imperfections, since his pain no longer existed in isolation.

For instance, in retelling one of his most painful memories of childhood—about an incident that occurred when he was five years old and his mother fooled him into waxing the floor with the promise that his father was to arrive that day—Dr. D's focus was no

longer on how the event was typical of his mother's peasant mentality, but rather on his own pain and despair as he waited until dark for a father who never came. Concurrently, for the first time, he started reflecting on the memory of his mother's getting up early to go to work on cold, snowy mornings, while everybody else, including his stepfather, was asleep. The patient no longer blocked his feelings of empathy and concern as he remembered another incident, one that occurred when he was six: he sobbed as he imagined the painful scene of his mother's tearful boss, breaking the news to her at work that her only son, the patient himself, had been hit by a cab while running across the street and was severely injured. (The patient recovered fully from his injuries.) Now, when Dr. D thought of his father's death, he would comment that the poor man must have been very severely depressed to be pushed to suicide, and about how awful it was that his depression had gone unrecognized and untreated.

It seemed that forgiveness had opened an expanded window to his past, a window from which he could observe others and their struggles, as well as his own struggles—with hurt and pain, but without feeling endlessly persecuted and tormented. The subsequent reparative and synthetic function of his mourning and forgiveness allowed him to see that he had been the object of affection, as well as seeing the failures and deficiencies of all those who had touched him in one way or another.

DISCUSSION

How does one mourn the loss of a father one has never met? Mourning, as Freud (1917) said, is work, requiring the mourner to invoke a variety of images of the deceased and persistently mourn each one. In the absence of any memory or association to his actual father, what did the work of Dr. D's poignant mourning consist of? As Freud aptly put it, a patient may know *who* he has lost without knowing *what* he has lost. The man whom Dr. D had lost was a humble immigrant who could not enrich him with any sense of strength, power, or masculine worth, all of which he needed

to face the predominantly white, Anglo-Saxon, Protestant world in which he lived, but from which he felt excluded in many ways. What the patient had not recognized, however, was the significance of that loss—that is, the trusting love of a father to provide him with an adequate masculine identity and sense of himself. This emotional component of the relationship to the dead object had been driven underground.

Thus, the mourning process was triggered by the patient's acknowledgment that until then, he had disavowed the potential significance of his father's love and had replaced it with the defensive idealization of intellect as a panacea for his existential problems. Once he recognized his devaluation and derision of his father as a defense mechanism, he was able to own his repudiated unconscious dependency and to conjure up the painful suppressed memories of his childhood yearnings for a father whom he felt had abandoned him to a foreign world and deprived him of his birthright. Thus, the recovered memories as they emerged in the transference were not so much those of the object itself, but of the patient's yearnings for the object. Consequently, despite the nonexistence of the father in the patient's life, the mourning process took the course of one in which a relationship had existed and could be mourned.

As we have seen, the meaning of the patient's loss was displaced defensively to other situations, leading, for example, to Dr. D's hatred and envy of WASPs. This, in turn, saddled him with a chronic depression and self-loathing that colored every aspect of his world. Additionally, in the absence of memories of his father, his anger was displaced onto a symbolic father, a projection that was evident when he cursed God. In line with Bowlby's (1963) conceptualization, Dr. D's disparagement of his father served the function of shielding him from the mourning feelings of yearning for him. The work of mourning allowed the patient to unmask this yearning that had been shielded by his angry dismissal of his father.

Throughout the analysis, it became evident that the narcissistic injury of this loss was compounded and complicated by Dr. D's sense of oedipal victory, insofar as he had been the sole male sur-

vivor in his mother's life. As a consequence, his omnipotent identification with the father imago (whom he had unconsciously destroyed) had replaced his love for him as an object of aspiration. This process was further complicated by the transfer of these affects to his stepfather. Thus, a significant outcome of Dr. D's successful mourning was to gain a relationship with his father as an object separate from himself, whom he could aspire to emulate (Caper 2001).

Nevertheless, this was only one of the necessary steps toward Dr. D's recovery from chronic depression, insufficient in itself to allow for psychological assimilation. His strong suspicion of suicide as the cause of his father's death had further tainted the already diminished image of the dead man. In short, the patient had to forgive his father for what he had not received from him, and also for the inadequacy and flawed quality of what he *had* received. He had to forgive his father for all the shame and deprivation he suffered as a result of his absence, as well as for his failure to be the model to which Dr. D could aspire—which would have allowed him to overcome his humiliation at being the unworthy son of an unworthy immigrant. Finally, he had to resolve his sense of guilt for choosing his stepfather as the object of identification.

Of what, then, did the work of forgiveness consist? Since forgiveness is often conceptualized as a deliberate and cognitive disposition, it is easy to lose sight of its dynamic quality and the unconscious affective underpinnings that pave the way for this presumably conscious state of mind. To further elaborate an in-depth look at the intrapsychic processes played out in the transference that led to the wish to forgive, I will delineate four features of the patient's forgiveness that complemented his work of mourning, and I will discuss the psychic reorganizations that were ultimately made possible by his successful forgiveness.

Features of the Patient's Forgiveness

First, it appeared that Dr. D's *unconscious* urge to forgive was as strong as his psychological readiness to mourn. His focus on a mi-

nor linguistic mistake of mine allowed him to rediscover his father in the transference, but, thanks to the prior work of mourning, in this encounter, he was no longer the ill-treated, hurt, fragile boy he had originally felt himself to be. In the following session, the manifest pleasure in his grin, emanating from his momentary experience of power in deciding my fate (the fate of the newfound relationship with his father), was unmistakable. At this moment, he had the choice of shaming me with anger and derision or of forgiving me. He chose to forgive. He no longer needed to defend against his shame with anger (Lansky 2001).

Furthermore, the patient's sense of envy, arising from feelings of inferiority created by the analytic situation, found the opportunity to be reversed in reality; these feelings were further repaired by the superior position in which Dr. D found himself once he forgave me. Rather than being angry at me for letting him down with my mistake, and instead of resuming his familiar litany of grievances about my shortcomings as an analyst, he prefaced his criticism by first imagining me as a young, determined immigrant in a scene that paralleled his mother's similar struggles to make it in a foreign land. This was a crucial point, not only in highlighting the patient's ability to empathize with the plight of non-WASPs (himself), but also in further demonstrating a shift in his identity: in his loving correction of the mistake made by me (as a non-WASP immigrant), his ability to feel like a WASP himself was no longer such a distant experience.

Therefore, in that moment of superiority to me, Dr. D could truly own the envied identity of the erudite member of the dominant social class (always so remote from his own modest background). He no longer needed to set up the dichotomy of immigrant versus WASP in order to split off his shame and hostile idealization. This was an uplifting experience that allowed him to feel superior to me (father/mother), while still retaining his affection and accepting a mild disappointment in me. The experience helped him to let go of his right to be angry and allowed him to safeguard the relationship through forgiveness (Akhtar 2002). Consequently, the unconscious creation of an opportunity to forgive in

the transference reflected his identification with a loving object (me) (Lansky 2001), and had the healing and empowering effect of ameliorating his sense of envy. The work of forgiveness was therefore directed toward the unconscious psychic reorganization initiated by the work of mourning. In this way, the unconscious wish to forgive dovetailed with the mourning process.

Second, whereas in unresolved mourning, anger is turned inward against the self, in the refusal to forgive, it becomes diffused and creates an angry orientation toward the world. This bitter mindset was evident in the case of Dr. D, who was mad at himself and the world. In fact, the refusal to forgive and its generalization to an unforgiving attitude toward the world also defended Dr. D from the self-abasement that results from identifying with the problematic aspects of the lost object. It appeared that by refusing to forgive his father's absence, Dr. D mitigated this disturbance in self-regard, which is one of the most prominent features of melancholia. Because he refused any identification with his dead father, the reproaches he directed at the unworthy immigrant could not be extended to himself. Dr. D thus replaced self-abasement with constant debasement of the dead object.

In this way, he engaged in a perpetual struggle to set himself apart and to distance himself from the shameful identity of the father figure. At the same time, the continuing effort to dissociate from that identity allowed him to hang onto (albeit as a punching bag) this diminished image of the humble father. Unlike the melancholic who wants to keep the dead object close through pathological identification, Dr. D protected his self-esteem through an unforgiving attitude that kept his father alive, but in effigy and at a distance. Dr. D's unresolved mourning thus served to provide a compromise formation, whereby, instead of succumbing to melancholia, he was plagued by a chronic mild depression and troubled by relentless bitterness and outward cynicism.

For years, by cushioning his pathological grief with a refusal to forgive, Dr. D shielded himself from full-blown melancholia. He thus projected onto the world the emptiness he would otherwise have felt within himself, by becoming, in his own words, "an angry

son of a bitch." At the same time, Dr. D did not relinquish his tie to the object. His anger was a constant reminder of his father, whose memory he revived both directly and consciously in his persistent debasement of the man, as well as indirectly and unconsciously in his bitter orientation to the world. Indeed, if Dr. D had truly been so fully engaged in pushing his father away by constantly ridiculing him, how could he have accepted his death? Rather, by keeping his father alive through scornful thoughts, by generalizing that bitterness in his angry relation to the world, and by refusing to forgive, Dr. D safeguarded himself from the awareness of what he had lost. These defenses also protected him from the melancholic sense of emptiness that may have otherwise consumed him. As the reader will recall, when he resumed his mourning and was able to acknowledge what he had lost, he admitted that for a long time, he had not wanted to recognize the situation as "a done deal."

Third, although there is an intimate connection between the two, mourning is triggered by an actual loss, whereas forgiveness is triggered by the threat of loss (Schou 2001). That is, without forgiveness as a final step in the mourning process (especially in cases of complicated mourning, in which anger toward the lost object is paramount), the newfound, benign relationship with the dead is at best precarious. As such, under conditions of stress and regression, there is a danger that the patient's anger will resurface and the newly formed relationship will crumble. In the course of mourning, Dr. D restituted a loving relationship with his father that had been threatened by the potential flare-up of anger emanating from the residues of his huge narcissistic injury. The act of forgiveness prevented anger from festering and causing unbearable loss. It thus enabled him to make reparations for his hostility toward his parents—by mustering, for each angry feeling toward them, a positive memory or a compassionate understanding of their lives as well. Whereas the work of mourning facilitated the establishment of a relationship with his father, the work of forgiveness, by means of a *voluntary* waiver of Dr. D's entitlement to be angry at his father, further protected this relationship by curtailing the threat of future losses (caused by similar injuries).

Fourth, in the course of mourning, the passive acceptance of loss had allowed for the affective charge of Dr. D's memories, so that they gradually lost their power to cause painful waves of sadness. The active mode of forgiveness supplemented this passive process by allowing a wider access and more balanced perspective to his past memories. By opening himself to forgiveness, he was no longer rigidly focused on his injury; he found the freedom to shift away from it and to actively choose what to remember and where to focus. This shift reframed his memories and reconstructed his past in such a way that their hitherto sadomasochistic quality gave way to a more benign experiencing of his history. Hence, the memories were dealt with neither à la "forgive and forget" (Akhtar 2002), nor through "forget and forgive" (Smith 2002), but were simply recalled without their previous grimness. This reframing of memory resulted in a shift of perspective and an alteration in cognitive processing of what was remembered. Thus, inasmuch as the passive process of mourning furthered the diminution of the painful affective charge of the memories, the active mode of forgiveness enhanced this amelioration by allowing a cognitive reorganization.

CONCLUSION

Dr. D's emerging empathic and philosophical outlook on life as he reorganized his past memories, and his constructive resignation both to other people's imperfections and to his own shortcomings in the course of forgiveness, gave credence to the old maxim, *à tout comprendre est à tout pardoner* (to understand all is to forgive all). He would not be able to forgive were he not ready for a broader and more profound understanding of himself and those around him. Certainly, Dr. D's aging, his retirement, and other reminders of his lost youth (which rendered his defenses less potent than they had been in the past) facilitated and perhaps accelerated the working through of this depressive position (Jacques 1965). Although one cannot generalize from only one case, we might speculate that genuine forgiveness may be motivated by an unconscious wish to better understand and to accept oneself and others, as well as the wish to hang onto the goodness of what one has received.

This case has challenged and called into question the popular adage of "forgive and forget," since Dr. D, rather than forgetting the raw deal of his childhood, simply accepted it within the restructured framework of his memory. He was able to do so because his forgiveness was addressed to his parents and not to their actions. Therefore, he did not have to erase the past, but had to rise above it, allowing him to start anew—which is the ultimate goal of forgiveness, according to Kristeva (2002). The tapering off of the patient's expectations after he renounced his anger and bitterness paved the way for an acceptance of the world and his past as they were, without a constant protest utilized to keep the pain alive through harsh memories. As Dr. D came to terms with the destructive forces and tragedies in the world beyond his own isolated situation, acceptance grew out of his wish to surmount misery, despair, and bitterness through a constructive resignation to the imperfections of man. It was the adoption of this philosophical outlook that shifted his focus away from his painful injury without requiring any effort on his part to forget.

Thus, it appears that, in forgiveness, the letting go of bitterness and vindictiveness is motivated by the unconscious wish to repair a powerful narcissistic injury, and to become reconciled with someone whose absence or negative presence has been felt as an impoverishment, and, in fact, as a partial loss—of one's very self.

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TO HAVE AND TO HOLD: ON THE EXPERIENCE OF HAVING AN OTHER

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This paper reconsiders familiar concepts (such as internalization, object representation, and object constancy) in light of the notion of having, *in order to facilitate creative thinking about how patients are or are not capable of experiencing analysts—and how analysts allow them to do so. The meaning of Other-having is examined from both a theoretical and a subjective point of view. The author suggests that the sense of having an Other results from positive real experiences, and that the ability to have an Other is the sine qua non, the building block, of all mental functions that require empathy.*

To capture a sense of what it means to have an Other is elusive, to say the least. Like Kohut's (1977) profound comparison of empathy to oxygen, Other-having has, so far, been most readily defined by the effects of object loss. There is a vast literature on the subject of object loss, the opposite of Other-having. But what is the metapsychological/theoretical, as well as the subjective, significance of such expressions as "I have a child," "I have a husband," or "my analyst," "my patient"? These common colloquial usages, which we all understand without difficulty, can be taken to refer not only to the world of external reality, but also—very accurately, I would suggest—to the internal world of objects. There is value in trying to link our psychoanalytic metapsychology with common ways of speaking and thinking; our common speech carries profound truths.

The mechanism by which one comes to have an object depends on initial, actual interactions with real Others.[1] Solidification of the sense of having an Other and subsequent relationships with the external Other are then facilitated by that internalized mental representation and by the represented relationship with that object. I hope that *Other* imparts a more humane, holistic, and experience-near view than *object*, the way many in our field refer to the real people in our patients' lives. A note on terminology: I will use *Other* to refer to the conscious or preconscious sense of the external person and *object* to refer to the mental representation of that person. I will also use *object* in such stock phrases as *object loss* and *object relations*, as other writers have traditionally done. However, it is often unclear in the analytic literature whether *object* refers to an actual person or to a mental representation or to both; consider, for instance, the expressions *object loss, object permanence, object representation*, and *object relations*. The term is variously used and I do not presume to settle any definitional issues.

A DEFINITION OF OTHER-HAVING

To have and to hold is a phrase best known from the ritual words of the traditional marriage ceremony, and it is to make the connection to marriage (as well as to Winnicott) that I have selected this as the title for this paper on the subject of *having*. Although lay persons think of having and holding in connection with weddings, *Black's Law Dictionary* (1990) tells us something different about the source of these words—that they refer to the conveyance of property in deeds. Known as the *habendum clause*, these words usually follow "the granting part of a deed, which defines the extent of ownership in the thing granted to be held and enjoyed by the grantee" (p. 710).

[1] Caper (1997) has written about the development of the sense of a separate self as dependent on the mother's ability to have an Other of her own—that is, the child needs the mother to have a relationship with the father that excludes the child. If this does not occur, then the child's ability to form a sense of differentiation between self and other is impaired. Caper's argument is essentially an exploration in object-relations terms of Lacan's concept of the Name of the Father and the crucial role this plays in allowing the child to enter the register of the Symbolic.

For my purposes, the definition given for the single word *habere*, from the Latin *to have*, is intriguing: "In the civil law, to have. Sometimes distinguished from *tenere* (to hold), and *possidere* (to possess); *habere* referring to the right, *tenere* to the fact, and *possidere* to both" (Black 1990, p. 710). This reminds us that marriages used to be contracts (and perhaps still are in some parts of the world) about the conveyance of a piece of property, a woman, from father to husband, the property owners. And although we have come to use the word *having* casually, it is indeed about possession, ownership, and the power to use that which one possesses. (It is interesting, too, that we speak about the feeling of *losing one's mind*, but not nearly as readily about the feeling of *having one's own mind.)*

This has implications for the therapeutic situation, as well as for the understanding of development. The feeling of having important Others is a crucial component of healthy development; it depends on having objects in one's mind and holding them—that is, having the freedom to use them productively in fantasy and playfully in reality. This having of the external Other and the internal object is a vital component of psychoanalysis as well, for this may be the patient's first opportunity for possession without bounds set by the Other's excessive narcissistic needs.

The meaning of *having* for adults is clearly related to the desire to have and to archaic experiences of having. The initial sense of object-having is related to the establishment of object permanence, that is, to the sense of Others and things continuing to exist while they are physically absent; more mature object-having, though, comes into being with the achievement of object constancy. Infants, of course, do not initially seek and covet in the way adults do (although one may certainly wonder—from the perspective either of drive or of object relations theory—whether there is some inborn, hard-wired striving to *have* either need satisfaction or Others themselves; if the infant, for example, is pre-wired to attach to Others, this sense of attachment could be experienced as *having*[2]). I do not want to address this at length, because the questions

[2] I thank Parens (2003) for suggesting this last point to me.

of need, desire, wish, envy, and greed have been dealt with extensively by others; however, I will outline some of the ways these issues may intersect with my own topic. I would also like to point out that, if we have any doubts about the significance of possessiveness in development, we need only remember that the word *mine* is one of the earliest lexical achievements, preceding the use of *I*.[3] The sense of having (the absence of which is not having, e.g., wanting, needing, or wishing) may go hand in hand with the sense of being, and may be articulated at an even earlier point. Later in development, of course, comes the crisis of having/not having par excellence: the oedipal situation.

This is a theory not only of object relations in the most technical sense—that is, of relations between internalized object representations—but also of how actual relationships exist between persons. Perhaps the knottiest issue is the relationship of the fantasy or feeling of having to the actual person/Other in the real world. There is also the interesting question of whether Other-having, of the variety I am considering, can occur in the absence of the willingness to give oneself to the Other. "Who giveth this woman . . . ?" Marriage, after all, involves a willingness not only to be given or had, but also to give oneself. Lacan's (1958) distinction between need, demand, and desire is relevant here. He uses *need* to refer to the biological requirement, *demand* to refer to the insistence on recognition that accompanies need (recall here Kohut's [1977] dictum that infants do not just need food—they need empathically modulated food-giving), and *desire* to refer to that which can never be satisfied, the quotient that always remains unfulfilled. Boris (1990) puts this succinctly:

> For the baby to develop it is not enough for him to be gratified: he must also know that he is being gratified. This

[3] The child will first refer to him-/herself as *me* or as his/her name. The use of *mine* comes next developmentally. *I* is a later achievement (Parens 2003; Sharpless 1985, p. 874). I would understand this progression as moving from a sense of self as object, then to the concept of possession, and finally to the sense of self as subject. Bergman (1999) does not directly address the developmental sequence of language acquisition in which I am interested here, but his views on the general subject of possession are nonetheless of interest.

> knowledge is a necessary precursor of knowing that there is a person there who is providing the gratification. [pp. 128-129]

Winnicott (1951), too, when he says that there is no such thing as a baby, acknowledges the parallel between actual time-space relationships and the developing structure of the mind.

Other-having, as I am defining it, is closely related to the concept of object constancy. Object constancy is usually thought of in a positive sense—that is, as a productive and necessary building block of mental structure (Fraiberg 1969); however, we know that it is often a sadistic or excessively ambivalent Other that is internalized. Even when a good enough Other is available, there must inevitably be aspects of badness present in the internalization. Perhaps it makes sense to conceptualize *good enough* as including elements that are *bad but not too bad*. This bad-but-not-too-bad element in object constancy leads to the harsh introjects, the internal persecutors or punitive superego functions, that constitute the bread and butter of psychoanalytic work. Internalized objects can be persecuting, harsh, and antilibidinal, as Klein, Fairbairn, and Kernberg have eloquently described.

But Other-having, as I am attempting to define it, derives from the positively valenced internalized object. It results from the confident expectation (Benedek 1938) in time-space reality and later in mental life that one is free to take and use the good enough Other. Lear (1998) offers a compelling argument that it is love that is responsible for the very structuring of the mind, that we require a good enough world in order to become human. I concur with Lear, and believe that it would not be possible to survive beyond infancy if relying solely or even primarily on persecutory internal objects. As we know from work with severely abused children, who persist in idealizing their abusers, survival in such environments depends upon denial and disavowal of the severity and inevitability of the trauma suffered. To the extent that our actual Others and internalized objects are not just *bad but not too bad*, but rather are actually traumatogenic, we need to engage in some level of denial of their propensity to inflict trauma in order to survive. In other

words, nobody *can* expect the Spanish Inquisition, even when we know it is likely to occur.

HAVING: ITS ROOTS IN FANTASY AND IN REALITY

The relationship between having in the dimension of reality (that is to say, in time-space) and having in the dimension of the mind is a complex one. There is obviously a real correspondence between the actual Other in time-space and the mental representation of that Other. As Boris (1990) notes, "Part of the 'goodness' of supplies may be actual and may consist in the care the mother or Other is able to offer" (p. 138). But as many have emphasized, the situation is more complicated than a simple one-to-one correspondence with reality, for one can internalize an aspect of reality that is imagined rather than actual (see, for instance, Schafer 1968, p. 9).

The prototype of giving, of course, is the nursing situation, in which, if our understanding of early experience is correct, the infant does not distinguish the breast as something that does not belong to him or her. If the mother cannot allow the baby to have the illusion that the breast belongs to him or her, then the infant will experience excessive frustration. The theory of infantile hallucinations (and of dreams as wish fulfillments) explains the mind's attempt to have for the self what, in fact, is lacking, to restore that which one does not have. The breast is a metaphor for the larger task of ordinarily devoted parents to give of themselves. The word *devote*, in fact, means the giving up or applying of oneself to something. Perhaps devotion can be understood to satisfy the demand (in the Lacanian sense) for recognition. It should also be noted that there can be no having without the Other's capacity for knowing—for perceiving and empathizing with the child in a way that is adequately free of conflict, projection, and narcissism.

True object-having depends on a sense of security in the possession—that is, on the freedom to hold (not in the Winnicottian sense)—and therein lies the relation of giving to having. What is vital here is the feeling that one has taken something that has been

freely offered, as opposed to having stolen something that is made available grudgingly or not at all. If a bad, persecuting breast is all that is "offered," will the baby take it in? Don't the best theories about the earliest months of life suggest that the infant by and large rejects or tries to eliminate what is unpleasurable? But beggars cannot be choosers, and it is clear that infants have to love the one they're with, even if that requires them to alter their sense of need and satisfaction—they learn to obtain gratification from the bad stuff that is the stuff of their lives. This is the essence of Berliner's (1940) understanding of masochism.

But, to return to the issue of having, it is not clear that the infant will truly have this need-satisfying but simultaneously non-demand-gratifying Other. Theoretically, it is possible that the infant may only truly be able to have a good Other, in the sense that I am delineating the concept of having (again, in the same sense that Lear has described the centrality of love). I am dichotomizing here for the sake of clarity. Naturally, few Others in the real world are either entirely good or entirely bad. I prefer not to speak of good enough Others here, however, because I want to emphasize that it is the good aspects of an Other that result in a sense of having.

Two important components of the capacity for empathy in the parents are the willingness and ability to *have* the baby—that is to say, to have in their minds an internalized image of the baby that is fairly accurate.[4] Successful development depends on this having and on devotion. The willingness to give oneself to be internalized, owned, and used by the child may be one of the most important tasks of holding in the Winnicottian sense. Only a very precarious sense of having can be attained in the absence of the Other's desire and ability to give. The characteristics of infants (and pa-

[4] When I use the term *accurate* here (and later in reference to clinical work), I do not mean it in a positivistic sense. What I have in mind is more the idea of good enough empathy; that is, the Other's mental representation of the child or analysand will be close enough to the self-representation of the child or analysand that the interaction (the experience of object, affect, and self) will be usable and internalizable as positive. I also do not mean to suggest here or elsewhere in this paper that all interactions are either entirely good or bad, but rather to state that there is a continuum, with virtually all interactions having ambivalent qualities.

tients) are obviously relevant here, for some are needier than others, and some may be born with less capacity to use even good enough psychological provisions. Perhaps "dandelion children" (Anthony 1990) have the capacity to develop a sense of having even under circumstances in which they have to scrounge for supplies, just as this flower can thrive even in a field of rocks.[5]

But one cannot securely have and hold that which one has gotten only by begging, borrowing, or stealing—and which may be taken back. (One of the injuries of the oedipal period is the child's discovery of his or her nonpossession not only of the desired person but also of the previously presumed knowledge.) The outlook is not always sunny, as we know too well. When a child is traumatized by environmental failures, he or she may be overwhelmed by negative affects, which in turn are not contained and metabolized by the Other. An insecure or avoidant attachment pattern will develop, and the child's capacity to use Others may be permanently impaired. When patients with this kind of history come to analysis, we see them struggle to manage the negative affects, to learn to rely on the analyst as a new and usable Other, and to develop a constant and adequately positive representation of the analyst and of the self.

What is it, precisely, that the infant comes to have and to hold? As Novey (1958) commented:

> We have no difficulty in the biological sphere in perceiving that ingested food undergoes various biochemical and physical processes before becoming an intrinsic part of the organism, but we seem to have much greater difficulty in perceiving of an equivalent process in the psychic sphere. [p. 73]

Sometimes objects are digested, such as in the mourning process, when we take in aspects of the lost Other and integrate those

[5] As Etezady (1990) wrote in his report of Anthony's presentation, "Even with the most depressed, disturbed or abusive mother, there may have been moments during which the mother was able to identify with the needs of the child, meet them and thereby provide a nucleus of organizing internalization. These small islands of peaceful interaction in a world of turbulence have greater impact on these infants than we have heretofore been aware of" (p. 5).

characteristics into our functioning. But we also have the object as a more or less whole image in our heads, in a way that is perhaps akin to the manner in which transitional objects are used. They are simultaneously both real Others and fantasy objects. While I would not want to minimize the importance of fantasy, I believe, along with Stern (1985), that the infant initially experiences reality relatively accurately. The capacity to fantasize, to imagine something other than what is, is a developmental achievement that results from the laying down of memories and the gradual entry into the world of language and symbols. With increasing age and sophistication of imagination, that which the growing child internalizes, or has, comes to consist more and more of fantasy. However, it seems to me that in the nonpsychotic, the connection to actual Others never entirely vanishes; virtually every time we and our adult patients fall prey to transferences and other fantasies about Others, there is still a piece of reality in the Other on which the fantasy is based.

It is the taking in of new thought, affect, perception, or experience—in whatever admixture of reality and fantasy—that is the building block of having. Novey (1958) points out the connection between the concept of mental representation and the concept of apperception. Apperception, we recall, refers not to the actual sensation received in the organism, but involves an interpretation that is influenced by previous experiences—and also, I would argue, by the individual's participation in the existing web of language that both facilitates and limits the possibility of meaning. Blatt (1974) notes, in a discussion of Piaget, that "representation is a union of a 'signifier' with a 'signified'" (p. 132). Although they derive from the real relationship with the mother and from the mother's existence in time-space, what we are talking about here are mental representations—shadows, ghosts, after-images of the Other—or, from the opposite perspective, creations of the individual's mind made from subjective experiences. As Boris (1990) puts it, "Identification is, of course, a fantasy given substance by mimetic activity" (p. 127).

Just as the mother needs to allow her baby to play with her body and its accoutrements, to pull at her earrings, to put fingers in her

mouth, so does the mother need to allow the baby freedom to have the illusion of owning her mind. This act of permitting oneself to be played with or used contributes to the feeling of ownership, to the sense for the infant that the external Other is subjective as well as objective (real in time-space). In the clinical situation, allowing oneself to be experienced in the transference according to the patient's needs is comparable to this parental function. Smith (2000) comments that "patients own their object representation of the analyst, and are under no obligation to modify it" (p. 114). Prince (1974) notes that it requires courage to allow oneself to be used in this way. I would add that it takes patience—and that it also requires respect for the patient's vulnerability.

As Saul and Warner (1967) point out:

> To have and to hold the love of the parents is the most important single goal of the young child's life. This same need is the core of the transference. It must be fully recognized by the patient and the analyst must be aware of its potential for damage. [p. 538]

And even when reality testing is intact, the overlap between the subjective object and the objective Other will inevitably be inexact.[6]

Thus, the relationship between reality and the mental representation is enormously complex for both infant and analysand. Kernberg (Skolnick and Scharff 1998) believes that "all internalizations are dyadic internalizations" (p. 19). One of the cornerstones of his metapsychology is that mental structure is created by units of internalization consisting of object, affect, and self. To integrate this into my line of argument, then, it may be that it is not, strictly speaking, the Other that is internalized, but rather the dialogue between infant and Other (Spitz 1965).

Another way of thinking about this would be to say that giving and having are mediated first through action (including expression of affects, as Stern [1985] has so vividly described), and then through language and other symbols. But, to return to Kernberg's

[6] For an example of this, see the section later in this paper on "The Patient's Experience of the Analyst," p. 962.

terminology, I am positing that it is solely the positively valenced units of object-affect-self experience—and the willingness of the parents to be used freely—that result in a sense of having for the infant. As Emde (1991) notes:

> Infant behavior has shown us that positive emotions are separately organized from negative emotions. Moreover, positive emotions are crucial for adaptation; they provide significant incentives for learning, communication, and development. For the infant and for the caregiver positive emotions are rewarding and have motivational effects that are independent of "relief" or the discharge of negative emotions. [pp. 24-25]

Coates (1998) addresses the role of the parents' positive affect in her writing about the development of the child's capacity to understand the existence of mental states and intentionality in the self and the Other. This capacity, she says, does not mature until the sixth year (p. 121). In the absence of understanding that a negative mood represents only a temporary state, the child is "simply stuck with the reality of a mother saying that he or she is a bad kid; the kid's inability to take a perspective on the attribution means that it is experienced as simply true" (p. 120). Therefore, a parent's negativity is internalized by the child as a negative sense of self.

A PHILOSOPHICAL VIEW OF DEVELOPMENT

By focusing on the positive, on the potential for growth in Other-having, I am writing (and I hope not naively so) more in the romantic than in the classic paradigm of psychoanalytic thought. Strenger (1989) has outlined these opposing and often intermixed positions. Here is his summary of the distinctions between the two views:

> Psychoanalysis is characterized by a tension to be found in intellectual history at least since the eighteenth century. The classic vision of man is that of distrust of the idiosyncratic and subjective and the emphasis on the need for ob-

> jectivity and rationality. In psychoanalysis this is reflected in the attitude of benevolent suspicion which seeks the traces of the pleasure principle in order to allow maturation . . . . The romantic vision sees man as essentially striving for full selfhood, and mental suffering is the result of the thwarting influence of the environment. [pp. 608-609]

As I have written elsewhere (Levine 2001b), Lear's (1998) rereading of Freud throws into question the way Strenger defined his categories. Nonetheless, there are clearly two different ways of looking at humankind: one stresses the centrality of love, and the other emphasizes aggression as the default position of humankind.

By proposing that Other-having be considered to take place only in the context of the positive, growth-enhancing internalized object, I am questioning whether one really can be said to possess—that is, to have power over—a predominantly negative mental representation. Perhaps this raises the question of the extent to which all such negative internalizations should properly be thought of as identifications with an aggressor. I am not, of course, arguing that negative mental representations have no power within the self, but rather that they do not create the sense of having and holding, possessing/using/enjoying, that is a vital component of healthy development.

HAVING AN ANALYST

Despite the tendency among many analysts to think of the analytic relationship as akin to the mother–child dyad, there has also been some reluctance in our field to use this analogy. Perhaps some analysts feel that the metaphor threatens to become reified. The most common objection to the mother–child metaphor is that in adult analysis, regression is a problematic concept—it is not a literal occurrence, and it does not involve all aspects of the patient's personality and functioning. As Grunes (1984) noted:

> Basically the therapeutic object relationship consists of a situation of primal intimacy between patient and analyst

> which contains both an illusional (transference) and real aspect. The intimacy involves a special type of empathic permeability of boundaries between analyst and patient, which varies from an advanced, symbolic-creative level to a more primitive level of sensory, motor and somatopsychic sensations and imagery. There are many compelling analogies to the parent--child relationship. However, the similarities can lead us astray. For we are dealing with complex condensations, not only of child and adult, but of pathologically inflamed and updated forms of childhood developmental need. For these reasons alone the therapeutic object relationship, though similar, is radically different from the parent--child relation. [p. 131]

What I find fascinating about Grunes's description of the therapeutic object relationship in psychoanalysis is that it would also seem to capture something of the character of a marriage. Marriages, too, encourage and tolerate regressions as well as advanced levels of play, a certain permeability of boundaries, and an admixture of illusion and reality in the way one sees one's spouse. While we cannot choose our parents, we do choose our spouses—and we also choose our analysts. Within the parent--child metaphor, however, it should also be noted that parents do not choose their children. Adoption may present an interesting analogy for psychoanalysis because of the active element of choice that exists, even if an analyst only "chooses" negatively, by declining to work with a particular patient. It may also be an apt analogy in that choosing a child may give parents the illusion that they can know what they are getting into; any experienced clinician, however, knows that even the most careful and thorough initial assessment cannot prepare him or her for everything the patient will bring into the treatment.

The following vignette demonstrates the beginning of the expression of the issue of having in the therapeutic relationship. I see this young woman as a dandelion child, but as one who, at the time of this encounter, was so insecure that it did not feel to her as though she truly owned or could utilize what she in fact possessed.

Clinical Illustration

An intelligent and sensitive woman of twenty-four, the patient had been brought up in a home in which she had somehow felt both suffocated and ignored. She was paralyzed by self-doubt about her ability in her chosen field. The material I will describe, in which she talked about her struggle to achieve a generative sense of having, took place after a pivotal moment in the analysis. I had had to end a session just as the patient was speaking of the pain she felt that no one wanted her; I did this with gentle humor about the inopportuneness of the timing of the ending, and the patient—and then I—burst into laughter. Later that day, she had an experience that demonstrated how she had taken me (or the interaction between us) into her mind in a way that she could use productively; in a situation with colleagues that would previously have led her into self-recrimination, a downward spiraling mood, and plummeting self-esteem, she had experienced a surge in self-confidence, along with a certain tolerance and empathy for herself. I believe that the mutative elements in this exchange were, first, my *having* the patient in a way that led to my knowing how she might experience the ending of the session at that moment, and second, my positive feelings for her and the warmth that animated our shared laughter.

In the following session, later that week, the patient talked about liking to do things on her own—to struggle, and as a result to achieve a sense of accomplishment. This, no doubt, was partially defensive, as she had had no choice as a child but to do things independently. Nonetheless, she contrasted herself with a friend who was phobic about the kind of challenging experience the patient herself welcomed—a friend who allowed her boyfriend of a few months to pay for her share of attending an expensive event. The patient went on to speak about the need to be alone in these new situations, that one could not carry out this kind of exploration with another person. Her next set of thoughts were about the uniqueness of analysis, in that she could not do this without me (this was said with an apparent calmness and comfort, reflecting a solid sense of trust in me and in the work). She went on to

speak of what I understood to be a sense of optimal distance in the analysis, when she could speak of things without fear that she would be suffocated or that her identity would be appropriated.

"My parents tried to impose their ideas on me—now I fear that more than anything," she explained. I commented that it was almost as if this was about who owned her. The patient responded by returning to the subject of her friend: "If her boyfriend pays for this, then it's as if he owns the memory." I wondered aloud, "Who is going to own your experience and your memory?" And the patient replied, "If I do the work, then I've earned it. Freebies are okay once in a while, but you can't spend your whole life getting them because then nothing's ever your own." I then explored with her whether she might be connecting the feeling of ownership to the sense of feeling genuine. The session continued productively, with the patient reflecting about ways in which she struggled to become certain of her opinions (i.e., that she had something true and good in her mind) before sharing them with colleagues.[7]

This patient suffered from a lack of self-confidence that had seemed to be almost immune to the reality testing provided by her very considerable accomplishments and the positive responses of others to her work. As she herself often noted, it was only the bad stuff that seemed to stick in her mind. One could hypothesize a constitutional deficit either in the ability to have and to hold—which I think unlikely, based on the patient's ability to internalize our interaction; more likely, the patient had lacked the experience of being in an environment that either gave her positive images to internalize or permitted and encouraged her to feel her own. This captured what she and I reconstructed of her childhood. Both parents, it seemed, suffered from narcissistic pathology that permitted them to develop neither accurate nor positive mental representations of the patient. The patient described (as one might imagine) significant deficits in their own self-esteem.

[7] As my clinical work described in this vignette suggests, it can be quite helpful to point out to patients for their consideration the ways in which they seem to have or not have the analyst.

Mitrani (1998) addressed this crucial issue. Although she did not speak directly of what the mother is able to give to the baby, she argued that it is necessary for the mother to possess enough self-love to be able to contain the baby's feelings of adoration for her:

> I would suggest that the containing capacity, initially felt to be located in this type of *external* object—when introjected—leads to the development of an *internal* object capable of sustaining and bearing feelings of ecstasy and love, an object that might form the basis of the patient's own self-esteem. This aim certainly calls for an analyst who truly thinks well enough of his or her own goodness that he/she is not dependent upon the goodness and cooperativeness of the patient in order for such a positive self-perception to be confirmed and in order for the analyst to continue to function analytically. [p. 119]

I have been speaking, of course, of what the infant's original environment provides. What sustains these patterns for the child, and later for the adult, is a more complicated matter as internalized interactions and intrapsychic conflict become more and more active.

HAVING A PATIENT

As Abend (1979) described, patients enter analysis with specific cure fantasies. Perhaps the selection of a particular analyst is a confirmation that the patient believes the loop has been closed, so to speak; unconsciously, this analyst is seen as one who can fulfill the conditions of that fantasy. Analysts, too, have fantasies about what they do to or with their patients, although these fantasies have been much less discussed. I have previously speculated, for instance, about the universality of a Pygmalion, or creation, fantasy in both analysts and patients (Levine 2001a).

As Akhtar (1995) has cautioned, taking a patient into analysis must be very carefully considered because it is like choosing a person who will become one's permanent neighbor. He suggests that one way to evaluate suitability for analysis (specifically, ego strengths and level of reliability) is to ask this question: Would the analyst

be comfortable having this particular person not necessarily as a friend, but as a neighbor, someone who can respect the fence and with whom one can resolve conflicts and conduct other neighborly transactions requiring trust and goodwill?[8] This question captures ego-level considerations, but the intimacy with one's patients goes far beyond this. Smith (2000) writes cogently about the extent to which the analyst does and should become deeply involved with the patient; projection is inevitably involved in the analyst's "necessary and potentially problematic immersion in the patient's world" (p. 110):

> Analysts are not only trying on the patient's world—that is, identifying, like trying on a suit of clothes—but also, in part unconsciously, trying their own world, their fantasies, their clothes, if you like, *on the patient* . . . . The analyst checks back and forth, examining the patient's material, gathering evidence, matching it with hypotheses, as he tries to draw as accurate a picture of the patient as possible. That picture is not simply an elaboration of the analyst's fantasy, although analysts vary in their conscious or unconscious capacity or willingness to make this distinction. That said, I suspect that what one finds in the patient is always a mix of oneself and the patient. [p. 110]

For me, it is as though each patient comes to inhabit a distinct area of my mind, as though each has his or her own file that can be clicked open or closed; however, while these are files that may eventually be placed in the recycle bin, they can never be permanently deleted from memory. Each file, it seems to me, consists of the collection of memories and associations that I have laid down in connection with that patient. They include both articulated and unarticulated responses. And just as the patient comes to have the parent or the analyst through the internalization of units of experiences of object-affect-self, so, too, does the analyst's having of the patient include all these elements.

To the extent that my discrete experiences of a particular patient might tend to be similar to each other, then I would think of

[8] "Good fences make good neighbors" (Frost 1914).

my mental representation as having the quality of a *character*. When a given unit of experience with one patient strongly resembles an experience with another patient, I come to a moment when I find myself momentarily uncertain as to what exactly has happened with which patient. It is as though my finger has slipped on the keyboard, and I have unintentionally activated the "find" function; my unconscious has thus clicked open a second file, and I need to do a bit of reality testing. I ask myself, "*Which* patient said that?" and "*Which* metaphor do I use with *which* patient?" to get myself back into the correct program.

Poland (1998) has noted that he has a sense of trepidation at the beginning of each analysis because he knows that there will be a need to go with the new patient somewhere that he (the analyst) does not want to go. It might seem here that Poland is denying that the element of surprise exists in analytic work, but I do not understand his statement in this way. I believe he may be referring to the certainty of being surprised and the expectation that these surprises will not all be pleasant ones. Whatever our fantasies of cure may be, in order to help a patient, we must be prepared to open our minds and take in whatever the patient wants and needs to put there. We must expect that we will encounter the unexpected. Smith (1993, 1995) writes about the effort analysts make in order to make room for the unexpected:

> However much we may try to approach every hour with some sense that it is the first or only hour, the first hour of the day with a familiar patient is very different from the first hour with a new patient. Like returning to a novel we have been reading, but not today, there is a feeling of coming back to something familiar, familiar transferences, that have an established fact and place in the analyst's life at the moment. [1993, p. 429]

My view is that the appropriate analytic listening stance requires both a sense of the patient as known and familiar and a constant striving to be open to the unexpected.

For me, the process of coming to feel that I *have* a patient in my head happens for the most part unconsciously, although often

with much conscious effort. In a lengthy evaluation process, there comes a point when I find that I have stopped taking notes, when I have somehow shifted from interviewer/questioner/evaluator to more of a therapeutic *being with* the patient (although I do not mean to imply here that either stance is ever totally absent from the analyst's mind). I can perhaps best describe this as a sense of *something clicking into place*—that I have found some kind of basic framework for understanding this new acquaintance. For me, it means that the type of work I need to do in the clinical process has shifted. It means that I feel I have reconnoitered enough to slow down and enjoy each view with some confidence that I have the tools to begin to place it appropriately in the total context of the patient's life. Having the patient in my head means that the working relationship is revved up and the engine is running smoothly; I can then attend with greater clarity to episodes when the engine catches or stalls. Poland (1998) similarly describes a feeling of "laying claim to the patient," referring to "the shift when someone moves in my mind from a new patient to *my* patient."

Sometimes, even with much effort, the feeling of having is slow to come or comes not at all. In the several situations in which this has occurred to me, I believe that there was some way in which the patient did not want me to have him or her, did not want to allow the intimacy that would permit a feeling of being understood. These are the clinical hours when I struggle to find the right thing to say, when I feel my intuition and empathy are off. I am not including in this category encounters that took place in my early years as a clinician, in which I simply assumed that I did not know enough to do a good job. Now, I regard this occurrence as potentially an early negative therapeutic reaction, or as representing an enactment or actualization of something in the patient's early life. It is also possible that a particular patient may stir up a countertransference reaction that leads me to foreclose the patient from my mind and, correspondingly, to withhold myself from his or her mind.

Perhaps what I am saying is no more complicated than that the experience of accurate empathy for the patient reflects the achieve-

ment of an accurate mental representation—of *having*, to put it differently. One patient expressed surprised pleasure when I mentioned a fact about his childhood that he had not brought up in a very long time. He said the fact that I had remembered this information and knew it was important and relevant at that moment meant that I understood him. This patient, who described his parents as never knowing what his worries or concerns might be, was encountering the fact that I *had* him in my mind. The timing of interpretations is certainly relevant, for it is clear that this mental representation must not be a fixed idea, but must change in such a way that we make accurate (for the most part) judgments about what the patient can hear at a particular moment.

I have found that, for this reason, I much prefer converting psychotherapy patients to psychoanalysis over starting an analysis immediately following an evaluation. I suppose that it is, for me, a question of comfort—that I am less anxious about whether I can be a good analyst, and whether the match is a good one, when I feel that I already know the patient well. I suspect it is an easier shift for the patient as well, for the patient already has me in his or her head when analysis starts. With some patients who have a history of emotional deprivation or abuse and consequent difficulties with trust and with object constancy, it is doubtful that they will be able to tolerate the deprivation of visual cues usually entailed in analysis.

I suspect that this process of coming to have the patient in one's head requires the patient's consent. I can think of one psychotherapy patient with whom the process did not take place. A woman in her late twenties presented with a history of emotional and physical abuse on the part of her mother toward herself and all the siblings in her rather large family. To give but one example, she had observed the mother attack the father physically on several occasions. Try as I might, the sense of clicking with her did not occur. Week after week, I seemed to have all the information I needed to form a picture in my mind, but found I had to struggle to be ready for each session. This is in sharp contrast to the way I feel with most of my patients. It is normally almost effortless to feel ready for each

session (although I may need to check my notes to jog my memory about the specifics of the last session, if there was nothing in it that struck me as unusual or dramatic). This particular patient left treatment after a few months, acknowledging cognitively rather than affectively the newly discovered significance of her history; she was strongly resistant to taking the stance of empathy toward herself that I felt for her and probably communicated to her.

When I speak about being ready to work with a patient, I am referring to a mostly preconscious knowledge of what the relationship demands of me. After all, we are accustomed to playing different roles in different relationships, the interaction drawing on some and tending to minimize other aspects of one's personality. Having a patient in my mind seems to mean that it is relatively easy to slip into this particular persona (Levine 2003a). And an important part of my having the patient is knowing how the patient has me. How is this patient able to use me or not? What does this patient require of me? What kind of holding environment does this patient rely on me to provide?

Later in treatment, having the patient also involves the analyst's sense of the patient's potential beyond what the patient can imagine. Just as parents use words with a baby who cannot possibly understand language yet, the analyst envisions the patient's growth before the patient can do so. This is what Lacan (1936) described as the mirror stage, that the mirror reflects an image more whole and unified than the baby feels. However, I am not using this idea in a pejorative way, or (as Lacan did) to emphasize the loss inherent in taking on this image. It is a necessary step in development. The vignette presented earlier demonstrates this phenomenon, in that my liking and respect for the patient extended beyond what she felt for herself. As Loewald (1960) put it, "The child begins to experience himself as a centred unit by being centred upon" (p. 20).

THE ANALYST'S POSITION DURING THE ANALYSIS

Although the analytic relationship is most often understood to be a parallel of early developmental phenomena, it is perhaps apt to

compare it as well to the situation of marriage. While it is certainly true that marriages gratify archaic as well as adult strivings, there is a fundamental difference—as I noted earlier, we choose our spouses or mates, while we are unable to choose our parents. There is something undeniably sexual and romantic—and uncomfortable—about comparing the analytic relationship to a marriage, yet there is no denying that the level of intimacy and the sense of familiarity with the Other attained in a well-functioning analytic dyad is in many ways similar to that of a good marriage. For the patient, analysis is always in a certain way the most intimate relationship he or she has ever had, in the sense that the barriers to psychological intimacy are generated primarily by the patient and not by social expectations. (This presumes a good enough analyst who is alert for the way in which his or her unconscious resistances will enter the analytic arena.) And even for patients and analysts in good, well-functioning analytic marriages, the analysis very likely generates more sustained, active talking and listening than tends to occur regularly in the hustle and bustle of ordinary married life.

Psychoanalysis is also like a marriage in its promise of fidelity —that is, there is a guarantee of confidentiality on the part of the analyst and an effort to curtail acting out and to bring things to the analysis first on the part of the patient, thus enacting a kind of forsaking of all others. The trust in a solid marriage derives in part from this security of having the spouse (and of course I do not mean this in the sense of literal ownership and the archaic vow to obey). So, too, does trust in the analytic relationship derive from the patient's confidence in the analyst's promise of confidentiality and devotion to the patient's needs and, for the analyst, from his or her reliance on the patient's commitment to working things through in the analysis.

The patient's primary vehicle for achieving intimacy is self-disclosure; the analyst, on the other hand, shares intimacies in the form of verbal self-disclosure only on those rare occasions when it would seem to benefit the patient.[9] The analyst's contribution to that

[9] I do not mean to suggest here that the analyst can know about this with certainty. The process is more one of utilizing the accurate enough mental representa-

intimacy rests in his or her actively available and present intellectual and emotional self (Levine 2003a). In order to do the highest quality analytic work, the analyst must use every fiber of his or her being in the process of listening and formulating interventions. The functioning of an analyst is selfless in the sense of not being selfish—the analyst's task is to focus on the patient's needs—but it requires the intense use of the analyst's self. Despite this requirement of devotion, which is clearly similar to the way good parents attend to their baby, the mature contract—the treatment alliance—is in some ways more akin to the partnership of a marriage than to the actual dependence of a baby on its parents.

There is a paradox here, for as much as we may wish for patients to take from us, to use us, we are in fact helpless to make this happen. As Casement (1990) pointed out, "therapeutic experience in analysis is found by the patient—it is not provided" (p. 343). All we are able to do is to take an educated and intuitive guess at what conditions may be optimal for any particular patient to find and use the analyst as that patient is able. While we certainly have the capacity to commit soul murder, we do not have a similar ability to generate souls; however, we can provide the conditions under which the patient's motivation and constitution may allow this to occur.

Finally, although it may seem as though it is the analyst who takes care of the patient (and in a sense, this is literally true, both legally and in terms of the analyst's responsibility of safeguarding the analytic process), in reality, psychoanalysis is a partnership between analyst and patient. Just as interpretation is a joint product, a result of the intermixing of thoughts, so, too, are the responsibilities of the patient and the analyst separate but equal, as in a marriage. Child rearing, earning a paycheck, cooking dinner, taking out the garbage, and doing laundry are all essential tasks; an analysis cannot take place without interpretation and free association, holding and being held, maintenance of the frame and enactments that threaten the frame.

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tion of the patient to make an educated or intuitive guess about what the patient will find most usable at a particular moment in the treatment.

THE PATIENT'S EXPERIENCE OF THE ANALYST

As Burland (1996) noted, all children have the right to feel that they own their parents' minds. Similarly, the fantasy of possessing/having the analyst may be vital to the analytic process. This can be reflected in the way the patient uses the actual analytic office space. In a sense, the possession that comes with a marriage is more actual than the possession that accompanies being a child. In the partnership of a marriage, there is a mutual agreement that what is mine is yours. And, as parents know, one has to submit to the reality that what one had thought was one's house is now regarded by one's child as his or her house (and accurately, too, particularly in the teenage years!). It is up to the parent and the analyst not to question the child's/patient's sense of shared ownership—that is, unless and until the house rules have been violated. Some patients, for instance, feel entitled to enter my office even before I invite them in. Some patients get up in the middle of sessions to use the bathroom without an acknowledgment of the coming and going. Adult patients need to feel as though they have free access to and ownership of the analyst's mind, in the same way a child patient may have his or her own drawer for artwork in the analyst's office. As one patient of mine phrased it, it was as though she had a "timeshare ownership" of me.

Perhaps *having* has something to do with the thorny issue of *character*, which, like pornography, we may not be able to define, but we know it when we see it. When I think about having, I think about the issue of surprise. For instance, as an analysand (albeit one with a certain amount of external knowledge about my own analyst), I could certainly not say that I knew my analyst in the way I know my friends or family. I did not know his particular history, life circumstances, and so forth. And yet, though unfamiliar with the specifics of his background, I came to know almost unerringly his style and rhythm of thought. When the mental representation so well matches the external reality, the sense of having the other person is buttressed. When we are rarely surprised by what anoth-

er person says or does, this would seem to be a measure of the extent to which we know that person's character.[10]

Things are, of course, more complicated in the clinical situation, for the analyst's relative anonymity facilitates the creation and maintenance of transference illusion—that is, of the analysand's ability to create the analyst that he or she needs. During the analysis, this illusion may be best left unexplored for a time, along the lines of Winnicott's (1951) recommendation not to examine too closely the source of the transitional object. It is also quite possible that neither analyst nor analysand will be aware of the existence of the illusion.

To give an example: In my own personal analysis, I would often make references in my associations to characters and plots from my favorite movies. I was aware, in reality, that my analyst was much more educated about film than I. However, I was not aware until well into the termination period of the degree of illusion in this. My analyst was (to coin a phrase) the strong, silent type, and one way that I read his silences was as meaning that he was instantly familiar with all the characters I mentioned. Undoubtedly, my further associations would jog his memory, even if he had not immediately placed the name. But—and this was my contribution to the maintenance of the illusion—I would never stop to ask if he was following my thoughts, knowing that if he could not do so, he would inquire. I did not ask, that is, until a few months before termination. In fact, he responded that he did not recognize the name of a character I mentioned. My sense of shock was profound, for it made me realize the extent of my illusion. In a sense, the illusion was not all that great, for my analyst shortly did recognize the name, as I had expected he would; but the fact that it had not

[10] I am not speaking here about surprise as written about by Smith (1995). I would term what he discusses *microsurprises*—incidents of unexpected statements, feelings, or insights that occur throughout an analysis. These are part of the ongoing process of analyzing; they do not fundamentally alter one's sense of the identity or aesthetic (Levine 2003b) of the Other, or throw into question the terms of the analytic engagement. By contrast, an analysis could also entail *macrosurprises*—for example, discovering that a patient had committed a criminal act.

happened instantly told me that the person I had in my head did not precisely match the external reality. While I thought I had had in mind what was actually there, in reality, I merely had what I imagined to be there. It does seem ironic that, once again, the best way to understand what *having* feels like is to describe what it is like when one becomes aware that this having has been threatened, that it did not obtain in the way one thought.

Being close as I was at that time to the termination of my analysis, it was appropriate that both my analyst and I permitted this optimal disillusionment to take place. Neither my sense of him nor my sense of self was threatened by this mini-loss. And this leads me back to the other side of the coin, the elusive question of what having an Other *does* feel like. Parens (1970) has perhaps come closest to describing what I mean in his paper on inner sustainment. He defines this as resulting from "the dynamic and economic state within the psychic organization that leads to feeling loved and supported from within. This quality of inner sustainment, or its lack, is derived predominantly from early experiences" (p. 223). Inner sustainment, he proposes, "at all ages depends on the character of internal representations, the actions of the assimilative processes, and ultimately the character these impart to ego and superego functioning as well as to self-concepts and identity-formation" (p. 225). Inner sustainment can thus emerge from the experience of having an object in a satisfactory, positively valenced way.

In a sense, I am suggesting that the feeling of Other-having is a building block of such larger and more complicated feelings as inner sustainment. Feelings like security, the confident expectation of being loved, the sense that the Other whom one loves is interested in oneself, and perhaps the very knowledge of being positively cathected and valued by another are also components of having. The notion of being valued might imply that in order to come to feel that one *has* the Other, one must already feel oneself to have been *had* by the Other. After all, *value* does involve a sense of possession.

TERMINATION—TO HAVE AND HAVE NOT

In psychoanalysis, of course, the event that throws into relief the issue of having is termination. Much of the literature on termination points to what is, in the context of this paper, a not-so-puzzling phenomenon—that is, the ease with which the transference neurosis is reawakened. Perhaps this paper addresses Freud's question about whether analysis is terminable in its proposal that having is more or less a permanent thing. Like bicycle riding, once we learn/have something, it is there forever, unless there are new opportunities to learn and thus alter the mental representation. The permanence of having explains why clinical research interviews of former analysands result in almost immediate resumption of the transference (Pfeffer 1961). Luborsky's research (Luborsky and Crits-Christoph 1990) on transference also contributes to an understanding of this phenomenon—that not only is the mental representation of the analyst permanent, but earlier parental and Other representations in the mind are also evoked. Luborsky and Crits-Christoph note: "Apparently, one's wishes, needs, and intentions in relationships are relatively intractable, yet the expectations about others' gratifying or blocking one's wishes and one's emotional responses to the others' actions or expectations have more flexibility or malleability" (p. 142).

Luborsky also reports that transference content tends to increase rather than decrease toward the endings of analyses that are judged to be relatively successful, as compared with analyses judged to be less successful (Luborsky and Crits-Christoph 1990, p. 4). A graduate of a psychoanalytic institute who had but little contact with her former training analyst reported that her transference and predilection to have fantasies about him remained quite strong; however, she noted a significant diluting of this tendency after she had actual chance contact with him. In other words, her sense of having her analyst remained more alive in her mind in the absence of data that would reinforce their altered relationship. Social constructivism aside, each new relationship does in some way

offer the opportunity for projection and repetition. As Freud (1905) put it, "The finding of an object is in fact the refinding of it" (p. 222).

An analysand approached her first August in analysis with much trepidation; and upon exploration, it emerged that she assumed her analyst would simply forget about her during the vacation. The analyst commented that she seemed to feel it was possible for the image of her to be erased from the analyst's mind much more easily than was in fact the case. Patients who have not had healthy experiences of having will doubt that the analyst (and other Others) can or will share such an experience. In these cases, one of the key goals of the analysis is for the patient to believe and to come to rely on the actuality of the analyst's ability and desire to have and to hold him or her. I know that, while I may not spontaneously recall all the details of a particular patient's life, there is a way in which I will never forget the essence of any patient I have treated in depth. When we work with patients, we truly make them part of ourselves in some permanent way. We may change them—both we and they hope this will happen—but, without a doubt, they change us. The very fact of mental representation, that the relationship persists in the mind and memory regardless of whether actual contact continues, means that in psychoanalysis, psychotherapy, and all relationships of intimacy and depth, we are always taking the vow, "Till death do us part."

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HEARING THE FAITH IN TIME: COUNTERTRANSFERENCE AND RELIGIOUS METAPHOR IN AN ONCOLOGY PATIENT'S PSYCHOTHERAPY

BY MOSHE HALEVI SPERO, PH.D.

Material from the psychoanalytic psychotherapy of a patient with breast cancer demonstrates the emergence of constructive meaning in areas of psychological experience burdened by conflicts regarding the dimension of time and faith. During analytic work, the spontaneous appearance of religious metaphors revealed deeper layers of memory where time, faith, language, and the sense of being listened to once interacted in ways whose significance could be conceptualized, with the help of the countertransference, as a rediscovery of a hearing breast, *or even a* sacred hearing breast. *Implications for the psychoanalysis of religious experience are discussed.*

This essay presents a close reading of the psychoanalytic psychotherapy of a breast cancer patient who initially elected treatment to address themes related to her illness and wider conflicts. During this work, a highly significant religious metaphor became prominent, having to do with listening or hearing and the meaning of faith. The timing of the metaphor's appearance, or, more correctly, its relation to the intersubjective meaning of time, seems to have been as crucial as its manifest content. From the point of view of psychoanalytic retrospect, the latent or the core repressed dimensions that eventually achieved representation through the metaphor may have been active from the start. This will hopefully be-

come evident in the material to be presented, particularly in the way in which the earlier repressed experiences regarding time, hearing, and faith were deferred and reinstated retroactively upon the patient's unconscious attitude to her breast cancer (Cavell 2000; Laplanche and Pontalis 1967, pp. 111-113; Thomä and Cheshire 1991), and, as inferred, from the manner in which the patient unconsciously coerced the analyst into the conflictual position of being both *able to hear* and *unable to hear*.

Yet wherein lies the specific contribution of the selected clinical transaction? By way of clarification, I should state that this case presentation is not intended to prove that it is possible to conduct effective, even fairly classical analytic work with oncology patients or religious patients. Although terminal illness and religious belief have each been historically considered impediments to pursuing a "standard" course of analytic treatment, numerous successful treatments involving minimal modifications of the frame continue to be reported, both in the case of the religious patient (Randour 1993; Spero 1992; Spezzano and Gargiulo 1997) and in that of the dying patient (Eissler 1955; Judd 1989; Knoblauch 1997; Minerbo 1998; Norton 1963).[1]

Both of these literatures, however, require additional research pertaining to the specific contribution of the transference-countertransference matrix to the perception and understanding of the deeper, proto- and even pre-mental dimensions of the psychological experiences of death and religious belief, and to the reception and unpacking of the metaphors that thematically representationalize or derepresentationalize these dimensions. In the psychoanalysis of religious personalities—or, more correctly, the analysis of religious material when prominent in work with personalities who may or may not claim to be religiously oriented or observant—the analyst's struggle with countertransference is conspicuously underreported, with the exception of a few studies that include brief reference to this aspect of the treatment (Kehoe and Gutheil

[1] Regarding the unique transference-countertransference dilemmas and challenges that can arise when the treating analyst is terminally ill, see the sensitive review and clinical vignettes presented by the late David Feinsilver (1998).

1993; Kochems 1993; Meissner 2002; Peteet 1996; Spero 1990, 1992, 1995).

And yet I believe that the specific metaphor that was eventually produced (or presented itself for re-production) by the patient I will present, a woman who declared herself nonreligious, could probably not have been articulated had the patient and therapist not first developed the sense that the therapist could hear it, and this required sharing certain transformations that emerged through the countertransference. In order to clarify the potential contribution of countertransference to the timing of the appearance of a metaphor of faith during psychoanalytic therapy, a few words are in order regarding how I understand the term *metaphor*.

COUNTERTRANSFERENCE AND LATENT STRUCTURE OF METAPHOR

In contemporary psychoanalytic understanding, metaphor, operating primarily on the principles of substitution and condensation, and metonym, operating on the principles of contiguity and displacement, represent the basic modes by which the linguistically structured, conscious mind accommodates a modest proportion of the pulsating chaos of the unconscious (Lemaire 1970; Nancy and Lacoue-Labarthe 1973; Wright 1991). Indeed, to have a mind is to perceive, create, construct, deconstruct, and refurbish a sense of reality through metaphor, metonym, and other tropes, and this on a constant basis, whether declared or not. Metaphors may be spoken of as having a grasp or reach that enables them to cross otherwise inviolable perceptual and sensory boundaries, cleverly blending the chasm between the mutually exclusive symmetrical and asymmetrical forms of logic that characterize the mind in formation. Accordingly, the quality of the mixtures of logic and of sensory overlap that a metaphor makes accessible to the psyche portrays a piece of the story of how libido and desire have gained representational status, giving form to the primary sense of lack with which human language and fantasy constantly struggle (Ingram 1996; Matte Blanco 1988; Ogden 1997a).

An advanced perspective on the impact of religious content upon analytic treatment would enhance our sense of the reach of religious metaphors into the clinical process. The *inward reach* I have in mind stems from an expanded capacity for unconscious mental receptivity during the treatment process, a capacity resulting from an enhanced awareness of the latent developmental dimensions of the treatment framework itself (following Bleger [1967] and Langs [1982, 1998]). The developmental literature that supports this perspective has focused on extremely subtle and even inchoate primary psychological processes that we have learned to identify as the fundamental and apparently universal prestructures of truly symbolized mental development.[2] Of clinical interest is that this important spectrum of human behavior tends to be apprehended only when it instigates some kind of perturbation of the analytic framework. Such disturbance in turn generates highly idiosyncratic countertransference phenomena that, upon closer scrutiny, may reveal the unconscious collusion that has enabled the analyst to share a significant mental state with the patient.

It follows, I think, that the most probing discoveries in the psychoanalysis of religious experience will be those that have been evoked when religious phenomena take the form of boundary violations, unpredictable regressions, flights into mystical or abstract dimensions, concretizing and obsessional enclaves, or subtle modifications of linguistic form and use (the positive or negative value being determined by context). The most significant of these reverberations will be those that have been refracted through countless varieties of countertransference reaction and enactment. The conative-connotative and even grammatical aspects of language are often pressed into this process, and thus, a numbingly repetitious sound or trope or an impenetrably concrete religious metaphor may provoke the countertransference, transporting the analytic couple beyond the level of underlying psychosexual contents (the symbolized, repressed-wish fantasy level) toward the structurally deeper,

[2] For example, see Alhanati (2002), Bucci (1997), Kumin (1996), Mitrani and Mitrani (1997), and Paul (1993).

nonsemantic or earlier sensory, spatial, and temporal protorepresentational foundations of faith and religious belief. Thus, when qualitative modifications in religious metaphors press for contact of such profundity via the countertransference, a unique opportunity exists for an empathic mapping of the earliest foundations of faith, which some have considered the "sacred" bedrock of faith (Britton 1995, 1998; Corte 1997; Grotstein 1996; Jones 1991; Laor 1985; Spero 1990).

The apparent universality of the deeper dimension revealed by countertransference has been adopted by an increasing number of theorists as evidence for a basic bedrock of religious experience that can facilitate, antagonize, or nullify the development of subsequent expressions of religiosity, formal or informal, and the general domain of faith in all human beings.[3] Examples of this bedrock level would be those experiences that comprise the primary sense of awe and wonderment (Harrison 1975; Laor 1985), elementary belief patterns (Cavell 1991), the realm of transitional phenomena (Meissner 1984; Pruyser 1983; Winnicott 1951), pre- and neonatal aesthetic and prototemporal perceptions (Loewald 1988; Meltzer and Williams 1988; Schroeder 1922), the elusive oceanic experience (Freud 1930; Harrison 1989; Parsons 1999), and early autosensual shapes (Charles 2001).

While the overall thesis is arguable (see Jones 2002; Parsons 1999), this is the level that most likely contains the relevant properties for discriminating among the qualitatively *more* or *less* complex, nuanced, and supple relationships among the representations of the

[3] See, in particular, Finn and Gartner (1992), Guntrip (1956), Jones (1991, 2002), Loewald (1988), Meissner (1984), Parsons (1999), Spero (1992), and Stein (1999). Mello Franco (1998) is explicit: "Everyone has a particular relationship with his God according to his needs, even if his need is for God to not exist" (p. 116). Rizzuto (1979, 1993) is careful to point out that she is *not* saying that everyone is secretly religious in the formal sense, but only that they possess religious representations of one kind or another. The essays in Spezzano and Gargiulo (1997) include discussion of the process-oriented definition of faith experience. Bomford (1999) posits that the cosmological and other elements of religious experience are basic components of the structure of the symmetrical unconscious, in counterpoint to the asymmetrically structured, and therefore limited, conscious. (Bomford does not offer pride of place to either the psychological or the theological dimension.)

objects of faith, belief, continuity, life, death, and the self, regardless of the particular theological design to which this quality of object relationship may be yoked. The important implication for the analyst is that, when derivatives of this so-called bedrock gain expression within the crucible of the countertransference, they open pathways to faith-relevant experiences common to all minds, while at the same time bringing the analytic couple closer to the edge of a reservoir whose chief characteristics are the sense of otherness and uncommonness.

Qualitatively, the interaction among the elements in the weave may be metaphoric and of the most creatively symbolic quality. Under such conditions, analyst and patient, *despite diverse beliefs or traditions on the surface level*, may feel united, sensing that they share a sacred dialogue or some other kind of awe-inducing, transformational experience. At other times, the cross-threads are painfully entangling or even strangling, and the themes of death, time, and faith become sharply dichotomized or split, the language of the patient's discourse regressing toward the literal and concrete. Such conditions tend to induce in the analyst either (1) undifferentiated, psychosomatic pressures; (2) acute, religiouslike delusions; (3) overwhelming and unwanted imagery of graven presences, magical forces and usurpation of divine prerogatives; or (4) a pervasive sense of ahistorical fatalism, terror, and seduction toward hopelessness and faithlessness.

Two things seem crucial in order to maintain the analytic course under these circumstances. First, the analyst needs to recognize that, in order to remain alert for the contribution of countertransference, equal attention must be aimed at the qualitative weave within the unconscious bases of the analyst's own representational structures and dynamics regarding death, temporality, and faith. The patient, manifestly religious or not, will seek out the analyst's representational structures in one manner or another, in proportion (direct or inverse) to the accessibility of these structures within him- or herself. Whether or not the analyst's religious beliefs are seemingly evident by virtue of certain normative religious behaviors or trappings, or whether they are deeply private, idiosyn-

cratic, or occult, patients are more likely to express themselves successfully along this register to the degree that the analyst has achieved inner peace within his or her area of faith, and are less likely to express themselves when the analyst is unfamiliar with this domain within the self (Sorenson 1997; Stein 1999).[4]

Second, the analyst needs to enable the wider metaphoric envelopes that surround the topics of death, faith, and religion to influence the analytic intersubjective register, always respectful of the qualitative fluctuations in the symbolic quality of these metaphors, and thus to attempt to effect a new relationship between the self- and object representations that lie behind the metaphors seeking expression (Kakar 1995; Spero 1995, 2003).

THE ONCOLOGY SETTING

I noted earlier that the patient to be presented here had suffered from breast cancer, and in this case, the therapist and the wider clinical setting were identified with that context as well. Some background is necessary, since this context was part and parcel of the treatment framework and the patient's unconscious perception of it.

I am a staff member of the oncology day hospital of a major Jerusalem medical center that offers psychoanalytic psychotherapy to

[4] I myself wear a small, black, knitted *kippah* or skullcap—which my patients will eventually notice—that *tends* to be associated with contemporary, nationalist, mainstream religious orthodoxy, but is equally capable of signaling finer shades of religious and national affiliations, or of suggesting complex, even contradictory combinations of these factors (e.g., did I attend a Lithuanian, anti-Hassidic yeshivah or some other kind? Have I been religious all my life? What quality of academic scholarship have I sought? Do I or my children serve in the Israeli army?). On the other hand, the *mezzu'zah* affixed to my door post, which might attract attention if it appeared prominently on the door of a psychoanalyst in America who did not show any other evidence of religious affiliation, generally generates no comment in Israel, since almost every door features one, whether the owner of the room is religiously affiliated or not, unless he or she has invested effort to have the *mezzu'zah* removed. This issue deserves discussion, which space limitations do not allow, but see the relevance of the *mezzu'zah* discussed by Jacobs (1993, p. 11). In general, when patients indicate that they have made assumptions based on this or that "evidence" regarding my religiosity, I attempt to bring this into the transference focus.

suitable patients who express interest in an exploration more intensive that palliative counseling. Therapy sessions for patients who elect them are held in my private suite, located near but not in the department. I encourage oncology patients to use the couch, which is generally welcomed.

In my experience, if a patient who has elected the analytic framework highlights practical goals, or addresses the themes of faith and terminality in a concrete manner, it is only as a prelude to eventual comprehension of these needs at the deepest level feasible. In fact, the motives of the oncology patient in analysis seem to be complex and multiply determined, and many have sustained their psychotherapy for five years and more, developing profoundly intense and workable regressions and transformations. To be sure, nearness to death and frankly predatory anxieties may take on a preternatural quality for these patients, yet within this pallor lie ancient, repressed, but somehow familiar qualities that have acquired new impetus owing to the current situation. Thus, their hours provide unique windows into the conflict-bound background of grief and mourning, creative coping, time and temporality, religious belief and the more broad divagations of faith—and, generally, these issues come to the fore without the patient's becoming preoccupied with concrete, here-and-now dilemmas pertaining to cancer, loss, death, and dying.[5] In these hours, paradoxically, nearness to death can give birth to a radical new experience of nearness to life.

CLINICAL MATERIAL

B, a tall, striking woman in her fifties, elected psychoanalytic psychotherapy toward the last phases of her medical treatment at the oncology day hospital. Based on concerns aroused by a prior med-

[5] Such preoccupation, from the perspective of the treatment as defined, may be legitimately considered resistance, insofar as the patient is unable/unwilling to consider the inter- and intrasubjective dimensions of the concrete concerns that have arrested his or her attention, or when the patient or analyst becomes entrapped within the concrete realities of the oncology-related material, rendering the work essentially nonmetaphoric (see Adams-Silvan 1994, pp. 336-337; Salander 2000).

ical examination with her primary care physician, B had been discovered to have a well-differentiated, infiltrating duct carcinoma of the breast with three affected lymph nodes (stage II-A). She underwent successful lumpectomy with axillary lymph node dissection, followed by four extensive series of chemotherapy and seven weeks of radiotherapy, after which she began her five-year program of daily preventive hormonal treatment.

B had seemed to be a rather compliant, even stoic patient during this period. However, during her first follow-up examinations, perhaps reacting to having reached the completion of most of the direct, more aggressive treatment against the cancer, B's more complex personality traits began to clamor for attention. No longer passive and obedient, she displayed an apparently characteristic tendency to violate boundaries, being ever present and under foot, conducting her private affairs in a raspy, attention-soliciting, loud voice, displaying seductive tendencies and a powerful sense of entitlement. All this made her physicians uncomfortable and wary. When she began to report depression, weepiness, and a general feeling of confusion, her main physician recommended that she consider psychotherapy.

It happened that I had already noticed some of B's characteristics while she was still an active chemotherapy patient in the oncology day hospital. During that period, B tended to be most demonstrative about her great distress, through a wide range of vexing antics that succeeded in evoking sharply divided or split opinions about her among the medical and social work staff. Even later on, when arriving at the hospital for appointments with me—which, aside from waiting in the designated area outside my office, required only a minimal exchange with the oncology secretary in the nearby department—B behaved like a returning member of the family, sauntering into the day hospital treatment rooms, sitting down alongside other patients, and engaging them in what she considered helpful, spirit-lifting conversation, sharing their food and reading their newspapers. B also succeeded in crossing the patient/therapist boundary by loitering about very near the staff lounge, kibitzing with the doctors, and asking to make personal

calls from the hospital phone. Most interesting to my eye was the anxious and disoriented look that would come over B's face as she very frequently pestered passersby for the correct time.

B's dramatic entry into my office aroused caution and curiosity within me. On the day of the initial session, she had already knocked on my door at three separate intervals prior to the appointed time, checking to see whether I "just happened"[6] to be willing to "take"[7] her now, since she was already here. At this point, I attempted not to interrupt her too forcefully—this awareness made me intuitively aware of the amount of force that was waiting to be applied to my mind—and simply restated the exact time of our appointment while gently closing the door.

At the appointed time, B entered my office while completing a conversation on her cellular phone, gesticulating with her hands somewhat wildly as she spoke. Her physical deportment was sexually provocative and noisy. She dressed in a somewhat adolescent way, in a manner that clearly and intentionally emphasized the feminine contours of her body. B paused in the corridor, and motioned to me with a common Israeli hand signal that she would be just a fraction of a second longer on the phone, though in fact the conversation continued for several minutes. Her mood seemed chipper. Yet her first words, uttered while still passing through the corridor to my inner consulting room, involved a desperate and somewhat overstated demand, in a raspy, weepy voice, for "help with *everything!"* She wanted insight into what she called her "depressions" and loneliness following the completion of chemotherapy for breast cancer and her entry into remission, whose value and durability she greatly doubted, and she was prepared to meet with me daily if only she had the financial resources. Before I had uttered a single word of orientation, B sashayed straight toward the couch while waving her hands, touching this painting and fingering that plant, and immediately reclined.

[6] All words in quotation marks are English translations of the patient's exact words.

[7] In Hebrew, the verb phrase *la-ka'hat o'te* ("to take me"), though sensible, carries a relatively more blatant sexual overtone than the more contextually appropriate *le-ka'bel o'te* ("to receive me") or even *le're'ot o'te* ("to see me").

The patient commenced by proclaiming her devotion to psychoanalysis—having "done it" many times throughout the period of her three divorces! (In fact, she had had some sporadic dynamic counseling.) She spent some time describing these marriages and her sexual needs, but mostly turned her attention to her fears about the possible return of cancer and the impairment of the beauty of her breast. She was bitter about the lack of support from her narcissistic, self-preoccupied mother, but was also aware that, in her words, she herself was "swallowing up" her own children as she turned to them in desperation, placing tens of phone calls to them throughout the day. Though B's verbal material was richly appointed with colorful aphorisms and catchphrases, and she showed a penchant for thoughtfully deliberating aloud about her choice of words, she did not linger on topics very long, nor did she relate much to the full symbolic meaning in her expressions.

B talked a lot and loudly. I did not experience her hours as metaphoric, but as somehow rather flat. Indeed, I thought to myself more than once during these initial weeks that there seemed always to be more words than the time or space of our sessions could contain. More significantly, I was consternated by a growing perception of how much more attention her voice required of me than her associations, and by the fact that I had already begun to perceive her as a painfully noisy patient. This concern was for me the first signal that our analytic partnership might need to become a crucible for B's difficulties in the dimensions of time, space, and sound.

Dilemmas with the dimension of time indeed heralded themselves from the outset. Scheduling sessions engendered great anxiety in the patient. Despite her almost voracious insistence that she would "grab" whatever hours I could give her, invariably, no matter what hour I offered, B counteroffered something else, or she would run through the hours of the day asking in turn if each was available. She also tried to insist that I write down the dates and times for her, even though they were fairly regular and the secretary with whom she needed to register her sessions sat a mere fifty paces from my consulting rooms.

Sessions generally ended with B's unawareness of the passage of time and her unwillingness to leave, as she commented—surprisingly, in accented English—"That's it? No more time?" or "But I just came in!" I considered it interesting that English suddenly appeared at this point, in the context of her difficulties with time, and wondered to myself if this might indicate an unconscious attempt to establish some kind of clandestine, significant "other" representation just slightly peripheral to our main focus, based on an identification with the analyst's native tongue or the analyst's sense of time. I did not comment on this just yet.

Despite her difficulties, B seemed to enjoy the sessions. She would have been agreeable to having one every day of the week, she said, although she was restricted by realistic limitations to two sessions per week. She understood these limitations, but for several months did not fail to routinely inquire whether I could see her twice a day or on extra days. She was intolerant of my having to cancel sessions on major religious holidays, insisting that she deserved makeup sessions or to be allowed to call me during these holidays. I was empathic with her needs, yet her insistence seemed to emanate more from an anxious, frustrated sense of entitlement and loneliness than from truly unmanageable distress.

On one occasion, I told B that she tended to become anxious whenever it seemed to her that she would be unable to ensure an uninterrupted flow of *speaking*, regardless of whether or not there was an atmosphere conducive to *listening*. This was in fact an intuitively important comment, which B neither rejected nor directly confirmed, except by way of the direction of her subsequent associations. She spoke of her compulsion to seek additional hours as if this were merely another way "to fill her days with interesting activity." And these she filled, effusively, in her loud, smoker's voice, with accounts regarding her precocious childhood, with special emphasis on her early sexual prowess, the boisterous family gatherings that generally ended in feuds or intense silences, her failed marriages, and the gruelingly repetitious, nagging arguments between herself and her husbands. The latter she understood as perpetuating similar conflicts she had witnessed at home between her poorly matched parents.

As months went on, B increasingly spoke of her sexuality in shameless detail, while manifest concerns about her illness receded into the background. In the emerging transference, I seemed to be the mother who would not have been able to pay attention to B's normal development unless something very unusual and provocative was brought up. It seemed to me, then, that B's shamelessness was somewhat forced, a screen for a more troubling shadow that cancer had awakened regarding her lifelong inability to derive a kind of maternally sanctioned, private pleasure from her breasts, specifically, and from her femininity, in general. B was careful to point out that, despite her sexual preoccupations, she had always been faithful to her men, yet they were all emotionally weak, and she expressed some awareness that she had selected her husbands accordingly. She laughed at herself mockingly: "I talk so much and so loud that I can only be attracted to men who I know will enjoy tuning me out." With this, and as later became clear, B portended a critical facet of the transference-countertransference, but I said nothing at this early stage, since I felt she would only have insisted upon the literal or surface meaning of her words.

While B could recall happy childhood times, she felt that her early years were marked overall by premature independence and loneliness. She was an early talker, "and I haven't stopped since, even to listen to myself!" Yet it was possible to discern certain subtleties in her way of speaking, especially the exaggerated aphoristic content of her verbiage. As I noted this, B became increasingly aware of the fact that her parents' dialogue was so filled with idiomatic expressions, superlatives, and exaggerations that it had been difficult for her to cut though the words to experience the full complexity of human relationship. And, despite the fact that B could sense her parents' backhanded appreciation of her intellectual potential, this dimension was not a high priority for her family, whose atmosphere, as B described with increasingly detailed memories, was heavily influenced by the shadow of the Holocaust, the confounding babble of languages and habits of a multicultural immigrant family and neighborhood, the waning preeminence of old religious traditions, and the generally strained circumstances in the

state of Israel during the 1950s. As B once reflected, "We were *expected* to have faith in all kinds of practical things for the sake of survival and for the sake of the young state of Israel, without much effort being invested in endowing us with any kind of comfortable, cost-free faith." Then she added, arousing my attention by negation, "If I ever achieved such faith, I don't recall when or how!"

In the following months, the patient slowly began to demonstrate a steady interest in themes of intense loneliness and fear of being alone, and her preference for sexual relationships that would "work for her" in the same way that her mother's somewhat sloppy provocativeness had lured men, despite the ultimately unsatisfying nature of those liaisons. Oddly, B professed a secure faith *(emu'nah*, she said in Hebrew) that, like her mother, she could attract sexual partners, though now this faith was jarred by her illness. Though B could only vaguely outline any deeper, subjective historical impression of the roots of these feelings, she did mention an important idea: "My mother gave me breasts, but not herself." B's immediate association was to her mother's tendency to forget to pick up B after school, generally resulting in her need to walk alone through dangerous alleys and along the no-man's-land boundary near her home. Perhaps, B wondered aloud, she had talked to herself while walking.

I told B that it occurred to me that this comment more or less characterized our sessions together, as she lulled herself with words while walking along the barriers that surrounded the minefield of the unconscious. B was moved . . . to silence. After a bit, she picked up the thread and told me that, when she had dared to complain about this loneliness to her mother, the response she got was: *"Az mah!? Lo kar'ah klum!"* ("So what!? Nothing happened!").

At some point, I tried to combine the insights of the session and commented that her habitual solicitation upon entering my office early—"Can you *take* me?"—might once have been appropriate to an anxious child looking for safe escort, and spanned the subsequent adolescent's willingness to rely on sexual attractiveness to solicit attention. I had felt reasonably certain that this interpretation was timely. B, however, with no apparent intent of irony, deflected the

emotional impact of my interpretation with the powerfully dismissive Hebrew expression, *"Az mah!?"* ("So what?!")—much the same, I imagined, as her mother had dismissed B's anxieties. I immediately shared this striking parallel with the patient, and she was both shocked and grateful for the observation. Yet in my inner critique, I suspected that the material that was beginning to coalesce around the fantasy of the more concrete, castrated, and castrating pseudo-oedipal breast representation—the one that produced the *"Az mah!?"* retort—seemed to hide still deeper elements linked to the earliest role of the "thinking breast"—the one that grants the earliest sense of "then-ness" and duration in time *(Az = then* in Hebrew).[8] Practically speaking, my initial interpretation had been one-sided, and, as such, unable to effectively span the gap between the internal state of the rambunctious, hypersexualized, well-endowed adolescent and the repressed, insecure, breast-deprived child within.

A Slip in Time

New dimensions surfaced as B began to lampoon her pathetic clinging to her adult children, despite her conscious awareness that this repeated her anxious, clingy relationship with her own parents. She complained that her children had no time for her, and yet she would ignore their needs and insist on "burning away the hours on the phone with them," as she had also once sought to supplant this void indiscriminately by asking for as many analytic hours as possible. Perhaps, B remarked in one session, her phone calls amounted to no kind of relationship at all, since "For all the time I spend on the phone, I register nothing, and the kids don't have any time to listen to me anyway." Then she added, "If my parents had had cellular phones, I doubt that they would have pestered me as much as I pester my kids. And it's not that they would have lacked for time to call."

I was alerted by the cascading references to "lacks" and "nothings," and by the increasing references to time. In my mind, a Bion-

[8] These are Kleinian conceptualizations (Bion 1962; Sanders 2001), which guide a certain degree of how I assess the relevant breast dimension—for there are more than one!—that is being displaced into the transference-countertransference.

ian syllogism suddenly occurred to me: "No-words, no-phone, no-time, no-breast." I suggested that some of B's clinging may have actually been a compensatory reaction to her parents' lack of time for her and to their inhibitions in attachment and their prevailing tendency to ignore B's dependency needs and anxieties. From this, I distilled a deeper interpretation that I felt I could share with B: "They offered you a bit of their presence through words and talking, but you felt that they were really not present with you in true time. An instrument of communication, if it transmits nothing of substance, is almost not an instrument at all."

B felt I had touched upon a real void, and shortly confirmed this with an uncommon slip of the tongue whose significance can be fully conveyed only by attempting to enable the reader to "hear" the tonal sliding point carried by the Hebrew in which she expressed herself. After I spoke, B said: *"Ka'khah a'ni me'le'ah ze'man"* ("That's how I'm full of time"), correcting herself immediately by repeating, *"Ka'khah a'ni me'ma'lah et ha-ze'man"* ("That's how I fill the time"). B would have ignored this slip, but I pointed it out, emphasizing that she had in effect offered us two approaches to time. She was thoughtful, commenting, "I *wish* that I was actually 'full of' time; I have such a poor sense of time. Since the cancer, I feel I live on borrowed time, but I have no place to borrow it from." Visibly moved, she continued, "So my whole life I've been talking my head off in order to cover an emptiness. I use other people's time to fill my time." With B's slip, I, too, began to feel that time and space as concepts were beginning to be available to lend a personal proportion to the spatial and temporal dimensions of our hours.

Toward the end of the first year of treatment, the themes of emptiness and finality of life began to appear regularly in B's hours. She often mentioned her dread of a lonely demise, though she could not sustain this topic for more than a few moments. Yet even her brief sentences were sufficient to reveal the emerging transference strain. In one session, B presented her internal impression of death, and indirectly her sense of the temporal blockade she was subtly bringing into our sessions, when she described a passing fantasy of "facing the angel of death, come with an empty hourglass in

his bony hands, and me, alone, with no man and no God!" She was not especially inclined to work with this image, and her associations seemed in her own judgment superficial and disconnected. Rather, she felt herself globally possessed by an abject sense of impending doom, leaving any feelings about the sense of time implicit. Nevertheless, her fantasy strengthened the impression that she was not as much afraid of death per se as she was immobilized in a dimension of static time, in which the sense of past, present, and future had become fused into a single, forgone nonperspective.

When hourglass imagery came up in a few sessions, I commented that B was apparently becoming more sensitive to something frightening about the experience of fleeting time, and that this evoked a deep and perhaps even familiar loneliness, a deathly loneliness. I used the term *familiar* as I customarily do when I begin to discern the presence of repressed or denied marginal objects ("no man and no God"). B's reaction was interesting: "The only thing I recognize in what I said is your bony hands on that hourglass!" Although my hands are certainly bony, B was demonstrating that she was not yet ready to recognize the full force of the movement of her unconscious memories regarding time into the overall experience of the session. I also had some sense of an analogy between the image of the hourglass and her midriff and breasts, filled with sand or artificial filler. Thus, I supposed that her relatively concrete presentation of her wish to be touched—and possibly the latent presence of screen memories—may have represented her own body-self rendered fragile and transparent by being emptied of time. Perhaps, I thought to myself, this level of sensitivity made it too difficult for B to do more with this fantasy at the moment. This was to change, however.

Bringing Time into the Dimension of True Hearing

Toward the end of this first phase of work (as viewed in retrospect), B came into my consulting room one day, eating noisily from a box of flaky pastry she brandished in her hand, and launched into what seemed likely to become yet another difficult session,

filled with gravel-voiced, nonstop verbiage that I could barely tolerate hearing. I was vaguely "aware" that B was talking about the similarities between a recent hospital administration mix-up, certain painfully botched cosmetic elements during her recovery from breast surgery, and some sexual and social misadventures during her adolescence. I place the word *aware* in quotation marks because, as in many previous sessions with B, I was again caught in one of those moments when I simply ceased listening, playing a game with myself to see whether a moment or two of premeditated blocking of her voice left me any the less oriented in time or place when I resumed paying attention to her material. I felt somewhat low about playing this game, yet I rationalized that my premeditated naughtiness was methodological rather than malfeasant. Indeed, while it had become exceedingly difficult to listen to B directly, I was listening wholeheartedly to what this problem of listening might reveal.

About ten minutes into her snack-filtered harangue, B began to speak with obvious pain about the displeasure some of the staff had expressed regarding her lingering around the treatment areas. Greatly hurt, she noted, "I've received complaints even from the ones who enjoy the food! Can't I give back to the department? Have they no faith in my intentions? [*Ein la'hem af e'mun be-kavan'o'tei?*]" Characteristically, B chose not to consider the fact that she habitually arrived some twenty minutes earlier than scheduled, and seemed obtuse to the troublesome boundary confusion she was creating by dragging her psychotherapy, with its ethos of modesty, privacy, and abstinence, into the oncology ward, with its ethos of public and concrete caregiving. The acting out of powerfully frustrated oral desires, the basic roots of faith and time, were already evident in this as in similar, oft-repeated situations.

But I was increasingly aware of being partly swept up by the subtle and not so subtle pressures to share in the powerful spatiotemporal qualities of B's "confusion" and distraction. Since framework issues were critical to our relationship, I shared with the patient my impression that she seemed afraid to be present in my room, or to reap whatever benefits she might from my potential as a source of

nutriment, without somehow bringing in her own supplies. "By supplying food to those who tended to your breast when you were ill," I told her, "you are in a sense saying that you are quite proud of your own breasts. Maybe you wish not only to be independent of the oncology department, but even to supplant its capacity, or *my* capacity to nourish you."

My comment disturbed B. After initially saying, "I suppose so," she reverted to an old defense that we had not seen for a while, of anxiously peppering me with intellectual questions about what could *possibly* be the relevance of her *physical* illness to *psycho*therapy. She now assumed that, like all her men, I must be secretly attracted to her ample bosom, her healthiness, and her bravado, "pretending" to not need what she had to offer. I took her response as indicating that, on some level, perhaps, I had internalized her wish that I become jealous of or attracted to her breasts, but that at the same time—and this I shared with her—perhaps I had come into deeper mental contact with her own internal confusion regarding the wish to nourish and to be nourished, to receive and to give, to admire and to be admired.

Yet it quickly became apparent that my interpretation had kindled an additional dimension of the patient's experience. After a few more moments in reflective silence, B added in a run-on manner:

> They don't like my loitering here, but what else should I do with the time [*a'val mah a'ni 'aa'seh im ha-ze'man*]? I'll go *crazy* if I just sit there, or I'll wind up pestering my daughter on the phone! I don't like to just be quiet; I like to be getting something or giving something, although it doesn't matter which, and sometimes really I must just be preoccupied with other people's problems so that I don't notice the time. What's wrong with my being the Big Advisor [*ha-yo'ez'et ha-ge'do'lah*], like my mother, the big *ey'tzah gebber* [here B introduced a colloquialism, half Hebrew and half Yiddish]—*she* decides how much to talk, which I think means she decides how much *time* she intends for me and everyone else to *not* be conscious of! It's sheer *craziness*. And mostly I like to talk, as you can see

> from our sessions; it doesn't even matter about what. The main thing—the time passes! [*Ha-eʿkkar: ha-zeʿman hoʿlef!*]

Time, and its concrete, almost material thickness, had suddenly achieved direct expression, and with a distinctly maternal transference connotation. I responded that I could hear in her comments a mixture of mockery of the artificial, pat advice of her mother as well as of the analyst, and our control over her time as well as her dread of timeless, quiet aloneness. I added, "You seem to be saying that when you enter my room for our sessions, you need to create a whirlwind or a 'craziness' comprised of lateness, being early, touching, telephoning, displaying, eating—in order to not focus on the time, to not go crazy from your mother's type of time."

Countertransference Interlude

Some personal reflections were becoming important to me at this stage. As I offered the previous interpretation to B, I caught a glimmer of my own association that B's cynical "Big Advisor" appellation might refer to a powerful, godlike breast that "gave and gave" *(gebber)* indiscriminately and, therefore, painfully. And while the sense of her Big Advisor's imposition of defective or flabby maternal time was becoming more evident, I did not think of the term *godlike* as other than a general simile, implying nothing more religious than the American expression "Big Man on Campus." And yet I *had* thought of the term *godlike*, and no other!

I also noticed that in my interpretive emphasis on B's preoccupation with concrete, breastlike derivatives, I had used the words "to not focus on *the* time." The Hebrew form of the sentence I actually delivered was *"lo le-hitʾmaʿked al ha-zeʿman,"* which, as in B's expression, "the time passes" *(ha-zeʿman hoʿlef)*, prefaces the word for "time," *zeʾman*, with the definite article "the," *ha*. This construction technically refers to "*the* time."

Now, in the sentence that I had silently composed in my own English-enabled linguistic laboratory, I had *thought*, and probably preferred to say, simply and absolutely, *time*. Thus, the Hebrew

sentence that I transcribed for B (and here for the reader) does not reflect fully what I had *wished* to say. In natural Hebrew dialogue, neither speaker not audience would hear *"ha-ze'man"* in, say, the heavy manner that an English speaker might hear the expression "He intended to study *The* Law," and yet the emphasis is palpable within the phenomenology of the concept, and concretely present in the orthography of the Hebrew term. It would have been acceptable for me to have said in Hebrew *"le-hit'ma'ked al ze'man,"* "to focus on time," without the definite article, just as it would have been for B to have dropped the definite article in her earlier comment, and to have said, "The main thing—time passes!" *("ze'man ho'lef!").* In my mind, I had thus apparently indexed *my time with B* as *heavy, thing-like time*.

I sensed yet an additional element bearing upon listening. Being bilingual, I am always speaking and certainly thinking under the aegis of several linguistic registers simultaneously—especially when attending to a patient like B, who peppered her Hebrew with English and Yiddish expressions at points of latent psychodynamic significance. I am sometimes able to sustain a relatively extended awareness of the translation process as I adjust my linguistic patterns to that which seems most relevant to the patient's intended expression. Thus, I was aware that, as I cast in my mind the statement that referred to activities that did not allow the patient *to focus on* the time, I had been *thinking* of using the poetic infinitive *to dwell* in English, but for some reason, I began searching for the more ordinary English infinitive, *to focus*.

Thus, it was the latter term that governed my selection of the suitable Hebrew expression *"le-hit'ma'ked"* (the reflexive form of *mo'ked* = focus). Though accurate enough, this was the poorer choice, whereas *to dwell* would have offered a richer connotation of place or space. But it then occurred to me that, for precisely that reason, I must have supplanted *to dwell* with a term more qualitatively suitable for the internal dimensions of B's concept of time. That is to say, B's sense of time was something that one could perhaps *focus upon*—or concretely see (as indicated by a watch) and *hear* (as signaled by a telephone bell)—-but not yet *dwell within* or occupy with a firm sense of temporal territory.

And yet what seemed to me to be the most significant thing by far was that I was finding these microanalyses so nontrivial! I remind the reader that the preceding reveries were private. B and I did not discuss these fascinating linguistic configurations, but, instead, the give and take of our sessions was informing me of these possibilities. Thus, they were not linguistic obsessions, strictly speaking, but rather the architecture of an object-relationally powerful translation between modes of listening through the countertransference. Regardless of how many languages analyst and patient speak, it is only the countertransference, weighted by whatever else is happening in the intersubjective dynamic, that sheds light on the clinically relevant point of refraction.

This reverie occupied only a few seconds of time and was primarily preconscious. Yet it was sufficient to enable me to capture a budding impression that the purpose of my preoccupation with "*the* time," *ha-ze'man*, in its capacity as "the main *thing*" for B, as she had insisted, was to make available to me a deeper, even if yet unarticulated qualitative dimension of B's experience of time. My linguistic preoccupation seemed to transport into me the heaviness of her concept of time—analogous, I thought, to her ambivalently fulsome breasts—and also something about the way B wished for others to *listen* to her own gradually expanding awareness of the internal psychological experience of time.

Returning to the session, B paused for a long time after my interpretation about time, maternal distraction, and "craziness." Her initial spontaneous associations focused on memories of her parents' subtle and not-so-subtle methods of intrusively dragging her and her everyday activities into the center of conversation in order to mask their own agonizing discomfort with each other. Soon, somewhat agitated, B spoke angrily of feeling, in her words, "confused and distracted" by these intrusions. In a singular comment, she said:

> *With time*, I lost the sense of whether they actually "heard" my needs [B made quotation signs with her fingers] and were expressing sincere concern for the difficulties I had

> during adolescence and young adulthood. *With the passage of time,* I simply swallowed their afflictions and assumed that these were mine. [emphasis added]

Significantly, B had committed a subtle linguistic error while speaking that was becoming somewhat typical of similar unconsciously motivated events taking place *within both our minds* that offered significant windows into her deeper experience. In the instance at hand, when B expressed the first prepositional sentiment *with time,* she did so in the adequate Hebrew idiom *Im ha-ze'man*. Yet when she made the second prepositional statement, *with the passage of time,* she at first began to say *"be-ze'man"*—which, strictly speaking, means *in time,* but would have been a primitive and essentially incorrect usage in this context. Thus, B corrected herself smoothly and immediately, stating, more appropriately, *"Be-me'shekh ha-ze'man,"* meaning *as the time progressed* or *with the passage of time*.

After finishing her comment, B lapsed into silence for the twenty-some minutes remaining in the hour, and I highlighted this. In an uncharacteristically small voice, B commented laconically, "I'm simply lost" [*"A'ni pa'shut halakh'ti li la-e'bud"*]. With this, I decided to put together what I believed to have happened in the interim. I pointed out B's earlier slip *(in time/with time)* and interpreted, more or less in the following words, that in the process of remembering the state of confusion that engulfed her parents' needs and hers, B had for a moment actually "lost" time, or lost the ability to express it, to the degree that she slipped naturally into the less guarded initial expression *(be-ze'man)* to truly convey the feeling of being concretely *in* time, and *lost* in that quality of time. "One wonders what happens to the sense of 'me' in such a state?" I ended rhetorically. B replied:

> Maybe that's why I did that dumb thing with the fingers when I talked about my parents "hearing" me, because I do not think they *were* hearing me. And I think that, *with time,* I no longer felt I was hearable . . . unless I made plenty of noise! [emphasis added]

Again the phrase *with time* appeared—that is, her sense of *being with(out) time*, or of *being with nontime*, a sense of semi-empty time that had been taking up space inside of her by virtue of her "swallowing whole" her mother's untimely breast, and which occluded B's ability to hear. Further sessions indeed confirmed the link we had just encountered between the dullness of mutual hearing, in B's experience, and the lack of an accurate, pleasurable sense of self within time. Unlike the more pathologically confused, intrusive, maternal "Big Advisor"/breast that B had introjected during her childhood, as an analyst, I was struggling as best I could to maintain the distinctness of her sense of time, to preserve a *ze'man* for her, by carefully attending to what was happening to our shared sense of time, as I became absorbed into listening to the previously unheard dimension of her time.

The Silent Dream

Deeper, unconscious qualities of B's experience of deathly loneliness, accompanied by an increasingly angry transference constellation, were inaugurated by an important dream in the middle of the second year of her treatment with me. This dream in fact also marked the beginning of a phase in which B began to bring dreams into her sessions on a fairly regular basis.

> I am in a hospital. People are milling about. I have only a general sense of "hospital". . . and I am speaking with my mouth wide open. I see no teeth, just screaming, like the famous Munch picture. But no one can hear [*A'val af e'had ei'no sho'meah*] what I really feel; how could they? So I am lost. Alone, even though there is plenty of staff around. I notice in the dream that they are all women, probably jealous of my boobs. And there I am, lying on a bed with my beautiful breasts all deflated, and the staff people indicate —I do not actually hear them—that they haven't any time for me, that I should just make do by myself as best as possible [*she-a'ni es'ta'der le-va'di ka'mah she-ne'tan*].

In her immediate comments, B said with biting sarcasm, "If *it* happens, and who can know when, the doctors aren't going to pre-

vent my death, and they're not going to hold my hand; and *you* will tell me that my agonies have to be 'brought into the hour' because you're only capable of *listening* here in your holy sanctuary [*be-mesh'kan'kha ha-kadosh*[9]]!"

In my judgment, the negated oedipal paternal fantasy ("they are all women") was relatively less deserving of attention just now than the frightening oral void and failing maternal breast. If my office was sacred, it also seemed to represent—from the additional associations B offered to her sarcastic use of the term *holy*—the memory of a rarified, "inhospitable," potentially awesome space into which one did not dare to tread with foolish, childish demands. I told B that if my office was in some sense a holy sanctuary, it was partly a refuge, but also, like her attractive but flattened breasts in the dream, an empty place, a sepulchral and possibly cold void, bereft of life-giving, filling content.

B's work with this dream over the next few sessions—a degree of investment that was remarkable in its own right—aimed at first at the concrete slights she felt she had experienced with the medical staff. I decided to indirectly solicit a deeper theme, and underscored the dream's reference to her dread of an unaesthetic and lonely death. In retrospect, as we shall soon see, it had not yet occurred to me to focus upon the precise sensory mode by which she had chosen to bring that dread to our attention.

B suddenly confirmed the sense of aloneness in a new way: "Listen!" [*She'ma*, the imperative form—"Hear!"] "I feel lost until I get here, I feel lost while I'm here, and I feel lost as soon as I leave. Sometimes I don't even recall if I *was* here!" Something about the way B turned this phrase struck me as remarkably familiar, but I could not comprehend in what way at the time. Toward the end of the hour, I said that I believed she was trying to formulate some

[9] *Mesh'kan* alludes also to the sanctuary or tabernacle, the spatiotemporal focal point of God's presence on earth during the years of the Israelites' wandering in the desert (predecessor to the Temple erected later by Solomon). B's ambivalence could well gain expression through this term, since it implies, at one and the same time, a tentlike structure, a symbolically secure dwelling place, and a cordoned bastion of splendid isolation.

sense of her experience of there being no time as a kind of death, which until now she had unable to share because no one was willing or able to hear it. B became uncharacteristically silent for the remainder of the session, and left looking reflective.

There were few fresh associations during the following hours, and, moreover, there were longer silences. Yet the transference themes of loneliness and being unheard had somehow stimulated the appearance of religious motifs, such as the aforementioned reference to my office as a holy sanctuary. The latter, I thought, indicated the beginning of an unconscious reckoning with a religious representation involving herself and the perceived orthodoxy of the analyst, both clinical and religious. But from what level in B's inner world was this reckoning drawing its greatest impetus? I wondered in my reverie about other mutations of this special term: after all, the pristine body--mind unity is itself also a sort of holy sanctuary—or, perhaps, from a surgical patient's point of view, a hole-y sanctuary?[10]

My fantasy about holiness/hole-iness was apparently attuned to additional developments emerging from dormancy. Up until the

[10] I paid careful attention to the appearance of English in B's treatment (see Amati-Mehler, Argentieri, and Canestri 1990, pp. 155-159; Javier 1989; Movahedi 1996). As stated, the *holy/hole-y* pun occurred to my mind in English, and was not directly shared with B, and it was also not the first time English entered the analytic space; "That's it?" B had exclaimed in English during her early protests against the time frame of the session. To be sure, we were both comfortable in Hebrew, yet ultimately, we needed to forge a metalanguage—one that may even on the surface have appeared to be conventional Hebrew, and that enabled the patient to speak to me in *the language that searched for faith* and *the language that sought time*. This metalanguage, of course, would include that type of speech that conveyed exactly those dystonic properties that in turn would create the appropriate surfeits or lacunae in my countertransference, enabling me to attune myself in *the language that afforded faithful and timely listening*. B's associations and behaviors had begun early on to establish the significance of an empty sanctuary, devoid of time and listening, and this signification was already in the air, awaiting representation. With time, I, too, became primed for certain English-oriented thoughts which, though obviously not the language of B's everyday parlance, stood out beyond customary proportions for me precisely because, analogous to what was latent in the Hebrew, these thoughts portended something important for the transference-countertransference context. Other words or languages might very well have sufficed, but only on condition that they successfully transmitted the concept of a void or hole that compromised the patient's sense of symbolic sacredness or faith.

phase I now describe, B had made only a single perfunctory reference to herself as having been formerly *dat'e'ah*, a religiously observant woman. At the time, she indicated that her family had been religious, but there had not been much emphasis on religious education and practice owing to a variety of factors, including her mother's disinterest in religion and her father's growing ambivalence toward making the effort to maintain a religious atmosphere in the home. Their neighborhood and most of the patient's friends had not been especially religious. The topic never entered the sessions again. Lately, however, B had frequently referred to lingering elements of her religious identity, categorizing herself as *mesora'tet*, which generally implies less attention to a fully orthodox level of performative rigor, a favorable approach to general Jewish traditions, or a positive investment in the philosophical aspects of Jewish faith.

At the beginning of one session, B had evidently noticed me conferring in the hallway with a senior physician robed in white, obviously an ultra-orthodox Jew, with a full-length beard, flowing ear locks, and a large *kippah*. Upon entering, nodding in the direction of the physician, B exclaimed, half in accented English and half in Hebrew, "My Gawd, *who da'ti?!*" ["he's religious?!"].[11] As she lay on the couch, she laughingly acknowledged that her seductive manner and way of dressing might not seem compatible with the term *religious* that had entered our sessions of late; yet she felt kindred to religious faith and "not embarrassed about it."

B then immediately noted her own peremptory negation. She acknowledged that she had sometimes felt a bit embarrassed at coming in her usual attire to the office of a religious Jew, and yet, as best as she could tell, she felt great comfort with me and with her noticeably decreasing need to "strut her stuff" in my presence. Recalling her bilingual opening exclamation on this day, I told B that she might be indicating her wish to feel comfortable with the English-speaking "god" of her American psychotherapist, to the point

[11] It bears mention that such visages are quite common in almost any Israeli institution, and B would have seen individuals of this sort in the hospital every week.

that she could even adopt it as her own *("My* Gawd"), but that she might also still experience the full range of her own, Hebrew-indexed religious memories as frightening, shocking, and exciting in some deeply conflict-ridden way.

B then wondered aloud that, whereas in the past she *had* felt lonely during our hours, with a particularly painful feeling of being lost in *no time,* she now felt that *solitude* might be the better term. She emphasized that my evidently being religious would neither have helped nor hindered, "because my father was religious and he didn't listen, and my mother, though she didn't bother me about religious obsessions, wasn't freeing me of them because she didn't listen to me any better." B added, "Maybe during the sessions, I somehow return a little bit to a feeling of the *meso'rah* [religious tradition] I received at home. But to what aspect?" she wondered.

B lapsed into silence after mentioning the term *meso'rah,* and, as the minutes went by, I experienced in myself a profound sadness of an unclear nature, apparently emanating from her use of this term. Gradually, it occurred to me that the idea of a *meso'rah,* which literally means *transmission* or *giving over,* is in many ways a metonym for the transference, though clearly not identical to the fully psychoanalytic definition of the term. Between B's newly conspicuous religious sentiments and the deepening of her unconscious conception of time, she was truly transmitting critical elements of her intrapsychic *meso'rah* into our relationship.

B soon commented that she felt as if she had suddenly "deflated" and had "fallen" into a period of time characterized, paradoxically, by strong belief as well as by great loss. She again became silent. In my inner thoughts, I wondered whether the loss the patient referred to might have been a normal depressive phenomenon, the result of developmental movement from concrete to more symbolically representationalized faith, or perhaps it reflected a traumatic loss, one that may have then caused further abandonment. Since this topic remained with us for several sessions, I eventually floated the suggestion that the term *meso'rah* seemed to be a much more personal term, implying, both by definition as well as by connotation, a handing over *through relationship,* as opposed to the term

dat, which implies no verb state, but rather a religious corpus or code.

B found this an interesting point. She produced some associations about holiday rituals that her family practiced when she was younger, yet she seemed to pursue this line of thought with little genuine interest. She sensed this, and criticized her own work with this topic as again "dried up," "superficial," and "flat." Also, as if in counterreaction to her earlier comments about her manner of dressing, she had begun to hold her jacket or vest close to her breasts as she lay down on the couch, in marked contrast to her former habits. I decided to pick up on this and to return to another of the themes from her old dream (to which we had returned on other occasions as well): that of the inattentive female staff at the hospital and B's flattened breasts. For I believed that B's cluster of adjectives represented her interpretation of the mother--child relationship and the quality of *meso'rah* through which her mother failed to transmit feminine wisdom, shared sexual wishes, and other traditions to her daughter.

B took to this, and worked for a while with the issue of the dismal lack of preparation she had for the onset of her first menses. She wondered whether it would have been the right thing for her to have also expected a modicum of *paternal* interest in this important development in her life. But there was none, just as male personnel had been conspicuously excluded from her dream. B was now able to recall that she screamed from sheer panic—like the Munch image that had appeared in so many of her dreams—when she experienced her first menstrual bleeding. "Typical for me," B commented, "my period is always a surprise to me; I don't seem to pay attention to that clock either."

I told her that I now understood that her dream underscored her failure to attract maternal or paternal attention to her emerging sexuality as a youngster, and the intensity of her wish that her parents would have been able to listen to her inner childhood needs. By virtue of their not hearing, I added, B felt she had lost her voice and her maternal sense of time. I was satisfied with the patient's ability to work with this last notion, but pondered silent-

ly more than once what might yet be the manifestations of her *paternal* sense of time.

Enactments in Time and the Emergence of Faith

As the second year of our work unfolded toward its middle, a troubling repetitive quality began to characterize our sessions as B rambled on about this and that—not always with sufficient intensity or content to maintain her interest or mine. As if aware that her content had paled, she began speaking in louder, more raspy tones, or raged into tearful diatribes that I was finding increasingly difficult to hear—and eventually did not wish to hear. It seemed to me that I was being subtly transformed into another of "B's men," whom she needed to be unable to listen to her.

Outside the consulting room, the patient resumed agitating around the time of her hours. For her appointments at 10:30 a.m., she would show up at the department desk at around 9:30, knock on my door inquiring as to my availability or to remind me that we had a session, waltz around the ward demonstratively, poking her nose into this or that, and chat loudly with other patients and staff, to the latter's escalating anger (shared explicitly with me). B also began to cancel scheduled sessions on last-minute notice with dubious justifications—an ill-defined malaise, lack of a sense of what she wanted to discuss that day, the decision to take an optional evening shift at work that would "probably" leave her too weak to do good work in therapy. At the same time, she pledged, in her words, her "unswerving loyalty" to the therapy, insisting on my offering her replacement hours. When I told her that there was insufficient basis for replacing most of these sessions, and that the phenomenon merited reflection, B seemed genuinely perplexed, and more depressed or deflated than angry.

Like the rest of the staff, I certainly found B's behavior irritating, though a countertransference constellation that had been slowly taking form enabled me to get beyond her provocation. That is, I felt I was perceiving in B's protested temporal lassitude a quality more akin to frantic *wandering*, and a compelled kind of searching

for some proper combination of maternal containment and oedipal authority.

Then, on three occasions, B came on the wrong day, expecting an appointment. On two of these, her insistence was proven wrong when she consulted the secretary's log, and on the third occasion, it seemed that B had given the secretary an erroneous date, despite the fact that, while in my office the previous hour, she had understood quite well the actual date we picked. I declined to offer makeup sessions, and though B at first let everyone know how mean-spirited I was, she quieted quickly about the matter, almost as if this was what she had anticipated, and went home. She did not complain about these disappointments in subsequent sessions, even seeming apathetic.

After yet a fourth lapse of this kind, I suggested that we might be experiencing an unconsciously combined effort to impose some hidden meaning upon our time framework. In her initial associations, B mentioned (1) her father's impatience and her mother's sloppiness about time, (2) the fact that B herself never wore a watch and did not trouble to ask people for the time either (except there in the hospital), and (3) her need to loiter around the office. I joined her comment to the image we had encountered earlier of the empty hourglass to which she felt I was holding so tightly—but to which she herself may have been holding equally as forcefully.

B linked up to this with deep emotion. She said that perhaps her jostling of our time framework was a way to emphasize that she *once was* but *no longer needed to be* a victim of cancer. Victims—and those who fell prey to the victim mentality—were pathetic, hopeless, and lonely people, in her view, and she needed to be certain that I *heard* this. B used the Hebrew plural noun *kor'ban'ot* when she referred to *victims*, a heavily loaded term that in fact denotes *sacrifice* or *victimization* in all senses. In the difficult realities of contemporary Israeli life, *kor'ba'not* is used primarily, and almost daily, to refer to victims of terrorist attacks.

I most probably comprehended her feelings with a significant amount of empathy; after all, as with many "successful" interpretations, my prior comments had in a sense anticipated her subse-

quent reaction. And yet, for a variety of personal, still very fresh reasons, this essentially everyday term caught me by surprise, and an unspeakable agony coursed through me from head to toe. I must yet exercise great caution regarding the degree to which I can and ought to share the details that will help explain this exaggerated personal reaction, but I feel certain that some specificity is necessary in order that my appeal to the countertransference contribution to the further developments be accessible to the reader's evaluation.

The relevant facts are that my own family had just recently sustained the grievous loss of two significant and much beloved relatives—my brother-in-law and his 20-year-old daughter—in a terrorist attack in a peaceful residential neighborhood of Jerusalem in early September 2003, when they had chanced to go out for a late-night snack. This little jaunt was intended to include a soulful chat, as my niece was to be wed the next afternoon. Individually and as a group, our minds and hearts could not possibly have been less prepared for this catastrophe, its proportions and implications. My brother-in-law was the head of emergency medicine in the same hospital in which I work, and we shared many evenings, working together, by virtue of my role as a member of the psychological support team of the emergency room. On that infernal night as well, I was driving back to the hospital as soon as I caught the news of a fresh terror attack, and while yet racing to the emergency room, I, along with the entire staff, learned to our horror—in manic, super-slow increments of time—exactly why my brother-in-law was not at his post long before anyone else. The sad fate of his daughter, at first thought to be hospitalized, took a few more agonizing hours to determine.

Owing to my late brother-in-law's medical reputation and to the specifically fateful ironies of the family tragedy, their story preoccupied national attention for several days. Surcease from the painful loss and respite from the ruptured privacy have been slow in coming.

My personal relationship to this now national image was not well known, except to those, including some of my patients, who picked up on it through various pieces of publicity within the hospital setting. I understood that B was aware of these circumstances

because she had made a brief consoling remark to me in one of her sessions when I resumed work following a hiatus of a few days. Other than that remark, the session was filled entirely with her usual preoccupations. I do not yet have a basis for determining whether B was conscious of the possible meanings for me of the term *kor'ba'not* when she uttered it; then again, perhaps she unconsciously strove for precisely that delicate point.[12]

In my internal countertransference musings, I felt that B had managed to reach me in my innermost sanctum, there joining up with the dynamics of my own aggrieved sense of history and time, and was searching for some kind of response. Put differently, B may have been seeking a link between her helplessness and dormant hopefulness and mine, on some field where an American-born and American-educated analyst who immigrated to Israel in the early 1980s could perhaps comprehend the anxieties of a little girl living in Israel of the 1950s. Like much responsiveness inspired by countertransference, a subtle resonance could suffice if appropriately and felicitously contained. In the painful reverie inspired by B's diatribe against (and use of) *my* victim mentality, my thoughts touched upon my own doubts and faith in God, and in the parental images upon which at least some degree of my experience of faith and God are based. During a period in which I was personally enduring much painful internal debilitation of my cherished ethnic fantasy of Mother Rachel's call to her children to return home[13]—

[12] There were numerous additional dimensions to my countertransference empathy that proportion compels me to delete. The following detail, however, was particularly useful. After my emotional shock at the patient's words, my first articulate fantasy was of turning to her and saying, *"You're* going to tell *me* about *kor'ba'not?!* Let *me* tell *you* about *kor'ba'not!"* It was not difficult to imagine the arithmetic validity and existential falseness of this unkind reaction. And yet it occurred to me that I had just enacted, via complementary identification, B's unconscious awareness that her parents' emotional unavailability was partly based on their preoccupation with their own deeply unarticulated sense of daily painful sacrifice on many levels. That sort of obtuseness, echoed by my countertransference reaction, was conveyed by the famous *"Az mah?!"* retort.

[13] I allude to the tradition that biblical Rachel, who was buried in a private sepulcher on the road to Bethlehem and not alongside her husband in the Tomb of the Patriarchs, cried as her children were being led into exile, and called out to them to leave the Diaspora and return home.

to which I would like to have believed that my family had responded!—my sole refuge was my consulting room, and the last sanctuary for my hopes of peaceful relations among the descendants of Isaac and Ishmael was the tranquil professional and personal relations among our hospital staff.

Most prominently, B's allusion to *kor'ban'ot* and, in response, my association to an inner sanctum brought back to my mind her one-time reference to my office as a holy sanctuary, a place where offerings are brought and supplications tendered, all within carefully orchestrated time schedules, but also a place where temporal confusion could be most devastating. Through this freshly minted representational container of a container, I felt quite clearly that I might now be able to amalgamate the split-off maternal and paternal-oedipal aspects of faith in time. After organizing my thoughts, I suggested that B's childhood sense of victimization and current illness ran deeply into her sense of her inner bodily space, as well as the spaces outside in which she often found herself. B was relating to my office in such a way as to say that God—as well as our other most powerfully paternal images—do not always hear or keep track of what is happening to us when we feel that they have no sense of shared time with us, that we do not exist in their time framework, especially when we feel that our bodies and minds are being continuously sacrificed.

B fell silent. After a few moments, and in a significantly mellow voice, she suddenly remembered that, as a child and adolescent, she had been very devoted to reciting the *She'ma* ("Hear!"), the biblical Credo, and she proceeded to recite its famous first phrase in a lilting chant: "Hear O Israel: the Lord is God, the Lord is One." In a voice thick with emotion, B wondered why this passage came to her mind just now. Her initial reflections were that what she appreciated most about the *She'ma* was that its thesis primarily emphasizes the love between God and Israel, rather than the fear, awe, and punishment dynamics. Her father had taught her this. She quickly added that even persons with minimal commitment to other Jewish religious obligations practice the habit of reciting the *She'ma* lovingly upon waking and upon retiring for the

night. Then she recited the relevant biblical phrase: "You shall speak of them when you are sitting at home and when you are on a journey, when you lie down and when you rise up."

Fortunately, I was able to remind her of a very similar, if significantly different, statement that she had made many months earlier, when she "commanded" me, also using the imperative *She'ma*, to *hear* her concrete experience of temporal disorientation: "I feel lost until I get here, I feel lost while I'm here, and I feel lost as soon as I leave. Sometimes I don't even recall if I *was* here!" The patient was enthused by this discovery. She continued, "The *She'ma* itself was a clock of sorts for me, and I think that as long as I used to recite it, I was able to pay attention to time." Then, after another few seconds' reflection, she spoke at length.

> I said that *She'ma* is about love, trust—not the usual fear motif. Maybe I have lost my love for time. Maybe I lost the time when I still felt love. I realize that I have felt that I don't have any more that special sense of being watched over as I should.

B then approached the dark side of her prayer:

> You know, *She'ma* is also part of the dying person's confession. I wonder how many Jews perished with that word on their lips? Maybe they were only able to mouth the words at times when they had no strength to get out a sound! If the biblical passage says that we are to recite *She'ma* prior to a journey, well, I may yet be taking the ultimate journey.

I pointed to the analogy between the silent, toothless scream that had appeared in so many of her dreams and her associations regarding martyred Jews; the open mouth was a void, I suggested, like a clock with no hands or numbers, perhaps. The *She'ma*, on the other hand, is addressed to a specific audience, and hence the feeling that reciting it enables one to feel not alone.

After a few moments, B added:

> I suppose I am using my current needs to think I always loved the *She'ma*. I used to say it to myself when I was

> alone, hoping that God heard me, and I felt that he did. But if he did, then why was I still scared? Why didn't he "make" my father hear me? [B signaled quotation marks with her fingers for the word *make*.] So, though I at first had no memory of this, I must have gradually concluded that only I listen to myself, and that no one else listens. But I think that my secret is that I also came to dread the *She'ma*, because it was what I used to repeat over and over again when I was alone. I remember now my many lonely journeys and walks alone, and the terrible anxieties . . . . For as much as I could tell, these walks took hours till I got home, and yet my parents never reacted, and so I thought that I must not be too late, after all . . . and in fact I have no idea how long it took. This was the way it was for many of us. And when I knew my parents didn't care, my sense of time began to dissipate. Who needs time if it isn't related to something believable, if there is no faith? Now, in the face of death, I wanted someone to hear me, but it had to be the right person.

After some moments, I said, "I think that *hearing* yourself recite the *She'ma* created a painful paradox. It seems to have meant hearing the emptiness of the space into which you projected your words. Empty of a listening God." I then added:

> And maybe you wished for me to *hear* that loss of love of time and space, and the sadness of the seemingly proud, take-charge little girl who is somehow able to endure wandering around in hospital corridors, without a good sense of benevolent adult orientation. Your associations now give me to think that you needed me to hear the potential yearning for the time you spend in the sessions that you wish to love and trust. And not as a quiet, embarrassed whisper one utters nervously to oneself, but as a sound that you can feel comfortable expressing to all.

B tearfully agreed, confirming this with a variety of associations, at this point all in the context of long-forgotten childhood prayers. Soon, a traumatic memory surfaced from a young age—the patient thought she must have been about seven or eight years

old—when she had had to attempt to admit herself to the hospital alone, owing to her parents' incapacity, and had to negotiate the long corridors, frightening doctors, dismissive clerks, and random, inconsistently helpful nurses, in order to obtain medical attention for what turned out to be serious, unremitting otitis media.

In subsequent sessions filled with emotion, several of the themes we had been working on began to coalesce even further, creating an almost paradoxical symphony of character "blindness" and "deafness" and an increasingly audible, if painful, sensory awareness. It was a symphony that paralleled my own clarification of the countertransference strain.

As an outgrowth of our progress into the meaning of listening, B revealed that, as a child and to some degree even now, she did not see well, requiring thick glasses, and did not hear well, though no auditory appliances seemed necessary. Her parents called her "half-eye" and *ha-he'reshet*, "the deaf one," nicknames that schoolmates naturally picked up very quickly. B elaborated:

> My parents essentially acted as if they didn't see or hear me. They assumed I was never fully aware of whether they were talking to me while looking in my eyes; often they spoke to me while looking at the wall, which of course made it hard to pick up what they were saying. My husbands did the same thing. I now understand where my scratchy, irritating, tearful voice comes from. I'm always secretly screaming to people, "Here's my face . . . I'm *here!* Talk to me *here!*" And so my needs were totally ignored, my presence rendered irrelevant—whether my parents were fighting, no matter what language they spoke, even if they whispered, and of course their poorly hidden sexual grunting. So I learned to make my physical presence damn well known—as if I was declaring all the time, "See these boobs? See this ass? I'll teach you all how to focus your attention!" But even as a child, I also learned to pay attention to absolutely trivial, minuscule details, to gain whatever evidence I could of what I couldn't physically see well or hear well, or what they contributed to these limitations by not seeing or listening to my needs.

B acknowledged how odd it was that she had not mentioned her sensory limitations earlier. Her hearing problem was perhaps the result of nerve damage from her inadequately treated childhood illnesses, but she was also willing to entertain the possibility that it was functional. "But how," B concluded in one session, "was I to continue to think God could see or hear me if I had such difficulty seeing or hearing anyone? I also spend a lot of time talking, as you've noticed, instead of enjoying listening."

Here I sensed, with the help of my countertransference disinterest in listening to B, that we had reached the nexus point between her declared difficulties and the gradually emerging religious themes—the conflict created by the way in which she unconsciously condensed her memories and her projections, reproducing the absence of a listening God/analyst, and sometimes reproducing the presence of a God/analyst who did not listen, at times with an emphasis on parental obtuseness, but increasingly with an awareness of the internalized wish to silence the potential for true hearing. And yet the level of listening that B had somehow made it possible for me to acquire through the countertransference—which, owing to its intimate openness to the unconscious, constantly blends artificial dichotomies and cleaves defensive condensations—enabled her to listen to herself in increasingly fruitful ways.

DISCUSSION

During the course of our work, B succeeded in bringing forward representational and emotional components of what has been referred to as a *latent theology* (Ahlskog 1985; Rizzuto 1993). This term is not restricted to any traditionally recognizable or formally structured corpus of belief as such, but rather to the fact that the deepest infrastructure of religious representations never ceases to exist, strictly speaking.[14] Under certain conditions, this infrastructure may be repressed or may fragment into components no longer

[14] Rizzuto (1979) prefers to say that these representations are never eradicated. However one phrases it, what remains of these bedrock "religious" representations are certain affective and cognitive contents, traces of the uncanny, awesome,

readily recognized in their former identity, becoming congealed into inexpressible psychosomatic states, or may take up active residence in other structures of the mind at different levels of consciousness. Under the proper conditions, these latent dimensions may become active again, creating conflict or imbuing current experience with some of the stillest, most profoundly elevating qualities of human experience.

In B's case, the roots of her earliest salutary but also frightening religious memories, closely alloyed to the fundamental development of her sense of faith and its disappointments, had been dispersed across seemingly unrelated, conflictual, or deficient dimensions of time and the sensory modes of seeing and hearing. The analyst was eventually able to identify (at least in part) the isolated temporal elements and the equally isolated sensory elements that had taken up residence within the analyst's countertransference experience. Then, under the additional influence of the intersubjective dynamics provided by B's associations and dreams, it became possible to initiate some organization and integration of these elements and make them available for B for further work, including a refound sense of religious faith.

Owing to her ambivalence regarding the possibility of being heard by a benevolent breast configuration, B early in life had suspended the dimension of time in such a way as to have great difficulty sustaining an internal dialogue with a resilient faith structure or representation. The maternal and oedipal dimensions of time were sharply split, leading to an essential impairment in her sense of existential constancy and consistency, which in turn further weakened her capacity for the kind of mourning that is so vital for the psychological accommodation of physical illness (see Green 2002; Hartocollis 1983, 2003). For this reason, B also could not easily imagine being heard in the external world, even when, objectively, the opposite was the case. Love and trust were demoted to concrete repetitions of sexual gymnastics, and time was abandoned to

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and transformational qualities that appear to be unique to what eventually takes formal religious form. Finally, like all psychic representations, the dynamic impact of these latent theologies can be deferred and reactivated retroactively.

magical gestures and wild guesswork. This was eventually displaced onto her attitude regarding the *She'ma,* and perhaps, we might say, onto the *she'ma* function. Facing the possibility of death, but now within the protective envelope of a therapy that contained her acting out against its temporal framework, B was able to establish a satisfactory base for rejuvenating her capacity to rediscover faith and time, as well as faith *in* time.

Faith—which Eigen (1981) once defined as the ability to "love with all one's heart, all one's soul, and all one's might" (p. 413)—emerges during analysis when paranoia and an excessive sense of mystery are transcended and replaced by mutual, trusting *hearing*. Interestingly, as Eigen must surely know (though he chose not to state it as such), the phrase he selected with which to define faith contains the specific wording of the second biblical verse of the Hebrew *She'ma!* Indeed, the text of the *She'ma* itself declares that it be evoked "when you sit in your house and when you travel on the road, when you lie down and when you arise"—and we saw in my clinical presentation what this text meant for one patient.

By way of contemporary interpretation, this biblical statement anticipates the idea that the *place, time,* and *listening* of the analyst, as certain kinds of patients perceive these modalities when lying down upon and arising from the couch, and when entering and leaving the framework, may initially need to be demonstrated concretely, necessarily evoking countertransference phenomena. B's fantasy of a void in time, or of an image of endless temporal stasis, represented damage to her breast of a different kind than that caused by her neoplastic illness, but not from a psychologically qualitative point of view. Regardless of the properties of her physical breast, all things being equal, the increasingly symbolized sense of the timelessness of the unconscious and the containing function of the breast allowed her to resume the internalization of the *timely* breast, and to draw faith from this.[15]

[15] For further discussion of the development of the sense of temporality and the containing breast, see Colarusso (1979), Green (2002, p. 149), Morris (1983), and Hartocollis (1983). Time and breast were already linked in B's first dream, and possibly in her hourglass symbolism as well.

Psychic growth inheres in the gradual process by which literal, or coerced, listening is gradually rendered concretely absent in the transference-countertransference, and then further transformed by mourning and symbolization into a truly omnipresent, inviolable wedding of *place*, *time*, and *hearing*. The primary repository of this simultaneous wedding of cradled or contained losses is part and parcel of what we conceptualize as the dyadic breast function, and, in particular, the higher-level, oedipal breast configuration, which includes the internalization of the triangular observing and listening situation.[16] As Fonagy et al. (2004, p. 288) have recently reconfirmed, to internalize the containing breast is to internalize the thinking self that is nested within it. I would extend their hypothesis by adding that this self-perception requires the experience of the containing, *hearing* breast.

Countertransference and Religious Metaphors

The countertransference in question draws at least some of its impact from the fact that it will have touched upon the bedrock of the analyst's own religious or faith representations, be these mutual, reciprocal, or opposing in quality (e.g., level of internalization) to the patient's. In terms of analytic process, the questions of chief interest are: Under what conditions of the larger transference-countertransference evolution did a distinctly religiously oriented metaphor enter into the dialogue, and to what degree was the allegedly religious or sacred quality of this development significant for the patient? And what might be the implications of the analyst's bearing the patient's projected God representations and other transferred as-

[16] B's conflicts seemed to be close enough to the higher-level breast function, and her personality structure in general seemed to have achieved at least an adequate triangular dimension (see Britton 1995, 1998; Ogden 1985, 1986). For this reason, her need for a certain kind of listening, even when reaching into the sublinguistic dimensions of my countertransference, did not require her to reach into the deepest, premental elements of sound—at which substrate she might have needed, for example, to destroy the analyst's capacity to imagine meaningful language at all, if only temporarily, as in one particular case described by Ogden (1997b). This would be the more autistic level of sound (compare this with Rhode 1997), as opposed to the mature, triadic listening context.

pects of the patient's perception of divinity—i.e., the analyst as God?[17]

In this paper, I have tried to illustrate two specific countertransference contributions. First, given the thesis that, on some level, every human being partakes of religious representational material or processes, one should expect that, when countertransference is relevant to the overall treatment, this bedrock floor will be touched upon by the patient—forcing the analyst's hand, so to speak, making atheists of believers and religious devotees of spiritual cynics when necessary. The patient's unconscious perception of the analyst's momentary, countertransference-induced religious feelings or beliefs will be accurate or semiobjective because both patient and analyst are for all intents and purposes the sole lords of this temporary faith.[18]

[17] Elsewhere, in a discussion of an orthodox Jewish woman's conversion to Catholicism (Spero 2004), I take up the nature of the transformation of religious representations, and, in a second study, the salutary influence of the countertransference in the context of the treatment of an orthodox Jewish patient who is a *Kohen*, a member of the priestly class (Spero, unpublished), whose God representation was very difficult to perceive directly.

[18] In recent work quite relevant to the contention that there is a universal potential for analysts of all stripes to react in so-called religious ways in the countertransference, Grotstein (1997a, 1997b) emphasizes a potentially religious countertransference constellation that devolves from what he identifies as the "Pietà covenant" (1997a, pp. 233-237), an element of the intersubjective relationship unconsciously upheld by all infants and mothers under the terms of normal development. This covenant, as Grotstein defines it, falls properly under the category of the quasi-religious bedrock structures described in this essay. Idiosyncratic forms of this covenant find expression in what Grotstein terms the "Pietà countertransference," in which the analysand unconsciously "agrees" to do his or her best to survive and thrive if the analyst "consents" to indemnify the analysand against unnecessary pain, sorrow, and anger, by containing it for the analysand. In the pathological version, the analyst must also accept the patient's guilt as well as his or her own pain, thereby placing the analyst in the position of the martyr/mother, which gradually enables the patient to surrender the defensive, depressive martyr complex and to begin to experience authentic psychic pain. I believe it is clear that, however readily a religiously devout analyst qua believer might wish to identify all the aforementioned dynamics with the historical image of the mother of Christ, or with any other coordinate that the analyst's faith attributes to an objective, long-suffering divinity, he or she will ultimately fail, simply because humans cannot perceive divinities perfectly. Nevertheless, the individual qua analyst ought to be able to maintain a position of comfort vis-à-vis the all-too-human dimensions of such transference, and leave aside the ever-present, unknowable remainder in this dimension as the potential space for the actual, objective God.

Second, although one generally expects that, as analysis proceeds, the relevant metaphors emanate directly from the patient, the pathway is more complex in actuality. Often, the metaphors of chief clinical significance begin to germinate within the countertransference, which, as already stated, represents the composite mind of analyst and patient in dynamic flux. Thus, a patient's "spontaneous" presentation of a change in metaphor or a new metaphor enables the analyst to envision the circumstances under which a more optimal symbol of faith may have been stillborn, desymbolized, repressed, or otherwise sequestered, or, under better circumstances, began to mature and achieve new levels of symbolization (see Freedman and Berzovsky 1995; Freedman and Lavender 1997). Given this, any metaphor that emerges during the analytic odyssey yields its greatest fruits when therapist and patient become aware of their respective contributions to its genesis.

Objects of Faith, "Sacred" Listening, and the Analytic Framework

In addition to the link between faith, time, and the containing (hearing) breast, I have mentioned the possible conceptualization of a *sacred* hearing breast, appealing to the nature of the developments in B's case, and inspired by a related notion found in the literature. Consider, for example, how the notion of the sacred emerges parenthetically in Britton's (1995) definition of the development of truly mature psychic space:

> When the absence of the object is recognized, the place the object originally occupied is experienced as space. If this space is felt to contain the promise of the return of the object, it is felt to be benign (possibly *sacred)* . . . . In contrast, malignant space arises when the idea of the object continuing to exist in its absence cannot be tolerated because it causes so much suffering. [p. 91, italics added]

Bollas (1987) is moved to a similar comment, featuring his characteristic type of emphasis: "The anticipation of being transformed by an object inspires the subject with a reverential attitude toward it . . . . the adult subject tends to nominate such objects as sacred" (pp. 16-17).

On a purely technical level, then, the point is that the conventional concept of tridimensionally symbolized space has specific and essentially paradoxical qualities that comprise what *sacredness* or the sacred is all about. This has to do, in part, with the way in which symbols can coexist with concrete objects or dimensions without conflict, and at the same time not diminish the relatively concrete aspects of the object or the relationship with it, with a mixture of symmetrical and asymmetrical logic, and with related admixtures that religion has always expressed in the dichotomies and antinomies of sacred and profane, holy and secular, earthly and heavenly, immanence and transcendence, clean and unclean, and so on (see Bomford 1999). While we can describe fairly well what we think goes on when such achievements take place, these dimensions remain inherently paradoxical and cannot be resolved (with certain exceptions—for example, by splitting). In our least defensive posture, to approach such dimensions is to be awed, and to recall the pristine beginning of our dim consciousness of these states has always been that which is nothing other than sacred.

Thus, from this perspective, the notion of a sacred dimension of the psychological experience of listening simply augments the descriptive validity of a patient's personal experience of a divine quality of listening, should his or her beliefs press in that direction, such as we saw in the case of B's dreams and other associations. But I think I can suggest a final sense in which the notion of a sacred mental dimension adds significance to our work and to the way we theorize about faith. Analysts who have previously been persuaded to speak in terms of *sacred* objects or *sacred* mental space are evidently reacting to the fact that classical psychoanalytic conceptualizations—including those of writers who are sympathetic to the experience of religious faith—tend to disallow any claim for the existence of an empirically identified, *objective* divine object behind the symbolized representations that typify religious or faith experience.[19] And yet they sense the need to allow for the psychological frame-

[19] Exceptions include Guntrip (1956); Küng (1979); Leavy (1988, 1990), McDargh (1992, 1993), and Vergote (1978, 1990). Nevertheless, conceptual gremlins still plague this point, which can have clinical impact if left unmonitored. Very specific types of religious object representations tend to be more problematic for

work in which such an object, from a theological perspective, might reside—or, from a general psychoanalytic perspective, might be fashioned.

One can now appreciate, I think, that the term *sacred* is a wonderful metonym, and not simply a metaphor, for the otherwise ineffable sense of the highly symbolized, transformative *absence/presence* that Britton, Grotstein, Bollas, and others wish to emphasize, especially since it does not require commitment to any specific representation of God. Few would deny that the sense of something sublimely, incommensurably benign or benevolent—or the symbolized capacity for a sense of timelessness within history (see Corte 1997; Loewald 1988), or the sense of the awesome impression of transformation in the presence of an ultimate Other (see Jones 1991, 2002)—corresponds to the way in which divinity has been characterized throughout the centuries. According to B's impression, a good analyst, a good breast, or a good God listens not simply by virtue of auditory acuity or temporal accident (that is, by happening to be in the right place at the right time). Instead, an object worthy of faith is one that is willing to absorb conflicting stimuli and to contain confusing sensory experiences, that defines the passage of time by that effort, and that is passionately interested in whether some kind of experience of mutuality has been made possible as an outcome. A sacred breast allows one to imagine a breast that not only contains, but has itself been contained within the wider expanses of the divine.

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analysts, as opposed to the more general or abstract conceptions of faith, such as those offered by Bollas (1987) and, more recently, by Charles (2004). But this is troubling, since it has yet to be demonstrated that abstract, highly symbolized, and transformational-type faith experiences—the ones I suspect analysts feel more comfortable discussing and working with—are necessarily more mature forms of faith experience than those that derive from literal or concrete myths and beliefs (compare this with Smith 1983). A bias of this kind can have practical clinical implications, which I elaborate elsewhere (Spero, unpublished).

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WHEN WORDS FAIL: PSYCHOSOMATIC ILLNESS AND THE TALKING CURE

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This paper discusses psychosomatic illness as a disorder of the individual's subjectivity in relation, or a surrender of mind and mindfulness to the other. Illustrative clinical material highlights the usefulness of Harry Stack Sullivan's (1954) detailed inquiry in locating the psychosomatic patient's own voice in the consulting room. Particular attention is paid to the form and use of language to impede or foster private experience and personal agency.

> Words are like bodies, and meanings like souls.
>
> —Abraham Ibn Ezra (c. 1080 a.d., p. XIII)

INTRODUCTION

Reviewing a new production of the Broadway hit *Gypsy*, Hilton Als (2003) describes a moment when the audience gasps. Louise, the star daughter, tells her pushy stage mother, Rose, that she is "not Louise," to which the mother responds, "Oh, yes, I am, more than you know!" The group shudder reflects the intensity of the exchange, but is also provoked, as Als tells it, "because it was a public declaration of a private fear: that we can never break free of our mothers and truly own ourselves" (p. 101).

Many patients who present with psychosomatic symptoms do not even claim a self that they struggle to own. Some report "having no opinion" during the mildest controversy, or say they feel like "pieces of paper being blown by the wind" and "lost without

mother." Broadway musicals dramatize these dynamics. Research psychologists codify the symptoms (Garner and Garfinkel [1982]), feeding apparently low-calorie foods to eating-disordered subjects, for instance, when the foods are actually infused with sweet-tasting substances (Coddington and Bruch [1970]). Compared to normal controls, these patients reported levels of sweetness and satiety in keeping with the *appearance* of the food, rather than with the internal sensations it produced. Bruch (1973), who studied and treated their families, understands these results as indicative of what she calls an *interoceptive* problem—that is, a problem in distinguishing inside from outside or self from other, after years of the mother's having superimposed her needs upon the developing youngster. Informed by today's psychoanalytic dialogue (Benjamin 1995; Kuriloff 2000), we might expand upon static models of mother as "bad object" and the child as her victim. We have learned to consider two conflicted subjects with temperaments, fantasy lives, and memories that have been neither recognized nor fully realized.

For the patients described in this essay, the flesh has become the storehouse of subjectivity. The inexplicable illness, pain, or physical compulsion hints at a beleaguered identity, the "bodily ego" (Freud 1923, p. 26), the bedrock of a self. Fantasies of alien microbes or growths may approximate fears and memories of maternal impingement, if out of the patient's awareness. Disavowed and/or poorly formulated affects and conflict regarding self and other are externalized onto the body. Remnants or glimmers of nascent psychic life are made concrete. Sensation trumps mentalization, precluding reflection and abstraction.

Smith (1988) describes a patient who had numerous eye surgeries that contributed to her sense of herself as defective and ineffectual. In one reconstruction, the patient compared panic-laden feelings and thoughts to the motion of trying to get onto an operating table. Smith describes how the confluence of real trauma, conflict, and character can lead some patients to experience psychic life viscerally, in bodily sensation and movement. How to help these patients better connect psyche with soma becomes the therapeutic challenge in each analytic hour.

This is especially so because, for the psychosomatic patient, communication is externalized. Language remains separate from thinking and feeling, and has a generic value largely irrelevant to the speaker. Rizzuto (2003) describes a bulimic woman's use of the pronoun *I* as a conversational convention. During a helpful session late in treatment, this patient finally exclaimed, "It is the first time in my whole life that I have said *I* and meant it" (p. 301). Such a long-standing difficulty with personal integrity and agency constrains any Piagetian (1937) *accommodation*, or adjustment of the assimilated or learned word, so that it can convey the speaker's unique experience, style, and preferences. For language to communicate with more resonance, there must be what Rizzuto terms a "connection between thing representation and subjective experience" (p. 300). In other words, *subjective*, or self, and *thing*, or other, must intermingle. Then the nourishment provided can be linked to internal satiety from moment to moment, or, as Rizzuto notes, words acquired from the world "out there" can become expressions of affect particular to the individual, making psychoanalysis possible as a *talking cure*.

At a time of cultural immersion in anonymous and public forms of relating (e.g., cyberspace, television, radio exposés), gaining access to this private, subjective self is a relevant concern across diagnostic categories, and outside the consulting room as well. As Lippmann (2000) states:

> Even though we are all socially constructed, and even though some think we are simply narratives, good or poor stories about ourselves, we have this private side nonetheless. We still live deep within ourselves, whether the other knows it or not, whether we ourselves know it or not. [p. 144]

I have chosen to highlight my work with psychosomatic patients as examples of a troubled therapeutic collaboration in the absence not only of a private, subjective self, but also of a resulting *self-reflexivity* (Aron 1998). Self-reflexivity can best be described as the ability to hold the "dynamic tension" between experiencing oneself "as a subject and as an object" (p. 5) of conversation. Thus, I attempt to

address how, in essence, patients might both *speak to us* and *speak for themselves*.

Toward this end, I shall illustrate the usefulness of a long-held tradition in interpersonal psychoanalysis, Sullivan's *detailed inquiry* (1954). I apply this *pursuit of the particular* (Levenson 1988) to the patient's language, but not only to pursue conscious memory or associations. As Smith (1988) puts it in his more open-ended work with patients who "deny their inner and outer reality," I believe such inquiry can foster "the active, fantasy making, recreating or reconstructing function of the [patient's] imagination" (p. 76).

As with all symptoms, I have found it useful to view patients' utterances as serving multiple functions, both expressive and defensive. One analysand would offhandedly say "I feel tense" when she sat down, with little else in the way of affect or associations. Rather than remaining silent, asking general questions, or making reflective comments—all of which I had done, to little avail—I suggested that we carefully deconstruct the very phrase she spoke. Taking Rizzuto (2003) quite literally, I embarked upon "finding the experiencing subject in the patient's own words" (p. 319). "What is 'I feel tense'?" I wondered aloud. Over time, we were able to connect the phrase variously to muscle contractions about her shoulders and neck, tachycardia, and a tingling pulsation in her genitals. These sensations were further explored, prompting images, fantasies, and memories of severe physical abuse, exhibitionistic experiences and yearnings, and the wish to seduce me and to have me "fall painfully in love" with her. The space and freedom for this woman to develop a psychic awareness that was better integrated with her somatic activity was predicated on various elements of the treatment, including a meticulous attention to her verbal punctiliousness. Her clichés actually covered over a primary process loosely associated with bodily action and reaction pregnant with connotation. In the absence of psychological mindedness or self-reflexivity, however, her words were akin to dream symbols—remarkably condensed and yet highly concrete, unformulated, and unintegrated in the light of day.

Thus, the detailed inquiry moves slowly from sensation to mentation because, for many embodied, unrealized individuals, we must *foster mind itself*. A curious, reflective "road map" is required, but with enough space for the concrete patient to find her own mind amidst disparate inner and outer prompting. At least, this is part of what happens.

CLINICAL ILLUSTRATION

Ms. O, suffering from chronic back pain, is often silent. At the beginning of one hour, she states, "I prefer it when you start the session." I could ask her why, as I have so many times before—pulling for her passivity; or I might even interpret her image of me as the encroaching mother. But my words usually lack resonance in Ms. O's awareness, serving to foreclose rather than to promote her curiosity regarding herself. When asked to speak about what matters to her, she says that her back hurts, and while she has made use of medications and extensive, dangerous surgery, both her physiatrist and surgeon have told her that her lingering pain represents an upset in her feelings, and that she needs psychological intervention. She regards these physicians with absolute and unquestioning reverence, as she does every socially validated authority, but their words mean nothing to her either. "Emotionally, I feel okay," she says. "I don't know what else to say."

My response to Ms. O's vacuous words is often an oversupply of my own jargon, which seems in retrospect an identification with her defensive use of language, in addition to being more simply an expression of my own palpable discomfort and frustration. Sometimes this feels like the only tie that binds us.

On this occasion, I manage to ask Ms. O about her choice of words. "What about this word *prefer*—what is *prefer?"*

She tells me that it is just a word, but I persist in asking her to define it.

"I don't know. I imagine myself sitting quietly" (notice the initial association to the bodily) "and you say what you like; it's a polite way to say what you like."

I ask, "What you like as opposed to what you don't like?"

"Well," she rejoins, "not necessarily what you don't like."

I continue, "Uh-huh. I guess you could have said, 'I like it when,' or 'I need you to start the session,' but that would have been more emphatic."

"Yeah. *Prefer* is . . . oh, I don't know how to say it. Um . . . careful, polite, maybe a bit wishy-washy."

"Wishy-washy?" An interesting expression—the association to wishes and wishing seems apparent, if unacknowledged.

"It's just a term, a known term. I'm sure you know it."

"Yeah, I know it, but what does it mean to you?"

"*Wishy-washy*. What it says." (There is a long pause.) "I am so bad at this." (Another pause.) "Someone who looks washed out. Maybe a cleaning lady who washes . . . so she looks washed out. Wishy-washy."

"And who is she?"

"She is . . . some mythic cleaning lady. She washes up. And she is pale from malnutrition and overwork. So she is Miss Wishy-Washy! Like on this dumb-ass kids' TV show I used to watch, full of English house servants. She is just this . . . pathetic-looking character." (Long pause.) "What does this have to do with anything?"

"What makes you think I know the answer to that more than you do?"

"I don't know—I don't know. I just said the first silly thing: Miss Wishy-Washy."

"I don't think it's silly at all. You're talking about being the servant, having to follow orders and pick up after others, memories from childhood. There is more *umph* in these words than in what you heard on a 'dumb-ass' TV show, no?"

"If you say so."

"Only if I say so?"

"Well, I'm just thinking . . . wishy-washy looks a lot like me. Mousy hair, too thin, pale—washed out, my look. Feeling sick and tired." Here Ms. O's concrete associations are infused with more affect. "You might say cleaning ladies develop bad backs. Ha! Her hat is crooked, her back hurts, she's cleaning, and she's a mess!" And after a pause, the patient asks, "Happy now?"

Ms. O begins to find the personal in the pro forma word. In persisting with my inquiry, I honor her psychic life in a way that reassures and encourages her more developed productions. Yet my questions, prompted by my theoretical bent, personal style, and relationship to Ms. O, also unwittingly re-create an intrusive, probing interaction, one that is similar enough to her history that she relives the moment of coercion and surrender of personal meaning. "*Happy now?*" she asks me, as though I have just yelled, "Sing out, Louise!"

I ask her why she thinks I am happy.

"Because you like it when I make more of things" comes the reply.

"I like it and you don't?"

"I think more about what *you* like," Ms. O replies, "so I don't know what *I* like."

"That's the story between you and me a lot, isn't it?"

"Yes," she agrees, beginning to cry. "I don't know why I'm crying now."

"You don't?" I ask.

"Well, it's so hard to know. It's not easy. The tears, they just pour out, like someone else turned on the fountain." There is a long pause. "I don't like it when you ask so many questions. I feel pushed into answering. I feel pushed all the time, by everyone, like I am still little. I don't know if that's why I'm crying."

* * * * * * * *

With a patient who, literally, speaks her mind, I may use a juncture such as this one to speak my own. That is, I would find words to express my experience of the patient as externalizing her tears, making them into alien invaders rather than signals to herself, a somatic expression of her conflicted psyche. I might wonder aloud about her underlying feeling. Is she rageful, sad, or both?

The hope is that this sort of contemplative stance is assimilated by patients who become interested in their behavior as motivated and complex. Yet for Ms. O, as well as for many others with whom I have worked, such a sense of the self is utterly alien. Moreover, the analyst's comments are experienced as a repetition of familial

conquests, during which the loudest—or, in this case, the most psychoanalytic—voice drowns out that of the other, obscuring, even defeating, the very worth of the interpretation.

In the spirit of Sullivan's detailed inquiry, I therefore stay very close to Ms. O's ostensible material, attempting to make only the most cursory connection between her action and her affect.[1]

"Your tears are connected to your feelings, the ones you're describing?" I ask the patient.

"Well, I'm paying you, but it's all just words. *Your* words. This is such an old feeling. And yet my back still hurts. I sound . . . pissed off, don't I?"

"Yes, a bit. Is the way you sound the way you feel?"

"Yes! For once, yes!"

No longer producing "just words," her voice echoes her subjectivity.

"So, why haven't you described it before, this 'old feeling'?"

"I . . . don't know. I didn't feel it before. I mean, I guess I did. I don't know why. I really didn't know quite that I felt it. But one thing I *am* sure of, something I've always felt: I don't want to make you mad. Or disappoint you."

"Those worries about my disapproval stop you from appreciating and expressing the rich thoughts and feelings of your own mind," I observe.

"*Would* you mind if I got mad?" Now Ms. O sounds excited. "Would you stop asking questions if I asked you to stop?"

* * * * * * * * *

My interpretation of the patient's inhibiting anxieties has fallen on deaf ears, as usual. Ms. O's choice not to hear my words,

[1] Gray (1982) and Busch (1994), often considered to be at the other end of the psychoanalytic spectrum from Sullivan, also value proceeding from surface to depth in their inquiry, in order to foster the patient's "self-analytic capacity" (Busch, p. 466) and "voluntary co-partnership with the analyst" (Gray, p. 624). For certain interpersonal and ego psychologists, this focus upon self-reflection and responsibility marks a shared interest in cognition integrated with or mediating affect, a fundamental aspect of language development. (See also Stern [1995] and Spezzano [1998] for a more complete discussion of this point.)

and her uncharacteristically enlivened question—more of a challenge to some sort of showdown between us—suggest much to me. She appears as happy as she is impoverished by the prospect of a power struggle between us. Perhaps I should note her excitement. Perhaps my willingness to follow along suggests an interactive matrix beset with the titillation of domination and surrender.

Yet Ms. O's tendency either to acquiesce or to remain deaf to such interpretations also brings to mind Hoffman's (1998) case of Diane, who demands that the analyst secure a Valium for her immediately. Hoffman succumbs to her urgency, which surprisingly ends the power struggle between them and ushers in a spirit of inquiry. Quoting Benjamin, who draws upon Winnicott, Hoffman understands this new dialogue as resulting from Diane's need to know that she can impact the other: "When I act upon the other, it is vital that he be affected, so that I know that I exist—but not completely destroyed so that I know that he also exists" (p. 212). Now two people are in the room—appreciating themselves and each other as subjects and objects of the interaction. Hoffman elaborates that his responsiveness to Diane breaks the cycle of "domination of the other, or masochistic surrender" (p. 212) that have been the only alternatives available in Diane's relational history.

Significantly, Hoffman describes Diane's emergence from "the prison house of projective identification" (p. 212) into a willingness to explore meanings. He uses Ogden's (1979) description of projective identification, that is, a "coercive enlistment of another person to perform a role in the projector's externalized unconscious fantasy. *The effect of this process on the recipient is to threaten his ability to experience his subjective state as psychic reality*" (Ogden quoted in Hoffman, p. 211, italics added). This collapse of the psychic is an apt description of Ms. O's mother's effect on her—a mother who imposed both her grand hopes and wishes, and her shame and vulnerability as an abused foster child, upon a daughter whom she treated as a receptacle. When Ms. O devalues my words ("I'm paying you . . . and yet my back still hurts"), she is projecting her own feelings of inadequacy and helplessness onto me.

The patient's delayed diagnosis of celiac sprue, causing projectile vomiting during infancy, fostered the familial interactive strategy of failing to integrate outside and inside or self and other. Ms. O reports her mother's having said, "You threw up everything I gave you—you were such a bad, difficult baby. I had to force-feed you until the doctors finally figured out what was wrong." Her force-feeding was, of course, a desperate attempt to nourish her baby, but the obvious hostility in the act and in the telling also serves to disavow the sense of herself as a bad, inadequate mother. This is the treatment that Ms. O expects from me, and she has to reject what she feels are my words sadistically forced upon her. She beats me to the punch—as I will illustrate—in her insistence on my silence. Furthermore, Ms. O's externalized, objectifying relationship to her own body and words are a part of this overarching template—the sense of herself, of her mindfulness, being barely felt and never owned.

Still, I try to enlist the patient as an agent of her own desire, asking, "What are you wanting from me now?"

"I . . . like . . . I don't know, am I? . . . Oh my God! I just thought of the wildest thing!"

"Yeah? Tell me."

"I just thought of saying to you, 'Get off my back!' " She giggles and shifts in her chair, after which her voice drops. "But then you would make a whole to-do about it and be like all, 'Aha! So you see, I am right about your back!' And you would feel victorious and my back would still hurt."

"You don't want me to direct this, or to claim sole ownership of what you're feeling and saying?"

Preferring a less reflective reply, Ms. O blurts, "Just be here and don't say anything now!"

I do not speak, and quite a long pause ensues. While my mind races, I feel physically stiff, palpably stifled—as I imagine the patient often does. I balk at this feeling in my body and my sense of myself as forced down. I wonder whether it is a shared "skin" (Anzieu 1985) between the patient and me—am I somatizing the terror of her mother's impingement, the paralyzing guilt inherent in the

rageful desire to rise up against an other who will not relinquish me? Anzieu (1990) speaks of *masochistic envelopes*, or a partnership of pain in which the patient's bodily preoccupations and complaints hold the experience, the response, and fragile psychic representations of the individual in relation. At the same time, I am most impressed by the general shift in the work—by the new traction between us, unmistakable in the genuine affect and expressiveness heretofore absent or merely implicit.

Finally, Ms. O speaks: "Jeez, well, you can say stuff" (here she laughs), "but not . . ." Her voice trails off and she sighs, resuming her words with great emotion. "Why don't I trust you more? It's crazy that I tell you not to talk. Why am I so . . . I don't know . . . uptight and always wondering that you'll take something from me? That makes me sad and uptight; I feel like my body is in a knot. And I know you're uptight, too." The patient smiles. "You would say, 'uptight—what is it in that word you keep using?' " (She momentarily attributes her desire and capacity for inquiry to me, illustrating our close connection, but also her conflict between making good use of the relationship and feeling forced or co-opted by it.) "It feels like not *able* to feel—like stuck. I want it to be different in here. I want us to let loose more." (Now that Ms. O is more able to hold onto her upset without projecting or concretizing it, her embodied imagery is infused with metaphorical meaning.) "But loose is scary too," she adds, and begins to cry. "I am afraid of what might come out."

* * * * * * * * *

We have engaged in a sadomasochistic dance, one familiar to Ms. O, and yet something new is happening as well. To whatever extent my technical choices are premeditated, in deciding to be silent, I allow Ms. O's emotionally alive request to have a direct and palpable effect upon my behavior. In so doing, I acknowledge her experience and its influence on both of us. In the words of Auerhahn and Peskin (2003), "without acknowledgment, there is no investment in meanings" (p. 623).

Research regarding the development and regulation of affect, and, more generally, of the mind (Fonagy et al. 2002), contends that "we learn to fathom ourselves through fathoming others" (p. 143). What Fonagy et al. are getting at is a subtle intersubjectivity during which the *other's* recognition and responsiveness toward our internal states promote greater tolerance and integration of our feelings and intentions, and less of a need to concretize and externalize them.[2] The authors describe the child's need for the adult to play along with pretend roles, "so that the child can see his fantasy or idea represented in the adult's mind, reintroject this, and use it as a representation of his own thinking" (p. 143). Expanding upon Winnicott, Fonagy notes that the playful quality of the adult's behavior is distinct from the adult's attempts to exactly replicate the child's subjectivity. Instead, it is an as-if *approximation* that fosters the youngster's more variegated self state, one in which he or she begins "to 'know about' his idea or wish alongside experiencing it" (Fonagy et al. 2002, p. 266). How similar this seems to my willingness to "play along" with Ms. O's demand that I be silent in the context of an analytic frame, holding the duality of her fledgling subjectivity alongside my spirit of inquiry, as she sees herself —to paraphrase Goldman (2003)—"both in and through" my eyes. Thus, Ms. O becomes more mindful of her mind.

Greenberg (1986) might understand this interaction and others like it in terms of his definition of neutrality, or the establishment of an *optimal tension* between Ms. O's experience of me "as [an] old or new" object (p. 149), an analyst able to evoke and to contain the familiar, impinging mother, but also to honor the patient's needs in a surprisingly novel, albeit destabilizing, way. It seems that it is the latter—the unexpected—that prompts Ms. O to do a double take and reflect upon herself in relation to the other. Yet Greenberg might suggest that it is the balance between familiar safety and provocative disequilibrium that makes Ms. O's resulting reap-

[2] These empirical findings support Winnicott's (1971) question and answer: "What does the baby see when he or she looks at the mother's face? I am suggesting that, ordinarily, what he or she sees is himself or herself" (p. 112).

praisals more tolerable, and even interesting, to her. Thus, I am sometimes the familiar other when my language is the act itself, the language of Ms. O's unreflective family. Like mother and daughter enacting the dumping and containing of disavowed affects from one to another, I might sit quietly and allow myself to be the receptacle of masochistic wishes, and at other moments, I infringe upon her self-possession as the instrument for her sadistic desire. Yet, despite these patterns, I also experiment with new ways of being—including my inquiry, one of sustained interest in her experience, and moreover in formulating meaning from that experience with language.

I ask Miss O, "What are you afraid might come out of you—or out of me—if you got loose?"

"I don't know. It's just a sense I have."

"Tell me about *loose*. What is *loose?"*

"Like—loose. Loose as a goose! I don't know . . . my mother used to use that expression."

"Yeah?"

"Yeah. Now you would say, 'So what about that?' " (She still struggles to distinguish her experience from mine.) "Loose as a goose isn't a very nice thing to say about someone. Like they are an animal or something." She pauses and squirms in her chair. "I can't believe I'm saying this, but my association—isn't that the word?—is to, yeah, well, goose shit." (Again, a reference to the visceral, the corporeal, emerges.) "You know—so much of it, like in the park near where I grew up, it was a menace. They actually shot at the geese to chase them away. I remember being disturbed by that as a kid. I wonder about geese—they're pretty, but they bite, you know. And they make a lot of gross shit. I guess I worry about that stuff . . . you know, being gross. Maybe there's gross stuff inside of me."

"What is gross inside of you?"

"I don't know. I worry you will think I am gross. Especially if you see my shit—my anger, my pain." Here the patient's body and affect are better integrated. "What if I let it out and it never stops? What if I do too much damage? But, you know, gross also means

big." (She owns her interest in the definition and intention of her words.) "How did it happen that the word *big* came to mean *disgusting*? I guess that fits with my family—the big fish eat the little fish. They can be really brutal, right?"

DISCUSSION

In the case of Ms. O, the detailed inquiry—mining the meaning from externalized, clichéd utterances—is an interactive process as much as a point of view. It may model and foster the patient's own introspective efforts because it challenges the conflictual memories and fantasies regarding a separate subjectivity, the very motives for collapsing experience and agency onto mother. In the momentary drama of my yielding to her desire and will, and in the ongoing space and time afforded by a meticulous deconstruction of this patient's subjectivity, Ms. O's mindfulness is not only detoxified; it is enhanced. It is honored as a means to achieve both robust expression and thoughtful reflection. I do not claim that Ms. O's familiar tendency to surrender—this time to the analyst's mind—has been forever banished. Yet, for at least a moment, Ms. O is freer to be both the subject and the object of her treatment. Perhaps for more than just a moment, she becomes increasingly more appreciative of the complexity and nuance in packed verbal productions that represent a far-ranging mindfulness indeed. In this way, the inquiry is both act and word, a new way of being in a conversation.

On one occasion, after too many futile attempts at interpreting the anger that I sense lurks within the patient's bodily pain and in her clichés, I exclaim to Ms. O, "You are so resistant! So split!" I am surprised by my choice of words, the armaments of a precocious child whose emotional life lags behind what has been memorized from books. My vocabulary is enormous, yet even as an analyst, I am capable of isolating poorly integrated feelings of aggression and desire that I dare not acknowledge, let alone utter. As Greenberg and Mitchell (1983) explain in their exegesis of Sullivan's work: "Sullivan was as impressed by the magical use of lan-

guage by the psychiatric 'scientist' to support an illusory sense of knowledge and control as he was with the autistic use of language by the patient" (p. 85).

Thus, the detailed inquiry can facilitate better integration for the analyst as well. Both my ancient propensity to use jargon and my impulses toward conquest and surrender within the dyad are mediated by the effort, as is my willingness to be surprised by ideas and experiences previously truncated, elusive, and ineffable.

At this juncture, I wish to provide a caveat: *Many times, the generally useful approach I hope to illustrate has not been useful.* Some patients experience my questions as an assault—attempts to shame and manipulate them into a concession or a surrender that derails or abruptly ends the work. Others complain that I hinder or interrupt their own voice with my inquisitive words. So many variables account for these distinctions—perhaps as many as there are personal relationships. That we might extol one therapeutic action, or generalize as to why our techniques work for particular patients or at various points in the same analysis, runs counter to our appreciation for the singular nature of mind in dynamic interaction. Thus, a detailed inquiry is called for. In this case, an overlap in our mutual areas of vulnerability facilitates the creation of a familiar (and familial) ambiance within which Ms. O and I can then chafe against one another. As Fonagy and Greenberg suggest from their respective points of view, the patient and I are similar enough to tolerate difference.

Still, Ms. O ends her more affectively rich, thoughtful inquiries with *"right?"*—perpetually pressured under the weight of my questions, perhaps wanting as much as dreading my impingement, the tie that binds. History, packed into the transference-countertransference matrix, constrains as much as it propels us. The pull of the relational field in the consulting room—and the quirks of any analyst's character—do the same, conspiring to remind us of the limits of any and all technique. Neither Ms. O nor I can destroy the ghosts of our past "in absentia or effigie" (Freud 1912, p. 108), no matter how developed our awareness and how sophisticated the words we use to convey what we know. As Smith (2004) puts it:

> All the analyst's activities, including his or her unspoken observations, shape the work in multiple directions, simultaneously advancing the analysis and fueling the resistance, and . . . the progress of an analysis and its therapeutic action are built in part on mutual, unconscious negotiations about the paths the analysis will follow as well as on mutual resistances to the roads not taken. [p. 629]

The essential question remains: How can our work expand awareness while we invariably participate in patterns—both old and newly created—that lie behind that coveted awareness?

The analyst is, after all, many things—enacted and verbally reflexive, old and new. She may be the stifled, embodied self, the excited, impinging other, but also a more responsive object than before, who can alternate as a less self-serving, sadistically controlling subject in dialogue. In such an interaction, analyst and patient begin to define the parameters of mind, enriching and sustaining self and other. This inquiry is many things, its mediating language, to quote Stern (1997), growing meaningful when analyst and patient "do not try to send it anywhere in particular, but allow it the freedom to follow the lead of our feeling" (p. 93), words for the talking and acting cure.

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A FALSIFYING ADOLESCENT

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The author describes an adolescent patient who, while often speaking factual truths, maintained an aura of falsity in her life, and in two interludes of psychoanalytic psychotherapy, that functioned as a barrier to psychological insight. To match her falsity, the analyst at times modified his functioning as a "real" therapist and took on her personification of neglectful and false adults. Eventually, the analyst became an object that the adolescent could trust and rely on. In discussing the case, the author introduces and applies Bion's ideas regarding truth and falsity, and three variations of container-contained relationships—symbiotic, commensal, and parasitic—in the context of the case's relational perspective.

INTRODUCTION

"Where are you going?"

"Nowhere."

"Who are you going with?"

"No one."

As parents, we have come to expect this exchange with our adolescent children. Indeed, bald adolescent falsifications are typical, even conventional. The dialogue is not without meaning, however, and serves communicative goals. In the questioning, the adult signals ongoing interest in and concern for the youth's life and welfare. In the falsifying responses, the adolescent reasserts motives for separation, privacy, and independence.

In this paper, I discuss the treatment of an adolescent patient who, I discovered, had not been asked these questions sufficiently, and who wanted to be asked. This left her in charge of how much I was going to hear, which was plenty, and how far we were going to develop meaning from what she had to say, which could be minimal. As I reflected on our early interactions, I found helpful Bion's ideas regarding truth and falsity and patterns of thinking and communicating, what he referred to as the *container-contained*. These ideas then guided the strategies I adopted in session to advance the analytic work.

Bion (1962, 1963, 1965, 1970) was unique in placing truth—the need for truth and the need for truth seeking—as the focal point of his metapsychology. He offered a conceptual framework that may be extended to understand the roles of truth and falsity in mental health and illness:

> There is a need for awareness of an emotional experience, similar to the need for an awareness of concrete objects, that is achieved through the sense impressions, because lack of such awareness implies a deprivation of truth and truth seems to be essential for psychic health. The effect on the personality of such deprivation is analogous to the effect of physical starvation on the physique. [1962, p. 56]

Individuals needing psychoanalytic treatment are starving for truth. But the truth has consequences, the often-painful realizations that change the way one feels, thinks, and treats others and oneself. Even the strongest may evade the "need for awareness of an emotional experience," and choose instead ways of avoiding truth.

Bion reserved a special category of evasive response, designated by the Greek letter *psi* (Ψ). The category *Column 2* on Bion's (1970) grid refers to statements "known by the initiator to be false, but maintained as a barrier against statements that lead to a psychological upheaval [i.e., growth and change]" (p. 9).[1] *Psi* communications carry a metamessage, "here is a truth," when in fact, the

[1] Column 2 responses serve to assert a superiority of falsity over truth, and hence they are members of a larger category of *antithinking* responses that Bion

individual cannot tolerate or admit not understanding. Or, the individual may pretend not to understand, when he or she fears thinking about the truth and its consequences. The individual may omit, slant, or exaggerate relevant data, leaving both speaker and listener confused or drawing false inferences.

Even when factually true, *psi* communications may serve falsity by being inauthentic, irrelevant, or clichéd, thus providing a buffer against genuine mental interaction. Conventional or familiar ideas are treated as definitive truth. In contrast, new or challenging ideas —emanating from the self as well as from others—instead of being greeted with interest and curiosity, are ignored or suppressed. Bion characterized individuals and institutions (including psychoanalytic ones) as corresponding to *psi*, to the extent that they represented the Establishment, which he saw as unable to accept new information, negating anything new, and resorting to lying rather than having established ideas disturbed.

While in Aristotelian logic, truth and falsity are categorically distinct, not so in human relations. In my reading, however, Bion neither emphasized how one's version of truth can be wielded as a hurtful weapon, nor noted how falsity may facilitate the building of constructive relationships. "How do I look?" a provocatively clad, adolescent girl asks her inwardly wincing father. Questions such as this do not always seek truthful answers, and even when they do, diplomacy, minimization, shadings of feeling and meaning—even white lies—lubricate and make possible social relations. A marker of mutual growth between parent and adolescent is observed when each can understand and accept the other's fictions and disguises—the respective social selves of everyday life (Goffman 1972).

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symbolized as "–*K*" (minus knowledge-seeking). Emotions as well as words can serve as Column 2 elements. Bion (1970) gives the example of rage, "of which the fundamental function is denial of [awareness of] another emotion" (p. 20). Technically, when false statements are offered to evoke, provoke, accuse, injure, or to defend oneself, rather than primarily to mislead, they remain in the realm of –*K*, but are categorized as belonging to Column 6 on Bion's grid (the action category), rather than to Column 2. In practice, the two columns overlap, and Bion himself seemed to ignore the technicality.

In the case that follows, I show how both truth and falsity may be used in developing a psychoanalytic relationship.

TRUTH SEEKING IN DEVELOPMENT

> The customary answers given the child . . . damage his genuine instinct of research and as a rule deal the first blow, too, at his confidence in his parents . . . . he usually begins to mistrust grown-up people, and to keep his most intimate interests secret. [Freud 1907, pp. 135-136]

To a significant degree, the capacity of the developing individual to tolerate truth seeking reflects the history of the caregivers' interest and success in responding to the child's truth needs. Only a certain amount of truth may be introduced into experience, and it is among the parents' first and most important tasks to protect the infant and growing child from too much or too little truth. From the start, parents introduce make-believe into the infant's world, creating (or in today's jargon, co-creating) "his majesty, the baby," and fostering mutually idealizing, bonding scenarios. However, to advance truth seeking, the parents must gradually dethrone the infant. We may hypothesize that certain depriving caregiving behaviors—for instance, those involving physical absence, delay of immediate satisfaction as in partial weaning, and so forth —stimulate thinking and a reality orientation. And thus arrives a most painful truth: others exist as separate objects; they can be present or absent. Our theory tells us that thinking involves an experience of "missing," of anxiety and frustration; and truth, when it emerges, may be difficult to bear.

If the infant is constitutionally able and early caregiving experiences progress satisfactorily, the child begins to take over parental functions of titrating truth. Through the development of reasoning and representational thought, the child begins to contain and articulate the reality of its own emotional experiences and to differentiate what is new and potentially valuable from what has become familiar and established. However, truth seeking remains an experimental process that involves a component of omnipotent and hallucinatory thinking, which is gradually but not

totally worked through. Even the mature human being must continually work through a level of "primitive" emotionality and unconscious fantasy to achieve separation from a world of subjective objects and events to think with some clarity and objectivity. Klein called this process achieving (and maintaining) of the depressive position.

In childhood and adolescence—indeed, at all stages of development—to seek truth and to challenge the human tendency toward falsification, the individual requires authentic communicative interaction. In some measure, the Establishment, consisting of parents, school, religious institution, and government, represents and upholds reality, including the values and standards of the status quo. But the established order must also encourage challenge and dissent, and must stimulate and respond to emotional truth and the individual's search for it.

Parents and societal caregivers who unduly rely on *psi* may reward conventionality, to the neglect and discouragement of curiosity. They may use truth for influence and control, for example, in order to impose a moral or political agenda. The Establishment, rather than providing a stable foundation from which the individual questions and explores inner and outer reality, may thus foster a resentful but inhibited "good baby," who emerges in adolescence with a conforming "good-citizen" or rebellious "bad-citizen" self (or both). In response to a psychosocial network that is suppressive, manipulative, or merely inadequate in fostering truth, the individual may become evasive and tentative as a form of self-protection. The need for significant truth remains unintegrated and dissociated. To escape from the resulting emotional and mental deadness, the adolescent may develop covert modes of seeking sensation, and may confuse sensation with vital truth.

DEVELOPMENTAL IMPLICATIONS OF FALSIFICATION: THE CASE OF HAMLET

Prior to adolescence, the truth is represented by the absolutist point of view of concrete operations (Piaget 1969), and the child tends

to adhere to the truths represented by the Establishment's concepts of reality and moral behavior. The achievement of abstract and relativistic thinking, which Piaget referred to as the stage of formal operations, brings new impetus and power to the drive for emotional truth. The adolescent has achieved the capacity to explore his or her own mind and the minds of others—breaking emotional and conceptual links to the dependable, known reality of the Establishment.

"There is nothing either good or bad but thinking makes it so," declaims Hamlet (Shakespeare, II, ii, 255-257), whom we may consider as an archetype of late adolescence. The adolescent may shift, permutate, combine, or reverse points of view, leaping mental boundaries from one affective view of reality to another, and from reality to fantasy, morality to immorality, narcissism to mutual recognition and concern.

Perhaps *Hamlet* describes the predicament of all adolescents, in danger of prematurely recognizing disconcerting truths concerning parents and the adult world. Hamlet was haunted by dream thoughts—ghostly, dissociated realizations concerning his parents, and was afraid to trust and act on his convictions. "With thoughts beyond the reaches of our souls" (I, iv, 56), adolescents are not quite prepared "to be," rather than "not to be." No longer unquestioningly loyal to the Establishment, they are not sufficiently experienced or solidified in their identities to trust their consciousness and unconsciousness to guide their behavior. They must depend on others—peers and adults—to enter into trustworthy dialogues. In this context, Vanier's (2001) remarks are apropos: "Adolescence is primarily a social phenomenon—that is, a phenomenon of discourse" (p. 583).

A legitimate and important function of adolescence is to question and test Establishment values and norms, and to contribute to their reevaluation and modification. In this manner, the adolescent is encouraged to find his or her own truths. To the extent to which the communications from the Establishment impede rather than encourage legitimate challenge and exploration, these communications correspond to the Bionian concept of *psi*.

In *Hamlet,* Shakespeare dramatizes how parental falsity inflames the adolescent and sets the course for intergenerational conflict. The audience first encounters a disingenuous Claudius who, with an unearned bonhomie, greets Hamlet as "son." Hamlet mutters a sardonic but not untruthful reply: "A little more than kin and less than kind" (I, ii, 65). Claudius pretends not to understand: "How is it that the clouds still hang on you?" (I, ii, 66). Hamlet counters his uncle's bland denial with an ironic play on Claudius's words, much like the adolescent who "raps" in semi-indistinct, anti-Establishment protest: "Not so, my lord, I am too much I' the sun" (I, ii, 67-68).

In this tense exchange, Hamlet's use of "sun" refers to the star, to the king (symbolized as the sun), and, as homonym, to "son." While Hamlet's complex word play partially disguises semantic meaning, it is sufficiently direct that a receptive listener would get the emotional gist. However, Gertrude, in marital collusion, professes not to understand the emotional reality motivating her son's surliness. "Good Hamlet, cast thy knighted color [of black, signifying deep mourning] off . . . Do not forever with thy veiled lids/ Seek for thy noble father in the dust,/Though know'st 'tis common—all that lives must die,/Passing through nature to eternity" (I, ii, 68-73).

Responding as he did to Claudius's insincerity, Hamlet mockingly reflects Gertrude's bromide: "Aye madam, it is common." He means, of course, "you, mother (and your truism), are common." Her perfidious maternal communication, perhaps as much as her hasty, incestuous marriage, has damaged trust, and Hamlet's first soliloquy describes his self-enforced and painful isolation: "Weary, stale, flat, and unprofitable/seem to me all the uses of this world!/ . . . But break, my heart, for I must hold my tongue" (I, ii, 133-134, 158).

Shakespeare dramatizes Hamlet's longing to find and communicate the truth about an Establishment that he suspects deceives, and through its deception, attempts to "pluck out" his independent spirit: "You would play upon me,/you would seem to know my stops, you would pluck/out the heart of my mystery, you

would sound me/from my lowest note to the top of my compass —and there is much music, excellent voice, in this/little organ— yet cannot you make it speak" (III, ii, 379-385).

Because Hamlet cannot quite believe what he knows to be true, he provokes and embroils the adults to reveal themselves: "Players cannot keep counsel; they'll tell all" (III, ii, 151-152). He defensively commits himself to counterfalsification, behaving like a crazy adolescent, putting "an antic disposition on" (I, v, 172). He speaks and acts purposely to confuse. Under the protective cover of an abrasive self-presentation, Hamlet attempts to "catch" psychological reality, to confirm his cynical but accurate view of the corruption of the adult moral authority. "The play's the thing/Wherein I'll catch the conscience of the King" (III, i, 905-906).

However, increasingly bitter and alienated from adult support, Hamlet cannot sustain constructive role-playing. Disregarding the prudence he offers to the professional actors—"Suit the action to the word,/the word to the action" (III, ii, 19-20)—he abandons truth and reason. When Laertes holds him accountable (for the death of Polonious, his father), Hamlet excuses his behavior: "And when he's not himself does wrong Laertes,/Then Hamlet does it not, Hamlet denies it./Who does it, then? His madness. If't be so,/ Hamlet is of the faction that is wronged,/His madness is poor Hamlet's enemy" (V, ii, 246-250). In his self-falsification, Hamlet has become his own enemy, as well as the Establishment's.

MY TREATMENT OF SIMONE, A FALSIFYING ADOLESCENT

Simone, an attractive and physically mature 15-year-old girl, appeared for her first appointment, accompanied by her mother. I introduced myself to both, and since Simone seemed to have no trouble separating, I indicated that I would see her alone. Following me into my office, Simone arranged herself easily, and with a lackadaisical "hi," she waited. I felt immediately that she anticipated being bored.

"So?" I asked, expectantly.

"So," she repeated. Her confident, carefree attitude informed me that she had been here before and knew what to expect.

I continued: "So, I'm supposed to ask you why you are here, and you're supposed to tell me."

"I know—I've already seen my guidance counselor and the school psychologist. They think I have problems and need therapy. I don't. I saw my mother's therapist, she didn't say anything, are you going to be silent, too?"

"Are *you* going to be silent, since you don't want to be in therapy?" I responded.

"I didn't say I didn't want to be in therapy. I said I had no problems and no need of therapy."

This was to be the first of Simone's many corrections for my failing to get right her presented version of the truth. I had the distinct sense—common with an adolescent patient—that I was being provoked and also tested to see how I would respond, such that Simone could "catch" on to me, and that she did not herself fully believe what she said. I looked at her quizzically, expecting that she would feel and think further about our communication. But she merely waited for me to continue, as if we were in agreement that she had answered sincerely and had made perfect sense.

"Mmm," I said with a slightly sarcastic edge. "This might be interesting. A person with no problems, no needs, but willing to come to therapy."

"That's right," she responded, ignoring the nuance in my response. "I have lots of study halls and my mother's driving, or I'll take a cab. It will break up a day."

So there would be perks in this unneeded therapy, I thought. Simone could vacate a portion of the school day and spend special time with her mother, or at least get her attention. With adolescents, I have often been impressed that a benefit of treatment has been the increased family contact imposed by the necessity of transportation to and from my office.

It was my turn to correct Simone: "Several days, if we decide to work together." Simone's mother had advised me that Simone

was failing in school and was listless and "out of it." If I were to make some inroads, analytic and otherwise, two sessions per week would be minimal.

"Several days," she echoed, unruffled.

"Why does everyone think you need to be in therapy?" I asked.

"My grades suck," she replied sheepishly. "Oh, also, my parents are going to get a divorce, and everyone thinks that might have something to do with it—maybe, but I don't think so. Most of my friends' parents are divorced. I'm used to it."

"Then what's going on?" I continued, noting inwardly the falsity in her omission of the indications of depression and drug taking, my inferences from her mother's report.

"With . . . ?"

"With you, that you're having difficulty completing schoolwork."

"Nothing. I can make it up when I want to."

"You don't want to?"

"I guess not now." (Pause.)

"So what's with your parents' situation?"

"Their problem, not mine." (Pause.)

"I see what you mean; you want me to talk."

"I'll talk. But you have to ask me questions."

I was confused, for I had been feeling that Simone was finding my questioning intrusive and was turned off by it.

"I just did," I said, hoping for clarification, perhaps direction, but she responded with a sweet smile that left me with neither.

"I guess not the right ones," I added.

I would discover, through trial and much error, a jarring but ultimately clarifying disjunction between an aspect of Simone's transference and my countertransference: What felt right for Simone were the therapeutic equivalents of "where are you going?" and "who are you going with?" But whenever I attempted to move the conversation in the direction of her feelings, she accused me of "getting psychological," and diverted the interrogation. However, often when I felt I was being mundane, unimaginatively concrete,

or pushing farther than most adolescents would like in asking personal questions, she revealed selective and often important bits of confidences. For example, her ground-floor bedroom—separated from the parental suite—had an easily accessible window that became a nightly portal for a small clique of party-minded friends. Thus, in time, I learned about different ways she acted and acted out, but what did her behavior mean? She offered no hypotheses and showed little curiosity in mine.

Unruffled and blasé, Simone was a late-twentieth-century, adolescent version of *la belle indifference*. She was surreptitious and deceptive, lying to her parents, shoplifting, copying homework, and cheating on exams, but she was not false when divulging these aspects of her life. Her falsity lay in her "antic disposition" (Shakespeare, I, v, 172). Her pleasant—if superficial—personality, represented by a bright smile, served as a barrier to psychological insight. Even when she was being honest, as in acknowledging her dishonesty and sharing her exploits with me, she resisted thinking or feeling about what she was communicating. No matter how alarming I found her situation, to Simone, everything was "good," "fine"—"it doesn't bother me, why does it bother you?"

After an unproductive go-round, in which I presented the risks in her behavior and got no affective response, I might ask: "Does it bother you that it bothers me?" "Not really" was her typical response. And then, occasionally: "This is what you do, you're doing what you're supposed to do." [Explain?] "Your job." [Explain?] "You don't know what your job is?"

I heard an insinuation that I was playacting "being bothered," and, therefore, I was a fake. Simone could seem vaguely disdainful, but when I attempted to check out my impressions about her critical feelings about my job, our relationship, or me, she would clam up and look at me vacantly. Particularly unappealing to Simone was an admission of annoyance or an expression of dislike, much less of anger. She expressed a genuine, if unfocused, care not to be malicious or purposefully hurtful. She was not going to be angry with her dispirited mother or callous father, who precipi-

tously abandoned the family, and she would not be angry with me. If she appeared blank, sleepy, or mildly stoned on marijuana or quaaludes, her parents seemed not to notice. But I *did* notice—and, unperturbed, she agreed that she habitually "tuned out," with or without drugs. Like Hamlet, she professed little interest in "all the uses of this world." I expressed concern and struggled to find the "right" questions that would wake her and give us access to her defended-against emotionality.

Simone derailed my therapeutic efforts by imputing an aura of falsity to our interaction. To give another example, when we talked about her mother and how sad her mother seemed, Simone's eyes clouded. I commented that Simone seemed sad, too. "Of course," she remarked gently, "she's my mother." She was sad for her mother, but not for herself, she explained. When I called attention to her eyes and their incipient tears, she granted me only: "Maybe, but maybe you're seeing things, saying what you want me to say."

"My eyes can't be trusted, or I can't be trusted?" I asked playfully.

"Same thing!" she retorted.

Simone seemed not the slightest bit annoyed by the proposition that I might be trying to get what I wanted by putting words in her mouth. She accepted without question (even with some pride) that she could be manipulative, a user, and a role player. It took me a while to realize that she expected the same behavior from me.

I had to learn to accept—even embrace—this role without offense or challenge, just as she did. I give the reader the following segment from one session that represented a turning point in my understanding and therapeutic stance. We were discussing the Thanksgiving weekend that had just passed, the first in which her family was no longer together.

Patient: My father wanted us [the children] to have a second Thanksgiving with him. It was supposed to be on Friday, then he changed it to Saturday night, because Elaine [his new live-in woman] was

going to be away, and he could hook up [with another woman].

Analyst: [I dramatized an aghast reaction. As my empathy seemed not to register, I continued with the following.] Don't you feel pushed aside?

Patient: I guess so.

Analyst: You're not mad?

Patient: I don't know. I don't like having to sleep at his house, because I can't go out with my friends. Besides, I don't like Elaine that much. I don't think my father does either.

Analyst: Oh. What don't you like?

Patient: I said I don't like her *that much*.

Analyst: [I was not going to give up a chance to explore an affect.] What don't you like about Elaine *that much?*

Patient: She's kind of a phony.

Analyst: Mmm? [Here I dramatically cleared my throat.]

Patient: [She smiled.] No, not like me. I don't pretend to like someone when I don't. Elaine thinks she might become my stepmother and she smiles too much. You don't say I smile too much. You say I smile so I don't show my feelings.

Whereas I might not have said that Simone smiled too much and could be phony (and I believed I *had* said both explicitly), I certainly had implied both, and I thought we had agreed. In response to Simone's distinction without a difference, I felt misunderstood and as though my therapeutic efforts had been betrayed. Yet I thought it best not to contradict or ask her to explain.

Analyst: I see what you mean; go on. [Not for the first time, I participated in Simone's self-misrepre-

sentation,[2] taking solace in Samuel Butler's maxim: "Truth does not consist in never lying but in knowing when to lie and when not to do so."]

Patient: Nothing. She's okay. She means well. She dresses a little young. You wouldn't know the label: "Betsey Johnson" [a women's clothing store]. If you knew it, you would know what I mean. Hippy-dippy. It's kind of cute, but not really my father's style. He's sophisticated. He got my mother a lot of expensive jewelry, even though she doesn't wear a lot.

Analyst: Did she appreciate it?

Patient: What?

Analyst: The jewelry.

Patient: I think so . . . . [dead pause]. What?

Analyst: What?

Patient: Nothing.

Analyst: Whenever we begin to look at your parents' relationship, you tend to get quiet.

Patient: We're talking about jewelry.

I again found myself tangled and near a therapeutic precipice. If I continued to play along, saying, "Yes, of course, we're talking

[2] Shakespeare described how one may "credit" or pretend to go along with a "false speaking tongue," utilizing counterfalsification strategically, to establish or advance an alliance—in this case, to give the lover the false impression of youthful naiveté:

> When my love swears that she is made of truth,
> I doe believe her, though I know she lies
> That she might think me some untutored youth,
> Unlearned in the world's false subtleties.
> Thus vainly thinking that she thinks me young,
> Although I know my days be past the best:
> Simply I credit her false speaking tongue,
> On both sides thus is simple truth suppressed.
>
> —Sonnet 138

about jewelry," I felt I, too, would be a phony, and like Elaine, I would be humoring Simone in an effort to win her over. Bion (1970) described predicaments like this one: "The analyst is challenged to accept them [the patient's falsifications], at the risk of showing himself unmindful of the truth, or to reject them and assume the role of being the patient's conscience" (p. 98). The therapeutic goal, which did not seem reachable in the immediate future of my relationship with Simone, was to cut through the dissimulation. But I felt it was essential not to cut her down, punishing her for obdurately refusing to think and feel psychologically, such as by unduly confronting her defensive inconsistencies, denials, and rationalizations.

However, it was difficult not to feel superegoish, as well as not to behave in that manner. I could do little at the moment, other than appreciate Simone for her unconscious ability to put me in the predicament that Bion described. She had not merely a "blind eye" (Steiner 1985), a capacity to avoid her unconscious (even conscious) knowledge of the parental relationship. She could be blindingly, enchantingly concrete and dumbfounding. The situation was hopeless, but not desperate.

Analyst: Okay, I'll play. We're talking about jewelry; before, we were talking about dresses.

Patient: Yes.

Analyst: And before, Thanksgiving dinner.

Patient: Yes.

Analyst: And your father.

Patient: My father's girlfriend. You're interested in my father's girlfriends.

Analyst: I sound pretty shallow. More of a gossip than a psychologist.

Patient: You said it. I didn't say it . . . .

Analyst: I can see how this fits into your theory that this is a waste of your mother's money.

Patient: [She corrected me.] My father's. See, you don't pay attention. [Simone could be quick at catching me at any imprecision, petty or important. This lent weight to my suspicion that, under her antic cloak, she had interest in truth, and was assessing my capacity to represent it.]

Analyst: You caught me. Now you know, I don't pay attention.

Patient: You do enough. [Here she relented.] I don't care if you get his money.

Analyst: You sound a little bit spiteful.

Patient: [She spoke flatly.] You're being psychological. [And then, she wearily preempted my interpretive response with embarrassing accuracy.] No, I'm not angry at you, or at him.

Analyst: I'm so predictable—a good enough useless psychologist. [I smiled, as much to myself as to her. Simone, of course unfamiliar with the Winnicott allusion, assented with a nod. She seemed neither amused nor interested in pursuing the topic of my therapeutic conventionality, which she appeared to take for granted. We returned to talk of her busy Thanksgiving weekend.]

I doubted that Simone fully believed her characterization of my sham professionalism, but we continued as if she did. To link up effectively with Simone's falsity, I had to get on better terms with my own.

THE ANALYST'S FALSITY

Bion argued that any interpretation involves a theory *about* the therapeutic experience, but because interpretations are intellectual, they interfere with what he called *becoming*, which involves the analyst's empathic identification with the patient's difficulties:

achieving the sense of being or becoming those aspects of the patient's problematic self to which attention has been drawn. While to some extent, the analyst seeks to evade becoming, the evasion does not necessarily involve countertransference. Rather, it is a function of the inadequacy of any human being in emotionally—not merely intellectually—embracing painful truth. To "reduce" the level of falsity in the analytic interaction, the analyst must attempt to "see the column 2 [*psi*] element in his thoughts" (Bion 1965, p. 168), as well as in the patient's.

In his groundbreaking work on transference and countertransference, Racker (1968) called attention to *psi* in psychoanalytic culture, theory, and practice, although he did not use the term. He described as *myth* the "analyst without anxiety or anger" (p. 132). Racker found the myth a dangerous one, a remnant of the traumatogenic "patriarchal order" and an expression of "'social inequality' in the analyst–analysand society . . . and the need for social reform" (p. 132).

Jacobs (2001) recently described and gave clinical examples of his self-protective use of an *analytic screen*. His term refers to "situations in which particular needs, conflicts and biases of the analyst, not infrequently rooted in narcissistic conflicts, lie embedded within, and are concealed by, his quite proper and correct interventions . . . derived from well-accepted theory and long-established techniques" (p. 654).

We may understand that Bion's position remains quite radical, in that he asserts that an "ineliminable" (see Louw and Pitman 2001) screen of falsity exists in *all* situations involving human beings: "In any situation where a thinker is present, the thoughts when formulated are expressions of falsities and lies. The only true thought is one that has never found an individual to 'contain' it" (Bion 1970, p. 117). The retreat into conformity and conventionality is not solely countertransference, but, more basically, an aspect of the inadequacy of the human being to tolerate the pain necessitated by bearing truth.

The truth of Simone, as I came to infer and had to patiently learn to accept, was too painful for her to bear and put into words.

Simone could not tolerate confronting the reality of parental neglect and evasiveness, but she herself came to represent these characteristics and to projectively identify them with me. In introducing traumatic themes and illuminating their symbolic currency, I had to consider when and if my interpretations were given in the service of protecting and relieving myself of Simone's insistent projective identifications—"shaking" them out of me and putting my own back on her.

Rather than merely or primarily talking about it, I had to be a part of the narrative and live with the emotional consequences of that. Bion (1965) put the consequences quite dramatically when he said that *becoming* might entail "the feeling that we are on the verge of a breakdown, or some kind of mental disaster" (p. 206). To a significant extent, Simone gave me no other choice but to *become* her projective identification. Smith (2000) identified one source of the analyst's anxiety in such a situation: "The patient allows no room to negotiate his or her image of us, a negotiation that we call interpretation of the transference and that inevitably helps analysts reestablish their own sense of themselves" (p. 114).

Simone arrived with an intuitive notion and active distaste of the analytic screen (Jacobs 2001). However, her notion of Establishment falsity was much larger and included authentic psychoanalytic activity. She found intolerable most of what defines our work—not only transference interpretation, but also construction and reconstruction, character and dream analysis, discussion of family dynamics, and free association.

To *become*, I had to share in Simone's particular form of mental disaster and willingly suspend many psychoanalytic prerequisites. This involved being more inquisitive and well informed regarding the superficialities of her life, and less interpretively active and confrontational. Here are some typical interventions and follow-up questions: "Really! You're kidding—you partied all night!" [Who with? What did you do?] "Aren't you having a Spanish test today?" [What grade did you get? Oh my! How did your friends do?]

"How did you like Aspen?" [You got a new jacket—so, what color? Which trails did you go on? Did you try X restaurant? Who'd you see there?] "What's up for the weekend?" "Who's in that movie, should I see it?"

I gradually relaxed into my degraded relational and clinical status, with less self-recrimination and remorse. I confess that I came to look forward to Simone's confidences regarding the failed marriages of her friends' parents, the rumors regarding the shops and shopkeepers in our suburban town, and, of course, her own intrigues. I became genuinely curious and well informed about her tastes in clothes, vacations, celebrities, cars, movies, music, and so forth, and offered my own opinions. My interest in thinking and formulating waned, as did even my ironic rejoinders (e.g., "okay, I'll play") that attempted to call attention to her bald falsities. So, Simone had found—or "co-created"—a therapist for someone who had no need of therapy.

To my confession, I add that, to the extent to which I could cease and desist trying to function as a "real" analyst, partnering Simone in "wasting" our time, I felt more genuine as a person relating to another person, and realer as a professional. Said differently, in functioning with increased awareness of my clinical dilemma, I crossed over a barrier of professionalism that to some extent was self-protective and thus false.

Simone relaxed as well into our gossipy relationship and, by our third year of work, she ceased calling attention to its failure as "real therapy." Our mundane conversations seemed to reawaken interest in Establishment endeavors, and she began spending her nights sleeping rather than partying. Chatting about the daily activities of an increasingly normal high school life took up more of our time. It went almost unremarked that her grades improved sufficiently for her to say goodbye shortly before leaving for college. Her major and career interest? I doubt it will surprise the reader who has endured long-term therapy of adolescents: psychology!

FALSITY AND THE RELATIONAL LEVELS OF THE CONTAINER-CONTAINED

Bleandonu (1994) suggested that Bion's appellation *psi* likely refers to *proton pseudos*, the "first lie" that Freud (1895) located at the heart of hysteria. Indeed, Freud understood the etiology of neurosis as related to one's lying to oneself. Cure was achieved by catharsis: the patient's finding and accepting the traumatic truth. Freud first attempted to uncover the archeology of his patients' truths through hypnosis, which he later abandoned in favor of the method of verbally articulated free association. Expanding on Freud's methodology, we now understand how associations may be suppressed or disavowed, yet intuited by the clinician, communicated by affect (or avoidance of affect), via gesture, paraverbal behavior (e.g., emphasis, tone, and cadence), dream, metaphor, and connotative meaning.

Bion's extension and important modification of Klein's seminal idea of projective identification has provided a conceptual vehicle for understanding disavowed associations (inter)subjectively. Associations may be inferred from gathering in or *containing* the patient's projections—that is, from consideration of the countertransference. Bion (1961) vividly described how the analyst might feel trapped and "manipulated so as to be playing a part . . . in somebody else's phantasy . . . being a particular kind of person in a particular emotional situation" (p. 149). The analyst must "shake out" the resultant numbing feelings, "to be able to think about and make meaning out of otherwise thought-destroying interactions" (p. 149).

A major shift in Bion's thinking occurred when he came to no longer see projective identification primarily as pathological and interfering with truth seeking. He now conceived of projective identification as a fundamental mechanism of communication, a method of coming to understand and convey emotional truth preverbally or nonverbally. He posited projective identification as a normal and basic mechanism of coming to know self and other, equal to introjection and identification. As with these other con-

structs, projective identification may be understood as a ubiquitous psychological function, and may operate normally as well as pathologically, in such domains as defense, fantasy, or object relations.

The early Bion (1961, 1967) stressed interpretive activity, both to inform the patient of discordant truth and to free the analyst from the patient's numbing projective identifications. The later Bion (1962, 1963, 1965, 1970) developed the rudiments of an intersubjective communicative theory, a tripartite model of the container-contained, based on the preverbal communicative bond between mother and infant. Bion came to emphasize the importance of the analyst's receptivity to pre-rational experience, patience, and inner security.

Bion described how the clinician, using primary process—the capacity to free-associate, imagine, and dream—as well as secondary processes, might gather in and decipher the patient's unformulated or unarticulated experience. The analyst's successful subjective transformations (containing) of the shared experience (the contained) provided the most reliable basis for eventual interpretations. Bion conceived of truth as tentative, an evolving, interactive process of meaning making, and subject to constant revision. The analyst's interpretations were merely current "opinions."

We have come to appreciate that for many patients, the analyst must continue to hold or contain the patient's projective identifications, i.e., "being a particular kind of person" in another's fantasy, without necessarily offering interpretive opinions. In registering the patient's projective identifications, and in responsively modifying the therapeutic stance in relationship to them (Mitchell 1993; Sandler 1976), the analyst offers him- or herself as a transmuted, milder version of the projective identifications. Thus, the analyst's *becoming* allows the patient to detoxify and work through pathological projective identifications (Grotstein 1995, 1999). In this projective-introjective process, the analyst may gradually become established as a trustworthy, thinking object. We may appreciate, then, that containing is not only a vehicle of empathic understanding, but also a way of being with the other and asserting influence.

The contemporary extension of Bion's concept of the container-contained aids the therapist in understanding the psychogenesis of disavowed associations, expressed via projective identifications, and the uses to which these ambiguous and subterranean communications are put in the psychotherapeutic situation to advance or interfere with truth seeking. The model provides a way of thinking about and working with the needs of many patients for noninterpretive activity conveyed via preverbal and paraverbal communication, symbolic play, and certain forms of enactments (Billow 2003a, 2003b).

Container-contained relations may be *symbiotic*, *commensal*, or *parasitic*, described as follows:

> By "commensal" I mean a relationship in which two objects share a third to the advantage of all three. By "symbiotic" I understand a relationship in which one depends on another to mutual advantage. By "parasitic" I mean to represent a relationship in which one depends on another to produce a third, which is destructive of all three. [Bion 1970, p. 95]

As was typical with Bion, he delineated only sketchily the terms and left it to others to fill in the conceptual gaps. Bion's intent was to provide a template that future analysts and generations of analysts could develop and infuse with clinical richness.

Symbiotic Container-Contained Relationships

Symbiotic container-contained communications are first apparent in infant–caretaker relations and continue throughout the life cycle. They provide the "foundation on which, ultimately, verbal communication depends" (Bion 1967, p. 92). Projective-introjective exchanges are communicated gesturally, behaviorally, and vocally. Language and other forms of behavior are utilized primarily to test, establish, or maintain a particular feeling of trustworthy connection. Thoughts and feelings are communicated, although they are not necessarily conscious, well articulated, or put into words.

Symbiotic communications require the thinking presence of both participants, although there may be significant divergence in the sophistication of the thinkers and the extent to which projective identification is relied upon to establish and maintain contact. When successful, one person feels satisfactorily contained by another —that is, recognized, nurtured, and understood, and so, safe. The experience—also profoundly cognitive—is growth producing for both parties.

At the level of symbiotic need, the adolescent, via positive and negative projective identifications, exerts interpersonal pressure on the analyst to carry out many aspects of a psychotherapeutic relationship. Truth seeking at the symbiotic level requires the analyst to maintain a "mindful mind" (Alvarez 1997), that is, to think actively about and to respond strategically to intense emotional reactions that are ambiguously communicated and that evoke the analyst's counterreactions. To contain at this level, the analyst must respond to the adolescent's symbiotic needs, longings, and fears, without mindlessly submitting to them, prematurely putting them into words, or interpreting them.

Commensal Container-Contained Relationships

Commensal relations involve the use of a shared language to represent and think about experience. Symbolic thought serves the functions of containing, i.e., organizing and transforming meaning, and extending to new, abstract levels functions that were once provided exclusively by essential caregivers. In the psychoanalytic relationship, the participants have established a symbiotic level of trust in each other and now rely more prominently on language and thought to deepen relatedness.

At the commensal level, the adolescent is willing to pursue a truth-seeking dialogue with the analyst. A measure of analytic progress is the adolescent's increasing ability to mentalize psychological experience, that is, to process (contain) psychic qualities. This entails "taking back" meaning formerly disavowed and expressed in projective identifications, putting meaning into words, and participa-

ting in truth seeking with the analyst and others. However, in my experience, even after intrapsychic and interpersonal commensal containment is established or reestablished, the adolescent may feel threatened by detailed and consistent exploration of the psychotherapeutic relationship, and thus, a full psychoanalytic dialogue may not be possible.

Parasitic Container-Contained Relationships

The *parasitic* level represents an assault on the container-contained, that is, on thinking relationships and on thinking itself. For the adolescent embroiled in parasitic intrapsychic and interpersonal relations, containing or being contained is experienced as threatening and untrustworthy, and must be deflected, challenged, or destabilized. The goal of communication is to subvert, even to destroy, meaning and meaningful emotional exchanges. The very act of thinking may be hated as a process that confuses and leads to pain; therefore, commensal dialogue is dangerous, since it stimulates thought and ushers meaning. Symbiotic relatedness may be experienced as inauthentic and entrapping, and the individual experiences a good deal of anxiety and little reliable pleasure in empathic contact with self or other.

Parasitic communications may be provocatively direct, as well as subtle and not immediately identifiable. Projective identifications, utilized defensively and pathologically, may be dispatched paraverbally and verbally, in affectively flat or excessive, insistent, or otherwise overly forceful language, in evasive or retaliatory silences, in motor or body action, and in frank acting out, in order to obstruct, evade, and mutilate the truth-seeking process.

In the psychotherapeutic relationship, the analyst must rely on internal cognitive and emotional resources to withstand and respond constructively to the challenges to his or her personal and professional legitimacy. In the face of parasitic attacks, the analyst needs a container for his or her own stimulated affects. The therapeutic frame (Langs 1978) of regulated availability, one's knowledge and training, the clinician's legitimate entitlement to assert limits—all these may contribute to this essential function.

Certainly, to the extent to which the analyst can achieve inner security, he or she can more easily evaluate that which the adolescent is projecting with such destructive intent, and also, what the adolescent dreads to project and therefore to reveal. By maintaining a nonretaliatory "disrespect" (Caper 1997) for therapy-destructive behavior, as well as a caring understanding, in time, the therapist may disarm parasitic communication. Patience must be maintained, with the faith that the adolescent will eventually respond to the inherent need for awareness of emotional experience, and so begin to cultivate longed-for but distrusted symbiotic and commensal relatedness.

The container-contained is a model of a communicative relationship, and, as such, it entails reciprocity. Hence, Bion anticipated the contemporary interest in two-person psychology (Billow 2000). One person does not determine the level of relatedness; rather, it is the pattern of patient communication and analyst response, and the introjective-projective volley between them. Finally, I note that any and all of the three relational modes happen at once and may be represented in seemingly simple communications.

MOVING SIMONE'S TREATMENT FROM PARASITIC TO SYMBIOTIC RELATEDNESS

Simone's parasitic assaults on my authenticity could be indirect and not immediately identifiable. An early clue was her detached, nonchalant disposition, which did not match her exigent situation and reason for being in my office. Like the endangered Hamlet, in critical impasse, she could "speak daggers but use none" (III, iii, 414). Simone threatened to starve me emotionally and numb me intellectually, transporting her projective identifications via bland affect and vacant speech. Thus, there was method in Simone's seemingly nonconfrontational manner of interviewing the interviewer.

Her description of prior clinical contacts was revealing: "I've already seen my guidance counselor and the school psychologist.

They think I have problems and need therapy. I don't. I saw my mother's therapist, she didn't say anything, are you going to be silent, too?" So, one danger was that I would talk too much—or too little. She did not "need" that kind of therapist.

I decoded an ambivalent invitation in her initial exchanges. As Simone put it: "I didn't say I didn't want to be in therapy. I said I had no problems and no need of therapy."

Whereas I understood Simone's distrust, her refusal to let me "play upon" her, I attempted to communicate that I knew she was playing on me. I aimed to establish at the outset that I was not hoodwinked into believing that Simone felt and thought as little as she conveyed. It would have been disastrous to be lulled by the patient into an inauthentically affable posture and to ignore her misleading and subtly provocative behavior. In my experience, even the most cynical and unforthcoming adolescents yearn to break through their silence and establish symbiotic connection. They grudgingly ally with a therapist who addresses their antagonistic falsity and the predicament that necessitates it. Hamlet's yearning for dependable communication echoes throughout the drama, expressed in his mournful final words: "The rest is silence" (V, ii, 368).

Meeting Simone's noncommittal smile with my own, I quickly and spontaneously adopted a humorously skeptical attitude. She was not going to be co-opted by the Establishment, and I was not going to be co-opted by her. My suspicion and distrust mirrored hers; I could be friendly, but not entranced by her friendly posture into assuming that we had or could establish a positive communicative link. My intended goal was to reciprocate an ambivalent invitation. Whereas I did not believe her, perhaps I could come to believe *in* her.

Simone herself had to take a similar journey from skepticism to trust with me. She did not want someone who would presume to define her, her problems, or her needs. She did not trust the reality that an adult could thoughtfully care and respond to her, and hence, why would she believe in the reality of a "real" therapist? My empathic gestures and interpretive forays were met with bland indifference. I was a member of the psychotherapy Establishment,

not truly "bothered" by her unacknowledged anguish, but rather, emotionally indifferent: "This is what you do, you're doing what you're supposed to do . . . your job."

I could not "pluck out" of Simone that which she chose to hide and protect; I could not make her speak (Shakespeare, III, ii, 379-ff). To engage in something approaching a meaningful dialogue, I would have to come up with the "right" questions, yet veer away from anything that smelled too much like therapy. I would have to find a way to represent moral principles without being moralistic, and therapeutic principles without being unduly or relentlessly therapeutic.

I grasped that it was essential to call attention to her parasitism: her unstated wish to have me participate in her falsifications. I had to learn to show her—and to accept emotionally—that to further a symbiotic bond, to some extent, I would participate. This entailed relaxing my psychoanalytic conscience, and becoming a (seemingly) superficial object of Simone's internal and external world. For, when I was being sincere and doing my job, as traditionally psychoanalytically defined, I was reinforcing her belief in adult falsity, and most often she blocked out those who did this. When I submitted to her pressure not to do my job, not to be "psychological" or a real psychologist, but to exchange small talk and gossip, she became less guarded, livelier, and affectively more available.

It was not easy to modify my professional stance. I could not and would not withhold feedback when Simone responded to my questions with tales of risky behavior. I remained openly troubled by the recurrent incidents of parental hurts and disappointments. I felt the seriousness of Simone's disavowed agony regarding her father's affair and philandering, and her loyalty conflict as she observed her mother's situation. Hearing the metaphors of displaced interpersonal and internal conflict, the idealizations and losses, tried-on identities, and so on that were embedded in Simone's accounts of peers, boyfriends, and would-be stepparents, I had to control my commensal urges—that is, my wish to interpret, to be helpful, to clarify, to inform. In drawing attention to her recurring dilemmas and their meaning, I had to consider that I might be

trying to relieve my own agony, whether or not I would succeed in relieving hers.

The window of interpretive opportunity with Simone would open but briefly. With humor, sarcasm, nonverbal as well as verbal acknowledgment, I attempted to bring to the fore—to our mutual consciousness—the reality of her negative feelings. These feelings and related fantasies about me were often expressed via her projective identifications of my mental vacancy, insincerity, or rigidity. I felt encouraged that the therapeutic relationship offered something new and valuable whenever Simone tentatively or explicitly criticized me—"You don't listen," "You're [just] doing your job"—or when she protested openly, "You're being psychological." My "kingly conscience" may be sullied with falsity, professional and otherwise, but unlike Hamlet's adversaries or Simone's parents, I was not averse to bringing this view of me to our mutual attention, putting this perspective into words, and accepting without protest that it could be right.

In other words, to contain Simone and to move her from parasitic to symbiotic and then to commensal levels of relatedness, I invited her projective identifications and encouraged her to stay with them mentally and linguistically, rather than merely to discharge them and withdraw. However, these exchanges, lively and important as I believed they were, were intermittent and short-lived, marked by retractions, denials, shifts of emphasis, and sudden and frequent withdrawal of interest and affect.

Simone effectively blocked commensal communication. There was no progressive, insight-oriented, verbally articulated exploration of transference-countertransference configurations. She forcefully resisted "awareness of an emotional experience," rebuffing entry into areas of her mentality, particularly when it threatened her with a realistically ambivalent view of the figures in her life, leading to an open acknowledgment of her anger and disappointment in them.

She repeatedly retreated to more primitive modes of relatedness, somewhere on the parasitic-symbiotic continuum. However, the therapeutic relationship was not without meanings. Our inter-

play, her vacant nonchalance, and her subtle and not-so-subtle put-downs expressed symbiotically (i.e., enactively) the disavowed emotional experience in which we alternated in roles of truth seeker and deceiver, abandoner and abandoned.

Bion drew attention to mutual falsity in certain types of analytic enactment scenarios, and he advised the analyst to "reduce" it. To reach this goal with Simone, I first had to aid her in exercising projective identifications. I had to embody and not shuck off her conviction that all adults are false. In participating in Simone's fantasy, we could both hone and lessen its substantiation.

To work through trauma, to achieve a "loosening of the infantile object ties" (A. Freud 1958), and to unblock development, the adolescent patient may need to reanimate early emotional involvements and ego positions, including fantasies, as well as pathological coping and defensive patterns (Blos 1967). I am suggesting that, at times, the analyst must join the patient in the reanimation process.

Blos (1979) recommended a similar use of the therapeutic self, which he referred to as *guided acting out:* "A carefully chosen concretization, introduced by the therapist, may substitute for symbolic speech" (p. 295). In contemporary terms, a therapist-facilitated enactment may provide "a bridge . . . to perceptions and affects that had not advanced to word representation or were excluded by them by either ego arrest or dissociation" (p. 296). Whereas Blos wrote that this type of interventionist modality was inspired by "highly personal predilections, intuitive, empathic and identificatory" (p. 302) responses of the analyst, he might agree that symbolic concretizations are mutually created and regulated.

Simone had inspired a kind of creative therapeutic response that Symington (1983) described as *an act of freedom*. Stern et al. (1998) referred to the process interactionally as a *now moment:* "The current state of the 'shared implicit relationship' is called into the open, . . . [forcing] the therapist into some kind of 'action,' be it an interpretation or a response that is novel relative to the habitual framework" (p. 911).

Bion emphasized that symbiotic relations provide a foundation for verbal thought, that is, for higher-level commensal thinking

and relating. While Simone refused to engage in a conventional psychoanalytic dialogue in which unconscious and preconscious meaning was gradually revealed and understood, she came to participate symbiotically. To some extent, this provided the basis for her treatment to be considered a successful analytic experience, wherein developmental arrests are unblocked, pathological acting out is decreased, and constructive social participation is resumed. We may infer that Simone began to utilize her capacity for commensal relating, as evidenced by her significant improvement in school performance, evaporating interest in antisocial thinking and behavior, and age-appropriate life choices and goals. Thus, enactments in the psychoanalytic relationship may provide the impetus for the emergence of more mature modes of engagement and experience (Davies 1999; Hoffman 1992; Jacobs 1991; McLaughlin 1991).

FROM SYMBIOTIC TO COMMENSAL RELATEDNESS: TREATMENT OF SIMONE, TEN YEARS LATER

"Hi, this is Simone," she said on the telephone, nearly ten years from our last conversation. She was unhappy and did not know what to do, and her mother suggested that she call. Could I see her soon? She was working for her father's business and commuting to New York City. He had married Elaine, and had a child whom Simone enjoyed. She wished to be on her own; becoming a school psychologist or guidance counselor remained an option. But her immediate problem was her husband, William, a young stockbroker whom she had married shortly after college. "All my friends were getting married, and I liked Will. I still do." She started to cry. "I don't know if I love him, and he complains about me. I don't want to hurt his feelings. He loves Mookie [her dog] so much."

Although sad for her, I was pleased that she could feel feelings —for herself and for another person—with a depth that I had not previously experienced in her. Apparently, she had not either, for she reported that she had not cried or spoken about what was on

her mind, not even to herself. But there was little pretense in this consultation, or in the twice-weekly individual sessions that followed, as Simone began to explore what she was feeling, mostly in relation to William. Why had she married him? Who was like him in her past? What made her happy/unhappy with him? Were there other men she felt different with? One of her high school friends made her laugh—maybe him, she was not sure, and she felt guilty when they phoned each other.

Intermittently, William joined us. He was pleasant, if rather humorless, and only vaguely interested in his own psychology. More important to him was correcting the marital problems, for he wished to buy a home and start a family. These were Simone's professed goals, too. William felt Simone was not interested in him or in being with him. "She lights up when she is with her friends from high school, but not with me." Simone acknowledged that he was correct. She could not or did not explain further, and instead proffered for the first time the falsifying smile from her adolescence.

Simone remained quiet, which I assumed was due to the newness of the marital consultation, but she continued to sink into the background in subsequent joint sessions. In our individual work, we began to explore how and when she hid and avoided being herself, and how it replicated her childhood and adolescence, as well as mirrored her mother's marital nonresponsiveness. We touched on her father's abandonment, and she agreed that she did not want to do to William what was done to her. But, to a striking degree, in the second therapy as in the first, Simone seemed uninterested in the possible effects of her parents' breakup on her development or present situation. However, rather than accusing me of being psychological, she politely gave nodding acceptance to my interpretations and directed us back to her pressing concern: "What should I do?"

Again, I had to readjust my analytic orientation and goals, relax, and first allow her to define the relationship. Then I could consider how she wished to use me and why, and the extent to which I would "play." Simone now could feel some of her negative

feelings, but they caused her confusion, pain, and guilt, and she wanted me to make her feel "nicer" (her word) and to repair her marriage. While I sympathized with her wishes—and respected that she could state them so directly—I offered no hope that, without her participation, I could fulfill any of them.

Whereas in the earlier therapy, I had to accept my being an untrustworthy object, in this therapy, I could challenge her desire to put all her trust in me. That is, I did not predominately accommodate her symbiotic wishes by taking on a role defined by her projective identifications. I offered interventions that encouraged her to function commensally, that is, to put her emotional experiences into words, such that we could both think about them. I affirmed that when she would come to articulate her own feelings, which she could no longer pretend not to feel, she would make constructive decisions. "But I don't seem to feel anything for William," she countered, quite sensibly, "that's my problem." How different this was, I reflected to her, for now she knew and could communicate that her lack of feeling signaled the presence of problems, rather than their absence. It became clearer to Simone that she wished to separate.

"You tell him," she pleaded. "I'm afraid to hurt him."

"But why would it hurt less if I told him?" I inquired.

"I can't do it."

Simone's unresolved conflicts around aggression, apparent in her need to protect William as well as herself from her negative feelings, had contributed to an increasingly false marriage. As she became more confident and emotionally expressive, and certainly less depressed, William began to assume that they were progressing with shared goals. He listened to Simone's feedback, and genuinely tried to respond to her tentative offerings of dissatisfactions and complaints. But the therapy was producing a false impression. While Simone expressed interest in addressing her marital difficulties with me, she reported no desire to continue to do so with William. We now knew that she was living a marital charade. Once again, I was entering into a deception orchestrated by the patient.

I explained the dilemma to Simone, and she was concerned, for she did not wish to mislead William. "That's why you have to tell

him," she begged. We compromised: we would tell William together. "You begin," she insisted.

At the following marital session, I shared my concern that William might be getting an unintended message about where the marriage seemed to be heading. I reiterated the obvious, that the couple did not communicate clearly or directly with each other, and that it would be harmful if Simone did not do so now.

William made it easier for the three of us, for he asked Simone if she was thinking of ending the marriage. She replied with a timid "yes." William bristled and expressed annoyance that Simone had not let him know sooner, and he turned angrily to me. I explained that it took Simone some time to become clear, and what made it so difficult was that she did not want to hurt him.

"I want to be your friend," Simone interjected. They both began to cry, and in short order, they began to discuss how to proceed. For the first time in the marital therapy, they were working together.

CONCLUSION: TWO TREATMENTS ON DIFFERENT RELATIONAL LEVELS

Blos (1963) differentiated between two types of acting-out adolescents, distinguished by different developmental levels and the therapeutic techniques they responded to. In both, the adolescent's sense of reality has been disturbed, due to parents who "falsify by word or action the reality of events to which one of the child's senses was a competent witness" (p. 261). In the more primitive type, which characterized the younger Simone, the adolescent denies ambivalent feelings toward primary objects and seeks re-merger via magical control (i.e., projective identification) of the external world. The adolescent remains concrete, does not respond to interpretive activity, but requires a therapist-inspired, "guided acting out."

In the second type, which came to characterize the older Simone, the individual is more compulsive and conceptual, and is capable of establishing a sense of historical reality, temporal ego

continuity, and meaning. As the adolescent remembers and puts memories into words, he or she no longer has to repeat (Freud 1914). In terms of the concepts advanced in this paper, Blos's two types correspond to the respective parasitic-symbiotic and symbiotic-commensal ends of the container-contained relational spectrum.

Throughout Simone's first therapy, I periodically offered interpretations, and while I cannot say what effects, if any, they might have had internally, Simone would not engage verbally. Therefore, it was necessary to think differently about how to advance the therapy. What proved effective was my thinking about our communications in terms of notions of the container-contained, in helping her progress through the three levels—from parasitic to symbiotic and finally commensal relatedness.

Simone entered therapy with the belief that all adults are false. It was necessary for me to become a sham in behaving as a psychological therapist, and thus an ironic personification of adult falsity. But by not insisting on my Establishment-sanctioned or professional-role prerogatives, I was able to become a good enough "bad" object that Simone became engaged in the process between us.

Thus, my falsity allowed access into her world, such that we could proceed from a parasitic relationship to a symbiotic one. In this therapy that preceded her college years, Simone established a preverbal foundation of trust, allowing her to retire many of her parasitic tendencies. My containing Simone involved efforts to intuit what she was feeling, to verbally formulate her emotional thinking (and mine), and to accept her evacuations and falsifications of these thoughts and feelings, which contributed to our symbolic enactments.

We developed a shared language, but we did not clear an analytic path leading to an ever-more-direct communication within the therapeutic relationship about Simone's disillusionment and distrust. We progressed close to a "Dear-Diary" or best-friend sort of relationship, openly embracing concrete but not abstract meaning making. Simone remained uncomfortable during the few instances when she acknowledged positive or negative feelings about the therapy, our relationship, or me.

I believe our first interlude of psychotherapy succeeded because Simone and I created and tolerated a benevolent balance of truth and falsity. She had learned what Hamlet could not: that not all Establishment falsity is toxic. She had built up a sufficient mental representation of me as a trustworthy symbiotic partner to respond unambivalently to her mother's suggestion to call me when she found herself in trouble again.

While she had bonded sufficiently to me and other Establishment figures to participate constructively in college life and her endeavors thereafter, Simone had difficulty thinking for herself and being on her own. There were consequences to her remaining symbiotic and failing to establish secure commensal relations. She married a man whom she did not talk to nor think with. This type of empty emotional relationship caused her sufficient pain to return to treatment.

In the first therapy, a blasé Simone conveyed the impression that she was doing me a favor by tolerating my presence and responding to my questions. She falsified, and I had to play along. In initiating the second treatment, an anxious, sad, and needy Simone questioned me: "What should I do?" She entered therapy feeling guilty and paralyzed, which seemed partially a defense against her aggressive impulses, which were not being directly expressed in any open exchange with her husband.

To some extent, Simone's helplessness falsified, by keeping her from connecting deeply to her husband or herself. At the same time, her unguarded impatience and frank desire for me to do her thinking and feeling were refreshingly different in their emotional honesty, and thus encouraging. Simone was openly immature and dependent at this inauguration of therapy, providing us both with a clear and realistic view of who and where she was in her development.

Simone began her second psychotherapy ready but not quite willing to function commensally, that is, to contain her thoughts and endure the process of self-conscious emotional thinking. She did not want to reflect on her situation, and I again had to think about how to contain her wishes not to think and how to trans-

form the relationship, such that she could exercise and satisfy her "need for awareness of an emotional experience" (Bion 1962, p. 56).

While Simone required my thinking presence—which involved my being inquisitive, emotionally reflective, and to some degree interpretive—she did not need me to think for her, although she attempted to make me feel that she did. She did not relinquish symbiotic wishes easily, as when she requested that I do her work with William, but she could tolerate my challenging her wishes. As she released me from her projective identifications—in which I was the object of all her trust—she discovered that she was able to find her own truths, make rational decisions based on them, and tolerate the consequences. Bion (1965) listed among the consequences of *becoming* the painfully high price one has to pay for increased self-consciousness: "becoming 'responsible' and therefore guilty" (p. 164). In facing William and in accepting the truth—the reality of her feelings—Simone suffered the unavoidable psychological turbulence that accompanies a responsible marital parting.

I felt a pang when Simone announced that she wanted to stop treatment and try it on her own in New York City. She seemed clear in her mind, speaking without much apprehension. Certainly, she knew that our work was not complete, and I wondered if, once again, I was going to be left to contain what Simone did not want to feel. During the following weeks, she took comfort from the truism that her life would involve unknown risks as well as possibilities, but I did not share this sense of comfort and continued to express my concern.

"I know where you live in case I need you," she commented warmly at the end of our last session. I then felt reassured, for I believe a mark of successful therapy is reached when containing is reciprocated. Simone addressed my separation anxiety gracefully, without rubbing it in my face. Her parting words represented sophisticated commensal communication, then, sparing the two of us from confronting all the truth that was at our disposal, without being false. To my ears, Simone was also acknowledging that there was much unsaid meaning in the room that remained

to be articulated and analyzed, should she appear for a third analytic interlude.

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SAYING THE RIGHT THING AT THE RIGHT TIME: A VIEW THROUGH THE LENS OF THE ANALYTIC PROCESS SCALES (APS)

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Skillful psychoanalytic technique presumably involves knowing what to say, and when and how to say it. Does skillful technique have a positive impact upon the patient? The study described in this article relied on ratings by experienced psychoanalysts using the Analytic Process Scales (APS), a research instrument for assessing recorded psychoanalyses, in order to examine analytic interventions and patient productivity (greater understanding, affective engagement in the analytic process, and so on). In three analytic cases, the authors found significant correlations between core analytic activities (e.g., interpretation of defenses, transference, and conflicts) and patient productivity immediately following the intervention, but only if it had been skillfully carried out. Findings were independently replicated by psychology interns.

INTRODUCTION

How to measure psychoanalytic processes remains a problem more than a hundred years after the invention of the procedure of psychoanalysis. Many psychoanalysts continue to question the value of systematic, empirical research in our discipline. They believe that

measuring and assessing their work would not only be intrusive and distorting, but would ultimately fail to capture the uniqueness of analytic interventions, which are often tailored to subtle changes in patient, analyst, and the relationship between them. They also fear that research might understate the effectiveness of psychoanalytic therapy. In addition, most analysts object to tape-recording their work for research purposes, in part because they feel it would violate the relationship with the patient. However, the lack of sufficient systematic study of this therapeutic procedure has reduced its acceptability to a broader scientific audience, and has reduced the possibility of comparing it systematically to other treatments, in turn contributing to a reduction of public support. It may also have slowed its internal development, since the accumulation of systematic knowledge may lead to discoveries improving the efficacy of psychoanalytic treatments.

SUMMARY OF THE LITERATURE

The problem of how to measure the relationship between treatment process and benefit is shared by the fields of psychoanalysis and psychotherapy. There have been a number of prior studies of the immediate effects of interventions on the patient or the process, such as those of Garduk and Haggard (1972), Malan (1976), O'Malley, Suh, and Strupp (1983), Luborsky et al. (1989), and Gedo and Schaffer (1989). However, the quality of interventions has generally not been assessed in studying immediate or long-term effects, in part because methods for such assessment have not been sufficiently developed.[1] In a review published in a National Institute of Mental Health bulletin, Borkovec and Miranda (1996) pointed out that: "Despite initial attempts for some types of therapy, there is no valid way to measure quality for any therapy technique" (p. 15).

However, several promising lines of research address the quality of analytic technique. Jones and colleagues (Ablon and Jones

[1] In this paper, we use the term *quality* to refer to clinician judgments of the way the comments of the analyst or therapist may be expected to affect the patient, including the aptness of the intervention's type, the potential usefulness of its content, and the skill and tactfulness of its presentation (see Appendix 2, p. 1116).

1998; Jones and Pulos 1993; Jones and Windholz 1990) have reliably characterized the nature of the therapist's approach to the patient. They make a clear distinction between psychodynamic and cognitive-behavioral features, demonstrating that the former correlate with successful outcomes while the latter do not, in *both* a sample of patients treated by psychodynamic therapy and another treated by cognitive-behavioral therapy. This finding was based upon measuring the techniques used by the therapists without attempting to measure their quality. *Quality* was measured in an interesting small study by Glass et al. (1989), which demonstrated a substantial relationship between skillful dynamic exploration and outcome in schizophrenia.

The studies carried out by Joseph Weiss, Harold Sampson, and colleagues have significantly contributed to assessing the quality of interventions (Weiss, Sampson, and the Mount Zion Psychotherapy Research Group 1986). In their view, interventions need to conform to the patient's plan for therapy, that is, the patient knows at some level what help is needed, and tests (purposefully, though not consciously) the therapist's ability to provide it. If the therapist intervenes in a way that is "pro-plan," the patient improves (Norville, Sampson, and Weiss 1996). This group of researchers has been very careful in supporting their claims with evidence, derived primarily from audiotaped psychoanalyses and psychotherapies.

Two other sets of investigations provide more indirect approaches to quality. Dahl (1988, 1991) has shown a relationship between interventions that address patterns of repetitive maladaptive emotion structures (called FRAMES) and the substantial reduction of those patterns, so that the quality of interventions can be assessed by how accurately the patient's FRAMES are addressed. Similarly, Luborsky and colleagues (1988, 1998) have demonstrated a relationship between addressing Core Conflictual Relationship Themes (CCRT) and benefit.

Caston, Goldman, and McClure's (1986) study of the effect of interpretiveness on the patient's insight and boldness assessed central psychoanalytic concepts with high reliability. It showed a significant impact, comparable to findings we report here, which we will refer to again in our discussion.

We believe that our group has taken an important step by developing an instrument, the Analytic Process Scales (APS), that makes it possible to study the impact of the quality of analysts' interventions on patients' immediately subsequent analytic productivity. Elsewhere, we (Waldron et al. 2004) describe our working conceptualizations of the psychoanalytic process as they evolved in the course of developing the APS and coding manual, eventually finding expression as APS variables. A distillation of these ideas defines the psychoanalytic process as a special interactive dialogue between patient and analyst, aimed at lessening the patient's emotional conflicts, suffering, and dysfunctions. If the procedure is successful, the patient communicates increasingly unconstrained and affectively expressive associations and reflections (which we consider to be a productive response to the analyst's communication). The analyst contributes to the conversation from time to time with requests for elaboration, with clarifications, interpretations, or support, aimed at facilitating the patient's communications and transforming the patient's awareness. Mindful of the patient's self-esteem and immediate emotional focus, interventions approach conflict, transference, and resistance.

In the unfolding interaction between patient and analyst, connections between the present, the past, and the analytic situation emerge. These aspects are illustrated in Appendix 2, p. 1116, which presents two variables from the APS Coding Manual that are used to assess the productivity of a patient's communication and the quality of an intervention.

METHOD

Development of the Analytic Process Scales (APS)

A review of the APS and its development will permit the reader to understand our findings and assess the validity of our claims.[2] Our group of mostly New York-based, experienced psychoanalysts has

[2] This research was supported by grants from the Research Advisory Board of the International Psychoanalytic Association. Patrick Shrout, recent chair of the Department of Psychology at New York University, provided important statistical consultation, both in the early phase of the project and in the evaluation and presentation of the results.

spent the past eighteen years devising the means to assess tape-recorded psychoanalyses in a way that reflects clinical psychoanalytic features as closely as possible, while inevitably limited by the perspectives each of us brings to psychoanalytic work. Our research group is led by Sherwood Waldron, Jr., and includes as directors Anna Burton, Shuki Cohen, James Crouse, Stephen Firestein, Fonya Helm, David Hurst, John Lundin, Seymour Moscovitz, Robert Scharf, and Kenneth Winarick.[3] Five of us are full-time practitioners, each with more than thirty-five years of clinical experience; and Dr. Crouse is an experienced social scientist and a professor of sociology and educational studies who has played a central role in evaluating our data. Our other directors have a special interest in research. We have aimed at studying the nature of psychoanalytic interventions, the nature of the patient's contributions, and the relationships and interactions between them. We tried to use methods that would avoid problems encountered by previous investigators. We studied only the work of experienced analysts and used only highly experienced analysts as raters for our initial studies. We tried to choose central, unambiguous, experience-near process features of both patient and analyst, and defined our variables in the language of the clinical surface.

From early in the project, the study of recorded psychoanalytic sessions led to sufficient clinical agreement among us that we were able to start developing scales for assessing the contributions of patient and analyst to the analytic work.[4] We found that if we eval-

[3] Marianne Goldberger also participated in our work for several important years. Shuki Cohen, Fonya Helm, and Seymour Moscovitz joined our group since this work was accomplished, and have contributed to the thinking and writing of this paper.

[4] In developing our instrument and methodology, we used recorded cases provided by Lester Luborsky of the Philadelphia analytic study group, whose work presaged our own, as well as sessions from the case of Mrs. C, a psychoanalytic treatment that has been widely studied by other researchers. We are indebted to Hartvig Dahl, the custodian of the recordings of Mrs. C. We have also studied recorded analyses from the archives of the Psychoanalytic Research Consortium (PRC), a nonprofit organization formed under the direction of Drs. Waldron, Firestein, and others to collect such recordings, preserve them under safeguarded conditions, and make them available to qualified researchers. The PRC is fully described at our website: http://www.psychoanalyticresearch.org.

uated one session without understanding its context, our views were as discrepant from one another as those reported by Seitz in his classical paper (1966) or by Vaughan et al. (1997). However, we discovered that if we listened to two or three sessions immediately preceding the one to be rated, in order to establish a better understanding of how the patient–analyst pair was working together, we found our views converging, which in turn served as the basis for developing reliable ratings of central clinical variables.

In addition to clinical experience and theory, we drew upon previous psychoanalytic and psychotherapy research to formulate variables for the Analytic Process Scales. These include the Psychodynamic Intervention Rating Scale, or PIRS (Cooper and Bond, unpublished; Milbrath et al. 1999); the Vanderbilt Psychotherapy Process Scales, or VPPS (O'Malley, Suh, and Strupp 1983); the Therapist Verbal Intervention Inventory, or TVII (Koenigsberg et al. 1988; Koenigsberg et al. 1993), and the Psychotherapy Process Q-Set (Jones and Windholz 1990). We were also influenced as time went on by our exposure to the Adult Attachment Interview (AAI) and the conceptualizations of the linguist Grice (1975), as cited by Main (1996)—particularly the four characteristics of coherent and collaborative discourse in persons manifesting secure attachment. Such discourse adheres to four maxims: quality ("be truthful, and have evidence for what you say"), quantity ("be succinct, yet complete"), relation ("be relevant or perspicacious") and manner ("be clear and orderly") (Main 1996, p. 240). We were also familiar with Bucci's (1997) four somewhat overlapping features as components of Computerized Referential Activity (CRA), the degree to which speech was clear, concrete, specific, and contained images (p. 167).

Dividing a Session into Clinically Meaningful Segments, Rated by the APS Variables

The long process of devising variables, testing them on new recorded material, and repeatedly revising them led to the development of eighteen variables assessing the analyst's contribution and fourteen assessing that of the patient, selected to track elements

central to psychoanalysis and psychodynamic therapy—for the patient and the therapist as they vary during the course of each session.[5] To accomplish this, we developed a reliable procedure for segmenting sessions into psychoanalytically meaningful units for rating, permitting us to study the impact of one participant on the other as each session unfolded. Our procedure for segmenting was a modification of that described by Stinson et al. (1994).

The segmenting of each session is fundamental to understanding the results reported here, because we are then able to estimate the impact of one participant upon the other in a sequential way. Essentially, all speech by each participant is contained within a segment, and segments are usually categorized as either patient segments or therapist segments. Division between segments is frequently located at the point of a change in speaker, resulting in an analyst segment and a patient segment. When there is a rapid exchange between patient and analyst, a segment may include several changes of speaker and is rated for both analyst and patient variables. The interaction between analyst and patient is studied by looking at the relationships between the patient and analyst variables studied over time. The segmenting procedure usually leads to about eight to thirty segments per session, and each segment is rated on the clinical variables applying to that segment.[6]

The APS Coding Manual

The APS Coding Manual (Scharf et al., unpublished) defines and illustrates each variable to be rated (see Appendix 2, Sections 1 and 2, pp. 1116-1122). Brief clinical examples illustrate ratings at the levels of "0," "2," and "4"; the intermediate levels of "1" and "3"

[5] Readers wanting more details may visit our website, and/or refer to our paper describing the APS and its development in more detail (Waldron et al. 2004). Although we focus our discussion on analysts and the analytic method of therapy, the APS is designed to evaluate all psychotherapeutic work derived from a psychoanalytic perspective. The APS Coding Manual is also available for downloading from our website, at http://www.psychoanalyticresearch.org.

[6] Further details, including data documenting the excellent reliability of the procedure in our hands, are reported in Waldron et al. (2004).

are left to the judgment of the rater. Each example is designed to be easy to read and to remember. In the course of years of examining scoring differences among our group members, we have refined our illustrations and instructions to raters. Our inter-rater reliability has steadily improved, and we have now achieved a satisfactory level on virtually all our variables. Moreover, we have found that analysts need only brief training to achieve reliability using the manual.[7] As little as one rating hour has sufficed for training, followed by a discussion with a senior investigator, during which the new rater's scores are compared with those of senior raters. We have found comparable levels of reliability for junior clinicians after a series of meetings with our investigators to discuss interventions and patient response. In the data we have presented here, each APS score is the mean of the scores of four trained raters.[8]

In the current study, the central patient variable studied in relation to the analyst variables was patient productivity, measured as progress either in response to the analyst's intervention, or from the patient's own momentum. Raters were instructed to score a segment as "0" when they could not find progress in understanding, in involvement or collaboration in the analysis, or in the nature of other developing emotional responses; as "2" when there was moderate progress in the depth and breadth of understanding, in emotional involvement and collaboration in the analysis, or in the nature of other emotional expressions; and as "4" when the patient made strong progress. Each of these points on the scale is illustrated with clinical examples (see Appendix 2, p. 1116, for coding manual definition and examples of this variable). *The patient's productivity immediately following each rated analyst intervention provided the central outcome variable (dependent variable) in this study.*

The analyst variables fall into three clusters. The first, *intervention quality,* comprises two variables: one measures how well the

[7] Full reliability scores with both senior and junior clinicians are reported in Waldron et al. (2004).

[8] The ratings reported here were made during the development of the coding manual, while the exact phrases and definitions were still evolving toward greater clarity. The nature of these changes was such that they would not be expected to materially affect the findings reported in this paper.

analyst follows the patient's productions, and the other measures the overall quality of the intervention.[9] The second cluster, *core analytic activities,* measures the degree to which the analyst clarifies, interprets, and focuses on resistance, transference, and conflict. The third cluster, *affective involvement,* measures how much the analyst is confrontational and expressive of feeling.

Intervention quality averages the ratings of the following two variables:

1. *Following the patient* assesses the degree to which an intervention follows the analytic surface by focusing on the patient's most experience-near issues. It often determines the success of the analyst's effort to communicate with the patient. For example, to what degree does the analyst follow meaningful affects (including negative affects, such as anxiety, guilt, or low self-regard) and the patient's moment-to-moment defenses?

2. *Good intervention* is a more global rating of the aptness of the type of intervention, the usefulness of its content, and the skill of presentation, including tact, timing, and verbal appeal.[10]

For the second cluster, *core analytic activities,* we assess five items: *clarification, interpretation,* and their major aims—addressing *defense, transference,* and *conflicts.* The raters estimate the degree to which each of these analytic activities is present, specifically disregarding the aptness or skill with which they are employed. Each of these elements is rated independently of the others, so that, for example, a given intervention could be rated "4" for clarification, "2" for interpretation, and "0" for addressing transference.

[9] A third variable has been added since these data were collected: the coherence of the analyst's remarks in the segment with other interventions. This variable is not further discussed in this paper, however.

[10] Those readers interested in understanding in more detail our coding manual definition of good intervention, with examples to illustrate scale points, may review it in Appendix 2, pp. 1116-1122.

1. *Clarification* is rated according to the degree to which attention is called to insufficiently noticed surface features and how they may be psychologically connected.

2. *Interpretation* is rated according to how well the analyst's intervention aims at transforming meaning by bringing aspects that are outside of awareness into full awareness.

3. *Addressing resistance* (or defenses operative in the session) is rated as the degree of focus on any measure the patient takes to avoid experiencing objectionable impulses, affects, thoughts, or fantasies. A psychological feature performing a defensive function may simultaneously serve drive, moral, or adaptive purposes. To be scored, addressing resistance must be manifest, or, if inferred, it must be easily identifiable by the rater and most analysts. Raters score the apparent aim of the intervention, not whether they agree with the analyst or therapist that defenses are present in the patient's communication or the skill with which they are addressed.

4. *Addressing transference* is rated by the degree to which the patient's reactions to the analyst or to the analytic situation are pointed out. This score increases with the amount of complexity and detail, which may include similar, prior responses to the analyst or other persons.

5. *Addressing conflicts* is rated by the degree to which the analyst focuses on the patient's conflicts in the segment —impulses or affects and their feared consequences or resulting moral concerns—and the connections between any of these, including related fantasies and memories.

The third cluster, *analyst's affective involvement,* is assessed by averaging the following two variables:

1. *Confrontation* is rated by the degree to which the intervention introduces a special emphasis, urgency, or re-

iteration to point out that the patient is denying, avoiding, or minimizing an issue at the psychic surface. Raters are to disregard whether the confrontation seems constructive or harmful and score only for emphasis and urgency. The confrontational aspects of an intervention may be conveyed by tone of voice as well as content, making it essential to listen to a recording.

2. *The contribution of the analyst's feelings* rates the degree to which voice quality and verbal content convey the analyst's emotions, regardless of whether such emotional expression seems to encourage or to interfere with the analytic work.

Encouragement of elaboration is separate from the three analytic intervention clusters and refers to the analyst's request that the patient expand on what he or she has been relating. The request may be general ("Can you tell me more about that?") or specific ("What comes to mind about the car emerging from underwater in the dream?").

The Patients Studied

This report is based upon the study of three treatments with three different analysts. They were initially studied to facilitate development of our scales, providing different treatment approaches and levels of clinical work. From perusal of several hours from each case, we estimated clinically that one patient had done relatively well; another appeared to be deadlocked after 660 sessions; and the third was chosen as a good representative analytic process.

Although we make no claim that the sample is representative of all analyses, there were no systematic biases in selecting the sample, except that only patients who had agreed to be audiotaped could be included. The cases were chosen as a matter of convenience, to provide us with material for developing our APS. The sessions for the first two cases were chosen from the very beginning, the middle, and a few weeks before the end of the treatment, with no oth-

er selection criteria except that the sessions be from a complete week of analytic work. The first case was chosen because it was already transcribed, and the second because it was from a different analyst than the first. The third case, by yet another analyst, was chosen to extend the sample for purposes of further refining our instrument.

Patient A2 was a young, agoraphobic housewife and mother whose symptoms improved considerably in the course of her 300+-hour, four-times-weekly analysis, which became a twice-weekly treatment as termination approached. Despite her improvement, her analyst thought she would have benefited from further work. Our raters concurred. Generally, they thought that the analyst–patient interaction was negatively influenced by the male analyst's imposing presence, toward which the patient seemed unusually compliant. They also thought that the analyst emphasized transference analysis in ways that were often not meaningful or useful to the patient. Despite this, the analyst seemed sensitive and attuned to the patient in ways that she appreciated and responded to positively.

Patient V4 had serious difficulties in relationships, including distancing himself from women. His initially positive reaction to this, his second, male analyst gradually gave way to a sense of alienation and feelings of being misunderstood. The analyst became increasingly frustrated and appeared to blame the patient for his failing marriage and faltering treatment, which ended after 660 hours. The analyst was rated as very confrontational and emotionally expressive. The confrontations seemed to become increasingly hostile. An absence of effective or meaningful interpretations of the pair's antagonistic relationship may have undermined the possibility of more productive analytic work.

Patient U8 was a married man experiencing relationship problems, who had left a previous analysis because he felt too distant from the analyst. The present, two-year analysis with another male analyst (about 400 hours, four times weekly) addressed ways in which he kept himself removed from others, including spouse, children, and his present and previous analysts. Positive changes occurred in both his analysis and his life. His analyst's contributions

aimed at conflict and defense, and the analyst was unusually active. This analysis was seen as a partially successful effort to break through the patient's wall of isolation and passivity.

The sessions from this third case were the only ones available from it, and came from the very end of that treatment. These were the only sessions rated using the APS; no other sessions were excluded from the sample. The data come from recorded sessions drawn from the eighteen cases then in the collection of the Psychoanalytic Research Consortium (Waldron 1998).[11]

The Raters and Their Training

The raters in the initial study were all experienced analysts (>35 years), trained at psychoanalytic institutes where the so-called American ego psychological viewpoint tended to predominate. Of course, their points of view about clinical work had altered through the experience of many years of practice following training. These raters participated variably in the creation of the instrument, developing a degree of shared understanding about the variables. However, all ratings of each of the sessions in the study were independent; that is, raters did not discuss amongst themselves their views of the particular session rated until after ratings were completed, nor were they privy to the case summaries provided above. Raters also did not know what followed each segment of the session at the time they rated that segment, and were not permitted to change ratings retrospectively.

The purpose of the replication study was to determine whether the relationship found in the initial study between intervention quality and patient productivity, reported later in this paper, would also be found if patient productivity were assessed by psychology interns who were blinded to the analysts' interventions during the session to be rated. These trainees had enrolled at the Karen Horney Clinic for their internships because of its reputation for teach-

[11] The recordings came from the collection of the Psychoanalytic Research Consortium (PRC). (See footnote 4, p. 1083.)

ing psychodynamic psychotherapy, which was a particular interest for each of them.

The training and data collection that took place with the Horney interns occurred as follows: Kenneth Winarick, the training director, met with the interns as part of their regular academic experience for several weeks, in order to familiarize them with the APS Coding Manual, a 78-page document that defines and illustrates the 32 analyst and patient variables constituting the APS. Following this initial familiarization, the interns were trained in the use of the APS via a sample session. Next, the interns read and listened to two complete sessions immediately prior to the session to be rated, to establish context (the same procedure undergone by the original senior raters). Then they rated separately each of the nine sessions studied, using the APS variables assessing patient functioning (the analyst's remarks having been deleted) and e-mailed their scores to Dr. Waldron.

Dr. Waldron prepared a printout of each response, showing the four raters' scores on each variable, along with the average score of the four senior raters for each segment and variable. These printouts were studied and discussed in detail in meetings among the interns and Drs. Waldron and Winarick. In order to sustain interns' interest and sense of continuity, the senior investigators read to them the actual interventions as the session was reviewed, which had been omitted while they accomplished their ratings. The discussions tended to be lively, and the students appeared to become engaged in the process of clarifying their own thinking about the treatments, leading to a sustained sense of involvement, despite their being blind to the analyst's remarks at the time of the rating.

STATISTICAL ANALYSIS OF THE DATA

The APS variables were chosen and defined to produce measurable differences between scores on each variable. These scores constitute the basic data of this study. Our statistical approach was developed in ongoing consultations with Patrick Shrout, a statistician

who has been instrumental (together with others [Shrout and Fliess 1979]) in developing the intra-class correlation coefficient used in this study. We also became aware of the utility of the multiple regression procedure when James Crouse, a social scientist and professor, joined our group.

We consistently check for relationships between the clusters of analyst intervention data and patient productivity scores. We also check for consistency of relationships between the individual analyst variables and patient productivity scores, to ensure that individual patterns are not being lost or concealed by aggregating the variables. Then, by the method of partial correlation, we hold constant the effect of differing analyst–patient pairs, to determine that any relationship found between analyst variables and subsequent patient productivity is true when examining each analyst–patient pair individually. Finally, by the method of multiple regression analysis, we hold constant the effects of the other variables, in order to discover the contribution of each individual analyst intervention variable to immediate patient productivity. In the replication study, we used the senior analyst scores on analyst variables and the psychology interns' scores on the patient variables, applying the same analyses as in the initial study.

To briefly review and elaborate, we remind the reader that we rated nine sessions from three psychoanalyses drawn from the collection of the Psychoanalytic Research Consortium (Waldron 1998). Four sessions were taken from early, middle, and late in a 324-hour analysis; three were selected from early, middle, and late in a 660-hour analysis; and two were drawn from the end of a 388-hour analysis. The nine sessions produced a total of 123 segments rated for the analyst variables, and 117 segments rated for patient productivity.

The data are arrayed to show analyst intervention scores in relation to patient productivity scores from the immediately prior and the immediately subsequent patient segments. This permits us to follow events of the session from two reciprocal perspectives: how the analyst's activity affects the patient's work, and how the patient's

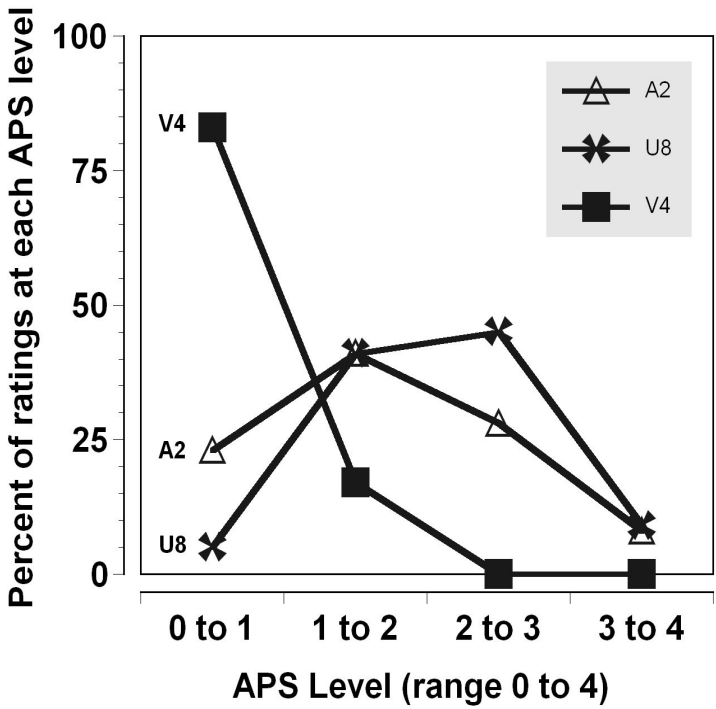
work facilitates the analyst's activity. When the patient becomes more productive, the analyst may be able to make higher-quality remarks, demonstrate better core analytic activity, and become more involved, so that any increased productivity following an intervention might result not only from the intervention itself, but also from the patient's productivity in the previous segment (as was demonstrated using similar measures in the Caston, Goldman, and McClure [1986] study). Since subsequent patient productivity might reflect *both* the patient's previous productivity *and* the analyst's intervention, we assessed the relative influence of these two factors using the method of multiple regression.

RESULTS

We report here the results based upon the ratings of senior analysts, with replications for certain central findings based upon patient productivity scores generated by Karen Horney Clinic psychology interns, who were blinded to analyst interventions. In our first study applying the APS (Waldron et al. 2004), we found differences between the analytic activities of the three analysts, differences in the patient's functioning within each session, and differences in the interaction between analyst and patient. In this paper, we will focus particularly on findings related to ratings of quality of interventions.

Figure 1 on p. 1095 reveals considerable variation in the quality of intervention within each analysis, as well as substantial differences among the analyses. We have arranged the quality scores along the horizontal axis, increasing from either "0" or "1" (the lowest level of quality) to "3" or "4" (the highest levels). For each of the three patients, the percentage of segment scores at each level of intervention quality is charted on the vertical axis. Inspection shows that 30% of interventions scored below "1," 64% between "1" and "3," and only 6% either "3" or "4." The striking differences among the patient–analyst pairs support the clinical impressions derived from reading the clinical summaries of the cases. For example, more than three-quarters of the segment scores for intervention

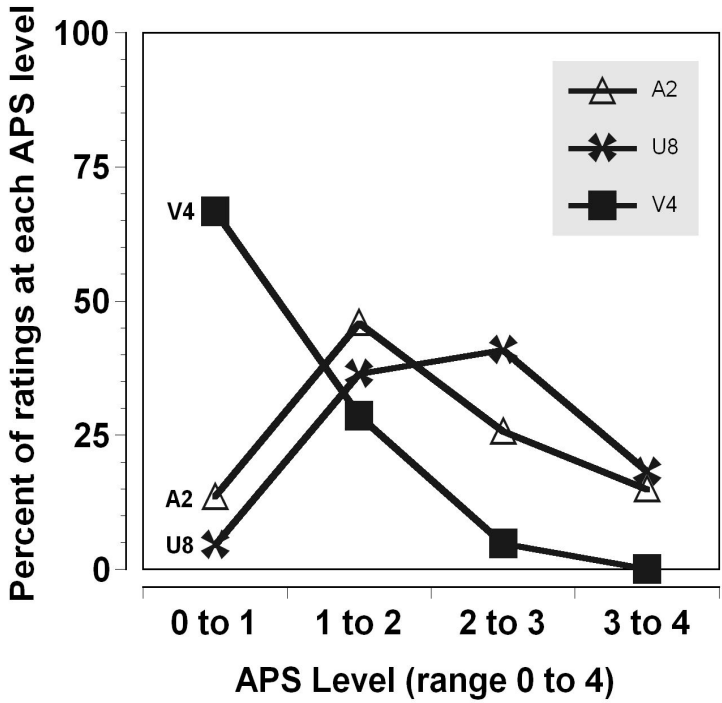
FIGURE 1: quality of analyst communications by case (123 segments from 9 sessions conducted by 3 different analysts)



quality fall below "1" for the case designated V4—a case viewed as problematic by the raters.

In the two cases viewed clinically as more successful, only 7 and 8% of interventions, respectively, were scored "3" to "4," while the seemingly unsuccessful case, V4, had no interventions at these levels. It is possible that high-quality interventions predict benefit even when they constitute a relatively low percentage of the total. However, a much larger sample will be necessary to examine the relationship between successful treatment and infrequent but high-quality interventions.

FIGURE 2: patients' productivity (117segments from 9 sessions conducted by 3 different analysts)



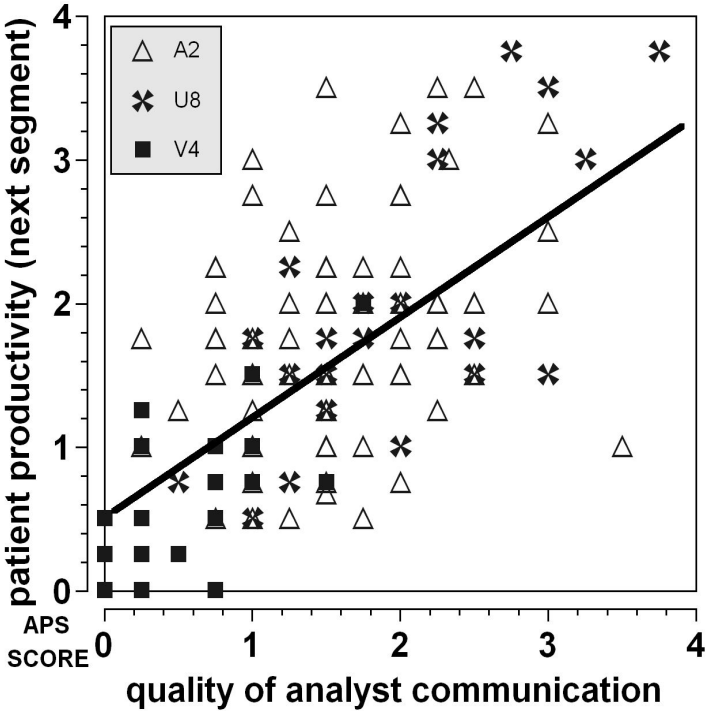
The percentage of segments falling at different levels of patient productivity is graphed for each patient separately in Figure 2, above, in a way similar to that of Figure 1. The congruity of the curves of Figures 1 and 2 may demonstrate the mutual influence of patient and analyst, and suggests that each participant may not be able to achieve a high level of work without the other's also doing so.

We next consider the relationships between the core analytic activities utilized by the analysts, the quality of these interventions, and the patients' responses in the next patient segment in the three treatments. (The correlation matrices may be found in Appendix 1, Table 1 on pp. 1112-1113, and the column and row numbers in

what follows refer to this table.) One potential problem in studying correlations between these variables is that such a correlation might be an artifact of differences among patient–analyst pairs, and might not represent changes in productivity *due to* specific interventions. For example, a spuriously strong correlation could appear if both analyst quality and patient productivity were consistently high for one patient–analyst pair, medium for a second patient–analyst pair, and consistently low for a third patient–analyst pair. To protect against such misleading results, we used the statistical procedure called *partial correlation,* which holds the influence of patient–analyst pair constant. When we calculate the partial correlation of the mean core analytic activity (averaging level of clarification, interpretation, analysis of resistance, transference, and conflict for each segment) with patient productivity in the next segment, there is a modest but significant correlation of 0.25 (see Table 1, row 3, column 1, pp. 1112-1113). Among the partial correlations of each individual core analytic activity with patient productivity, only analyzing resistance (r = 0.22, row 6, column 1) and analyzing conflict (r = 0.37, row 8, column 1) are significantly related to subsequent productivity. The reader will recall that these assessments of core analytic activities are made without considering the quality of the intervention, which is rated separately.

Continuing an examination of the results of our partial correlation procedure while holding patient–analyst pair constant, we find intervention quality to be moderately correlated with immediately subsequent patient productivity (r = 0.44, row 2, column 1). Also, previous patient productivity has an important influence on the intervention quality that follows (r = 0.43, row 9, column 2), which illustrates how much the analyst's work may depend on the patient's contribution. Finally, subsequent patient productivity is related to previous patient productivity (r = 0.49, row 9, column 1), showing that the patient's work has its own momentum as well. We have, therefore, found that the *quality* of the interventions is more strongly correlated with patient response than are the core analytic activities, when either combined or examined singly.

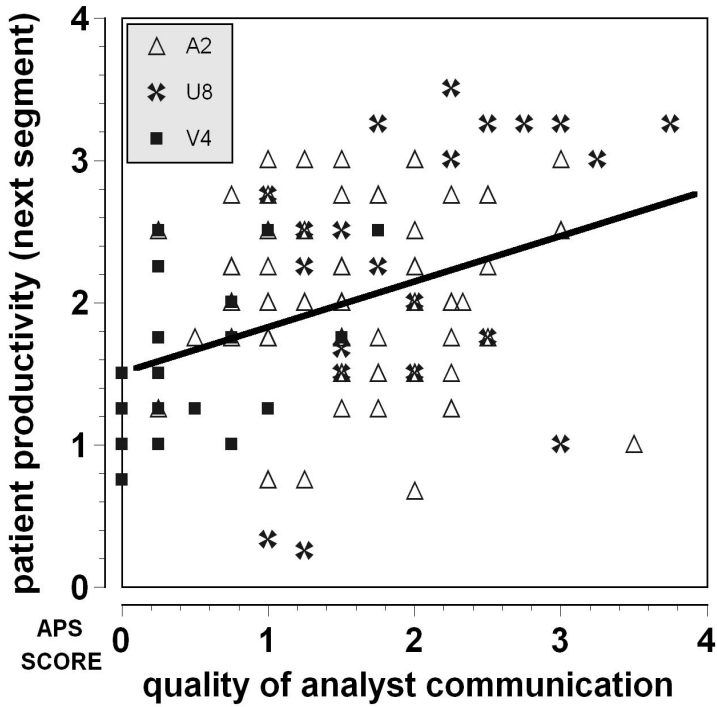
FIGURE 3: Relationship between quality of intervention and next segment patient productivity
(117 segments from 9 sessions conducted by 3 analysts)



In Figure 3 above, we have demonstrated in another way the degree to which quality analytic interventions are related to patient productivity by graphing the analyst's intervention against the patient's response. For each of the three analyses studied, the points are clustered along the straight line shown, and the relationship between the two variables is directly proportional.[12]

[12] Each graphed symbol in the figure represents a pair of scores for one segment: on the horizontal axis, the value for the quality of the analyst's intervention,

FIGURE 4: Quality of intervention rated by senior analysts vs. patient productivity rated by blinded interns
(same 9 sessions as in Figure 3)



and on the vertical axis, the score for the patient's productivity in the immediately subsequent segment. The markers in the figure are different for each patient–analyst pair; thus, the pattern of correlation between these two variables can be seen for each of them. Close inspection of the figure shows that each patient–analyst pair had a strong correlation between these two variables (and all were statistically significant), although the patient designated as A2 had somewhat lower values than the other two. The corresponding B scores for quality of intervention in relation to analytic productivity were .333 for A2, .894 for U8, and .846 for V4 (see footnote 10, p. 1087).

This relationship between the analyst's intervention and the patient's response is present in each analyst's interventions compared to that patient's immediately following segment, indicating a consistent relationship between quality and productivity for each of the three cases in this sample.

Note the absence of markers in the upper left quadrant of Figure 3. If these patients were sometimes successfully carrying on their own analyses with little help from their analysts, we would find a number of markers in this area. Similarly, the lower right is virtually empty, indicating that there were no very high-quality interventions followed by an absence of productive work.

Figure 4 on p. 1099 represents the same comparison as Figure 3, except that the scores on patient productivity are those of the psychology interns who were blinded to the interventions of that session. The relationship between intervention quality as judged by senior analysts, and patient productivity as judged by blinded interns, continues to be significant, as can be seen for each patient separately on the scatter-plot diagram.[13] Thus, a bias on the part of the senior raters in favor of patient responses to interventions favored by these raters does not account for our findings.

Statistical multiple regression analysis was applied to examine which elements in the analysts' interventions were most strongly associated with subsequent patient productivity (see Appendix 1, Table 2, Equations 1 through 9, p. 1114). Multiple regression is a procedure that tests the degree of association between what are called independent variables and a variable that is hypothesized as perhaps dependent on these other variables. In this study, patient productivity in the next patient segment following an analyst segment was the dependent variable, and we measured the associa-

[13] For the statistically inclined, the correlations between intervention quality and immediate patient productivity (next segment) were highly significant, even though the level of correlation was less when scores from the interns were used ($r = 0.64$ for Figure 3; $r = 0.34$ for Figure 4).

tion between this productivity and five APS variables or clusters of variables.

We have already described the correlations with patient productivity of (1) core analytic activities and (2) the quality of interventions. We also measured (3) the degree of the analyst's involvement in each segment (by averaging the degree of confrontation and the degree to which the analyst showed feelings that contributed to or shaped the intervention in the segment), and (4) how much encouragement of elaboration occurred in the segment. Finally, we measured (5) previous patient productivity. These five *independent variables* were entered into a multiple regression procedure that determined how much each variable was associated with subsequent patient productivity—*when the other four independent variables were held constant statistically* (see Appendix 1, Table 2, p. 1114).

The results show that, among the four predictor variables derived from the analyst's activity, only the quality of intervention has a strong association with subsequent patient productivity when the other variables are held constant. Each one-point increase in intervention *quality* is associated with an average increase of six-tenths of a point in subsequent patient productivity (B = .616 in Appendix 1, Table 2, Equation 2, and a correlation [beta] of 0.59), a clinically significant effect.[14] *This strong relationship between quality of intervention and patient productivity is the central finding of our work to date and the major focus of this paper.*

To review, quality was assessed by averaging two variables with four major features: the degrees to which the intervention followed the patient's immediate focus, was suitable in the type or

[14] The B score may be unfamiliar to most of our readers. It has a particular property that makes it important and worth understanding. The size of the B score directly indicates how much change will occur in any variable in response to a one-point change in the variable upon which it is dependent. In our study, we have found, for instance, that as intervention quality increases by a whole point on the APS, patient productivity in the next segment increases by six-tenths of a point. This is indicated by a B of .616 in Appendix 1, Table 2, Equation 2, p. 1114.

blend of types of intervention, was apt in content, and was delivered with skill. Among the other analyst variables, only the core analytic activities proved importantly related to immediate patient productivity (B = .477, Equation 4), and even this significant relationship is dependent on the quality of interventions (the B drops to .037, a negligible value, in Equation 5, when the quality of the intervention is held constant).[15]

Thus, multiple regression analysis demonstrates that the averaged core analytic activities of clarification and interpretation, as well as the analysis of transference, resistance, and conflict, have a substantial correlation with immediate patient productivity, *but only if these activities are carried out with high quality*.[16] The reader may well wonder whether the individual core analytic activities differ from one another in regard to the crucially important quality of the intervention. Further multiple regression analyses of the data showed that the quality of analytic work remained centrally important in affecting patient productivity for each of the five core analytic activities taken individually, just as it had for the five averaged together, as shown in Appendix 1, Table 2, p. 1114.[17]

So, in this preliminary study, the quality of the analyst's intervention—reflecting attunement to the patient, choice of content,

[15] The B scores are not significant for analysts' affective involvement in Equation 6 or for encouraging elaboration in Equation 8. These findings can be tentatively interpreted as showing that, in this sample, (1) the analyst's affective involvement does not have a negative impact on patient productivity, and (2) encouraging elaboration has no particularly positive impact on patient productivity, any more than do any other aspects of interventions.

[16] The B score of the regression between the core analytic activities variable and subsequent productivity in Appendix 1, Table 2, Equation 4 (.477, highly significant) drops essentially to zero (.037) if the quality of the intervention is held constant, as it is in Equation 5 (see p. 1114).

[17] We ran five multiple regressions, as in Equation 2, of productivity on quality, for each of the individual core analytic activities in place of the value for the five core analytic activities averaged together. In each regression, the coefficients for quality were very close to the .616 of Equation 2. Therefore, we omit these tables here (although they may be obtained from the senior author).

and aptness and skill of the intervention—was the analyst variable most strongly related to observed patient productivity in the ongoing therapeutic relationship. This was true whether the intervention was predominantly an interpretation or clarification, and whether or not the analyst approached transference manifestations, defenses, or psychological conflict.[18]

We have also examined the degree to which the quality of the analyst's intervention depends on the level of the patient's productivity that preceded it. We would expect that, when a patient delves into matters of psychological importance, this productive process tends to develop momentum that carries over through multiple segments. Such a pattern of relationship between current level and immediately prior level is quite typical of complex, evolving phenomena sampled over time, such as the historic stock market.

And indeed, as mentioned earlier, we found that prior segment patient productivity correlates with both the analyst's intervention quality (0.60) and subsequent segment patient productivity (0.62). Our multiple regression analysis allowed us to determine the relative contributions of intervention quality and prior patient produc-

[18] The reader may wonder how this statement can be understood in relation to Appendix 1, Table 1 (pp. 1112-1113), which shows that core analytic activities are only moderately related to immediate patient productivity. What our multiple regression analysis has shown is that no particular individual core analytic activity shows a consistent relationship to immediate patient productivity *apart from its quality*. The explanation must take into account that the quality of an intervention is, after all, the quality of something being done. And the activities being done by the analyst *may* be well described as core analytic activities, done with more or less quality, as earlier presentation of our results has shown (Waldron et al. 2004). Multiple regression analysis also shows that, among the three sets of variables—(1) core analytic activities, (2) the analyst's affective involvement, and (3) encouragement of elaboration—only the core analytic activities set of variables has a significantly positive association with subsequent patient productivity (see the B score in Equation 4 versus the B scores in Equations 6 and 8). This demonstrates that core analytic activities *do* show a moderate degree of relationship with the patient's immediately subsequent productivity in this sample, when these activities are studied separately from the quality of interventions.

tivity to immediately subsequent patient productivity (Appendix 1, Table 2, Equation 3, p. 1114). We found that about half of the relationship between intervention quality and subsequent patient productivity was accounted for by the patient's prior level of productivity; that is, when the patient had been more productive in the segment prior to the analyst's intervention, the analyst made a higher-quality intervention, and the patient continued to be more productive. But the other half of the relationship was a direct one between intervention quality and subsequent patient productivity, independent of prior patient productivity. This degree of direct relationship implies an important causal connection, unless another explanation for it emerges.[19]

We next asked how much of the variation in patient productivity had been accounted for by our variables. It turns out that differences in analytic productivity across segments are only 46% accounted for by the variables we have measured, together with the momentum of the process itself.[20] Thus, despite the significant effect of intervention *quality* and prior patient productivity on later patient productivity, more than half of the differences in subsequent productivity remain unexplained by our variables. We believe this is expectable in view of the complexity of the process we are assessing and the often-delayed impact of interventions.

In view of the close relationship found between the quality of intervention and immediate patient productivity, we must examine whether this could be accounted for by rater bias. Confirma-

[19] In more formal language, controlling prior segment productivity reduces the effect of intervention quality from Equation 2 to Equation 3 by (.616 - .338)/.616 = 45%. This means that 45% of the effect of intervention quality in Equation 2 arises because it is correlated with the patient's prior segment productivity, whereas 55% of the relationship found is a direct effect of the quality of the intervention on subsequent segment patient productivity.

[20] The percentage of the variance in subsequent patient productivity accounted for in this study by intervention quality, core analyst activities, affective involvement, elaborations, and prior patient productivity is indicated by the adjusted R squared of .462 in Equation 3. Thus, 46% of the variance has been accounted for.

tion bias could incline our raters to find the productivity that they thought should follow a good intervention in the patients' responses. Our replication study allows us to make a definitive test of confirmation bias by recalculating the regression analysis expressed in Appendix 1, Table 2, p. 1114. Recall that this analysis demonstrated that for each one-point increase in intervention quality, subsequent patient productivity increased by six-tenths of a point. When we recalculate this using patient productivity scores as rated by the blinded Horney Clinic raters, we find a less strong relationship, but one that is nevertheless statistically highly significant. Patient productivity increased by one-third of a point for every one-point increase in intervention quality.[21] This result further affirms a meaningful relationship in this sample between intervention quality and patient productivity.

We also studied the relationship between scores for intervention quality and patient productivity of the next several segments following a given intervention, because our clinical experience led us to expect that the impact of an intervention may not become evident immediately. Indeed, the multiple regression for intervention quality and patient productivity continued to show a statistically significant relationship to the fifth segment following a given intervention.

DISCUSSION

We report here the application of a newly published research tool for the investigation of psychoanalyses and psychodynamic therapies, the Analytic Process Scales (APS). The APS allows us to investigate psychoanalyses and psychotherapies by studying aspects of each case in a way that is both statistically reliable and clinically valid. The variables serve to delineate cases using central psychoanalytic

[21] When controlling for prior patient productivity, as we did in the earlier analysis of the data—but this time using the Horney rater scores—we found that the B score in Appendix 1, Table 2, Equation 3 (p. 1114) declined only slightly, from .34 to .26. It was still statistically significant ($p = .011$).

concepts. We have demonstrated that experienced clinicians can agree on the nature and quality of interventions, once they are sufficiently familiar with a case. Because the APS assesses the nature and quality of interventions sequentially throughout an hour, we have been able to examine their effects on subsequent patient productivity in the very next segment of the hour. The reliabilities we have achieved in assessing core psychoanalytic dimensions provide a basis for optimism about systematic studies of psychoanalytic process with suitable analytic data. The problems of achieving consensus in evaluating analytic treatments are not insurmountable, and can be resolved by methodological innovation and the participation of experienced clinicians (Caston 1993; Caston, Goldman, and McClure 1986; Caston and Martin 1993; Rubovits-Seitz 1992; Seitz 1966).

We have discovered that the strongest analyst variable influencing patient productivity is the quality of the intervention that preceded it, rather than the specific type of intervention. This indicates that, in our small sample of three patient–analyst pairs, attunement to the patient's present state, the choice of an effective intervention, and its timing and tactfulness are most important to the progress of the analysis—refuting any suggestion that interpretation in general is necessarily more helpful than clarification, or that analysis of transference is necessarily more helpful than analyzing resistance. The *quality* of the analyst's contribution of any kind, so long as (s)he says "the right thing at the right time," is the essential element. We do not dispute the major importance of interpretation, but with these three analytic pairs, we conclude that the other core analytic activities seem equally important, and that none is very effective unless of high quality.

A reader might gain the impression that we think there is only one "right thing" that can be said at any given time. In this respect, the title of our article could be misleading. However, we tentatively believe that clinician judges are very aware of choices made in interventions, including tactfulness and timing of any given commu-

nication by analyst or therapist, and that it is these aspects that are reflected in the ratings of quality. Less idiomatically expressed, we respect the positive impact of the analyst's *saying a right thing at a right time.*

Most clinicians already assume the clinical truth of what we have found, but researchers have largely been unable to demonstrate the effects of differences in treatment approaches to patients, much less the impact of differences in the *quality* of these approaches. Sequential analysis of the evolving contributions of patients and analysts or therapists provides a tool that can disentangle these varied contributions, as we have outlined in a recent paper (Crouse et al. 2003).

We have been able to find strong evidence for the role of the patient's previous productivity in facilitating the analyst's making a high-quality intervention. This empirically supports the contention that there is a complex interdependence in the dialogue between the analyst and patient. We have accounted for one-third of variations in patient productivity in the immediately subsequent segment, reflecting the varying quality of core analytic activities of the analyst and the patient's own productivity in the previous segment. These constitute substantial findings, since psychoanalytic treatments are extremely complex emergent systems (Kauffman 1995; Palombo 1999; Waldrop 1992). Since the consequences of any intervention are multiple and often delayed, this degree of immediate relationship implies an important causal connection.

Relevant findings were obtained in a similar study (Caston, Goldman, and McClure 1986), in which the raters of patient response were blind to the interventions. Here Caston and colleagues used segments chosen on the basis of a coherent unit of patient material immediately following each intervention (p. 288), similar to our patient segments. In that study, one variable, *insight* (as defined in the article's Appendix 18, pp. 387-391), is approximately equivalent to our *patient productivity* variable. A separate group of judges rated the interpretiveness of the interventions, a meas-

ure that approximates a blend of our variables for the analyst's clarifying and interpreting (see description of scale anchor points in Caston and colleagues' Appendix 14, pp. 377-379). With blind judges, these researchers found a correlation between interpretiveness and insight of .30 (p. 291), similar to our own findings of a .22 correlation of clarifications with productivity and a .26 correlation of interpretation with productivity (see our Appendix 1, Table 1, pp. 1112-1113). The Caston, Goldman, and McClure study eliminated possible bias that could stem from rater reaction to the analyst's prior remarks, and ultimately provided a convergent line of evidence to support our findings.

The results of the present study were not anticipated by the participating clinicians. The most strongly held belief of this group of psychoanalyst raters at the outset of the study was that immediate patient productivity would be most enhanced by interventions rating at least moderately high for interpretation. Yet the correlation between the degree of interpretation and patient productivity was quite low (0.14 in Appendix 1, Table 1, pp. 1112-1113, when the patient–analyst pair was held constant), and this relationship was no longer significant when the quality of interventions was held constant. One central requirement of a scientific procedure is that hypotheses can be disconfirmed by evidence (Grünbaum 1984), and the APS is an effective tool for such disconfirmation of hypotheses about the variables of treatment process and their impact in different treatments.

A central requirement for application of the APS is respect for the need of clinician raters for a reasonably full context. This is supported by Rubovits-Seitz (1998):

> The anchor point for interpretations is not strictly empirical, but depends on a network of interdependent and continuously modifiable interpretations . . . thus, there is no satisfactory way of interpreting a segment of clinical data in isolation from the contexts (including other interpretations) that precede and follow it. [p. 213]

Raters' knowledge of both patient's and analyst's prior comments contributes to our study's strength: we have achieved reliability on our clinical measures and can claim validity *based upon careful attention by expert analyst judges to the meanings of the exchanges between patient and analyst, where context is indispensable.* It should be noted that our psychoanalytic raters assessed the work in each segment without knowing what followed. We may then state that psychoanalytic interventions of *quality* lead to greater patient productivity in this small sample. That expert judges appear able to sense which interventions are likely to be beneficial to the patient in the short term probably reflects the impact of expert knowledge that may be difficult to verbalize, and is reminiscent of the burgeoning recent work on implicit memory and procedural knowledge. This finding, if replicated on wider samples, may lend further support to the value of clinical wisdom in conducting psychotherapy and psychoanalysis.

It may be asked why the relationships reported here have not emerged from earlier studies. In *Reassessing Psychotherapy Research* (1994), Russell provides a cogent discussion of the limitations of previous approaches to assessing relationships between intervention and benefit. For example, he shows how efforts to correlate the use of interpretation to patient benefit are bound to fail because the requirement of effective therapy is to make interventions attuned to the requirements of the patient at a particular moment in time. A well-attuned therapist will make very different interventions with patients, depending on the individual patient's needs and degree of resistance at the moment. This flexibility of technique cannot be measured using simple correlational research techniques, based upon simple hypotheses of what contributes to therapeutic benefit (Wampold 1997).

In contrast, the APS ratings, anchored by a manual with examples, reflect many of the complexities of clinical judgment in regard to interventions that are actually made by a treating analyst. We conclude that the only way to judge whether a given interven-

tion is appropriate and helpful (of high quality) is through the lens of psychoanalytic understanding. How widely this may obtain in the broad field of psychotherapies is a question awaiting further research.

What, then, are the major limitations of this study?

1. We have not established, even preliminarily, whether high-quality interventions are correlated with *treatment outcome*. The APS variables have a built-in potential to measure outcome when applied from early to late in treatment. Positive changes observed in patient functioning in the analytic situation from early to late in treatment are expected to reflect improved functioning in general, but the degree of relationship remains to be established. What will ultimately be required are investigations of the relationship (or lack thereof) between a psychoanalytic or psychotherapeutic process characterized by frequent high-quality communications from the therapist and productive psychoanalytic work by the patient, on the one hand, and follow-up assessments of quality of life (Seligman 1995), on the other. Successful outcomes are the only gold standard for evaluating treatments.

2. It is clear that a *clinical evaluation* of analytic work, which is necessarily non-experimental in nature, cannot rule out rival explanations of findings to the degree that may be achieved in some other areas of science (Rubovits-Seitz 1998). We maintain that this does not invalidate our results, but does give reason for caution in generalizing from our findings. The heuristic value of the APS measures can only be determined by their ultimate utility in generating a pattern of useful findings.

3. The small size of our sample—117 analyst interventions and patient responses from only three patient–analyst

pairs—limits the generalizability of the results. A larger sample of recorded analytic work from other patient–analyst pairs is needed.

Our investigation of the quality of treatment may turn out to represent another way of examining elements addressed by the Boston Change Process Study Group (CPSG) researchers, who have studied change from the vantage point of the moment-to-moment interaction—what they call *the local level* (Nahum et al. 2002; Stern et al. 1998). The emphasis of this group is upon the co-construction of the relationship, which they believe provides the opportunity for changes in *implicit relational knowing*—changes at a level that may correspond with Bucci's (2000) *non-symbolic* and *nonverbal symbolic* levels of information processing. The intricate detailing of how the analyst's moment-to-moment response to the patient can facilitate such positive developments through participation with the patient has been conveyed in an example from a child analysis (Nahum et al. 2002, pp. 1054-1055).

One consequence of these considerations is a proposed change in terminology. It has been customary to speak in terms of the analyst's *interventions*. This term may not imply the subtle, ongoing interaction that can lead to special *moments of meeting*, impacting the degree of *fittedness* between the two participants in treatment—terms used by the CPSG to describe important dimensions of treatment. The analyst's contribution is certainly reflective of his or her implicit relational knowledge, in regard to each moment with each patient. It seems to us preferable to describe *the analyst's contribution* and *the patient's contribution*, in order to more truly reflect this complex interplay. We believe that our clinician raters have responded to this complexity in assessing the quality of the contribution of the analyst from moment to moment, and it is most likely because of its importance that we have found a strong relationship with the very next patient contribution.

* * * * * * * * *

Appendix 1, Table 1: Correlations and Partial Correlations of Variables *

Standard correlations are above the diagonal; partial correlations holding analyst–patient pair constant are below.
The most important comparisons with our clustered variables are in the double box.
The single box shows correlations of the various individual core analytic activities.

	next segment pt. productivity	intervention quality	core analytic activity	analyst clarifies	analyst interprets	analyzes resistance	analyzes transference	analyzes conflict	prev. segment pt. productivity	analyst involvement	encourages elaboration
next segment pt. productivity	(1.00)	.61	.41	.22	.26	.35	.29	.49	.62	(.04)	(.13)
intervention quality	.44	(1.00)	.69	.56	.55	.47	.53	.67	.60	(.06)	(.05)
core analytic activity	.25	.62	(1.00)	.68	.85	.74	.86	.89	.36	.40	(–.24)
analyst clarifies	(.08)	.50	.64	(1.00)	.40	.39	.54	.54	.25	.22	(–.30)
analyst interprets	(.14)	.49	.83	.32	(1.00)	.54	.67	.74	(.20)	.29	(–.25)

analyzes resistance	.22	.38	.70	.33	.50	(1.00)	.47	.70	.39	.49	(–.16)
analyzes transference	(.16)	.46	.83	.48	.63	.38	(1.00)	.65	(.18)	.36	(–.16)
analyzes conflict	.37	.57	.87	.46	.69	.69	.59	(1.00)	.48	.28	(–.12)
prev. segment pt. productivity	.49	.43	(.19)	(.11)	(.07)	.24	(.01)	.37	(1.00)	(.11)	(.17)
analyst involvement	(.07)	.21	.50	.31	.37	.48	.40	.41	(.16)	(1.00)	(–.21)
encourages elaboration	(.03)	(–.10)	(–.36)	(–.39)	(–.32)	(–.24)	(–.25)	(–.21)	(.09)	(–.22)	(1.00)

*** Correlations appear in parentheses if p > .05.** Correlations in this table are Pearson correlations, which can range from –1.00 if the two variables are perfectly inversely related, to zero if there is no relationship, to +1.00 if there is a perfect positive correlation. Three standard correlations, above the diagonal, are no longer significant when controlling for analyst–patient pair: these three pairs of boxes are lightly shaded. Any correlation above .24 is significant at the .01 level or higher. N = 117 for full correlations that included the patient productivity variables, and n = 123 for analyst variables with each other. For the partial correlations, degrees of freedom equal 113.

Appendix 1, Table 2: Regressions of Next Segment Patient Productivity on Analyst Interventions and Prior Segment Patient Productivity: N = 117 Analyst Segments (With Complete Data on All Variables)

	Independent Variables						
Equation	Intervention Quality	Core Activity	Affective Involvement	Encourage Elaboration	Prior Pt. Productivity	Constant [1]	Ad. R2 [2]
1. B [3]	**.644					.490	.370
beta [4]	.613						
2. B	**.616	.037	.008	.102		.388	.364
beta	.586	.031	.006	.111			
3. B	**.338	.095	–.088	.048	**.395	.301	.462
beta	.322	.081	–.063	.052	.403		
4. B		**.477				1.080	.159
beta		.408					
5. B	**.660	.037				.491	.365
beta	.628	.031					
6. B			.058			1.569	–.007
beta			.042				
7. B	**.645		–.010			.495	.365
beta	.613		–.007				
8. B				.118		1.486	.008
beta				.129			
9. B	**.639			.093		.402	.375
beta	.608			.101			

Notes on Appendix 1, Table 2

** Designates "B" coefficients significant at $p < .01$.

1. "Constant" represents the intercept of the slope on the y-axis. Since the y-axis represents the intervention, if it is a positive number, it signifies that the patient has some productivity even when the analyst's intervention is judged to have no value in the respect measured by each equation.
2. "Ad. R2" is an abbreviation for "adjusted R squared." This number, part of the multiple regression formula output, represents the variance in the dependent variable (patient productivity) accounted for by the combination of independent variables in each particular equation.
3. "B" is the most important measure of the relationship between the dependent variable, patient productivity, and the independent variables listed. "B" is the change in patient productivity associated with a one-point increase in the variable, holding all other variables in the equation constant. Beta represents the standard deviation change in the dependent variable associated with a one-standard-deviation change in the independent variable while holding other variables constant. While included here because beta is customarily reported in a regression analysis, it does not convey additional information in our study, because the "B" statistic serves this purpose fully when the measures being studied all have the same metric (in this case, Likert-type scales with a range of from zero to four).
4. Beta represents the standard deviation change in the dependent variable associated with a one-standard-deviation change in the independent variable while holding other variables constant.

APPENDIX 2, SECTION 1: SCORING OF PATIENT PRODUCTIVITY

This variable measures the degree of the patient's *overall psychoanalytic progress* during the segment, whether occurring in response to the analyst's *intervention,* emerging from the patient's *independent momentum,* or a mixture of the two. It is scored according to the degree that, overall, *progress* during the segment is achieved in the *depth* or *breadth* of the patient's or rater's *understanding*; and/or in the *intensity* of the patient's *involvement* and *collaboration* in the analysis; and/or in the quality of other momentary *emotional expressions.* The score increases as there is more *complexity* or *detail*, and decreases as the patient's *expressions* are less *affectively* meaningful —for instance, when feelings are either suppressed or exaggerated.

The following elaborations may be helpful:

- *Improved understanding* includes greater comprehension of any psychological features such as *conflicts*, *fantasies*, *identifications*, or *self-esteem.*
- Advances in the patient's emotional *involvement* and *collaboration* in the analysis consist of better *emotional expressiveness*, *self-reflectiveness*, or useful *attention to the analyst's focus.*
- Improvement in any other momentary *emotional expression* is seen in headway with *defenses*, *affects*, *inhibitions* (e.g., of assertiveness), *specific symptoms* (e.g., obsessive doubting), or *character symptoms* (e.g., antagonism).

This variable is scored as "o" when, *overall,* there is no analytic progress in *understanding* by the patient or rater during the segment, nor in *involvement* or *collaboration* in the analysis, nor in the quality of other momentary *emotional expressions.*

Following is an example of a segment scored as "o":

A businessman is undertaking analysis because his wife finds him removed and insensitive to her concerns and has

threatened to leave him. He works in a family business founded by his father, who thinks he is insufficiently capable of shouldering major responsibilities. The patient is somewhat afraid of his father.

The patient begins in an indifferent tone: "There's really nothing new, so I'm going to tell you the usual things . . . . It's a month since the baby was born, and Sally [his wife] is nervous because the nurse will finish this week . . . . [with more enthusiasm] The appliance line is selling pretty well, which is a surprise in this economy."

Here the patient begins by indicating his lack of *emotional openness,* and then ignores his emotions and those of his wife. There are no dimensions of analytic advance.

This variable is scored as "2" when the patient, *overall*, shows *moderate analytic progress* during the segment in the *depth* and *breadth* of his or her *understanding*, or in emotional *involvement* and *collaboration* in the analysis, or in the quality of other momentary *emotional expressions*, including inhibitions and symptoms. There is usually *moderate complexity* or *detail*.

Following is an example of a segment scored as "2," using the same patient described above:

The patient continues, "I was driving a company van yesterday, and a truck backed right into me. He took off like a bat, but I wasn't going to let him get away from me. I drove after him and got his license number! Back at the factory, my father acted as if it was all my fault. I thought I handled it pretty well, but I can never *win* with that guy. A lot of the time, I end up feeling that he thinks I'm ineffective, and that *he's* the great, efficient operator."

During this segment, the patient shows a *moderate understanding* of his feelings of rivalry with his father and the fugitive truck driver, as seen in his reflections about his father's depreciation of him and his feeling that he never wins. A time dimension is included: *"A lot of the time, I end up feeling . . . ."* His emotional *engage-*

ment, collaboration, and *self-reflectiveness* are *moderately* improved, and there is *moderate complexity* and *detail*.

This variable is scored as "4" when the patient, *overall,* makes *strong analytic progress* during the segment in the *depth* and *breadth* of the patient's or the rater's *understanding, or* in the emotional *involvement* and *collaboration* in the analysis, *or* in the nature of other momentary *emotional expressions*, including inhibitions and symptoms. There is *usually strong complexity* and *detail*, which may link *current experiences*, *past experiences*, and *responses to the analyst.*

Following is an example of a segment scored as "4," using the same patient:

> He continues, "I feel that my father doesn't really want me to do better in the business, but I can't be sure that it's happening. Maybe I'm making it all up because I'm stressed out by the accident."
>
> The analyst remarks, "At moments with strong emotional charge, like this one about your father, you become vague and indecisive so as to obscure feelings that frighten you."
>
> Patient: "I can't see that at all. I guess I *do* stay away from confrontations with people—I can see *that.* Going against my father or the other people at work can be big trouble, so it's better to just go along . . . . I don't open my mouth much here with you either. You understand this stuff better than I ever could, and could make me look like a real jerk in about two seconds. I *really* used to be afraid of my mother when I was a kid . . . . she screamed and strapped me all the time."

The patient is responding to the analyst's interpretation with *moderate understanding* of his passivity and his fear of his father and co-workers; and he expresses a similar fear of the *analyst.* He then recalls *memories* of his mother's terrorizing him as a child. Although he has only *moderate* understanding of these experiences, his communications permit the *rater to strongly comprehend* the connections between the three sets of experiences concerning his father, ana-

lyst, and mother. Emotional *involvement, collaboration*, and *self-reflectiveness* are *strong;* and there is a *high degree of complexity and detail.*

APPENDIX 2, SECTION 2: SCORING OF QUALITY OF INTERVENTION

This is a global variable that rates the overall quality of the intervention. It is scored according to the degree of aptness of the intervention's type, the potential usefulness of its content, and the skill of its presentation. The skill of the presentation is scored higher when the intervention is more tactful, well timed, and made in language that is more clear, vivid, or likely to appeal to the patient. The score also increases when the intervention is more direct or more relevantly complex and detailed. The length of the analyst's contribution should not necessarily influence its score.

The following elaborations may be helpful:

- We divide interventions into four types: three distinctively analytic ones—encouraging elaboration, clarification, and interpretation—and those offering support, which include all other interventions.
- There is, of course, more than one useful response to a patient's material. The rater should evaluate the potential effectiveness of the intervention by following the analyst's chosen direction, but should also consider how well the intervention approaches what the rater regards as optimal, with some thought as to what the rater him- or herself would have done in the same situation. Raters are cautioned not to score inappropriately highly by giving the analyst's effort the benefit of the doubt.
- Ratings are assigned according to the highest level of variable reached, even if the segment is long and most of it warrants a lower rating.

- If an intervention seems useful but not remarkable, it is usually rated as "2" or less.

An intervention is scored as "0" when the type of intervention, its content, or the skill of its presentation do not suit the patient's expressions at all.

Following is an example of a segment scored as "0":

> The patient is a vulnerable, self-defeating young man who is conflicted about expressing his anger, and began analysis because of insufficient progress in his career. This session starts with the patient's description of an evening with his parents and his younger brother, John, who had been visiting.
>
> "The dinner with my parents went all right. John and I walked past a beautiful church, and I pointed out a carving on an arch. John seemed interested, but didn't have much to say about it, so I started talking about work."
>
> The analyst says, "You seem to have let your brother get the best of you."

Although this intervention applies to the patient in a general way, its content does not match the patient's communications, and it is insufficiently tactful.

This variable is scored as "2" when the intervention is a moderately suitable response to the patient's communications. The type or blend of types of intervention is at least reasonably apt, the content addresses the patient's expressions in a potentially moderately useful way, and the presentation is reasonably tactful, well timed, and verbally appealing to the patient. There is a moderate degree of directness or relevant complexity. If an intervention seems useful and reasonably well designed, but not remarkable, the rating is usually "2" or less.

Following is an example of a segment scored as "2," using the same patient described immediately above:

> The patient continues, "John wanted to know if he could stay at my apartment, and then, out of the blue, he punched

me on the arm so hard that it really hurt. Well . . . I mean! . . . I told him that he could stay with me last night, but not over the weekend. We're inviting a lot of people to a party on Saturday."

The analyst intercedes with the following comment: "You speak about your brother punching you on the arm, and then continue as if that were quite usual. You seem to be avoiding getting angry at John."

This blend of clarification and interpretation is an apt type of intervention, which calls attention to the patient's denial of his anger moderately well. There is reasonably suitable tact, timing, and verbal appeal, as well as moderate directness and complexity.

This variable is scored as "4" when the intervention is a highly suitable response to the patient's communications. The type or blend of types of intervention is very apt, the content focuses on the patient's expressions in a potentially highly effective way, and the presentation is usually very tactful, well timed, and uses clear and vivid language. There is typically a high degree of directness or strong relevant complexity, possibly linking current experiences with past experiences or experiences involving the analyst.

Following is an example of a segment scored as "4," using the same patient:

The patient says, "I had a dream last night. There were two holes in a barren rock and I was lying in one of them. I guess it means that I was dead, like in a grave . . . . [He sighs.] It reminds me of the time my family went on vacation when I was nine, and John and I found an opening in a rock face and he crawled in. The earth over the entrance started to slide, and my father ran over with a piece of wood and braced it. Dad turned to me, white-faced and furious, and said, 'He could have died in there! How could you let him do that?'"

The analyst says, "Your father's accusation touched on a deep feeling in you. John's hitting you seems to have brought the accident and your father's accusation back to your mind, that you would be willing to see John die. It's

> as though you are guiltily saying in your dream, 'I'm the one who deserves to be in a rocky grave, not John.' Feeling that you are capable of being so destructive leads you to back off from standing up for yourself with John and to feel pessimistic about yourself and about this treatment helping you."

Here the interpretation is an apt type of intervention, strongly calling attention to the punishment the patient feels he deserves for his past and present murderous impulses. The interpretation is sensitive, well timed, vivid, and dexterously expressed. Links between the patient's recent conflicts and past experiences show considerable complexity. (For illustrative purposes, this intervention is presented as if it had been said all at once. Most likely, such an intervention might best be given in a way that would give the patient an opportunity to respond to each part of it before proceeding to the next part.)

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BOOK REVIEWS

NEW CLINICAL REALMS: PUSHING THE ENVELOPE OF THEORY AND TECHNIQUE. By Salman Akhtar, M.D. Northvale, NJ: Aronson, 2003. 300 pp.

Salman Akhtar is a training and supervising analyst at the Psychoanalytic Center of Philadelphia and a professor of psychiatry at Jefferson Medical College. In addition to four other books in the realm of psychiatry and psychoanalysis, he has published six books of poetry, three in Urdu and three in English. He has edited twenty books on a wide variety of subjects, and this same breadth of interest makes him a much-sought-after lecturer as well. *New Clinical Realms: Pushing the Envelope of Theory and Technique* reflects both the depth of his psychoanalytic knowledge and the expansiveness of his attention.

This volume of ten chapters is a collection of papers on quite diverse topics that Akhtar considers to have been relatively neglected in our field. The table of contents reminds us of the individuality of his psychoanalytic vision, including as it does subjects like "mental pain," "writer's block," "the shy narcissist," and "mentorship." Chapters 2, 5, and 6 are new to this volume; the rest have been published before.

As with many such collections, this is not an integrated work, but a series of distinct essays, loosely woven together by the author's underlying perspectives. It ranges widely and reflects, as Akhtar says, the "tripartite paradigm composed of psychiatry, psychoanalysis, and poetry [that] constitutes *my voice*" (p. xvi, his emphasis). And Akhtar has a compelling voice—that of a poet, a psychoanalytic scholar, and someone far from home.

Akhtar's writings have largely focused on the early developmental processes that drive and organize emotional life. He is interested in the crucial structural and motivational distinctions between needs and wishes, as well as their clinical and theoretical implica-

tions.[1] Attachment, separation, individuation, object loss, mourning and growth, and maintenance and repair of self organization are central features of his conceptual landscape, *leitmotifs* throughout this collection. Mahler and Winnicott are significant influences in his psychoanalytic thinking. In addition, he has a poet's passion to capture and express the inescapable and ineffable ambiguities of human experience. He says in the chapter on mental pain that "Poetry speaks to the unconscious and facilitates the *mentalization* (Fonagy and Target 1997) of the nonverbal substrate of the psyche. Reading [and presumably writing] poetry informs one about the inner state of affairs, enhances empathy with the self, and therefore facilitates mourning" (p. 15, his emphasis). Leaving mother and leaving home are deep currents in his experience and his thinking, as a clinician and as an émigré.

Nonpsychoanalytic readers will learn a great deal from Akhtar's psychiatrically comprehensive and psychoanalytically informed descriptions of the various topics. Psychoanalytic readers may find the book somewhat uneven, and should consider it an opportunity to "visit" with the author, to enter his mind and his world, and to experience and observe how he thinks, feels, and works.

The first chapter, on mental pain, is excellent. I find the topic important, and the author's melding of issues of separation and loss with a personal view of poetry and communication is quite moving. The second chapter, "Writer's Block," is remarkably informative, and also enlists the author's sensitivity to the relationship of creativity and the state of one's internal object world. It includes some penetrating illustrations of his clinical sophistication in treating the problem. "The Shy Narcissist" is a phenomenological chapter that would have been enriched by a more extensive discussion of related therapeutic issues. "The Other Woman" is an intriguing description of this phenomenon through a series of lenses keyed to varying levels of borderline personality organization and its clinical consequences. The chapter includes some pearls of clin-

[1] See Akhtar, S. (1999): The distinctions between needs and wishes: implications for psychoanalytic theory and technique. *J. Amer. Psychoanal. Assn.*, 47:113-151.

ical wisdom: the importance, for example, of recognizing the patient's conflictual motives for entering psychotherapy, and the consequent countertransference reactions that may result.

In Part III of the book, the chapters on animals and things have a descriptive textbook feel of the kind that is likely to appeal to nonanalytic readers. This effectively furthers the author's "aim . . . to broaden the reach of psychoanalytic theory and to enhance the clinician's empathy with matters that are frequently overlooked" (p. 122), and he succeeds. "From Simplicity through Contradiction to Paradox" is also a teaching chapter, well worth recommending to therapists in training. It is a rich essay on the application of clinical theory to clinical process in the treatment of patients with borderline personality disorder. The author uses some very interesting clinical moments to illustrate the way the holding functions of the treatment process foster growth in the patient's capacity to rely less on splitting and projection and to tolerate complex mental states.

The last three chapters are among the most intriguing and engaging. In his most analytically focused chapter, "From Schisms through Synthesis to Oscillation," Akhtar takes up the challenge of how theory guides and informs clinical analytic work; he addresses particularly how the polarities of various models—defense versus deficit, preoedipal versus oedipal, interpretation versus new object relationship, and the like—shape or even dictate views of transference, resistance, process, and therapeutic action. This chapter more than the rest invites a conversation about the issues, and permits a deep appreciation of the way Akhtar thinks about his experience of analyzing patients, especially "more fragile" ones. As is true throughout the book, the best parts are the clinical vignettes, and in this chapter we are most richly rewarded.

We might want to argue with the author over a tendency to dichotomize; note that his developmentalist perspective prompts him to suggest the following:

> The technical polarities of listening with credulousness and responding with affirmative interventions versus listening with skepticism and responding with interpretive in-

> terventions seem to have as their respective developmental prototypes the maternal and paternal styles of relating to young children. [p. 193]

Still, we know that our conversation is with a very sophisticated clinician who offers ways of thinking and feeling about complex experiences.

In "Mentorship," we sense again a very personal voice, especially in the discussion of the working through of idealizations. In "Forgiveness," again in a textbook taxonomic style, Akhtar takes us through the clinical phenomenology of forgiveness, returning at last to the themes of mourning and repair. This material is narrated throughout in his poetic, worldly, and clinically wise voice. The "Forgiveness" chapter does raise one objection in me: given the depth of the author's appreciation of Kleinian (and other) contributions to this topic, is it fair to consider forgiveness neglected? Still, this is a minor quibble about an otherwise rich and sensitive book.

Akhtar tips his hand toward the end of our visit, in his elegant discussion of mentorship:

> Even when a mentor is explicitly didactic, he comes across as having undertaken a task larger than transfer of knowledge. He excites the student, recognizes unevoked potentials, nurtures talents, and sponsors his student toward the outer intellectual and organizational limits of the latter's vision. [p. 203]

In this instructive, and at times fascinating, collection of essays, Dr. Akhtar has most generously accomplished his task.

ROBERT ALAN GLICK (NEW YORK)

TRANSSEXUALISM: ILLUSION AND REALITY. By Colette Chiland. Translated by Philip Slotkin. Middletown, CT: Wesleyan Univ. Press, 2003. 193 pp.

This book, by a seasoned, experienced psychiatrist and psychoanalyst, who has had an unusually rich experience over many years

with patients seeking transsexual hormone therapy and surgery, will be of inestimable value to anyone interested in gender issues. For those who work directly with such patients, as I do, the book impresses me as required reading. In France, people who want sex-change surgery are required to obtain psychiatric treatment at designated treatment centers, so there is relatively ample opportunity to study the phenomenon of transsexualism in considerable depth.

Colette Chiland is, among other things, psychiatrist-in-chief at the Alfred-Binet Center in Paris. She has written numerous articles on transsexualism, drawing upon extensive experience over many years at three different centers that work with such people, but her papers have previously been available only to those with access to the French literature. In this book, translated into English, she pulls together her conclusions about the transsexual phenomenon in a literate, eminently readable, informative, and pragmatically useful manner. I recommend the book highly to anyone interested in the topic.

On a linguistic note, Chiland points out that the French language distinguishes more precisely between the words *gender* and *sex* than does English:

> The words that a given language accepts or rejects reflect profound differences in conceptualization. For instance, in English "gender" has come to be the normal term for social or psychosocial sex, but the equivalent French word cannot always be used in this sense. Similarly, words like *sexué* or *sexuation*, used in French with reference to the division between the sexes, will not go into English directly. [p. xii]

As Chiland indicates, the patients to whom she addresses herself suffer enormously but are far from easy to treat psychotherapeutically. They may or may not be psychologically minded, but, even when they are, they adhere powerfully to the view that their problems are strictly biological, and that the only solution to the misery they experience in life is a change in their bodily appear-

ance and habitus so that they can be seen—*and see themselves*—as members of the gender opposite of that to which they believe their DNA has falsely consigned them. They tend to be convinced that their only hope for any degree of happiness in life is to undergo a transformation in bodily appearance. Helping them consider the route they have traversed in arriving at that conclusion, as well as the implications of the limitations of what medical and surgical science can offer, presents a formidable set of challenges to the clinician who agrees to work with them, as I can attest from my own clinical experience.

As Chiland puts it in the preface to her book:

> Inherent in the transsexual contention is a contradiction that lies deep within our culture. Transsexuals say that their identity is defined not by the sex of their body but by that of their mind and soul. Yet they are not content to occupy the symbolic place of the other sex . . . but require a bodily token of their change of status . . . [that] becomes the proof of the truth of their assertion that they are members of the other sex . . . . This book is concerned with transsexuals . . . on the basis not of *a priori* ideas but of my clinical experience—in which I have done my best to understand patients and to relieve their suffering, even if I have not always succeeded. [pp. xi-xii]

Transsexuals strongly reject the notion that gender attribution contains an element of learning and experience. They object to the idea that they might have been shaped in part by transmission to them of conflict-driven feelings and attitudes on the part of their parents and other significant figures or by their experiences during their formative years. They tend to insist that unsatisfactory or painful interpersonal experiences they have had as children *did not contribute to* their gender dysphoria but actually *were caused by* the gender dysphoria. They strongly reject the notion that human beings are complex, biopsychosocial creatures. They tend to seize upon the burgeoning number of assertions available in print and on the World Wide Web to the effect that gender is strictly biologi-

cal, in order to support their claim that their psychological sex is their *true* sex and should be recognized as such.

Transsexuals tend to rail against society for failing to recognize what they view as their essential nature and for trying to mold them in accordance with society's presumed sociopolitical agenda. Chiland states in this regard:

> At the *psychological* level, sex is subjective: it is the sex each individual sees himself as possessing. If one's psychological sex does not conform to one's biological or assigned sex, serious problems arise—namely those confronted by *transsexuals*. It is not a question of intersex, for the transsexual is biologically normal according to the current state of research . . . . Would the suffering of an intersexed or transsexual subject be alleviated by recognition of a third sex with a specific social status? . . . That is not what these patients are asking for; they want to be full-fledged men or women. [pp. 9-10, italics in original]

Chiland emphasizes that transsexuals intensely loathe the genital organs they possess. Biologically male transsexuals loathe their penis, which they tend to view as an instrument of violent infliction of pain and injury; and "biological females have a comparable loathing of the breasts" (p. 17). Female-to-male transsexuals tend to view the possession of breasts as particularly abhorrent—partly, according to Chiland, because possession of breasts demonstrates to the world that they possess a female body, and partly because of serious, unconscious issues stemming from their childhood mothering experience. (In my own clinical practice, as in Chiland's, I have encountered associated, intensely painful feelings about possession of feminine-appearing hips and about not being taller—again, because of the powerful need to present an appearance of masculinity rather than femininity.) Male-to-female transsexuals present the obverse attitude about breasts:

> The breasts are so important to male-to-female transsexuals that, according to some statistics, half the males who

> have had surgery have asked for and obtained a mammoplasty . . . . The breasts are the visible mark of one's sex . . . . Outward signs are what is needed when the aim is social recognition . . . [and] one's reflection in the mirror is important. [p. 74]

The need among transsexuals to obtain mirroring from the world around them of the validity of their view that their *true* gender conforms to their psychological sex, rather than to their biological one, cannot be too strongly emphasized. "Transsexuals speak much more eloquently about their loathing for the sex of their bodies and for their assigned sex," Chiland points out, "than about what they feel to be desirable in belonging to the other sex" (p. 40). She notes at several points in her book that transsexuals do not have an idea what in actuality it is like to be a member of the opposite sex, only that they do not want to be a member of their own assigned sex.

Chiland reports that the patients seen at the clinics of which she has been a part have had a variety of childhood gender issues. The male-to-female transsexuals tend to have been feminine boys who were inclined to dress up as girls from an early age—but very few boys with that history actually evolve into transsexuals: "On the basis of the samples of Green and Zuger, the probability of a feminine boy's becoming transsexual is between two and three percent" (p. 63). Male-to-female patients coming to the clinics where Chiland has worked have rarely followed the pattern described by Stoller of having experienced smothering, excessive closeness with the mother, and a largely absent father. What they have seen, however, is that their "parents came from families who had suffered cumulative traumas of various kinds, with a substantial element of violence, in the form of murder, suicide, early seduction, abandonment, and the like. For both parents, virility had the connotation of murderous violence" (p. 57). This is consistent with my own (albeit much more limited) clinical experience.

"The effects of treatment are very hard to evaluate," Chiland tells us. "*The only tendency that emerges seems to be that the treated*

cases do not develop in the direction of transsexualism, but often in that of homosexuality" (p. 64, italics in original). When patients come for treatment in adolescence, a strong sense of urgency tends to be expressed:

> Whereas adolescence is often a difficult turning point, puberty, for a child who is unhappy with his gender identity or rejects his sex, is a drama . . . . Neither girls nor boys can doubt any longer that their bodies correspond to their assigned sex; *they can no longer dream of a miraculous transformation that will give them the body of the opposite sex*. [p. 67, italics in original]

Thus, the cry for sex change becomes importunate.

The female-to-male transsexuals Chiland has encountered have tended to have a history of being tomboys and/or of finding themselves attracted to girls. Female-to-male transsexuals, she notes, often, though not always, have had associated homosexual trends in their psychological makeup, with the attraction to other girls often contributing to the idea that they really must be boys. "A girl who rejects her assigned sex often was an ugly baby" who did not elicit a gushing response from her mother, Chiland observes.

> Her depressed mother was incapable of showing tenderness to her, doting on her, or attaching value to femininity. And if she wants to be a boy, it is not out of identification with an admired father, but, once again, with the idealized image of a man who has very little in common with the father. [p. 61]

Chiland elaborates:

> When an adolescent asks for reassignment, the request is characterized by *great impatience* . . . . The first step must be to listen to what these adolescents say and to delve into the ideas they have formed—I say ideas rather than fantasies because they find it difficult to speak of their fantasy life. Some psychoanalyst colleagues advocate maintaining

> the position in which the analyst listens and only speaks in order to interpret. I would feel that I was playing the same game as the journalists who aroused such absurd hopes in these people if I did not tell them what they could realistically expect from surgery; it seems to me that I could not work with them without setting down some markers of reality. [p. 69, italics in original]

The adolescents seen at her clinics have been much more difficult to help than are children brought for assistance because they want to be members of the opposite sex:

> The existence of sex-conversion "treatment" makes the already difficult process of psychotherapy with these patients even more difficult because of the way they function. Since such treatment exists, they want to have it. They are not willing to explore their inner world. Their mental functioning is organized around splitting and disavowal . . . . They fail to hear what honest surgeons tell them about the limits of plastic surgery . . . . It is in the nature of adolescents to believe that nothing will stand in the way of their wishes . . . . These adolescents stage everything in the theatre of the body and nothing in that of the psyche. If the doctor takes an interest in what is happening inside of them and how they became that way, and attempts to understand it, that to them is a *manoeuvre* (sic) designed to postpone the achievement of the goal they have set themselves, a *threat* leveled at their language of conflict and wishes. [p. 72, italics in original]

The attitude of these patients' families toward their wish for sex reassignment tends to be complex and variable: "Whereas some parents 'aid and abet' their children—that is, impel them to have surgery without, or even against, medical advice—others respond with rejection and do not want to have anything more to do with them" (p. 76).

Psychotherapeutic treatment of adult transsexuals is not necessarily very much easier than that with adolescents:

> The psychotherapy of such a disorder is indeed very difficult . . . . The reason for the difficulty, I contend, is that the initial organization of the patient's narcissism has been severely compromised . . . . Psychotherapy is difficult with these patients owing to their mode of functioning . . . . They come to us determined to have surgery. The psychotherapist is suspect because they think that he will want to divert them from their aim and cause them to change their minds. [p. 146]

Chiland emphasizes that "to give psychotherapy a chance," it is necessary for treatment and gatekeeping to be kept strictly separate:

> Psychotherapy sometimes forms part of the reassignment "programme" as a preliminary to it, and is conducted by the specialist unit itself . . . . It is in our view . . . important for the psychotherapy to be conducted elsewhere, and above all for the psychotherapist's opinion to play no part in the decision. [pp. 147-148]

The kinds of treatment administered at the centers at which Chiland has worked have varied greatly, in accordance with each patient's psychological makeup and openness to therapy. She provides only a few terse clinical illustrations, but they are meaningful. Some patients have been seen in brief treatment that has consisted mainly of countering naiveté or of dispelling fantastic beliefs about the capacity of medical and surgical science to effect transformations in people's bodies (some patients actually have believed that their chromosomes could be changed). Others have entered into psychotherapy that has ranged widely in scope, from brief all the way to lengthy, intensive treatment. At times, patients have decided not to proceed with a sex change or have elected to undergo a lesser change than they initially wanted, but many have adhered to their plans to undergo hormone treatment and major surgical procedures. I should have liked to hear more about what seemed to determine the outcome of psychotherapy in the various categories, and about the longer-term, intensive treatments, but

Chiland indicates that confidentiality considerations prevent her from providing such material.

The author examines the relationships among transvestitism, homosexuality, transsexualism, and sexual aversion. She also addresses the various outcomes of hormonal treatment and sex-change surgery. About half the female-to-male and a fifth of the male-to-female transsexuals they encountered in the centers where she worked agreed to be interviewed postsurgery. Their average age was about thirty-five years, and the average time after surgery was about six years. They reported variable degrees of satisfaction, depending in part on whether they had achieved success in finding a partner (at times with a sexual component to the relationship, and at other times without one) with whom an ongoing relationship could be established. Some of those seen in follow-up regretted having undergone the sex change; a few had become psychotic; and there were some suicides:

> *Suicide* is a threat quite often wielded by transsexuals to get themselves accepted for surgery, and before their operation they do indeed make sometimes very serious attempts. However, they also attempt suicide after surgery, often in the wake of the break-up of a relationship or a failure in love . . . . The less strict the selection criteria for surgery, the greater the number of suicides. [p. 100, italics in original]

Chiland makes an important observation:

> The patients in our sample were operated on only after a long period of observation, which they acknowledge to have been necessary even though they found the waiting time hard to endure, because they had seen the catastrophic state of some of the other people who shared their plight but who could not accept not having surgery or not having it quickly, went abroad for their operations, and proved unable to tolerate the change. [p. 104]

Even those who have felt relatively satisfied with the results of hormone administration and surgery have had to contend with sig-

nificant difficulties. They have been restricted in the opportunity for social interaction and, especially important, in the opportunity to establish meaningful, lasting relationships. Many of the transsexual patients who have come through the French clinics have gone on to lead very narrow, and not infrequently marginal, lives after surgery. They have continued to find life difficult.

Chiland does her best to help her patients wrestle with their demons, to consider their choices as realistically as possible, and to build as much strength as they can, so that they might become better prepared to contend with what they can expect to face in life, with or without surgery. The treatment process is never easy, and the outcome is often disappointing. She holds to her task, nevertheless, trying as best she can to help the generally tortured and frantic transsexual patients who come her way. The compassion, decency, and respect with which she approaches these patients come through repeatedly. They are epitomized in her statement, in connection with follow-up visits, that: "Given a capacity to leave aside any preconceptions we may have, these interviews are meetings with individuals who differ greatly from each other, who have suffered monumental ordeals, and who can only merit our respect" (p. 98).

MARTIN A. SILVERMAN (MAPLEWOOD, NJ)

WHY DO WOMEN LOVE MEN AND NOT THEIR MOTHERS? By Marie-Christine Hamon. Translated by Susan Fairfield. New York: Other Press, 2000. 251 pp.

In this book, the French Lacanian psychoanalyst, Marie-Christine Hamon, examines the question, posed by Freud, of how and why girls change their love objects from mother to father in the course of psychosexual development. The book does not provide a novel or creative answer to these questions, but rather a careful, well-documented exposition of Freud's thinking on this subject, as well as that of the early psychoanalytic pioneers around him. In addition, Hamon evaluates and reframes this material in terms of her own Lacanian perspectives.

In tracing Freud's thinking about the girl's oedipal complex, Hamon shows how Freud undertook a process of working through in which he assimilated the thinking and clinical findings of his contemporaries. Hamon argues that Freud's protestations that he lacked the clinical material to understand women masked a progression within his own thinking, until he was able to realize and reinterpret the importance of the role of the mother for the girl. He came, finally, in the 1930s, to two understandings: the prehistory of the female oedipal complex, with its long attachment to the mother and the role of the recognition of the lack of a penis —the "castration of the mother"; and the turning to the father. Misunderstood, she feels, is Freud's claim of ignorance about females. Rather than ignorance, this is a mode of doubting and an appeal to the knowledge of the Other, to which other analysts did indeed respond. By cross-checking texts and projecting later ones onto those that came earlier, Hamon finds already present in Freud the idea of symbolic value of the male organ (a concept important to Lacan), even before he formulated this explicitly.

> Before 1925 and the thesis of the asymmetry of the Oedipus [complex], everything was already there in a certain sense: the manifestations of the castration complex in the form of penis envy, the difference between castration accomplished and castration threatened, the initial masculinity of the little girl, and the symbolic equivalence penis = child. Everything was there, except the connection for the girl, between the Oedipus and the castration complex. [p. 12]

The author adds that it also took time to relate the implications of the castration complex to object choice and identification for boys and girls.

Why Do Women Love Men and Not Their Mothers? focuses on this interplay of ideas of Freud within himself and with his circle of colleagues, and how each of the other analysts rose to his challenge, with a constant subtle tension underlying their dialogues. Thus, in spite of differing conclusions or objections to Freud's

ideas, each contributor accented something Freud had pointed out without seeing its implications. Later, Freud might pick up one of their ideas to advance his theories.

In a fascinating set of chapters focusing on such early pioneers as Deutsch, Lampl-de Groot, Abraham, Klein, and Brunswick, among others, Hamon beautifully details the mutual influences between Freud and his contemporaries. Of special interest is her explication of less familiar work by Van Ophuijsen on the masculinity complex in women.

The author begins with Helene Deutsch. She points out that Freud did not acknowledge Deutsch's priority in appreciating the girl's hatred for the mother and the "Unnaturalness of the Oedipus" (that is, the girl must renounce her original attachment to mother to achieve the oedipal stage). Hamon argues that where hate is concerned, Deutsch and Fenichel (the latter's contribution on this subject was not mentioned by Freud either), are surely those who, even more than Klein, presented case material that enabled Freud to reach definite conclusions about this phenomenon, independently of the way each of them analyzed it. Freud took ideas about the girl's phallic activity and the intensity of attachment directed toward the mother from Deutsch and acknowledged this to an extent. He did not, however, criticize in her what he criticized in Horney: namely, the notion of the masculinity complex as a defense against incestuous wishes.

After her clear, detailed account of the work of Deutsch, Hamon then translates it into her own understandings. The woman's role as an active mother, as articulated by Deutsch, is reformulated as a fantasy of re-completion or "re-phallicization" that enables her to accept her castration. Hamon shows how Deutsch's account of the activity and passivity of each phase of infantile sexuality reflected both Ferenczi's and Abraham's work on the primacy of the genital organs, the idea of the identification of the whole with the part, transfers of early libidinal pleasures into unpleasures, and an exchange of a perceived loss for a gain elsewhere.

A brief chapter concerns the work of Fenichel. Hamon applauds Fenichel's caution in making theoretical leaps from clinical mate-

rial, which characterizes his conclusions about the pregenital antecedents of the Oedipus complex in females. This caution is reflected in Fenichel's judgments about a supposed active phallicism in girls, which he did not find clinically. In spite of her appreciation of his caution, Hamon finds faults with his conclusions. What she criticizes in his writings is what she criticizes in most of the works she examines in this book: namely, that it does not take into account the primacy of the phallus as symbolizer of the demands and frustrations involving the mother in the pregenital stages. Hamon stresses the importance of the girl's perception of the father's role in the mother's castration during the act of intercourse. She argues that Freud also recognized this idea, preceded in this regard by Horney's paper on the genesis of the castration complex in women with reference to beating fantasies. That is to say, being beaten = being loved = being castrated by the father.

Hamon sees the debate between Freud and Jones as really one between Freud and Abraham. She feels that, for many complex reasons, Freud did not explicitly acknowledge his disagreements with Abraham. Abraham's proposals included the child's identification with the father as a cannibalistic incorporation of the penis, partial love as the first step toward object love, and oral sadism as the cause of penis envy. According to Hamon, Abraham did not understand oral penis envy as symbolic, reinterpreted retroactively from later stages. Nor did he perceive the difference between primary and secondary identifications, as Freud did, with primary coming before object love and knowledge of sexual differences. Hamon suggests that Freud recognized the ambiguity of his own first formulations about stages of development, as well as Abraham's. In this context, Hamon argues—as she does repeatedly throughout the book—against a genetic hypothesizing backward from clinical data. For example, to posit a theory of linear development from oral to anal to phallic does not take into account what for Hamon is the symbolic nature of an oral fantasy, which should not be equated with a previous causality.

Hamon finds much to agree with in Klein's ideas about the female oedipal complex. Appreciating Klein's clinical material with

her first child patients, Hamon finds in it a logic that she can follow even as she reinterprets the cases in Lacanian terms. Hamon suggests that the hardening or radicalization of Klein's early papers, which were stated more tentatively than is usually realized, grew out of her quarrels with Anna Freud and her adherence to Abraham's theories on early development, which became fixed as an unquestionable authority upon his death. Klein borrowed from Abraham an emphasis on early oral deprivations and a reliance on the concept of introjection.

Klein, as no one had done before her, called attention to an oedipal meaning of privation. The mother, who removes the infant's sources of pleasure, is envied for her possessions, including the father. Hamon shows that the oedipal myth in retrospect serves to make sense of the structural fact that, in the minds of both the boy and the girl, there is an assumption that the benefits of which the child is being deprived by the mother will be reaped by a third party.

This mother described by Klein is the cause of all good and all evil. Hamon points out that this maternal imago is the mother *before* the recognition of castration. In that sense, therefore, castration—or, more accurately, the fantasy of castration—puts an end to the mother's omnipotence. In Lacanian terms, Klein's phase of identification with the mother who possesses all goods and all power is *phallic*. This is similar to Klein's reinterpretation of Brunswick's case of a woman with jealous delusions. Brunswick related the patient's homosexuality genetically to an older sister who seduced her, while to Hamon, the patient's problems reflected a struggle against the recognition that she had not been selected as a love object because she could not satisfy the other's *jouissance*.

Klein's oedipal phase is a domain situated very differently from Freud's, based on highly ambivalent early introjections. Although Freud rejected Klein's early timetable for the Oedipus complex, he was influenced by her. What Klein and Freud have in common is, as Hamon puts it, "an equation of Jouissance and knowledge on the part of the Other" (p. 134), that is, the impotence of the child in the face of the enigma of sexual difference. In contrast to Klein,

Freud stressed the masculinity of the little girl, as opposed to the oral and presumably "feminine" receptive aim of the girl's genital and the idea of an inherent mutual attraction of the sexes, a notion that he slowly discarded.

A repeated theme throughout the book is Hamon's insistence on the importance of the role of castration in the girl's turning away from her mother. For Hamon, the marker of the girl's entry into the oedipal phase is the presence of hate for her mother, a hate for a castrated mother, at the moment the sexual difference becomes known. The author argues that, while a preoedipal phase exists, it does not directly lead into or prefigure the oedipal phase, except chronologically. Hamon argues further that what others label as so-called preoedipal hate must be seen in terms of castration or lack, the phallus as the symbolizer of all lack. Heterosexuality, for the girl, is an acquired limitation in object choice.

In summary, the book is interesting on several counts. First, it is an interesting and convincing account of how theory is built. Second, it constitutes a good casebook on Lacanian thinking, presented more clearly than most accounts that attempt to explicate Lacan to American psychoanalysts, in my opinion. As I have described, Hamon explicates a series of pioneering analysts' views on the change of object that leads to the female oedipal complex. In her associated critiques, she reformulates their ideas into Lacanian theory. What this does is allow those of us who are less familiar with Lacanian conceptualizations to follow their translations from more familiar terrain. Her explication becomes a kind of cross-psychoanalytic theory translator.

What is striking to this reader is how little is translated from contemporary American writings about female development into this Lacanian and French account. There are no references to concepts about women that are common in American psychoanalysis: primary femininity, the construction of femininity out of something other than lack, the developmental line of gender identity, and so on. Contemporary American theorists on the female oedipal situation would start from an entirely different premise than the one encapsulated in the title of this book: The question would

not be *why do women love men and not their mothers*, but rather *how do women love men and women?*

Many contemporary American psychoanalysts would argue that for girls, there is an *addition* of object, not a *change* of object. Moreover, many would not automatically equate heterosexuality with oedipal development, as does Hamon. They would question the notion of a necessary change of sexual aim in female psychosexual development as well. The role of asymmetry of the female and male oedipal complex in America is understood more frequently in terms of differing object relations (as, for example, by Chodorow and Person), and not simply as a result of the differential effects on the girl and the boy of penis envy. This theoretical disparity is reflected in Hamon's bibliography, which includes no American authors and very few references later than the 1960s. The divide between the United States and France on this subject seems to be great.

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FROM LATE ADOLESCENCE TO YOUNG ADULTHOOD. By David Dean Brockman, M.D. Madison, CT: Int. Univ. Press, 2003. 320 pp.

The ever-increasing globalization and technical complexity of world civilization continues to prolong the process of achieving full adult personality organization and social status, not only in the industrialized world, but in developing societies as well. Thus, it is understandable that Dr. Brockman, who some years ago published a well-received book on late adolescence, has now found it desirable to follow that with a new volume that extends the scope of his psychoanalytic explorations into the phase of young adulthood, or what the social psychologist Kenneth Keniston called "youth"—a loosely defined period sometimes extending well into the thirties, as graduate education becomes increasingly normative, stable and fulfilling employment increasingly elusive, and parenthood increasingly delayed.

Brockman has assembled here a number of chapters, some previously published elsewhere, approaching his topic from a variety

of viewpoints, some primarily clinical in emphasis, others centering on applied or interdisciplinary themes. All demonstrate his erudition and easy command of a massive literature ranging far beyond psychoanalysis into areas of literary, philosophical, and developmental concern. Indeed, several chapters emphasize extended reviews of the literature, with clinical considerations appended almost as afterthoughts.

Thus, the reader will find here a thoughtful discussion of the issues involved in the clinical assessment of young persons, including a judicious statement of the necessity of a multidisciplinary approach to the evaluation of the wide range of psychological and social tasks that confront them, and of their capacity for a "therapeutic split" that might make them accessible to psychoanalytic intervention. Sections on "Identity" and "Gender and Sexual Identity" consist almost entirely of literature reviews, potentially useful for those who seek to delve into these topics. It is notable, by the way, that Brockman pays considerable attention to Erikson's contributions here, restoring him to his deserved place after years of neglect by "official" psychoanalysis.

Brockman appears to be particularly fascinated by the dynamics of power as they play themselves out in the psychology of later adolescence, and, in particular, in the so-called Don Juan syndrome. He devotes his longest chapter to this topic, surveying it from a wide range of viewpoints covering historical as well as clinical perspectives. His conclusion—that "pathological distortions of power issues in the main arise from a set of dynamics that resemble and remind one of a prephallic attempt to unite with an omnipotent maternal object to relieve the childhood terror of powerlessness, fears of abandonment, and helplessness" (p. 171)—seems plausible enough, but is poorly supported by his very brief and somewhat formulaic clinical illustrations.

The related issue of "Narcissistic Rage" is explored along essentially Kohutian lines, building on the Homeric account of the story of Achilles (Brockman prefers the classical spelling, *Akhilleus).* The author's erudition is in especial evidence here, although, again,

his clinical vignettes do not quite equal in their force his interdisciplinary exegesis.

For this reader, the book's greatest strengths are in the areas of developmental theory and cultural scholarship. Brockman's literary style is fluent and readable. The practitioner will not, however, find much to guide him or her through the special technical problems posed by the challenge of psychoanalytic work with patients in this phase of life—particularly their characteristic action orientation and their widespread propensity for substance use and abuse. Brockman has, however, performed a service in focusing psychoanalytic attention on a little-explored segment of the life cycle, and for that, as well as for his efforts to integrate its clinical and cultural applications, he is to be commended.

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ABSTRACTS

CANADIAN JOURNAL OF PSYCHOANALYSIS

Abstracted by William Butler, Ph.D.

X, 1, Spring 2002

Growing Psychoanalysis: Rethinking Psychoanalytic Attitude. H. E. Gorman, pp. 45-69.

In this paper, Gorman draws on his previous work, as well as on that of Wallerstein and Schlesinger, to argue that supportive and interpretive interventions are "inevitable, inextricable and not, by nature, contradictory" (p. 54). He also proposes that the "classical analyst's claim to the objective ability and authority to distinguish supportive from interpretive statements cannot be sustained," because countertransference is now "recognized to remain radically alive" (p. 54).

The author argues that psychoanalytic attitude, and thus psychoanalysis, has been mistakenly equated with classical analytic technique. He first traces the history of this error, noting that Freud presented his techniques as recommendations; he believed that any approach that "worked by undoing resistances and interpreting transferences" was psychoanalysis (p. 48). The problem began when, because of Freud's status, his technical recommendations, rather than the analytic attitude they were intended to serve, became the defining statement regarding psychoanalysis. In part, the background of Freud's technical recommendations was his abandonment of therapies based on support and persuasion, as well as his adoption of the then-dominant belief in the possibility of a totally objective scientist.

The attempted exclusion of, and diminished importance of, supportive measures in the treatment of symptom neuroses supported the equation of classical technique and psychoanalysis. How-

ever, "attempts to analyze character made it increasingly clear that classical technique," which excluded supportive measures, "was frequently insufficient," bringing psychoanalysis to a "crossroads" (p. 50): either the status quo could be maintained (leading to the conclusion that psychoanalysis was inapplicable to the character neuroses), or the exclusion of supportive measures had to be reconsidered.

The problem was in part dealt with by the "formal creation" of the psychoanalytic psychotherapies, which allowed for the use of supportive measures with patients "unable to tolerate a more rarified" psychoanalysis (p. 50). Eissler furthered this approach with the idea of support as a "psychoanalytic parameter" that, when used in analysis, must eventually be "completely analyzed and worked through" (p. 51).

The problems with this approach, according to Gorman, are that: (1) supportive measures are ubiquitous in any analysis—e.g., the analyst's holding a door open, tone of voice, smiling, and so on; (2) the supportive measures' meanings cannot be analyzed away, any more than "a jury disregards crucial evidence that a judge later deems inadmissible" (p. 52); and (3) analysts cannot objectively differentiate interpretations from supportive interventions, such putative objectivity being a remnant of "nineteenth-century notions" of science (p. 52).

Gorman cites Wallerstein's work as showing that the "entire analytic process, including the interpretive process, has an intrinsic supportive process," and that "supportive and interpretive dimensions of an intervention belong to different and non-comparable categories . . . and, therefore, their coexistence provides no necessary contradiction" (p. 54).

What is crucial, however, according to Gorman, is that psychoanalysis must be defined in terms of a psychoanalytic attitude, which he provisionally defines as "an uncompromising but flexible focus on the unconscious and conscious psychoanalytic meaning of both the patient's/client's and psychotherapist's communications" (p. 57). Communication with the patient "for the primary and ultimate purpose of conveying psychoanalytic meaning, in order to provide . . . [increased] emotional, cognitive and conative understanding," is a

necessary component; and, for Gorman, the patient also has an "intentional role to play," involving the "at least verbally expressed intention . . . to allow the psychotherapist's intention to govern the therapist's role in the relationship" (p. 57).

Next, Gorman reintroduces and redefines Eissler's concept of the parameter as a variable whose manipulation may affect the analysis. In this way, what was once a priori considered unpsychoanalytic can now be studied in the context of the proper analytic attitude, as defined above.

The author holds that his proposed changes would work to rectify a variety of problems in psychoanalysis that have been precipitated by the equation of classical technique and proper analytic attitude. These problems include isolating the analyst from the patient, driving a "wedge between psychoanalysis and the psychoanalytic psychotherapies" (thus watering down the latter), "aggravating schisms between different analytic points of view," and "alienating analytic therapy from systematic analytic research" (p. 47).

The Psychodynamics of Terrorism. Diane Casoni and Louis Brunet, pp. 5-24.

In this article, the authors explore the psychodynamics of terrorism in both terrorists and those terrorized as witnesses at a distance. They argue that for both, a "symbolic equation is unconsciously made between acts of destruction that occur in reality and fantasized threats of internal destruction" (p. 6).

Casoni and Brunet describe the response of witnesses as involving an identification with both victims and terrorists. This sets up an internal battle between a destructive part of the self and a good part of the self that feels wounded. This in turn can create anxiety and despair about the security of good internal objects.

The authors describe two potential responses to these feelings. The first involves facing one's powerlessness and destructiveness, feelings involved in the depressive position. The second entails regression into a paranoid-schizoid position, with the use of pathological projective identification and splitting that can lead to broad acts of revenge under the guise of self-protection. The authors illustrate

these theoretical proposals with clinical material seen in the aftermath of 9/11.

Next, the authors propose that the terrorist's identifications with victims in his or her own life, the self included, "constitute an intense motivation for the future terrorist to resort to vengeance as a means of conquering his overwhelming anxiety and despair" (p. 17). Thus, just as witness identification with victims might lead to projective identification, splitting, and vengeance, so do the terrorist's identifications with victims lead to the act of terror/vengeance.

The authors go on to argue that, in order for the terrorist to protect his or her good objects, the terrorist must project them onto God or a leader of some sort. Thus, the terrorist becomes even more despairing, as everything that is good resides outside the self. This promotes envy and may relate to the terrorist's unconscious choice of innocent victims as representatives of the envied goodness.

Acting Out, the Death Instinct, and Primitive Experiences of Loss and Guilt. Robert Waska, pp. 25-44.

In this paper, Waska describes three overlapping phases in the treatment of some borderline and psychotic patients. Acting out, somatization, and compliance, with aggression and rebellion represented in dreams, are typical of the first phase. If the analysis survives the first phase, the second becomes apparent as the clinical material shows how the analysand tries to "erase connections to the object, to knowledge, and to life" (p. 27), while at the same time attempting to maintain such connections. Here the death and life instincts operate together but in opposition. The third phase involves the experience of "primitive loss, guilt, and persecution" (p. 27), which can evolve into "the more manageable problems of the depressive position" (p. 28).

Waska argues that in the first phase, an active stance is necessary and often forced on the analyst by the analysand. He describes this as using interpretation to "verbally restrain the patient from acting out" and using "restrictive and supportive measures" to "re-

train the immature and overwhelmed ego" (pp. 30-31). In the second phase, the work moves to a focus on a "working through of the ego's destructive motives and the ego's resistance to introjection of good objects" (p. 37), i.e., a working through of the defensive use of the death instinct and blocking of the life instinct. The third phase involves the analyst's continued containment and interpretation of resurgent acting out, as well as interpretation around "issues of loss and persecutory guilt" (p. 38).

Waska uses examples from the seven-year analysis of a rather difficult analysand to give the reader a clear sense of each phase. Particularly useful are Waska's quotations from the analysand's speech. For example, Waska uses the following quotes to illustrate how the death instinct becomes pathologically defensive rather than adaptive, working to destroy the "creative, reflective, and knowledgeable" (p. 35) part of the mind: "I am trying to keep myself at zero. I don't want to improve; that would be dangerous and beside the point. If I can avoid becoming a negative number, I am happy . . . . The only trouble with this is that I am all alone and can't ever reach anything or anyone" (p. 35). And, in grittier terms: "I would rather endure all this pain and the shit I am in than try to figure it out" (p. 33). And finally, the analysand's response after Waska attempted to point something out to him: "I am not interested in that now and I will never be . . . . I hope you don't push it because I am already feeling pissed and I don't need any more fucking pressure" (p. 33).

X, 2, Fall 2002

Psychoanalysis in the Making:
A Special Issue of the *Canadian Journal of Psychoanalysis*,
pp. 203-364.

This special issue of the *Canadian Journal*, under the heading "Psychoanalysis and Poiesis," was guest-edited by Marike Finlay-de Monchy, who asked contributors how a work of art, be it "fiction, poetry, theatre, film, sculpture or painting," "might think about psychoanalysis—even in some cases *think* psychoanalysis. Which is to say, add to the thinking that constitutes psychoanalysis, expand upon, profitably challenge, or invent anew its terms" (p. 203).

While acknowledging the contributions of other ways of thinking, Finlay-de Monchy proposes that psychoanalysis can "justify itself epistemologically by simply admitting that what it does is to construct stories" (p. 205). The author wonders whether psychoanalytic thinking might be less encumbered if the intent were poetic, if we sought "to listen to an analysand more as a character than as a category—as Christopher Bollas has suggested" (p. 205).

As stated in the introduction, this special issue contains a variety of "stories" that *think* psychoanalysis in new ways. First is an excerpt from Heidegger, exploring the importance of poiesis in what Finlay-de Monchy describes as our "unpoetic time" (p. 208). Next, Godbout argues that the operation of poiesis is necessary to life, and scientific epistemology must therefore be grounded in subjective referentiality. A translation of an excerpt of a work of "psychoanalysis in fiction" by J. Bigras follows, exploring how "we fall into a story's zone of affect; we are written and rewritten by it," much as we are "written and rewritten" in the consulting room (p. 209).

Zimbel, E. Bigras, and Carson provide three stories that "demonstrate the manner in which certain stories direct lives, cannibalize them, ruin them, haunt them, or foreclose them" (p. 210), with another story being the only possible, yet far from certain, means of escape. Following these stories is a series of drawings by Guzder, sketched while listening to a presentation by Bollas. Following this is an excerpted translation of a "fictive" work by Davoine, in which she looks at the "deeply ethical" need to engage the "philosophical ghosts who inhabit psychoanalysis—and psychoanalysts" (p. 213).

A contribution by Finlay-de Monchy follows, in which the author "attempts to render the experience of being adrift, cut loose, lost, terrified, thrilled, regressed—and accompanied," an experience viewed as "one of the 'black holes' of the scientific discourse of analysis—indeed, a void in many training analyses" (p. 213). A transcript of an interview with Joyce McDougall follows, about her use of the theatre metaphor—which serves as a "very canny piece of theatre" itself (p. 214). Perkins then explores secrets, "incest, gender, and diagnosis" in a "bit of play therapy to psychoanalysis" (pp. 214-215). Finally, Cope presents three short works that culminate in

a confusion of "characters, analysts, analysands, authors, and readers," perhaps showing how we can "build something moving from the confusion of our tongues" (p. 215).

Editor's Note: In conjunction with the following abstract, the reader may be interested in a review of Salman Akhtar's recent book, *New Clinical Realms: Pushing the Envelope of Theory and Technique*, pp. 1129-1132 of this issue of *The Psychoanalytic Quarterly*.

XI, 1, Spring 2003

Things: Developmental, Psychopathological, and Technical Aspects of Inanimate Objects. Salman Akhtar, pp. 1-44.

Starting from the premise that "psychoanalysis has paid inadequate attention . . . to the inanimate surround in which the human mind evolves and functions" (p. 2), Akhtar uses the sparse literature in this area, as well as his clinical experience, to argue the importance of a "deep regard for the inanimate world" (p. 1) in our theoretical and clinical work. He details the relationship between the inanimate surround, personality development, and psychopathology, as well as describing the importance of the inanimate surround in the therapeutic setting.

In outlining the role of the inanimate surround in personality development, Akhtar takes us from cradle to grave. Citing the work of Spitzer, Stern, Piaget, and others, he notes that the distinction between animate and inanimate begins to develop in early infancy, but continues far beyond the early years. The differentiation of animate from inanimate is a crucial organizer of the psyche. It combines with the development of the ability to use transitional objects and the development of physical object usage in Mahler's practicing subphase to promote a deeper sense of object constancy and play.

In the oedipal position, the use of physical objects for purposes of identification increases. During latency, games help to "rework both phallic-oedipal and separation-related concerns in an aim-inhibited and ego-dominated way" (p. 7), while hobbies and collec-

tions promote enjoyment of cognitive and motor skills. In adolescence, the inanimate surround is employed in the move away from parents and the forging of a new identity via trial identifications. Young adulthood involves culture-influenced acquisitions related to partnering and raising children. Middle age presents one with an "existential fork" (p. 9) in relation to the inanimate surround, with greed on one side and asceticism on the other. Old age can bring "a great dependence upon, even an anxious attachment to, health-care accoutrements," while inevitably forcing "everyone to say goodbye to the world of things" (p. 10).

Akhtar outlines several ways in which the physical surround plays a role in psychopathology. In psychosis, there can be a loss of the ability to discriminate between animate and inanimate, delusions of control by physical objects, the imbuing of physical objects with magical properties, and the use of "autistic objects" (p. 14), à la Tustin. Inanimate objects are an important part of many perversions, addictions, obsessions, and phobias. The hysteric and the narcissist may use "aesthetic adornments" (p. 20), though in different ways. Physical objects are also an important part of mourning, and may play a particularly critical role in immigration-related problems.

Akhtar describes many ways that the inanimate surround is important in the therapeutic setting. The use of physical objects to facilitate the expression of thoughts and feelings is a standard component of child treatment. Promotion of continuity in the inanimate surround of the hospitalized psychotic can help ward off self-fragmentation. The analyst's office is an oft-neglected aspect of the treatment that carries much meaning for both patient and analyst. Moves or changes in the office must be carefully considered, as should any items the patient brings to the analysis, including gifts. Akhtar notes his use of physical "linking objects" in the treatment of pathological grief reactions. Finally, there are times when analyst or analysand can become nonhuman and even inanimate "in the other's subjective experience" (p. 30).

Akhtar's paper contains twelve brief clinical examples that help the reader appreciate the variety and complexity of issues involving the inanimate surround in psychoanalysis.