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EDITOR'S INTRODUCTION

In focusing on the contemporary uses of the concept of conflict, we can begin to discern various layers in the clinical history of psychoanalysis, like sediment in the banks of a river. To be sure, some psychoanalysts no longer consider conflict to be the defining feature of analysis and rarely speak of it. Others are silent on the subject but more because, like the air we breathe, they consider it implicit in the work. Even those who consider themselves conflict theorists analyze different forms of conflict, in different locations—not only in the mind of the patient, but also in the material of the hour.

Thus, some analysts focus on conflict as reflected in the structural theory, others on topographic conceptions of conflict. Some attend to more conscious manifestations of conflict, others to the deeper reaches of unconscious conflict. Some stay firmly rooted in the intrapsychic; others include more of the interpersonal or intersubjective. Each of these theoretical differences entails a different inferential process and a different mixture of conscious and descriptively unconscious components. In current psychoanalytic discourse, all these various uses of the concept of conflict tend to be mixed together, as if we were all speaking the same language, when in fact the meaning of the term is often unclear and inconsistent.

As a result of these confusions, it seemed an opportune time to ask thirteen leading analysts to spell out how they see the role of conflict in the lives of their patients and in the work of analysis. If they accord pride of place to unconscious conflict, what sort of conflict do they analyze? Where is it, and how do they know it is there? How does unconscious conflict relate to conscious conflict,

conflict as experienced by the patient? And how consciously do they as analysts pursue the analysis of conflict?

The result of this inquiry is the issue you hold in your hand. I am extremely grateful to all participants in this project for responding with such clarity to my request to describe how they conceive of conflict from within their own frame of reference and to illustrate that conception with clinical material.

We begin with Sander Abend, who, in his typically clear and incisive fashion, reviews the early history of the concept of conflict, highlights Charles Brenner's elaborations of it, and then illustrates his own personal use of the principles of conflict and compromise.

The next two papers are by analysts who, like Abend, have been closely associated with different branches of ego psychology, and we can see their own evolution from that main trunk. Fred Busch illustrates how he addresses "interferences in healthy narcissistic development"—patients, that is, whom some might find unsuitable for a conflict-based approach, and in parts of his paper you will find him sounding quite different from the conflict theorist you may expect.

Roy Schafer discusses his integration of various perspectives into his own approach, including contemporary Freudian and Kleinian ones, and in this paper, he both reaffirms his commitment to the concept of conflict and discusses its use as a "narrative choice," thus knitting together a number of his own conceptual threads.

Otto Kernberg, who has long bridged ego psychology with Kleinian and object relational concepts, orients the ego psychological version of conflict within his view of internalized object relations, and then illustrates how, from an object relational perspective, one might analyze unconscious conflict on a continuum from more primitive to more neurotic forms.

John Steiner represents the contemporary British Kleinian point of view and, in a highly original paper, extends his earlier discussion of conflict within the Kleinian model (1996), to focus on the intrapsychic conflicts inherent in facing the reality of loss so that

mourning can take precedence over melancholia—a process he elaborates as a general principle of growth and development.

In a similarly personal and original statement, Jay Greenberg describes an area of conflict that he terms "conflict in the middle voice," the middle voice being a verb form in ancient Greek that was used to convey both passive and active voices simultaneously. He illustrates how patients suffer from conflict over whether they are the desiring subject or the object of desire, along with the conflict they experience in being, always and simultaneously, both.

The next two papers take us to the French perspective, with its particular integration of topographic and structural theory, together with a number of more contemporary points of view. Gail Reed and Francis Baudry discuss and illustrate their view of André Green's theory, applying it to the treatment of borderline and narcissistic patients. As Kernberg did with his own model, they use Green's theory to illustrate how a focus on conflict can be adapted to the analysis of the entire spectrum of patients who present to us. In the clarity of their exposition, they perform a great service to the English-speaking world by making Green's work more accessible and more clinically usable.

Alain Gibeault, in a highly unusual paper, shows us firsthand how the French theory of psychic conflict can be used to treat a psychotic patient in a modified form of analysis, psychodrama.

Cordelia Schmidt-Hellerau takes us back to the same period in Freud's theorizing that gave birth to contemporary French psychoanalysis, the era of his metapsychological papers—in this case, to his first dual-drive theory and the conflict between libidinal and self-preservative drives. She illustrates the usefulness of thinking of the Oedipus complex as a conflict between love and care or between sexual excitement and self-preservative needs.

Next, we have two very different views from the perspective of self psychology. Anna Ornstein and Paul Ornstein review the controversy between the analysis of conflict and the analysis of deficit, suggesting that non-drive-related conflicts appear both alongside deficits and secondary to them.

Extending his view of vertical splits, Arnold Goldberg illustrates the idea that certain conflicts arise between disparate configurations of the self. He understands these as existing on a continuum between subtle and more dramatic moral dilemmas.

The last two papers are broader discussions of the subject, seen through the lenses of particular psychoanalytic cultures. Both focus in part on an earlier paper of my own (Smith 2003). Adrienne Harris gives us a scholarly discussion of the concept of conflict in relational psychoanalysis, notes its use at many levels of abstraction, and describes points of similarity and difference between relational theory and contemporary conflict theory. Thus, we have a perspective on conflict from within a frame of reference that has explicitly kept its distance from conflict theory.

Finally, Jorge Canestri does the same from within the perspective of European psychoanalysis, noting, too, that the concept of conflict is not as explicitly discussed in Europe as it is in North America, but is implicit in the work. In contrast to those authors who illustrate a view of conflict that extends to earliest development and to the more pathological states, Canestri speaks of a preconflictual phase of development, but does so in a manner quite different from that of similar voices in North America.

The issue concludes with my discussion of the thirteen papers.

We hope you find this clinical menu of ideas both illuminating and thought provoking as we try to make clearer one of the core concepts in our psychoanalytic discourse, including the similarities and differences among our points of view. We also hope this issue will prove a useful tool to extend the dialogue further, and that you, the reader, will join in the conversation with creative contributions of your own.

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ANALYZING INTRAPSYCHIC CONFLICT: COMPROMISE FORMATION AS AN ORGANIZING PRINCIPLE

BY SANDER M. ABEND, M.D.

The author highlights the idea that analysts' recognition of intrapsychic conflict and compromise formation provides them with a most effective way to formulate their patients' problems. A clinical illustration is presented, with attention to the analyst's use of these concepts during the course of the patient's treatment. The author discusses ways in which his thinking about intrapsychic conflict, compromise formation, and unconscious fantasy informs his approach to clinical work. He emphasizes that viewing compromise formation as the organizing principle of much of mental life gives analysts an effective way to understand the underlying structure of the psychic phenomena in which they are interested.

INTRODUCTION

In order to describe what is involved in the analysis of intrapsychic conflict, it will be helpful first to set forth those fundamental ideas about mental functioning upon which the relevant technical precepts are based. The primary proposition central to the theory of the analytic significance of intrapsychic conflict is that a dynamic state of opposition exists between or among various important components of mental life, and that some of them lie outside the realm of consciousness, remaining unavailable to it by means of ordinary conscious introspection alone. Over the course of more

than a century of psychoanalytic theorizing, the account of the constituents of conflict—of the motives for the state of opposition that characterizes them, of the range of possible consequences of the internal clash of the forces or elements involved, and of the role played by psychoanalytic intervention in altering the outcome of conflict—has undergone substantial refinement. To set the stage for a presentation of the technique of the analysis of conflict in contemporary terms, it will suffice to give a condensed outline of the historical development of the theory of intrapsychic conflict, and of the psychoanalytic techniques devised to address its vicissitudes.

DEVELOPMENT OF THE PSYCHOANALYTIC METHOD

Almost from the very beginning of Freud's efforts to understand neurotic afflictions, he recognized that certain aspects of mental life are held in a state outside of consciousness precisely because they are, for one reason or another, unacceptable to the individual's conscious awareness. As he progressed from the earliest cathartic techniques to the development of the first truly psychoanalytic method, he soon realized that his analytic patients, without recognizing how or why they did so, silently struggled against permitting the unwelcome material to become conscious. Even more surprising and frustrating, he saw that they were often likely to again relegate it to the hidden realm, even after the threatening material had been identified and discussed in treatment. Freud termed this phenomenon *resistance*, since it made its appearance in the clinical situation as an obstacle to the analyst's efforts to help the patient understand the nature of disturbing unconscious contents. He reached the logical conclusion that the preexisting internal state of opposition, or conflict, between various components of the analysand's mental life became transformed in the analytic situation into a conflict with the analyst and his or her efforts to intervene in the patient's psychic economy.

Resistance emerged in spite of the patient's sincere, conscious desire to cooperate with the treatment in order to obtain relief from emotional suffering. This formulation of the paradoxical nature of the analytic situation has continued to intrigue and challenge theoreticians of psychoanalytic technique, even as our understanding of the complex nature of the relationship between analyst and analysand has grown in sophistication and subtlety over the course of time.

Intrapsychic Conflict

Years of clinical experience taught Freud that his initial focus on the identification and interpretation of unconscious libidinal wishes, whether in the transference or in the recaptured infantile past, was not sufficient to deal therapeutically with the range of emotional problems that psychoanalysis sought to alleviate. Clinical evidence documenting the frequent occurrence of self-destructive behavior forced him to abandon the view that self-preservation was his patients' sole motive for regarding the unconscious wishes as threatening, and he gradually developed a more comprehensive and accurate understanding of the nature of intrapsychic conflict. The importance of unacceptable unconscious aggressive wishes (in addition to libidinal ones), the complex variability of defensive aspects of mental functioning, the range of imagined dangers against which defenses are mobilized, and the elaborate part played in psychic life by self-punitive trends were all incorporated into his revised understanding of the true nature of intrapsychic conflict.

These revisions were comprehensively described in two seminal works, "The Ego and the Id" (1923) and "Inhibitions, Symptoms and Anxiety" (1926). However, it was not until a number of years after those publications appeared that psychoanalytic technique truly incorporated the implications of the new formulations, which we now collectively refer to as the structural theory. The emergence in the 1930s and '40s of what analysts called ego psy-

chology, with its emphasis on the analysis of defenses and their role in conflict, was a further consequence of these theoretical developments.

Other subjects of interest, some of them originating outside the mainstream of Freudian psychoanalytic thought, came to influence the technique of the analysis of conflict, in some cases not without considerable questioning and debate. Without attempting to credit all the various sources of these additional factors (a task that would take us too far afield), I can mention that among the most significant were: (1) recognition of the role played by the therapeutic relationship in bringing about change; (2) utilization in psychoanalytic technique of countertransference data as a source of information about the patient's mental life; and (3) a vastly increased interest in certain quarters in preoedipal factors, whether as loci of conflict in themselves, or as developmental deficiencies that affect defensive and adaptive capabilities.

Perhaps equally important, analysts today are likely to have a far more extensive and subtle conception of what is included in the transference dimension of the analytic encounter than was the case when Freud concentrated more or less exclusively on the manifestations of unconscious libidinal wishes toward the analyst. It is also common nowadays to reflect on the interaction between analyst and patient as expressing a potentially informative blend of transference and countertransference elements, as well as to acknowledge the impact of the analyst's personality and behavior on the patient's experience in analysis.

These developments are certain to be familiar to analysts of every persuasion, and I do not propose to elaborate them here in further detail. Instead, I shall concentrate on the steps involved in the understanding and interpretation of instinctual conflict, and thereby of the effort to provide the analysand with helpful insight into its nature and origins, and thus to mitigate its influence on his or her emotional difficulties. In order to do so, I shall place special emphasis on the theoretical and practical importance of the concepts of unconscious fantasy and compromise formation.

Unconscious Fantasy

The assumption of the importance of unconscious fantasies in normal and pathological mental life is hardly a new idea. Once Freud replaced his belief in the etiological ubiquity of experiences of childhood seduction with the recognition that imagined scenarios could also play a determinative role in producing adult neuroses, of necessity, he assigned unconscious fantasy life a central place in psychoanalysis. His elaboration of childhood sexual theories and anatomical confusion in "Three Essays on the Theory of Sexuality" (1905) further underlined the lasting influence of unconscious fantasies in normal as well as pathological development. His description of the part played by the growing child's conviction regarding a series of imagined danger situations (Freud 1926) in determining the fate of infantile libidinal and aggressive wishes placed unconscious fantasies at the very crux of childhood instinctual conflict. Generations of analysts who followed in Freud's footsteps have employed the concept of unconscious fantasy to elaborate their way of understanding the meaning of patients' symptoms, beliefs, reactions, and behavior. It is clear that they attempt to detect the particular unconscious fantasies that lie beneath the surface of analytic material, and are likely to explicitly mention their conjectures about such entities in the course of doing analytic interpretive work.

While countless publications, panel discussions, and case presentations have documented the attention that analysts pay to unconscious fantasies in their clinical work, it is not always explicitly indicated that important instinctual conflicts are invariably involved in the formation of all such fantasies. Nevertheless, it does follow logically that analytic work on uncovering and clarifying the nature of important unconscious fantasies is necessarily, at the same time, an aspect of the technique of analyzing instinctual conflict. The relationship between unconscious instinctual conflict and the fantasies in which they are expressed has been further explicated as a result of the elaboration of the

concept of compromise formation in the work of Brenner (1982) and those influenced by his ideas.

Quite early in his work (1896), Freud presented the notion that neurotic symptoms can be thought of as the product of a compromise between forbidden unconscious libidinal wishes and the defensive forces that impinge upon them to disguise their nature. This relatively simple conception of compromise formation persisted in the language of psychoanalysis, despite the growing understanding of complexity reflected in the introduction of such terms as *overdetermination* and the principle of multiple function (Waelder 1936). Actually, Freud himself had long since provided a more complete and accurate outline of the nature and composition of instinctual conflicts, but he never troubled himself to incorporate this broader understanding into his conceptualization of compromise formation, nor did he apply his ideas about it beyond symptom formation into the realm of normal development.

Compromise Formation

Brenner (1982) revised our understanding of the meaning of compromise formation in order to bring it into harmony with the intervening evolution of psychoanalytic theory. He suggested that compromise formation should be understood to describe the result of the interactions among *all* the components of an instinctual conflict. Furthermore, he demonstrated that instinctual conflicts and their resultant compromise formations are not limited to the sphere of psychopathology, but also constitute the structural underpinning of much that is considered normal in mental life.

According to Brenner, compromise formations can always be shown to incorporate four categories of components. The first, of course, is some manifestation of the libidinal and aggressive drives, which on the manifest level appears in the form of wishes that involve a specific activity and its corresponding object. If the wish is a conflicted one, there is, by definition, also some form of moral injunction—the second category—in regard to it, as part

of the compromise formation. This gives it the quality of being unacceptable to consciousness by virtue of its appearing to be forbidden and dangerous. The moral component of the compromise formation may well include some expression of the threatened punishment connected to it, such as the loss of parental love or castration, to mention familiar examples. A third component of the compromise formation must of necessity be some kind of unpleasure (whether or not it is clinically manifest): either one or another form of anxiety, depressive affect, or both. Finally, in the service of a more or less successful effort to disguise the forbidden wishful elements (and sometimes the punitive threats as well), compromise formations include some mental contents that function as defenses.[1]

While it is logically appealing to think of compromise formations as if they are functional mental entities or structures (and, in fact, any psychoanalytic dissection of a symptom, fantasy, or character trait will show that it consists of some version of the four categories of component elements described above), it is more accurate to think of compromise formation as an organizing principle of conflictual mental life. The importance of this distinction is that it can clarify what has sometimes been a source of confusion to some analysts—that is, the layered or hierarchical nature of compromise formations. Thus, for example, the defensive component of a given compromise formation may appear in the form of behavior that can itself be understood to be a compromise formation. A character trait such as extreme solicitousness toward weak and helpless individuals may well be more complex than is suggested by the familiar designation of it as a reaction formation against murderous wishes. This trait can, for example, include an unconscious identification with an admired and beloved figure from the individual's past, one whose kindli-

[1] It should be noted that while defenses were originally thought of as a relatively simple set of mental mechanisms, such as displacement or reaction formation, it has long been recognized that, in fact, many aspects of mental activity, including quite complex ones, can be employed to serve defensive purposes in compromise formations.

ness the person wishes to emulate in order to gain the admired person's love and approval. The identification that lies at the heart of the solicitous trait is itself a complex unconscious fantasy—or, in other words, a compromise formation that in turn serves as a component of the compromise formation dealing with unacceptable sadistic wishes.

In my opinion, the most advantageous aspect of adopting the view that compromise formation is an organizing principle of conflictual mental life is that it provides the analyst with the most accurate and comprehensive point of vantage presently available from which to study and understand psychoanalytic material. Consequently, it constitutes a most useful guide for the conduct of clinical work, including the task of formulating interpretations. I do not mean to suggest that the analyst always holds the idea of compromise formation as the conscious central focus of his or her mind while assessing the patient's productions. However, if he or she has absorbed this conceptual framework as a meaningful description of the architecture of conflict as it affects the analysand's normal and pathological mental activity, it becomes an omnipresent template, often in the background, but sometimes ascending to the foreground, which will shape the listening analyst's grasp of the material. What is often subsumed under the heading of clinical intuition is given its structure, in fact, by this underlying theoretical framework, even though the theoretical considerations remain implicit.

Noting the evidence of dysphoric affect, for instance, may be taken as a sign of less than fully successful modulation of some of the patient's forbidden wishes. Nevertheless, in any given clinical moment, the analyst's attention is just as likely to be focused on the defensive aspect of the compromise formation under examination, or on the nature of the imagined punitive risk or condemnation attached to the wishes, as on the identification of the exact nature of the currently active unacceptable desires themselves. He or she may thus choose to interpret any aspect of the compromise formation, singly or in interactive combination (or may choose to say nothing at all), depending on his or her intuitive assessment

of what the patient can absorb and utilize at the time. The same general technical posture would apply whether the analyst is considering a symptomatic act, a dream, an unconscious fantasy, a daydream, a form of interaction in the transference, or the patient's account of past or current experiences.

It goes without saying that in daily analytic work, the analyst's grasp of underlying compromise formations may be incomplete or inaccurate, and his or her judgment about what, if anything, to tell the patient will often be less than perfect. Those who remind us that such qualities and characteristics of our patients' mental lives as their innate intelligence, verbal and symbolic skills, special talents, biological variations of all sorts (including inherent limitations, damage, and the like) will be in evidence in the analytic material they produce are, to be sure, absolutely correct in that assertion. Those of us who subscribe to the view that the analysis of instinctual conflicts, and of the compromise formations to which they give rise, is the centerpiece of psychoanalytic therapy look on the infinite variability of our patients' individual mental qualities as most significant *insofar as they lend particular shape and color to the fate of their important instinctual conflicts.* Although we cannot fail to notice the effects of those qualities on our patients' lives, for better and for worse, we believe that the analytic task is to try to understand and modulate the disadvantageous outcome of conflicts.

We therefore concentrate our efforts on the problem of detecting the outline of those conflicts, together with the structure of the compromise formations to which they give rise, in the material our patients present to us. Using this schema to map our patients' mental lives, insofar as they become the subject of analytic attention, then leads us in the course of time to the interpretive offerings that we hope will expand their insight into the nature and origins of their emotional problems, providing the possibility of a modicum of relief of that dimension of their suffering.

At this juncture, I will present a sample of clinical work with which I hope to illustrate how this approach unfolds in the clinical situation.

CLINICAL EXAMPLE

X, a successful attorney in his late thirties, came to treatment in large part because of his inability to form a lasting satisfactory attachment to a woman. His history, as it unfolded in the early months of his treatment, strongly suggested that conflict—derived in the main from the particulars of his childhood relationship with his mother—contributed to this problem.

One failed love affair that took place during the second year of his therapy gave some evidence of this linkage. The segment of his treatment on which I shall concentrate begins later, during the third year of therapy, when he fell in love with another woman, whom I shall call A, an attractive female colleague employed at a different law firm. It was not very long before his conflicts once again surfaced to disrupt the course of this affair, just as they had in the previous one. This woman was bright, cultivated, sexually seductive in a somewhat provocative fashion, and she came from an ethnocultural heritage quite different from my patient's. They were immediately attracted to one another, and after a passionate affair of only a few weeks' duration, they decided to marry, setting a date a few months away. My patient's fiancée disliked her job as an entry-level employee at a large law firm, feeling exploited, overworked, and underpaid. X, albeit with some hesitation, agreed to support her so that she could leave the position in order to look for a better situation. In the succeeding weeks, he said that she was devoting herself to planning their wedding, seeing friends, and going to exercise classes, but not, as far as he could see, to seeking a new job. He grew increasingly uneasy and resentful.

As I mentioned, at an earlier period in his treatment, X had fallen in love with another woman, who for the sake of clarity I shall call B. He had also rather quickly decided to marry her, only to become increasingly disenchanted as the wedding date approached. B, also from a distinctly different cultural background than X, was successful in another profession, and had achieved

considerable financial independence. The problem was that she both lived and had established a business in a nearby city, and the negotiations over who should relocate and how it would be arranged became a source of mounting tension between them. I use the term *negotiation* deliberately, since my patient's descriptions of their acrimonious discussions took on the characteristics of a business deal, with demands and counterdemands, compromises, and conditions; this process became the focus of his increasing resentment. Though they remained very attracted to each other and still shared many interests, the relationship eventually foundered because of the mounting suspicion, anger—and, finally, contempt—that came to dominate his conscious thoughts about her.

It was notable that both X's former fiancée and his current one had described having had difficult emotional relationships with their respective mothers, each of whom was said to be grasping, selfish, and possessive, as well as antagonistic toward men, though neither of the mothers appeared to display the latter trait with respect to my patient, as far as I could determine. As I have indicated, the clinical material had long since documented the complexities of X's tie to his own mother, an unsuccessful artist who had constantly denigrated his passive, moderately successful, businessman father. Her attacks were sometimes about their different social and cultural backgrounds and preferences, but were much more often about money. According to my patient, his mother was a spendthrift, was perpetually dissatisfied, and manifestly contemptuous of his father's inability to provide a more luxurious lifestyle. She also favored my patient, who was her oldest son, in an openly admiring and somewhat seductive way, extolling his achievements and virtues, often at the expense of his siblings and his father.

His description of his family members and their interaction also included an acknowledgment of his intense childhood attachment to his mother. During adolescence, his possessive devotion had been replaced by a distinct, conscious ambivalence marked by

an attitude of disdain. In the course of his up-and-down love affair with B, frequent spontaneous associations had linked his confused and contradictory feelings about her to thoughts about his mother, and, in particular, about his observations of his parents' contentious relationship. He had come to understand that his increasing uneasiness at the prospect of marrying B was to some extent influenced by his fears of getting caught in an intimate involvement that might somehow come to replicate what he had seen while growing up at home.

As he became more and more anxious about the prospect of marriage to A, X grew consciously suspicious of her, especially with respect to financial matters. He imagined that she never intended to work at all, and once or twice he quarreled with her about her expensive tastes, which clashed with his own frugal tendencies. His thoughts about her included disdain for what he regarded as the superficiality of her materialism. He concocted schemes in which he would educate her in fiscal responsibility, which he described to me without any apparent awareness of their dictatorial, not to say quite unrealistic, quality.

At this point, I will interrupt the clinical account in order to summarize certain aspects of X's relevant conflicts as I came to think of them during the course of the analysis, and to address the technical problems I encountered in attempting to analyze them. In the interest of brevity, I will confine my attention to those of his conflicts and fantasies pertinent to his trouble in forming and maintaining a committed relationship with a woman.

X had been a sickly boy, and felt that he had been utterly dependent on his mother's physical and emotional ministrations, which continued throughout his childhood. This intimacy colored their charged mutual admiration, which appeared to have dominated his psychological life until his adolescence. It seems entirely plausible that his teenage retreat into cold distance from her, and the development of a conscious attitude of ambivalence, were motivated by the need to defend against unconscious oedi-

pal wishes and their associated threats, which were reactivated and intensified as a consequence of his sexual maturation.

Although at this point, it was still too early to say how work with the transference would eventually come to play a part in his treatment, X then maintained a determined focus on the reality-bound, doctor-patient aspect of our relationship, denying any awareness of an emotional tie to me. I am inclined to think of this as a transference defense against any kind of threatening emotional dependence on a caretaker that might constitute a repetition of his childhood attachment to his mother. There were also hints of a kind of skeptical, mildly contemptuous attitude toward analysis, suggested by his occasional use of derogatory terminology, which reminded me of his disdainful thoughts about his mother and both girlfriends, even though such hostility was never directed toward me personally. This was consistent with (although hardly proof of) my speculation that the main underlying transference paradigm was a maternal one. I do not mean to suggest that the transference was uniform or simple, and, in point of fact, it was at that point not possible to demonstrate any clear, unmistakable link to the objects of his past. Up until then, I had confined my interpretive comments about the transference to observing that X appeared to prefer to see our relationship as a mutually respectful, conventional, professional one, devoid of any emotional dimensions. I also suggested that he might be uncomfortable if he were to recognize that feelings of affection, need, irritation, disappointment, disparagement, or the like could also play a part. He acknowledged that much, but without indicating any willingness to explore what might be motivating this posture of his.

As my selective summary indicates, it is easy to conjecture that my patient's conflicts stemming from his complex relationship with his mother played a central role in the problems he had in sustaining an intimate, loving connection to a woman. As with the transference situation, the technical problems included that of

assessing the evidence in support of my various specific conjectures about the nature of his conflicts and compromise formations, and about the unconscious fantasies in which they were embedded. It was also problematic to decide which questions, connections, or explanations were likely to be emotionally convincing, meaningful, and useful to him at any given moment in the course of his therapy.

For example, I believe that X's preference for women of an ethnic and cultural background different from his own combined an element of connection to his image of his mother, who stressed her cultural difference from his father, with a defensive denial of this oedipal link, since the obvious exogamy constituted a surface negation of the resemblance these women had to his picture of her. At that point in the analysis, we could talk only about how important it was to him that the woman he was drawn to should be demonstrably different from the stereotypic women of his own ethnocultural group, for whom he professed nothing but disrespect.

The other elements of the compromise formation whose existence I suspected were still too far removed from his consciousness to be usefully interpreted. He was certainly far away from any awareness that his childhood possessiveness toward his mother included an infantile wish for sexual possession of her. Consequently, he could not consciously recognize what I believed to be his fear that the imagined fulfillment of such a wish carried with it compelling fears of being devoured and destroyed by her, as well as crushing guilt in regard to his father. These and other conjectures about his conflicts were tentative hypotheses that rested in the background of my clinical thinking, but derivatives of them seemed to me to appear in the material.

For example, X was quite conscious of both pleasure and guilt connected to being favored over his siblings, but much less so with respect to his father. He could think about this circumstance in relation to a pattern he had long recognized in himself, that is, he needed to be assured that a woman he was to take seriously

was unmistakably attracted to him, so that there was almost no chance of rejection. It was also the case that there could not be seen to be another man competing for her, because if there were an obvious rival, he would find a reason to retreat. He was not yet aware that guilt and fear of punishment might contribute to this pattern, in addition to the obvious need to preserve his fragile self-esteem. He had come to see that a certain element of playful struggle with the woman he was drawn to had to be present in order for him to be sexually excited by her, and that this had some as-yet undefined connection to the aggressive tensions he had observed in his parents' relationship. If the level of friction intensified beyond a certain point, however, his avoidant distaste overpowered the attraction. He had some degree of conviction that there were emotional links between past and present, but until recently, he had no appreciation of any specifics of the unconscious fantasies involved.

For purposes of illustration, I will return now to the case material and briefly summarize a representative segment of the work with my patient that highlights a particular aspect of his conflicts about marriage to A. For several sessions, with mounting anger, X had described his concern about her taste for luxury, expressing moralistic disapproval of her values. He voiced suspicion of her sincerity about intending to find a new job, and, with considerable anxiety, he expressed the fear that his substantial savings would be eroded, his future security threatened by her appetite for material pleasures. Although his angry tone and contempt were reminiscent of what had arisen during the end stages of his earlier failed relationship with B, the anxiety about depletion was a new symptom. I was inclined to attribute its appearance to a shift in his defensive armament, but I was not really clear about precisely what had changed.[2]

[2] In general, I am disposed to think that analytic progress leads to an increased tolerance for previously warded-off material, including permitting conscious recognition of unpleasure that had been blockaded. I must add that I have no evidence beyond my clinical impressions that would support such a belief.

I drew the patient's attention to the anxiety, inviting his curiosity about the degree of threat he was experiencing and about his conscious fantasies of impoverishment and risk. He could readily agree that these seemed exaggerated and unrealistic, but he nevertheless remained anxious; he concocted various schemes for educating A in financial management and for restricting her expenditures after their marriage.

I conjectured that X was in the grip of an unconscious fantasy of being engulfed or devoured by a woman's uncontrollable appetites, and I proposed to him that such an idea might have originated in his early childhood in the form of a fearful characterization of his mother's possessive attachment to him. I did not add my suspicion that such a fantasy could well include disowned and condemned, projected elements of his own insatiable desires for his mother—since, even if accurate, such an idea was too far removed from his conscious views to be useful to him at that moment. Likewise, my guess that there might be fantasies of danger to his phallic identity through oral incorporation and merger was not at that point supported by clear material, nor would it yet have been helpful, I thought, to try to explore such an idea, even in order to determine more accurately whether it was relevant to his current distress.

At least intellectually, the patient could entertain the notion that his fears about A were magnified out of proportion by archaic images of his mother's appetites and attitudes. In one session in particular, immediately after talking about this linkage, his conscious preoccupations changed to incorporate a new element. He began to devise schemes of compromise, in which a certain amount of gratification of A's desires would be acceptable, but only if balanced by restraints that he would impose on her. I heard in this material echoes of the construction of possible compromises that had been a part of the end stages of his previous stormy engagement to B.

I interpreted to X that his conscience now seemed to be playing a larger role in his thoughts about how to deal with A's desires.

In response, he elaborated on his ideas that he always sought to be fair and equitable in the arrangements he was contemplating. I pointed out that his compelling concern with devising fair compromises was taking place entirely in his own imagination, much as had the antecedent fixation on condemning A's values and behavior and on the danger of impoverishment, none of which he had discussed with her. He reminded me that a few very tentative attempts to talk to A about finances had upset her very much; he had quickly retreated in the grip of frustration and guilt. He acknowledged that he was afraid of losing his temper and destroying the relationship.

At this juncture, the patient's thoughts returned to the theme of fairness, which now seemed clearly to be determined by his unconscious effort to deal with his guilt about hurting A. Just at this moment in the session I am describing, X suddenly recalled that, as a child, when he was witness to open battles between his parents about money and expenditures, he would silently but compulsively occupy his mind with devising plans of how to settle their arguments "fairly"! It seemed clear that this recovered memory served to increase his slowly growing conviction about the influence of the past on his present symptom picture.

DISCUSSION

This brief case vignette, and the segment of material including the part of a session I have described, is presented in order to illustrate typical, rather than exceptional, work in the process of analyzing intrapsychic conflict. In my experience, analytic progress is rarely as concise, clear, or dramatic as some condensed case reports might lead one to think. Progress is incremental, and the steps are usually small ones, not infrequently repetitious. I have indicated that my patient gained some awareness that his childhood experiences continued to influence his current emotional life. The incident described, in part because a new connection occurred to him spontaneously, seemed to strengthen his acknowl-

edgment of the ongoing power of the past, at least for this moment in his therapy.

I have also offered a sample of the kind of conjectures I entertain about what might be active in my patient's mind; these undoubtedly reflect my own theoretical preferences, in interaction with my individual clinical sensibility. They are also shaped by my attention to the long-established principles of context and contiguity in the patient's material as I hear it. My own interventions, as I have tried to show, are constrained by my best judgment about what my patient can make use of at the moment.

Inevitably, I make my way as best I can toward a sense of comprehension about my patients' mental lives, sometimes misunderstanding what is going on, sometimes misjudging what he or she can hear and find meaningful or interesting. My questions and interpretations sometimes lead to helpful clarification, but at other times are not so productive. Furthermore, at times, I may be hesitant to go where other analysts would be bolder to venture, and I am sure I miss meanings others would detect. Such is the nature of the work that I do, although I take some comfort from the fact that many discussions have led me to conclude that my most trusted and respected colleagues have a similar sense of things in our demanding world.

I have tried to make it clear that I do not attempt to consciously formulate my patients' intrapsychic conflicts as a consistent feature of day-to-day work. As for the conjectures I consider, these can be fleeting or recurrent, vague and fuzzy, or quite sharp in my mind. They can emerge in my thoughts encased in doubt or compellingly insistent in my imagination. I am as likely to concentrate my attention on what I think are my patients' active unconscious fantasies, or to think in terms of compromise formations, or to wonder about affects expressed or concealed, as I am to think about the precise ideational content of their conflicts. I see these different clinical foci as parts of a single psychic tapestry, so it is not essential to examine all of it at the same time; in fact, it is not possible to do so.

There is no set system or progression that I follow—not even to give primacy to the transference, although I always think it is important to consider that aspect of the work. The same can be said of my interest in and attention to the defensive aspects of the material. While the concept of compromise formation is fundamental to my understanding of the architecture of the mind, I would probably never use that term in talking to patients, since I think such language is too abstract and intellectual. On the other hand, I would not hesitate to speak directly to a patient of his or her conflicts, or to label and discuss unconscious fantasies, whenever I think those terms might clarify for them what I believe is influencing their thoughts, feelings, and behavior.

I cannot do full justice here to the question of what constitutes evidence for my conjectures, although I have made passing reference to such familiar precepts as context and contiguity. However, this does seem to be the place to say something about how I utilize countertransference data in my technique. For me, the subject of countertransference is inextricably interwoven with the question of clinical intuition and with the problem of assessing evidence. I am certain that some conjectures about my patients' mental lives are more likely to occur to me, others less so, because of my own predominant intrapsychic makeup, as well as its day-to-day situational fluctuations. Given that view, monitoring my ideas about the patient—like attending to my affective state, fantasy life, and behavior in sessions—is a constant challenge.

In weighing the validity of my internal responses to the patient's material, I try to measure the force of their insistence and persistence in my mind as a general indicator that they deserve serious consideration. That said, I nevertheless always try to find as well some fit with the external data, that is, the shape and content of the patient's associations, in order to help me determine the reliability of my self-reflections. I do not doubt that what emanates from my patients has an impact on my mental life, just as I acknowledge that my personality and behavior have an impact on my patients. I must add that I never think in simple terms of

projective identification or role responsiveness; this reluctance is a function of my inherent caution about possibly underestimating the influence of my own unconscious predilections on the moment-to-moment patterning of my responses. In short, as I have tried to indicate, I am aware of trying to do the best I can, while maintaining a healthy respect for the uncertainties of my analytic sensibility.

CONCLUSION

For me, then, the analysis of unconscious conflict, and of the compromise formations to which it gives rise, is the quintessential feature of my way of understanding the patient's mental life and of the complexities of the clinical situation. I prefer it to other schemata because I remain convinced about the superiority of its explanatory power to that of other approaches, and I like to think that what I find of value in other theories can be assimilated into the framework of my accustomed theoretical stance. It is certainly true that I am comfortable with my approach because my psychoanalytic education was steeped in the teachings of Freud and his followers, and my further career development has been strongly influenced by the evolution of those ideas in the hands of modern conflict theorists. Consequently, I am most familiar with its many nuances and applications from years of clinical work and from many clinical interchanges with like-minded colleagues. Of course, I am also aware that colleagues whose work I respect hold exactly the same conviction about other theories and principles to which they adhere. I believe that engagement with alternative views stimulates all of us to try to find room in our preferred models for whatever we may find interesting and valuable in other approaches to our psychoanalytic task.

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CONFLICT THEORY / TRAUMA THEORY

BY FRED BUSCH, PH.D.

There has been a tendency in psychoanalysis to view the effects of trauma, and our ways of working with it, as something separate from our understanding and techniques of working with intrapsychic conflict. While appreciating certain differences, the author explores, primarily via clinical examples, how an integrated perspective may be most helpful to our patients, especially in the area of the patient's capacity to reclaim feelings.

I have never seen a patient in psychoanalysis in whom there has not been some form of interference in healthy narcissistic development that has led to unconscious fantasies of causation and solution, *resulting in intrapsychic conflict.* For example, a child's egocentric view of the world leads him to experience his depressed mother's inability to nurture and mirror his healthy demands as due to his excessive needs.[1] Thus, the ongoing trauma of a lack of mirroring leads to his needs becoming associated with unconscious fears of deadness, abandonment, and guilt. In analysis, when he begins to feel needful toward the analyst, these internal dangers pull him back to an inhibited emotional stance.

In short, it is not only the trauma itself that remains traumatic. Inevitably, the *feelings and fantasies the trauma stimulates* become part of a dangerous intrapsychic field. *In this way, a trauma*

[1] For the sake of brevity, masculine pronouns are used to refer to both genders in this paper.

also becomes part of an intrapsychic conflict. Thus, it seems to me that analytic work has to be informed by attunement to empathic breakdowns, past and present, and their effects on the patient's psychic life both in- and outside of the analysis, *while we also listen for the resultant unconscious fantasies and intrapsychic conflict.*

However, I still hear many analysts singularly emphasize trauma interpretations in clinical work (based on interferences in development or countertransference enactments), without at some point addressing its intrapsychic meanings. Working with trauma alone helps patients understand that they have split-off feelings due to current or past empathic breakdowns, but without their being helped to understand the intrapsychic conflicts that lead to keeping such feelings unknown. The patient is told he must have felt this or that, while the reasons for his not being able to feel his feelings, especially currently, remain untouched, or primarily viewed as a fear of being retraumatized. The role of ongoing intrapsychic conflicts in keeping feelings hidden tends to be ignored.

In this paper, I will present some historical reasons that I think are responsible for this way of working and its clinical implications, as well as two clinical examples in which a trauma occurs (i.e., a countertransference enactment), and two different ways it is dealt with in analysis. However, first I will briefly muse about some ways I have come to think of trauma and conflict in the clinical situation.

CONFLICT AND TRAUMA: CLINICAL MANIFESTATIONS

In my work with a spectrum of patients from neurotic to those with moderately severe personality disorders, I have noticed (without any preconceived plan) that I tend to work *first* with the implications of interferences in narcissistic development. These include such reactions in the analyst as empathy with the feelings induced by having a self-indulgent mother, or having a father whom the child cannot idealize, and the sense of danger to which

such feelings lead.[2] A typical interpretation for me at this time is evident in the following interaction: Early in treatment, a patient whose mother suffered from intermittent depressive rages described one such incident, and his response of going outside to the street to wait for his father to come home. He brought a ball with him, and kept trying to throw the ball higher and higher. At this time, I suggested that throwing the ball might have been a type of "smoke signal," representing the patient's hope that his father would get the message and hurry home to intervene by calming the mother's anger.

I have come to realize that these types of interpretations generally speak to important preconscious feelings that are acceptable to most patients (those who do not engage in excessive splitting), as such interpretations do not arouse intense guilt. It is especially important in the beginning of treatment to help our patients understand these behaviors as adaptive strategies, as we begin the analytic process of meaning making in an atmosphere of safety. In theoretical terms, we are speaking to what is most acceptable to the ego at this point in the treatment. Such a strategy serves as an important buffer to those times when areas dominated by an unconscious sense of guilt are explored. Further, since our patients generally suffer, in part, from a feeling of not being heard, the analyst's capacity to hear and to understand the patient's preconscious perspective is crucial as part of the curative process. In working through developmental interferences, this way of working is necessary but not sufficient in itself.

Thus, with the patient just described, the father's seeming inability to control the mother's outbursts left the patient with a sense of the father as weak, which both emboldened and frightened him. He marched confidently through life, while simultane-

[2] In looking at this further, it seems that certain feelings associated with narcissistic injuries are most accessible to consciousness early in treatment. However, the deeper narcissistic injuries addressed by the Kleinians, for example, are not accessible until later in treatment.

ously keeping a low profile. In the treatment, whenever his confident or competitive side came into view, he quickly became deferential. Whatever the initial causative factors, the problem had become an internal conflict between the wish and the fear to "show his stuff." Empathy with his trauma (i.e., mother's rages and his feeling unprotected by the father), or the analyst's way of being, could not resolve this internal conflict.

While the analyst's kindness and tact are essential for analyzing the patient's sense of danger, behavioral methods are not enough in themselves.[3, 4] However, before discussing the benefits of working with both narcissistic trauma and intrapsychic conflicts, I will turn briefly to some of our historical roots for their separation.

CONFLICT SANS TRAUMA

The seeds for radical discontent with the role of intrapsychic conflict lie, in part, within our own history. Freud's (1897) move from the seduction hypothesis, to the theory of unconscious fantasies based on intrapsychic conflict as causative in psychopathology, sealed over the role of early object relations for some time. Furthermore, Richards (2003) noted that politics may have played a role in the rejection of the ideas of British object relations theorists in the United States by those associated with the American Psychoanalytic Association, as these theories were embraced by analysts outside the organization. However, within the United States, from the time of Spitz's (1945, 1946) work onward, studies conducted by

[3] Compare this perspective with that of Vermote (2003), who views psychoanalysis as providing deepening, changed, internal object representations.

[4] Smith (2003) points out that there are various ways to consider conflict, all of which are important for the clinician to consider. The same holds true in considering the narrower confines of intrapsychic conflict. The contemporary clinician would find it difficult to understand his patients without a conceptualization of unconscious conflicts between and among object representations, self-representations, selfobject representations, and so on. Such an understanding indicates that we have come a fair way from the time when true conflict was thought to occur only in the oedipal phase, and only between particular agencies in the mind fueled by energy sources.

"mainstream" analysts, showing the centrality of environmental circumstances on mental and physical development, seemed to have little overt effect on clinical thinking.[5]

Ambivalence over Kohut's (1971, 1977, 1984) attempt to integrate intrapsychic conflicts (e.g., the vertical split) with the traumas of childhood, followed by intolerance, seemed to be in part the result of this same threat, at a time when many American analysts were faced with the significance of events from infancy, childhood, and adolescence. Thus, conflict as the result of internal processes *only* was promulgated in awkward ways through the 1980s (see Busch 1999, pp. 19-50). As far as I can tell from the literature of the time, it was only in a little-known article by Sachs (1967) that the traumatic effect of treating an external trauma as a purely intrapsychic event was highlighted.

My most painful analytic memory from the early '80s occurred with a stolid, taciturn patient in her fifties, Mrs. S, who came to treatment reluctantly after her daughter's analyst strongly recommended treatment for herself, pointing out the benefit to her daughter. The daughter had been seriously self-destructive, and the analyst felt that the mother's ongoing withholding and denigrating attitude was interfering with the daughter's moving forward.

It did not take long to discover how barren Mrs. S's life was, in part because of her sadistic superego, which was also directed outward. In her controlled, schizoid existence, Mrs. S believed that she needed little, but always felt underappreciated. She found it difficult to take in what I had to offer, and had little to give.

However, it seemed that enough progress was made on all sides to enable Mrs. S's daughter to take up a profession and to marry. The wedding itself was part of the healing process for mother and daughter, as they slowly attempted to build a mutually satisfying relationship. I was happy for both of them. At the first session after the wedding, the patient came in with a piece of wedding cake. I was touched, but having been taught to analyze

[5] Hartmann (1950) viewed infant and child observation as the path toward the next generation of psychoanalytic thinking.

gifts rather than to accept them, I immediately put the wedding cake under the analytic microscope for much of the week. If Mrs. S did not bring it up, I would.

It was only when I realized that Mrs. S was becoming increasingly blanked out that I realized this method was not working. Gradually, I came to understand that I had inflicted a minitrauma on her by ignoring the trust she felt in herself and in me in presenting this gift. Luckily, I consulted a colleague, who helped me understand the gift as a sign of both her appreciation and her newfound capacity to give. It dawned on me that I had inadvertently enacted a childhood trauma with Mrs. S, wherein she, at age five, had prepared breakfast for herself and her two-year-old sister so that her parents could sleep late on a Saturday; but all she had heard from her mother afterward was a bitter complaint that she had made a mess in the kitchen.[6]

While unconscious fantasies played an important role in Mrs. S's gift to me and in my response, these could only be taken up when each of us was ready to approach them. However, what I think many of us did not recognize at the time was how the exclusive focus on unconscious fantasies could be traumatic in itself.

TRAUMA THEORY

The application of trauma theory in the clinical situation, extant separately from conflict theory, is exemplified in a paper by Lichtenberg and Kindler (1994). Using a self psychological perspective, the authors describe how they organize clinical material based on the following factors: significant past or present *life experiences;* the analyst's knowledge of *life experiences* as organizers of fantasy and transference; and unconscious fantasy and beliefs as based on past and present *life experiences.*

[6] It is not that I believe such an event is traumatic in itself, but rather that it represents a telescopic memory (A. Freud 1951; Kris 1956)—i.e., a memory that captures a particular set of experiences for the child. Further, the child's developmental stage and unconscious fantasies also play a role in how the event is experienced.

Thus, these authors' clinical lens is focused on past and present traumas. The view expressed in the paper cited seems to be that mental forces—ones that in analysis are based on spontaneously formed structures, such as compromise formations or other intrapsychic structures—do not appear to be significant causative factors. Let us see how this plays out in Kindler's clinical example in the same paper.

Before discussing this case, I wish to point out that I am sympathetic to the authors' highlighting of the importance of empathic attunement and its calming effect on our patients, as well as the significance of understanding split-off feelings as adaptations; however, in my discussion, I will focus primarily on a problematic position to which this approach can lead. Further, I am not suggesting that a trauma-based treatment method is the wrong way to work with the case described; after all, with any case, we are presented with small pieces of an ongoing process. Rather, I hope that the reader will view my comments as musings on a particular approach.

Kindler's patient, Jill, frantically calls him a few minutes before her appointment, saying that there is a power failure and no trains are running. As she is speaking to him, the power is restored, and she abruptly ends the phone call. Kindler takes a nap while waiting for Jill, who shows up halfway through the scheduled session in an agitated state. She curses the transit system, describes the haughty behavior of a ticket collector, and eventually runs out of steam, ending by insisting that Kindler is angry with her.

As Jill demands that her analyst come clean about his feelings, he starts to feel irritated. Musing about his nap, he is aware of feeling quite relaxed and alert in listening to Jill. Yet Jill is positive that he had hurt feelings when she abruptly stopped the phone call. She confesses that it is the type of thing that would make her really angry. Kindler's response is to tell her that he was calm, and in fact fell asleep while waiting for her. Jill then comments, more calmly now, that she has noticed a change in his level of activity in the session. It is not clear how the ensuing material unfolds, but what emerges is Jill's feeling that her analyst has been

energetically with her in the past few days, and she views his decreased activity as a sign of his anger in response to her cutting him off on the phone.

Kindler understands Jill's reaction as based on the loss of his calming function when he was less vigorously responsive, which often led to her perception that he was being punitive.

> In a situation like this, where the weekend loomed and the transportation system had let her down so cruelly, she was in need of a welcome that included a degree of attunement to her state of agitation to be able to maintain her sense of connection to me. [Lichtenberg and Kindler 1994, p. 416]

In retrospect, the analyst wonders if, by napping, he was soothing himself in response to the expected onslaught from Jill. However, this point seems to get lost in the latter parts of the discussion.

While I have no doubt of the veracity of Kindler's understanding of Jill's narcissistic vulnerability, we see that his interpretations are geared primarily to past and immediate traumas. The present "trauma" is interpreted as based on the analyst's affective state of calmness not matching Jill's agitated state. The past trauma, as imagined in his *model scene,*[7] is one of the distress of a child, possibly after an agitating experience such as an unexpected separation, who is attempting to establish a lively intimacy with a disinterested or aversive, possibly depressed, adult. Her efforts go unnoticed, and depletion threatens her fragile sense of self.

Kindler goes on to imagine the child Jill's having become angry, demanding an acknowledgment of her distress, which led to a guilty or shameful response from her parents. This does not convey an authentic understanding of her need for secure attachment, and Jill is left feeling like "an irritable nuisance" (1994, p. 418). Kindler then states: "After my self-revelatory response, contact with my inner affective state, especially the image of me sleep-

[7] The *model scene* is described as a way that patient and analyst organize narratives, transferences, role enactments, and so on (Lichtenberg, Lachman, and Fosshage 1996), by reconstructing scenes of how things might have been.

ing peacefully waiting for her, served to restore her tie to me and allowed her to return to the self-exploratory dominant mode" (pp. 418-419).

While the analyst struggles with his own inner state (i.e., was he calmly waiting for Jill, or withdrawing into sleep in anticipation of an onslaught?), he seems to bypass the patient's intrapsychic conflict over acknowledging her anger with him. We see indications of her conflict in her insistence that it is the *analyst* who is angry with *her*. There seemed to be something in Jill's feeling thwarted in getting to the session that made her angry, but her recognition of this anger as her own seemed to be threatening, thus leading to the projection. Jill could then be angry because the analyst "was upset with her," not because of what was stirred up by being thwarted in getting to the session.

It is clear from the transcript that Jill's thoughts about Kindler's being upset occurred *before the session began*, when she abruptly stopped listening to him on the phone. In the session, she confessed, "That's just the kind of thing *I* would get upset over if *I* were in your situation" (p. 416). Jill calms down only when the analyst asserts his calmness, possibly making it difficult for her to further express her own intrapsychic conflicts over acknowledging angry feelings. Instead, the analyst focuses on the trauma in the session, representing it as a repetition of a previous narcissistic trauma in his model scene.

In one sense, Kindler and I see the challenge of this session in similar ways—i.e., how to help Jill own her split-off feelings. Kindler's answer is to take the blame for her feelings due to his lack of attunement, thus assuaging her unacceptable feelings of anger. *However, this leaves Jill's difficulty with owning her angry feelings, and whatever caused them, untouched,* at least at this moment. In fact, Jill seems more ready to explore the conflict over owning her feelings than her analyst is, when she acknowledges, in regard to her projection, "that's just the kind of thing I would get upset over." By thinking exclusively about trauma, Kindler possibly deprives Jill of learning more about the conflict over

owning her angry reaction. She is left with her unconscious fears of something bad happening if she becomes aware of her anger.

Much of the reaction against helping patients own feelings has, I suspect, been due to an underappreciation of the role of defenses. Overzealous analysts have attempted to get patients to admit to feelings, often with an accusatory tone (Busch 1992, 1995, 1999). We have not been sensitive enough to the disorganizing effects these feelings produce. If this were not the case, there would be no reason to defend against them. For someone like Jill, it would be important to recognize and analyze the terror of acknowledging her angry feelings, and what the anger was about.

The aim is *not* simply to help patients recognize how angry they are, which would be based, in part, on *topographic technique* (Paniagua 2001) and the belief in aggression as a primary instinct.[8] Rather, we hope to help the patient understand what is so frightening about being angry, or why the need that led to the anger is so intolerable it cannot be fully experienced. While Jill's acceptance of her anger will be helped by making it understandable, as Kindler did, the unconscious terror of her anger and the reasons for this remain untouched.

A CLINICAL EXAMPLE USING AN INTEGRATED PERSPECTIVE

I bring the following example because in this case, as with Kindler's patient, an external event led to a temporarily traumatic effect on the patient, causing him to feel angry, which in turn led to a conflict over this feeling. *Analyzing this conflict became a crucial part of understanding the traumatic nature of the event.* That is, while the event itself (a countertransference enactment) would not be pleasant for any patient, and in fact touched on this patient's narcissistic disturbances from an earlier time, we can see in this session that it was the patient's conflict over his emotional reaction that made the feelings especially traumatic.

[8] See Schmidt-Hellerau (2002) for an alternative to the view of aggression as a primary instinct.

My patient, Harold, was in his mid-forties, the director of a postdoctoral fellowship program in the social sciences, and in his fourth year of analysis.

HAROLD: I'm thinking about this great applicant for the fellowship. When she came for her interviews, I wasn't prepared for her. Her application was just one amongst many, and it was only a few minutes before I was to meet her that I realized what a great applicant she might be. Then, when I interviewed her, she was a perfect "10." So, at the end of the interview, I told her we would really like her to come here, and outlined the various opportunities. She was pleased by the offer but noncommittal. She's also looking at Berkeley, and for personal reasons, she might end up there. About a week later, I wrote her an e-mail telling her again that we'd like her to come, and that we have so much to offer her. It's something I've not done before, preferring to have the program sell itself. She wrote back, saying how flattered she was and how appreciative of the note. I was going to leave it at that, but then decided "what the hell?" I wrote her back and said, "Why don't you just come to Boston—it's great here." It was so unlike my usual stance, but it was fun.

F. B.: *(Here I thought I found myself enjoying the patient's freedom to feel playful, spontaneous, and able to enjoy the sexual undertones of the interaction without withdrawing. This had been a major issue in the past. I also thought he was highlighting something I hadn't allowed myself to think about when I used to interview prospective faculty members and trainees in academia: the element of seduction.)*

(I then said the following.) It's like a seduction.

(I thought I would say this in the same playful manner in which Harold was speaking. However, in retrospect, what I said came out as defensively authoritative. It was as if I was showing him something new, rather than that he had just helped me understand something. This was conveyed more by the tone of my remark. I did not grasp this at the time. Even more striking was that I said anything; according to my usual technical stance, there was no reason to speak, since I could see that Harold had a newfound freedom to feel, act, and observe all this.)

HAROLD: *(There was a brief pause before Harold started talking again, and when he did, it was as if all the life had been drained out of his voice. His animated account of his interaction with the applicant was replaced by hesitation and a deadened voice.)*

F. B.: I'm not sure if you heard the change, but after my comment, your whole manner changed from animated and lively to hesitant and much less lively.

HAROLD: I did notice it. *(Now more animated.)* I was talking with Esther yesterday. *(Esther is a postdoctoral fellow in whom he is consistently disappointed; he has given her many projects, but she barely does them. He feels that she does not appreciate how much he has given her.)* I laid out a plan for her for the next few years, including a grant proposal, so that she could get an academic position. It was all there on the blackboard. All she did was complain about how much work she has to do, and how she's torn between working in the private sector, teaching, and re-

search. I wanted to say to her, "Listen, just do the work I'm paying you for." In the midst of my discussion with Esther, Sam *(another post-doctoral fellow)* came in, and commented on the research design. I said to him, in a not very nice way, "Sam, that's obvious." I guess it's another example of how I stay distant from people. *(He then starts to describe various ways he feels he distances himself from others and from me. His readiness to take on blame in the face of irritation has been a familiar defense.)*

F. B.: When I point out the change in your voice after my remark, your thoughts go to someone unappreciative of how much you offer, and how irritated you felt with someone who pointed out the obvious. While it seems likely that this is how you felt about my initial comment, something seemed unsettling about these feelings, which led to your inhibiting yourself and then blaming yourself for your distance, rather than blaming me. *(While I could have interpreted that the patient felt unappreciated and criticized by me, I would have been telling him HOW HE WAS FEELING, rather than helping him understand how these feelings bring about a CONFLICT OVER KNOWING HIS FEELINGS. As I have written about previously [Busch 1995, 1999], the latter is a crucial part of the self-analytic process.*[9])

HAROLD: What you said was fine. You were just describing what I was talking about. Hmm! Maybe I just said that you said the obvious. But I didn't feel

[9] The technique of returning to the sequence of events in the beginning of the interpretation has also been discussed in my previous writings, and I will not elaborate here.

it. Yet, Sheila *(a co-worker)* has a habit of summing up what I say, and I know I hate it when she does that. So I guess what you said was really to the point. I realize I'm afraid that if I say something critical to you, then you won't say anything again. I don't know why I'm thinking this, but I'm worried about not finding Jodie *(his wife)* attractive. When I saw her this morning, she looked so tired and washed out. But she really looked good once she got dressed and put on her makeup. Did I really have to say that? I guess I did. *(Brief pause.)* I realize there's been something in the back of my mind while I was just talking. It finally came to me. I was taking this English class as an undergraduate and we were reading one of the American classics *(which he mentioned)*. We were supposed to write a paper on this one novel, and I went to the professor and told him about my idea. *(The idea had to do with a character's seeing something and never wanting to go back to the way things had been.)* The professor's eyes lit up, like I had literally opened his eyes to something he hadn't seen before. He then spent the first five minutes of the class talking about how you could never tell from whom you might learn something. You know, I wasn't ever really able to admit this at the time, but I felt disappointed that he wasn't able to say it was me. He made it seem like *he* saw something, rather than that it was me who saw it.

F. B.: I wonder if you're telling us that you wish I could have acknowledged that *you* were seeing something very interesting in recruiting this woman, and that my comment made it seem

like I was taking ownership of your observation, and I can see how that could be. While you felt disappointed and angered, you could not show me this side of yourself, which felt unattractive and would drive me away.

HAROLD: *(After a pause.)* You mean like I felt toward my mother *(who had frequent rages)*. Or do *I* mean like I felt toward my mother? I feel myself starting to withdraw again. I was really moved by what you said. I felt we're real partners here. I also felt some irritation with you. Then I felt, "Okay, enough."

(At this point, our time was up.)

In this moment, we can see Harold's moving struggle between the acknowledgment of previously split-off feelings and a return to his old solutions. *Harold's analytic triumph is that the struggle is now conscious.* He projects his thought that the feelings of anger and disappointment with me echo feelings toward his mother, and then is able to own it. He finds himself withdrawing from owning the feeling, and then pulling back from his usual schizoid-like stance via his feeling of connection with me. However, this arouses his feelings of anger toward me again, and once more he wants to withdraw.

This whole sequence captures Harold's conflict over feelings brought about initially by trauma, which led to the distancing from others that brought him into treatment. The inevitable disappointments in any close relationship aroused such frightening feelings that a pleasant, removed stance was the one in which Harold felt safest.

DISCUSSION

Harold, like Kindler's patient (Lichtenberg and Kindler 1994), was dealing with angry feelings that were disturbing. I think our ways

of approaching this feeling, *in the way I've brought the examples,*[10] demonstrate significant differences in how the analyst defines the therapeutic task in working through these feelings. Kindler searches for the empathic breakdown in the analytic moment and tries to imagine (via his *model scenes)* the historical antecedents in parental breakdowns in empathy. In short, he is searching for the *cause* of the patient's anger in a particular area. However, it has been my position (Busch 1995, 1999) that looking for the cause of a feeling before exploring the patient's conflict over owning the feeling will often prove fruitless. Thus, with my patient, I focused on the pressure to bury feelings and the resulting deadening effect this had on him. Analysts approaching from the standpoint of the trauma of empathic breakdowns often talk about how deadened the patient becomes if this is not recognized. However, the same thing can be said with regard to conflicts over the awareness of feelings.

I am in full sympathy with Lichtenberg's (1998) question about the patient's antagonism and withdrawal in the analytic situation:

> Are we, through a perceived empathic failure, the source of the aversive response, or are we a listener sensitive to the patient's aversive stance? . . . Many instances of antagonism and withdrawal that I had been taught to regard as resistance I now consider a patient's trusting response to an ambiance of safety. [p. 26]

However, Lichtenberg writes this in opposition to the concept of defense interpretation *as he understands it.* He suggests that motivations become evident only when the patient can experience *affects, contents, and actions.* But for the past two decades, defense interpretation has focused on the patient's conflicts over experiencing *affects, contents, and actions* (Busch 1993; Gray 1982). Kindler's patient's antagonism seems primarily based on her resistance to owning a particular feeling (i.e., her anger).

[10] I do not necessarily mean in the way things *are.*

Analysts like Kindler have helped us understand that the patient's antagonism and withdrawal in analysis *can* be an adaptive response to an empathic breakdown. It has been an important addition to our ways of helping patients understand their feelings. I would have no difficulty with this perspective if it did not also include a dismissal of another important way we help patients understand feelings—i.e., the analysis of conflicts over the awareness of feelings.

With the flourishing of various methods to understand our patients in American psychoanalysis, adhering to a slavish devotion to any one method of understanding is to deprive our patients and ourselves of new insights. After years of pretending that all we needed to know could be obtained from Freud's *Standard Edition,* we now realize that we have to keep abreast of current thinking. However, as Goldberg (2004) points out:

> Every new idea upsets the apple cart and leads to a tendency to move in two directions for a solution, so that it is all much too diverse to encompass in a single uniformity, *or* it all boils down to this (or that) particular aspect. [p. xii, italics in original]

Further, we all have a tendency to pigeonhole someone (as I have probably done with Kindler), but mostly, we are aware of when this occurs with ourselves. For example, I am surprised by my colleagues' surprise at the variety of methods I use to understand the clinical moment when I discuss clinical material in various places, even though I have consistently emphasized this (Busch 1995, 1999).

I dislike the term *pluralism*, because in my experience, those who advocate it justify an "anything-goes" or "we-know-nothing" attitude to the clinical experience. However, a well-thought-out pluralism in understanding our patients seems the only justifiable position for an analyst to take at this point. With apologies to Tom Wolfe, the analyst of today might best be known as the "contemporary Freudian, countertransferentially aware, self psychological, relationally interested, Kleinian-inspired, ego psychologist."

It seems to me that what will eventually be the most crucial explorations are those aimed at uncovering the differences in how we apply these methods. It is in this spirit that I have approached what I see as the difficulty in integrating trauma theory with conflict theory.

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CONFLICT: CONCEPTUALIZATION, PRACTICE, PROBLEMS

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Although intrapsychic conflict *has proved its usefulness as an organizing concept in both theoretical and clinical discourse, it should be regarded as a narrative choice, for there exist other useful ways to address the relevant phenomena. Ignoring the narrativity of intrapsychic conflict opens the way to simplistic and anthropomorphic psychoanalytic discourse. Technical difficulties may result. The author presents two relatively brief case summaries to illustrate the varied narratives used to describe intrapsychic conflict and its analysis.*

INTRODUCTION

Conflict is so well established in ordinary language that it may be said to have been naturalized, that is, to have come to seem a given aspect of the world, a hard fact of reality, one that is encountered or discovered in others and within oneself. Once naturalized, *conflict* is no longer considered merely one common and succinct way of referring to a certain kind of more or less stressful subjective experience. However, there are other ways to refer to the components of this subjective experience: for example, pursuing irreconcilable aims; being required to make a difficult choice; confused by having set mutually exclusive goals for oneself; and having a difficult time in coming to a decision or in embarking on a course of action without regrets or misgivings.

In ordinary language as well, we tend to refer to conflict and its constituents as independently active entities. In this vein, we

speak of being beset by conflict, of being torn apart by conflict, weighed down by it, or bogged down in it; we also speak of one wish or ideal contending with another or clashing with it. These figurative locutions add variety, color, and intensity to the clinical dialogue, perhaps most of all by touching on concretely conceived unconscious fantasies.

However, we also pay a price for using these locutions, in that by doing so, we implicitly disclaim agency, both the analysand's and our own. We imply that it is no longer persons who do the wishing or who narrate subjective experiences as *torn*, *burdened*, and so on; instead, it is as though these subjects are dealing with animated material entities or spaces in their minds, hearts, spirits, guts, spines, and so on. We are thereby referring to all those actions that we feel to be urgent, desirable, dangerous, and so forth as autonomous agents within the self, each propelling us in one direction or another. We are not presenting ourselves as human beings performing actions: wishing for this and that, setting and maintaining certain goals, striving to meet treasured ideals, and choosing courses of action. Thus, these figurative locutions introduce anthropomorphism into psychoanalytic discourse.

As early as 1969, Grossman and Simon presented an excellent, lengthy discussion of this issue, and I continued that discussion in several of my books, *A New Language for Psychoanalysis* (1976), *The Analytic Attitude* (1983), and *Retelling a Life: Narration and Dialogue in Psychoanalysis* (1992). I will resume that critique—especially in connection with its technical consequences—as I develop my conception and use of *intrapsychic conflict* in this paper.

FREUDIAN FOUNDATIONS

Freud drew heavily on ordinary language in the course of developing psychoanalytic theory and its particular principles of technique. Consistent with his empiricist orientation, he often took ordinary language at face value, that is, as simply specifying what is indubitably there in the external and internal reality, as something that each of us encounters or discovers and is free to explore

in a purely objective way. Although at times, Freud transcended this empiricist set of beliefs and recognized the constructivist aspect of his monumental creation, psychoanalysis, he put forth so many propositions based on these beliefs that he established a lasting and central place for a material, reified *intrapsychic conflict* in psychoanalytic discourse. When that astute conceptualizer of psychoanalysis, Kris (1947), recognized this trend in his definition of psychoanalysis as "human behavior viewed as conflict" (p. 6), he steered clear of participating in this reification, but in this, he was, as usual, something of an exception (Smith 2004).

Freud also had theoretical reasons to favor accounts of intrapsychic conflict that implied autonomous agencies acting within some component or area of the mind—the mind itself being one such agency or place, the overarching or containing one, the one that a person can lose or go out of, shut down, or set to work on a problem.

Perhaps the most important of Freud's rational bases is his theoretical presupposition that psychoanalysis requires a theory of instinctual drives, each with its aims, objects, and impetus; further, that infancy should be conceived as dominated by these drives and inevitably engaged in conflict with the external world; and further still, that development from infancy to socialized maturity requires a theory of stable internalizations of external regulations and a resulting set of psychic structures (ego and superego), by means of which, and in terms of which, an internal world of experience and fantasy can be developed in more or less communicable form.

Following the advent of structural theory (Freud 1923)—and especially after 1941, when Fenichel published his brilliant monograph on technique—the constituents of conflict have usually been conceptualized as *impulse* (or *drive derivative)* and *defense.* The recommended mode of interpretation has been to identify currently active defense and interpret its motives before or while attempting to interpret that which is being warded off by that defensive measure. Taken in its most general sense, this obviously sensible technical recommendation has proved its value

over the years, for analysands typically experience interventions that disregard their defensive postures as coercive, insensitive, critical, tactless, and unempathic. They usually respond to them with shallow compliance and intellectualization, sullen silence, or open protest, and, in any case, with increased defensiveness. On this level of conceptualization, there seems to be no reason to quarrel with this technical recommendation, at least not so long as one follows, as I do, the approach that characterizes contemporary Freudian and Kleinian analysis.

Upon reflection, however, it seems that this conceptualization is relatively abstract and formulaic, something on the order of an organizing concept that serves as a general guideline for conducting an analysis. As such, it does not capture the narrative and rhetorical richness of specific analytic dialogues. Its business is to categorize the many twists and turns of thought and feeling that make up an analysis, and that it does very well.

Within the clinical dialogue, however, both impulse and defense are necessarily particularized in terms of persons, places, times, hierarchies of component interests and fantasies, memories, anticipations, acknowledged or unacknowledged ambivalence and doubt, and prior subjective experience within the analysis itself. Continuing analysis develops a series of contexts for the constituents of intrapsychic conflict, each context with multiple implications of its own. On this level, the idea of one clear-cut factor opposing another does not convey the rich texture of analytically explored experience. Consequently, when we encounter impulse and defense in case formulations, we must deconstruct them before we can get the feel of each analytic process.

Additionally, "analyzing defense first" is a far more complex process than is suggested simply by recommending it as an initial step. Often, that process must follow a meandering course if the analyst is to stay in emotional touch with the analysand and hope to get any kind of hearing from him or her. At times, it can seem that the analyst has remained oblivious to both impulse and defense; such is the case when the analyst must contain a projected

impulse, defense, or both, as a condition of the analysand's reaching a point where she or he can tolerate recognizing that there is an influential intrapsychic conflict worth considering, and that understanding its origins and consequences may offer an opportunity to advance the analysis.

The analysand might use the anthropomorphic element mentioned earlier to introduce further problems. For when the analyst's words seem to accept the idea that the analysand is struggling with conflicts or with their components, as though these are things apart from the experienced self, the analyst is disregarding a defensive split. The analysand is not being viewed as disowning what she or he wishes, thinks, or imagines, not seeing it as an aspect of him- or herself as agent. The analyst who unquestioningly accepts an analysand's posture of being "up against it" in internal reality is colluding with the analysand, even though it may seem that the psychical problem of the moment is being addressed in an effective way.

This disowning or disclaiming is a feature of the experience of internal objects or introjects. Experientially, these objects or part-objects (voices, faces, and so on) seem to speak up, frown, or exert other forms of influence; they do so from time to time or constantly. Analysands construct these subjective experiences because they are not ready to consciously acknowledge that they are emotionally attached to them and using them to express desires that they regard as dangerous or despicable. In *Aspects of Internalization* (1968), I discussed at length this experience of introjects as autonomously acting agents. For a while, the analyst's acceptance (containment) of these split-off accounts can be the tactful or empathic way to proceed, but ultimately, the analyst must interpret the analysand's use of these internal objects as puppets, so to speak, through which to express split-off aspects of the analysand's self. As introjects, these objects are not as well integrated into one's sense of being a person as are fully developed identifications with others. Identifications are internalizations that appear under the rubric of *I, me,* and *myself,* not as inhabitants of

the self as introjects do; nevertheless, the time comes when it will behoove the analysand to own or claim these internal presences as constituents of one of his or her ways of thinking about the self or of experiencing feelings.

Another problem is that impulse-defense thinking simplifies subjective experience by reducing it to dichotomies. Dichotomous or binary thinking stands in stark contrast to well-conducted and sustained clinical work, work that usually delineates a number of factors feeding into what is experienced as conflict and each of its components: unacceptable desires, secret gratifications, two or more defensive preferences, apprehensive fantasies, values that are equally precious but seem incompatible, significant others in their past and present, and so on. Analysis shows up the black-or-white or either-or reductiveness of the beliefs that analysands use to define experience and the surrounding world—beliefs that they typically defend with great determination.

I believe that Freud's penchant for grand dichotomies (though it is not characteristic of the clinical work he reported in his published papers) has contributed to the prevalence of binary formulations in the Freudian literature and in the clinical practice conducted by many analysts. I refer here particularly to Freud's favored binaries *primary process/secondary process, pleasure principle/reality principle, life instinct/death instinct, activity/passivity,* and *masculine/feminine.*

As an organizing concept, *intrapsychic conflict* is best approached as a center of distress, a hub into which, or through which, many of the analysand's tendencies pass. As such, it is not defined in a way that facilitates clear-cut accounts of compromise, for what is compromise in one contributory context may be triumph in another and surrender in a third. "Complex and full of contradictions" says it better than "conflict" does. In the psychoanalytic vision of psychical reality, life is like that (see, in this regard, Schafer 1964, 1970, 2003a).

The case summaries that follow illustrate how I apply the preceding discussions in specific clinical instances.

VARIED NARRATIVES OF CONFLICT: TWO CASE SUMMARIES

First Summary

Among other problems presented by a student, Rhoda, is her feeling consciously distressed over having to make what is for her a painful choice: on the one hand, her desire to be slim, and, on the other, her need to stuff herself with sweets in order to be able to continue her conscientious preparation of term papers and her studying for final exams. Analysis establishes that excessive eating is only one of a number of means she uses to disfigure herself. Being disfigured represents safety in more than one way, and it also has its gratifying aspect. It seems that, unconsciously, she believes that disfigurement helps protect her from the envy of her vain mother. Rhoda has experienced her mother as so vain that she conveys in an unmistakably threatening manner her need to be considered "fairest of them all." Deferring to her by being "unattractive," Rhoda is found, through interpretation, to spare herself numerous sexual anxieties. Not to be forgotten, however, is that she also envies her mother's good looks, and so is likely to be projecting her envious attitudes into her mother and magnifying her mother's dangerousness. Her "unattractiveness" is also a rebuke to her mother and an effort to shame her.

Rhoda's sexual anxieties seem to be rooted in her relations with both parents in the following way. In addition to avoiding her mother's envy (and her own) and her mother's retaliation, Rhoda has been seeking to curry manifestly asexual but unconsciously sexualized favor with her ambitious father; this she does by excelling in her studies. In this way, Rhoda—surreptitiously, and, to some extent, successfully—competes with her envious mother.

In my experience, it is not unusual to encounter this configuration of incompatible desires in female students—libidinal, aggressive, and self-integrative actions, all taken on more than one developmental level and all contributing to and being gratified

by the "presenting problems." Only some fragments of this conflict-laden context are consciously available to Rhoda; this, too, is not unusual. Rhoda's unconsciously contrived subterfuge is her way of seeking to simultaneously gratify seemingly irreconcilable desires. Some of these desires serve defensive purposes, though her difficulties suggest that they do not do so altogether successfully. We could say of Rhoda that she is a multiply conflicted person. Although a number of her significant aims in life are, on the face of it, mutually exclusive, she seems to be trying to satisfy all of them, including the aim of paying a price in anxiety and self-punishment for some of her primary gains.

In my work with Rhoda, I showed sustained interest in trying to understand (1) how she experienced each constituent of her conflicts as it came up in her sessions, especially in relation to me, and (2) what she felt was in it for her to achieve each of her incompatible goals and how it had come to that pass. My primary aim was to be able to be with her wherever she was psychically. I anticipated that she would manifest her conflicting tendencies in the way she told her story and how she tried to structure and limit her relationship with me. My comments usually emphasized how her situation seemed to me, based on what she was telling me; only occasionally did I make comments implying that I was objectifying her by pronouncing what I *knew* was true of her, despite her subjective experience to the contrary. I tried to limit myself to working with her responses to my efforts to understand. I was, of course, interpreting, but I do not believe that I was dissembling; for any effort to understand more fully or more clearly what is being told must involve interpretation. The point is not to assume an all-knowing posture.

In voicing my comments, I often worded my remarks in terms of Rhoda's dilemmas, her all-or-nothing attitudes and black-and-white portrayals. As well, I conveyed my recognition of her feeling that there was no way out, that she felt hopeless or helpless in dealing with these apparently insoluble problems. She had a way of avoiding subjective experiences of conflict by finding and then exaggerating her own problems in others, as though deal-

ing with implacable forces. I did not hesitate to point out, when Rhoda seemed ready to hear me and to reflect, what seemed to me to be significant connections among the dynamic factors we had been able to clarify, and not rarely would I suggest that these connections had played significant parts in her development and her present difficulties. Thus, I took her history into account, all the while allowing for future revisionist retelling of that history. But, here as elsewhere, I was particularly focused on how she responded to, and the use she made of, my interpretations.

Prominent among my interventions were attempts to show Rhoda how she was playing out her conflictual situation in the way she related to me: latent seductiveness, fantasies of me as an ambitious paternal figure, envy, and so on. For example, Rhoda consistently strove to be an A+ patient: quick to anticipate and grasp interpretations, develop them, and modify them to make them her own, while simultaneously trying to remain otherwise unattractive to me, in these ways bringing her conflictual oedipal situation into the transference. In taking this path, I counted on the ego-strengthening effects of Rhoda's increasing belief that, to the best of my ability, I was trying to be a trustworthy presence in her psychical life, someone who was not pursuing my own narcissistic aims. The desirable outcome of her analysis was yet to be determined. I conveyed no expectations regarding her weight, scholastic accomplishment, family relations, or the correction of distortions in her perception of her life situation.

Second Summary

A young sculptor, Terry, had just exhibited new work and had received lavish praise from a noted figure in his field and from art critics. They had compared him favorably not only with his contemporaries, but also with well-known senior sculptors. Prior to his show's opening and contrary to his virtually lifelong inclination to react with anxiety and shame to "showing off" or being consciously proud of any of his talents or accomplishments,

Terry had already felt free to judge that his work was indeed superior. In his analytic sessions, he could tell me how consciously pleased he was at this manifestation of hard-won freedom in the realm of self-esteem.

Terry's account of his upbringing featured his having been severely criticized by his father for any departure from abject humility "before God and man"; equally condemned had been his departures from absolute conformity to the mores of his cultural and class surroundings and his creative moves toward individuality. He could not avoid feeling that his artistic endeavors were sinfully rebellious and self-aggrandizing. Understandably, it had not been possible for him to consciously and unambivalently enjoy both his creative processes and their end results. Although it seemed to him and me that his by-now extended analysis had greatly helped him reduce the intensity of these prohibitions, judgments, and painful feelings, it was easy to see signs of his continuing, though reduced, vulnerability in this area.

As I expected, analysis revealed that these issues were invested with many sexual and aggressive gratifications and defenses, as well as adaptive meanings and functions other than those just described. As a result, Terry's being a sculptor at all, and —much more so—his being gifted and his showing himself to the world and being praised seemed to have consistently stimulated intensely conflictual feelings. The problem was intensified because his persecutory father figure stood in the foreground of his various internal objects. Appearing frequently in his transferences, these conflicts had steadily occupied center stage in his analysis; for example, in talking to me, he was ostentatiously modest, doubt-ridden, and circumstantial whenever his associations touched on the quality of his work.

That even now Terry had not completely broken his chains was suggested by several dreams that followed the triumphant opening of his show. In their manifest content, these dreams seriously challenged the merit of his artistic work. These dreams led him to wonder once again and most dispiritedly whether

his work really was of superior quality. Basing my response on previous analytic work, present context, and associations during this session, I took these dreams to be expressive of his efforts to appease the anger felt by the "higher powers" in his internal world in response to his "hubris." In the transference, he had identified me with these powers, especially his already projectively magnified image of his father, and he dreaded my response to his display of pride and self-confidence.

At this point in Terry's analysis, neither of us was surprised by this coda to his success: owing to the conflicts I have described, he had to compromise his enjoyment of both himself and his favorable reception by significant figures in the art world. Although Terry was still a conflicted artist, it seemed to be an important sign of beneficial analytic change that he was free to show that this was so to a much-diminished extent. Also, he was now able to tolerate crediting me a bit with having helped him make these gains, a change that conveyed a decreased need for omnipotence and all those fears of envy and dependency that are among its chief constituents.

I traced these enactments as far as I could to a set of split internalizations. These internalizations included a conflictual mix of grandiose, persecutory, and humiliated self-representations and a clashing set of ego needs and ideals. These extremes manifested themselves in Terry's haughty, controlling, ashamed, and submissive ways of relating to me and to his artist-self at one time or another. Equally mixed and conflictual were the sexual and aggressive elements in being creative, as already mentioned, and also his having used my help to make his way into his internal world and reflect on it. He had to feel omnipotent, and, as had been the case for a long time, he had to believe that he was not entitled to claim any authority or even the capacity to think analytically. On top of that, he maintained that I had no right to intrude on his "shameful" secrets, of which there were many; nor was it right for me to present myself as adept at finding individualized unconscious meaning, since I was, as he put it, obviously just a doctrinaire analyst, a mechanical, brainwashing, Freudian

conformist who was aiming to reduce everything to castration anxiety. To make matters worse, his working in harmony with me meant submission to me, and that idea stimulated frightening fantasies of castration and homosexuality.

In my view, I had been wrestling particularly with those of his identifications that favored unconscious self-idealizations, denials, grandiose fantasies of achievement, and persecutory projective identifications. I viewed all these tendencies as standing in the way of reliable testing of internal as well as external reality. Equally, to the extent that these were defensive operations, they precluded object relations of a kind that could provide gratification and security, with diminished shame and a heightened sense of reality. Behind these self-limiting tendencies lay the conflict between Terry's ambitions and ideals on the one hand, and, on the other, his desire for total surrender—and with that, his fear of sinking into ordinariness, deadness, or madness, much of which seemed at times to imply castration fantasies. But of those fantasies I said very little until late in the analysis.

DISCUSSION

Although my way of analyzing conforms to well-established models of contemporary Freudian and Kleinian analysis, my theoretical writings on action language (Schafer 1976, 1983) and narration (Schafer 1983, 1992) have led some readers to the unwarranted conclusion that, all along, I have been advocating a new analytic technique: on the one hand, forcing responsibility onto the analysand, and, on the other, developing interpretations as collusive fables about the analysand's subjective experiences and their life-historical roots—fables designed to help the analysand feel and function better. This, despite my consistently being explicit that I aim to develop contemporary ways of formulating *traditional,* systematic psychoanalytic thinking about the human mind, clinical technique, and the nature of the analytic process.

Elsewhere (Schafer 1976, 1983, 1997, 2003a, 2003b), I have argued at length that my key terms—action and narration and

their correlates—better describe analysts' traditional practices. I believe that, compared to what has preceded them, my suggested reconceptualizations of what takes place in traditional analysis give a clearer and experientially richer account of it and the changes that it brings about.

That my basic psychoanalytic orientation is traditional—one might even say conservative—should be evident in the two case summaries I present in this essay. I do not limit myself strictly to locutions consistent with action language, nor do I avoid figurative language with its reifying potential (about which more will follow below). I try to see to it that my sense of analysands as agents, and of myself as telling about them from a relatively systematic, Freudian-Kleinian point of view, runs through my formulations.

I described my first case example, Rhoda, as a multiply conflicted person. In doing so, I was using only one of the narrative options open to me. As mentioned earlier, *conflict* puts it all so succinctly, and is in such wide use in both ordinary communication and in traditional psychoanalysis that it just feels natural to use it—not a choice at all, but rather the right way to say it. It *is* right in that it seems to explain Rhoda's troubled psychical situation without recourse to technical jargon. However, I could have instead chosen to describe Rhoda as suffering from poor integration of the aims she sets, as being host to irreconcilable motives, as setting goals that she also considers inappropriate, unworthy, and damaging to her sense of self, or in still other ways. My use of the word *conflict* is to be understood as my having made a narrative choice; it provided me with one story line for telling about Rhoda's problems. As mentioned, I do not always choose to follow the *conflict* story line; for example, there are times when integration, disintegration, and fragile integration better match my narrative design.

Earlier, I emphasized anthropomorphism as a consequence of careless use of the highly figurative language we use when narrating *conflict* to ourselves or others, especially the analyst. Certainly, analysands often reify their subjective experience. But, sooner or later, the analyst who fosters this archaic view of mind will have

to face serious technical consequences, for analysands are then likely to view these factors in the same fixed and deleterious way that they often do when they discuss their childhood deprivations and their difficult life situations. With their analysts' unwitting collusion, they will feel encouraged to regard these factors not as versions of real and imagined experience that they have constructed in their own contradictory and unconsciously concretized manner, and not as versions they continue to use in the same way—that is, simultaneously for purposes of gratification, defense, and/or punishment. Instead, these analysands will tend to regard all these problematic aspects of their lives as fixed, unalterable, self-defeating features, and to see themselves as limited to coping with them, or submitting to them and learning to live with them as harsh, mind-independent realities. Despite all the talk of conflict during their analyses, they will feel supported in taking the view that there is no need to give the internal world its due. The internal world will seem just like the external in being full of independently acting objects. In the end, the external world will emerge from the analysis triumphant over the internal one.

The contrasting mode of thought I advocate, and the one many analysts use, even if inconsistently, is this: by regarding all these factors as narrative actions in the here-and-now analytic situation, and most of all in the transference, one begins to feel it is possible to approach them as issues that, in ways and to an extent still to be determined, are both subject to interpretation and possibly modifiable. Analysts and the analytic process are not supported by a mode of conceptualization that implicitly endorses viewing these factors in the way the defensive analysand would wish, that is, as unalterable givens or fixed features of the psychic terrain.

To regard conflicts or their constituents as autonomous agencies of one sort or another is to do more than absolve the analysand of the responsibility that inheres in recognizing that the world is as much constructed by the subject as encountered by him or her; and it is the conflictual aspects of the constructions that call for the heaviest interpretations. Also, attributing this autonomy to

conflicts facilitates projective identification of one's sense of agency and responsibility into factors excluded from the conscious and unconscious sense of self. Consequently, the scope of what is there to be analyzed—the analysand's construction of psychic reality—will be drastically limited, and the motivation for change will be transferred mainly or entirely to the analyst—who is now, however, in a hopeless position.

We see this reduction of scope when an analysand declares that there is nothing to be done about such inevitably unfortunate consequences of a terrible childhood as constant rage, severe mistrust, and intense fear of intimacy. I have already mentioned that analysands usually come to see us with conscious or unconscious convictions of having suffered unalterable damage; the hazard we face is succumbing to the temptation to join them in this position and consider certain topics closed to analysis. As I see it, it is the analyst's job to help create conditions that render less urgent the disclaiming of action and defensive use of projective identification, and to do so primarily through monitoring countertransferences as much as possible, while working out graded and timely transference interpretations.

Working this way does not entail dismissal of past and current suffering and life-historical details that in all probability are capable of leaving lasting psychical scars or that continue to feel like bleeding wounds. But I also believe that the analyst facilitates deep analysis by remaining aware that accounts of past life-historical details frequently change over the course of analysis, and that the past can never be reconstructed exactly. *The past* is made up of memories that have been, in accordance with the stages of development, progressively telescoped (Kris 1956a), or, in related terms, made up of narratives that have been revised (Schafer 1992). *The past* is best regarded as a presently active and psychically useful set of narratives that include many *personal myths* (Kris 1956b).

For these reasons, I bear in mind that *intrapsychic conflict* is a narrative choice, not a discovery of autonomous agencies colliding with one another. Compromise is worked out by the analy-

sand—a person or agent—and not by antagonistic forces in the manner of a resultant in physics. I try to formulate my interpretations in ways that do not foster the belief that it is important to me whether or not the analysand feels a certain way, which might lead to my becoming anxious, impatient, and persecutory if things turn out otherwise. Freud (1937) put it this way:

> Our aim will not be to rub off every peculiarity of human character for the sake of a schematic "normality," nor yet to demand that the person who has been "thoroughly analyzed" shall feel no passions and develop no internal conflicts. The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task. [p. 250]

This said, it is not for the analyst to presume to know for sure the uses to which this increased ego strength either will or should be put.

CONCLUSION

Analytic interventions are a mix of optional organizing concepts and ways of retelling the analysand's narratives. They are ways that hold some promise of promoting beneficial analytic change, that is, change based on the insight and working through that prepare the ego to deal with its conflicts. While remaining alert to potential theoretical and technical complications that can result from careless use of the intrapsychic-conflict narrative, I nevertheless continue to favor the many versions of intrapsychic conflict in my analytic retellings of analysands' narratives, and so I continue to feel secure in thinking of psychoanalysis as a conflict psychology.

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UNCONSCIOUS CONFLICT IN THE LIGHT OF CONTEMPORARY PSYCHOANALYTIC FINDINGS

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In considering unconscious conflict, the author looks at the influence of contemporary psychoanalytic findings on the formulation and treatment of various psychopathologies. Technical considerations related to furthering the understanding of unconscious conflict are addressed, with attention to the roles of drives and affects, and to the influence of deficit theories and other developments on current psychoanalytic thinking and practice. A brief clinical illustration is included.

THE CONCEPT OF UNCONSCIOUS CONFLICT

Within traditional ego psychology, the concept of *unconscious conflict* refers to the conflict between impulse or impulse derivatives and defensive operations directed against them. Unconscious conflict, in this perspective, is embedded in the tripartite psychic structure, most typically as a conflict between unconscious impulses from the id and ego defenses directed against them, usually motivated or reinforced by superego-determined pressures or defenses. Under the influence of developments in contemporary object relations theory, this classical formulation has shifted into a consideration of both defenses and impulses as represented, respectively, by impulsive and defensive internalized object relations. In other words, the *unconscious conflict* is one in-

volving a desired and/or feared object relation against which strong unconscious prohibitions are in turn represented by defensively organized internalized object relations (Kernberg 1988).

Insofar as each of these internalized object relations consists, at the very minimum, of a representation of self in relation to a representation of object under the impact of a powerful affective state, the fundamental nature of the organization of self-representations and object representations as constituents of the tripartite structure becomes evident. For Kleinian authors, these impulse/defense constellations could be described as unconscious fantasies, both desirable and frightening, and the defenses against them in turn could be described as unconscious fantasies of persecution, guilt, punishment, or loss of love and consequent abandonment (Segal 1973).

However, the very discovery by Klein of primitive defensive operations linked to unconscious conflict at very early levels of development also highlighted another crucial dimension of unconscious intrapsychic conflict, namely, the struggle between idealized love and destructive aggression, reflected in Freud's final dual drive theory, and powerfully illustrated in the conflicts characteristic of what Klein (1946) described as the paranoid-schizoid and the depressive positions. These primitive defenses and object relations also highlighted the centrality of the mechanism of splitting and derived mechanisms, particularly projective identification, denial, and omnipotent control, with splitting itself as the major defense common to this primitive defensive constellation.

Freud (1938) had originally described splitting as a peculiar, simultaneous recognition and denial of castration anxiety, but the dynamic aspects of splitting—in contrast to the static quality of it—were elucidated in the work of Fairbairn (1954) and Klein (1946). The developmental aspects of the theory of early object relations provided by the work of Jacobson (1964) and Mahler (Mahler, Pine, and Bergman 1975) permitted us to link the primitive organization of internalized object relations with the tripartite structural model, an integration specifically outlined in Jacobson's *The Self and the Object World* (1964).

INTRAPSYCHIC CONFLICT IN SEVERE PSYCHOPATHOLOGIES

One major consequence of the advances of psychoanalytic theory regarding the notion that early developmental stages predate the consolidation of the tripartite structure has been the possibility of clarifying and approaching therapeutically the severe psychopathologies. This applies particularly to borderline personality organization and severe narcissistic pathology, as well as to many cases of sexual perversion, severe eating disorders, and to patients with significant antisocial behavior, who present a fixation at the primitive developmental levels in which splitting and other related mechanisms predominate (Kernberg 1984, 1992, 2004a). The clinical study from a psychoanalytic perspective of all of these cases reveals the consistent observation that intrapsychic conflict at these severe levels of psychopathology does not seem to be unconscious, but, to the contrary, is expressed as an alternation between completely contradictory and mutually incompatible conscious affect states, each unconsciously representing a specific internalized object relation. Thus, the conflict seems to be between two areas of experience that are alternatively accessible to consciousness, but that cannot be tolerated together.

Here a major problem has emerged regarding both the concept of ambivalence and the nature of the unconsciousness of intrapsychic conflicts. Regarding the former, if ambivalence represents the simultaneous presence of contradictory experiences, desires, and fears toward the same object—a combination of love and hatred, to whatever mild or intense degrees—then the conflicts centered around splitting are essentially nonambivalent or preambivalent. In fact, I believe it is reasonable to consider that ambivalence is a characteristic of normal preconscious and conscious functioning, an indication of psychic maturation, and, particularly, maturation and deepening of internalized object relations. What remains unconscious in conflicts centering around splitting is the very intolerance of ambivalence, so that contradic-

tory impulses occupy consciousness alternatively, rather than simultaneously. This intolerance reflects the unconscious fear that the destructive nature of fantasized primitive hatred and envy will result in the loss of all love and ideal object relations, as well as the fear of retaliation from needed others. In fact, typically, there are remarkable resistances against the simultaneous experience of defensively split-off, internalized object relations involving, respectively, love and hatred; these resistances require long-term, complex, and consistent analytic work in order to be resolved.

By the same token, what used to be called *prestructural* conflicts—which, by the same traditional definition of unconscious conflict as that linked to the tripartite structure, were considered to be more interpersonal than intrapsychic—represent, I believe, an erroneous assumption regarding the nature of early psychic development. I believe a general consensus is evolving that, before the consolidation of ego, superego, and id as three clearly differentiated structures, it is the world of internalized object relations, both dyadic and archaic triadic, that constitutes the predominant structure of the mind (Kernberg 2004b). The very concept of structure needs to be expanded from its reference to the tripartite structural theory, or Freud's "second topic" (De Mijolla and De Mijolla 1996), to a broader concept of structure as a relatively stable organization of channels for the activation of specific functions, as Rapaport (1960) originally suggested. Primitive internalized object relations, within this viewpoint, constitute the earliest intrapsychic structures, within which early forms of unconscious intrapsychic conflicts arise between these constituent structures.

Clinical Example

To illustrate this concept with a clinical case, I refer to a patient, a man with a severe narcissistic personality disorder functioning on an overt borderline level. This patient consulted me because of chronic, severe characterological depression and suicidal tendencies, the incapacity to establish a satisfactory relationship with a woman, obesity, social withdrawal, and—in spite of

his age, which was forty years—a conflictual, exaggerated dependency on his parents, toward both of whom he was very submissive, on one hand, and whom he despised and bitterly criticized, on the other. The patient idealized me as his last hope after several unsuccessful trials of psychotherapy: I had been recommended to him as a specialist in his difficulties.

At one stage of his treatment, his behavior toward me oscillated sharply. There were times in which, motivated by what he experienced as a terrible failure on my part (for example, when I took an emergency phone call during a session, having forgotten to let him know that we might be interrupted), the patient accused me of irresponsible and exploitive behavior, comparing me to previous treaters who had not been able to help him, but were, at least, considerate and respectful and not ruthlessly exploitive nor as inconsiderate as I. In other sessions, his behavior replicated his pathological submission (as he described it) toward his mother, leading him to consider every one of my comments as an explicit critique and demand for him to change radically. His feeling that he could not comply with my demands would lead to his considering himself as suffering from a wasted life, as a useless, despicable individual, and as feeling the urge to commit suicide—or, at the very least, to withdraw from all relationships.

It would seem easy to interpret this alternating pattern of behavior as an activation of the same object relation between a sadistic parental image integrated into his pathological grandiose self, on the one hand, and the projection onto me of such a sadistic grandiose self, on the other. But it took many months for the patient to be able to tolerate subjectively the combined experience of these contradictory emotional states, linked to an ambivalence toward me previously made intolerable by the fear that his aggression would destroy the one ideal person who, he imagined, might be able to help him escape from his impossible life situation. Here the unconscious conflict was first between the contradictory affective constellation described—that of ridding himself of his aggression by means of projective identification,

while simultaneously identifying unconsciously with his internalized sadistic object in the transference. Later, the conflict was between a tolerated, conscious ambivalence and guilt over his aggression toward an idealized version of me, which, in turn, evolved completely split off from the earlier relationship I have described. That guilt had been manifest only in rare moments, completely dissociated from the dominant transference pattern that I pointed out.

I hope this brief vignette illustrates the complexity of structural development in severe and primitive psychopathology in which intrapsychic conflicts are apparently conscious rather than unconscious. It must be kept in mind, at the same time, that a similar complexity also presents at later levels of development, when the consolidation of the tripartite structure evolves in parallel to the ascendance of repression and its related, advanced defense mechanisms, as described by Anna Freud (1936). In fact, as is well known, patients with a consolidated neurotic personality organization—in contrast to a borderline personality organization—present not simply one layer of defense directed against a deeper layer of impulse, but rather a complex layering of impulse-/defense-derivative structures that warrant a careful exploration of unconscious conflicts by proceeding from surface to depth. It is essential to be aware that what appears as the impulse defended against at one point may later emerge as a defensive structure against a still deeper-layer impulse, and so on.

Technical Implications

Here the careful application of the dynamic principle of interpretation—i.e., moving from surface to depth, as elaborated by Gray (1986) and Busch (1995)—represents, I believe, an optimal approach to a gradual deepening of the understanding of unconscious conflicts in work with neurotic personality organization; while, in patients with borderline personality organization, the direct interpretation of primitive defensive operations related to the internalized object relations activated in the transference consti-

tutes an optimal technical approach, facilitating the interpretation of the alternating nature of impulse and defense, as represented by the respective object relations activated (Kernberg 2004a).

These observations may be generalized, beyond their application to standard psychoanalytic technique, to a contemporary psychoanalytic psychotherapy for borderline personality organization, as well as to a psychoanalytic psychotherapy for patients with neurotic personality organization, thus utilizing an updated version of Fenichel's (1941) metapsychology of interpretation: that is, in reconsidering the technique of interpretation from an economic, dynamic, and structural viewpoint, we may apply this formulation to patients with both neurotic and borderline personality organization.

In the case of patients with neurotic personality organization, the economic approach to interpretation refers to what is affectively dominant in the patient's communications, with a particular emphasis on what is dominant in the transference—except where it first appears that an extratransferential subject seems so strongly invested affectively that the road to the transference is through examination of that affectively invested issue, i.e., by observing the ways in which it will eventually lead us to transference dominance. The dynamic principle of interpretation in these cases focuses on starting from the viewpoint of the conscious ego, and deepening the patient's understanding by bringing about a split between his or her capacity for self-observation and the surface manifestations of defensive operations, gradually proceeding to a deeper interpretation of conflictual levels between defensive and impulsive, internalized object relations that are clearly embedded, respectively, in ego, superego, and id functions. The structural principle of interpretation here consists then, simply, in the analyst's clarity of his or her working through of a particular defensive structure as part of ego, superego, or id structures.

The economic principle of interpretation is the same in the case of borderline personality organization, with the therapist intervening at the point of maximal intensity of affect—except that what is affectively dominant is likely to be found not in the free as-

sociations of the patient, but rather in nonverbal communication and behavior, together with the therapist's countertransference. Extreme cases either of apparently total absence of affect activation, or of intense affect storms, require specific technical approaches in order to gradually permit the clarification of the representational world enacted in such states (Kernberg 2004a). The dynamic principle of interpretation leads to the diagnosis of which internalized object relationship dyad is activated in the transference in the service of defense against another internalized dyad that is split off from awareness—a relationship that may easily be reverted during the course of a single session. In other words, here, impulse and defense tend to alternate their functions, and the awareness of this helps the analyst in the working through of the same conflict expressed in this alternating fashion. The structural aspect of interpretation with borderline personality organization does not refer to the identification of which tripartite structure is now defending against which other opposite one, but rather, of which internalized object relations are now maximally activated in an impulse/defense configuration involving opposite ones (Clarkin, Yeomans, and Kernberg 1999).

The Role of Drives and Affects

This brings us to the still controversial issue of the nature of unconscious conflict in terms of drives, affects, and unconscious mental structure. While I have developed a theory that considers affects as the primary early motivational structure, and libido and aggression as the superordinate integration of, respectively, idealized, rewarding affect states in the case of libido, and of all painful, aversive affect states as aggression, this theory is compatible with the traditional assumption that all we know about the drives are affects and representations, as Freud stated (Kernberg 1992, 2004a, 2000b). In other words, the manifestations of drives are affectively invested representations, and also—following Jacobson—specifically affectively invested self- and object representations, the mutual relationship of which are framed by these specific affect states. Unconscious wishes and fears are, at

bottom, unconsciously desired or feared internalized object relations: specific, affectively charged relations between the self and an object. Clinically—and here, controversy seems to end—drives are clearly represented by affect states, and this justifies to this day, I believe, the metapsychology of interpretation originally suggested by Fenichel.

Now, is unconscious conflict a conflict between opposing psychic structures, opposing affects, opposing drives, or all of these? I believe that unconscious conflict is always between affectively invested psychic structures, be they primitive ones represented by internalized object relations, or advanced ones constituted by the tripartite structure that has integrated its constituent internalized object relations into ego, superego, and id structures. From this viewpoint, then, unconscious conflict is not simply between drives, but between the object relations-invested affects that represent them (and, I would add, that organize them). I would therefore prefer to leave aside the concept of *prestructural conflict* as outdated, and I am in consonance with the French psychoanalytic approach that sees an essential compatibility between Freud's first and second topic (the topographic and the structural models of the mind) (De Mijolla and De Mijolla 1996).

In fact, the clinical analysis of whether a patient's conscious and preconscious experience tolerates ambivalence when confronted with a conflictual affective relation with the same object, or whether such contradictory affect states toward the same object are rigidly separated by a barrier of mutual denial and splitting, contributes to the diagnostic conclusion of whether we are being confronted with a neurotic personality organization or a borderline personality organization, and, by implication, to what extent we are dealing with a truly unconscious intrapsychic conflict or a conscious intrapsychic conflict marked by ambivalence.

THE CONCEPT OF PSYCHIC DEFICIT

We can now explore the subject of the apparent controversy between unconscious conflict and deficit theories. Under the in-

fluence of self psychology and post-self psychology developments, on the one hand, and of intersubjectivity theory and relational psychoanalysis on the other, the tendency to ascribe severe borderline and narcissistic pathology to psychic deficit, while questioning the centrality of unconscious intrapsychic conflict in those patients, has become a significant feature of psychoanalysis, particularly in North America. This general orientation has also reinforced the emphasis on preoedipal psychopathology, and, particularly, the etiological relevance of the mother–infant relationship, and has been strengthened by empirical research on the importance of attachment pathology. In this context, there has been a certain deemphasis, in practice, on infantile sexuality and aggression. A related tendency has been the reactivation of the focus on a supposed dichotomy between intrapsychic and interpersonal conflict (Kernberg 2001).

From a clinical standpoint, there certainly are cases with significant central nervous system deficits that undoubtedly influence psychic organization. To begin with, cognitive deficits affect early orientation to time and space and, by implication, sensitize the infant and small child to temporary abandonment in the realm of object relations. Deficits in prefrontal cortical structures related to effortful control and affect modulation may decrease affect regulation, particularly regarding negative affects, and accentuate the dominance of aggression in early development (Posner et al. 2002; Silbersweig et al., unpublished). In addition, genetic disposition to pathology of neurotransmitter systems related to affect activation may predispose to a constitutional and temperamental exacerbation of negative affective responses, and tilt the intrapsychic equilibrium to a predominance of negative affects (Depue 1996; Steinberg, Trestman, and Siever 1994). Less clearly understood deficits of brain development, affecting areas related to the internalization of representations of self and others—such as in autistic cases and in the (still controversial and largely unexplored) field of antisocial personalities proper—may represent significant central nervous system deficits that powerfully affect early object relations.

In addition, insufficient activation of the baby's emotional and sensual responses, and severe deficits in physical and emotional care—particularly in the context of chronic, aggressive traumatization—will create the precondition for severe psychopathology, such as we see in the entire area of severe personality disorders, with strong predominance of aggression, and sexual inhibition related to the primary lack of development of sensual response, rather than that secondary to repression. These factors may justify the consideration of severe biological or psychological care deficits as the fundamental etiological factor of psychopathology (Fonagy and Target 2003).

At the same time, however, in considering the end product of such deficits—the fundamental balance between libidinal and aggressive affects is severely distorted in the direction of the dominance of aggressive affects and the related consolidation of primitive defensive operations geared to defend against them—we might note that this range of deficits will still translate into an exaggerated intrapsychic conflict between love and hatred. Given the persistence and exaggeration of severe splitting processes that, together with their related primitive defenses, will then predispose the infant and child to a borderline personality organization, unconscious intrapsychic conflicts will be paramount, regardless of whether the pathology has been predominantly neurobiologically determined or mostly psychodynamically determined.

The practical implication is that a psychoanalytic approach to unconscious, conflictually internalized object relations and their defensive organization is indicated in many cases, regardless of how the etiology of pathological fixation of primitive psychic structure originated. Generally speaking, "deficits" are never simply absences or "holes"; they are a failure of development of certain normal structures, as a consequence of which compensating pathological structures carry the day. As a practical matter, they always imply the development of severe distortion of internalized object relations and related unconscious intrapsychic conflict. From the viewpoint of clinical experience, I think it is reasonable to state that—probably only in cases that correspond clinically to either

autism, Asperger syndrome, or a severe deficit in IQ—a cognitive behavior therapy, conducted in the context of an optimal emotional therapeutic relationship, is preferable to standard psychoanalytic or modified psychoanalytic psychotherapy approaches.

Implications for Psychoanalytic Practice

It is problematic that patients with narcissistic personality disorder, described as being perfectly able to sustain a standard psychoanalysis, should be considered as presenting psychic "deficits," under conditions when clinical experience shows that many patients who definitely would not be accepted as analytic cases by most analysts—in other words, much more severe cases than those that are typically treated analytically—respond successfully to a psychoanalytic psychotherapy centered not on deficits, but on unconscious intrapsychic conflict. (I am excluding, for the purpose of this discussion, cases of psychotic illness—major affective disorders, schizophrenic illness, or paranoid psychosis, where questions of etiology, psychopathology, and psychotherapeutic treatment necessitate different approaches, outside the realm of the present exploration of unconscious intrapsychic conflict.)

My main point is that, in the usual case seen in psychoanalysis or psychoanalytic psychotherapy and considered to present "deficits" rather that unconscious intrapsychic conflict, a careful analysis of the clinical condition would most probably demonstrate that unconscious intrapsychic conflicts are also dominant under such conditions.

One other area of apparent controversy, that of *intrapsychic* versus *interpersonal* conflict, may now be elucidated briefly. In the case of patients with significant psychopathology, all unconscious intrapsychic conflicts, at whatever level, sooner or later emerge as dominant transference patterns and transference/countertransference enactments. This is not the case when a realistic, nonneurotic interpersonal conflict dominates the picture. There is no reason why a patient with a bona fide interpersonal conflict in the absence of a neurotic or borderline or narcissistic structure should not be

able to deal with such a conflict consciously in one way or another. And while, of course, all interpersonal conflicts have an unconscious resonance to them, they usually do not require treatment; we only treat patients with significant psychopathology that affects one or several areas of their functioning, and in particular their character structure. And here we always encounter significant unconscious intrapsychic conflict.

In this regard, character neurosis is really the hallmark of structuralized unconscious intrapsychic conflict, manifest at roughly three levels of severity: first, as characterological inhibition/rigidity, usually, but not always, the least severe of characterological distortions; second, as reaction formations—that is, long-standing, structuralized behavior that has a defensive function against opposing unconscious impulses, reflecting a more severe characterological organization and pathology; and third, the repetitive alternation of contradictory behavior patterns that, typically, reflect underlying splitting mechanisms and borderline personality organization, where unconscious intrapsychic conflict may apparently be conscious (as we examined earlier).

In all these cases, however, the interpersonal conflicts that result, and for which the patient may consult, are rooted in unconscious conflict. Certainly, in patients with a predominant splitting-based organization give the impression that they present conscious conflicts between love and hatred, between libido and aggression. In all these cases of character pathology, their interpersonal problems reflect unconscious intrapsychic conflict and pathological structuring of internalized object relations.

One area in which interpersonal conflict tends to be stressed (as opposed to unconscious intrapsychic conflict) relates to patients who have been severely traumatized, physically and/or sexually. Again, it is important to differentiate here the etiology of the pathology—of which severe early trauma may be an essential factor—from the structural organization of the patient, which is related to, but becomes an autonomous outcome of, the original trauma. From the viewpoint of the treatment of severely traumatized borderline patients, it may be stated quite categorically that,

in those cases where the trauma effectively altered psychic structures in a consistent way, the treatment always reveals an unconscious identification with victim and victimizer that needs to be analyzed as an important origin and expression of unconscious intrapsychic conflict (Kernberg 1992). The traumatized individual has to come to terms with this dominant unconscious identification that forces him or her to reenact the trauma again and again, with the alternative role distribution (victim/persecutor) between self- and object representations referred to before, which is most strikingly present in such traumatized individuals. In contrast, so-called trauma therapies that treat the patient only as a victim may produce the effects of a good supportive psychotherapy, but, typically, tend to maintain an unchallenged severe inhibition, whether it is in the sexual or aggressive realm, reflecting the patient's unanalyzed, unconscious identification with the aggressor.

There is another traditional assumption that is vaguely related to the concept of ego deficits, namely, that of *ego weakness*. A generation ago, this was considered a characteristic of borderline patients, and supposedly required supportive approaches rather than analytic ones. Nowadays, we know that so-called ego weakness represents the dominance of ego-weakening defensive organizations that, by means of their interpretation in the transference, can be resolved, thus leading to ego strength (Kernberg 1984).

CONCLUSION

I believe it is reasonable to state that unconscious intrapsychic conflict originates as a conflict between love and hatred at their most primitive levels, elicited under conditions of peak affect states in the relationship between infant and mother, but very soon transformed by the archaic triadic structuring of this relationship, already present in mother's unconscious relation to father, and its implication for the relation with her baby. Conflicts between love and hatred may take the forms of conflict between idealizing ecstasies and sadomasochistic strivings, between sensual wishes and projected aggression emerging as primitive paranoid

fantasies. The complex transformation of rage into hatred and envy, of love into its integration with sadistic components, and its transformation in the ego ideal, reflect a broad spectrum of affective constellations embedded in specific dyadic and triadic object relations from early life onward. Unconscious conflict is not one between pure drives or affects, but rather, as mentioned before, it resides in their structuralized quality as internalized object relations.

It is a standard psychoanalytic experience that, in the course of the psychoanalytic exploration of ego and superego structures, their component internalized object relations are clarified. In fact, it is possible to analyze the structures of ego and superego in terms of their component internalized object relations, as evidenced by the work of Joseph and Anne-Marie Sandler (1998), and of Jacobson (1964). By the same token, the intricate integration of dyadic and triadic relationships from early on calls into question the linear analysis of oral, anal, and genital stages of development. In the light of our findings with severely regressed patients, it seems reasonable to assume that a hierarchical analysis of the interdependent development of archaic oedipal and preoedipal structures is warranted, the emphasis being on progression and regression, *après coup* and fixation. This is a formulation that French psychoanalysis has pioneered, one that is beginning to be absorbed into both British and American mainstream psychoanalytic approaches (Kernberg 2001).

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THE CONFLICT BETWEEN MOURNING AND MELANCHOLIA

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Conflict between facing the reality of loss on the one hand, and denying it on the other, is explored in clinical material drawn from an analysis approaching termination. The intrapsychic conflict over loss was expressed as a conflict between morality and reality, and was externalized as a conflict between patient and analyst. For the patient, giving up resentment toward the analyst became tantamount to giving up the ideal object and losing omnipotence. In the course of the analysis, his complaints became less convincing, and the conflict over loss became more conscious, allowing some moves toward mourning to take place.

Change in psychoanalysis, like change in general, invariably exposes the patient to something new, unknown, and, to a degree, frightening. It is therefore not surprising to find that, despite the suffering involved, many patients cling to what is familiar. Yet a desire for change and a hunger for new things and new developments drive the patient forward and bring him into conflict with conservative tendencies, which bind him to the status quo.[1] Nor is it simply a question of the anxiety of the new, since change always involves giving up the old; it is often the case that relinquishment of the familiar is the more difficult part of the task.

I will argue that this conflict is critical in both life and in analysis, and becomes acute whenever the status quo is disrupted, of-

[1] Masculine pronouns are used to refer to either sex in this paper, for the sake of simplicity and clarity.

ten when a development has taken place and presents the patient with a new capacity to appraise reality. Development and integration increase awareness of reality, so that the conflict over loss can begin to be faced, worked through, and understood. These experiences involve relinquishing omnipotence and facing loss, and the mental processes entailed have much in common with those that arise for a bereaved person confronted with an actual death. Just as in bereavement, the central issue for analytic change is whether the reality of loss can be faced, with the attendant feelings of regret, remorse, and guilt. If the patient can tolerate the painful consequences, he is able to work through the various stages of mourning and is eventually able to reap the developmental advantages and enrichments that result.

If reality cannot be faced—and this is at least initially the case when the loss is significant and painful—then defensive processes are mobilized, which deny the loss and which lead in the direction of melancholia. In the patient I will describe, these defensive processes involved a variety of mechanisms, including manic triumph, obsessional control, and sadomasochistic humiliation of his objects, which lessened in their omnipotence and virulence over the years of the analysis. However, these defensive processes left the patient having to contend with what he had done to his objects, and confronted him with an internal situation similar to that described by Freud in "Mourning and Melancholia" (1917). A damaged, reproachful internal object was internalized and held onto as a concrete object, casting its shadow on the ego. In this way, the melancholic solution offers a compromise in which the object no longer exists in the external world, but is retained as an internal object. It is possessed and controlled in the internal world and projected onto new objects, who play the same role in the patient's mental equilibrium that the original object did.

Although often reluctant and hesitant, my patient also made moves in the direction of relinquishing his objects, and with them the melancholic compromise, permitting him to face reality and to form new relationships. In the early stages of mourning, the conflict was unconscious, and the denial of loss and possessive inter-

nalization of the object were automatic, not subjectively experienced as choices. In later stages, as the reality became gradually more acceptable, the choices were more apparent and were consciously experienced as such.

It is confusing that the word *depression* has been applied both to the state that accompanies mourning and to that which results from the defenses mounted against mourning. The path that leads toward facing the loss, and mourning it, is associated with painful depressive feeling, involving guilt, regret, remorse, and a wish to make reparation. These feelings were thought by Klein (1952) to represent the depressive position and are very different from those observed in depressive illness. Although mixed states are common, severe depressive illness or melancholia results from defenses against loss, and hence against all those feelings associated with the depressive position. The clinically depressed patient is likely to suffer anxiety and persecution, to harbor grievance, and to deploy manic and obsessional defenses that aid in denying the reality of the loss.

Our contemporary orientation to this theme continues to be indebted to Freud's (1917) description of both mourning and melancholia, and gains further depth from his later formulation that all conflict has deeper roots in the conflict between the life and death instincts (Freud 1920). While attitudes to this formulation vary, it seems to me to be particularly applicable to the conflict over mourning. After a bereavement, the life instinct seems to slowly recover and to help the patient relinquish attachment to the dead object and to reengage with life. The death instinct is more difficult to formulate, but can be thought of as an anti-life force expressed as the conservative tendency to hold onto the object, and in this way, to favor the development of melancholia.

Fortunately, these deeper issues need not concern us in the everyday task of following a patient in the to and fro of an analytic session. Here, I believe, the conflicts are nevertheless expressions of the same dilemma about the relinquishment or possession of the object, but one in which the patient is preoccupied with a need to be loved, which he believes protects him from cat-

astrophic anxieties. The patient becomes concerned with losing the love of his good objects, which he fears will confirm the damage he has done to them in his phantasy.[2] Sometimes, the feeling that one is no longer loved can give rise to a terrible feeling of loss, as though the whole world has collapsed. Freud (1923) suggested that this is linked to the fear of death in melancholia, in which "the ego gives itself up because it feels itself hated and persecuted by the super-ego, instead of loved. To the ego, therefore, living means the same as being loved—being loved by the super-ego" (p. 58).

Earlier, Freud (1917) had described melancholia as a form of pathological mourning related to the loss of love:

> In melancholia the occasions which give rise to the illness extend for the most part beyond the clear case of a loss by death, and include all those situations of being slighted, neglected, or disappointed, which can import opposite feelings of love and hate into the relationship or reinforce an already existing ambivalence. [p. 251]

These "situations of being slighted, neglected, or disappointed" are met in every meaningful relationship and are part of ordinary experience in life and in analysis. Each of these rejections of love involves a loss and presents the patient with a conflict that centers on the capacity and willingness to recognize the reality of the experience. The central issue remains the capacity to judge reality. In the case of an actual loss through death, Freud (1917) described how "each single one of the memories and situations of expectancy which demonstrate the libido's attachment to the lost object is met by the verdict of reality that the object no longer exists" (p. 255).

In the case of those situations in which the patient is "slighted, neglected, or disappointed," and comes to believe that he is no longer loved, a judgment of reality still has to be made. Here the judgment involves the question of the loss of love, and the par-

[2] The Kleinian spelling of the word *phantasy,* used specifically to refer to *unconscious fantasy,* is respected in this paper.

ticular incident of "neglect or disappointment" has to be gone over, and again the "verdict of reality" applied. The choice determines whether the loss of love is faced and perceived in realistic proportions, requiring that an appropriate quantum of guilt be suffered, and with it, a loss of idealization of both the self and the object. One of the reasons a judgment of reality seems to be so difficult in these circumstances is the fact that the external object remains present, alive, and potentially loving. The patient can project the internal object onto it, and can keep the hope alive that the loss can be reversed and the idealization sustained without the need to mourn.

I will argue that an experience of loss arises from a variety of sources throughout an analysis—sometimes when the patient has to deal with an actual absence, such as that occurring between sessions, in breaks, and at the end of an analysis, and often when the patient feels "slighted, neglected, or disappointed" (Freud 1917, p. 251). Sometimes, the patient's development propels him in the direction of change, as the patient comes to believe that he is strong enough to survive threats to the status quo.

These reactions to loss are not always recognized as involving a choice because anxiety tends to take precedence over mourning. Narcissistic defenses may then be so successful in replacing loss with an identification that the loss is only recognized if the narcissistic position begins to give way to a greater reality sense. Nevertheless, I think that such a loss can be discerned in the interactions in the session, as one observes the patient's reactions to change. Rey (1994a, 1994b), for example, has argued that every meaningful analytic contact, such as that taking place when an interpretation is understood by the patient, has associated with it a quantum of loss and hence a quantum of depression. The understanding of something new means giving up a belief which, in these circumstances, is experienced as giving up a thing felt to be a concrete object. It always involves a degree of "being slighted, neglected, or disappointed," and confronts the patient with a conflict. It is common to see the patient struggle between acceptance and denial in this setting where acceptance involves a mini-relin-

quishment and a mini-mourning, while denial involves a return to dependence on a concrete internal object, as well as the redeployment of earlier mechanisms that deny the loss.

I will look at this type of conflict in some clinical material from a patient who initially denied loss in various ways, and subsequently, as a result of the analytic work, seemed to come closer to accepting it and to working through the mourning that of necessity followed. While the mechanisms he used were individual to him, a pattern emerged that I suspect is fairly common. First, there was a tendency to transform the conflict from one involving a judgment of reality to one of morality. Rather than examining the reality of what had happened, the patient expressed a grievance against an object that had been internalized. The incident that had led to feelings of "being slighted, neglected, or disappointed" was treated as if it had not happened because it was unfair and should not have happened. The analyst was expected to confirm this judgment, and if he failed to do so, the complaint was turned against him.

We could say that an ego judgment about reality was replaced by a superego judgment concerned with morality (Britton 2003), and the question of what had happened was replaced by the question of what should have happened. Associated with this shift was a predominance of grievance over guilt, and of anxiety over depressive feeling.

What seemed to happen in all these defenses against reality was that an intrapsychic conflict over loss became transformed into an interpersonal one between patient and analyst. The patient often seemed determined to draw the analyst into a moral judgment and to create a fight over what was right or wrong. As the analyst, I was often unable to resist joining in the fight, and found myself drawn into a collusion to avoid looking at the reality of what had happened.

This type of collusion to avoid reality is a type of enactment on the part of the analyst—one that I was often unable to prevent, and that I believe damaged the neutrality of the analytic setting and jeopardized the analytic work. Recent research has examined

the way such enactments lead the analyst to play a part in the patient's defensive system, and has led to a better understanding of the patient's habitual ways of relating to his objects. Sandler (1976a, 1976b), for example, sees enactments as arising from the way an internal relationship between the self and an object becomes *actualized* in the relationship with the analyst, who is prodded into playing the part of an internal object, and hence is led to enact an *infantile role* relationship.

Of particular importance to the approach I take in this paper is Joseph's (1981, 1983) description of the way the patient uses the person of the analyst to establish a psychic equilibrium that resists psychic change. She and others (e.g., Feldman 1994, 1997) have shown that it is through such enactments that the analyst is drawn into playing a role in the patient's phantasy, and, as a result, is used as part of the patient's defensive system.

CLINICAL MATERIAL

Mr. A was nearing the end of a long and often difficult analysis. For many years, the pattern of his sessions had included an initial moment of understanding and contact that sometimes seemed to reflect insight, but that often came across as a caricature of what a naive analyst would want to hear. The patient would wait for my comment, which was only acceptable to him if it took the form of praise or blame. While he clearly sought praise, often in a quite childish way, the important issue was that I should make moral judgments and take sides. Usually, he felt that the injustice he reported could be put right if I gave him unqualified support, but he was almost equally satisfied if I could be persuaded to criticize him on moral grounds. Almost invariably, my attempt to remain neutral and to look at reality rather than morality led to an angry outburst about what I had said or failed to say. The predominant complaint was one of injustice, and Mr. A's failure to find the support from me that he sought engendered an indignant incomprehension and resentment.

Gradually, as a result of repeated such experiences, the confrontations lessened, and, particularly after we had decided on a termination date about a year hence, a calmer atmosphere prevailed. Mr. A was less indignant and more thoughtful, but still found it hard to use his intelligence or to observe what was happening around him. His predominant response to change was no longer panic, and when I failed to meet his requirements, he was less convincing when he complained that he felt desperate, that I had removed a lifeline, and that everything he had built up was collapsing. The material no longer had such catastrophic connotations, although he still brought images of terrible isolation and neglect, which led him to feel he must keep going at all costs to avoid breaking down. For a long time, contact with depression, guilt, or with any aspect of loss seemed possible only for brief periods, although some sadness was evident as he wondered what it would be like not to come to his session every morning.

Mr. A had always found breaks in the analysis difficult, anticipating isolation and anxiety, and, earlier on, he had dealt with them by making himself busy, often extending my breaks by taking holidays or business trips of his own. There were many fewer trips in recent months as he began to realize that his analysis was soon to end, but some two months before the termination date, he decided to accept an invitation to give a talk at a business convention in Germany, which would necessitate his missing his usual Friday session.

The First Session

On the Thursday session immediately before this business trip, Mr. A began by launching into a description of what he called a very difficult situation. The idea had been put to him that he might help his son, B, by finding information for him from colleagues about job openings. When he did so, at the cost of considerable effort, it had led to disaster. Instead of winning approval from B, the patient was accused of interfering and of trampling on his son's independence. Mr. A began to describe a catas-

trophe, reiterating that he was a terrible failure, that there was something wrong with his thinking, that wires were connected up wrongly in his head, and that he was beyond being saved.

The patient continued by saying that he thought this experience must be a revenge for the feeling of complacency he had felt in recent weeks, when he thought he had been improving. Things had been going deceptively well: he had felt good about a directors' meeting at work, and about his relationship with his wife, with whom he had relaxed in the garden over the weekend. He had gazed with pride at the work he had done on the stone patio, the flower beds, and the water feature, which all looked nice. It had made him think that he had built things up again and reestablished a better link with his wife. Now he reiterated that he had pulled the rug out from under himself and everything had come crashing down.

Mr. A's protestations, however, did not carry the same sort of conviction of previous material of this kind. They seemed more to show me how trapped he was in his wish to seek approval, and how difficult it was for him to judge reality. He even acknowledged that he had asked himself why he had collapsed so readily in the face of his son's accusations, which he did not quite believe to be true. He had apologized as if they were true, but now he was unsure.

I linked the patient's description of disaster with his anxiety over the business trip he was to take to Germany the next day, and interpreted that he was trying to persuade me that this trip would wreck the analytic work we had done. He was afraid that I disapproved of the trip and that my disapproval would lead to disaster. This fear then led to the claim that he had collapsed, and that my work with him had also collapsed, and I suggested to Mr. A that he wanted to see whether I would defend the work and not agree with him that missing his Friday session would be a disaster, even if it made him feel bad. I added that he *did* feel we had done useful analytic work, but that he did not really believe that it had created the ideal situation he wanted, which would serve to protect him from reality. I interpreted that neither the ideal fig-

ure of the analyst he had created in his phantasy, nor the collapse he presented as a disaster, was quite real.

Mr. A seemed to listen, but nevertheless continued to insist that the disaster was real. When he was with his wife, he felt he had a family and a home and that he was not alone; but now he had lost everything.

The Next Session

After the weekend in Germany, Mr. A came back on Monday in a different mood. He said that a lot had happened since the last session. First, he received a long e-mail from his son, B, which was apologetic and open about B's feelings and plans. Some of the heat of B's resentment had been diverted from the patient to the patient's aunt; B complained that she was controlling because she gave money and then expressed an interest in how it would be used.

The patient said he was surprised because he had only warm feelings toward this aunt, who had always been an ally for Mr. A against his father, and who used to take him camping when he was a boy. He had always been curious as to why it was his aunt and not his father who took him on such outings. Then, in watching a television documentary about D-day (broadcast at the sixtieth anniversary of the landings the previous week), he felt he understood more, and thought that his father had been through enough pain and discomfort in landing in Normandy and fighting through Northern France to Germany. He could now understand why his father had not wanted to go camping, but felt that the war had left a barrier between them.

I pointed out the contrast between the patient's mood today and how he had felt in the previous session on Thursday, before his trip to Germany, when the world was collapsing around his ears. I thought that the improved relationship he had established with me—perhaps in part because I did not collapse on Thursday—had helped him to understand his father better.

Mr. A replied that he had some thoughts about Germany, and reminded me that some of the tension in his family lay between his

mother, who admired Germany, and his father, who, because of his bitter experiences in the war, had an antipathy to all things German and idealized the French. When Mr. A gave his talk in Germany the previous Friday, he was aware of experiencing some excitement when the Germans were impressed by his work, and he wondered if this had something to do with his father.

I suggested that the patient might think that, like his father, I —and psychoanalysis as well—had a history connected with World War II, and, consequently, he might fear that, like his father, I might be hurt if he embraced this aspect of Germany with too much enthusiasm. He said that he had been thinking of psychoanalysis as German in origin, and then realized it was Austrian and Jewish. He himself had not been happy in France; he had always wanted to study at Heidelberg.

Mr. A remembered one remarkable day when he had been sitting in a café in Germany, near the French border. He had had a good meal and some wine, and wrote some notes for a business venture he was planning. He wrote what he thought of as his personal manifesto. It was long and involved, but it had flowed easily. If he were to look at it now, he was not sure what he would think; he might see it as nonsense.

After a silence, the patient added that he felt controlled by his father, and this made him angry. But as he watched the D-day documentary, he was moved when the newscasters said that this was the last time they would go to Normandy; there would be no veterans left on the next occasion.

I interpreted that he was now more aware of the end of the analysis, which linked to a time when I would no longer be here. This created a conflict. He could easily see me as controlling and as demanding that he submit to my authority. Then, if he rebelled, he expected a terrible collapse when he felt he was so powerful. He said, yes, it was a manic sort of freedom and dangerous. He knew it was connected with fascism and power. He said that as he got older, his father did seem to realize that when one generation passes money on to the next, they will not be there to see how it is spent.

I suggested that he was more aware of having regrets about having taken the long weekend for the business trip to Germany, and perhaps feeling he had hurt me, but that he now was less convinced that his actions and phantasies would lead to a catastrophic loss of love and to a collapse. Now, he seemed more aware of his father's age and of the ending of the analysis, when I would not be there to supervise how he used what he had gained from it.

Mr. A said that his father could not tolerate the patient's success and was easily threatened. He was even threatened by the way plants grew in his garden: they had to be kept in their place—and, like the plants, Mr. A had always felt that his father tried to cut him down to size.

I interpreted that he now felt safer with me and believed that both he and I had survived his long weekend in Germany, despite his temptation to make an alliance with powerful fascist ideas with which to attack and triumph over the analysis. But he remained unsure if he could grow and develop in a more normal way. I thought he was still unsure whether I could bear to see him do well and perhaps even become more successful than I was. He said that he had a number of promising business projects, but he found it difficult to judge if they were real or just excited and mad. I suggested that, when his omnipotence was so readily stimulated, he found it difficult to judge his achievements—as well as mine.

DISCUSSION

The sessions in recent months had shown a thoughtfulness that seemed to be linked to the patient's awareness of the end of his analysis and involved what I thought was a more realistic evaluation of his situation in life. The impending termination revived earlier losses, some of which provoked feelings of smallness and vulnerability to which he was particularly sensitive. When he felt small, he typically felt humiliated and turned to an omnipotent solution in which he triumphed over his object and reversed the feeling of smallness. This had often led him to take a break from

the analysis either when I was about to take one, or (in retaliation) after I had taken one. In recent months, he had not done this, and at some pain and cost, had managed to sustain contact with me and to value the sessions. The trip to Germany seemed to involve a need to rebel against someone he viewed as a tyrannical father who threatened him with a humiliating feeling of smallness. Having decided to miss the Friday session, he reversed the experience of being left by leaving me to wait for him, and this made him fear that he had damaged the relationship with me by establishing his superiority and triumph over me.

What Mr. A felt unable to experience was *loss*—partly, the loss of the Friday session itself, but chiefly, the loss of love that he feared would result from my disapproval. He could not accept a degree of guilt that left him intact, and that also left the relationship with me intact. Instead, he continued to present his situation as though his world had collapsed, and he seemed to be identifying with a collapsed internal object to whom he was linked by mutual feelings of blame and resentment. At this point, he did not feel sufficiently free to think in a way that would permit tolerance of the bad feelings that arose over missing a session at this stage of his analysis. Rather, he relied on an identification with a concrete internal object that led to a return toward melancholia.

The self-reproaches that dominated the session had the same quality as those in "Mourning and Melancholia" that Freud (1917) pointed out were directed toward an internal object. Mr. A's sense of having built up internal strength through the analytic work was present in the form of improved relationships at his work and also with his wife, but alongside this was a phantasy of an omnipotent son who could destroy everything that his father had been trying to build. He was turning to a more primitive world, peopled by retributive figures operating at a moralistic and punitive level, and I was meant to feel that my work with him could not stand up to the power of those forces.

Nevertheless, the complaints lacked force, and the patient even expressed the idea that he was too ready to agree with his son that he had been in the wrong. This led me to think that he

had a picture of me as someone who would see his guilt, and also his anger and distress, but keep it in proportion and not overreact.

In the second session, a degree of defensiveness remained, but Mr. A was more reflective and able to bring thoughts that helped him to understand his reactions to me and to see their similarity to those his son had with him, and that he had with his father. Seeing the documentary about the D-day landings put him in touch with appreciative feelings toward his father. As he understood his father more sympathetically, he was less resentful toward him—for example, about his not having taken him camping. When his ideas were admired by the German audience at his business presentation, he was reminded of the manifesto he wrote in the café on the French-German border, and he connected his sense of freedom and power with an escape from an analysis that restricted him and that he felt was trying to "cut me down to size."

It seemed to me that the patient was taking a step in the direction of acknowledging loss and mourning it, and that this made him feel less trapped in an identification with a melancholic object. The conflict nevertheless repeatedly returned, and he swung between accepting the reality of the loss of his analysis and denying it. Once the analysis ended, he would not feel so controlled and cut down to size, and could use his inheritance as he thought fit. But he was also aware of the violence of his protest and of the powerful fascist alliances he made in his phantasy, through which he believed he could destroy what I and his father stood for. To work through the mourning would involve recognizing the guilt and shame that arose in relation to these phantasies. It was not really the loss of the Friday session that bothered him, but rather, the recognition that he sought strength from powerful forces that he did not really approve of, but that helped him reverse his feeling of being small and distressed at the imminent loss of the analysis.

I believe that the patient was in touch with his regret over the conflict with me, which he saw as a kind of power struggle, and he

hoped that, like his own son, he could be more open and allow a reconciliation with me to take place. However, this reconciliation made him feel more aware of endings. He had spoken recently of my age, his father's age, and of the possibility of my retirement after the end of his analysis. The realization that I would no longer be there to check on how he used the analysis made him feel more free, but at the same time, he was reluctant to give up his power over me because that meant relinquishing his narcissistic defenses against the loss. At the end of the session, he once more turned to the difficulty he had in making judgments, as he tried to apply the verdict of reality to both his creative work and to my work with him.

Choice and Conflict in Mourning

I believe that the choices facing the patient were similar to those facing a bereaved person, and that these involve a painful conflict between relinquishment and possession of the lost object. Even in normal mourning, in the early stages, attempts are made to deny the experience of loss, and these must be overcome if the subject is to proceed to the later stages of mourning, where the reality of the loss is faced (Bowlby 1980; Lindemann 1944; Parkes 1972).

In the early stages, the patient attempts to deny the loss by trying to possess and preserve the object, and one of the ways he does this is by identification with it. Every interest is abandoned by the mourner except those connected with the lost person, and this total preoccupation is designed to deny the separation and to ensure that the fate of the subject and of the object are inextricably linked. Because of the identification with the object, the mourner believes that if the object dies, then he must die with it, and, conversely, if the mourner is to survive, then the reality of loss of the object has to be denied. It is often at this first stage that mourning becomes stalled, as the defenses leading to melancholia are deployed. Indeed, melancholia can be thought of as a failed mourning.

The conflict becomes more conscious as the patient's reality sense persuades him that the loss can be faced, while the patient's preferences, in contrast, create the illusion that the object remains alive. The compromise provided by the melancholic solution that up to now has sustained an equilibrium no longer satisfies the patient, as he begins to become aware of the wish to once more engage in life and to allow development to proceed.

This type of conflict is vividly described by Klein (1940, p. 355) in the patient she calls Mrs. A.[3] After the sudden death of her son, Mrs. A began sorting out her letters, keeping his and throwing others away. Klein suggests that she was unconsciously trying to restore the son and to keep him safe, throwing out what she considered to be bad objects and bad feelings. At first, she did not cry very much, and tears did not bring the relief that they did later on. She felt numbed and closed up, and she also stopped dreaming, as though she wanted to deny the reality of her actual loss and was afraid that her dreams would put her in touch with it.

Then she dreamed that she saw a mother and her son. The mother was wearing a black dress, and she knew that her son had died or was going to die. This dream put Mrs. A in touch with the reality not only of her feeling of loss, but also of a host of other feelings that the associations to the dream provoked, including those of rivalry with her son—who seemed to stand also for a brother, lost in childhood, and to bring up various other primitive feelings that had to be worked through.

Later, she had a second dream in which she was flying with her son when he disappeared. She felt that this meant his death—that he was drowned. She felt as if she, too, were to be drowned, but then she made an effort and drew away from the danger, back to life. Her associations showed that she had decided she would not die with her son, but would survive. In the dream, she could feel that it was good to be alive, and this showed that she had accepted her loss; sorrow and guilt were still experienced, but

[3] In fact, Mrs. A was Klein herself, who was reacting to the death of her son in a mountaineering accident (Grosskurth 1986).

with less panic, since she had lost her previous conviction of her own inevitable death.

Here Mrs. A pulls herself away from death, toward life, but has to suffer the painful consequences of separateness between herself and the son she lost. We can see that the capacity to acknowledge the reality of the loss, which leads to the differentiation of self from object, is the critical issue that determines whether mourning can proceed. This involves the task of relinquishing control over the object, and means that the earlier trend aimed at possession of the object and denying reality has to be reversed. The individual must face the inability to possess, preserve, and protect the object. His psychic reality comes to include the realization that the individual's love and reparative wishes are insufficient to preserve the object, which must be allowed to die, with the consequent desolation, despair, and guilt.

These processes involve intense mental pain and conflict, and it is a part of the function of mourning to work through and resolve such conflicts. In analysis, they become acute when disruptions threaten the analytic setting, and, in the case of the patient I described, they became more conscious as the termination of his analysis approached. The impending loss of his analyst accentuated Mr. A's wish to retain the status quo, in which the analyst was available to support a defensive organization, and, at the same time, a growing sense of reality—also accentuated by the impending loss—made the patient aware that his analyst would soon cease to be available, and enabled him to turn to his own resources to anticipate and mourn this loss.

Grievance as a Means of Avoiding Loss

One of the many remarkable observations Freud made in "Mourning and Melancholia" (1917) concerned the self-reproaches of the melancholic patient. These, he suggested, were actually reproaches against an internal object with which the patient had identified. This seems to be an important characteristic of the depressed patient, whose resentments provide him with a link to

the internal object. Often, the grievance centers around an early narcissistic wound inflicted on the patient by a mother who failed to fulfill what was believed to be a promise of narcissistic perfection. The counterpart to the grievance is the hope provided by a persistent belief in the existence of an ideal object who will reverse the injustice and fulfill the promise. It seems particularly difficult to apply a reality sense to these objects—both the resented one and the ideal one; they are easily recognized as the same object, and the resented figure has only to admit fault and agree to change in order to become ideal.

Britton (2003) has pointed out that the internalized figure toward whom grievance is directed is not seen as a bad object, but rather as a good object behaving badly. In the analytic situation, both the resentment and the hope are projected onto the analyst, and pressure is applied to make good the resentment by fulfilling the hope.

In these conflicts, a struggle takes place between reality and morality, since what the patient considers to be a just solution comes into conflict with what is observed to be a realistic one. Often, the central issue is the loss of the ideal object and of the ideal self that it brings into being. The intense longing for the ideal object to take away all feelings of badness, especially feelings of persecution, failure, humiliation, and guilt, is an important part of the early relationship to the breast. Klein (1957) wrote about this as follows:

> The infant's longing for an inexhaustible and ever-present breast stems by no means only from a craving for food and from libidinal desires. For the urge even in the earliest stages to get constant evidence of the mother's love is fundamentally rooted in anxiety. The struggle between life and death instincts and the ensuing threat of annihilation of the self and of the object by destructive impulses are fundamental factors in the infant's initial relation to his mother. For his desires imply that the breast, and soon the mother, should do away with these destructive impulses and the pain of persecutory anxiety. [pp. 179-180]

It was the analyst's failure to provide such magical relief that reinforced Mr. A's resentment, and it was the continuing possibility that he might yet do so that kept that hope alive, and that persuaded the patient he could continue to avoid facing the reality of loss. In the process, he could also continue to avoid coming to terms with the loss of his omnipotence.

CONCLUSION

In the first session, I reported how Mr. A put pressure on me to agree that his world had collapsed. He behaved as if an ordinary good relationship, one in which guilt and disappointment can be tolerated and survived, had failed to develop. He felt that he had lost the positive relationship he had developed with me in analysis, and he could not face the reality either of his present state or of the idealized and quite evidently unreal phantasies he had previously erected. These phantasies were connected with the belief that I could take away all his feelings of distress and guilt and restore him to an ideal state, making him feel loved and protected. Although he was clearly distressed and disappointed, I felt that he did not completely believe his own propaganda, and he seemed to recognize that he wanted to see if I could sustain confidence in him and in our work.

Nevertheless, in that first session, the patient was in no mood to look at the reality of, or to mourn the loss of, his omnipotence. Nor could he face the loss of the idealized analyst who, he believed, had promised him that all his damaged objects could be restored without any need for guilt or pain. The overwhelming mood was of collapse and grievance that I had failed him.

In the second session, the atmosphere was different. Mr. A had survived the long weekend occasioned by his business trip to Germany, and I was seeing him as usual, without any apparent acrimony. The program on the D-day invasion had touched him and allowed a more sympathetic attitude to prevail. Later in the session, he came closer to the recognition that he admired things German in opposition to his father, just as he had taken a long

weekend away in opposition to the analysis, and he felt some relief that I had not overreacted to this. The sense of freedom he had had in Germany seemed connected with the escape from a critical, overbearing analyst, and he was aware that this view of me made him turn to an alliance with what he saw as a fascist power in order to oppose me. It was partly this awareness that made him more understanding of my response to him—and, I think, led him to recognize some of the strain that working with him involved.

It seemed to me that these thoughts were connected with the patient's awareness that the analysis was ending, as well as with a similar awareness that his parents were aging, so that this was likely to be the last D-day celebration they would witness. I thought he was nearer to accepting these realities and to forming a more realistic view of the state he was left in. Mr. A himself felt that he had changed as a result of his analysis, but his position was far from what he had hoped for, and even the achievements he recognized were felt to be insecure, easy to undermine and destroy. Resentment could come to dominate his relationships with little provocation, and the working through of mourning was postponed by the absence of a sense of finality about the ending of the analysis.

As the termination approached, the conflict seemed to me to become increasingly conscious, involving Mr. A in agonizing choices. He came nearer to communicating an appreciation of what the analysis had achieved, as well as to the recognition of how disappointed he was that it had not achieved more. He was desperate to be left in a state of certainty and security, and he resented the fact that we were likely to end without his being able to resolve the conflict—which was more clearly revealed, it seemed to me, to be a conflict between his feelings of love and hatred.

When this conflict seemed impossible to resolve, the patient continued to try to transform it into a conflict between what was *really* the case and what he felt *should* be the case, and that led him into the area of grievance when he felt what should have

been offered to him had not been. This grievance, which I thought had its roots in his resentment toward an idealized internal object who kept failing him, found expression as a conflict between the two of us, and erupted with great intensity when he was confronted with the inevitability of his disappointment with me.

I, too, had to face my disappointment, and I was helped when I was able to accept the limitations of my work and of psychoanalysis in general. I was also sustained by the idea that a good deal of working through and mourning for the loss of an analysis takes place after the analysis is over.

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CONFLICT IN THE MIDDLE VOICE

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The author presents material from Homeric texts that is expressed in the middle voice, an ancient Greek verb form that strikes a balance between passive and active voices. A clinical vignette is presented in which the analysand expresses herself in a way that captures some of the sensibility of the middle voice. The author discusses ways in which the vision of human experience expressed by the middle voice, a vision that was developed and elaborated in the later Greek tragedies, can illuminate psychoanalytic approaches to problems of personal agency and conflict.

In the midst of a crucial scene in Homer's *Odyssey*—the recognition of the returning Odysseus by his childhood nurse, Eurycleia—the narrator inserts what appears on the surface to be a distracting digression. Turning the reader's attention away from the moment when Eurycleia will see a scar on Odysseus' leg, leading her to realize that her master has returned home after twenty years, Homer describes the moment during Odysseus' adolescence when he first got the scar. The wound was inflicted in the course of a boar hunt that took place during Odysseus' visit to the distant home of his maternal grandfather, Autolykos. Heroically, Odysseus located and flushed out the boar, simultaneously being gored by and killing it.

This story, coming at an emotionally tense and narratively climactic moment in the poem, seems so out of keeping with the immediate events that some commentators have thought it to be a corrupt interpolation in the text. Recent scholarship, however,

indicates that, to the contrary, it continues and deepens the theme of recognition that Homer is describing. Reinterpretation of a remark in the *Poetics* suggests that no less an authority than Aristotle believed that the story of the boar hunt embodied the central theme of the entire epic (Dimock 1989).

Homer's digression does not stop with the boar hunt, however. Rather, that episode frames another, earlier one: the naming of Odysseus. This story also involves Autolykos, something of a rogue (his name means "the wolf itself") living on the fringes of society. Described by Homer as a man who "excelled all others in stealing and the art of oaths," Autolykos is probably the right person to name the man who will spend so much of his life away from home, at odds with man and the gods alike. So when he is invited to name his new grandson, he replies: "Let his name be *Odysseus* . . . the Son of Pain, a name he'll earn in full" (Fagles 1996, p. 403, 19.463-464).

This passage requires some explanation. The word *Odysseus,* it turns out, is derived from the Greek verb *odussemai*, which is variously translated as "to inflict pain" or, more strongly, "to hate." But, notably, the name uses the verb in what is called the "middle voice," a form that strikes a balance between active and passive (Fagles 1996, p. 514). Greek is one of the few languages that has a unique verb form to express the middle voice, and it is difficult to translate these verbs into languages that do not. It is even more difficult to hold the tension between active and passive that a single word in the middle voice conveys.[1]

Thus, the name given to Odysseus suggests that he will both inflict pain on others and have pain inflicted on him; he will hate and be hated. And, of course, his life bears this out; it is, as Autolykos prophesied, "a name he'll earn in full." The story of Odys-

[1] Another use of the middle voice implies self-reflexivity, as in "I touch myself." The existence of a unique verb form to convey this experience is of interest to psychoanalysts, but in this paper, I restrict myself to the connotation of simultaneous activity and passivity with respect to an external object. For this use, see, in addition to Fagles (1996), Dimock (1989, pp. 257-260), Mendelsohn (1999, pp. 33-34), and Peradotto (1990, pp. 132-134).

seus will be a story of pain inflicted (on Troy, on the Cyclops, on the suitors) and pain endured (the hatred of Poseidon and his ten years of wandering to get home). The importance of the boar hunt story is clear in this context: it captures a moment—perhaps the first in his life—in which Odysseus simultaneously is wounded by and wounds the other. It is, we might say, the moment at which he grows into his name (Dimock 1989, p. 258). And for Homeric Greeks, this was a heroic moment.

We can see now why Homer chose to describe these two episodes in the midst of recounting the recognition of Odysseus; they represent three different perspectives on the question of who the man we have been hearing about really is. Within a relatively few lines, we see him recognized at home, learn the meaning of his name, and are told about a moment that defines his adult character. By this point in the poem, we have heard a great deal about the hero's adventures and exploits. Now, at the moment of homecoming, we need to and are prepared to know more about the character of the man whose story we have been told.

CLINICAL MATERIAL

A patient who has been working hard on problems organized around her inability to value or to enjoy what she has and does —her career, her family, her analysis—said, resignedly, "When I feel excited, something has to happen." In putting things this way, she was primarily referring to a fear that she might act "inappropriately," as she would experience it, on her impulses. She frequently felt that what she said was "blurted out," that she either had or was on the verge of presuming too great an intimacy with others, that she surrendered her professional authority in efforts to promote artificially friendly feelings.

All these were familiar concerns that had been expressed many times over the course of a long analysis. This time, however, what most struck me was that she was speaking in something close to the Greek middle voice. First, consider the phrase

"When I feel excited . . ." This phrase is ambiguous as to the origins of the excitement; she may be excited by someone else, she may be excited about someone else, she may—as a product of fantasy or who knows what else—be describing an experience in her body that is not yet about anybody or anything external to herself.

And notice what happens next: there is a shift in voice to "something has to happen." Here, "I" has—poignantly—disappeared as the subject of the sentence. With this shift, the nature of the event that the patient is anticipating or predicting becomes highly ambiguous. The "something" may be something that the patient *does;* she may express the feeling or defend against it, or move on to another feeling such as guilt or shame or anxiety. But the shift in voice suggests that she is not sure that what is going to happen next will be an action that she, as subject, will initiate. The "something" that "has to happen" may be an act of hers, but it may also be something that is done to her by somebody else.

In fact, the very idea that "something has to happen" when she is excited may originate with the other who observes her excitement (mother, who tends to squelch it; brother, who exploits it; father, who claims it; analyst, who welcomes it and may even grab onto it as a relief from the patient's overbearing depression). We do not know—and, I suggest, the patient does not know—whether in what happens in the aftermath of her excitement she will be subject or object, an active or a passive participant.

As I understand this analysand, her difficulty in finding a way to live freely and comfortably in the midst of the anxieties that inevitably accompany the experience of—simultaneously—acting and being acted upon is at the core of her intrapsychic conflict. One solution, emptying herself of desire, leaves her feeling victimized by predatory, rapacious others (including, of course, a narcissistically preoccupied analyst whose interest in self-aggrandizement extends to the results of helping her get better, which she accordingly resists). Another solution (less prominent in the presenting picture but certainly latent), in which she sees herself as containing all desire, leaves her feeling

like a "wild child," eating up everything that crosses her path, human and otherwise (including, of course, a fragile, vulnerable analyst who might easily succumb to her wiles, and to whom she accordingly gives wide berth). In neither case can she experience herself as both the desiring subject and the desired object. To do so is terrifying.

A few sessions after talking about how something has to happen in the wake of her excitement, this analysand and I lived out her experience in a dramatic way. On the day before the session in question, she and I became more aware than either of us ever had been of how confused she becomes when she wants and needs. This confusion is, almost inevitably, compounded by the response of the person she is involved with. This response never feels right, and so she never feels better. Frustrated and frightened, she becomes angry and spits back at the other person, typically initiating either an argument or a mutual withdrawal that leaves her feeling embittered and untouchable.

Although spelling out the idea of these repeated interactions over the course of the session "makes sense" to her, she cannot get a grip on it, and she tells me that it certainly does not help her to feel any better. In fact, she is feeling the confusion that we have been talking about as powerfully as ever. This leaves her feeling desperate, even to the extent of fearing that our long years of work may prove futile.

So she begins the next session by saying that she needs help, that things are miserable. She could complain about all the things that have gone wrong since yesterday's appointment, but she knows that I think this reflects her reaction to the session and that I think she should be talking about what went on between us. Still, she has lost emotional touch with what happened yesterday, even though she knows it is important, so she needs me to help her get back to it. She is stuck.

I agree (silently) with the thought that she needs help talking about what goes on between us, and I am pleased that she is able to ask for help, which is by no means easy for her. But I am less interested in—and far less clear about—what happened yesterday

than I am in how a similar theme is being enacted today. She is stuck in the miseries of her life, which is all she can think about, so she needs my help. But help means bypassing what is consciously on her mind, and pulling her into thinking about what she imagines (correctly) that *I* believe she should be thinking about. She remains passive; she cannot imagine even how to begin unsticking herself, which leaves me in the position not only of dislodging her, but of insisting that she address concerns that (in the short run, at least) are more mine than hers. I am afraid that this will feel to her like a rape, or at least like a hostile intrusion.

Enthusiastic that we have right in front of us the very thing we have been talking about, I lay out for her what I think is going on, tying it to the feeling of confusion that always comes about when she becomes aware of needing or wanting, and when she has to grapple with the unpredictable reaction of the other. In my own excitement about catching an enactment as it is happening, I certainly use too many words, and perhaps too eager a tone. She, in turn, gets furious; she wanted help understanding what happened yesterday, and here I am blaming her for what is happening today.

So this is where we are left: She comes in aware that she wants my help, but not quite reckoning with the fact that this leaves her at least more or less at the mercy of my reaction to her desire. Furthermore, I am somebody who—despite the well-known cautions of both Freud and Bion—wants *her* in ways that are shaped by our individual histories and by the shared history of our analytic work. Thus, my interpretation, however correct, is a response to her desire to be helped that expresses my own desire to help in a particular way. And in turn, her experience of my way of helping is shaped by her ambivalence about wanting to be helped. This ambivalence is in large measure the residue of the history of how her desire has been responded to by those she has desired in the past.

In the present situation, I think it is likely that an aspect of my desire may be that I want to move things along, while she

wants to be comforted, to be held in the confusion about her confusion. My desire to move things may be too close to confirming her fear that her desire will be met exploitively, co-opted into the agenda of the other. "When I feel excited, something has to happen," and at the moment the *something* is that her need for help will feed the urgency of my needs—most likely phallic and/or narcissistic needs. We are both living the session in the middle voice. And neither of us, for the moment at least, can get a handle on it.

LIVING IN THE MIDDLE VOICE

There are, of course, any number of compelling explanations for this analysand's experience to be found in her personal history. But this paper is not about personal history; it is about the ambiguities and the anxieties that are inherent in living every moment of our lives as both subject and object, simultaneously. These are the ambiguities that the Greeks captured so well in their use of the middle voice as a grammatical form.

Living in the middle voice is daunting. So, too, is theorizing in the middle voice. The classicist John Peradotto (1990) has noted that contemporary readers of Greek texts inevitably have a difficult time holding the implications of middle-voice verbs in mind. We tend to think of verbs—and of people—as being either active or passive at any given moment, leading to an artificial dichotomization of experience that impoverishes our understanding (Peradotto 1990, p. 132). This can be a particular danger to psychoanalysts. Because we live constantly in a world of things done by and things done to—consider the dynamics of the hour I described, or of any analytic hour—the tendency to think exclusively in terms of active versus passive, and the accompanying elision of one dimension that Peradotto describes, is particularly palpable. One could construct a compelling history of psychoanalytic theorizing organized around the elisions that various authors have chosen, but that is not the theme of this paper.

I do want to include a brief word about Freud's strategy, which was to speak in the active voice, especially in the way in which he framed his theory of conflict. Freud's conflict at its root is intersystemic. Despite later emendations that introduce intrasystemic conflict or the ubiquity of compromise formation, fundamentally, the struggle is between desire and restraint, both of which emphasize the intentions and the activity of a conflicted subject. Moreover, on the level of desire, Freudian conflict theory also posits an agent whose libido is directed toward particular objects (mother and father) and whose aims are reasonably stable in contrast to those of the younger child.

It is likely that Freud's preference was personal at its roots. Recall the reason for what was certainly his weightiest conceptual shift: the abandonment of the seduction hypothesis, the enthroning of fantasy, and the consequent substitution of psychic reality for material reality in the etiology of neurosis. Writing to Fliess in 1897, he confides the "great secret that . . . I no longer believe in my *neurotica,*" because he finds it difficult to hold on to the idea that so many bourgeois Viennese men have molested their children. The decisive point, however, is that the seduction theory implies that "in every case the father, *not excluding my own,* had to be blamed as a pervert" (1897, p. 259, italics added). It was difficult, evidently, for Freud the conquistador to experience himself as the object of others.

Of course, Freud's dilemma is my analysand's dilemma as well; it is the dilemma we all live with. In characteristic ways, we rid ourselves of one or another aspect of our experience—sometimes of ourselves as subject, sometimes of ourselves as object—thus limiting what we are able to know. When we keep the idea of the middle voice in mind, we can see that these omissions mark a sense of unease. In this respect, Freud and my analysand are interesting cases in point. Freud retreated from whatever reminded him that he was the object of the intentions of others. This is clear in the way he analyzed his own dreams; consider the striking omission of the acts of his friend Fliess in his account of the so-called specimen dream of psychoanalysis, the

dream of Irma's injection (Erikson 1954; Schur 1972). And, of course, Freud generalized this approach, leading him eventually to the wish-fulfillment theory of dreaming itself. This theory gives us a powerful tool for probing our desire, but it leaves no room for appreciating the formative role of unconscious experiences of being acted upon by other people. If we think about the anxieties that are inherent in living in the middle voice, Freud's omission suggests that his theory lends itself to being used as a counterphobic defense.

Compare my analysand's solution. Terrified of what her excitement will lead her or others to do, she empties herself of desire. In contrast to Freud's dreamer—consumed by wishes—she wants nothing at all. As a result, she loses touch with herself as an active subject; she lacks inner direction, because without desire there can be no direction. And, further, because she tends to project desire into others, she is surrounded by people who are filled with want; they want things for themselves and they want things from her. The confusion that plagues her results from this; she does not know where she wants to go, and a great deal of what she feels reflects her reactions to, and her need to cope with, what is done to her.

Both Freud's solution to the problem of living fully in the middle voice and my analysand's solution compromise the fullness of experience; both are reactions to the inescapable anxiety that grows out of the need to live effectively in a world of other people.

CONFLICT AND AGENCY

Homer and the heroes he wrote about in *The Iliad* and *The Odyssey* seem to have accepted the shared agency captured in the middle voice as a simple fact of life. This comes across most powerfully in epic accounts of the relationship between mortals and gods. There are episodes in both poems in which we find actions that are initiated by the gods alone, others in which the will of humans determines the course of events, and yet others in which

agency is shared by god and mortal acting in concert. Neither the author nor the characters involved seem either particularly surprised or particularly troubled by the constantly shifting locus of control.

A few brief examples will illustrate the mix of acting and being acted upon that gives shape to human experience in the epics.[2] In *The Iliad,* Aphrodite snatches Paris away and brings him to the safety of his bedroom as he is about to be strangled by Menelaus; her uncompromised power to do this is acknowledged by all who are involved (Fagles 1991, p. 141, 3.439-441). There are many such incidents, but other events that are instigated by the gods require the collaboration of mortals. In a famous example, when Achilles is about to attack Agamemnon, he is visited by the goddess Athena, who says:

> Down from the skies I come to check your rage
> if only you will yield.
> [Fagles 1991, p. 84, 1.242-243]

Here Athena wishes to restrain Achilles (who has himself been shown to be ambivalent about his urge to attack), but she cannot do so entirely on her own. The hero has it in his power to yield or to resist; what eventually happens will be determined both by the pressure put on him by the goddess and by his own choice. No less than Athena's power to stop the arrow, this shared initiative is a fact of life that is accepted by mortal and god alike.

And, finally, some events in the epics are caused entirely by the will of mortals. In what is perhaps the most dramatic example of this, the entire course of events in *The Iliad* is set in motion by the all-too-human rage of Achilles, itself a response to Agamemnon's all-too-human belief in his own entitlement.

Three centuries after the epics were written, in the midst of an enlightenment period during which the Greeks were making

[2] The gods themselves are not immune to being acted upon by humans. They are frequently saddened by human behavior, and they can even be physically harmed by mortals: Diomedes wounds Aphrodite in *The Iliad* (Fagles 1991, p. 175, 5.380-ff.).

tremendous advances in mathematics, medicine, and other sciences (and during which Athens had achieved unprecedented political and military success), the shared agency that had once been simply assumed began to chafe. Human potential—the conviction of the power of mortal intelligence and rationality—seemed unlimited. In this changed intellectual climate, a new literary form, tragedy, emerged quite suddenly. In the tragedies, the belief in shared agency (between mortals and gods, but also among humans themselves) continued. But now the sharing was seen as problematic by the authors of the tragedies and as a source of conflict by the characters in the plays.

The historian of tragedy Jean-Pierre Vernant (1990), noting that tragedy as a dominant literary form arose and declined in Athens over a period of only 100 years, suggests that it reflects the concerns of a society that was moving beyond what he calls "heroic values and ancient religious representations" and toward "the new modes of thought that characterize the advent of law within the city-state" (p. 26). In this developing culture, there was little room for the kind of unquestioning submission to divine will that we find in the epics; instead, people sought guidance from laws that were invented and enforced by mortals themselves.

Vernant is talking about a historical moment; once the rule of law was firmly established in Athens, great tragedies were no longer written. Drawing on his perspective, scholars in a number of fields have explained the ongoing appeal of the tragedies by noting that they address the difficulties people face when rapid social, scientific, and political changes cause upheavals in traditional ways of experiencing and living in the world. For example, the political theorist Richard Ned Lebow (2003) has suggested that "Tragedy can be understood as a response of modernization . . . . Changes threaten traditional values and encourage the emergence of new ones" (p. 25).

This formulation resonates with sensibilities that emerge from doing clinical psychoanalysis. There is a striking parallel between the societal changes that, in the views of Vernant and Lebow, form the cultural background for the emergence of a tragic vision and

the developmental processes that we analysts live through with our analysands. But there is one notable exception: The historical changes are episodic and may even occur infrequently. The Nobel Prize-winning poet Czeslaw Milosz stressed this infrequency:

> People always live within a certain order and are unable to visualize a time when that order might cease to exist. The sudden crumbling of all current notions and criteria is a rare occurrence and is characteristic of only the most stormy periods of history. [Milosz quoted in Lebow 2003, p. 25]

This "sudden crumbling" looks quite different from a psychoanalyst's perspective: the breakdown of "current notions" and the demands of "modernization" are, I suggest, analogs of individuation. They parallel what we know as the developmental move from dependency toward increasing autonomy. What Vernant, Lebow, and Milosz are describing on a societal level is a feature of everyday life as we emerge from embeddedness and move toward the creation of our own individual lives. Thus, in contrast to the rare and episodic havoc that is wreaked by cultural modernization, our personal "current notions" are at risk of crumbling on a daily, or even minute-to-minute, basis as we strive to express ourselves in ways that move us into a world beyond the "certain order" that we have always known.

So, whether we are aware of it or not (and, most typically, we are not), each of us experiences "the most stormy periods of history" on a regular basis in the course of our own personal development. This points to ways in which the tragic vision poignantly informs and is informed by our own experience.

Consider a motif that is characteristic of the tragedies. Oracles, pronouncements from the gods about the future course of events, are more prominent in the tragedies than in the epics. But despite the frequent occurrence of oracles—and despite the universally acknowledged power of the gods—mortals regularly try to circumvent what has been decreed, often with disastrous con-

sequences. In perhaps the most famous example of this, Oedipus—told *unconditionally* by Apollo's oracle at Delphi that he will kill his father and marry his mother—sets out to take fate into his own hands. He believes that he can, irrespective of the will of the gods, unilaterally determine the course of his life; this is why he leaves home and resolves never to see the people whom he believes to be his parents again. And indeed, for a very long time, Oedipus is extraordinarily effective; he saves Thebes by solving the riddle of the Sphinx,[3] and for twenty years, he is the godlike ruler of the city. But Oedipus' attempt to assert his will succumbs, ultimately, to the limits of human capacity. Both what he can achieve—and, perhaps more important, what he knows—are constrained in ways that he could not have imagined at the beginning of the play.

Oedipus' attempt to create a life based on human rationality alone, a life not dictated by and perhaps even lived in defiance of the will of the gods, captures our own struggle to experience personal autonomy. This theme is central in many Greek tragedies; in contemporary psychoanalytic terms, tragic conflict arises from the incompleteness and instability of the experience of agency. And because the extraordinary transitional period during which the tragedies emerged as a literary form resonates with our own personal developmental struggles, tragic themes speak to us across the millennia. Vernant's (1990) characterization of the vision of the Greek tragedians captures what we and our analysands live through in every clinical encounter: because agency is not yet fully achieved, all human action is "a kind of wager—on the future, on fate and on oneself . . . . In this game, where he is *not* in control, man always risks being trapped by his own decisions" (p. 44, italics in original).

Listening to the tragedians and translating their lessons into terms familiar to individual psychology require us to rethink what

[3] In his bitter argument with the prophet Tiresias, Oedipus imperiously declares that he has solved the riddle on his own—through the use of human rationality—neither asking for nor receiving any help from the gods.

has become the traditional psychoanalytic perspective on the relationship between conflict and the achievement of a sense of personal agency. The impulse/defense theory of conflict requires a subject who has already developed a considerable degree of personal agency—in Freud's own terms, someone who has achieved stable psychic structure. In this view, both agency and conflict are developmental achievements, and only an active agent can have the sort of structured intentions that define conflict.

In contrast, the sensibility expressed by the use of the middle voice and the tragic vision suggests that the experience of agency itself is ineluctably ephemeral. Agency is a paradox, perhaps the central paradox of human existence, and this breeds conflicts that occupy every moment of our lives. On a daily basis, the tragedians taught, we are faced with the need to act as agents while remaining aware that we live in an interpersonal world in which others (god and mortal alike) are simultaneously asserting their own agency. And we must strive to act autonomously and effectively despite the constraints imposed by our histories (personal, familial, and cultural), and despite the uncertain consequences that our acts will have in the future.

This parallel between individual development and Athenian cultural development suggests an approach to understanding the continuing appeal of the tragedies 2500 years after they were written, one that is, again, at odds with the received psychoanalytic explanation. Freud's account of this appeal was too intimately involved with his ambition to create the Oedipus complex; he failed to see that a historical reading of the texts could deeply inform psychoanalytic thinking. Today, while nobody doubts the power of his invention, his strategy has made it difficult for analysts to engage readers from other disciplines in conversation. Freud's narrow vision of the nature of conflict—that it always involved inner impulses and defenses against them—shaped his reading of *Oedipus* and was in turn shaped by it.

Thinking about conflict in terms that stay closer to the sensibility of the middle voice and the problems of living within it that are highlighted in the tragic vision suggests that we must consi-

der more than just our own conflicted intentions. We must also take account of the conflicted experiences of being the object of the intentions and reactions of others at the same time that we are experiencing these conflicted intentions.

When we think this way, we discover my analysand as I described her in my vignette. The conflicts of which she is becoming aware in her analysis—and that she and I are living out together—reflect the dilemmas that plague us all: how can we act when we cannot know either the reasons for, or the effects of, our actions? How can we even desire when we cannot predict the events that our desire will set in motion, because our desire is directed toward a desiring other? My analysand says, "When I get excited, something has to happen," and because she cannot know either why she is excited or what that something will be, to experience excitement is to place a wager in which everything is on the line.

So, for my analysand to be able to own her desire, she must struggle more effectively with anxieties about the ambiguous origins of her excitement, and with anxieties about the uncertain future that will follow when she acts upon it. And this is not, for her or for any of us, a one-time thing—it is something that must be lived through (sometimes more, sometimes less consciously) in every moment of our lives. Conflict is inevitable, both because we cannot be sure how to act in a way that is most true to ourselves, and because we cannot be sure how others—driven by their own inner imperatives—will act upon us or how they will react to us. The experience of agency, including the awareness of its limitations, emerges from—and recedes back into—this sort of conflict.

Conflicts around the need to experience agency constitute my analysand's deepest dilemma. This is conflict in the middle voice, the conflict of all the tragic heroes who have grappled with the need to act while remaining aware both that they are living out the history of being acted upon and that they are irreducibly uncertain about how they will be acted upon in the future. For my analysand, and for all of us, to own our humanity is to claim our place as an active agent in our interpersonal world and to

submit to the agency of others—past, present, and future—in one and the same fateful act.

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CONFLICT, STRUCTURE, AND ABSENCE: ANDRÉ GREEN ON BORDERLINE AND NARCISSISTIC PATHOLOGY

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The authors understand the work of André Green as addressing unresolved and uncharted issues in Freud's views on the earliest phases of development, particularly as those issues concern the evolution of psychic structure, the development of drive components, and the internalization of object representations. The authors describe Green's conceptualization of primitive conflict and its most deleterious result, absence, *or the failure to represent the object. These ideas lead to an original way of imagining the analytic setting and to a modification of the classical stance of analyst with patient. Two clinical vignettes are presented.*

BORDERLINE AND NARCISSISTIC PATHOLOGY IN FREUDIAN THEORY

Those borderline and narcissistic patients included by Stone (1954) in his felicitous widening-scope phrase, and to whom we will refer, for simplicity's sake, as *nonneurotic,* have confronted classical Freudian theory with a dilemma. The theory assumes that a substantial part of their disturbance has roots in the preverbal period of development; yet psychoanalytic theory and the "talking cure" it supports were devised to deal with disturbances having their origin in the developmental period, after the acquisition of language. What is more, the entire concept of structure and the conflict contained in that structure assume the establishment of substantial

ego development. The mechanism of repression, for example, requires a clear-cut boundary between the conscious and unconscious parts of the mind, and, according to the theory, this boundary does not exist until the beginning of the oedipal period.

Moreover, the very first in the sequence of libidinal phases and associated content that lent the theory a developmental perspective, the oral phase, has always posed significant and representative problems. To be sure, Abraham (1916) described an oral receptive and an oral cannibalistic phase, together with relevant fantasy content, but the absence of substantial language acquisition, not to say structural development, in the period between birth and eighteen months (especially in the earliest part of this period, during which this phase is said to be dominant), makes it extremely unclear how an ideational or derivative aspect of the drive can come to exist—and, therefore, how these very early fantasies can have a content. The particular area of structural development in question is that of the internal registration of the object.

During the Controversial Discussions, Anna Freud (1943) lucidly distinguished between satisfying thirst, which is an instinctual reduction of tension, and wanting a drink, which requires an object and allows the operation of primitive fantasy. She used this example to emphasize that Freudian theory does not posit the extremely primitive perceptions and sensations at a level of minimal-ego organization that would enable us to imagine a nine-month-old baby's having a cannibalistic fantasy (Reed and Baudry 1997).

Freud's hypotheses about the primary organization of the mind (primary symbolism, primary repression, primary masochism, primary narcissism, primal fantasies) seem like awkward attempts to plug holes in order to create a stable base onto which later structure could be grafted (Laplanche and Pontalis 1967). Another uncomfortable solution devised to reconcile these contradictions was the hypothesis that reconstructed oral fantasies were given form in a later period, and that these were then projected backward to an earlier time. The concept of *nachträglichkeit*, for example, was devised to deal with early registration that acquires meaning at a time when development has advanced; but the the-

ory does not address the form in which the original, unmetabolized experience is registered in the mind (Laplanche and Pontalis 1967). It would seem that it is neither transformed nor encoded in memory in the sense of being linked to a network of associations.

Problems concerning the formulations of symptom formation in the first two years of life are related. What sort of symbolization processes (and, therefore, what sort of primitive apparatus for the transformation of sensation into ideation) need one postulate to account for disturbances of feeding, anxieties, and phobias, as well as for the registration of early traumas? If the theory makes no room for the existence of conflict before the verbal period, how are we to conceptualize such manifestations, let alone deal with them in the clinical situation? To be sure, Bornstein (1935) published an account of her successful work with a 2½-year-old girl who had a severe sleep disturbance and very minimal language, but she made no attempt to revise the overall theory.

Technique develops in tandem with theory, the one influencing the other. It is therefore not surprising to find that a theory in which symptom formation and conflict are considered to occur only after structure is well established (Arlow 1963; Brenner 2000) often does not provide a satisfactory technical framework for the treatment of patients in whom the development of structure is compromised. To be sure, there is a practical way in which classical analysts adjust their approach to suit the specific requirements of individual patients that is often too little appreciated, and there is, as well, the sometimes unacknowledged support provided by the listening and speaking presence of the analyst, day after day. In order to contrast the very barest bones of technical prescription for heuristic purposes, however, we might say that encouragement of free association on the patient's part and restriction of the analyst's role to interpretation of unconscious content (whether that content concerns defensive operations or id-dominated material), on the basis of that free association, are often, by themselves, not entirely effective tools in the treatment of nonneurotic patients. These patients often use language to enact rather than communicate, frequently recount dreams (if they

bring them at all) in order to evacuate unpleasant inner affects and thoughts, and have difficulty observing themselves. They are often in thrall to very powerful, unattenuated affects, and feel intruded upon, invaded, or otherwise threatened in the face of the analyst's attempt to interpret unconscious conflict. They may begin to see the analyst as so dangerous that his or her interpretations are equated with murder, dangerous invasion, or permanent and painful subjugation. Their consequent terror and inability to imagine an as-if relationship force them to challenge the frame of the treatment.

CONFLICT AND STRUCTURE: RESTRICTIVE AND RADICAL SOLUTIONS

Nevertheless, the elegant unity between the method of investigation and the method of cure (A. Freud 1976) has made analysts reluctant to deviate from the standard technique and theory that have proven themselves with neurotic patients. One way of dealing with the theoretical problem we have outlined in the previous section has been to see the theory as applying equally to both neurotic and more disturbed patients (Arlow and Brenner 1969). When classical treatment does not work with nonneurotic patients, the position that stands for theoretical consistency tends to reinforce the tendency to restrict patients accepted for psychoanalytic treatment to the neurotic end of the spectrum of pathology.

A less restrictive solution from the point of view of treatment has been to alter radically the *theory* in two major ways. First, the concept of structure is revised. Second, the development of that structure is severed from reliance on the acquisition of language and placed at a time either antedating that acquisition, or in no clear developmental timetable. These represent fundamental changes—extra-analytic imaginings of the early preverbal life of the infant, or attempts at reconstructions based on later phenomena, or intuitions of extremely early inner processes on the basis of the external observation of infants—all of which introduce major changes in theory, in technique, and in the content of inter-

pretations. They also lead to entirely different ways of conceptualizing conflict.

Perhaps the most radical and well known of these revisions is Klein's (1928, 1930, 1945, 1946) location of psychic structure in the preverbal period and her deemphasis on the centrality of language. She introduces preverbal organizing phantasies, with internal part objects being a prominent part of these phantasies, and revises the concept of development so that the Oedipus conflict is seen as occurring at the age of six months.[1] She replaces psychosexual stages and psychosexual regression and progression with the less chronological paranoid-schizoid and depressive positions, and posits an increased and extremely early role for the death drive in the form of aggression, an assumption that necessitates emphasis on the defensive processes of projection and introjection. Drive and internal part object tend to be condensed, so that conflict is said to occur between a rudimentary self and, for example, a bad breast, which threatens destruction of the good breast. The latter is conceived as essential for the child's survival. Also threatened is the existence of this very early self (annihilation anxiety), conceived of as an entity quite separate from the part object from the earliest weeks of life).[2]

Other attempts at revising the concept of structure and making it chronologically earlier and independent of the acquisition of language turn in the opposite direction, toward the young infant's interaction with his or her actual environment and objects. Thus, Winnicott (1965, 1971) emphasizes the mother–infant interaction and the *transitional* (and largely preverbal) process by which the external object becomes an internal and symbolic one, while Kohut (1968) elaborates a deficit model of narcissistic pathology based first and foremost on the parents' unempathic and therefore trauma-inducing response to the child. In both, conflict

[1] The Kleinian spelling of the word *phantasies,* used specifically to refer to *unconscious fantasies,* is respected in this paper.

[2] Although Kleinians today do not necessarily accept the timetable described above, we limit ourselves here to the original formulation to show how its theoretical revisions correspond to the problems posed by traditional theory.

is seen as occurring between the very primitive self and the environment or object world, and structure is the result of that conflict, with the infant and preverbal child making deleterious, adaptive structural changes to conform to the unempathic demands of the actual object (false self or grandiose self organizations).

Kernberg (1976, 1984) pursues a more integrative approach, attempting to weave together ego psychology (particularly the work of Jacobson and Mahler) and the Kleinian version of object relations. He, too, reduces structure to smaller units that can be said to appear earlier in development than the well-developed ego of neurotic conflict. These consist of a self-image, an object image, and the affect connecting the two. In nonneurotic pathologies, self- and object representations remain fixated to a time when the immaturity of the ego lacked a well-developed, synthesizing function, so that they are split into all good and all bad parts. Only later will splitting become a defense. Drive and self- or object representation, as in Klein, are condensed. Conflict is then conceived as arising from incompatibilities in demands from unintegrated (all good and all bad) self- and object representations. Aggressive forces fueled by hatred, envy, and fear of dependence on an (internal) object that is seen as fundamentally unreliable are the primary motives for defensive operations.

STRUCTURE AND ABSENCE: THE CONTRIBUTIONS OF ANDRÉ GREEN[3]

André Green solves the problem outlined above in a different way. His thinking, developed in France over the past thirty years, integrates object relational theory directly with Freud by offering an

[3] Although all expositions of this type are at bottom interpretations, the difficulty of Green's writing, with its alternations between complex metapsychological formulations and lucid, clinical-level insights, as well as the relative rarity of specific clinical illustration, makes what follows even more than in most instances entirely our interpretation. Thus, we make no claims to be definitive interpreters of Green. We offer what we have been able to understand, integrate, and utilize.

integration of Freudian psychoanalysis with the ideas of Winnicott and Bion, and, through the latter, with the ideas of Klein. Rooted firmly in a creative reading of Freud's texts, Green's work seems to us to permit a less theoretically discontinuous solution to the widening scope of analytic patients. Since it is not as well known in the United States, we propose to explicate our understanding of it in some detail.

Green's (1983, 1986, 1993a, 1993b, 1995, 1999, 2002a) approach to the problem of the structure and genesis of conflict in nonneurotic pathologies places Freud's model of psychosis at the core of his theory, shifts emphasis from the structure of Freud's tripartite model to the more primitive components of that model, and shows how pathological affects associated with representations of somatic drive manifestations that contain no ideational representative disrupt existing structure or interfere with its development. In extreme cases, the devastating effects of what Green terms the *disobjectalizing function* lead to an absence of representation, rather than to repression. Conflict, then, in the most experience-near translation we can offer, may be seen to occur between the psychic representation of the somatic need for satisfaction that constitutes the infant's primitive link to the object, and the inner destruction of that link consequent to the object's repeated failure to satisfy those needs.

Green describes this early conflict in typically abstract terms as the interaction of drive functions that link through love and disconnect through destructiveness. Despite his abstraction, however, Green's thinking is clinically grounded. He stresses the role of materially real early-object care in influencing the balance of this life-versus-death struggle, for instance. Most important, the outcome of this conflict determines whether an individual presents as a psychoanalytically manageable neurotic patient, or as a more clinically problematic nonneurotic one.

Since Green wants to focus on the treatment of sicker patients, his description of the neurotic patient is designed as an idealized contrast for that discussion. Neurotic pathology is thus said to occur when the resolution of this early conflict has been optimal.

When that happens, there is no major structural weakness; memory traces of objects that satisfy needs are cathected and linked together so that associative pathways are established; the establishment of associative pathways then facilitates displacement and allows drive energies to be bound; primary objects are gradually differentiated from the subject and represented within the psyche.

Given the way Green generally writes about psychic structure and conflict, it is safe to assume that he sees neurotic conflict as Freud described it, with an unconscious wish being opposed by some defensive process, and he certainly understands the wishes in question to be more often sexual than not (Green 2002b). He also sees castration anxiety as playing a central role in neurotic conflict (Green 2002b). He admits both the topographic and the structural theories as frames of reference, although he has reservations about how the latter has been interpreted.[4] What is perhaps most salient is that, for him, neurotic conflict occurs within a structured and integrated psyche in which object constancy and differentiation are established; memory traces of satisfaction are connected with sensorial representations of the drives; and words symbolize and are the carriers of internal fantasy structures. Under these circumstances, free association is an effective tool for treatment.

Less optimally, when external factors of milieu and object failure, as well as internal factors of endowment, prevent integration of the psyche and differentiation and consequent representation of the object within the psyche, the resulting clinical picture changes. Then we see the more seriously disturbed, nonneurotic individual who is not differentiated, who suffers from impulsive and somatic disorders, and who is characterized by ego discontinuities. These individuals are plagued by anxieties of separation

[4] Unlike many French psychoanalysts, Green (2002a) pays attention to Freud's structural theory. He interprets the theory in a way that is different from the approach associated with Hartmann, Kris, and Loewenstein, however, in deemphasizing anything related to a general psychology or to conscious ego phenomena, such as adaptation. Instead, he stresses conflict involving the unconscious ego, which provides the drives originating in the id with content.

and catastrophic annihilation. They fear being taken over or intruded upon by a malignant, omnipotent object. They may resort to massive projective identification, splitting, and attempts to drive the analyst crazy in order to escape from the latter's influence. They are characterized by desires for revenge and other conflicts around destruction. Sexual conflicts are secondary and are heavily distorted by primary destructive ones (Green 2002b).

Without changing the theory of neurosis, Green nonetheless recontextualizes Freudian thinking in a way that makes possible the integration of object relations with drive theory. Conventional wisdom has it that the model of neurosis lies at the core of Freud's theory, so that conscious thought is understood always to stand for and to contrast with what was repressed. Thus, what is unseen is nevertheless present in multilayered form, both in its disguise and obscured beneath that, in its truthful, if unacceptable, undisguised state. The sign of this hidden presence is variously the symptom, the derivative, the dream, or the character trait, all compromises among forbidden wishes and acceptable solutions. For both Freud and the ego psychologists who adhered to this trend in his thinking, the psychoanalyst moves in a world in which meaning may always be discovered because it always exists underneath consciousness in an unaltered form. Klein inhabits this "universe of presences" with Freud (Green 1998), although for her, it is less a question of unearthing unconscious material than of locating missing parts of self and object both within and without.

Positive and Negative Worlds

In this *positive* world of Freud and Klein, the analyst's interpretation acquires enormous technical importance. It also acquires considerable emotional power within the setting because it is assumed that everything the patient feels and experiences has hidden meaning, and that the analyst will come to know and will then interpret that which the patient cannot see for him- or herself. Green (1975), however, demands that we face the possibility

that the psychic universe may not only be full of unknown but apprehendable presences; it may also have a *negative* side, that is, it may contain voids.

This radical shifting of the theoretical ground beneath our feet makes it possible to imagine that every manifest content is not symbolic, i.e., that it does not refer to a latent content. The analyst cannot then be the all-powerful interpreter who deduces meaning from the patient's associations. Instead of focusing on the patient's words, the analyst must look within him- or herself to those inner states and reactions through which the analyst picks up what the patient lives but cannot verbalize. Since the patient cannot use words alone to communicate that which is not represented, the analyst must proceed inductively, joining the patient in a journey of exploration into unknown parts of him- or herself, collaborating with the patient in creating meaning where meaning has been destroyed by conflict and circumstance.

Under these different circumstances, the opposition that defines, and effectively expands, the psychological field might then be conceived as existing between a symbolized presence of the object in the mind, and a void—what we are terming an *absence.* This absence is, for Green, the result of the work of the pathological negative (1993a), in contrast to the work of the normal negative found in displacement, condensation, and symbolic disguise. In other words, the opposition that defines Green's psychic universe —no longer filled only with presences, but also with absences— would be between meaning and no meaning, since it is through relation to objects that meaning is created.

There could not exist, of course, a pure culture of the pathologically negative. Such a pure culture would end in death. The idea, for us, must be understood uniquely as one end of a theoretical continuum. Moreover, Green himself agrees that even clinical evidence of a less than pure culture must be seen as questionable. Reports of "catastrophic or unthinkable anxieties, fears of annihilation or breakdown, feelings of futility, of devitalization, or of psychic death, sensations of a gap, of bottomless holes, of an abyss" (Green 1993b, p. 84), such as may be manifested in acute

forms of depression or ego disintegration, can never be taken as conclusive evidence for the absence Green envisions. There is always, for us, the possibility that such a manifest description has different latent content, of course, but Green points to an alternative explanation: that the argument remains at a theoretical level because no clinical argument for the force that creates voids can be conclusive. Nevertheless, he believes that serious forms of self-destruction are closer to a purely pathologically negative than is sadomasochism, for example.

Even though we must assume the conflict resolution that comprises our patients' psychic structure to be located on a continuum between the extremes of meaning and no meaning, the fact that no meaning is posed as a theoretical possibility changes the way we listen. A model of the mind that sees the opposition as between meaning and no meaning envisages that investment in objects can be withdrawn rather than only transferred. Objects can go missing rather than substitute the one for the other. On a clinical level, the chain of associative displacements can be interrupted by emptiness.

Green does not believe he diverges from Freud in this recontextualization of conflict. Rather, he sees himself as following the hints of the later Freud, who became more and more interested in manifestations of a realm of experience beyond repression, and who elaborated a sequence of alternatives to repression, from negation to disavowal, to psychotic expulsion and decathexis. This Freud, already in 1911, saw Schreber as withdrawing cathexes from the objects in the real world before attempting to reconnect through hallucination and delusion.

Green is also integrating the work of others, particularly Bion (Green 1998), in his emphasis on delinking, and Winnicott. Green's (1997) rereading of Winnicott's (1971) revision of his transitional object paper makes us aware of Winnicott's little-recognized idea of how the representation of the good enough mother may fade away for the infant if a separation or a maternal illness or depression endures for longer than the small child can hold onto the original nurturing image. It is a kind of death, Winnicott

writes, but one that leaves a terrifying emptiness, not an image of an object that has been lost. And the return of the mother in external reality does not banish the emptiness. What is there instead of an object representation is a hole in the psyche, a *nothing,* rather than *no thing* (a phrase Green takes from Bion). This is not the province of symbolization, but of absence, the realm of the "Dead Mother," to cite the title of Green's famous paper (1983, 1986). The somatic representative of the drive, now severed from the object representation by decathexis, may rush into the void, unbound by associative links that no longer exist. Such a situation accounts for the troubling impulsivity in certain borderline, perverse, and addictive cases.

Objectalization and Disobjectalization

By expanding the field of Freudian psychoanalysis to include absence, Green makes it possible to address a level of conflict inherent in the formation and malformation of that very structure that is seen to provide the components of and space for neurotic conflict. The actual formative conflict is envisaged as taking place between opposing functions of the life and death drives (Green 1993a). The death drive, for Green, has a very different meaning from that of Freud —or from that of the Kleinians, for that matter. Its function is uniquely to withdraw investment, to decathect, or to delink. *Decathexis* is the manifestation of the pathological negative referred to earlier, a radical destructiveness that Green connects with a more general *disobjectalizing function.*

Opposed to it is the objectalizing function of Eros. As the death drive delinks, fragments, and unbinds, so the life drive invests, links, and binds. It can also absorb a portion of the death drive and transform it. Aggression, for instance, is a product of such a fusion between life and death drives. Unlike the purely destructive death drive, the function of which is disobjectalization, aggression does not withdraw its investment from an object. It seeks it out, even to destroy it. Aggression requires the binding function inherent in Eros. In aggression, there is a fusion of the

cathecting function of the life drive and of the decathecting function of destructiveness, or the death drive.

Most important, Green (1993b) assumes that the life drive is "capable of transforming structures into an object" (p. 85). This idea surpasses the concept of the drive as connecting or relating to an object. What Green envisions is an expansion of Freud's idea of the ego's coming to be loved by the superego, for instance. That is the way a part of the psychic apparatus, through investment, can become the object of another part. Moreover, "it is the investment itself which is objectalized" (1993b, p. 85), he states. We understand this statement as a description of the spread of the binding function of Eros beyond structures that are as organized as the ego, or that are similar to actual objects, so that the function of creating objects becomes itself a capacity that is represented in the psyche (1993b, p. 85).

This idea is crucial because it bears directly on structure building and on the establishment of the healthy psyche. Objectalization is the function that integrates. The life drive invests in objects and in other parts of the psychic apparatus, binds, integrates, and unites, facilitates relations between subject and object. But it is not only the object that is cathected; it is also the activity of investment itself. It is the investment of investment, as we understand Green, that creates greater and greater areas of integration and linking. Disobjectalization, on the contrary, leads to psychic discontinuity, to splitting, fragmentation, and disorganization. Not only the object relation but also whatever substitutes for it—including the investment itself—finds itself under attack by the unbinding of this function.

In practice, this struggle between the drive functions of objectalization and disobjectalization is heavily influenced by the interactions of mother (and father) with the infant. Adequate containment, in Bion's terms, of the psychic representations of the somatic drive manifestations within the infant, on the part of the mother especially, leads gradually to the association of somatic awareness of the drive with memory traces of satisfaction. These memory traces serve to bind the somatic representative of the

drive through associative pathways, that is to say, along the paths of similarity in memory traces, or in contiguity in space and time of the memory traces. Traces of affect that are not discharged remain with the somatic representative of the drive (Green 2002a).[5]

This binding of the representation of the instinctual impulse with the object presentation that satisfies the impulse leads to the healthy or neurotic picture in which the somatic representation of the drive acquires a content. The union of the representation of the somatic urge with the corresponding ideation (the memory of satisfaction) is what we refer to as a *drive derivative*—assuming too often that the connection between the somatic component of the drive and the memory traces that become its content is a foregone conclusion. Green (1977, 1999, 2004), however, argues for a distinction he finds already in Freud, between the psychic representation of the somatic component of the drive and the ideational component of the drive.[6]

Green terms the psychic representation of the somatic component the *psychical representative of the drive*, that is, the internal, somatic manifestation of tension or pain in the body—"the representation of the body stimuli in need of satisfaction, once they reach the mind" (Green 2004, p. 116). This concept makes no reference to anything external to the body. Instead, what is represented is a "movement in search of something" (2004, p. 116).

The ideational component of the drive is referred to as the *ideational representative of the drive.* This component concerns experiences in the outer world—for instance, those memory traces of early satisfaction that led to Freud's description of the breast hallucinated in the description of wish fulfillment. The psychical representative of the drive refers to the drive as *"being* the representative of the body," while the ideational representation of the drive refers to the drive as "*having* representatives" (2004, p. 116).

[5] See Green 1999, pp. 4-ff, and 2002a, pp. 176-183, for more thorough explanations of his ideas on affect.

[6] Green's *psychical representative* of the drive is Freud's *psychische repräsentanz;* the *ideational representative of the drive* is *Vorstellungsrepräsentanz.*

For Freud, says Green, "*the matrix of the mind is characterized by the meeting of the psychic representative . . . with what the mind has kept as traces of former experiences of satisfaction that bear some similarity to the sought-after situation*" (2004, p. 116, italics in original). But this coming together is the result of a process with two parts:

> . . . one coming from the innermost body (which does not really know what it is seeking, and expects only a degree of relief from its tension and pain), and the other from the contents provided by the mind to fit the demand. It may even be postulated that it is only when the memory traces of the object meet the urges of the body that meaning is retrospectively found. [Green 2004, p. 117]

The process by which a memory of the external world and internal tension come together depends crucially on the object. "The mobilization of the wish reproduces the mobilization of the body stimuli that seek satisfaction and the awakening of the memory traces during such a mobilization, reproducing the attempt to reach the object that once brought satisfaction" (2004, p. 117). It is not, therefore, the mere existence of the object, but the consistency and attentiveness of the object facilitating satisfaction and tension reduction that play a decisive role in establishing similar enough memory traces of satisfaction so that the multiple psychic representatives of the drive are bound and integrated and the life drive holds sway. For the life drive to predominate, the object needs to be consistent enough over time in its containment and tension reduction so that neither abandonment nor intrusiveness come to characterize it. As Green (1975) points out, these dual anxieties are characteristic of the nonneurotic patient and are what make treatment so difficult.

Ultimately, the linking of the psychical to the ideational representative of the drive leads to a process of differentiation of self from object, and thus to the establishment of internal object representations. The construction of an internal object representation depends not only on consistent enough experiences of sat-

isfaction, but also on the gradually acquired capacity to differentiate the subject that hungers and needs from the object that satisfies well enough. The gradual establishment of object representations in turn furthers the capacity to differentiate. Both the establishment of object representations and the recognition of difference are necessary components of symbolization. There must be an internal object different from the self present in the face of loss for the individual to symbolize it.

The radical unbinding process of disobjectalization, on the other hand, affects the capacity for symbolization in a negative way. The decathected object has not been differentiated from it and cannot be internally represented. Where the capacity for symbolization and its associations might have been is the void that is manifested by discontinuity in associative pathways. Thus, discontinuity is a manifestation of disobjectalization.

The developmentally early replacement of the capacity to represent the object with such discontinuity dictates that later object relations cannot be represented internally in any stable way, but can only patch over the void caused by the absence of the need-satisfying object. One way such patching can occur is through the substitution of affect for the object relation. The affect associated with the psychical representative of the drive would ordinarily become joined with memory traces in such a way as to bind the somatic representative of the drive with the memory traces associated with the satisfying object. In the absence of a reliable need-satisfying object, however, the psychical representation of the drive, with its linked trace affect, instead erupts (in its unattenuated, disrupting form) as what Green (2002a) calls *passion,* a kind of desperate substitute for the unrepresented object (Reed 2001).[7] The emptiness may be patched over in other ways: by an idealized, unreachable object who is indifferent and abandons, or by a de-

[7] Green (2002a) avails himself of the classical French categories into which affect may be subdivided: feeling, emotion, and passion. *Feeling* refers to the psychic representation of the drive linked to memory traces; *emotion* refers to the sense of internal movement in search of the satisfying object; and *passion,* encountered most often with borderline patients, refers to the (impossible) demand of the sub-

lusional, intrusive presence (as opposed to a symbolized absence) —that is, a constant internal persecutor or torturer—or their remnants. In this second case, paranoia can be seen as a defense against emptiness, rather than one against aggressive or sexual wishes toward an object represented in the mind.

ABSENCE AND THE ANALYTIC SETTING: REIMAGINING THE ANALYST–PATIENT INTERACTION

Green, then, focuses on the possibility of absence, rather than on some sort of representation of the need-satisfying object; he emphasizes the relation between representation and differentiation, as well as absence and a failure of differentiation; he distinguishes between the somatic and ideational drive representatives; and he asserts the necessity for them to come together for stable psychic structure to be established. All these interrelated ideas not only allow us to think about the difference between neurotic and nonneurotic patients somewhat differently from the way to which we are accustomed, but also encourage us to imagine a difference between the way the neurotic and the nonneurotic utilize the analytic setting.

In keeping with his more general distinction between the neurotic and nonneurotic patient, Green's description of the difference in their uses of the analytic setting emphasizes the difficulties posed by the more disturbed patient, while minimizing the requirements and difficulties posed by the more classically neurotic patient. He describes the neurotic patient, despite occasional regressed states, as bringing a well-established and differentiated psychic structure to the analyst and the analysis. He sees that structure functioning as an already-established container, so that the neurotic patient does not ordinarily rely on the frame of the treat-

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ject that the (materially real) object substitute for the object that is not represented. That is, passion is an attempt to fill an absence that cannot be filled.

ment to contain his or her impulses or to satisfy unrequiteable longings. Although the neurotic patient may struggle against specific aspects of the analytic frame, he or she does not mount a generalized attack on it. Rather, the neurotic patient accepts the strange analytic setting, with its unfamiliar ground rules meant to maximize unconscious revelations and connections, and trusts the analyst sufficiently to work within it. The analyst is less needed to perform a specific holding function, and can listen to the patient's associations, follow the intersection of those associations with emergent feelings, and focus on interpreting transference and its links to unconscious fantasy.

The nonneurotic patient, on the other hand, requires that the analytic setting provide the containing structure the patient lacks. The structure the patient does bring—incorporating the absence of a representation of a need-satisfying object, a continued separation of the somatic and ideational representations of the drive, and a concomitant lack of differentiation between what is attributable to the self versus to the object—can be thought of as parts of a mind that work against the cooperative use of the analytic frame. Cooperation would be hard to envision, given the existence of secondary object relations that emerge in the transference and are attempts to patch over the internal absence: adhesion to bad objects that substitute for a torturing, ever-present, quasidelusional internal presence, or the imagination of an always-present external persecutor, or unassuageable hunger for an ever-distant idealized object. *The analytic setting—or, more accurately, its transformation into an analytic space in which understanding can take place—will become the focus of the treatment.* In order for this transformation to occur, the analytic work requires that absence be transformed into presence, and that the analyst attend not only to the transference as he or she and the patient can observe it, but also to the analyst's existence within the transference. *We believe this transformation of the classical stance to be central to Green's contribution.*

This requirement changes dramatically the way the analytic interaction is conceptualized. Despite the vast theoretical differ-

ences that separate Freud and Klein, the analyst immersed in either of their universes of presences interprets a product of the patient's mind that is deemed to have genetic specificity. In the mental universe of absences in which Green locates many nonneurotic patients, however, the analysis is an opportunity to create internal structure, to transform absence into presence, and the analytic setting is a space *in statu nascendi, a potential space* that is always becoming. In it, the internal somatic movement of the psychic representation of the drive in the patient can be joined to new experiences of satisfaction through the analyst's understanding and articulation of that which is subjectively unknown but longed for. These new experiences link up with fragmentary residues of past satisfactions.

One might say that before there is an analytic space, there is a gap, an absence, that *could become* an analytic space (Reed 2003). Only the awareness of this absence enables us to imagine a potential space formed by a good enough relationship with another. However, patients who live in the gap (such as borderline patients who do so by shifting from one side to the other of the gap) cannot imagine a potential space, or that there *is* a gap, or that two differentiated individuals exist. They experience from within their fragmentary, unindividuated, nonsymbolizing perspective. In this sense, the analytic space exists at the frontier of what is analyzable, of *no thing* and *something,* of *no relationship* with another and *a relationship* with another that can continue in the absence of the other, of somatic representation of the drive and a true derivative, and thus of passion and eventual feeling.

The transformation of a potential space into an analytic space requires that the analyst provide adequate care analogous to that of the good enough mother. That care is not provided by any specific actions that necessarily deviate from standard technique. Green does not argue for any modification of abstinence and neutrality, except insofar as a specific patient may explicitly require it, and then he would adjust the frame as little as possible. Rather, a caring attitude toward the patient is conveyed by the way the analyst expresses his or her understanding of what the patient

lives and can only attempt to articulate. When the analyst interprets the part of the patient that he or she does not recognize (that is, his or her unconscious) but is gradually expressing, the analytic setting, or frame, begins to function as a containing structure—as if, that is, it were the mother's arms (Green 1997).

Analytic Listening

It is in relation to the process of listening and seeking to understand the patient that Green's work, both theoretically and what the theory gives rise to, is most original. Green keeps in mind a double register in which the analyst is the recipient of an unconscious message and its stimulus at the same time.

> I hear the analysand's communication from two points of view at once. That is to say, on the one hand, I try to perceive the internal conflicts that inhabit it and, on the other, I consider it from the point of view of something addressed, implicitly or explicitly, to me. The conflicts to which I refer do not concern the particular dynamic conflicts that would emerge in interpretation, but rather the way in which the discourse in turn approaches and moves away from a kernel of meaning, or a group of such kernels of meaning, which are trying to break through to the conscious. [Green 1999, pp. 295-296; also quoted in Smith 2003, pp. 54-55]

Green is here not simply referring to his inclination for thinking, as do many French analysts, in topographic terms. Rather, by *discourse,* he intends both the chain of associations with its attendant affects and the "me" to whom the patient's words are addressed. This "me" is a complex, wished-for transference object. Moreover, not only is the analyst observing him- or herself as a transference object, in the usual meaning of the term, but the analyst is also cognizant of existing *within* the transference. This second aspect plays itself out in relation to language. That is, the speech of the analysand is a transference from psychic content, from that which is lived, into what can be expressed in words. This earlier Freud-

ian use of the term *transference* draws attention to the psychic work by which representations of ideas and affects in the unconscious are transformed into preconscious verbal forms.

The "me" addressed refers also to the unconscious of the analyst concealed by "the void that the analytic speech . . . must cross" (Green 1999, p. 298). This void is carried not only within the patient's speech, as it both conceals and expresses unconscious transference desires. The void also exists in the analysand as the gap between what he or she is conscious of and what is repressed in his or her unconscious. At the same time, the analyst as "witness or object of a demand, is changed in the internal world and becomes, unknown to the analysand, the *cause* of the movement that animates his or her speech" (1999, p. 297, italics in original). Hence, Green sees the analyst as having a double role, as both the receiver of the message and its stimulus. "The addressee—invisible in the analytic situation—is so to speak reduced to the movement of speech, merges into it and is now interpreted in terms of a double register" (1999, p. 297).

Green thus listens both from *within* the transference and *to* it. The former perspective is most necessary for the nonneurotic patient because it brings the analyst closer to the patient's lived experience, almost identified with the drives seeking satisfaction —from which point the analyst can articulate the drives' inner movement. Green refers to this position of the analyst, a *quasi identity* with the patient's unconscious, as that of the *similar other* (a central clinical concept to which we shall return). Thus, to establish the frame as a containing structure, the analyst must attempt first to understand him- or herself *with* the patient.

CLINICAL MATERIAL

Mr. L

A brief clinical example of an initial failure to establish the frame as a containing structure and its subsequent correction will illustrate our understanding of Green's approach.

> Mr. L began his analysis with prolonged rages. Although these rages were directed toward people in his current life, he was completely taken over by them on the couch. He had come to analysis after finding himself overwhelmed by anxiety subsequent to having started work for a severe, critical, and demanding boss. He described his mother as similarly critical.
>
> The analyst was curious about these violent affect states, and after they subsided would ask Mr. L to associate to them. That request made the analyst the focus of Mr. L's rage. When the analyst attempted to explore Mr. L's reactions to the request, Mr. L became ever more angry, frustrated, and hurt.
>
> The analyst realized that the standard approach of asking for associations was counterproductive, and began to work inductively, looking to his own subjective state for information about Mr. L's. He eventually recognized that he was feeling completely powerless, and suggested, quite tentatively, in view of his awareness of Mr. L's fear of intrusion, that Mr. L might have felt powerless with him before he became so filled with rage. Mr. L became reflective and agreed. The analyst subsequently offered the idea to Mr. L that the rage was Mr. L's way of now being the powerful one in control. For the rest of the session, Mr. L remained reflective and receptive.

From our reading of Green, we understand the difficulty with the analyst's first approach to have been that the analyst assumed Mr. L was capable of providing associations to his violent affect states. In fact, by virtue of a severing of the somatic and ideational representations of drive components, he was *in*capable of providing associations. Rather than helping Mr. L cross the void to engage in an object relation that could satisfy his needs by articulating the unconscious content he was attempting to communicate, the analyst, by asking for associations, was emphasizing the gap. This request for a functioning that was impossible for Mr. L re-created in the transference the inner pathological relationship between the patient and his demanding, critical mother. Moreover, asking for associations in a more general way also

meant treating Mr. L as though he were differentiated, when he was not yet able to function in a differentiated way.

Instead of interpreting from a differentiated position and asking Mr. L to function in the analytic setting in a way that he could not do, the analyst shifted his approach so that he began interpreting as a *similar other*—someone close enough to understand and experience (in the double register) the patient's inchoate subjective state, to process his information as he was able to communicate it (in this case, by projective identification), and to articulate it as a way of providing a container for the patient. The interpretation that identified Mr. L's sense of powerlessness functioned in this way.

To create the analytic space with a nonneurotic patient, then, the analyst works, as Green puts it, by induction, beginning with his or her own internal states, rather than by deduction of the unconscious fantasy from the patient's free associations (Green 1975). By coming to understand what is alien in him- or herself, the analyst begins to understand what is *other* in the patient, that is, what the patient is not aware of in him- or herself. The patient makes a corresponding effort to put as much as possible of what he or she experiences into words that convey both the known and unknown portions of him- or herself, so that the analyst has the opportunity to discover the patient's otherness and present it to him or her for consideration. This interaction creates a complex intertwining of doubles: what each party "lives and what they communicate" (Green 1975, p. 12). Only through such an interaction will shared metaphor become possible.

Even though he rarely reports verbatim material,[8] Green writes with incisive brilliance about clinical matters. This passage further describes the nonneurotic patient's need for an analytic space and the reasons behind Green's interpretive stance:

> For the patients, who are dependent on affective communication, seem to need a sharing of their experience,

[8] An exception is the clinical material that concludes his paper on Winnicott (Green 1997, pp. 1077-1080).

> which does not mean collusion with it, in a nonintrusive exchange which gives them a feeling of existence, in which sufficient space can be formed, albeit manufactured space, for their silent self, and where the defensive meaning of their state can be acquired without there being a compression of their inner world . . . . This implies that specific powers of communication with the patient should be found which are not unacceptable to him and which require a modification of the means of perception by which we apprehend the patient and simultaneously an interpretative technique which does not speak to him from the outside, even if it seeks to communicate what is most intimate to him. What can be admitted by the patient must conform, at least in part, to the way in which he received in himself the gifts of his internal world, as well as those of the external world. [Green 1977, pp. 145-146]

When the analyst manages to put into words a part of the patient that the latter communicates but does not know, it seems to us that, at the moment of communication, when the patient understands and recognizes what the analyst says about the patient, the analyst gradually ceases—for a little while, at least—to be a part of the pathological object relationship with the patient. In the case of Mr. L, this was the relationship between the intrusive, derogating mother and the helpless child, a relationship in which the patient felt himself to be once more engaged in the transference. The analyst becomes instead one who understands and brings the ingredients for a third perspective to the pathological dyad. That is, the analyst, in Green's terms, does more than interpret the pathological object relationship itself. *When the analyst can function in the analytic setting as the similar other, he or she interrupts the pathological object relationship and replaces it, at least momentarily, with a more satisfying experience.*

Moreover, this more satisfying experience created by the conveying of the analyst's understanding works a significant change in what Green would call the basic conflict between destruction and love underlying the creation of structure. In tiny increments, the

patient's psychic economy moves in the direction of a cathexis of the object and general integration, rather than toward decathexis and fragmentation. The experience of satisfaction simultaneously prepares the way for a coming together of the somatic and ideational aspects of the drive.

Green's approach is then both intersubjective and intrapsychic (Green 2000). The more that work in the intersubjective sphere leads to the creation of more integrated structures and the differentiation of the analyst from the patient, the more the analysis can concern itself with the patient's unconscious, internal psychodynamics.

Ms. K

While the example of Mr. L illustrates a general approach to nonneurotic patients, this cross-section from the analysis of Ms. K, a borderline patient in a four-times-a-week analysis, is more specific. Careful attention to the patient's contradictory affective states over several years was now allowing her to use free association more consistently and to begin to observe her own psychic processes. The analyst was influenced by Green's ideas about absence, or the failure to represent an object internally, and the relation of absence to the difficulty that nonneurotic patients have in differentiating themselves from objects that inflict pain, frustration, and disappointment.

> Ms. K, a 34-year-old graduate student, had spent most of her life complying with her family's designation of her as their black sheep. She experienced a chaotic adolescence and young adulthood that had included serious drug problems. She described her father, a powerful, behind-the-scenes force in local politics, as alternately intrusive, neglectful, seductive, and punitive. When Ms. K was eleven months old, her infantile and self-preoccupied mother had given birth to twins, depriving Ms. K of her babyhood. Ms. K felt perpetually deprived of the love of others, was excruciatingly sensitive to what she felt was any

disregard of her, and was intensely envious of those perceived to have the love she felt she had never been given. In addition to her sense of deprivation, she felt obliged to care for her mother and forced to behave in the way her mother wanted for the latter's benefit.

Ms. K began a Friday session several years into the analysis by accusing her analyst of destroying her life. The angry attack against the analyst was occasionally interrupted by contradictory remarks about how the analyst was the only person who had ever understood her. The analyst pointed out that she, the analyst, had recently announced that she would be away during the following week. The patient sulkily acknowledged that fact, then went on to berate the analyst for taking her money and going off to have a good time. In the midst of these angry remarks, she mentioned the analyst's importance to her, then just as quickly returned to her accusations.

The analyst intervened to say that Ms. K experienced her in two different ways: one as supportive and helpful, the other as dangerous and destructive. The patient responded by talking about the pain caused by her inability to decide about the analyst, and wondered again whether she had been totally misguided. She then began to attack herself as naive and stupid. The analyst interpreted the displacement of her transference rage onto herself, but went on to remind the patient of previous work in which it had become clear to both of them that, when Ms. K attacked herself, part of her was reconnecting with her father by becoming him, and was indeed reconnecting with her entire family by reclaiming the role of the scapegoat. The analyst further wondered to the patient whether their recent work on Ms. K's separating from her family hadn't made her very anxious.

The patient mentioned the pull she was currently feeling to accept her family's invitation to join them for a ski vacation. She wanted to go, but knew it was likely to be a disaster. Then she had the thought for the first time that she could take her own vacation when she felt like taking one. She next revisited a ski vacation she had taken with her family three years earlier; she had felt "a

horrible vacuum" and had cried herself to sleep. "What I really remember is leaving and going home. I felt like they didn't exist for me at all. I didn't exist for them. Emptiness. I don't feel love. I feel indifference."

Ms. K then once again questioned her perceptions and accused herself of being too needy. Sometimes, she thought she was so sick that everything she had said to the analyst about her family had been lies. The analyst commented, "Shifting back and forth makes it hard for you to know who you are and what you feel and think," and eventually added that it would be helpful to understand what prompted this shifting.

The patient responded by describing her out-of-control affects, particularly her rage, as "a big blotch of something you can't see out of." She then began to notice on her own that her rage at someone became an attack on herself, as though part of her were a bully. She thought it was getting easier just to have angry feelings, but after a moment's reflection, she added that maybe she did believe she didn't deserve certain things, and that was why she had to get rid of them. A little later, she complained that she always felt she left her sessions with nothing.

The analyst said that Ms. K probably felt great pain at having to leave the session, and that it must be difficult to take away with her the memory of the analyst, or of what they had talked about, because Ms. K got so angry at the analyst for saying the time was up.

Ms. K then mentioned her fatally ill bird. She had wanted to go out to a movie, but saw him looking at her and decided not to go. The analyst commented that Ms. K believed her ending the session, now that the weekend was coming, was similar to the way the patient felt about leaving her bird in order to see a movie: that she was condemning the bird to death for a transitory personal pleasure.

Ms. K immediately described a dramatic childhood incident in which she had been in danger of dying. Her mother panicked, ignored her, and called out the names of her twin siblings. Ms. K had thought at that moment, "She can't take care of herself—how is she going to take care of me?"

> She then commented thoughtfully about feeling empty when she was not with the analyst: "Maybe I think I'm like my mother, not present . . . . Maybe here I feel related to a person who exists and can take care of me. When I'm alone, I don't exist; I'm invisible. Maybe I can't stand to own two feelings, so . . . yeah, that's what it is. Who am I going to be when I shift—the helpless child or the pissed-off person?" The session ended with Ms. K's becoming aware of the intense rage she felt toward her family and being able to put more of it in words.

We believe it possible to see Ms. K, by virtue of her history and from the material of this session, as exemplifying the *absent maternal representation* that Green has described. The history suggests that an already self-involved mother was lost to Ms. K when the birth of twins so soon after her own birth deprived her of the necessary maternal attention and love. What is more, the patient reported being expected to function as a narcissistic object, feeling loved only to the degree that she lived up to the mother's expectations. According to Green, the frustration and destructiveness secondary to this emotional climate so early in the child's life favors a process of disobjectalization over objectalization, so that the object representation of the need-satisfying mother is destroyed, leaving in its place what we have termed an *absence* in structure formation. There is a parallel absence in the resultant self-representation, so that rages or impulsive actions can erupt in this gap with no meaning attached to them. Pathological object relationships are utilized to cover over this absence.

One might understand Ms. K as manifesting such a gap in the form of very early splitting, as she struggled in analysis with unintegrated images of the good and bad transference object. Green sees splitting of this type as a defense against the emptiness of absence, an attempt to patch over the gap by creating two objects that are quasidelusionally present as, alternately, the unattainable good object or the persecutory bad one. Dependence on neither the good nor the bad object is a viable solution, however; dependence on the bad object causes suffering, while dependence on

the idealized object reveals the underlying intensity of need and leads to unavoidable disappointment. Thus, the analyst is either dangerous and destructive, or, since her leading her own life prevents her from providing for the patient during weekends and vacations, abandoning. Typical reactions of envy, hatred, and self-hatred come to the fore.

When Ms. K turned the aggression directed at the analyst away from the latter and toward herself, the analyst, although pointing out the defensive maneuver in the transference, moved to interpret the function of self-hatred as a way of maintaining the object tie with the bad primary object.[9] The analyst here followed Green's understanding that the tie to the bad object is the last defense against the patient's facing the void and emptiness of the absence of a maternal representation within her. Ms. K's next associations referred to the pull she felt to accept her family's invitation for a week-long ski vacation, even though she also thought it would likely be disastrous. She continued by revisiting the memory of the earlier ski vacation with her family. In doing so, she used words neither the analyst nor she had ever used before about her experience, speaking of a "horrible void" and an "emptiness" inside her.

Although it is, of course, possible to assume a different, latent content beneath the state the patient described, for the analyst, Ms. K's words reverberated with Green's description of emptiness consequent to the absent (i.e., unrepresented) object. The affect accompanying them conveyed, in addition, a sense of acutely painful desolation. Moreover, the retrospective description of the earlier vacation significantly contrasted with the patient's rage-filled account of the same vacation immediately fol-

[9] Although the analyst moved away from the manifest transference, she was still interpreting from within it (Green 2002a). The patient's tie to her primary objects was so strong and ongoing that the analyst understood that she herself was experienced as bad not only because she was abandoning the patient for the weekend and vacation, but also because the analytic work posed a threat to that primary tie. The shift to the primary objects was an attempt to deal with that aspect of the transference.

lowing it, three years earlier. The contrast suggested to the analyst the patient's growing capacity to put painful and heretofore unverbalizable affects into words, in the context of the analytic relationship with her. In other words, the presence of the analyst in the analytic space allowed Ms. K to speak about the *absence* with the analyst.

Later in the session, rather than interpreting the content of Ms. K's struggle with her family, the analyst followed Green's idea about the inadvisability of imposing external interpretations when the patient is struggling with a fragile sense of self, by focusing instead on Ms. K's affective state in the session, and particularly on her complaint that she left the hours with nothing. Although the complaint also reverberated with Ms. K's feeling undeserving and with her reproaches to the analyst as a bad object, the analyst connected the patient's sense that she was left with nothing after sessions with her frustration and disappointment at the analyst's abandoning her at the end of the hour and over the weekend. One might say, a bit abstractly, that the analyst showed Ms. K how the process of disobjectalization was occurring in the transference.

The patient's next associations described her decision not to leave her sick bird in order to go to a movie, and her guilty feelings about having contemplated doing so. These led the analyst to pick up on the patient's dual identification with the abandoner and with the sick bird, by suggesting to the patient that she believed that her leaving the bird would condemn it to death, in just the same way that she believed the analyst's leaving her condemned her to death. This intervention led the patient to recount a childhood memory in which the patient, perceiving herself in danger of dying, was ignored by a panicky mother who instead called to her siblings.

By the end of the session, the patient was observing herself within the analytic space. She was unsure, for example, which split aspect of herself would emerge at any given time, and realized that the discontinuity of that experience frightened and disrupted her. Moreover, she seemed to be beginning to integrate the af-

fective extremes of her previous relation to the analyst. When she said that she felt invisible when not with the analyst, and then articulated for herself the insight that this *representation of herself as invisible constituted her identification with the absent mother,* she was working independently and creatively. Contemplating her sense of herself when alone, she contrasted this with her sense of herself when with the analyst ("Maybe I think I'm like my mother, not present. Maybe here I feel related to a person who exists and can take care of me").

CONCLUSION

Isolated interpretations in our material resemble the work of analysts other than Green—notably Winnicott, Bion, Klein, Kernberg, and Kohut—either because these thinkers have substantially influenced Green, or because the cauldron of clinical experience has highlighted the advantages of similar technical approaches. Although our readers may therefore dismiss what we find to be innovations worth attending to, we caution them to resist this reaction. Even when an isolated intervention resembles that of another school or author, there is a difference that reaches back to the theoretical nexus of each. In the case of interventions growing out of differing theories, a single intervention is always embedded in a complex and particular theoretical matrix and linked to a particular, far-reaching network of concepts that is unique to a particular author. The intervention does not exist alone. Thus, in the case of Green's influence on the analysis of Ms. K, when the analyst intervened to point out the patient's separation anxiety (as expressed by her manifest rage at the upcoming weekend and the analyst's vacation to follow), the analyst had in mind the defensive importance of holding onto the bad object in order to avoid the inner emptiness occasioned by the absence of the maternal object representation. Of course, neither separation anxiety nor the attempt to hold onto a bad object are original ideas, but their location in a chain of consequences orig-

inating from the idea of a hole in the psyche, one resulting from disobjectalization, represents Green's unique perspective.

Similarly, the initial intervention by the analyst concerning Ms. K's having two separate ideas about the analyst follows Kernberg's (1976, 1984) technique of systematically interpreting primitive defenses such as splitting. We believe, however, that it would be Kernberg's position that the nonneurotic patient can understand and integrate the therapist's interpretations about the nature of his or her conflicts, so long as the therapist pays close attention to the patient's distortion of the analyst's comments and analyzes those distortions. Green, on the other hand, attends as well to the jarring and intrusive nature of interventions that overanticipate the patient's readiness for differentiation; and, in addition, he would be careful to begin any exploration from within the transference, very close to the patient's affective state, in that *quasi identity* with the patient's unconscious we have described. This is because he would also be keeping in mind that the patient's inner void, consequent to a failure to represent the object, impedes the transformation of unconscious thought into preconscious ideation, as well as his belief that one of the major tasks of the analyst of the nonneurotic patient is to cross that void and to make connections that the patient cannot yet make.

The technical emphasis on staying close to the patient's affect state in turn resembles Kohut's (1959) emphasis on empathic interventions in the treatment of narcissistic personality disorders. In both cases, the technical precept is to intervene at a level as close as possible to the patient's subjective feeling state, and to accompany the intervention by an acute awareness of the need to participate in the patient's subjective experience as a self-object, rather than to remain too differentiated. Kohut's (1977) technical advice, however, is connected to his self psychological theory, with its concepts of self-defects and pathological compensatory and defensive structures that stem from early parental failures of empathy, and the role of transmuting internalizations in cure. Green's somewhat similar technical emphasis moves in a different direction, that is, from intervening as a similar other in order to

bridge the gap between what the patient lives and can communicate to the promotion of an ability to differentiate, in which the patient can communicate more of what he or she lives with less help from the analyst. Green's technical position thus reflects his very complex and consistent theoretical revision of psychoanalytic theory, as we have tried to describe it in these pages.

This complexity begins with Green's basic concept of conflict, which allows for both the absence of the object representation and its presence, and ends up envisaging the psychoanalytic setting in the treatment of borderline and narcissistic patients in a new way. Although the idea of absence remains a hypothesis, and a controversial one at that, it makes it possible to imagine treating nonneurotic patients differently from neurotic patients without doing violence to Freud's theory of the pathogenesis of neurosis. It is a contribution that is creative at the same time that it is conservative in the most fundamental meaning of that term.

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MR. A'S CREATIVE ADVENTURE: REFLECTIONS ON DRIVES AND PSYCHIC CONFLICT

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The author discusses psychic conflict in the context of Freudian drive theory and its relationship to primal fantasies and repression. Freud's metaphor of the "Mystic Writing Pad" is reviewed, with particular attention to psychotic perception, especially the lack of ability to differentiate between self and object. Psychoanalytic psychodrama is proposed as an effective treatment modality in such cases, and an illustrative clinical example is presented.

> I even dreamed of the Dutch phantom ship and Le Horla and, although I otherwise cannot sing a note, I apparently produced an old nursery song while musing on the tunes the cradle-rocker used to sing to the sailors—an idea I had tried out in an arrangement of colors before I fell ill . . . . As an arrangement of impressionist colors, I have never invented anything better.
>
> —Letter from Vincent van Gogh to Paul Gauguin, January 23-24, 1889 [van Gogh 1889, pp. 58-59]

DRIVE DUALISM

The sexual drive is inherently a source of conflict, as well as a constitutive element of a binding process that, on the basis of the sub-

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Translation by Philip Slotkin.

ject's openness to the world at the time when an object relationship is established, can organize a process of differentiation and structuring. This is reflected in the use of the mechanisms of negation (*Verneinung*) and repression observed in neurotic organizations. However, the sexual drive can also give rise to an unbinding that underlies a process of destructive de-differentiation and annihilation, as shown by the use of disavowal (*Verleugnung*) and splitting of the ego in nonneurotic organizations. Hence, the drive dualism upheld by Freud throughout his life, as well as his final drive theory, which, through a biological myth, confronts us with the struggle between Eros and Thanatos, union and disunion, love and hate.

After all, the birth of the sexual drive, occurring at a time when the autoerotism of the onset of the object relationship holds sway, gives rise to a conflict in which love and hate stem respectively from a libidinal drive involving binding to the object and a destructive unbinding drive. This explains Freud's unwavering insistence on a dualism of the drives, since ambivalence lies at the heart of psychic conflict observed in clinical psychoanalytic work: the drive is dualistic from the beginning, owing to the duality of object cathexis. Freud offered several theoretical accounts of this conflict; the one most consistent with clinical experience is without doubt that of ego libido and object libido, whose mutual relationship tends toward opposition—toward a conflict between the aims of object binding (preservation of a relationship with the object) and narcissistic unbinding (rejection of that relationship).

THE DRIVE AND PRIMAL FANTASIES

Freud sought to identify the foundations of the link he had discovered between sexuality, trauma, and defense, and to determine why sexuality is traumatic and gives rise to a defensive conflict. His first attempt was embodied in the theory of early seduction; later, however, when evidence of actual traumatogenic scenes proved not to be forthcoming in every case, he espoused biological realism, in which hereditary predisposition was invoked to explain the ap-

pearance of sexuality, as well as the stability, power, and relatively organized character of fantasy life.

In order to account for the fantasy nuclei whereby children attempt to solve the riddles presented by the sex lives of their parents, the difference between the sexes, and their own sexuality, Freud (1915a) introduced his theory of primal fantasies (seduction, castration, and the primal scene). He assumed that these fantasies had been part of the real experience of early man, in accordance with the scenario portrayed in "Totem and Taboo" (Freud 1913), and that they were phylogenetically transmitted.

What is the significance of this explanation by phylogenesis? Structuralists see it as a nostalgic return to the notion that psychic conflicts are founded in reality. This reality is no longer that of the individual, but of mankind. The same dilemma of event versus constitution that is seen in an individual's history is observed in the prehistory of humanity. To avoid a situation of infinite regress, it is then assumed that there was a primal moment when the vicissitudes of the species were fixed—but this is an explanation from the realm of mythology. This "reality," in which imaginary circumstances are considered to be embedded and that is deemed to impress the stamp of its law upon them, can thus be seen to foreshadow the *symbolic order* of Lacan and Lévi-Strauss. Lurking behind the myth of a prehistory, there must then be a structure transcending the will of the subject itself, equivalent to a pure transcendental schema. However, as Laplanche and Pontalis (1964) point out, primal fantasies are first and foremost *fantasies,* and, even if they supply experience with its attendant conditions of possibility, they are assembled from contingent elements.

This apparent contradiction can be understood only by keeping in mind the elaboration of the concept of the drive with respect to the ambivalence of the object relationship. Eighth-month anxiety and the negative reaction to strangers are in fact defense mechanisms deployed with the aim of countering depression; the fantasy of the primal scene is merely a further development of this same process. If primal fantasies are not to be regarded as contents frozen in the unconscious (phylogenetic traces or Kantian

transcendental schemata), then they must be seen, as rightly noted by Diatkine and Simon (1972), as "a defensive elaboration with the aim of mitigating the painful consequences of object ambivalence" (p. 389). These authors add that it is precisely because "object cathexis is ambivalent from a very early stage that fantasying cannot be deemed to be attributed to the pleasure principle alone"; it is not merely the onset of fantasying that constitutes a defense against the absence of the object, but its very internal organization that takes the form of a defensive elaboration.

The role of primal repression, which, according to Freud (1915a), allows the drive to be bound to a representation—by the sole mechanism of countercathexis—can be understood in these terms. Primal repression's aim is to contain the tendency toward absolute discharge of excitation and to defend against a hallucination of satisfaction by the creation of a fantasy process and the constitution of primal fantasies. At the same time, this attachment lies at the root of what Freud (1926) termed the "power of the compulsion to repeat" and "the attractions exerted by the unconscious prototypes" (p. 159) in connection with id resistance.

Primal repression is responsible for the primitive inertia of the psyche that, in return, permits illumination of consciousness and openness to the world. Perception presupposes mourning for an absolute presence, and indeed its negation, failing which it is likely to be mere hallucination. The unconscious functions as the index of this negativity, whose present manifestation is a negative process—namely, resistance, autoerotism, and the absolute discharge of tensions. Yet this negativity has an underlying raison d'être that is no longer negative but positive, because it allows consciousness to appear and to exist, and permits the judgment of existence to take place.

PERCEPTION AND MEMORY

These ideas are illustrated by the working of the so-called Mystic Writing Pad, used by Freud (1925a) as a metaphor of psychic functioning. Consciousness is possible only by virtue of unconscious

cathexis, just as writing on wax paper depends on contact with a wax slab; at the same time, however, it is because this contact is not permanent that the system Pcpt.-Cs. can renew itself.

> If we imagine one hand writing upon the surface of the Mystic Writing Pad while another periodically raises its covering-sheet from the wax slab, we shall have a concrete representation of the way in which I tried to picture the functioning of the perceptual apparatus of our mind. [Freud 1925a, p. 232]

This concrete reference to periodic raising of sheets shows that the dimension of temporality must be introduced in order to account for the structure of the psychic apparatus and to overcome the difficulties inherent in optical or photographic models, in which *simultaneous* performance of the functions of perception (succession) and memory (permanence) is not possible. As Derrida (1967) rightly points out, "the traces therefore create sufficient space for their inscription only by allowing themselves the time needed for their erasure" (p. 334). The dynamic element must be restored if we are not to be locked into a representation of the psychic apparatus based on Cartesian space and time, characterized by the mutual externality of the parts. The dimension of psychic conflict presupposes that there is neither permanent contact nor discontinuity between psychic systems—no pure perception and no pure memory. On a certain level, Freud's neo-Kantianism causes the differentiation of the psychic apparatus resulting from the work of the drive to be lost; the diversity of the systems cannot be reduced to the mere opposition of positive and negative.

Here, then, is the foundation of the functional opposition between perception and memory that Freud borrowed from Breuer to describe the succession of psychic systems. Perception does indeed appear *in the place* of the memory trace; the two cannot exist *at the same time* (Freud 1925a). Simultaneity is never absolute. Where they do coexist—i.e., in schizophrenia—there is a topographic split, rather than a regression. Gillibert (1977) correctly notes that in such cases, there is, on the one hand, a memory trace in

the form of the word *cathexis,* and, on the other, *perception,* as the obliteration of this trace—in another place and at the same time. Here this perception no longer corresponds to a perceptual *experience,* but instead takes the form of a *sensation:* that of an affect of fright that reflects the terror inspired by the hallucinatory image. *Word presentations* henceforth constitute a form of inert protection from this terrifying sensation.

Repression actually correlates with object loss, as well as with the elaboration of this loss as not permanent; the permanence of the object itself guarantees its appearance/disappearance and the symbolic substitutions of its reappearance. It is when the loss is experienced as final, as in psychosis, that fixity substitutes for permanence, mobility for movement, and the juxtaposition of opposites for contradiction. Thinking in terms of opposition is tantamount to losing the dimension of psychic conflict, which can be understood only in terms of difference. The aim of work with psychotic patients is precisely to encourage the transition from *splitting* of the ego, which is imprisoned in the juxtaposition of opposites, to the dimension of conflict that *contradiction* underlies.

The foregoing illustrates the gulf between the Freudian approach and that of philosophy. True, Freud refers to a theory of knowledge, which he likens to Kantian thought, perhaps suggesting at times that psychic conflict involves an opposition between an inside and an outside. In fact, however, the perceptual field is organized from the beginning by drive cathexis, because, from the onset of the object stage, an immediate difference arises between cathected external objects and objects corresponding to the processes of projection and introjection—i.e., internal objects. The transition from the "purified 'pleasure-ego'" (Freud 1915b, p. 136) to the "definitive reality-ego" (Freud 1925b, p. 237) represents a genesis of perception bound up with the development of the introjective processes.

From this point of view, the conflict is at first internal, as indicated by the emphasis Freud places from the beginning on hallucinatory wish fulfillment, and it is only at a second stage that meaning is assigned to this internal conflict through the opposition of

an inside and an outside. From the time he wrote "Project for a Scientific Psychology" (1895) onward, Freud stressed the importance of an inhibition by the ego of a quantum of excitation in making it possible for the *indication of reality* (or quality) to appear in consciousness. However, a reference in "Negation" (Freud 1925b) to the internalization of the conflict of object loss shows that this indication of reality, in order for it to be correlated with a perception and not with a hallucination, presupposes the existence of a hallucinatory process connected with the internal object: the *constant state of the ego*, whereby the quantum of excitation that can be inhibited has to do with the presence of an internal object, and is therefore indicative of the functioning of the psychic topography.

The establishment of an unconscious system that correlates with a preconscious system is the condition underlying the possibility of openness to the world, which Freud saw as the transition from primary to secondary process. Unlike philosophers, Freud (1915b), bases this openness to the world on an *economic* process reminiscent of the "demand made upon the mind for work in consequence of its connection with the body" (p. 122), which defines the drive. The openness to *being*, in which *being* and *nothingness* are not opposites, results from an achievement that lies at the very heart of libido and of narcissism. As Merleau-Ponty (1964b) wrote:

> For an ontology of the inside, it is not necessary to construct transcendence, which is there from the beginning, as Being with its complement of Nothingness; what calls for explanation is its splitting in two (which, incidentally, is never fully accomplished). [p. 290]

Yet this splitting in two surely does exist, as in the case of psychosis, and the entire effort of psychotic thought may be seen as concentrated on the construction of this transcendence. For psychosis demonstrates the possibility of *not* going beyond the opposition between being and nothingness, between fullness and the void; when confronted with annihilation anxiety at the total void, the psychotic person cannot but resort to omnipotence and the repudiation (*Verwerfung*) of all differences—that between the sexes

and between the generations, for example. He or she is literally the totality of *being*. The psychotic's concrete way of thinking indicates despair at the possibility of rediscovering being through the roundabout route of words.

This critique of the power of consciousness, voiced by the unconscious, is tantamount to a wish to rediscover the *difference* between being and nothingness, rather than the *opposition* between them. Topographic difference is the guarantor of the twofold difference between the sexes and the generations; from this point of view, the judgment of existence relates primarily to the *reality of castration,* an external reality that is nothing more than the externalization of a conflict in the sphere of the *reality of thought.*

NEGATION AND SYMBOLS

The foregoing offers an explanation of the correlation established by Freud (1925b) between the appearance of the symbol of *negation* and the operationalizing of the judgment of existence. Symbolization as a mechanism to combat depression indeed correlates with the binding of the affects of pleasure and unpleasure, and it is readily understood that this process can culminate in the development of language, as in the reel game (Freud 1920), which shows that the child has mastered the unpleasant affects aroused by the disappearance of the mother and demonstrates the success of a process of drive introjection through visual perception, gesture, and words.

The genesis of symbols is described by Segal (1964) as "the outcome of a loss" and "a creative work involving the pain and the whole work of mourning" (p. 63). This description takes account of the notion of sublimation, which Freud describes as one of the possible vicissitudes of drives. The process of aim-inhibition of the drive, which underlies tenderness, leads to sublimatory activity, and therefore has to do with a genuine mourning process and the working through of object loss. Freud (1920) in fact interprets the reel game in these terms: "[The game] was related to the child's

great cultural achievement—the instinctual renunciation (that is, the renunciation of instinctual satisfaction) which he had made in allowing his mother to go away without protesting" (p. 15).

From this point of view, it is the possibility of working through mourning for the object—both its loss and its recovery as an internal object—that allows the use of negation, which can be expressed equally in positive and negative terms. In this context, *yes* and *no* are equivalent in the conscious mind, as Freud points out in "Constructions in Analysis" (1937, p. 262). Again, Freud states in "Negation" (1925b) that, in this way, "thinking frees itself from the restrictions of repression and enriches itself with material that is indispensable for its proper functioning" (p. 236). The raison d'être of this freedom of judgment lies in the relationship with the world, which is both accessible and inaccessible, in the "proximity by distance" (Merleau-Ponty 1964b, p. 170) that simultaneously constitutes a starting point and an objective to be attained. From this point of view, negation is not the mark of an insuperable difference from the world, but in fact causes the world to appear, insofar as the mediation it presupposes constitutes precisely the element that brings the subject closer to the world. This resolves the seeming contradiction inherent in the mechanism of negation, which is at one and the same time a substitute for repression—and hence close to it—and different from repression, because it partially lifts it.

Negation as defined by Freud (1925b) enables the patient to identify with the analyst's interpretive function, and ensures that interpretation does not take place in a state of coincidence and confusion between the *act* of interpreting and the *content* of the interpretation (Donnet 1983). The aim of the various hypotheses that will then be suggested to (and not forced on) the patient is to restore to psychic reality its features of ambivalence, doubt, and uncertainty, in contrast to the psychotic defenses, which seek to deny the conflict of ambivalence and to place the subject in the world of the predictable and of absolute certainty.

INDIVIDUAL PSYCHOANALYTIC PSYCHODRAMA

Toward this end, the particular form of psychotherapy represented by individual psychodrama introduces a variation in setting and technique based on play. The paradox of psychoanalytic psychodrama is that it systematically prescribes, in the form of play, something that is otherwise regarded as an obstacle to the development of the analytic process—in particular, the lateralization of the transference and motor or verbal action. The fact that this action can take place in the context of play prevents it from becoming a resistance of the kind characteristic of these defenses, in the form of acting out, so that it instead becomes a preferential means of working through for patients who are unable to tolerate a transference relationship organized around the analyst. Both the mainspring of the process in psychodrama—namely, the transference—and its aim are those of classical psychoanalytic treatment; it is the setting that differs.

Psychoanalytic psychodrama, in accordance with theories developed in the 1950s by Serge Lebovici, René Diatkine, and Evelyne Kestemberg (Kestemberg and Jeammet 1987; Lebovici, Diatkine, and Kestemberg 1969-1970), and more recently by Jean Gillibert (1985) and Philippe Jeammet (Jeammet and Kestemberg 1981), supplies the economic and topographic conditions whereby interpretations can be heard without being experienced as intrusive. Thus, they can be introjected. This kind of psychodrama centers on a single patient and involves a group of therapists comprising a leader, who is responsible for interpreting. There are no fewer than four cotherapists—two of each sex—as potential actors. Each weekly session lasts about half an hour.

The specific setting of individual psychoanalytic psychodrama is intended for adult or child patients who in general present major phenomena of either excitation or inhibition, which are often characteristic of psychotic functioning or a phase of large-scale inner reorganization, such as immediate preadolescence or adolescence itself. Differences among the leader and other mem-

bers of the treatment team break up any massive transference cathexis, thereby reducing the economic weight of such excitation. Under favorable circumstances, alternation of play and nonplay interpretations results in a concentration of displaced and ambivalent impulses onto the person of the leader, where they can be dealt with in the same way as in psychoanalytic treatment with a single analyst.

The aim of interpretive tactics is in fact less that of systematic transference analysis than of encouraging a process of representation corresponding to the establishment of formal and topographic regression. Considered in these terms, the fragmentation of the transference cathexis over the entire group of psychodramatists is directed toward the organization of the analytic process; it is only at a second stage, by virtue of temporal regression, that it might become possible to interpret the transference onto the leader. Mr. A's psychoanalytic psychodrama, described below, illustrates the value of this technique in affording access to psychic conflict in a psychotic patient.

MR. A'S PSYCHODRAMA: AN EXCEPTIONAL PSYCHOANALYTIC CASE HISTORY[1]

"I dreamed that I was a surgeon. There was a patient on the operating table and the operation was to remove his eyelids." So Mr. A began a recent psychodrama session, associating to the idea that removing someone's eyelids caused blindness and was a form of torture.

Six months later, he dreamed that he was tearing out a man's eyes. His association—given that I was not present for this session—was that a man was missing that day, and that the man in the dream who had his eyes torn out might be the usual leader, whose place on this occasion was taken by Dr. L, one of the group's female psychodramatists, who had been present since the beginning of Mr. A's treatment. It was as though the patient were saying,

[1] The account of this clinical case is taken partly from Gibeault 2004.

"That man, [the author], who won't or can't see me, doesn't need his eyes." Later in the session, however, he produced another association—that "you look at paintings with your eyes"—while at the same time failing to see a picture by Riopelle on the wall behind him, even though he had just commented that the last picture he had seen recently was in fact a Riopelle.

Mr. A produced both these dreams precisely on occasions when I was absent. This manifestly showed that my absences confronted him with the risk of nonexistence and annihilation if he could not look and be looked at, as a token of a cathexis *of and by the object,* thus allowing acceptance of a differentiation between himself and another person.

As noted, six months separated the telling of these two dreams, which formed part of a prolonged, eight-year process of individual psychoanalytic psychodrama. The symbolism of the two dreams differed: first, removal of the eyelids meant that Mr. A could no longer protect himself from being dazzled by a blinding light —such as that he had experienced at the age of thirteen on sharing his mother's bed after his parents had separated. The second dream, on the other hand, represented the absence of a father unable to see the patient's needs—a problem reactivated in the psychodrama by my absence and replacement by a woman. The dream work could not have offered a better representation of the psychotic adventure of Mr. A, whose psychic life was frozen between an excess of maternal presence and an excess of paternal absence.

From Self-Begetting to the Primal Scene

Mr. A had consulted another analyst at the same treatment center eight years earlier, following a suicide attempt in which he had tried to shoot himself with a pistol and at the same time to drown himself in the River Seine. At the last minute, Mr. A had held back and instead gone to a psychiatric emergency unit. The prospect of violent self-destructiveness had led the first analyst to suggest psychoanalytic psychodrama, in order to help the patient establish a psychic space for himself and to gain access to tempo-

rality through the transcending of omnipotent disavowal and of splitting of the ego. (Mr. A's psychotic functioning had not been overcome by a previous two-year, couch-based psychoanalysis, nor by a further two years of face-to-face psychotherapy.)

Suicide had presumably seemed to Mr. A the only possible way of countering the annihilating threat of nondifferentiation from the object; it had involved a process of "casting out the object" (Green 1980), with a view to emerging from psychotic confusion. But during the course of his individual psychoanalytic psychodrama, led by his original analyst at our center for the first two years, and by me for the following six years, Mr. A traveled an astonishing distance. During the last year in particular, we could appreciate the efficacy of psychic work in enabling him to emerge from psychosis.

At the beginning of his psychodrama treatment, the patient had been in great distress. He had lost his job two years earlier and was in a state of total apathy, spending whole days in bed, "playing dead," until the idea of suicide crystallized in his mind. He had previously had a psychotic episode involving visual hallucinations and mystical delusions about the Virgin Mary. A software engineer by trade, while hospitalized psychiatrically, he had found a form of healing in painting. At the beginning of his treatment with us, he brought in some of his nonfigurative paintings in the style of Poliakoff. The conflict between gainful employment and his unpaid painting was to become an important issue.

Mr. A had the youthful appearance of an adolescent, despite his approximately fifty years. At first, he looked like a disheveled, insubstantial waif, but he later manifested a more cared-for appearance. For a long time, it was impossible to interpret the transference, as such interpretations would merely reinforce his anxieties of intrusion and reincorporation by the object, but later on, it was possible to initiate and interpret an incipient differentiated transference, enabling him to exist for himself in the presence of others without fear of mutual intrusion and destruction.

In particular, Mr. A needed to become capable of acknowledging his incestuous wishes, in order to free himself from them

without the use of projection. These problems were partially reactivated by my occasional absences and replacement as leader by Dr. L. This situation enabled me to interpret that my absence and the handing over of my role to a woman rekindled in Mr. A the anxiety of having been abandoned by his father when his parents divorced at the beginning of his adolescence. It also reactivated the intolerable seduction of his mother's invitation to him to share her bed in the absence of his father; in that context, lidless eyes left him at the mercy of unbearable excitation, from which he had long been able to protect himself only at the cost of negative hallucination.

In an early session, having mentioned how impossible he found it to imagine sexual intercourse between his parents, Mr. A had agreed to play the primal scene and his wish to look through the keyhole. In the scene, he felt alone, confronted by what he called "a white hole," the aim of which was to banish any perception that might give rise to violence and terror—a "black hole." Our work on this scene enabled us to interpret the unconscious fantasy underlying his apragmatism and difficulty in earning money: earning a living like everybody else was tantamount to accepting the idea of having been born of a father and mother like everyone else, but this thought had been unbearable and unacceptable to him for a long time. Through acting the disavowal of the primal scene in psychodrama, we were able to defeat his psychotic mechanisms of disavowal and splitting of the ego, enabling him to introject the interpretation without his experiencing it as a violent intrusion into his psychic world. The working through of his ambivalence toward the primal scene allowed him to overcome the immobility concealed behind his fantasy of self-begetting.

Devouring Anxiety and/or Castration Anxiety

Transference interpretation became possible only after prolonged psychodramatic work, which enabled Mr. A to represent and tolerate his violent, murderous impulses. One might wonder whether the temporary change of psychodrama leaders allowed

him to begin to process the distinction between men and women, and to undertake an incipient differentiation of parental imagoes.

This was the context of Mr. A's first transference dream, *in which he brought me a huge bunch of fragrant, colored flowers, behind which I disappeared.* This highly condensed dream was indicative of a capacity to stage a reversed Oedipus complex by projecting the female position onto the male analyst, while at the same time representing the patient's anxieties about the flower-as-woman-as-vagina. In this way, he was returning to a fantasy of dangerous flowers that had been a theme of earlier scenes—representing, at one and the same time, the wish to breathe the scent of the flowers and to touch them without thereby being devoured and destroyed. These scenes may well have contributed to the latent dream thoughts.

In that session, Mr. A mentioned a relationship with a woman, which he had broken off after an experience of impotence: "Maybe it was my fault; one day she went upstairs in the nude and I lost my erection." I then invited him to play a scene to give us a better understanding of what had happened. He chose Dr. B to play the part of himself and Dr. L that of his girlfriend, while he took the role of observer and of his own double. Dr. L played the seduction scene with high-heeled shoes and sexy underwear, while Dr. B manifested increasingly intense desires. Mr. A was unable to stop himself from commenting on his attraction to women's shoes, or from expressing accusations and prohibitions. Finally, he made an insistent demand: "Tell me why it didn't work." I then asked Dr. I to play his mother. She said to him, "You little brat—you've just seen me naked in the bathroom." The patient retorted, "No, I've never seen you naked." Stepping outside the scene for a moment, he added, "But I did look into the bathroom; there were pipes and I wondered what they were for."

I interrupted the scene to allow us to consider the significance of this insistent demand, and pointed out that one of the reasons why he had been turned off was perhaps that his girlfriend was completely naked, rather than endowed with all the appurtenances referred to by Dr. L. His interest having been aroused by this

hypothesis, he suggested playing another scene, involving the scent of flowers. He remembered walking in a botanical garden as a child, and that he had liked to breathe the scent of the flowers; he now wanted to play this scene, casting the women in the role of flowers and the men as trees. Many elements were suggested to him by the scene—not only the intoxicating, bewitching scents, but also the perfume of the untouchable virgin flower, with its reference to his earlier psychotic hallucination of the Virgin. The tree-men told him to beware of being trapped by all these flowers and to calm himself by taking refuge with them instead.

This scene is reminiscent of the second act of Wagner's *Parsifal*, with its bewitching flower maidens and the seduction of Kundry that suggests mother love; the hero, of course, draws back from this seduction in the face of castration anxiety, represented by the incurable wound of the knight Amfortas. In the same way, Mr. A expressed the danger inherent in the flowers that might devour him if he got too close, and the importance of distinguishing between the scent breathed at a distance and the flower that was liable to devour you if you touched it. Faced with this dilemma, Mr. A hesitated between, on the one hand, the fetishistic solution, in which a woman was desirable only if a material reality, "an inanimate adjunct contiguous to the body" (Pasche 1975, p. 52), could be interposed between the mother imago and the subject himself, and, on the other, the homosexual solution (taking refuge with the tree-men), which entailed forgoing the wish for a woman.

Interestingly, while grappling with the problem of the nature of sexual desire and the conditions for its existence, Mr. A contemplated a fetishistic solution in order to tackle both castration anxiety and the psychotic anxiety aroused by the possibility of being devoured by the archaic maternal imago—thus demonstrating the importance of both genital and pregenital aspects in the constitution of the fetish. This sequence illustrates the great distance traveled by Mr. A in his psychodrama, via a technique that laid the foundations for a process of symbolization in which the patient was enabled to accept himself as a wishing subject, and thereby to overcome his psychotic anxieties. These anxieties had left him

with the delusional "cure" and the temptation of suicide as the only possible solutions.

Mr. A's Love Life and Its Vicissitudes

Some time later, this opportunity of working through his anxiety in relation to women enabled Mr. A to strike up a relationship with another young woman, M, with whom, in contrast to his previous liaisons, he was eventually able to enjoy satisfying sexual experiences that did not preclude tender feelings. In one session, Mr. A expressed surprise at several dreams of the night before. In one dream, *he was with his girlfriend, but she actually looked like another woman friend who was older, and, he said, not pretty;* he added that in another dream, *he was in bed with his mother;* he commented that this might mean that he wanted to sleep with her.

The patient now wanted to play a scene incorporating these dreams. Unlike many previous scenes in which he had cast himself in the role of observer, he decided to play the part of himself, giving the part of M to Dr. V, that of the older woman in the dream to Dr. G, and that of his mother to Dr. E. In playing the scene, he expressed his wish to be close to M and to be apart from the other woman and from his mother.

Interestingly, he then mentioned another dream of the same night, in which *he saw a woman who had a little mustache like Hitler's.* This induced the various protagonists to point out not only that he saw women as dangerous dictators, but also that this dictator role corresponded to a part of himself that wanted to subjugate women. He concurred with these comments.

Another point raised was that desires for other women might lurk behind the patient's commitment to M, and that "one train might be hidden behind another."[2] After this scene had been staged and I asked Mr. A what he thought about it, he was surprised to find himself feeling like someone who sometimes had a penis and

[2] *Translator's Note:* A warning sign to this effect is displayed at all French grade crossings.

sometimes did not; it was therefore possible to experience sexual desire and at the same time the fear of losing it. In his associations after the scene, he added that, in the dream of the dictator-woman, she was pulling his penis, which hurt. He then recalled a childhood memory in which his parents had taken him to a doctor who had examined him for a suspected phimosis: "He pulled my penis and it hurt a lot." Whereas he had been confronted for a long time with annihilation anxiety in regard to women, he was manifestly able to bind this in the form of castration anxiety.

He decided to stage this scene, too, once again opting to take the part of himself. He assigned the role of the doctor to Dr. B, that of his father to Dr. I, and that of his mother to Dr. R. In the scene, Dr. I (his father) showed him that, by indulging in masturbatory pleasure while thinking of his mother, he was bound to fear that his penis would be cut off; Dr. I, a female therapist, was thus taking the part of the father in enacting the prohibition of incest and the threat of castration. Mr. A was surprised to note, as the scene was played, that the castration threat came from a man and not a woman.

Afterward, when we discussed the link between the patient's desires for his mother and his anxiety about his penis, he said for the first time that he remembered noticing his mother was beautiful while walking with her in the street; he remembered having found her beautiful in a photograph on another occasion. His emphasizing that this feeling had been aroused by a photo indicated a need to place a distance between his desire and the reality of his mother. He then produced a surprising confirmation of this interpretation, in the form of an association to a memory dating back to the age of thirteen: "I remember that, once while I was in my mother's bed, I wanted to see her breast, and then, all of a sudden, I went blind in one eye." The session ended with this association, which recalled the fact that, just as he entered adolescence, his father's departure had reinforced his incestuous desire for his mother, giving rise to overwhelming castration anxiety. However, this had not prevented the development of an an-

nihilation anxiety that related not merely to a part of his body, but to the whole of it. The dream of the lidless eyes was thus confirmed by a dazzling incestuous cathexis resulting in blindness, analogous to the self-mutilation of Oedipus.

In this regard, it is interesting to note that, although in this second scene Mr. A assigned the role of his father to a woman, his representation of a woman included a masculine attribute—a mustache—thereby suggesting the image of an uncastrated, dominating woman. Adolescence had forced him to confront the theme of maternal castration, which was unacceptable to him because it suggested the possibility of his own castration; this led to his denial of maternal castration and the "rent in the ego" represented by splitting. Evidently, then, in the previous session, in which he had expressed his anxiety about naked women and his attraction to women's shoes, fetishism had appeared to him as a possible solution to the problem of keeping up his sexual desire for women. In psychosis, anxiety affects desire and the drive itself, thereby threatening to destroy the subject's very being.

Psychodrama enabled Mr. A to assure himself that his destructiveness was not absolute, and hence to accept a tendency toward differentiation from the object that did not entail the disruption of narcissism. According to Kestemberg (1984), the capacity to experience an impulse of primary homosexuality, corresponding to the acceptance of tender feelings toward the object, permits the toleration of pleasure induced by the object without immediate destruction. Psychodrama thus allowed Mr. A to overcome his psychotic defenses.

Anxiety Induced by Maternal Femininity

An important aspect of Mr. A's psychodrama in the latter few years was the working through of his anxieties about being swallowed up by the maternal object. This was reflected in a large number of scenes in which he described difficult relationships with women that led to his feeling completely drained, both affectively and financially.

The working through of this anxiety concerning maternal femininity enabled him to enjoy a more satisfying relationship with his girlfriend, M, as was clear from the previous session, in which, by virtue of the dream of the three women, Mr. A had been able to work profitably on recognizing differences between the sexes and the generations.

A month later, Mr. A was to show how the interpretation of sexuality correlated with the working through of anal erotism, the only possible way of overcoming the confusion between subject and object and between the various erotogenic zones. On Mr. A's arrival, I told him that Dr. N would not be there that day, but Dr. N then appeared unexpectedly during the course of the session. Seeing that Mr. A was puzzled, I asked him what he was thinking, and he replied: "Well, I heard that Dr. N was going to be away, but I was thinking that someone else was not here." I asked, "Who?" and he replied, "A woman—M."

I commented that we could give some thought to this impression that M was not there, and that we could stage this scene. Mr. A cast Dr. B in the role of himself, chose also the part of the double for himself, and asked Dr. R to play M. Acting as Mr. A, Dr. B turned to his double and told him that M was not there, and that he needed her to be there all the time without fail, in order to feel strong. In the role of his double, the patient replied, "No, it's too much—she can't be there all the time. It would be like being glued together." Dr. B, acting the patient's part, commented: "You must be able not to be there all the time with her, because otherwise you won't be able to think."

Dr. R, as M, then expressed the wish to be with Mr. A. At this point, Mr. A said that C, his male friend, had come to see him and told him, "You are in a *ménage* [a relationship]." Mr. A had replied: "I don't like the word *ménage* because it puts me in mind of *faire le ménage* [doing the housekeeping]."[3] Dr. R associated to the mother's doing the housekeeping—shaking out bedclothes and

[3] *Translator's Note:* Here there is a double meaning: the word *ménage* can mean both *a relationship* and *housekeeping.*

getting rid of bad smells, and therefore rushing about all over the place. She said to the patient, "You're like dust, so you must disappear"—echoing his mother, who had once commented on his birth as follows: "You were born like mailing a letter," which he had interpreted as: "I was born like a turd."

Dr. R then countered, "But I'm M, not your mother, and that makes a difference." At this point, I interrupted the scene, commenting to Mr. A: "There is indeed a difference between M and your mother, and when something reminds you of the idea of being a child, that's the point when you can no longer feel good with M." The patient's immediate association was: "I had a dream: *I was in a gut; I was looking for the way out, but could not find it.*"

When I suggested that Mr. A stage this dream, he specified: "Let us act a scene in the subway; there will be a map." After casting himself in the role of the map, he changed his mind and assigned it to Dr. M, instead taking the part of himself. He then cast the other therapists in the role of subway passengers. Each was trying to find his or her own route, traveling around in the subway as though inside a human body. Dr. G was talking to her husband, who had gone the wrong way, and instead of inserting his penis into her vagina, he had put his head in there to explore what was going on inside. Mr. A declared dreamily, "It's like a cathedral, like Notre-Dame"—suggesting a baby's sense of wonder in its mother's arms.

At the same time, other psychodramatists were asking what happened when you went in through a hole in front, or through a different one behind. In a questioning tone, Mr. A inquired, "They must join up somewhere. Where is it—in the navel?" This question demonstrated his confusion about the vagina and anus.

Mentioning the various orifices of the head, Dr. V said that the map would show where to go in and where to come out again. Mr. A's association was: "No, I can't see; I don't know where I'm at." Dr. R answered, "Yes, you're right—you don't know if you are on top, down below, in front, or behind; in the confusion, you can't think any more." Mr. A then remarked, "Yes, it's true. When you are glued together, you can't think any more, and that's why I need to get away."

After this last comment, which contained an important psychic truth, I halted the scene. I worked with Mr. A on the idea that he might have experienced his relationships as being in confusion—confusion between the body's holes, between the sexes, and the difficulty of getting his bearings between himself and others. I suggested that this had probably been his own childhood experience when he had needed to remain glued to his mother, but that now, through our work, he was able to think about it, and the distance he thereby gained had enabled him to find within himself the wish to feel like a man with a woman. Mr. A replied, "You're right; I never knew how a man and a woman were made." This was an expression of the tragedy of his existence—that of a child in a state of adhesive identification with the mother, like the image he had presented to us at the beginning of the psychodrama: someone totally subjected to other people's wishes and lacking a firm outline, as though he were transparent.

While this session presented an image of the body in the form of a *strainer*, with its metaphors of a black hole, an endless flow, falling, and dissolution, it also suggested the body's constitution as a *system of pipes*, one of the central images arising in emergence from autism (Tustin 1986, p. 227). This metaphor suggests the revitalization of the psyche by the body, and hence by the object, in accordance with the image of blood circulation and channels of digestion and defecation. The fact that Mr. A, in his dream, was enclosed in a gut surely expressed his anxiety at the possibility of being swallowed up by the maternal female object.

Through its representations, the dream also expressed an incipient regulation of bodily orifices, which were now no longer mere holes reminiscent of the ones that stood for the discontinuity between subject and object, but were also indicative of a rediscovered intercourse with it. This was a constitutive experience of anal erotism, through the establishment of a dialectic of preservation and loss—a telling metaphor of the mutual relations between the belly and the mind, in which the body assumes a psychic dimension and the psyche a physical incarnation.

Anxiety Aroused by Female Erotism

Through acquisition of density, corporeity, and a vigorous inner life, Mr. A provided himself with the psychic means to rediscover the route to genitality and creation. In the next session, after an initial silence, Mr. A said that he had failed to find a full-time job. But he had been doing some drawing and had combined oil paints and pastels, wondering if they would go together. When I asked him what he thought and whether he was satisfied with the result, he answered that it was not bad and that he was satisfied rather than dissatisfied.

In addition, he produced the association that he wanted to be paid by S, who ran the software house for which he occasionally worked part-time. There had been many prior sessions in which he had mentioned his difficulty in getting paid by S, who kept putting him off. Although he complained about her, his continued passivity confirmed the existence of an unconscious complicity of incest with his employer, as though she were his mother.

In this session, he mentioned that S was not prepared to pay him and that he was losing patience. He associated to his relationship with M, saying that, although he wanted a sexual relationship, it was actually she who wanted to make love all the time. When he fell silent again, I pointed out to him that he had mentioned three things: *love*, *work*, and *painting*. When I asked him what connection there might be between the three, he replied: "The satisfaction of satisfaction."

I then suggested playing a scene to include M. Mr. A played the part not of himself but of the double, casting Dr. N in his own role and Dr. I as M. The performance began with Dr. I's having M say, "Anything goes; let's take advantage of it." Mr. A held back, wishing to set limits and thereby to control the situation. Dr. I (M) said to him, "Well then, perhaps you could ask for money." Mr. A answered, "Don't be stupid! That's impossible—but I must say, it did occur to me that I could ask you to advance me enough for the rent." Dr. I, as M, responded sharply, "If that's what you're thinking, it turns me off; go and tell S to fork out the money she

owes you, rather than asking me for something like that!" The psychodramatists continued the scene by referring to the pleasure of painting, and the fear that, as in lovemaking, satisfaction might be raised to an uncontrollable pitch.

Halting the performance, I commented that money fulfilled the function of setting limits to pleasure, but that at the same time, it became something that would eliminate satisfaction. The patient's association was that "M is possessed," and that he would like to "strip her of something of hers." He now wanted to stage a scene with M in which he would strip her of her capacity for pleasure. He chose Dr. V to play M, asking Dr. B to play the part of himself, and opted to act as his own double.

Before playing this scene, Mr. A had another association, to a dream he had brought in previously, in which *he was with a woman with a big ass on a motorcycle and was to ride pillion.* He had acted this scene with Dr. V, who had mimed a woman mounting a motorcycle. The patient felt that her ass was squashing his face, turning into something so terrifying that the scene had to be halted.

In the ensuing scene, again staged with Dr. V, Mr. A protected himself from the confusion and violence of unlimited sexual pleasure. The psychodramatists attempted to show him that the "possession" was inside himself. Dr. L made a comment about painting, asking him what he felt when he combined pastels with oils. He answered, "I apply oil paint and wait for it to dry. When it's dry, I use the pastels, and it must not be wet—you mix them, but not too much, because if you mix when it's wet, it all tends to get lost."

Stopping the performance, I reflected with the patient on his need to separate oils and pastels clearly, in order to avoid total confusion, remarking that this was probably what he felt in lovemaking when a woman expressed an unlimited wish for satisfaction. For each person to remain whole, one had to keep one's distance.

Lovemaking challenged Mr. A with the limitlessness of female erotism and the need to be able to experience narcissistic regression in lovemaking in the same way as in artistic creation—to lose one's boundaries momentarily, without fear of disorganization.

This underlay his view of temporality as a regulation of anxiety represented by a tendency toward the limitless and the timeless, in which one had to make love all the time, twenty-four hours a day. He commented, "You can't live on love and fresh air all the time." Painting also represented this tendency for boundaries to be lost; the painter (Mr. A) must not lose himself in a situation in which such regression was likely to lead to confusion. The only course, then, was to reestablish boundaries, but this could only be done at the cost of inhibiting the pleasure of painting, or of working without satisfaction. At the end of this session, Mr. A was surprised when this contradiction was revealed: "You're right —I do wonder why I get no satisfaction from work, because I enjoy what I do."

For a long time, Mr. A saw the tendency toward limitlessness and timelessness as synonymous with death. At the time of his attempted suicide, he had been very aware of the interval between aiming a pistol at himself and pulling the trigger. Similarly, when he had fallen into a river at the age of two, the experience had seemed to him like an endless pleasure. The quest for absolute satisfaction could lead to death, but this could be avoided by playing a scene in which he could dream of limitless satisfaction while remaining sheltered within the boundaries of the psychodramatic setting.

Psychoanalytic psychodrama thus made it possible for Mr. A to transform an intolerable passivity—too much presence or too much absence—into a receptivity favoring the introjection of the drive and the representation of the body in the psyche. Considered in these terms, the route traveled by Mr. A confirms the notion of the fear of maternal femininity as a primordial irrational fear of men when faced with the archaic maternal imago (Rich 2004). It also confirms the importance of allowing not only for a maternal femininity, but also for an ineffable female erotism, bound up with limitless female sexual pleasure—which arouses men's fear and envy, in accordance with the ideas of Cournut (1998):

> To counter the threat that the erotic and maternal aspects of femininity might, as Freud considered, give rise to the

> horror of possible castration, or, even worse, confront the male subject with the unrepresentable, thus entailing the risk of unbinding and consequent psychic death, psychic means of withdrawal, or indeed reinforcement, must be organized. [p. 405]

These means, in Cournut's view, are the possibility of *naming*, *representing*, and *introducing a dialectic*.

Psychoanalytic psychodrama enabled Mr. A to deploy these three strategies, or, in other words, to combine the three aspects of regression as understood by Freud—namely, topographic, formal, and temporal. It is worth pointing out that, after the sessions in which we worked on the patient's anxieties about the erotic and maternal aspects of femininity, he was able, for the first time —with the support of the protective superego of the leader and of the setting—to speak of his father as a man who was, perhaps, not so guilty after all. For a long time Mr. A had rejected any possibility of masculine identification with his father and grandfather. But if Mr. A's father was not so guilty, he might also be the bearer of the law protecting him from incestuous experience. These considerations gradually enabled the patient to free himself from the domination of S and to demand payment of his arrears.

Proceeding along this path, Mr. A was to find love and the pleasure of creation. The psychodrama sequence described above illustrates the *psychic creativity* that underlies both psychoanalytic work and artistic creation, both of which are based on the ego's twofold capacity to regress in the analytic sense and to fantasize. Creativity per se presupposes the occurrence of something else, too—namely, the translation of images, affects, and rhythms grasped in this way into a material representation—in this case, a painted canvas—the mastery of which is acquired and possessed by the artist, perhaps in accordance with a familiar code (Anzieu 1974).

Considered in this light, the discovery of the pleasure of painting in opaque oils combined with transparent pastels can be seen as the result of a reowning of bodily density and its projection onto a material. The painter's eye, then, is one that can overcome the opposition between dazzlement and blackness, insofar as the

painter's color vision brings about a correspondence with the entire palette of perceptions—olfactory, tactile, auditory, and visual —which come together in a synergy characteristic of what Bion (1963) calls the consensuality of the breast experience.

CONCLUSION

Through his psychodramatic work, Mr. A was thus able to work through his aesthetic conflict—a conflict described by Meltzer (1988) as the experience of the overwhelming presence of the object, the mother's beauty, which cannot be assimilated by the child if there is too great a distance between the "outside of the 'beautiful' mother, available to the senses" and "the enigmatic inside which must be construed by creative imagination" (p. 22). As Meltzer rightly points out, the child

> . . . has, after all, come into a strange country where he knows neither the language nor the customary non-verbal cues and communications. The mother is enigmatic to him; she wears the Gioconda smile most of the time, and the music of her voice keeps shifting from major to minor key. [p. 22]

Painting and music here again correspond, thus accounting for Mr. A's experience of having been unable to cope with his mother's ambiguous messages, so that he had been condemned to suffer psychotic confusion and the impossibility of integrating his intellectual, affective, and artistic creativity. The need here, in Bion's terms, was to transform the elements corresponding to intrusive, unassimilable sensations into ones conducive to thought, dreams, and fantasies. This is in line with the description given by Laplanche (1987), in the context of his generalized seduction theory, of the child's need to make sense of the mother's enigmatic messages.

Through the words, actions, and affects of psychodramatic performance, Mr. A experienced a kind of joint creation that enabled him to integrate these enigmatic messages and to negotiate his

search for the absolute without disorganization and loss of self. The rich analytic work accomplished by Mr. A is thus indicative of the possibility of representing the interplay of outside and inside that underlies all creation, and of finding pleasure in it without loss of self. This experience is echoed in the description given by Merleau-Ponty (1964a) of the conditions of the painter's creative power: "The painter's vision is a continuous birth . . . in which one no longer knows who sees and who is seen, who paints and who is painted" (p. 32).

It is quite conceivable, then, that psychodrama enabled Mr. A to experience this continuous birth, and thereby to accept the vicissitudes of birth and death, the primal scene, and human sexuality. Emerging from psychosis in fact signifies the possibility of accepting the limits inherent in human existence, and, subject to this condition, of *living* one's life instead of dreaming it. It also involves the possibility of abandoning frozen, immobile time in favor of the dimension of internal duration, which correlates with access to psychic conflict.

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THE OTHER SIDE OF OEDIPUS

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The Oedipus complex has been understood as a series of conflicts between feelings of love and hate (sexuality and aggression) in the relationship between the child and his/her parents. This article presents a different view, defining oedipal struggles as conflicts between love and care, sexual desires and self- and object-preservative needs. The crucial conflict the child has to deal with is: to love the one and nevertheless to preserve the other (the rival). Further, the author distinguishes between monolithic conflicts, *which are conflicts between different objects of one drive's strivings, and* binary conflicts, *which involve the objects of both basic drives. In three illustrative examples, she shows that monolithic conflicts can indicate a regressive movement, while binary conflicts tend to foster a progression in the analytic work.*

The royal conflict in psychoanalysis is the *Oedipus conflict.* Discovered during his self-analysis in 1897 and formulated in his *Interpretation of Dreams* in 1900, this jewel of Freud's psychic archeology was cherished by him throughout his life, and he did not hesitate to make its recognition "the shibboleth that distinguishes the adherents of psycho-analysis from its opponents" (1905, p. 226n). In fact, Oedipus Rex became the most famous amongst Freud's ancient

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heroes, and—as frequently portrayed in all sorts of cartoons—Oedipus even advanced in public culture to some sort of representative of psychoanalysis itself. Thus, everybody knows about Oedipus—the man who killed his father and had sex with his mother.

However, this version of oedipal conflict presented only a rough general scheme. In further exploring this important period in human development, Freud eventually realized that the oedipal situation is actually a configuration made up of *several* conflicts—a fact that he acknowledged in 1910 in introducing the more comprehensive notion of the *oedipal complex*. This complex of conflicts was not just about love and hate or sexual fantasies and rivalry; it included the narcissistic injuries of gender and generational differences, castration anxieties and penis envy, the many versions and failures of infantile sexual theories (compromise formations between the eagerness and anxieties to know), and it was complicated by constitutional bisexuality, expressed in the positive and negative Oedipus.

Few concepts have been so extensively elaborated in innumerable papers and books, both in support and in negation of Freud's conception, as has the Oedipus complex. Yet I contend that there is more to it—a whole other side of Oedipus that plays a silent though crucial role in the many conflicts that haunt our patients throughout their lives.

As analysts, we struggle with conscious and preconscious derivatives of emergent neurotic conflicts, while trying to analyze how the dynamic unconscious is involved in them, because

> . . . the pathogenic conflict in neurotics is not to be confused with a normal struggle between mental impulses, both of which are on the same psychological footing. In the former case the dissension is between two powers, one of which has made its way to the stage of what is preconscious or conscious, while the other has been held back at the stage of the unconscious. For that reason the conflict cannot be brought to an issue; the disputants can no more come to grips than, in the familiar simile, a polar bear and a whale. A true decision can only be reached

> when they both meet on the same ground. To make this possible is, I think, the sole task of our therapy. [Freud 1916-1917, p. 433]

What a subtle warning to the clinician: You might lumber with your patient like the polar bear that sometimes catches a fish while the major part of the conflict keeps on moving, like an archaic, mysterious sea-mammal, a whale, in the depths of the unconscious —it takes a while before it shows up for a moment, then disappears again and leaves us back on the ice floe.

Smith (2003), emphasizing the central role of conflict in psychoanalysis, has recently highlighted the essential positions of Freud, as well as those of some prominent American theorists (Brenner, Boesky, Gray, Kris, Bromberg, and Pizer), concluding that conflict is ubiquitous, and can be observed, analyzed, and described with different methods and on different levels of abstraction. The two levels of abstraction on which I choose to explore the basic tenets of the Oedipus conflict are the theoretical and the clinical perspectives of drive theory. I contend that if we resist the trend to marginalize the past (Smith 2001) and to limit ourselves to an "archaic view of drive theory" (Smith 2003, p. 89), we can think in new ways about this most archaic side within ourselves, as it is conceptualized in drive theory, and learn something new about the many conflicts of the Oedipus complex.

Thus, I will not address here either modern developmental theories or infant research. Instead, I will stay with the basic psychoanalytic scheme of the Oedipus complex as presented by Freud and by Klein—because these views still provide our basic, background understanding—and I will add to these perspectives another view, based on the concept of the preservative drive.

THE PRESERVATIVE DRIVE: A METAPSYCHOLOGICAL SKETCH

It is my understanding (Schmidt-Hellerau 1997, 2001, 2002, 2003a, 2003b, in press) that an important shift in Freud's theoretical think-

ing with far-reaching consequences, equal to those of the move from the topographic to the structural model, occurred in 1920, when Freud reorganized his drive theory. Up to that year, he had conceptualized the dynamics of mental life on the basis of two primal drives, the *sexual* and the *self-preservative drives*. This idea, borrowed from Darwin, formed part of Freud's lifelong interest in evolutionary biology, and it made sense: *preservation* and *procreation* seemed to be the two success categories in the evolution of each species. Of course, Freud focused his research nearly completely on the sexual drive, leaving the self-preservative or ego drives (as he called them from 1910 on) much on the sidelines. However, he never abandoned the concept of a self-preservative drive, not even in the midst of his struggles with the introduction of narcissism (1914). Yet in his famous essay "Beyond the Pleasure Principle" (1920), he fundamentally rearranged the definition and division of his drives—which had a tremendous impact on the further development of psychoanalysis.

It was not so much the new notion of his pair of primal drives, the *life drive* and *death drive;* rather, it was their conceptualization, and the transition from the first to the second drive theory, that changed things dramatically. In this 1920 turn, the original antagonism of self-preservation and sexuality was *jointly* subsumed under the umbrella of a *life drive* (Eros)—while the new *death drive* was understood as an *aggressive drive*. Thus, *sexuality and aggression* emerged and prevailed as the two basic motivating factors in mental life.

It goes without saying that aggression is an important phenomenon in human behavior and mental life. However, as I have expressed elsewhere (Schmidt-Hellerau 2001, 2002), I doubt that it is wise to conceptualize aggression as a primal drive, or that it is *in itself* a motivating factor. Yet more important here is that, in consequence of Freud's 1920 shift, the concept of a self-preservative drive got lost. Even though sexuality and self-preservation can easily be thought of as contributing to life—at least according to a phenomenological plan fitting the term *life drive*—it seems to me a crucial factor that we are able to distinguish in the material of our

patients between what is *sexual* and what is *preservative,* or between what is *love* and what is *care.* And without the concept of a preservative drive, we have a much harder time being aware of these differences and recognizing their specific strivings—if indeed we pay attention to them at all.

It is quite an amazing fact that such a basic and primal need as self-preservation could become marginalized in our thinking, or even excluded from psychoanalysis, as Laplanche (1997, p. 153) suggested.[1] Thus, it has strangely escaped our theoretical and clinical perception that *the struggle to survive,* in its many derivative and often subtle expressions, is something *man is constantly and powerfully driven toward*—something that actually involves and stirs up a considerable amount of our daily mental activity (we cannot help it). Following is a rough outline of what *self-preservation, understood as a comprehensive drive activity,* might be about.

On a physical level, self-preservation concerns our general bodily well-being. This includes, e.g., eating, drinking, digesting, defecating, breathing, resting, sleeping, being warm and clean, and immunologically well defended. Psychologically, anxieties and neurotic, perverse, or pathological derailments around these issues include fantasies of engulfing, stuffing, starving, suffocating, and dying while sleeping, to name a few examples. Further, the different versions of rescue fantasies (both passive and active) revolve around survival; greed and stinginess stem from the wish for it; anxieties of becoming infected or poisoned, obsessions with washing oneself and cleaning things are also based in it; and eating disorders, hypochondria, and psychosomatic diseases seem to be parts of this same family. There is no doubt that all these fantasies, anxieties, and pathological formations are complex configurations that need to be analyzed in detail. At the same time, however, I propose that they can be advantageously understood as mainly *driven* by self-preservative and survival needs.

[1] In a few exceptions, the notion of a self-preservative drive has been considered (Loewenstein 1940; Modell 1985; Plaut 1984; Simmel 1924, 1933, 1944; Young-Bruehl and Bethelard 1999).

Further, I suggest that we are driven not only to *preserve ourselves*; we are equally driven *to preserve those we care about.* Most prominently, we experience the driven nature of these preservative strivings as mothers with babies or parents to our children. To nurture, preserve, and protect one's children is such a powerful drive that we are not surprised to hear of parents' risking or giving their own lives in order to preserve those of their children. Thus, since the object is "what is most variable about a drive and is not originally connected with it" (Freud 1915, p. 122), the notion of a *self*-preservative drive was misleading. We are better off calling it a *preservative drive,* implying that it is viewed as directed toward oneself *as well as* toward another object; its strivings are thus *self-preservative* or *object preservative.*

We are accustomed to talking about what we conceptualize as *sexual drive activities,* making use of the energy term *libido* in speaking simply of libidinal objects, libidinal strivings, or libidinal investments. Freud never came to terms with an energy notion for the self-preservative drive (although he briefly tried using the word *interest).* For reasons elaborated elsewhere (Schmidt-Hellerau 1997, 2001), I have suggested the term *lethe* as an energy term for the preservative drive. Having this notion enables us to talk about a *lethic object* (which can be both an object to nurture, as is the baby, and a nurturing object, as is the parent), or lethic strivings (as in wanting to be taken care of, as well as wanting to take care of someone else), or lethic activities (e.g., eating, cooking, cleaning, and so on, as mentioned above).[2]

On the affective-behavioral side, there is a range of healthy to pathological expressions that I attribute to *lethic strivings.* These include a tendency toward carefulness, introversion, quietude, and silence—on up to mutism—all processes of mental digestion. These represent healthy caution and hesitation, but also rigidity and immobility; the capacity to be alone, but also withdrawal; and, finally,

2 *Lethe* is a term taken from Greek mythology, meaning *forgetting.* It therefore captures the quieter tendencies of the preservative drive—including resting, sleeping, and perhaps healthy forgetting (its repressive function).

they include hopelessness, coldness, darkness, heaviness, sadness, passivity, absence, falling asleep, depression, lethargy, and suicidal thoughts.

In contrast, we might assume a dominance of *libidinal strivings* when we work with a patient who loves, fights, and talks, but is also chatty or even logomanic, moves yet also rushes to conclusions. Such a patient may be quick, funny, clear, active, creative, spirited, alert, flexible, cheerful, happy, social, and may show initiative—but is also restless, hyperactive, manic, and so on, just to mention some strong libidinal opposites to the former lethic ones. This indicates a major shift: Freud based his drive antagonism of *sexuality* and *aggression* on feelings of *love* and *hate*. I suggest affective opposites for the antagonism of the sexual and preservative drives, such as *lively* and *deadened*, *happy* and *sad*—or, as Freud (1930) put it, *noisy* and *silent* (p. 119), or, in Damasio's (2003) terms, *joy* and *sorrow*.

BINARY AND MONOLITHIC CONFLICTS

Amongst the different ways of thinking about conflict, I want to show how drive theory can illuminate our understanding of psychic conflict. In 1910, Freud stated:

> Our attention has been drawn to the importance of the drives in ideational life. We have discovered that every drive tries to make itself effective by activating ideas that are in keeping with its aims. These drives are not always compatible with one another; their interests often come into conflict. Opposition between ideas is only an expression of struggles between the various drives. From the point of view of our attempted explanation, a quite specially important part is played by the undeniable opposition between the drives which subserve sexuality, the attainment of sexual pleasure, and those other drives, which have as their aim the self-preservation of the individual—the ego-drives. As the poet has said, all the organic drives that operate in our mind may be classified as "hunger" or "love." [pp. 213-214]

Here as well as on many other occasions, Freud not only links *ideas* directly with *drives*—thus, whatever comes to mind can be viewed as representative of an ongoing drive activity—but he also conceptualizes conflict as a struggle between the two basic drives, namely, sexual and self-preservative. Whichever drive is stronger (i.e., supplies more energy) will prevail and suppress the other and its related ideas. It follows that in this conception, the energetic side of repression (the force required to suppress any drive activity) is provided by the opposite of each of the two drives (Schmidt-Hellerau 1997, 2001).

Conflicts that involve *both* basic antagonistic drives can be called *binary conflicts*. According to Freud's statement, they would manifest in a struggle or shift of the guiding *ideas*, which include the aimed-for *objects* and/or the kind of *satisfaction*. For example, thoughts about the libidinal object might be repressed and become permanently replaced by an increase in self-preservative thinking (such as obsession about nutrition or other concerns with health issues); or, if self-preservative needs seem unacceptable (shameful), they can be defended against by a surge in a promiscuous sex life.

In these examples, both drives involve different objects—the libidinal (love) or the lethic (care) object—with the repressed one fading out of sight or being replaced by the self as an object of this very drive activity. In a mature version of binary conflict, both drive objects stay cathected, e.g., "Shall I clean my apartment, or shall I go for a weekend trip with my lover?"—and the answer would be: first the one, and then the other (whichever comes first). Yet both drives can also aim for the *same* object and cause conflicts expressed by the question of, e.g., "Do I want to have sex with my partner, or do I want to take care of him/her?" While a healthy decision might momentarily opt for the one *or* the other, a rigid either-or choice indicates a neurotic defense.

In his two "Contributions to the Psychology of Love" (1910, 1912), Freud talks about people who fail to resolve these kinds of conflicts: "Where they love they do not desire and where they desire they cannot love. They seek objects which they do not need to love, in order to keep their sensuality away from the objects

they love" (Freud 1912, p. 183). Freud describes patients who suffer from total or psychical impotence or frigidity, or who show passion only for unavailable partners or for prostitutes. The interesting point here is Freud's explanation based on the strivings or currents of his two basic drives:

> Two currents whose union is necessary to ensure a completely normal attitude in love have, in the cases we are considering, failed to combine. These two may be distinguished as the *affectionate* and the *sensual* current.
>
> The affectionate current is the older of the two. It springs from the earliest years of childhood; it is formed on the basis of the interests of the self-preservative drive[3] and is directed to the members of the family and those who look after the child . . . . It corresponds to *the child's primary object-choice*. [1912, p. 180, italics in original]

It is worthwhile to note that in these failed love relations, Freud sees the conflict as not between *love* and *hate* (sexuality and aggression), but between *love* and *care*, the sensual (sexual/libidinal) and the affectionate (preservative/lethic) currents. In his understanding, mature love necessitates the union of both drives' currents. To put it differently, mature love requires a structural integration of the love and the care object, a convergence of both drives onto one object. Love relations fail when the self-preservative drive's *affectionate* strivings for the *primary object* remain *divided* from the sexual drive's *sensual* strivings. Thus, we must not mistake the *affectionate* for the *libidinal*. The distinction might become more apparent if we stay with the above wording and differentiate between the *caring* current of the preservative drive and the *sensual* strivings of the sexual drive. If there is a split of objects between the sexual and preservative drives, the sexual object cannot be preserved in a maturing relationship (i.e., the lover does not care for the love object), leading either to promiscuity, or—as we will see later in this paper in the example of Eveline—to a caretaker without a love life.

[3] Strachey translated Freud's *Trieb* with the word *instinct*.

All the examples above involve the activity of both drives, and thus they are binary conflicts. However, other conflicts may also play out between different objects without involving both drives, but instead only one of them—and I call these *monolithic conflicts*. Monolithic conflicts struggle with the choice of the aimed-for objects. In a developmentally early state, we might find on the side of the preservative drive an expression such as, for example, "Shall *I* eat all the cookies or give some to *my sister?*" Later in life, this same conflict may read: "Shall I take advantage of my insider knowledge and sell my stocks, or shall I care for all the other stockholders and notify the authorities of the state of accounts?" The failure of a mature resolution of this conflict—correctly called a greed crime—might indicate an unconscious exaggeration or perversion of self-preservative needs, and even more so when there is no awareness of any wrongdoing. An example of monolithic conflict on the side of the sexual drive is the unconscious struggle in narcissistic states of: "Shall I love *myself* or shall I love (give some of my love to) the *object?"* Or, in the oedipal phase, a monolithic conflict may be expressed in the choice of parental objects: "Do I love *mother* or do I love *father?*" Or later: "Do I love *mother/my analyst* or do I love *my spouse?"*

In wondering "what is a conflict about?," I suggest a basically simple answer: Conflicts are about drives and their objects. *Binary conflicts* play out between the preservative and the sexual drives (both of which might aim for different as well as the same objects). Since each of these drives involves its own cathexis of object representations, binary conflicts are more complexly structured, thus indicating a progressive line of psychic processes. By contrast, monolithic conflicts involve just one of the two primal drives and the struggle between its different objects—with the self's usually being one of them. I suggest that monolithic conflicts presuppose a powerful repression of the opposite drive's strivings, and/or a deep split between the two drives' objects, followed by a regressive state or movement. All fantasies, objects, or actions are then either sexualized or relate to being taken care of. When this is the case, we have to first deal with this division or split in order to equally

balance the spheres where the whale and the polar bear move—that is, to help the whale surface again.[4]

A CASE IN POINT: EVELINE

In order to illustrate lethic drive activities, as well as the above outlined types of conflicts, let us look at "Eveline," one of James Joyce's *Dubliners* (1914). (In the section below, the original text is printed in italics.)

> Eveline is nineteen years old, and she is about to leave home in order to marry Frank. On the day of her departure, she sits at the window, *the evening invades* her thoughts and she is *tired.* She looks around at her home, *all its familiar objects which she had dusted once a week for many years.* She thinks *she would never see again those familiar objects from which she had never dreamed of being divided.* She wonders, *was that wise? . . . In her home anyway she has shelter and food; she had those whom she had known all her life about her.* As she promised her mother when she died, Eveline has always worked *hard . . . to keep the house together and to see that the two young children who had been left to her charge went to school regularly and got their meals regularly.* Her father is hard on her—he is stingy, and Eveline *sometimes felt herself in danger of her father's violence . . . . he had begun to threaten her . . . . she had nobody to protect her.*
>
> This has been Eveline's life, a mostly lethic life: the hard work of cooking, cleaning, and caring for younger siblings, thus replacing the dead mother. This heightened demand and promise to be object preservative toward the family seem to have recently come into a (monolithic) conflict with Eveline's basic needs for self-preservation: she is *threatened* by the *violence* of her father and *has nobody to protect her.* Yet now she is about to embark on a new life.

[4] My suggestions resonate with Kris's (1985) notion of *divergent* and *convergent conflict*—except that here, convergence and divergence are specified as applying to the drives and/or their objects. Thus, monolithic conflicts are always divergent, while binary conflicts may be divergent or convergent.

She was about to *run away with a fellow, she would be married . . . . People would treat her with respect . . . . She was about to explore another life with Frank. Frank was very kind, manly, open-hearted. She was to go away with him by the night-boat to be his wife and to live with him in Buenos Ayres* . . . . He took her to the theater, and *she felt elated* . . . . *He was awfully fond of music and sang. People knew that they were courting and, when he sang about the lass that loves a sailor, she always felt pleasantly confused . . . . First of all it had been an excitement for her to have a fellow and then she had begun to like him.* When her father found out that she was having an *affair,* he demanded that it stop, and *she had to meet her lover secretly* . . . . She felt *she had a right to happiness.*

Here comes the love object, arousing pleasantly confusing feelings in Eveline when he sings of love and takes her to the theater and has *fun* with her. It seems as if sexual wishes have been stirred up, and Frank has become a libidinally cathected object: this fellow, this kind, *manly,* open-hearted sailor. Yet the *invading evening* has already cast a dark shadow on her mind:

Eveline is thinking about her *home*, her *shelter*, that *her father was becoming old lately . . . . He would miss her . . . . She remembers the last night of her mother's illness; she was again in the close dark room . . . . The pitiful vision of her mother's life laid its spell on the very quick of her being . . . . She trembled . . . . Escape! She must escape! Frank would save her. He would give her life, perhaps love, too. But she wanted to live* . . . . She was standing with Frank *in the station. He held her hand and she knew he was speaking to her . . . . She felt her cheek pale and cold and out of a maze of distress, she prayed to God to direct her, to show her what was her duty . . . . Their passage had been booked. Could she still draw back after all he had done for her? Her distress awoke a nausea in her body . . . . All the seas of the world tumbled about her heart. He was drawing her into them: he would drown her.* Having let go of him, *she gripped with both hands at the iron railing.* He called her again: *"Come!"* But *No! No! No! It was impossible . . . . Amid the seas she sent a cry of anguish!* He, already on the boat, called her to follow because the barrier was closing. *"Eveline, Evvy!". . . . She set her white face to him,*

passive, like a helpless animal. Her eyes gave him no sign of love or farewell or recognition.

This is the end of the story. How can we understand it psychoanalytically, in terms of Eveline's inner conflict? If we deal with this literary figure as though it portrayed the essentials of human conditions, and if we follow Freud's statement that "every drive tries to make itself effective by activating ideas that are in keeping with its aims" (1910, p. 213), then we can be deliberately simple and say: Eveline's conflict plays out between her preservative and her sexual drives and the objects and ideas/fantasies about them.

For a brief moment, she struggled with a *binary conflict* between love and care: *She had a right to happiness—yet was it wise* to go away from *food* and *shelter?* Praying that *God* would *direct her,* she seemed to give up resolving this conflict between her duties (of caretaking) and her rights (for love). Instead, her preservative strivings prevailed: *she wanted to live*—and yes, to *love,* too, but love took a back seat when she felt she had to rescue herself. Self-preservation (the familiarity of her home) and object preservation (caring for father and siblings) succeeded in completely repressing her sexual longings for the man who wanted to marry her and sing with her. Her *lethic thoughts* started to grow profusely, and the whale of her sexual strivings—having recently shown up and filled her with hope—disappeared again in the ocean of her unconscious.

At this point, we are no longer witnessing a conflict between going with the libidinal object or staying with the lethic objects, a binary conflict between *love* and *care.* Instead, it all turns *lethic,* ending up with simply the wish to be *saved.* At first, Eveline thought *Frank would save her*—but Frank did not carry the same familiar lethic cathexes as did her old objects. Thus, she let go of Frank's hand (and, with it, of his libidinal investment), completely falling prey to an excessive self-preservative panic. Who would rescue this *pale and cold, nauseated and helpless animal* that she then felt herself to be—and her conviction was: *Frank would drown her.* Was it her libidinal self that was drowning with the lost love object? In the vortex of her struggle to survive, Eveline could think only of res-

cuing herself by turning back to the poor and dusty, yet familiar, safety of her father's home. Her eyes had lost all signs of *love* or *recognition* for her lover.

What was for a little while a binary conflict between the two drives and their objects—*love* and *care*—has regressed to a monolithic preservative conflict between different objects: Would Frank take care of Eveline? Or should she take care of her aging father and younger siblings—in order to be taken care of herself by her family, in the end?

But couldn't staying with her violent father also represent a masochistic surrender to an unconsciously loved oedipal object? No doubt, there is masochism present, if only in its moral version. However, if we call Eveline's father an oedipal object, it might still be helpful to scrutinize whether her (a patient's) attachment to him is libidinal at all (tinged with infantile sexual longings), or whether it is predominantly object- and self-preservative (limited to issues of taking care of the object that is supposed to save oneself). This latter notion, at least, is where Eveline ends up in this story: all she can think of is the need to rescue her very survival.

KLEIN'S EARLY STAGES OF THE OEDIPUS COMPLEX

While for Freud, the Oedipus phase takes place between the ages of about three and five, Klein places the early stages of the Oedipus complex within the first year of life. The difference between the formulation of these two concepts was not rooted in factors related to the sexual drive—of which, as is well known, Freud acknowledged the existence from the time of an individual's birth onward. However, his understanding of structural development made it difficult for him to reconcile his views with Klein's. Freud postulated the mental representation of *one object* in the oral phase (a "me" who incorporates the mother and everything relevant to the infant's needs), *two objects* in the anal phase ("me" and "you"—with father and mother and everybody else being "you"), and *three objects* only in the genital phase, when gender differences start to

divide objects into *male* and *female*. Since the mental representation of an object is a crucial determinant of a drive's purposeful strivings, and since triangulation is basic to Freud's Oedipus complex, he called those phases preceding the mental acknowledgment of three different objects *preoedipal*.

Klein (1928), by contrast, proceeded from different assumptions about (inner) objects and object relations. Since she conceptualized objects as an active part of the infant's mental life from birth on, the existence of phantasies of triangular relationships—and, consequently, of the early stages of the Oedipus complex—were consistent with her thinking.[5] She suggested that, for both sexes, the Oedipus complex usually starts with weaning, and then takes on specific oral- and anal-sadistic features, mostly revolving around the mother's breast and phantasies about the good and bad contents of her body, urine, and feces, mingled with phantasies about the father's penis and the babies. Sadistic expressions of these early phantasies and actions were attributed to a primary *aggressive drive* that conflicted with the sexual drive. Thus, a failure to resolve early oedipal conflicts would weigh heavily (most often in an inhibitory way) on later sexual life.

I will use one of Klein's famous case examples, that of 10-year-old Richard, as a model to rethink, from my point of view, not the object concepts of Freud and Klein and how they differ, but instead, a different view of the *drives activating these early objects or their representations*. It is my view that conflict in these early years does not arise between aggression and sexuality, but rather between self-preservation and sexuality.

Klein (1945) portrays Richard as a boy who was "excessively preoccupied with his health and was frequently subject to depressed moods" (p. 340). His "suckling period had been short and unsatisfactory." His mother was depressive and was "very worried about any illness in Richard, and there was no doubt that her attitude had contributed to his hypochondriacal fears"; she "lavished much care

[5] The Kleinian spelling of the word *phantasies,* used specifically to refer to *unconscious fantasies,* is respected in this paper.

on him and in some ways pampered him." Richard "was over-anxious and over-affectionate towards his mother and clung to her in a persistent and exhausting way" (p. 340). In analysis with Klein, Richard drew a starfish, explaining that it was "a hungry baby which wanted to eat" (p. 342), and then an octopus, representing "his father and his father's genital" and unconsciously a "monster." He identified himself with a "destroyer" named "Vampire" and had it "bump into the battleship 'Rodney' which always represented his mother" (p. 344). Klein understands the bumping of the two ships as symbolizing sexual intercourse, and Richard's then pulling away from this as a "repression of his genital desires towards his mother" because of his fear of the "destructiveness of sexual intercourse" (p. 344), in consequence of the oral-sadistic character he attributed to it.

Richard, who suffered from an "unsatisfactory feeding period" (p. 362), and shared with his mother a heightened concern about both his and her health and well-being (depressed moods), seemed not to have been able to establish a solid sense of good self- and object preservation. However, a child's feeling of safety for the self and the nurturing object is a precondition for the capacity to phantasize about sexual penetration not as an act of destruction (endangerment), but as a pleasurable and procreative drive activity. Richard was afraid of his own penis because it seemed to him a "dangerous organ that would injure and damage his loved mother" (p. 365). *Thus, his sexual strivings were in conflict with his object-preservative needs.*

> Because of his unconscious fear and guilt about his own oral-sadistic impulses, however, infants predominantly represented to him oral-sadistic beings. This was one of the reasons why he could not in phantasy fulfil his longing to give children to his mother. More fundamental still, oral anxiety had in his early development increased the fear connected with the aggressive aspects of the genital function and of his own penis. Richard's fear that his oral-sadistic impulses would dominate his genital desires and that his penis was a destructive organ was one of the main causes of his repression of his genital desires. [Klein 1945, pp. 363-364]

It seems to me that Richard could not maintain a binary-conflict level in which his preservative and sexual strivings for his mother were sufficiently balanced. Instead, he seemed caught in a vicious cycle: oral, self-preservative frustration with his depressive mother might have (aggressively) intensified his lethic drive activity—making him a "vampire" who would attack and endanger his mother. Thus, he needed to withdraw, which increased his frustration and greed—and, consequently, his concern about his potential to attack his nurturing object ("He often asked, even after quite harmless remarks to his mother or to myself: 'Have I hurt your feelings?'" [p. 346]). His developing sexual urges further complicated these difficulties. The increased push of the sexual drive aroused phantasies of penetration and of intruding on the mother's body, which appeared as a catastrophic danger—thus necessitating a defensive regression to a lethic preoccupation with self- and object-preservative concerns.

Klein (1945, pp. 365-ff.) confirms Freud's above-mentioned contribution to the psychology of love as she formulated it in Richard—namely, the presence of a split between the affectionate (preservative) and the sensual (sexual) strivings (Freud 1912, p. 180), or, as Klein (1945) also puts it, a split between the "good breast-mother" and the "bad genital mother" (p. 346). Presupposing destructive damage, Klein then emphasizes a "drive for reparation" (p. 380) that counters aggression and supports feelings of love. This drive for reparation is *part* of what I would conceptualize as (object-)preservative drive activity. Klein describes Richard's conflicts, as well as early oedipal conflicts in general, as binary: struggles between sexuality and aggression. I would agree with her analysis and general conclusions while understanding these struggles as a conflict between the sexual and the preservative drives, with a hyperactivity of the latter.

THE LIBIDINAL SIDE OF OEDIPUS

Freud (1900) describes conflicts within the oedipal complex as what I would call *monolithic* conflicts (affecting the different objects

of just the sexual drive), even though they seem to exist as conflicts between sexuality and aggression: "It is the fate of all of us, perhaps, to direct our first sexual impulse towards our mother and our first hatred and our first murderous wish against our father" (p. 262). It is worth noting that *this is not a conflict between love and hate;* rather, these murderous wishes are fully in accord with sexual strivings for the mother; they occur in order to eliminate the paternal obstacle on the way to the libidinal object, and can be understood as a reinforcement or *intensification*—or simply as an expression of the sexual drive (Schmidt-Hellerau 2002). In fact, this conflict is not with mother, but instead arises because there are positive feelings (identification) for father as well (Freud 1923, p. 32). Yet are these feelings primarily "affectionate" (lethic), or are they "sensual" (libidinal)?

Freud bypassed this question by introducing his notion of *bisexuality* and the *negative Oedipus complex* (p. 33). Thus, he focused on conflicts between homo- and heterosexual fantasies about a *male* or a *female self* who is in a sexual relationship with a *male* or *female* object—stating that the boy also behaves as mother does and wants to be loved by father, just as mother does. This might bring up another conflict, one occurring around a confusion between *passive* as in "wanting to be loved" (receptive), and *passive* as female or homosexual. Thus, the child struggles between wanting to love mother, wanting to love father, wanting to be loved by the one, and by the other—and all of this at different times and without any annoying interference by the respective other.

With all these facets, Freud described a whole range of conflicts on the *libidinal side of Oedipus.* They all concern the sexual drive and its objects and work on the structural development of what I have called the *erotogenic self* and the *erotogenic objects* (Schmidt-Hellerau 2001, pp. 219-ff.). In the end, complete resolution of the Oedipus complex will require not so much the *repression* of the negative Oedipus as the *integration* of male and female identifications and strivings, in order to foster the formation of an erotogenic self that strives for and is empathic with the desires of the erotogenic object.

THE LETHIC SIDE OF OEDIPUS

Earlier, I suggested that monolithic conflicts tend to be more regressive than binary conflicts. Calling the conflicts Freud outlines for the Oedipus *monolithic* thus seems to contradict our common understanding of the progressive nature of this developmental period. Therefore, we might wonder whether lethic strivings and structural formations are occurring simultaneously with libidinal ones that so far have not been part of our general Oedipus concept, since their presence would elevate these struggles to the more advanced, binary-conflict level.

Freud (1923) suggests the arousal of considerable aggression not only within the jealous oedipal child, but also within his/her parents, which eventually—at the height of the Oedipus complex—leads to the threat of castration and the "demolition of the Oedipus complex" (p. 32).

> If the satisfaction of love in the field of the Oedipus complex is to cost the child his penis, a conflict is bound to arise between his narcissistic interest in that part of his body and the libidinal cathexis of his parental objects. In this conflict the first of these forces normally triumphs: the child's ego turns away from the Oedipus complex. [Freud 1924, p. 176]

Freud (1923), in focusing on the sexual drive, again presents this centerpiece of his Oedipus as a conflict between object-love (mother) and narcissistic self-love (penis); this conflict leads to the "transformation of object-libido into narcissistic libido," which is understood as a "desexualization—a kind of sublimation" (p. 30). However, if we are serious about Freud's concept of a self-preservative drive, then we understand castration anxiety as creating a binary conflict: on the one side, there is the libidinal desire to love mother; on the other side, there is the lethic need to preserve the penis/oneself—and, interestingly enough, self-preservation "normally triumphs," as noted in Freud's remarks above. I suggest that, in the shadow of the glamorous libidinal side of the oedipal conflicts,

there are important processes going on to deal with the child's self- and object-preservative urges and their conflicting, as well as balancing, potential; they constitute the other side of Oedipus, and advance these processes to an altogether more integrated binary-conflict level.

It should not come as a surprise that self-preservative strivings conflict with sexual ones when the latter begin to gain strength. Without reference to self-preservative issues, Freud (1932) speaks to the heart of these new difficulties by quoting Heine: *"Was dem Menschen dient zum Seichen/Damit schafft er Seinesgleichen"* [6] (p. 192). He elaborates:

> The sexual organ of the male has two functions; and there are those to whom this association is an annoyance. It serves for the evacuation of the bladder, and it carries out the act of love which sets the craving of the genital libido at rest. The child still believes that he can unite the two functions. According to a theory of his, babies are made by the man urinating into the woman's body. [1932, p. 192]

While these and other infantile sexual theories (Freud 1908) are well known—and we are certainly familiar with some children's and patients' worries about the genitals being dirty, sexuality being disgusting, and/or masturbation making people sick—we have not conceptualized these conflicts as *driven* by the *need for self-preservation* (e.g., being clean, healthy, not harmful, and also decent) and the *desire for sexual pleasure*. To conceptualize the "antithesis between the two functions" (Freud 1932, p. 192) of one organ (and later one object) is a mental challenge that affords the resolution of conflicts between lethic and libidinal drive activities.

Thus, a complicated task in the genital phase is to differentiate between what I have called the *biogenic* (preservative) and the *erotogenic* (sexual) functions and zones, and, further, between a *biogenic* and an *erotogenic self and object* (Schmidt-Hellerau 2001). The *biogenic self* demands to be taken care of and is preoccupied with

[6] Strachey translates in a footnote: "With what serves a man for pissing he creates his like."

taking care of him-/herself in order to be healthy and to feel safe and well. The *biogenic object* is the object who has to take care of, nurture, and protect the child and has self-preservative needs of his/her own that might require being taken care of by others. By contrast, the *erotogenic self* is pleasure seeking, as is the *erotogenic object,* which is also required as a pleasure-providing partner for sexual encounters in both direct and sublimated ways. *It follows that the complicated task of the oedipal phase is not only to differentiate between a male and female self and object; it is also to differentiate between biogenic and erotogenic self- and object representations.*

The subsequent step will afford this re-*union* of "the affectionate and the sensual current" (Freud 1912, p. 180). That is to say, the preceding *differentiation* (elimination of confusion) is the necessary precondition for a subsequent mature *integration* of both functions. Then the self will be represented as capable of taking care of him-/herself and others, while also having sexual pleasures, and, in addition, the object will be represented as self- and object preservative, while also being sexually exciting and enjoying him-/herself.

The active and passive strivings of sexual and preservative drives aiming for parental objects create a full range of conflicts within the triangular situation of the Oedipus. For the positive Oedipus, the formula says that the child's aim is to establish a two-person relationship that would eliminate the third—*the boy wants to love mother and fights against father.* Yet the child also expects to be taken care of by this third. This situation constitutes a conflict between *the wish to get the love object*—which requires fighting the rival—*and the wish to be taken care of by this very rival.* One way to resolve this conflict is to distribute the sexual and preservative strivings to both parental objects, keeping father and mother simultaneously cathected with different drive energies. We could thus visualize two sides to the oedipal structure: a libidinal front side that is balanced by a lethic reverse side.[7]

[7] A more detailed scheme of these conflicts was published in Schmidt-Hellerau 2001, p. 225.

If we look at it this way, the *active libidinal side of the positive Oedipus* would read: "The boy wants to love mother (as father does) and fights against the paternal rival." On the reverse side, however, another silent wish might occur: "The boy wants to take care of father (as mother does), and fights against the maternal rival." That is to say, the identification with both parents, father and mother, is constantly at work (the boy internally enacts the relationship with the parental couple). Further, we realize that feelings of rivalry are not limited to libidinal (erotic) strivings; they also come into play with lethic (caretaking) needs and urges (who does and gets the "better" caretaking?).

On the *passive libidinal side of the positive Oedipus,* we then find: "The boy wants to be loved by mother (as father is) and fears the father"—with its reverse side: "The boy wants to be preserved/protected by father (as mother is) and fears mother." The boy's wish to be also taken care of by father (as mother is) might feel competitive with mother's being cared for by father, thus creating the (later unconscious) fear of an envious, retaliatory action by her. Therefore, if we wonder why preservative wishes need to be repressed and become unconscious, we might remember that it is the gratification of these wishes within a meaningful relationship with parental objects, together with fantasies of envy and rivalry (arising from the infantile idea that *all love* or *care* goes to only *one* object, with nothing left for a second or third), that appear to be too dangerous to know about. The same active and passive configuration as described with the opposite objects would then apply to the scheme of the negative Oedipus as well.

In thinking about different combinations of libidinal-lethic conflicts, a much more complex picture emerges. We realize, for example, that there is a subtle but crucial difference between a negative homosexual wish (*the boy wants to be loved [penetrated] by father [his penis])* and a lethic wish (*the boy wants to be protected by father*)—in short, there is a difference between *love* and *care.* I think that the creation of structures to organize issues of care (for both male and female objects) is essential for psychic development and growth—and that these structures must exist *separately* from

issues of sexual love. Analysts must know about these differences (which do not presuppose aggression, I might add). This conception also ensures that the libidinal wish *to love mother* is counterbalanced by the antagonistic drive's wish *to preserve father*, which modulates the impulse *to fight against the father*—and thus, the sexual strivings for the maternal love object are eventually relinquished. Therefore, it seems to me that *the classical Oedipus conflict is not between love and hate, sexuality and aggression; it is between love and care: to love one parent and to preserve the other (rival), nevertheless* (see also Schmidt-Hellerau 2001).

In this manner, the basis for a triangular representation of object relations can be established—even though there is still one more step for the child to master: that is, to keep on loving and caring for his/her parental objects, even while realizing that they have loving and caring relationships with each other without the child's being part of the parental couple.

The outcome of these developmental achievements at the end of the oedipal phase is understood to be crucial for the development of the superego. As I have elaborated elsewhere (Schmidt-Hellerau 2001), the preservative drive's structures will form the foundation of the superego's protective functions (which could not be explained by aggression as a primal drive), while the libidinal precipitate (ego ideal) creates its orienting function; and both interact favorably in a balanced way.

LORA

In order to illustrate the complexity of conflicts of differentiation between sexual and preservative strivings, I will briefly sketch representative vignettes from the third and fourth years of a five-times-per-week analysis with Lora, a 35-year-old, married mother of three. She came to me because she often felt depressed and suffered from migraines, backaches, and frequent incontinence; she also had great difficulties in her marriage.

Lora grew up as the only girl among five brothers. She always felt devalued, incapable, and sad, and she remembered that she

cried a lot when she was little. She thought that people behaved "as if I weren't there." She might enter a room and nobody would look at her. Nowadays, she might cook an elaborate meal, but people would thank her husband when leaving. For a long time, she did not want to apply for a job because she was afraid people would find out that she could not do it. All her efforts seemed never to yield the appreciation she wanted so badly. She said: "I'll never be good enough; I'll never have it all. There is something missing." Our work often centered around understanding the links she made between being a girl/woman (not male) and the many disappointments and frustrations she had experienced in her life.

One day in the third year of her analysis, she told me of her recent birthday party. The band had played for her and she had danced all night. Eventually, the bandleader asked her on stage and she had sung a song. She felt great. "I walked around having the sense that my inside was out. I felt so powerful—it was really exciting!" That night, she dreamed the following: "I had to use the bathroom. I was standing over the toilet—it was a men's toilet—the water started bubbling up, and I was torn between having to go to the bathroom and the feeling that I could have an orgasm. I was so excited, yet I had to go to the bathroom."

Later in the same session, Lora wondered: "What do men do when they get excited and have an orgasm?" I said, "Your dream seems to say that there is a conflict with urinating." Lora answered, "Yes, I only learned at age nineteen that I had a vagina, and it was extremely uncomfortable to use tampons." She told me that she could not wear pantyhose; the stockings always wound around her legs oddly. "It drives me nuts being a woman!" she exclaimed. Many sessions followed that wrapped around penis issues, highlighting her fantasies, worries, and curiosities.

Lora lived with the unconscious wish to have an inner penis—which, as it turned out, was one of the reasons that she was unaware of having a vagina until she was nineteen. As a part of her sexual fantasies, this was an important source of hope: one day, she would make it; and it was also a constant source of renewed disappointment: she would never have it all. In this brief vi-

gnette, she demonstrated that she finally felt recognized and accepted by the men in the band at her birthday party, joining them as alike (male). She had the sense that *her inside was out,* and this made her feel *powerful.* Proudly, she presented this feeling to me. But how to deal with this new achievement? The dream spelled out that it aroused a binary conflict: "I was torn between having to go to the bathroom and the feeling that I could have an orgasm." Her question to me was: "What do men do when they get excited and have an orgasm?" The sexual excitement (having an orgasm) conflicted with the preservative urges (having to urinate).

In the fourth year of her analysis, Lora told me another dream: "I was in a clothing store, trying on a white dress. I had taken up my other clothes and my necklace with a golden-heart pendant and put them somewhere. The new dress looked very round on me, as if I were pregnant. After I had changed back into my clothes, I couldn't find the necklace with the heart pendant. I searched on the couch. A security man said, 'It isn't there.' I put my fingers in the slit of the couch, pulling out a fold, and behind this fold I found it."

Lora found this dream interesting. She said that when the fold came out, it looked like a woman's genitals. She thought that she often had dreams about searching and finding her jewelry. She concluded that in this dream, she found her womanliness in the slit of my couch—because it looked like my couch. What she was searching for she found here, she said, in my office—it was her *self,* her womanliness. The heart of the matter, reflected in her pendant, was to be found here in analysis. She said it was hard to bring her love here and to put it on the couch, but now she *found* love in my couch—she had found *my* love. And she talked of the dress, white like a wedding dress, in which she also looked pregnant.

The next day, Lora came in angry with Pete, her husband. Eventually, she wondered: "What has my anger to do with having found your love here? I can only love one at a time. How is it different—Pete's love and your love and my love for you and my love for Pete? It is so confusing. I don't feel comfortable in myself, my legs hurt, it's so unfair, why can't I be comfortable with myself?"

The next day, she came in angry with me and did not feel like talking. We gradually understood that she had thought I would push her to be with Pete. She felt offended, thinking that I did not love her. She had thought that her life was going so well, and yet deep down, there was still a tiny spot where she felt she would kill herself. She knew she would not really do it, but there was this feeling, and she thought she would not tell me about it because she was mad at me. "I thought, I could do it alone, without you. But this isn't really the case until I have understood how I can love people—separately and differently."

I understand this dream as part of Lora's negative Oedipus, her wish to find my love (heart) by using her finger-penis to penetrate the slit in my couch, representing my vagina. By doing so in her dream, she created a concept of a woman's genitals. This helped her to find her womanliness and to fantasize herself as pregnant. Unconsciously, it was *I* impregnating *her* while she was doing the same with me; we were the wedding couple. This made her angry with her husband, who interfered with our relationship.

I think the patient had correctly picked up some subtle countermovements on my part in the second of these three sessions, which had offended her and made her express her anger with me in the third session. However, she came to an important insight: even though she had been disappointed with me, she would not withdraw; she would stay with me until she had understood how she could love people *separately* and *differently*—which meant how to *love* and how to *care for* both her *husband* and her *analyst*, or for both her *father* and her *mother*.

All these conflicts provoked aggression. Lora was angry with herself, angry at her husband, and angry at her female analyst. Most of this anger focused on impatience and annoyance for not *getting it,* or for feeling prevented from *getting it*. Yet this anger and the aggressive outbursts it triggered did not represent a conflict, but rather emphasized sexual strivings and their aim: wanting to get *it* and get *through* to the sexual object—and, in the end, to do so without losing the care and protection of the preservative objects.

These few analytic moments—from the patient's *never having it all* (the missing penis/the parental love objects), to this *powerful*

and *exciting* feeling of *having it out*, to the question of *what it does*, to *using it* (putting her fingers in the slit of my couch) in order to *find the heart of the matter, her womanliness = her jewel, in the vagina*—illustrate how our patients need time and space to sort out their different and conflicting fantasies and feelings about love and care, and about being male and/or female with a male and/or female transferential object, the analyst. It is not just about finding out what one *really* is (gender identity); rather, it is about trying all this out in order to integrate it into a gendered sense of one's *erotogenic self* as coexisting with an *erotogenic object* in a sexual *and* caring relationship.

CONCLUSION

The other side of Oedipus is the lethic side of structure formation, the side that is at work during all these difficult developmental processes in childhood. In the pregenital phase, the lethic demands of self- (and object) preservation dominate the expression of early libidinal strivings, but in the genital phase, it seems crucial that the sexual drives prevail, simultaneously retaining the preservative currents in a stabilizing function. Both drives must and will at times be pursued aggressively, whenever they seem to be thwarted. However, I suggest that, instead of an aggressive drive, we might conceptualize the *preservative drive* as the primal antagonist to the sexual drive. Thus, we might better comprehend the *two directions* of man's motivational strivings that shape the oedipal complex, two basic demands of the body to the mind: the need for safety (preservation) and the desire for love (sexuality).

The concept of a preservative drive existing alongside sexuality helps us grasp the difference between monolithic and binary conflicts. Further, appreciating the direction of lethic strivings prevents us from interfering with their expressions (e.g., in not interpreting concern and care as veiled hostility or guilt and reparation for preceding aggression) when they are about (progressively) building up the structures of self- and object-preservative functions. Such an appreciation also helps us understand when a pa-

tient's clinging to safety needs eventually becomes a defense against sexual strivings, and—if not analyzed as such—might even lead to malignant regression.

Thus, knowing about the importance of the lethic side of Oedipus by no means implies *favoritism* of preservative issues. Green (1995) is concerned that our interest in early disturbances leads to a *predilection* of the preoedipal issues, with a corresponding neglect of oedipal ones, a trend he describes as a shift from the penis to the breast. Yet "the role of a sexual relationship is not to feed and nurture but to reach ecstasy in mutual enjoyment" (p. 877). Green emphasizes the importance of sexual drives for achieving and working through the oedipal phase and reaching a certain stability of psychic functions.

> We should ask: what is important? What has the greatest value? The price of life is attached to what all human beings share and are longing for: the need to love, to enjoy life, to be part of a relationship in its fullest expression, etc. Again, here we are confronted with our ideology of what psychoanalysis is for. What is its aim? Overcoming our primitive anxieties, to repair our objects damaged by our sinful evil? To ensure the need for security? To pursue the norms of adaptation? Or to be able to feel alive and to cathect the many possibilities offered by the diversity of life, in spite of its inevitable disappointments, sources of unhappiness and loads of pains? [p. 874]

Can this be an either-or choice? Isn't it always about both? While in both psychoanalysis and in life, we might hope to develop sexual pleasure within a loving relationship, as long as we are haunted by primitive anxieties and basic threats to our security, there will be no room for erotic enjoyment. And even after we have overcome these primitive fears in a healthily neurotic life, the basic threats to our survival travel with us as an ever-lurking potential to regress that flings open as soon as we feel endangered. That is why I think psychoanalysts need to know about the power of both the preservative and the sexual drives, because this knowl-

edge will help them analyze, and thus to structure, their patients' capacities to love and to care for themselves as well as their objects.

Finally, the other side of Oedipus is also the other side of the ancient myth—the parental failure and its consequences, which were left out of Freud's conception. Laïos, reacting to the oracle that his son will kill him, pierces (that is, penetrates and hurts) Oedipus's feet and abandons him in the wild, thus hoping to kill or get rid of the child and *to preserve his own life*. If this is meant to imply a conflict at all, it is a monolithic one—self-preservation versus the preservation of a newborn son—that is decided regressively in favor of Laïos's own survival needs. The father's decision amounts to a murderous plan shared by Jocaste, the baby's mother. Thus, the story says that both parents want to enjoy sexuality, but are not willing to care for their offspring.

Whether we take this to encapsulate the horrendous fantasy of the oedipal child who is excluded from the parental couple (Britton 1998, p. 36), or whether we take it as a failure in parenting, the myth tells us that Oedipus—even though he was accidentally saved and well reared by his foster parents—unconsciously carries on what has informed his early mind. He lacks the very object-preservative concerns toward his real parents that they failed to provide for him. The wisdom of Greek mythology implies what psychoanalysts know: that a defense against an imagined threat (oracle) brings about the very danger that attempts are made to avoid. Thus, the tragedy makes sense to us when Oedipus ends up killing Laïos—not only as a failure of the incest taboo, but also, and most important, as a failure of object preservation.

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CONFLICT IN CONTEMPORARY CLINICAL WORK: A SELF PSYCHOLOGICAL PERSPECTIVE

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The authors review the history of controversy regarding conflict versus deficit. They suggest that conflict, when conceptualized within the theory of self psychology, may arise in one of two ways, either: (1) along with deficit when caregivers are unable to provide developmentally needed selfobject functions, and, at the same time, these needed caregivers are also feared; these conflicts are unconscious and potentially pathogenic. Or: (2) conflicts may appear secondary to deficit. Such conflicts also require the analysis of selfobject transferences that have arisen on the basis of the underlying deficit.

A clinical example demonstrates that deficit related to the oedipal phase may give rise to oedipal-selfobject transferences, requiring their working through for a successful termination.

INTRODUCTION

Any effort to place psychic conflict in the theoretical fabric of psychoanalytic self psychology requires a brief survey of the history of the controversy related to the developmental and pathogenic significance of conflict and deficit (functional disability) in psychoanalysis. The controversy relates to the question of the way in which early, potentially traumatic experiences resulting in structural deficits are related to intrapsychic conflicts and compromises. Because of the theoretical, developmental, and far-reaching clinical signifi-

cance of the issues involved, this controversy has been with us throughout the history of psychoanalysis.

In considering the role of conflict in self psychology, we must raise a question: Are we speaking here of unconscious, potentially *pathogenic* conflicts, or conflicts that are ubiquitous and not *primarily* responsible for the ensuing problems patients may develop (that is, the conflicts of everyday life)? Therefore, in our discussion, we shall distinguish between (1) conflict as an unconscious, drive-related construct held responsible for normal and pathological development in traditional psychoanalysis; (2) unconscious, not drive-related, potentially pathogenic conflicts that may arise along with the deficit, as these are conceptualized in self psychology; and (3) secondary conflicts based on deficits, which may or may not give rise to psychopathology. When they do, such hard-to-resolve conflicts require attention to selfobject transferences based on the underlying deficit.

The question of whether a conflict is created by the caretaking environment's need to "tame" or "neutralize" sexual and aggressive drives, or whether it arises secondary to deficit in which needed environmental responses were absent or faulty, cannot be argued without the appreciation of the *method* by which clinical data are gathered, and without recognizing the nature of the transferences to which structural deficits give rise. The method of sustained empathic immersion in the patient's inner life provides a different view of the patient's subjective experiences than does a perspective "from without." Though all analysts rightly claim that empathy informs them about their patient's experiences, not all analytic theories equally facilitate entry into the patient's inner world. Drives, as biological givens, are not accessible to empathy and introspection; only the experience of drivenness can be empathically encompassed. In addition to drives as experiences of drivenness, Kohut (1975) spoke of "isolated drives" and drives as "disintegration products" in a fragmented self (p. 787). In the clinical situation, these are best conceptualized as reactive *affect* states (such as erotic lust and narcissistic rage), arising in response to a disruption of

the patient's selfobject tie to the analyst (Stolorow, Atwood, and Brandchaft 1987).

The remainder of this paper is divided into four main parts: (1) a review of the history of the controversy regarding conflict and deficit; (2) clinical implications of the deficit theory, including presentation of a clinical example; (3) a developmental perspective; and (4) our concluding remarks.

HISTORY OF THE CONTROVERSY REGARDING CONFLICT AND DEFICIT

Questions related to conflict and deficit originated with Freud's (1916-1917, 1924) distinction between psychoneuroses, on the one hand, and the psychoses and traumatic neuroses, on the other. This distinction was based on his observation that *actual events* played different roles in these two groups of disorders. Freud revised the significance of actual events in pathogenesis in his own mind several times over the course of his lifetime. He gave five successive accounts of the changes of his views (see Schimek 1975). He drastically changed his seduction theory (described in his writing between 1892 and 1897), which held actual events responsible for neurotic developments in the course of his own self-analysis. With the formulation of the Oedipus complex and infantile sexuality, he considered *endopsychic conflicts* created by sexual and aggressive drives and the resulting *unconscious fantasies* to be responsible for hysterical symptoms. The factual reality of unconscious memories was now replaced by the *psychic reality* of unconscious fantasies (Freud 1914, 1916-1917).

Important for the subsequent evolution of the controversy was the role assigned to potentially traumatic events and the manner in which these affect patients' *perception of reality*. The role of reality in psychoanalytic theory was primarily established by Hartmann (1956); and its place in ego psychology was ensured by Arlow when he integrated perceptual reality with psychic reality. Describing the relationship between unconscious fantasy and reality, Arlow (1969) wrote:

> This is what I think is the proper understanding of the concept of "psychic reality." It is not a fantasy that is taken for the real truth, for an actual event; [rather, it is] the "real" recollection of a psychic event with its mixture of fact and fantasy. [p. 43]

In other words, how reality is experienced depends, for the most part, on the interaction between one's perception of the external world and the effect that unconscious fantasy has on that reality; unconscious fantasy is expected to distort reality in keeping with fluctuating drive needs and impulses.

Questions related to the relative importance of external events (specifically, traumatic experiences) in the genesis of neuroses were first raised by Ferenczi in 1933, when he stressed that

> The traumatic factors in the pathogenesis of the neuroses had been unjustly neglected in recent years. Insufficiently deep exploration of the exogenous factors leads to the danger of resorting prematurely to explanations—often too facile explanations—in terms of "disposition" and "constitution." [p. 156]

Ferenczi's interest in the "exploration of the exogenous factors" was sparked by his realization that his patients' complaints and criticisms of him were not necessarily based on distortions, but rather on an accurate perception of his attitude toward them, of which he himself was not aware. Ferenczi began to question himself (similar to the way Kohut did, many years later), only to discover that, in spite of his best intentions, there was some truth in his patients' accusations that he was cold and insensitive. Ferenczi came to the conclusion that these *accurate perceptions* by patients were related to a repetition of the original trauma that had been inflicted on them in childhood by their caregivers. In this, we recognize Ferenczi's effort to resurrect Freud's seduction theory of 1898, as he insisted that the pathogenic factor of trauma (especially sexual trauma) "cannot be valued highly enough" (1933, p. 161).

Ferenczi's concern was overshadowed by the increasing importance given to drive-generated unconscious conflicts in the genesis

of neuroses. In the early years of psychoanalysis, the demarcation between exogenous and endogenous factors in neurosogenesis had become increasingly sharper.

Because of the implications for child analysis, Anna Freud (1968) stated the need for such delineation most clearly. She emphasized that symptoms based on libidinal fixation and regression —which brought about defensive actions in the ego, thus creating the need for internal compromise formation—had to be distinguished from symptoms that were created by untoward external influences. She offered a detailed description of analyzable infantile neuroses, characterized by the following features: conflicts between different agencies of internal structures, unsuitable defenses against drive activity, anxieties, fixations of large quantities of libido, regressive moves in the area of drives or ego, and severe repression of aggression.

Anna Freud differentiated the group of children with these features from those who were "victims of the external circumstances in their lives" (1968, p. 39). In this second group of children, the damage "was not self-inflicted as a result of internal strife, but was caused and maintained by active, ongoing influences lodged in the environment" (p. 40). These children exhibited immature object relations, intellectual backwardness, and a lack of impulse control. While they obviously needed help, this was not an area in which psychoanalysts could be helpful. Anna Freud summarized her findings as follows:

> For the therapeutic concerns of the child analyst it is vital to distinguish in his assessment between the neurotic and developmental disorders, in which the child's ego plays the central pathogenic role, and the "deficiency illness," i.e., the pathological distortions which can be traced back to the *lack of some external agent that is an essential requirement for normal growth.* [p. 43, italics added]

Probably because this sharp demarcation was difficult to maintain clinically, in a later publication, the distinction between the two forms of psychopathology became blurred, when Anna Freud

noted that: "However different in origin the two types of psychopathology are, in the clinical picture they are totally intertwined, a fact which accounts for their usually being treated as one" (1974, pp. 70-71).

The controversy regarding conflict and deficit could have been settled at that time, had clinical problems not brought it repeatedly to the fore. In clinical practice, the need to separate the two forms of psychopathology continued due to the separation of "true neuroses" from "preoedipal" psychopathology. The controversy now focused on the question of *analyzability,* determined by the level of psychological organization the patient had achieved in the course of development. What became clinically significant was the difference between psychopathology related to inadequate structuralization of the psyche (preoedipal psychopathology), and neuroses that arose in relation to an unresolved Oedipus complex. This particular development in psychoanalysis can be traced to two factors:

(1) Freud's (1926) *qualitative distinction* between the experience of "preverbal helplessness" as a prototype of psychic trauma and his subsequent delineation of a developmental sequence of potential traumas: loss of an object, loss of the object's love, castration threats, and superego anxiety. Trauma suffered during the early phases of development was believed to create deficits in the ego, while at a later point in development—especially during the oedipal phase—traumas of "everyday life" (the birth of a sibling, a death in the family, and the like) might alter the structure of a neurosis, but were not supposed to be causally responsible for its occurrence. The cause of such neurosis had to be sought in *conflicts* related to sexual and aggressive *oedipal fantasies.*

(2) This particular distinction was further argued on the basis of the assumption that psychological structures are built through modification of the drives, and the environment is part of the infant's and young child's

> inner world only during the period prior to the differentiation of self from other. Only during the oedipal phase was the psyche assumed to have achieved adequate self-other differentiation to permit the development of an intrapsychic conflict that would be accessible to the psychoanalytic method.

While this distinction between preoedipal and oedipal psychopathology had become important to all practicing analysts, it was of particular interest to child analysts, and created an ongoing debate regarding the technique of child analysis. For example, Anthony (1980), in an effort to separate internally created pathogenic agents from externally created ones, suggested that child analysts ought to be able to disentangle the three forms of families children construct in their minds: the intrapsychic oedipal one, the idealized representational one, and the actual interpersonal one —leading to the ability to appraise the family *realistically* (emphasis added). The reality of the family, said Anthony, becomes superimposed on unconscious oedipal fantasies, which, once exposed, become the *legitimate subject* of the analyst's interpretations. Since such a distinction is not likely to be successful, and it does not appear to have any clinically useful purpose, the next question to be examined is how these various family factors—(a) internal (fantasy-related), (b) internalized (experienced and secondarily internalized), and (c) interpersonal (currently experienced but not internalized)—might be interrelated in the genesis of neurosis.

Kris (1956), in attempting to answer the same question, postulated a continuum between "the stress on *endopsychic* and the stress on *environmental* factors" (p. 65, italics added). This was in keeping with Freud's (1916-1917) suggestion of the complemental series. Observing young children in interactions with their parents, Kris became interested in exploring the way "preverbal imprints may determine the modes of later reactions to environmental stimuli" (p. 66). Although he was clearly impressed with the "peculiarities of the parents' personalities" (p. 68), he considered these parental personalities important only in a general sense, and not as a specific cause of a neurosis. If a child were to develop an ana-

lyzable psychological condition, that illness had to be understood and explained in terms of sexual and aggressive fantasies related to the Oedipus complex.

Hartmann's (1939) introduction of the idea of an *average expectable environment* facilitated a sharper focus on the vicissitudes of the drives in development. However, Hartmann was also the one who observed that theory based on a conflict hypothesis left the child's parents' personalities out of the etiological equation. This seeming contradiction in his position explains why Hartmann's name is not only associated with the so-called average expectable environment, but also with the idea of a conflict-free area of the mind. We are suggesting that such a conflict-free area becomes established when the environment meets the growing child's developmental needs for validation and the need to be merged with an idealized other. Kohut and Seitz (1963) spoke of an area of *progressive neutralization,* in their effort to further specify the conflict-free area of the mind, where no repression barrier exists. The possibility of its existence, however, was not further pursued; the idea that *all* psychological development was based on conflict continued to dominate psychoanalytic developmental theory.

A more recent contribution by Tyson (1991), concerning the relative importance of environmental factors and drive-related fantasies, makes similar points to those put forward by other child analysts. Tyson distinguished three different types of conflicts: internal, developmental, and internalized. He considered the appearance of intrapsychic conflict a developmental achievement, culminating in the well-known conflicts of the oedipal phase. Tyson here added an important observation, namely, that "*mental health or illness is based, not on particular conflicts, but on the degree of success or failure in resolving the conflicts to which everyone is subject*" (p. 31, italics added).

Accumulated clinical wisdom has brought forth increasing evidence that the importance of exogenous, environmental factors—especially those concerning the caregivers' personalities—ought not to be restricted to the early years of infancy, prior to the time of

self-other differentiation. In the 1950s and '60s, efforts were made to integrate object relations perspectives into ego psychology.

Object relations theory and the various developmental theories had extended the boundaries of psychoanalysis beyond the oedipal into the preoedipal area of development, but these extensions had not occurred without serious controversies. Analysts remained preoccupied with the distinction of *oedipal* versus *preoedipal* forms of pathology as an indication of important differences in the expected course and expected outcome of a particular analysis. In terms of the course of an analysis, *preoedipal issues* were considered more likely to indicate the need for *parameters* (Eissler 1953), and a favorable outcome in these analyses was not considered as likely as in cases in which the patient developed a *true transference neurosis*—that is, a transference reproduction of the infantile neurosis.

One of the more recent contributions related to the question of conflict and deficit (Dowling 1991) indicates that the controversy is far from settled. Arlow (1991) is most explicit about his concern regarding the inclusion of early developmental experiences in one's analytic work. He finds the "tendency of many analysts today to emphasize the role of traumatic experiences or relationships during the first and second year of life as the source of the psychopathology" unfortunate, because this "takes the origin of their difficulties back to a period in their lives when they had only needs and no responsibilities . . . hence no need to feel guilty" (p. 13). He considers trauma to represent "a special vicissitude of development, seen in *the context of continuing intrapsychic conflict*" (p. 7, italics added). This is in keeping with Arlow's (1963) earlier view that: "In clinical practice it is most important to be able to uncover the precise way in which the unconscious instinctual wish is given form in fantasy" (p. 21). Brenner, who suggested that "an event is traumatic because of the way it impinges on the traumatized individual's preexisting psychic conflicts" (quoted in Rothstein 1986, p. 219), shared Arlow's views. These statements express the generally held assumption that intrapsychic conflict based on drive vicissitudes is the context in which all normal and pathological development takes place.

Gill (1994) challenged this assumption, wondering whether or not early trauma that leads to deficit could *precede* conflict. This question implies that, while ego psychology recognizes reality as "one of the components of conflict and compromise," it does not explain how reality becomes an *"etiologically significant* part of psychopathology" (p. 761, italics added). Modern ego psychology has continued to struggle to accommodate reality and object relations into its theory, in spite of Hartmann's (1956) efforts to integrate the reality principle into the concept of the ego. As Boesky (1991) noted: "An object relationship cannot and should not be tacked on to *id, ego,* and *superego* as a fourth dimension of compromise formation, because the terms represent very different frames of reference" (p. 27).

The integration of lived (potentially traumatic) experiences into ego psychology, says Gill, may be related to trauma being understood as it appears to the external observer, rather than to the way it is *experienced.* Once trauma (reality) is viewed from the perspective of a particular individual, external reality becomes an aspect of psychic reality. *Such a perspective would provide a common ground in the controversy, in that deficit would be recognized as the intrapsychic effect of an event:* "The argument arises from the fact that mainstream analysts do not recognize that when interpersonalists, object relationists, and self psychologists speak of deficit, they usually *do* mean the intrapsychic result of an event" (Gill 1994, p. 765, italics in the original).

There are reasons for misunderstandings. One is that when self psychologists speak of *deficit,* it sounds as if they are referring to a "hole" in the structure of the psyche. Rather, the term refers to the fact that *needed* psychological structures have failed to develop, and defensive structures have taken their place. *Deficit* describes functional disabilities, such as a lack of self-soothing capacity or affect regulation. We agree with Lachmann and Beebe (1992) when they maintain that *deficit* does not adequately describe the underlying psychological organization. Rather, on the basis of empirical infant research, they believe that the term is better thought of as an organization in and of itself: "For example, characteristic ex-

pectations of the nature of the interactive regulation, such an expectation of non-response or non-mutuality, constitute structure" (p. 139). Nevertheless, this concept of *deficit* is probably difficult to accept, because it implies some kind of activity on the part of the analyst that would be contrary to what is generally considered analytic technique.

The clinical examples discussed in the volume by Dowling (1991) demonstrate that analysts in the 1990s were recognizing the importance of deficit in analyzable clinical conditions, and, while this changed their attitudes and responsiveness to their patients, it did not affect their professed theoretical orientations. Kohut's claim thirty years earlier that theory had become increasingly irrelevant in clinical practice is demonstrated in these reported clinical examples. One of us (P. H. Ornstein 1991), in discussing these clinical examples, was particularly interested in the extent and the way in which the concepts of modern ego psychology—the professed theory guiding the treatments—were actually translated into each analyst's attitudes, understandings, and interventions. He asked:

> Are treatment and theory when looked at from within of one cloth, as the authors portray their work? Or are there discrepancies, certain experiences within the process that, in fact, necessitated moving outside the territory staked out by the theory, while insisting on having essentially remained within the area of conflict and compromise? [p. 141]

In this respect, it is instructive to look at the clinical material presented by Willick (1991), who highlighted two transference elements in the treatment of Carol: (a) her experience of weekends, when she would have to drive by the analyst's home in order to tolerate the separation; and (b) the fact that she could not start a session unless the analyst spoke first. Though uneasy about it, Willick complied with her needs in order to "facilitate the treatment process" (see P. H. Ornstein 1991, p. 152). What *meaning* the patient gave to the analyst's compliance could only be inferred from her responses: it appeared to move the process forward, indeed. In

P. H. Ornstein's (1991) view, Willick *responded* to deficit while searching for conflict, maintaining that "it is not helpful to see Carol's inability to start each session as [an aspect of her] deficit" (p. 153). Ornstein wondered: "If this 'modification' was necessary, and not merely a matter of style, should we not try to find the [theoretically explicable] reasons for it?" (p. 153). Willick acted in the "microprocess" (P. H. Ornstein 2004), based on his sensitivity to the patient's needs—but acting in this fashion was contrary to his professed theory. Why not formulate a theory that guides the analyst to the use of that sensitivity and thereby justify its un-self-conscious deployment in the clinical setting?

"Modifications" were introduced in all four cases reported in the volume by Dowling (1991), but these were essentially relegated to mere "technical necessities" in each instance. The question is: What kind of clinical experience warrants a change in theory? As long as modern ego psychology assigns a central and primary role to conflict, it must, by definition, extend the applicability of conflict throughout the entire spectrum of psychopathology, continuing to concern itself with the question of analyzability on the basis of the level of the patient's psychological organization.

Willick's clinical example and Ornstein's discussion of it underline the nature of the current controversy: there is an unanswered question regarding the relationship between analysts' professed theories about the nature of their patients' difficulties, and the theories of treatment employed to effect changes in those difficulties.

Other aspects of ever-evolving psychoanalytic theories have continued to influence the controversy regarding conflict and deficit. One such influence is exerted by the fact that today's analysts recognize the continual shifting of analytic ground, as patients and analysts co-construct what becomes available for understanding and for explaining in the course of an analysis. This perspective takes the position that "the intersubjective context has a constitutive role in *all* forms of psychopathology, ranging from the psychoneurotic to the overtly psychotic" (Stolorow, Atwood, and Brandchaft 1987, p. 4, italics in the original). In other words, in "diagnos-

ing" patients—even when such diagnoses are not based on symptomatic behavior, but on the analytically sophisticated diagnosis of the level and nature of psychological organization—we should keep in mind that such assessments are supposed to become relatively meaningless in the analytic interaction when viewed from an intersubjective perspective.

Corresponding to the influence of intersubjectivity on practice has been the mushrooming of a variety of psychoanalytic theories; analysts are now (supposedly) able to employ multiple theories in response to whatever the clinical moment may require. Smith (2003), for example, states emphatically that "the correspondence between theory and practice is not, and should not be, one-to-one." He goes on to say that, "while theory may serve as a guide, and may justify our moves in retrospect, no theory can prescribe the appropriate intervention at any given moment" (p. 139). Like most analysts, Smith uses a *theoretical core* (which, in his case, happens to be conflict theory), and this "serves as a stabilizer and a guide (sometimes conscious but often preconscious) to which I return and around which I hover" (p. 139).

Probably the most ardent advocate of the use of multiple theories within the same patient–analyst dyad is Pine (1990). Pine compares individual theorists and clinicians to "the familiar position of the blind men and the elephant, each touching a different part and mistaking the part for the whole animal" (p. 4). In the case of the elephant, the perspective changes with the location—*where* the elephant was touched. In the case of human beings, the perspective changes with time. "The view you get," says Pine, "depends on *when* you are looking" (p. 4, italics added). Pine is here referring to the multiplicity of variables that are central to human functioning, which have been highlighted by diverse theorists. He hopes that the use of multiple theories will "increase the space in our theories for complexity—complexity reflected in the central place of conflict and the multiple functions of behavior" (pp. 4-5).

We suggest that, when psychoanalysis is viewed not only in terms of moment-to-moment interactions (the microprocess), but also longitudinally, as the totality of the patient's experiences with

a particular analyst (the macroprocess), the decisive question is not *when* the analyst is looking, but from *which* listening perspective: Is he or she touching the elephant from the outside, or is he or she interested in the animal's experiences over time?[1] Are we interested in the isolated parts, or should we make an effort to find out what it is like to *be* an elephant?

Thus, we believe that, despite momentary changes in our patients' experiential states (hunger, tiredness, level of sexual desire, changing physical and environmental circumstances that create ad hoc defensive responses), human beings retain their sense of sameness and their sense of continuity over time. While in any one clinical moment, the analyst's responses may not be directly determined by his or her professed core theory *alone,* it is one's core theory, nevertheless, that has an enduring and overarching influence on the total conduct of an analysis. Theory becomes a successful guide to treatment when it is relatively well integrated into the analyst's personality—when it informs the work more or less unconsciously. Since the analyst's private theory (amalgamated with his or her chosen public theory) becomes part of the analyst's personality organization, thus influencing his or her attitude and listening perspective, as well as the content of verbal communication, theory affects the nature of the emerging transference. We would suspect that changing one's theoretical outlook in an ad hoc manner would interfere with the establishment of a sustained cohesive transference.[2]

The question of the relationship between theory and practice has more than practical, clinical importance. In psychoanalysis, the reciprocal feedback between the mode of listening, the theory of mind, and the theory of treatment requires periodic reexamina-

[1] A developmental analogue is the manner in which Stern (1985) uses the idea of RIGs. It is not that the caregiver's behavior during an isolated period of time will constitute his or her representation in the mind of the developing child, but rather that a variety of experiences are internalized once they have become generalized.

[2] Transference becomes cohesive when the patient's needs, wishes and expectations center on the person of the analyst in a sustained manner, and thus form the basis for the interpretive process.

tion. In our view, analytic progress can only be assured when the relationship between these aspects of analytic theory is preserved. Should they become seriously out of tune with each other, the discrepancy between them signifies that the theory that is to guide the treatment needs to be revised. We agree with Kris (1956) that "progress in psychoanalysis tends to manifest itself by a gradual, sometimes imperceptible shading of our views and procedures, as a process of sifting, of constant adjustment of theory and practice" (p. 55).

Relevant to the controversy between conflict and deficit is Greenacre's (1975) observation that genetic reconstructions in their original form were being neglected by the then-current generation of psychoanalysts. Did this omission mean the neglect of the genetic point of view, she asked—or does this neglect indicate uncertainty as to what it was in a person's development that had become significant to him or her later in life? Greenacre's questions are significant not only for the conduct of psychoanalysis, but also because genetic reconstructions provide analysis with a scientific tool. Recall that genetic reconstructions of his cases furnished Freud with an outline of the various libidinal phases of psychosexual development that served as a basis for the formulation of his developmental theory. The systematic use of his transference findings constituted the foundation for the building of his theoretical edifice.

Kohut followed a similar route in formulating psychoanalytic self psychology. For the theory of treatment to be a relatively reliable guide in analysis, it had to be related to the theory of psychopathology (structural deficit) and to the theory of development (the structure-building property of caregiver responsiveness). For Kohut, as for Freud, psychoanalytic theory constituted a system in which parts of the theory had to fit into a systematic whole. An ongoing feedback mechanism between theory and practice is unavoidable; evidence for the usefulness of a particular theory can be empirically established and its validity proven only by an extra-analytic source. For such validation, psychoanalysis has depended on child psychoanalysis and on the findings of infant research.

THE NATURE OF SELFOBJECT TRANSFERENCES AND A CLINICAL EXAMPLE

In view of the direction in which analytic practice was heading, it is not far-fetched to say that Kohut's (1971) description of the selfobject transferences was a timely development in psychoanalysis. Based on deficits in the structure of the psyche (manifested mainly in vulnerability to fragmentation, problems related to tension regulation, and a flawed self-esteem regulatory system), the source of these transferences was to be found in faulty caregiver responses to the infant's and child's mirroring, idealizing, and alter-ego developmental needs. In other words, deficits in the developing psyche occur not only because of gross neglect or overtly traumatic events, such as physical and/or sexual abuse, but also because of subtle (to the caregivers themselves, unconscious) failures to be responsive to the child's mirroring and idealizing needs. Winnicott (1960) made similar observations when he discussed the development of the true and false selves. He observed that in cases where the mother's adaptation is not "good enough," infants cannot "gradually abrogate omnipotence" (p. 146). Such lack of maternal adaptation is a trauma by *omission,* rather than by *commission*. It is to be noted, he said, that patients remember actively inflicted trauma, but do not remember anything happening when something ought to have happened (p. 146).

The essential feature of the selfobject transference is that the patient expects the analyst to function in place of his or her missing psychic structure. If the sustained focus is on the patient's subjective experience, and the analyst's interpretive responses make the patient feel understood, the analyst becomes a stabilizer in the patient's psyche. An increase in self-cohesion, manifested in improved functioning, indicates that one of the selfobject transferences has become established. Whether this will be a mirror transference (in which the patient expects to be validated), or an idealizing transference (in which the patient derives temporary strength

from feeling merged with the perceived greatness of the analyst), or an alter-ego (twinship) transference (in which the patient insists on sameness with the analyst) depends on the sector of the personality in which the developmental deviation or arrest originally occurred. These forms of transferences rarely appear in pure form. Though one or the other may predominate, more often than not they appear in mixed forms.

A clinical example will illustrate some of the points made thus far.[3] The analyst (A. O.) understood the presenting symptom and the nature of the transference as an oedipal-selfobject transference.

The Oedipus complex is supposed to signify the achievement of a relatively high level of psychological organization. The question now becomes: How has our conception of this so-called complex been altered by self psychological considerations? Simply stated, self psychology maintains that the oedipal phase, similar to other developmental experiences, can be fully understood only when viewed within the context of the child's emotional milieu. Kohut (1977) called into question the classical conception of the Oedipus complex as a universal, *normal* human experience, positing it as a manifestation of an already *pathological* condition. What is reconstructed in an analysis could hardly have been a normal developmental experience if it has given rise to a neurosis, he said. He argued that the dramatic, conflict-ridden Oedipus complex, in which the child's developmental aspirations are impacted by castration fear, is not a primary developmental necessity. Rather, the Oedipus complex is the result of frequently occurring failures of caregivers to respond to the oedipal-age child's competitive behavior with joyful acceptance, he maintained. Parental selfobject failures can account for discrete defects in the developing self, and, specifically, those related to the developmental tasks of the oedipal-age child. Kohut (1977) distinguished (1) a silent and joyful, normal developmental *phase* from (2) an Oedipus *complex,* in which this phase of development becomes derailed and may later give rise to some form of self pathology.

[3] A detailed version of this case was first described in A. Ornstein 1983.

Clinical Example

The patient, a 34-year-old, single man, presented with the complaint of difficulty establishing a lasting relationship with a woman. He tended to have intense, short-lived affairs. He sought out a female analyst, as he believed his problems to be related to the difficult relationship he had had with his mother. However, in the course of the analysis, the patient regretted having chosen a woman, since he developed a persistent wish to experience his female analyst as if she were a strong male. He felt that, without being able to look up to the analyst as a strong man, who in turn would respect and admire him, his analysis would not be complete.

The patient was specific about the nature of his difficulty: in the course of sexual foreplay, he would lose his erection as soon as he noted any blemish on the woman's breasts. He also described himself as having been depressed most of his life, as living life without joy—and as not anticipating any joy in the future, either.

The patient's mother had died of a chronic illness when he was eleven years old; she had been sick during much of his childhood. The patient remembered his father's asking him or his brother to crawl into bed with their mother before they went to school. As soon as the patient did so, his father would get out of bed. This infuriated the patient. He recalled feeling disgusted when his feet would accidentally touch his mother's pubic hair. The analysis of the patient's sexual inhibition was made easier when the patient developed a transference symptom: he became irritated with the analyst's voice, regardless of the content of her comments. The analyst became the seductive but eventually rejecting mother.

The wish to idealize the analyst as if she were a strong man emerged after the conflicts related to the patient's sexual inhibition in relation to his mother appeared to have been worked through. The transference affects in relation to his father emerged against considerably more resistance than that toward the mother. His anger and disappointment threatened not only his tender and loving feelings toward the father who had been his primary caregiver, but also a vital connection to his father, which the patient had

established through a massive and gross identification with him. The content of this identification was a chronic, futureless depression and a conviction that he was destined to repeat his father's joyless life. The analyst considered the massive identification with the patient's father to be a defense that "filled in" a deficit related to his not having been able to phase-appropriately idealize his father.

Traumatic disappointment in the homogenital parent during the oedipal phase has a pathogenic significance for the child: the problems that may develop under these circumstances appear to be related to a discrete deficit in the pole of ideals in the bipolar self. It is at this phase of development that ideals become the carriers of gender-linked values and standards, such as "masculine" strength and self-assertiveness, and "feminine" beauty, as these are defined in our Western society. The patient's dreams and associations began to express concern about homosexuality; he dreamed about "pretty boys," and thought that he really preferred the company of his male friends to that of the women he was dating. In keeping with her theoretical orientation, the analyst considered these dreams and associations to be expressions of erotized longings to be enhanced by the strength and power that the patient attributed to his idealized male friends. Contemptuous of the effeminate features in his own personality, he expected to be cured of these by being close to and admired by his male friends.

Using traditional psychoanalytic theory as a guide to understanding the same transference phenomenon, it might be interpreted as a fixation on the negative Oedipus complex. Traditionally, the negative Oedipus complex has been viewed as a pathological constellation, a retreat from the infantile sexual longing for the mother and from competitive and murderous wishes toward the father. However, this phenomenon has also been linked in normal development to the fate of archaic narcissism. Based on his analysis of adolescents, Blos (1979) maintained that the joint appearance of idealization and erotization is the manifestation of an intense need to merge with and to be admired by the homogenital parent. Blos's observation supports the self psychological understanding of the erotization of the need to be merged with an

idealized other. This transference phenomenon, rather than being viewed as a defense against the positive Oedipus complex, can now be understood as an effort to resume psychological development where it had been interrupted.

The interpretation and working through of the patient's fear of homosexuality produced further memories about his father. The patient's most traumatic disappointments related to his father's inability to stand up to his mother, who would berate and belittle him. The transference wish that the analyst be a strong man, one who could help the patient become a man different from his father, was well expressed in a dream in which he wanted to fly, but the airplane was not perfect. The pilot was brilliant but physically unable to handle the plane. Associating to the dream made the patient sad and irritated with himself, and he complained to the analyst: "But it isn't *you* who is the inadequate one—my inability to look up to you is *my* flaw, not yours. Still, I would kill *you,* not me."

Just as the analyst's understanding of the meaning of the patient's idealization and erotization in the transference was affected by her theoretical outlook, so her understanding of the source of the patient's anger at her was affected by her self psychological frame of reference. Questions that had to be raised were: Did the patient wish to kill the analyst as a revival of the oedipal wish to kill his father for sexually possessing his mother? Or was the anger related to the child's traumatic disappointment in his father for not being someone he could look up to, and for not encouraging him to become a self-assertive boy?

Whether the wish to idealize the analyst as if she were a strong male was a defense against oedipal rivalry and hostility, or a legitimate developmental need that had been traumatically frustrated, places the question about conflict or deficit squarely into the clinical arena. Considering the patient's oedipal wish to kill his father belongs to a different axiomatic assumption than does considering his rage at his father for having traumatically disappointed him with his passivity and weakness. Each understanding requires a different interpretive response. The idea of *overdetermi-*

nation or the concept of *multiple function* as justifying both interpretations is—in our view—valid only for possible *different meanings* within the same theoretical systems.

A fantasy in which the patient thought of the analyst as someone he could spar with indicated to her his effort to solve the problem of her femaleness. In the fantasy, the analyst was not only able to withstand his challenges, but also took great delight in his assertiveness. The change in the patient's perception of the analyst was represented in a dream in which the two were engaged in a boxing match. In the dream, he felt free to hit hard and was enjoying the vigor of the interaction. This was the essence of his wish to idealize the analyst: she would be the strong father who was delighted with, and who welcomed, the son's assertiveness and competitiveness.

Whenever the patient was able to maintain an image of himself as competent and able to take charge of his life, he could explore new aspects of his life. Important changes took place in his behavior during this period: he stopped smoking and began exercising regularly. These changes were important, as he interpreted his previous inability to stop smoking or to lead a healthier lifestyle as manifestations of an inevitable compulsion to relive his father's life and to die young.

For some time, the patient remained vulnerable to the tone of the analyst's voice, experiencing her as belittling and/or humiliating him, and this regularly created disruptions in the transference. The working through of these disruptions in the here and now, as well as genetically, was essential to his progress. There were also many relatively calm periods during which the patient displayed considerable self-analytic skills. He made keen observations about himself, his friends, and their families, which facilitated his efforts to reconstruct his childhood experiences with both his parents.

Most telling of all were interactions he observed in a young family: he witnessed a child about three years old who was pulling away from his mother's embraces. He thought the mother was imposing her kisses on the child: "The kisses were not for him, but for her." He sensed that the child wanted to be with the mother, but

was caught in a terrible dilemma: he wanted closeness, but not the kind his mother was offering.[4] Indeed, this situation echoed the patient's experiences with his own mother; he, too, had wanted to be close to her, but not under conditions that were in keeping with her needs rather than his own. His having had to comfort his mother in bed exposed a lack of empathy with the growing boy on the part of both parents.

The patient observed the same child being caught by his father as he was about to fall off a swing: "What perfect timing!" The patient thought that the child must have experienced two feelings at the same time: both the exhilaration of swinging all by himself, and the safety of his father's firm arms as he was caught in midair, just in time. "What rejoicing!" the patient exclaimed, referring to the joy he observed on their faces as the child landed safely in his father's arms after accomplishing the feat of swinging all by himself. This was the kind of father he had wished for himself.

In discussing termination, the patient said that the analyst was most helpful when she understood what it was like for him to have to get into bed with his mother just as his father would get out of bed. He always knew that he had a love-hate relationship with his mother, but he could not bear his anger toward his kind and loving father. He also thought that suffering in small ways (by not buying himself warm, well-fitting clothing, for example) kept him close to his father: "I have to hold on to my sadness, as if this were all I had left of him."

It was during termination that the patient recalled more and more pleasant memories from his childhood. He saw home movies

[4] The incident the patient observed here is an example of a situation in which conflict may be arising either in relation to an already existing deficit, or simultaneously with a new deficit. In this case, there are two possible scenarios: (1) The child may not have experienced his mother's unconditional emotional presence *prior* to his efforts to separate from her. This would be a situation in which a current developmental phase cannot be optimally navigated, and a pathogenic conflict is created because of prior deficit; or (2) The mother's need to remain close to the three-year-old was *specifically* related to the mother's own problems with separation, in which case deficit and conflict arose simultaneously because the person who was needed to approve and validate the child's need for separation could not respond in the desired manner.

of himself, and was surprised to discover that he had been a vivacious, outgoing child at around the ages of four and five. He became gloomy during adolescence, around the time his mother died, and had never properly mourned her. When I commented that our understanding of the origin of his depression was particularly liberating to him, the patient began to cry, and spoke of his father's kindness. He thought that the care he and his brother received from their father during childhood made both of them sensitive and caring people; but, while his father could protect them from the outside world, he could not protect them from his own depression or his own anxieties. The patient wondered what kind of a father he himself would make, and was pleased that his thoughts were now turning to the future in a positive way.

Discussion of the Clinical Vignette

The objection could be raised that there is no need to conceptualize an oedipal-selfobject transference here, and that this patient's need to experience his female analyst as if she were a strong male in relation to whom he could experience himself as a vigorous, self-assertive male could just as well be understood as his desire to exchange a pathological identification for a healthy one. However, we do not think that this patient exhibited a pathological identification. Rather, we conceptualize these two ways of viewing the case as highlighting the difference between structure building as it occurs through transmuting internalization of phase-appropriate selfobject responses, on the one hand, and structure building as it occurs via identification in traditional psychoanalytic theory, on the other.

Structure building through transmuting internalization facilitates the transformation of archaic narcissism because the changes it brings about are in harmony with the child's developmental needs and are specifically tailored to the child's skills and talents. Identification, by contrast, is an internalization in which another person's characteristics become part of one's self. In the case of this patient, identification with the father's joyless existence and fu-

tureless depression appears to have "filled in" a defect—the legacy of the patient's inability to idealize his weak and apologetic father. These considerations raise the question of whether or not patricidal wishes and castration anxiety are part of the *normal* oedipal phase, or whether these phenomena appear in the transference as childhood responses to the caregivers' failure to respond to the child's developmental need to be affirmed for his or her self-assertiveness, competitiveness, and budding sexuality (Kohut 1977).

In this instance, it was important for the analyst to recognize the patient's need to complete a specific developmental task in the analysis. We believe that it is a mistake to expect the nature of the transference to be determined mainly by the analyst's gender. Rather, the transference evolves in keeping with the patient's unconscious developmental needs. This patient's conviction that his analysis could not be complete unless he experienced himself in relation to his female analyst as if she were a strong male expressed what has been termed a thwarted need to grow (P. H. Ornstein 1985). It was the recognition of these needs and their systematic interpretation that exposed the patient's paternal identification as a defensive psychological structure. Progress in the analysis was indicated by the patient's increased vigor and aliveness, including a fuller and freer experience of his sexual passions, his anger, and his competitiveness.

DEVELOPMENTAL CONSIDERATIONS

Psychoanalytic theory is essentially a developmental theory. All psychoanalytic developmental theories have certain assumptions built into them. Traditional analytic theory assumes that development is propelled forward by the maturation of the two biological drives: sex and aggression. It is the maturational sequences of these drives that motivate the various phases in development: oral, anal, phallic, and oedipal. The basic premise or assumption of Kohut's developmental theory is that the task of early childhood is the establishment of a cohesive self. "Kohut's baby" (Tolpin 1980) is

not a helpless, passive infant; it is a reasonably cohesive unit with its center of initiative, capable of eliciting developmentally needed responses. This baby is very different from "Mahler's baby," who is autistic at birth and has to overcome a conflict-ridden phase of separation and individuation. It is also different from "Klein's baby," who is constantly endangered by hostile-aggressive impulses.

Kohut did not assume that infantile rage over helplessness leads to conflict that becomes the source of later psychopathology. Facing transient helplessness is inevitable. However, in a healthy baby, this gives rise to assertiveness and demands on the environment. Only when the environment fails to respond, when such demands are repeatedly frustrated, does rage become intensified. Since maintaining emotional contact with the environment is of paramount importance for young children, the rage cannot be experienced, and it certainly cannot be expressed; the rage is split off (disavowed) and becomes the potential source of psychopathology. Later in life, symptoms become manifest as disavowal is "reinforced" with layers of defensive operations; each compromise solution creates renewed anxiety. In this manner, chronic narcissistic rage may find symptomatic solutions in varied clinical pictures that might include, for example, sadomasochism, depression, eating disorders, addictions, or suicidality, among others (A. Ornstein 1998).

Symptom formation is conceptualized differently in self psychology than in traditional psychoanalytic theory. In the latter, repression (a defense against internal danger) plays a central role: drive derivatives and socializing forces give rise to conflicts, compromises, and eventually to manifest symptoms—the return of the repressed. Traditional psychoanalytic theory tied compromise formation to drive-related conflicts. However, once Kohut gave unmet developmental needs etiologic significance, this coupling had to be undone. In self psychology, it is not repression that is called into action in response to unconscious conflict and related anxiety. Rather, disavowal (a defense against external danger), as Freud formulated it in the "Project" (1895)—and later in relation to fetishism—takes on importance in pathogenicity.

Concerned with the abandonment of drive-related conflict theory in self psychology, Bacal and Newman (1990) suggested that the developmental theory of self psychology ought to be combined with drive-related, conflict-based theories of development. They called attention to the work of Winnicott (1960) and Bion (1977), both of whom recognized the step-by-step internalization of the mother's soothing function for the baby's acquisition of self-regulatory capacities, while retaining the drive-determined conflicts as essential in normal development. In the view of Bacal and Newman (1990), Mahler modified classical drive theory by stressing the importance of the quality of the mother–child bond as a precursor of structure and self-formation.

> While much of drive theory is retained, the object's role is greatly extended beyond simply that of the target for unfolding drives . . . . It is now possible to identify the dual aspects of the mother's role at all stages of development as the essential provider of phase-appropriate responses to maturational drives and needs and as equally vital affect regulator in her capacity as a provider of paradigms for modulating and containing. [Bacal and Newman 1990, p. 114]

In our view, drive theory cannot be meaningfully combined with self psychology in the manner in which Bacal and Newman suggest, because each theory has a very different axiomatic assumption. It is from each of these assumptions that all the rest of traditional and self psychological theoretical systems are separately derived, and within which each makes sense, even if neither can be "proven." Freud assumed that the human infant is born as a bundle of drives in need of being tamed, controlled, and civilized into a human being by its caregivers—hence, drive-defense conflicts are built into the *normal* developmental process. How and why these normal conflicts become pathogenic is variously understood within Freudian theory.

Kohut, on the other hand, assumed that the human infant is born with the capacity to elicit the nutrients it needs for its mental and emotional development in a potentially empathic surround.

Rather than considering conflicts and their age-appropriate resolutions to constitute the building up of psychological structure, Kohut conceived of structuralization as occurring through transmuting internalization—meaning that, with optimal frustration, essential caregiver functions become internalized and depersonalized. The functions and capacities so acquired are then in keeping with the infant's temperamental and other idiosyncratic, developmental needs.

In other words, drive-defense conflict in self psychology is not considered to be part of normal development. Rather, conflict arises either between the need for and fear of the caregiver early in life, or secondarily in response to an already existing deficit. In either case, conflicts that necessitate compromises already represent some form of psychopathology. With such diverse basic assumptions, then, concepts from one theoretical system cannot be transferred to another system, and they cannot be combined without the need to find their bases in different axioms or sets of axioms.

Furthermore, conflict in self psychology cannot be conceptualized independently from the intersubjective context in which psychological development takes place. In this particular intersubjective context, the personalities of the individual's caregivers —and, specifically, their capacity for "generative empathy" (Schafer 1959)—play a crucial role.

> The understanding of emergent conflict is (best) served by recognizing that, at every phase of development, the structuralization of conflict is determined by the specific intersubjective field in which it is embedded, just as its resolution in analysis is determined by the intersubjective dialogue in which it reemerges. [Stolorow, Atwood, and Brandchaft 1987, p. 90]

The child's needs for *specific* selfobject responses change with changing developmental needs. Caregivers who may be able to respond to a crib infant may not be able to be optimally responsive to a toddler-age or adolescent child. Some of the most severe forms of self pathology arise in situations in which caregiver roles are

reversed, and instead of having caregivers who provide needed selfobject functions, the child is *used* for the establishment or maintenance of the caregivers' self-cohesion and/or self-esteem (A. Ornstein and P. H. Ornstein 1985). Because of the developmental imperative to retain the selfobject tie to the caregiver, any attempt on the child's part to extricate him- or herself from feeling responsible for the caregivers' self-cohesion and/or self-esteem can lead to guilt and self-punitive behavior. As mentioned earlier, when such affects (rage, guilt, shame) and their related defenses come to be structuralized in a highly complex, layered manner, they become the source of a variety of self disorders. It has to be remembered that, under these conditions, the growing child is deprived of needed parental responsiveness; hence, the conflicts the child experiences in relation to these affects do not arise in a well-structured psyche, but in one that also suffers the consequences of deficits.

As we turn now to a discussion of some of the findings of the "baby watchers," we do not mean to imply that infant research can replace developmental theory based on the reconstruction of transferences; there is no one-to-one correlation between infant research and adult psychopathology. However, the findings of infant researchers have been traditionally used to confirm and/or to question well-established assumptions. The results of infant research can inform some of the assumptions that self psychology has made on the basis of the working through of selfobject transferences.

For self psychology, probably the most important of these findings is that the newborn is not undifferentiated, passive, and unrelated to its surround. This supports Kohut's assumption that the human infant, prepared by evolution, is born to live in a human environment. There is no need to neutralize and sublimate the infant's inborn aggression, since it is well equipped to elicit developmentally crucial responses from its environment. Infant literature has detailed a great many perceptual, social, and cognitive capacities with which the infant is ready to engage its human and nonhuman environment (Demos 1982; Lachmann and Beebe 1989;

Sander 1983; Stern 1985). Self psychologists note with some satisfaction that current infant research considers the establishment of a tension-regulatory system to be a fundamental developmental achievement, because self- and mutual regulation appear to affect many aspects of psychological development: "The infant is born with its own organization and capacity for self-regulation . . . . From birth, the infant has the capacity to regulate arousal and sleep-wake cycles, given an adequate mutual regulation with the caretaker" (Lachmann and Beebe 1992, p. 141).

In attempting to place conflict in a developmental, intersubjective context, we are greatly aided by the findings of researchers studying disorganized attachment. The findings of these scholars help us to conceptualize the developmental deviations that can give rise to intrapsychic conflicts and the need to compromise, without their being based on drive vicissitudes. In disorganized attachment, conflict in the infant arises because the caregiver is simultaneously needed and feared.

> The simultaneous activation and inhibition postulated stems from the nature of the attachment behavioral system itself, which is normally activated in the presence of fear or threat but which must be simultaneously inhibited in the case where the attachment figure is the source of the threat. [Lyons-Ruth 1999, p. 592]

CONCLUDING REMARKS

Psychoanalysis has long been characterized as a conflict psychology par excellence, with the clear implication that *only* drive-related conflict can be analyzed and thus resolved through analysis. Over time, the characterization of psychoanalysis as a conflict psychology has proven to be too narrow. Deficits (developmental arrests or derailments), too, had to be considered as playing a role in the genesis of psychopathology. The controversy regarding conflict versus deficit has become intensified by Kohut's introduction of self psychology. His idea that pathogenic conflicts occur secondary to an underlying deficit has turned into a fruitful, heuristic

assumption. It offers not only a plausible explanation for the way in which ubiquitous, normal conflicts turn into pathogenic forms,[5] but it has also expanded the range of psychoanalysis by encompassing the understanding and psychoanalytic treatment of severe self disorders.

Maintaining that the oedipal phase of development, similar to other developmental experiences, can be fully understood only when viewed in the context of the child's milieu, Kohut brought the neuroses under the umbrella of self psychology. We have illustrated this point with the clinical example of a patient whose analysis centered on the working through of his oedipal-selfobject transference.

The developmental theory of self psychology, based on reconstruction from the working through of selfobject transferences, has been buttressed in its essential claim by the findings of the "baby watchers." These mother–infant researchers do not view development as motivated by drives that create developmental conflicts that have to be overcome, neutralized, and sublimated in order for development to proceed normally. Instead, they describe the infant as competent at birth and capable of eliciting responses that assure progressive development. Potentially pathogenic conflicts arise when the caregiver, the provider of needed selfobject responses, is also feared.

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[5] In this context, we are reminded of Tyson's (1991) statement about the ubiquity of conflict (see p. 226 of this article).

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I WISH THE HOUR WERE OVER: ELEMENTS OF A MORAL DILEMMA

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In contrast to the viewpoint that sees conflict as deriving from defense against instinctual drives and thus as an intrapsychic phenomenon, this essay presents conflict as sometimes being an external opposition between disparate configurations of the self. These parallel sectors with different goals and ambitions can be seen in a continuum from the dramatic narcissistic behavior disorders to more subtle instances of moral dilemmas. A clinical illustration is offered to demonstrate its occurrence and management in psychoanalysis.

INTRODUCTION

A patient in psychoanalysis, shortly after contemplating and then voicing agreement with an interpretation that had been offered, announced an intense urge to get up and leave, i.e., wishing the not-yet-terminated analytic hour were at an end. Yet no sooner had this thought been uttered than there followed another wish of possibly equal intensity: that the hour not soon end. One might readily say that this patient was ambivalent about staying versus leaving, and, surely, it could also be said that he was in conflict about these two impulses or feelings.

The interpretation that had just been offered had to do with a somewhat corresponding set of issues in conflict, these having to do with the patient's father. Although initially, this patient voiced only negative and disdainful memories and feelings about

his father, over time, he had recalled more and more positive emotions about this parent, and, eventually, he had been able to contemplate how much the loss of his father meant to him. This traumatic loss had occurred when the patient was ten years old, resulting from an acrimonious separation and divorce. Although this had first been presented by the patient as an episode of relief to all (i.e., to the patient, his mother, his older sister, and a younger brother), it now served as the carrier of memories of both sadness and longing for the absent man.

The aforementioned relief of the household over the father's departure had been accompanied by an assignment to the patient of the role of man of the house—an assignment made by his mother, and one he had fulfilled with much satisfaction and pride. And so the conflict about departing the analytic hour early seemed to serve as a miniature enactment of that childhood event, in that getting up to leave allowed him to feel independent and no longer in need of his analyst, while remaining a patient for the rest of the hour became associated with the never-relieved sadness and yearning of the forlorn little boy. We seemed to be present at a paradigmatic illustration of conflict.

MULTIPLE PERSPECTIVES ON AMBIVALENCE AND CONFLICT

In "Inhibitions, Symptoms, and Anxiety" (1926), Freud presents his prototypical version of a conflict due to ambivalence, positing the case of Little Hans as demonstrating a "well-grounded love along with a no less justifiable hatred" (p. 102). Freud states that although this conflict may well lead to a symptom such as the phobia in Little Hans, it may also be resolved by way of an intensification of one of the two feelings and the vanishing of the other. Although the conflict arises from ambivalence, there may be no evident trace of either of the forces of opposition. The two feelings are no longer experienced consciously, and the conflict has now moved to another arena.

That move and disappearance of conscious conflict has been described in modern psychoanalysis as one existing between posited agencies of the mind. Thus, as the loving feelings of the little boy toward the father remain conscious, the hostile ones are kept at bay by the strength and opposition of the superego. Of course, the loving ones may also be repressed and vanish as well.

The simple formula of ambivalence is now a complicated complex, with some ambivalence being conscious and remaining so; some leading to conflict that in turn may give rise to a symptom, such as a phobia, or to a reaction formation in which overwhelming love drives away the hostility, or vice versa; and some simply seeming to vanish altogether. Indeed, the universality of both ambivalence and conflict gives one license almost to dispense with the specific meanings of the words. We can be ambivalent about the choice of a dessert, in conflict about a particular career decision, and seemingly free of either issue while the struggle remains an unconscious one.

It may be prudent to recognize that much ambivalence lies outside the usual meaning of conflict, as when one goes back and forth in choosing a particular piece of clothing for an ensemble; while some conflict may seem to be without ambivalence, as when we rid ourselves of an annoying fly or mosquito. The significance of Freud's presentation was to underscore the presence of opposition in the form of love versus hate. And the further import of his illustration was to position this opposition within the psyche, thus identifying it as an internal and constant struggle.

Keeping these simple perspectives in mind—internal, oppositional, and unconscious—I would like to offer a puzzle: a form of conflict that appears at times to satisfy none of these requirements, yet, paradoxically, also qualifies as conflict. This form of conflict is represented by the narcissistic behavior disorders, which range from cross-dressing to thievery to all manner of substance abuse. They are external for all to see. They exist, sometimes though not always without a sense of opposition, and they are conscious without exception. For sure, one sees a variety of qualifications to these points, but for the most part, they are con-

flicts that seem to defy the neatness of an internal, unconscious opposition of mental agencies. Many of these patients are completely aware of what they do and are not at all in conflict about it while they are doing it. Yet they unhesitatingly insist that they dislike or even despise these behaviors in retrospect, presenting them on those occasions as a conflict. They are miniaturizations of Jekyll and Hyde, and as Robert Louis Stevenson (1886) wrote, "Henry Jekyll stood *at times* aghast at the acts of Edward Hyde" (p. 87, italics added).

SOME THEORETICAL WAYS OF CONCEPTUALIZING BEHAVIOR DISORDERS

The theoretical underpinnings of narcissistic behavior disorders have been presented in detail elsewhere (Goldberg 1999), with reference to a variety of clinical case studies (Goldberg 2001). The crucial distinction offered to explain this form of disorder is that of a focus on the mechanism of disavowal, utilizing the concept of the vertical split. This configuration presents a psyche that is divided into two usually unequal, parallel sectors. These sectors are separated from one another and are initially characterized by having different and often opposing sets of goals and values. Thus, a seemingly proper and mature heterosexual man might coexist with one having a periodically active involvement in some sexual perversion. The activation of the perverse sector, of whatever form it takes, is episodic, yet that sector is capable of a complete domination of this man's personality. After the perverse activity subsides, there may be remorse and regret, and so these parallel sectors qualify as being in conflict and oppositional, yet the one or the other regularly submits to the control of its counterpart, and the opposition disappears.

What has become apparent in further studies of such behavior disorders is the lack of their confinement to the usual outstanding and dramatic forms of misbehaviors, such as the sexual per-

versions, and the recognition of similar configurations present in more subtle and common examples of conflict. Due either to our alertness to the existence of the phenomenon or to our reorientation in the ways of conceptualizing clinical material, we can now recognize the operation of disavowal and the existence of the vertical split in a wider variety of maladies. Thus, we can revisit an analytic patient and his or her presumed conscious conflict with an eye to ascertaining the likelihood of the patient's possession of parallel selves in a struggle (a conflict) to dominate and gain control of the psyche and the motoric mechanisms of behavior.

THE MORAL CONFLICT

To return to the patient of mine whom I described earlier, the initial examination of his battle between leaving and staying in the analytic hour, between independence and dependence, turned out rather surprisingly to me to be a moral conflict as well. We should all be familiar with what may be considered everyday and common (to therapists at least) moral conflicts. These range from our billing insurance companies for missed appointments, to changing diagnostic codes in order to ensure the payment of claims, to not declaring cash payments as income subject to income tax, to employing family members in mock positions in order to claim deductions, to moonlighting on top of salaried jobs that forbid outside employment, to claiming deductions that are personal forms of dining and entertainment as business related, and on and on. It is a rare professional who has not at one time or another been forced to consider and even to struggle with one or another of these issues, and it is probably an equally rare one who has not in some manner rationalized the embrace of one or more items on this very abbreviated list. The active involvement in such an activity that might be considered immoral or illegal is felt by some to be a game of getting away with as much as possible, and by others as an indicator of conforming to a strict code of propriety. Regardless of where one stands, the differentiation between saints and sinners is not an easy one.

Clinical Case Elaboration

In order to maintain confidentiality, I shall offer only that a particular psychoanalytic patient of mine, the one referred to above, was an active participant in one of these immoral ventures, and this fact became clear at the very start of the analysis. When I first learned of it, I had not a whit of personal condemnation, feeling it to be both *justified*—in that it was a perfectly proper thing to do, and *justifiable*—in that I and my patient could readily explain and support this sort of behavior. Thus, the supposed moral dilemma was initially without a voice.

My patient's peccadillo was not unfamiliar to me, and it seemed further legitimized by his having been given a form of a "don't ask, don't tell" injunction by a superior when he first inquired about it. Thus, the two of us conspired in an agreement that seemed to highlight the peculiar bind that is practiced and indeed forced upon so many people who continue to live by necessity in areas of moral and ethical discomfort. Of course, I do not offer this as anything more than a further bit of armor in the defense of one's ultimately unacceptable behavior.

Indeed, this behavior *did* become openly unacceptable when the patient announced one day that a particularly stupid act of his had led to the exposure of his heretofore secret misdeeds. As he described to me the foolish bit of behavior that led to his exposure, and as he asked me if it were possible that he himself had unwittingly and unconsciously brought about his own state of shame and embarrassment at being "caught in the act," I was unable to do much more than offer the opinion that I felt it unlikely that he wanted to get caught. Thus, we became further joined, now in stupidity.

Much of this patient's treatment after the disclosure of his misdeed seemed focused upon my championing his efforts to feel righteous and vindicated in what he had done, and there can be no doubt that I was quite unable to reach some midpoint of neutrality, or at least of analytic detachment, for quite some time. I cannot now be certain as to the moment at which I finally man-

aged that feat, but it was certainly after our analytic work revealed the father as a man who was himself wrapped in corruption and double-dealing, primarily with members of his own family. I am convinced that my own recognition of a personal and private moral dilemma did not arrive as a bolt from the blue, but instead grew out of a succession of uncomfortable feelings that were triggered by my efforts to see the situation from the point of view of my patient's protagonist. I think it is vitally important that one live for a while in this gray area of conflict. Although any psychoanalyst must or should have at least a touch of larceny in order to really help a thief, it is an equal requirement that a period of uncertainty be allowed to have its day.

I vividly recall presenting some of these ideas to a group of psychoanalysts in Philadelphia, when one analyst responded by recounting a vignette of a patient who had stolen a dress in a department store, and who then asked her analyst what he thought of her. He proudly told the audience that he had informed his patient she was a thief, after which he triumphantly sat down. My private thought was that she, of course, knew that she was a thief and hardly needed him to tell her that. What she needed, and what he could not supply, was for *him* to experience *her* conflict.

Living in uncertainty is not as easy as it sounds, since we know that most of our patients with behavior disorders do instead live in alternating periods of certainty. Surviving in the limbo of a dilemma is necessarily uncomfortable, and one is tempted to come down vigorously with a definitive pronouncement, just as did that unhelpful man in Philadelphia. However, the capacity to sustain the parallel state of supposed opposition is the first step in the achievement of a hoped-for integration of what has previously been split apart.

Integration does not by any means gain victory by favoring good over evil. Just as we all know or should know that forensic psychiatry has no room to breathe, with the prevalent McNaughton rule of only knowing and acting upon right from wrong, we should also know that mere cognitive certainty is a poor guide to emotional conviction. It is especially difficult in our efforts to

comprehend misbehavior for us to realize that what seems to be wrong beyond a shadow of a doubt is not to be simply judged according to the dimensions of right and wrong. Indeed, I finally succeeded in seeing that what my particular patient had done could have relatively equal support on both sides of the question. And so I was left with the proper stance for any analyst: a state of puzzlement, a condition that must necessarily precede that of understanding and the promise of resolution.

Analysts are not good moral barometers, despite their wish to be so. Our primary tool of interpretation represents but one way of looking at things amid a myriad of such ways. When we offer an interpretation, it is an invitation to the patient to appreciate a new and different perspective, but it cannot completely erase the point of view that the patient has lived by up until now. As much as we might like to feel that we know best, it is best to know that we but know differently.

The difficult task of integrating disparate points of view is no more one of reaching a compromise than it is of choosing one over the other. It is here that psychoanalysis offers a unique perspective by its claim of being a depth psychology: we must attend to what lies beneath this duality of purpose—a hint of which was offered to me by my patient in his announced struggle to leave or to stay.

A Dual Transference

The vision of the father retained by this patient was realized by his seeing me as a bright and competent figure on one hand, and as a corrupt and somewhat doddering fool on the other. Statements that I had made in one hour came back as deliveries by the patient in a much transmogrified form several days later, sounding like the mutterings of an idiot. My much-sought-after and happy neutrality was continually on the edge of being destroyed by a vigorous defense of mine—one aimed at clarification and a restoration of me as possessing unappreciated wisdom. Yet at times, I was convinced that I was indeed a fool, and so I

made a silent resolve to keep my mouth shut. (Perhaps some of the long silences commonly attributed to analysts derive from a similar sort of resolution.)

My patient seemed different from Little Hans not so much in his possession of "well-grounded love along with no less justifiable hatred" (Freud 1926, p. 102)—both of which were quite apparent—as much as in his failure to reconcile these emotions by way of identification with both aspects of his father. It became clear to me that he had suffered a traumatic de-idealization of a father who, in one sense, remained always outside of him and for whom he had conducted a relentless search. And what lay beneath this oscillation between the great and the belittled, the good and the bad, and all the other possible dualities was the depression that wrapped itself around him when he admitted to wanting to stay in the hour. The very recognition and articulation of that wish introduced him once again to an empty sadness that he now recalled had enveloped him when his father left home. He could try with limited success and urging from his mother to replace his father, thereby covering this inner feeling of emptiness, or he could vent his rage at the departed and disappointing father in a different but equally unsuccessful effort to obliterate his depression. Interestingly enough, one psychiatrist had earlier diagnosed him as bipolar.

The patient's split of the representative hour and those that followed could be said to nicely mesh with that of the analyst in his parallel, complementary split. We both knew right from wrong, yet had chosen a course based on a set of rationalizations that drowned out the legal issues. While never blind to the sector that we had chosen to disavow, we gave it little heed—until it slowly began to make a claim to recognition. At some undetermined point, we became locked in a moral dilemma and remained there until further psychoanalytic work revealed some of its origins.

I have here presented my main points about this analysis by focusing on the father, with little reference to the patient's mother. I do so in the interest of brevity, as well as out of my wish to pursue the line of inquiry introduced by Freud in regard to Little

Hans. Surely, no study of depression can be considered complete without an examination of the early maternal relationship. Nevertheless, this patient's life story did seem to founder on the rocks of some core depression that had telescoped into the time of the loss of his father, and it was there that the work of analysis came to be concentrated. And so it is there that one answer to the connection between psychoanalysis and morality can be focused. This is not to say that all moral conundrums are fundamentally psychological problems, but it is to suggest that psychoanalysis may have a contribution to make to issues of morality. Moral principles are not to be seen as either exclusively God given or intrinsic to humanity, but as solutions to psychic discontent as well.

THE CONTRIBUTION OF DISAVOWAL TO SUPEREGO EXPLANATIONS

The classical explanations for moral lapses have to do with the power and position of the superego as presented in the tripartite model of the mind. Failures in the strength and integrity of the superego allow for the escape of immoral or amoral action. Sometimes this has been conceptualized in the form of superego lacunae (Gedo and Goldberg 1973, p. 14), and at other times, as an identification with a criminal sort of superego (Benedek 1973, p. 246). The predominant feeling that dominates this oppositional scene is that of guilt, and the predominant defense that is operable or absent is that of repression.

A different model of the mind was first presented by Freud (1927) in his discussion of fetishism, where the predominant defense was that of disavowal. This was further elaborated by Kohut as a disorder of narcissism, illustrated by the positing of separate self configurations split off from one another. Neither model can or should claim exclusivity, since models should be viewed as conveniences or tools of explanation rather than as factual representations.

Disavowal, again according to Freud, has to do with perception of the reality of castration: either one has a penis or one does

not. In its more familiar usage as denial, once again, we see it in the denial of bereavement over a lost one, as well as in all sorts of common ways that the real world is not allowed to exist. When we move to moral issues, it becomes a case of the forbidden being allowed because of that absence of reality. From the commandments of religion to the injunctions of law, one is confronted with choices and options, to do or not to do, and the denial of the one allows the other. All of the "thou shalt nots" become abandoned or erased by the process of denial following the law of two negatives that yield a positive. All the boundaries vanish through the employment of disavowal.

If we return to the more obvious standards of the allowable, the study of behavior disorders enables us to better study the vertical split in individuals who are grossly aberrant. We are now able to see this split as operant in much more subtle kinds of struggles over what is proper and what is improper. And the inevitable conclusion is that there is no clear and unmistakable point at which a moral conflict moves from the minor to the significant, and so any and all such differences become a proper arena for psychological study.

The model of the superego in conflict with forbidden impulses arises in psychoanalysis by a transference displacement from patient to analyst—i.e., the analyst becomes the bearer of superego prohibitions, and the struggle takes place between analyst and patient. Thus, Little Hans might see his analyst as the embodiment of the superego, as one who would condemn and punish him for erotic feelings toward his mother and hostile ones toward his father. Agencies of the mind become realized in transference interactions. However, conflicts in these forms of narcissistic disorders often take a different form—they become realized within the person of the analyst who matches the patient's personal split. Thus, the patient's misdeed is not enacted and condemned in the interaction between patient and analyst, but rather, it is recognized as a conflict that is then experienced by the analyst. I do not tell my patient that he is wrong, so that together we can analyze the origins of his struggle, with its possible ensuing guilt. I

feel that his misdeed is justified at the same time that I feel it is wrong, and so I share his split. Unless I can do so, I may as well sit in mutual triumph with my colleague in Philadelphia as but a mere bearer of correctness.

DISCUSSION

Pluralism seems to predominate in today's psychoanalysis, but it runs the risk of engendering a certain laxity in the clarity and coherence of our thinking—while it also provides an opportunity to try out various perspectives in the effort to explain mental operations. It is certainly no radical move for us to consider a more central role for disavowal, and it is reasonable to suggest that the transference configurations relevant to disavowal will have a corresponding distinction from those witnessed in the mental model underscoring repression. Disavowal invites a scrutiny of reality. The objective analyst is able to form a realistic appraisal of the position or perception offered by a patient, and may respond accordingly—e.g., "you are wrong in seeing the world that way." We see this in the work of mourning, wherein the patient has to accept the fact of his or her loss. The empathic analyst is able to be realistic, but needs to share the disavowed sector as well—e.g., "You are correct to want the world to be different." My point is that the analyst, like the patient, can be both objective and empathic, thereby living simultaneously in what are essentially two visions of the world—visions in conflict.

One other unremarkable but often forgotten contribution to the conviction that one is correct and one is doing right is a feeling of pride and righteousness. The corresponding or complementary feeling attributable to uncertainty and error is often depression. This can be related, of course, to the vicissitudes of the operations of the superego, but, as in my patient described earlier, it can also represent the underlying depression found in many instances of disavowal. I suspect that further study of the types of transferences that present themselves in more subtle forms of be-

havior in conflict will lead to a deeper understanding of the qualities and treatment of various forms of depression.

SUMMARY AND CONCLUSIONS

The preeminent position of intrapsychic conflict in psychoanalysis merits rethinking with an eye to seeing it as but one way of examining and explaining a variety of oppositional struggles, ranging from indecision to ambivalence to reaction formation to all manner of symptomatology. The battle between instinctual drives and their control is an oversimplified truism that has failed to fully explicate the complex and different forms of transferences that emerge in psychoanalytic encounters.

The best available evidence for confirmation of a different way to think about a wide range of oppositional phenomena is gained by examining different forms of transference manifestations. Viewing disavowal as not only a defense offers us an opportunity to expand our theoretical vision. The particular form of transference seen in those who employ disavowal is a correlation of the vertical split in the patient to one that develops and emerges in the therapist or analyst. The split-apart sectors are often seen in opposition to one another, with one corresponding to reality (the reality ego) and one demonstrating a disregard of reality (the "misbehaving" sector). Psychoanalytic phenomena encourage a matched split in the analyst, reflective of the psychic makeup of the patient.

Analytic work involves the integration of these divided sectors, with particular attention to the underlying depression that seems to regularly characterize these patients. Interpretations of the drive-defense model may be more disabling than helpful, while interpretations of the dual sectors are experienced as ameliorative. As always, the best principle to follow in psychoanalysis is that of the interpretation of the transference, with the added recognition that transference takes many different forms.

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CONFLICT IN RELATIONAL TREATMENTS

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Various features of relational perspectives on conflict are outlined. Points of contact and difference between relational and modern conflict theory are discussed. Five approaches to considering conflict are examined: countertransference conflict as the site of interfaces between the social and the intrapsychic; conflict within the register of speech; conflict within a theory of multiple identifications; conflict as the site of psychic change; and conflict in the context of intersubjectivity. Clinical vignettes are introduced to illustrate the scope and function of conflict within one relational perspective.

INTRODUCTION

In a wry and ironic title, Spezzano (1998) asked what relationalists do in between their disclosures and enactments. He was addressing a quite persistent critique of relational technique, namely, that relationalists do not easily tolerate the play of conflictual states and experiences, either within or between individuals, tending instead to work toward the release of tension through gratifications of various kinds.

Given that their theory developed out of some antagonism toward drive theory, combined with their view of intrapsychic and interpersonal experience as co-constructed, as well as their commitment to intersubjectivity and often to explicit work with analytic subjectivity, relational theorists face a number of legitimate questions. Where is conflict, how is it constituted, how is it imagined, what model of mind underwrites the function and place of con-

flict, how is it sharpened and/or blunted, where is its place in technique, and are there conflict-free areas of functioning, in the vein of Hartmann (1939)?

The exercise involved in writing this article—to think about conflict from a relational perspective—has been challenging and demanding, because relational theorists have not made conflict a central, explicit focus of interest. Looking at my own theoretical landscape through the prism of a concept more closely connected to ego psychology or modern conflict theory has been a welcome adventure. Some familiar sites look different and some ideas tucked away on the margins get pulled to center stage.

In scrutinizing my own work, I find five different (but interdependent) ways that I think about conflict. Perhaps characteristic of the relational perspective, I see conflict in multiple forms and functions. I realize as well that I am using the concept of conflict at different levels of abstraction. I will illustrate with clinical vignettes five different but overlapping ways of considering conflict. I approach conflict (1) in countertransference and transference sites, at the interface between the social and the intrapsychic; (2) as a process within the register of speech; (3) as a concept within a theory of multiple identifications; (4) as the site of psychic change; and (5) in the context of intersubjectivity. First, however, I will present an overview of relational perspectives on conflict.

RELATIONAL PERSPECTIVES ON CONFLICT: DIALECTICS AND DISSOCIATION

Looking at relational writing with an eye to the place or function of conflict, I see that other terminology and other conceptual preoccupations fill the theoretical spaces where conflict might arise. Dimen (2003) and Hoffman (1998), for example, prefer the term *dialectic*. Both are interested in the productive tensions that appear under certain conditions of contradiction, primarily between analyst and analysand, but internally in either member of the dyad as well. It is important to stress that contradiction is not simply dis-

agreement or difference; rather, through various interactions, intrapsychic conflict can be triggered and developed, and vice versa. Intrapsychic conflict can be productive of external conflicts that are lived out interpersonally.

For Hoffman (1998), the fundamental source of conflict is neither sex nor aggression, but rather our deeply conflictual relation to mortality. Yet in one striking analogy, conflict—internal to the analyst, at the outset—between "working by the book" and working spontaneously is compared to the conflict experienced by the child between oedipal rival and love object (pp. 236-237). This analogy suggests how inevitably indebted any analyst is to the view of the centrality of sex and aggression to conflict, although these conflicts erupt in shifting states of affect (Spezzano 1998) or intersubjective space (Benjamin 1995, 1998) or relational constellations (Davies 1998, 2001).

Hoffman articulates a shifting model in which conflict comes to light both in the unique co-constructions of the analytic pair—that is, between its two members—and also flares within the individual. Co-constructions, in this sense, must include unconscious processes and multilayered experiences triggered intraindividually and interindividually. Conflict is an emergent property of interactions. Hoffman, like Benjamin (1998), argues for a fluid, shifting focus on the intrapsychic and the interpersonal, in which motivation exists on both an interpersonal level and in the service of relatedness and narcissistic needs. If there is a dual theory here, it is object relational/relational.

One can see a different, more postmodern perspective in Dimen's (2003) work: a focus on the liminal, unstable aspects of sexuality. For Dimen, sexualities' volatile, protean qualities position sexual experience as simultaneously internal/external, social/intrapsychic, and personal/political. Conflict is present both between and within levels of psychic experience. Like many relationalists, Dimen is interested in the phenomenological feel of conflict as a guide to clinical intervention and to understanding. While analysts from many perspectives may draw on this power of direct, apprehended experience as a guide to understanding,

it is located very much at the heart of Dimen's unique way of writing—as well as in her way of working, with the unsettling tensions, disruptions, and conflicts felt in the session sometimes serving as catalysts for a theoretical and conceptual understanding and dyadic process.

The preference for a term like *dialectic* is, of course, more than rhetorical. For Hoffman and Dimen, *dialectic* captures the dialogic, active, and interactive aspects of conflictual experience, its protean character. *Dialectics* offers the sense of a dialogue among alternatives, a registry of multiple voices, whether choral, harmonic, atonal, or of the call-and-response type. For Dimen, in particular, the form and function of conflictual life within the realm of sexuality attests to fecundity, surprise, excess, and irreducible trouble.

Conflict is relegated to a footnote in Stern's (1997) book, where the author explains that the absence of explicit use of the term *conflict* signals its use as a background supposition, while noting that it is of less formal interest than the shifting states of psychic experience. This is quite like the use to which Bromberg (1998) and Davies (1998, 2001) put the term. Conflict, for Bromberg, usually appears in the context of dissociation (see Smith 2000a for a discussion of the intersection with, and differences between, dissociation and conflict in Bromberg's work). Bromberg's working model stresses the expansion of the experiential relational field, so that conflict *becomes* discernible.

Both Stern and Bromberg place conflict within a model of multiple and shifting self states, where it is lived out in dissociated and discontinuous experiences, in ruptures in going on being. The apprehension of internal conflict, in a Brombergian treatment, is made possible by the creation of an interpersonal field in which the analysand can tolerate being seen by another person, and can, in a sense, borrow or absorb that observational capacity. Awareness of conflict is an emergent feature of this kind of relational work, requiring the establishment of conditions of interpersonal safety such that dissociated material can be held in awareness.

What is central in Davies's and Bromberg's technical choices is the need to attend to conflicts that arise in countertransference experience. The analyst's capacity to metabolize conflict may constitute a first zone of safety for the analysand's apprehension of conflictual material. I think that there is a strong appreciation of the power of unconscious conflict in this way of working, including the belief that unconscious conflict is transpersonally communicated—a notion that goes back to the preoccupations of and the early discussions between Freud and Ferenczi. Many relational analysts have a strong interest in the Freud who thrived in interaction with Ferenczi, the Freud of a particular historical period. This might be thought of as the Freud interested in mysticism, in unconscious transmissions, and in the particular power of regression (Aron and Bushra 1998).

Davies and Bromberg focus on dissociation, split selves, and shifting self states. Their model of unconscious conflict is actually more topographic than structural, in the sense that unconscious conflict is the impetus for changes in self states. Davies's attention to unconscious conflict is a nuanced attunement to shifting forms of identifications (partial and whole), played out in various permutations in the analytic relationship. One of her signature images is that of the kaleidoscope, suggesting the protean, changing experience of multiple identifications, as well as the subtle shifts introduced by the experience of conflict that lead to radical reorganizations. Conflict lies between states.

In some analytic traditions, these fissures in consciousness are captured in the distinction between horizontal and vertical splits. Smith's (2003) overview and organization of the concept of conflict is of relevance here, as well as his essays in which a number of cherished metaphors of psychic experience and the mental architecture of the mind are called into question (Smith 2000a, 2001). Much in the spirit of these articles, I have begun to wonder what exactly is at stake—or, to put the question in the language of pragmatics, what is the "cash value" of the metaphoric distinction between horizontal and vertical splits? In himself questioning the value of these distinctions, Smith opens up intriguing possibili-

ties: the interdependence of repression and dissociation, and their shared or perhaps oscillating presence in many micromoments of psychic and interpersonal experience.

A possible advantage I can see to using the concept of vertical splits in consciousness is that it is a way of describing or conceptualizing dissociation. I think this distinction is better captured by a shift from spatial to temporal metaphors, however. A focus on temporality was one of the features of Loewald's (1962, 1972) thought that was most attractive to Mitchell (2000). A rich and salient representation of unconscious conflict must be able to encompass both the experience of disavowed knowledge and that of doubled knowing/not knowing—the uncanny elements of conflict, simultaneously deeply familiar and frighteningly unknown. These states of mind oscillate and alternate in real-time experience.

Conflict in Aron's (1996) conception of co-constructed meaning making could arise from two sources: either the divided experiences of subjectivity that come from interaction and symbolization, or from experiences of recognition and solitude that arise in various interactions (Benjamin 1995, 1998; Slavin and Kriegman 1992). One type of acute conflict, from Aron's perspective, is located in the interpersonal and intrapsychic realm of the analyst and analysand, and that is the conflict between the wish for recognition and the wish for distinction, uniqueness, and separation. In fact, this is a conflict less of wishes than it is of relational transactions, a clash between paradigms of relatedness.

In the work of Dimen (2003), Layton (1998), Altman (1996), Flax (1990), Corbett (2001a, 2001b), and Goldner (2003), in particular, conflict is always located inside and between systems, political and personal, social and psychic. From this perspective, influenced by postmodernism, feminism, and queer theory, there is inherent conflict between regimes of surveillance and those supporting individuality and health, conflicts around normativity and freedom. These contradictions, which in political theory are sometimes posed as structuring conflicts of class, ethnicity, culture, or gender, are often lived out in countertransference conflicts experienced by the analyst.

Of course, the issue of political or politicized conflict in theoretical and clinical psychoanalysis is a very charged, unsettled, and unsettling one. It is one aspect of the dichotomy of internal and external reality. I think that postmodern psychoanalysts are striving to realize a particular vision of paradox or conflict in which a number of distinct but interrelated self states can coexist —those of healer, psychoanalytic police officer, subject and object of theory, and one who is the subject of and is subject to particular cultures, subgroups, and families. These ideas will be illustrated by clinical material in what follows.

Conflict in Relational Theories of Motivation

Any theory of conflict must entail some theory of motivation (Harris 2005). One of the foundational theorists of the relational perspective, Greenberg (1991), has come to feel the need to retain a concept of drive in order to talk about function. Mitchell's (1997, 2000) work followed a trajectory similar to a Fairbairnian model of relational conflict, moving on to a Loewaldian interest in attachment and development. Mitchell's view came to be that one is not drawn into, but rather is always already embedded in, interactive matrices.

It is not, perhaps, that relationalists eschew drive theory, but instead one might say—in the spirit of Ghent (2002)—that they view drive as having a lowercase *d*. Ghent's motivational ideas owe a debt to Edelman (1987), who imagines that human experience begins with quite simple, uninflected, primitive behaviors (turning to light and warmth, for example) that gradually become imbued with what Edelman terms *values*. In a developmental cascade that quickly becomes complex, small, subtle experiences (not consciously intentional) emerge as elaborated motivational systems. Sexuality, aggression, and safety are outcomes, not preset engines of development. Conflict then emerges into awareness—and note that it also is emergent, not preset at an unconscious level, according to Edelman.

Differences and Similarities of Relational and Modern Conflict Theories

In placing relational models of conflict within a wider consideration of psychoanalytic tradition, Smith (2003) poses some intriguing questions about differences and similarities across analytic schools. He connects Brenner's (1994) concept of *compromise formation* (that is, the ubiquity and interdependence of different compromise formations *within* wishes, defenses, and anxieties, as well as *among* these forces) to a model of mind that many relationalists (Davies, Pizer, Bromberg, Harris) might find compelling. Writing about the interlacing aspects of compromise formations, Smith notes that:

> Such a formulation suggests a fundamentally altered view of the architecture of the mind, one that we might compare to the endlessly repeating patterns, known as fractals, that we find in the natural world . . . . the analyst is immersed in a kind of cascade of conflictually organized compromises. [2003, p. 59]

For Pizer (1998)—who prefers the term *paradox*—conflict is unpredictably fractal, creating fragmentation and difference in multiple configurations. This may be an interesting theoretical evolution to watch. Is conflict a polarity and a dyadic opposition, or more fractal, informational, and multiply configured?

I would cite three principal differences between relational models of conflict, in the context of multiplicity and dissociation, and the conflict models of ego psychology as it has evolved since the time of Brenner's contributions. First, in the realm of technical choices, relationalists pay closest attention to unconscious conflict and the discontinuities and shifts in state that reflect unconscious forces. In a certain way, this may not always be so experience-near—or, more precisely, the relevant experience often involves an eerie sort of complete absence. Second, I would argue that relationalists like Davies and Bromberg follow a more topographic than structural conception of conscious and unconscious

conflict. A third distinction, important to me, is that a model of conflict within split selves and dissociated states allows a conception of conflict (and a model of minds) that is transpersonal as well as individual (Olds 1992a, 1992b).

Considering the shift in modern ego psychology introduced by Brenner (1982), it is hard not to hear as well the influence of another voice, namely, that of Schafer (1976, 1978), whose interest in action language and a less structure-driven way of thinking about mind and analytic work began to appear at about the same time. For Gray (1994), Brenner (1982), and others, clinical theory entailed a form of experience-near listening and imagining. And conflict is palpable in conscious experience—whether transpersonal, intrapsychic, or focused on affects, wishes, or ego states.

One intriguing (for relationalists, at least) development in modern conflict theory is the extension of Brenner's concept of compromise formation engendered by conflict to all areas of mental functioning. Rothstein (1999, in press) and Smith (2003) make this argument most explicitly. I take it that this point of view abandons Hartmann's (1939) notion of conflict-free zones of functioning. What replaces it is a model of analytic countertransference functioning that must be saturated with compromise formation. This change decenters analytic authority, a tendency also present in Lacanian thought and in relational critiques of ego psychology (Mitchell 1997; Renik 1993).

FIVE APPROACHES TO THE CONSIDERATION OF CONFLICT

I. Countertransference Conflicts: The Personal Is Political

In the light of Foucault's (1977) work and of the critical discourses of feminism and queer theory that have been formative for me, I try to attend to conflicts among regulatory practices. By this, I mean the conflict between psychoanalysis's coercive pressure toward normativity and its emancipatory impulse. I am part of the psychoanalytic generation that came into the field from

practices and histories of activism and highly conflictual relations with authority. These intellectual and pragmatic habits render the analytic position a carrier of conflicts about access to knowledge, power, and objectivity. I consider these contradictions to constitute an indissoluble conflict within the analyst's sphere of functioning—consciously, preconsciously, and unconsciously.

Psychoanalytic work always carries utopian and dystopian impulses. We work with contaminated tools, and, in carrying never fully resolvable conflicts ourselves, we are, in a strong sense, wounded healers (Harris, in press). This is one of the most intriguing kinds of conflict to manage, requiring our ongoing vigilance, repeated doses of humility, and persistent curiosity. Countertransference conflicts organized around these variables are a powerful spur to the interest of many relationalists in analytic subjectivity.

I have, for the most part, thought of these matters in the domains of gender and sexuality:

> Where gender or sexuality is concerned, we struggle with our own commitments and anxieties in regard to gender arrangements. As analysts we swim in complex waters, among all the eddies and currents of sexual and gender practices that our patients want help navigating and charting. It is one of the unique dilemmas of analytic work: the instrument of understanding, precision, insight, interpretation is the analyst's own incompletely conscious, rationalized body/mind. The unconscious or preconscious aspect of our analytic functioning is paradoxically the flaw in our knowing and the source of our knowing. We come with varieties of blindness—scotomas—in our ways of seeing. Our blind spots arise from our own histories as well as our places in history and culture. [Harris, in press]

Clinical Material. In my patient James's analysis, the external world intrudes, is made use of, is defended against, and contributes to our understanding of points of conflict in and between the two of us. I have thought of the various interdependencies of ex-

ternal and internal conflict as aspects of thirdness, but it strikes me that that term in this context submerges and dilutes the elements of conflict between analyst and analysand, between external and internal worlds. It is a treatment in which the dilemma of analysis in its utopian and dystopian forms—the conflict between analysis as normative hygiene and analysis as site of freedom and transcendence—is acute.

> James reports a dream. His friend (a doctor) is lecturing on mathematics. There is an equation on the board in which she is interested. James is seated, looking at his piece of paper. His equations are entirely different from the ones on the board. He cannot even understand how he got his forms and symbols from hers. In the corner of the blackboard there is a big projector, which James calls a *projection*. It is a swirling design that threatens to pull him into a big, moving hole.
>
> He rushes to tell me all the details, all his associations. He is fearful that if I don't hold all he has to say, he will be panicked. He wants not to be mad and not to be so frightened. How are women's equations mapped to men's? What swirling hole does he fear/want? What if his system of wants and equalities were like his mother's? Would he be a girl? Would he want her lovers? Or she his? He used his mind to claim separation but something has not worked.
>
> Am I stuck in formulas for desire and identity? Is the math a stand-in for the law? How many mathematical systems can you have? Can you break the law and make your own law? He has been involved in a scene with someone who represents to him the need to keep sex and love separate. He cannot do it; they are interlaced. Is he mad or what? [Harris 2005, p. 188]

James and I are both caught up in conflictual relations with normativity. The analyst is both the bearer and conveyer of law—in the dream via a mathematical formula to which he and I must adhere. But is the law of desire and sexuality like mathematical law—is it inexorable and indifferent to longing and direction? That

these are not merely postmodern debates over sexuality and performative identity is conveyed by the associations and further dream material that follow.

> When James really needs to convey to me how frightening his early and his internal worlds can be, he evokes the threat of terrorism. Not hard in New York. F-16s overhead, a drone of helicopters, siren sounds floating through the day or the night. James speaks about his fear that we might be incinerated right in the room, that the catastrophes ahead are inevitable. This works, I notice. I feel the visceral, thick fear that visits and revisits in the past year. He is apologetic but I realize as I sit in a numb, scared state that he has at last actually conveyed to me what he is feeling. Nor has thirdness disappeared or changed. Have he and I now come to sit numbly under the powerful control of either state-generated or privately generated fear? In the sense of a principle of thirdness that allows reflection, we are both in that moment bereft and unthinking.
>
> But we turn and work around terrorism in odd ways. James has a dream that I am an FBI agent (I think Clarice Starling; he is enigmatic), and I have an assistant. Perhaps it is James. But there is a terrorist bent on doing damage, and that man has an assistant. Definitely James. So we toggle back and forth between the idea of James as the assistant of the one who pursues terror and the one who deals it out. There is one odd detail. I have access to a light switch, which, at the moment I turn it on, will illuminate everything, and the terrorist and he will be killed at once by the teams of sharpshooters I have deployed. James is enigmatically the junior killer and the junior policeman who will be sacrificed in the wake of illumination. He is inside and outside the law. [Harris 2005, pp. 189-190]

Here the question of law and criminality is conflictual for analyst and analysand at many levels. The wish/need to contest rules and regimens of sex and gender must be seen as a site of multiple conflicts between social order and personal stability. Looked

at in one way, the political dimensions of our conflict in the dreams and in sessions may defend against intrapsychic and unconscious longings—incestuous, seductive, and asocial in function and intent. Looked at another way, the analysis is the necessary site for struggles over subjectivity, the inevitable—and inevitably conflictual—penetration of person to person and culture to person.

II. Conflicted Speech: Confusion of Tongues

I listen for conflict expressed and felt at the level of speech or representation. This conflict appears and structures itself in speech in a variety of ways. Multivoicedness and shifts in speech register are ubiquitous aspects of the language practices of parents and children from very early childhood. Wolf's (1990) fascinating observations of the speech of young children, aged three to five years, reveal the multivoicedness of even relatively inexperienced speakers. Children switch personas, speak in other vocal styles, and perform distinct characters in play, in dialogue, and in monologue.

It is this expression of the multiplicity of self states that in adulthood and in clinical analysis becomes the site of shifting perspectives and conflict. The conflict is manifest in the change in speech register that itself signals a shift in state.

To follow linguists like Bahktin (1981, 1986) or philosophers like Austin (1962) or psycholinguists like Lakoff and Johnson (1980, 1999) is to take up the inherent, indissoluble conflict in speech and in language practices of many sorts. Conflicts exist at the levels of meaning, of dialogue (who is speaking, who is listening?), and of pragmatics or action.

Because speech always entails an imagined listener, one can be pulled into experiences of and with another in the act of creative listening, experiences that cause one to be decentered. To be spoken to can be an act of colonization, an assault, an act of freedom—but, crucially, it is an act. Ricoeur (1970) developed this perspective with particular relevance for psychoanalysis. It is the active element in speech, its conflict with pure abstraction and rep-

resentation, that lies at the heart of the talking cure (Harris and Aron 1997). Conflict in the register of speech is one of the elements that makes psychoanalysis psychoanalytic (Harris 2000).

Speech acts theory (Austin 1962), the work of Bahktin, and the current models of embodied cognition developed by Lakoff and Johnson can illuminate aspects of this mutative force endowed to speech in psychoanalytic work. Talk functions as a cure because of the excess in words, because of words' materiality, their archaic residues of love and loss, and because the constitutive power of speech always depends on the intense object relations hidden within it. Talk cures through the puzzling interdependence of transference and speech's effects. This process has deeply preoccupied Laplanche (1989, 1997), who describes the infusion of unconscious desires in what he terms the parent's enigmatic signification to the child. For Laplanche, the message—occupying a third space, neither fully self nor fully Other—carries an excess of what is intended and an excess of what can be processed and taken in. Both the initiation and the reception of the message carry inherent conflict.

Clinical Material. In my work with Dee, the textures of speech and affect were major grounds of psychological work. An early and pervasive, recurrent topic of our work was the profound early loss of a maternal object and a maternal environment, a radical shift in the context of ongoing being in toddlerhood. This was a shift entailing enormous total loss of familiarity. There had been both a language change and a change in geography.

In the earliest stages of our work, the acoustic, material facts of my speaking were experienced as quite a stunning novelty. From time to time, as Dee thought about her earliest remembered history, I talked to her about what children at one and two years of age can do, think, say, feel. I was attempting to help her register the power of what had happened to her, to recover that lost little girl. Often in our sessions, dissociative states were pervasive, and my efforts to contact Dee in this way were frequently met with silence, brimming eyes, and a kind of inchoate affect which seemed beyond representation. Yet it was speech *action* that was effective, not *content,* for the most part; Dee made it

clear to me that what was helpful was being spoken to—the process, not the words. The solacing function of speech seemed to form the connective tissue of the analysis.

Horton (1984) wrote about this use of language. He was interested in the way words can soothe and regulate. He saw words and speech as a kind of transitional object, and he was particularly interested in *prosody,* the rhythms and tones of speaking. Horton's view of speech as embedded in and embedding mother–infant dyadic relations is certainly one of the ideas Kristeva (1980) had in mind in her concept of the *semiotic* and of *maternal chora*—a presymbolic registration of relatedness, sometimes somber, sometimes jubilant.

These moments of affective, vocal linking with Dee gradually came to seem more problematic, more conflict laden, more pregnant with ambivalence. I would feel increasingly long-winded; I was trying too hard, wanting to convey something. But I could feel that the effect of my speech was deadening, that perhaps the unbearableness of submitting to awareness of pain was leading me to move both Dee and myself away from feeling. The didactic commentary began to feel as though it were more for my benefit than for hers, a way of keeping out of awareness my own countertransference to her catastrophic losses.

When we think of language in this performative way, as both action and symbolization, conflictual elements in analytic speech are revealed, I believe. Psychoanalysis was founded in some formal sense on the distinction between word and action. Yet everything in contemporary linguistics and philosophy contests the purity of this distinction. Any act of speaking gives and withholds, names and acts, speaks to and speaks for another. In this way, the conflictual aspects of speech are both mutative and resistant, colonizing and linking.

III. Internal Conflicts: Multiple Selves

Influenced by Bromberg and Davies, I concentrate on conflicts that arise within shifting self states, both in a clinical dyad

and within the individual. Mitchell's (2000) term for this was the *manifold* self. In one sense, the debate over the unitary or manifold self may be a discussion about the levels of analysis. Coherence or unity of identity may constitute a powerful intrapsychic and personal experience. Yet from data on children's language, from developmental accounts, and from models of clinical interaction, a perspective on multiplicity of self states emerges out of more fine-grained microanalysis. The variability comes in the acuteness of the psychic shift and the presence or absence of a covering reflectivity that notes, observes, or regulates these shifts, which can be subtle or gross. Within this perspective, dissociation is the signature of unconscious conflict. Performativity may be consciously or unconsciously ironic.

The following vignette illustrates both the focus on speech as the site of conflict and the mutative conflictual power inherent in multiplicity and shifting self states.

Clinical Material. Elizabeth's speech practices, with me and with others, bring with them her conflictual relationship to her own needs and those of others. At the surface level, she is a brilliant practitioner of a kind of social mimesis, matching the tone and cadence of the other person in the dyad. But this attuning, caretaking way of being, originally tailored to the management of malignant levels of depression in her mother, could be exhausting. Others were construed as requiring huge reservoirs of social labor, and then resented as burdensome. Her relationship with me created a conflictual experience, as I appeared to both confirm and disconfirm her view of others and her responsibility toward them.

These conflicts emerged through particular forms of speech. In one session, during a period of Elizabeth's treatment when we had been explicitly questioning together her need to match and attune to others, we were examining a series of relationships in which the other's excessive neediness seemed so obvious, so prominent, so desperate. We had agreed that, in theory, these attributes of the other must reflect some aspect of the patient herself, some lost feeling of need and burdensomeness that was too terribly conflicted to be directly experienced.

On one particular day, our mode of talk—which could be at times quite easy, playful, and light—became a little firmer. I did not give up the seriousness (or perhaps I should say the intensity and aggression) in my comments. I held on strenuously to my interpretation of unconscious conflict. The next day, Elizabeth was quite tearful; still, she found an amusing way to speak about her experience. She said that the previous session had been like a meal at a sushi restaurant when the green mustard was too strong—there had been too much wasabi in the session. I had been too harsh. I was struck by how out of touch I had been with the too-rough play of the session. I had been quite blind (and deaf) to some aggressive resistance in me, or to some disavowed resistance to being dragooned so often into being the needy one. Two unconsciouses were in conflict.

Later, we revisited this moment in the context of another struggle around burdensomeness. Elizabeth was detailing the difficulty of handling neglected bills when she stumbled over the word *neglect,* and realized that she had not paid me that month. The next day, smilingly presenting her check, she said, "Okay, that's taken care of." I asked for her thoughts, and she was at first silent—then chagrined to have to report that the image/word picture that had crossed her mind was that of diapering and powdering a little baby, so that it was all cleaned up.

The shift in Elizabeth's state and in mine, often expressed in distinct vocal registers, covered and uncovered angry, contemptuous personae masked by sunny and calm exteriors. Performativity in the analyst or analysand reflects the possibility or impossibility at any given clinical moment of the awareness of conflict and pain.

IV. Conflict as a Site of Growth: Chaos Theory

Fourth, I think of conflict through the lens of nonlinear dynamic system theory, or chaos theory, in which conflict is the very provocative initiator of change. Within chaos theory, there is a theory of transformation. Disequilibrium arises out of conflict. Conflict is a source of change, movement, and understanding.

In many clinical accounts of the onset of reflective functioning, we might see that a complex, multiply configured experience of mindedness *emerges* from a polarized (often interpersonally deployed) experience of antagonism, in which the conflict is either invisible to the analysand or lived as an interactive battle in the transference. But this is a delicate matter. Some conflictual states are too hot to handle, as in a vignette described by Fonagy and Target (1996): A little girl playacts a set of games and imaginary adventures, passionately and determinedly, between an imaginary girl and her imaginary father. At a certain moment, the analyst "interprets" the sadness in the child in relation to the real losses she lives with—that is, he remarks on the conflict between levels of reality and pretend. At his words, the game of pretend daughter and pretend father instantly collapses. Conflict between imaginary and realistic situations is intolerable, and the following day, a new game is generated by the child—one with a new parent and a new conflict-free game. Here conflict was too hot to be bearable; it was therefore ineffective in serving as a catalyst for change.

Conflict in the service of growth or transformation takes different forms. Conflict, even at the unconscious level, between ways of being or ways of relating, can usher in a destabilization of pattern and negotiated experience. But there is a particular point in analytic work at which conflictual contradictions, either of mental representations or of object relations, are held in mind unflinchingly—a point where conflict may hover just at the edge of chaos. This is perhaps most acutely present in work with patients experiencing mourning and object loss.

Clinical Material. In my work with a mother of young children, widowed in the attacks on the World Trade Center of September 11, 2001, I found myself often dwelling in a world mixed with the living and the dead.

> Fifteen months after Chris's death, Pam and her daughter Sarah leave a holiday party. In a quiet, contemplative moment, a shared reverie on the ride home, Sarah says,

> "Mom, I want to say 'Dad.'" What does she mean, exactly, her mother wonders. "I want to say 'Dad' and have Dad pick me up." Pam realizes that amid the active party, Sarah has probably watched a number of children ask to be picked up by fathers. Pam says she misses Chris, too, and wishes he were there to talk to. They drive home in the dark.
>
> In this very affectively charged communication, Sarah has done something I believe is quite extraordinary. She has, in one sentence, been able to represent a wish, an envious feeling about the happiness of others, a lost hope, and a memory. [Harris 2005, p. 259]

A lot of work has gone into Sarah's reflective capacity in this moment. The pressures on Pam and her children in the aftermath of the father's death were excruciating. The developmental demands on the children to manage conflict were intense. But this is a dramatic example of the kinds of developmental transformations that all children successfully grow through. From a Piagetian or neo-Piagetian perspective (Fischer 1980), we might say that new forms of knowledge emerge from the challenge of conflict arising between experiences or beliefs at different levels of functioning.

V. Conflict at the Border of Self and Other: Intersubjectivity

I think about the presence of conflict in experiences of intersubjectivity. Ambivalence is present in all analytic and clinical dyads: an indeterminacy of location, of boundedness. Conflict arises at the often fluid points of contact of subjectivities, at the border of otherness, a border that moves, gets redrawn, and around which war and peace are often enacted. This unsettledness of self and other, this site of difference, may be a matter of alienation (Lacan 1977) and/or hope (Bahktin 1986). In clinical treatment, conflict —and, I would add, the deep asymmetry in conflictual states—constitutes a liminal space, like Bromberg's intermediate bridging space, in which psychic work can take place.

Clinical Material. Jeremy is a young man who has come to treatment after a long history of crippling depression and episodes of panic and annihilating anxiety. Frightened and painfully aware of the seriousness of his struggle to maintain sanity and hope, he has undertaken and arranged for his treatment in a careful, thorough way. As he says to me by way of explanation, "I am a clean machine."

Jeremy *has* to be a clean machine, as he is terribly afraid of his mind and his body—and, above all, of his feelings, which sometimes belong to his mental life, and at other times seem to become an embodied experience. In Jeremy's world, people chew each other up. Relationships are fraught with difficulty, self-consciousness, outbreaks of shame, and deeply dangerous rages. Jeremy's conflict lies between the deep loneliness of his situation, on the one hand, and his terror, pessimism, bad history, and uncertainty with regard to relationships, on the other.

The striking aspect of this treatment, to me, is that I feel no such conflict. In the room with him, I feel engaged, interested, involved. I do sometimes feel at the beginning of the hour that I am with someone really crazy, when he makes remarks such as "I feel like a refugee" or "I have a wooden leg." His face is contorted and grimacing.

But inevitably, in the course of the hour, I come to feel more and more connected to Jeremy. He gradually makes more and more sense. I have the experience repeatedly that we are becoming more familiar to each other, and that Jeremy is making more sense to himself. About this development, I suspect that he has great conflict, but little of it is visible. On the one hand, he despairs of being humanly related. On the other hand, giving up his identity of the eccentric oddball, the outsider, entails another kind of loss. One might say that his conflict is one of competing wishes or between modes of relatedness.

On occasion, after much work together during a session, Jeremy can locate this conflict in his own awareness. But, much of the time, at a phenomenal level, he exists in another kind of hell-

ish conflict. Since he is often crippled by anxiety, very simple tasks —getting coffee at Starbuck's, walking to the bus, choosing a pair of shoes, going to the gym—can become heightened torture scenes. Once we are able to slow down his process sufficiently to describe and articulate his shifting states, I hear that any encounter with another person stirs up intense storms of affect for Jeremy. He can become derailed merely in holding out his hand for a coffee cup. What if he drops the cup, spills the coffee, loses his keys, and cannot get back into his apartment?

It is notable—and almost frightening to me—that I do not get caught in this maelstrom. I look forward to Jeremy's sessions. We sit in a lively experience of engagement. Why is he carrying all this conflict? Where am *I?* I begin to realize that I do not hear or otherwise experience the transference in the room.

In writing notes after a session, I find myself describing an episode that Jeremy has just been describing: He met by chance a women trainer from his gym, who asked him in a friendly, easy way how he was. To his horror, unbidden and unwished for, he answered, "I feel like a rainbow." The rest of the session was spent in agonizing over why he is so crazy, so disorganized, out of control, "loopy," odd, and so on. When I offered the mildly expressed thought that perhaps he was happy to see her, he got much wilder, more sardonic, and made a mocking pretense at free association: When I said, "rainbow," he answered, "head in the clouds." He insisted until the end of the hour that this episode was emblematic of the fractures, holes, and muddles in his mind.

Only when I have committed the scene to a written note, later and by myself, does it occur to me that perhaps *I* am the woman trainer—a woman, Jeremy said, whom he likes very much and works well with. Talk about having one's head in the clouds! Once I begin to think about this discrepancy in affective states and my countertransference dissociations, I find embarrassing evidence of them in many clinical moments. Something has been very powerfully held at bay in my office, such that I am thinking more analytically only outside sessions.

Jeremy begins to describe the difficulties he has with writing. He details the experiences of collapse, disorder, loss of awareness, destruction of meaning, mental agony, and terror that this process entails for him. He is trying to convey the terrible feeling brought about by the collapse of meaning, by losing his way, and by finding his own words unrecognizable. One might conclude that he is conflicted about writing, creativity, aggression—all ideas that he and I explore.

But what I find myself musing afterward is that Jeremy has managed an hour of exquisite narration and nuanced thought about the mental conflicts of writing and thinking. This is a Jeremy who can really tell a story about a stalled, broken-minded Jeremy. He is certainly tortured—but not, I come to feel, conflicted. His conflicts (of which he is rarely conscious) might exist more in the realm of fear of surrender or fear of change—fears that lead to the psychic default of submission.

In a subsequent session, we go back to this narration, and I point out the difference between the person speaking and the person spoken about. "But I can never count on which one will be there, and I cannot hold onto anything I think," Jeremy complains. This is true, I feel; one dimension of the difficulty in holding and sustaining the self is the presence of another or others. Jeremy's conflicts are consciously intrapsychic, but unconsciously interpersonal. The effect on me in the room with him is to be split off from analytic reflection and from direct conflicts with him. He has retreated into a subterranean, split-off part of himself in which he remains very attached to me, and he keeps the links between us out of both his and my awareness. Conflict between us would be intolerable—the occasion of battles and chewing each other up.

Thus, Jeremy's experience of mental conflict does not meet the criteria I want to specify for conflict. That is, his deepest conflicts arise in the experience of another, and that is to be kept out of our shared awareness.

This particular, uneven division of emotional labor forms one thread of Jeremy's transference to me as a too easily idealized,

sunny, inattentive mother. In a sense, he reenacts with me a central role: that of the identified patient, the family member whose madness functions as a kind of caretaking of others. We explore our separate and our collaborative fears of changing this arrangement, of letting conflict appear between us or within me.

At this point, it becomes clearer that Jeremy is protecting me and himself from his potential for violence, either in feeling or in intended action. The fear of hurting whomever he loves, the confusion of love with violence, is overwhelming. A number of conflictual relational matrices have been reproduced between us in the analysis. So, the conscious intrapsychic conflict in this analysand reveals the force of his unconscious conflicts about damage, relatedness, and safety.

CONCLUSION

One of the signs that this task of writing about conflict from a relational perspective has been deeply important and informative for me is that I am left with more questions than when I began. Certainly, one's theory of motivation plays a large role in how conflict is imagined. Does conflict arise or emerge from situations of interpersonal or intrapsychic unsafety, of anguish, danger, transgressive desire?

To me, the most interesting questions relate to how one might distinguish and interconnect dissociation and repression. This is an issue raised by Smith (2000a, 2001) in various contexts. Are dissociation and repression different processes, given that the outcome is different? Is the crucial distinction the different engagement or status of unconscious, preconscious, or conscious states? I find myself mindful of the thinking of McDougall (1980, 1989), whose account of certain kinds of hysteria describes a disavowal of conflict prior to mental instantiation, a process that has very much the feel of the way many relationalists speak of dissociation.

Conflict seems not only to have multiple functions, but also to be lived within a wide affective spectrum. Conflict can be disa-

vowed, of course, but as it comes into consciousness, it can be variously intolerable, mournful, playful, or bracing. Psychoanalytic skill, perhaps, consists of the ability to titrate conflictual experience in order to maximize transformation and change. Almost invariably, this means titrating and tolerating the experience of conflict in the analyst (Smith 2000b). Indeed, analysts from many different traditions use conflict as a signal, particularly a signal in the analyst, taking up the experience in variable and creative ways that can potentially lead to insight, caution, hope, and dread.

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SOME REFLECTIONS ON THE USE AND MEANING OF CONFLICT IN CONTEMPORARY PSYCHOANALYSIS

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The author reflects on the concept of conflict in contemporary psychoanalysis, and especially in European psychoanalysis. In the latter, this concept does not seem to have aroused significant interest. This does not necessarily mean that conflict has been rejected or replaced; rather, there has been a greater focus on preconflictual stages of development. Indeed, conflict is generally implicit in psychoanalytic work, and, like many other concepts, it has very different and at times divergent meanings, both in various psychoanalytic schools of thought and within the same school.

The author presents a clinical example to illustrate some of the possible choices of the analyst at work concerning the use of the concept of conflict.

In this paper, I will not deal with the history of the concept of conflict or with the variations it has undergone, both in Freud's work and in that of his successors; nor will I analyze the different positions of the better-known theorists of conflict, who are mainly from North America. Smith's (2003) excellent work exempts me from the task, which he has done much better than I could. The reader must keep this in mind, since for the most part, my ideas are expressed in dialogue with Smith's theses.

"Time was when conflict was universally acknowledged as the defining focus of psychoanalysis . . . . This is no longer the case" (Smith

2003, p. 49). Since when, we might wonder—when did psychoanalysts stop considering conflict as the main focus of psychoanalysis? And to what extent have they done so?

A search for *conflict* using Psychoanalytic Electronic Publishing identifies more than 10,000 papers that in some measure discuss the concept. Most of these are not specifically about conflict, but a thorough sorting process reveals that at least thirty of them focus on the theme: psychic conflict and defense, psychic conflict and the structural model, the components of psychic conflict, inner conflicts, conflict and deficit, convergent and divergent conflict, conflict and splitting, conflict and compromise formation, and conflict and reconciliation, among other aspects. (See, for example, Abend 1981; Abrams 1974; Boyer 1971; Brenner 1979, 1982; Kris 1985, Pao 1970; Pine 1994.)

This research sample includes only works written in English. Recently, some English-language journals—specifically, the *International Journal of Psychoanalysis*—have published several articles written in other languages and translated into English. It is noteworthy that most of the works written on the theme are by North American analysts, with few exceptions, which correspond mainly to the sector of British psychoanalysis that adheres to the teachings of Anna Freud. There is no doubt that French psychoanalysis allocates an important place to conflict in its theorizations; however, as in other psychoanalytic cultures, this occurs with very different emphases and iterations.

But I do not intend—nor could I do so, without lengthy and detailed research—to follow the comparative development and use of the concept in various cultures. I wish only to make some observations that elaborate Smith's comment quoted above—that is, when it was that the concept lost its explicit centrality in psychoanalysis.

The Kleinian psychoanalytic world can be taken as an example. If we consider the four volumes of Klein's work, we find that *conflict* is mentioned many times in the index of the first volume (e.g., the capacity to bear conflict, displacement of conflict, the ego exposed to conflict, and conflict between love and hate). The works in this volume were written between 1921 and 1945. In the third volume,

which incorporates Klein's writing of 1946 to 1963, the term appears only once in the index, as the "need for conflict," in reference to the following quotation:

> The absence of conflict in the infant, if such a hypothetical state could be imagined, would deprive him of enrichment of his personality and of an important factor in the strengthening of his ego. For conflict, and the need to overcome it, is a fundamental element of his creativeness. [Klein 1994, p. 186]

From this quotation, it can be seen that, even though the concept appears once only in over 350 pages, the author attributes to it a fundamental role in child development.

If we now turn to the last of the above-mentioned Kleinian volumes, the number of times the term is included in the index increases, but its specificity becomes rarefied, and the editor of the index associates *fights* to the term *conflict,* clearly indicating that it is used on many occasions and not always with the classical psychoanalytic meaning of *conflict.* Under the index heading of *conflict,* we find the following subcategories: that between analyst and mother, the attempt to avoid it, conflict about the current relationship, that about the loved person, that between love and hate, conflict of loyalty, that between nurse and cook, that between parents, and between parts of the self. Some of these conflicts are interpersonal; some are clearly conscious; and the conflict between parts of the self appears for the first time in Klein's work. This last entry refers to the "Notes to the Ninety-Second Session of 'Narrative of a Child Analysis,'" in which Klein writes:

> The collision between the good objects and what he [the child analysand] felt to be the bad ones (because he had attacked them and wanted to deprive them) was also a conflict between one part of himself felt to be good and allied with the good object and the hostile part of himself allied with the objects felt to be bad. [1994, p. 461]

What can we deduce from these references taken from the indexes to Klein and from these quotations? It seems to me that,

during the first period of Klein's work, the concept of conflict was used in more or less traditional terms; at the time of the third volume, the only mention of conflict was its central role in the structuralization and development of the infantile mind. During the last period, it is possible to identify three specifically psychoanalytic uses of conflict: the attempt to avoid it, that between love and hate, and conflict between parts of the self. However, one has the impression that conflict as a theoretical term, the "defining focus of psychoanalysis" (Smith 2003, p. 49), has already been integrated into a more general theory of the functioning and development of the mind.

A superficial and rapid search through the indexes of some of the better-known Kleinian authors reveals some interesting results. In Joseph (1989), Rosenfeld (1965, 1987), Britton (1998), Steiner (1993), and others, the term is not included in the indexes at all. What is the meaning of this absence?

It does not seem reasonable to suppose that Kleinian psychoanalysis has eliminated the concept of conflict, or that it feels it can do without it. Alternatively, one might think that Kleinian psychoanalysts—and not only that particular subgroup—take the existence of conflict for granted, and yet integrate it into a conception of the mind that has replaced or renamed many terms of the traditional psychoanalytic vocabulary. An example can be found in Rosenfeld (1965), in which the term *conflict* does not appear in the index, as noted above, but the title and content of his fourth chapter, "Notes on the Psycho-Analysis of the Superego Conflict in an Acute Schizophrenic Patient," are mainly about this topic. Rosenfeld, who takes his inspiration from various authors, including Pichon Rivière (1947), defends the centrality of conflict between id and superego (or the ego at the service of a primitive, sadistic superego). In the follow-up to his interpretation of this conflict, his theoretical reference is explicitly that of Kleinian theory relative to the early origins of the superego—to the paranoid-schizoid position, to schizoid mechanisms, to idealized and persecutory objects, and so on (Rosenfeld 1965, p. 70). It is fairly clear that the concept of conflict—in this case, in partial contrast to the Freudian placement of

conflict in schizophrenia "between the ego and the external world" (Freud 1924, p. 152)—is omnipresent in Rosenfeld's thought, although it is not taken into particular consideration.

In fact, after having emphasized the role of the superego in schizophrenia, the task that Rosenfeld sets himself is that of pointing out how a different theory of the mind in the "very early developmental stages" (p. 70)—the paranoid-schizoid and depressive positions—can contribute to a better understanding of psychotic pathology. Conflict remains integrated within the general theory and is not dealt with as such. This can be deduced from the work of Steiner (1996) as well, in which, after clearly explaining his "theory of mental conflict," he notes that:

> The conflict theory retains a central importance but has been greatly enriched by Melanie Klein's description of schizoid mechanisms (Klein 1946, 1952). In particular, the discovery of splitting and projective identification radically affects our understanding of mental conflict, alters the basic model of mental disorder, and fundamentally affects the aims of psychoanalysis. [p. 1074]

I think that other theorists in the Kleinian area—as well as those of other orientations—behave no differently. This does not detract from the fact that, as Smith (2003) rightly points out, the concept itself, even for those who explicitly refer to it, can assume very different meanings, not only concerning its contents (this is obvious), but also regarding different levels of abstraction, different inferential processes, differences between intrapsychic or intersubjective conflict, and differences between unconscious and conscious conflicts. This is a topic that Smith's (2003) paper developed very clearly in his careful study of the different positions of four North American conflict theorists, and I shall not further discuss it here. I prefer to examine the compatibility—or not—of the different versions of conflict as described by those authors who theorize about it explicitly, as well as those who use it implicitly without dwelling on it.

But before doing so, I would like to propose a brief digression relative to the dialogue about psychoanalytic concepts. I for-

mulated what follows during the course of research on the concept of projective identification carried out in the various psychoanalytic societies constituting the International Psychoanalytical Association (Spillius et al. 2001). This meant analyzing the variations that the concept had undergone in different psychoanalytic cultures and the use that was made of it in clinical practice. It was a conceptual research project that utilized material published in various countries. Even though this study related to a different concept, the results that it produced led to my reflections on conflict.

SOME GENERAL AND EPISTEMOLOGICAL PREMISES

Some preliminary statements could be useful in illuminating our discussion:

1. Even when we have in mind the study of the development of a specific psychoanalytic concept, it is necessary to first outline the history of the general evolution of psychoanalytic theory in each geographical area, and to describe the training modalities in the psychoanalytic institutes there, as well as the general social and cultural orientation. The acceptance of a particular concept by the psychoanalytic community is the result of many factors, as is clearly illustrated in Smith's (2003) article. It is not by chance, as I emphasized previously, that the majority of the works explicitly dealing with the topic have been written within the arena of North American psychoanalysis.
2. From an epistemological point of view, it is advisable to offer some preliminary specifications. Two interpretive positions vis-à-vis today's theoretical pluralism can be identified. One position states that psychoanalysis possesses a central, indispensable nucleus composed of a small number of fundamental theoretical propositions, to which "puzzle" solutions (Cooper 1985) are linked in

an attempt to solve particular problems. The other says that we are dealing with divergent and competing theories concerning the psychic apparatus. My view is that each of these positions presents a different theoretical picture, both in the sense of a global theory and in regard to the details of the functioning of the psychic apparatus.

3. The unity of analysis, from an epistemological point of view, is theory. The empirical data with which we work are data of the methodological empirical basis—i.e., they are data that presuppose the use of material or conceptual instruments that in turn derive from a theory. A different theory of the instrument (or the use of a different instrument) has an inevitable effect on the methodological empirical basis, on the method itself, and, consequently, on the theory. This assumption is the most definitive from an epistemological point of view, and certainly the most interesting, for the problem with which we are dealing. Waelder's (1962) schema are relevant here, but could prove to be the source of some difficulties. If we agree with Smith (2003) that Waelder's three levels of clinical observation, clinical interpretation, and clinical generalization do not present a contradiction between the different views he analyzed, then we must admit that we are assuming that different theories and different instruments do not modify the methodological empirical basis. The methodological empirical basis, as I have already noted, consists of data that even in the purest state must be filtered through the lens of the theory on which the instrument is based.

   Let us take the example suggested by Smith: Gray, who, according to Smith, "has moved the theory of conflict and compromise to the forefront of the analyst's mind at work, where the notion of conflictual interference with the expression of drive derivatives becomes

a kind of filter through which he views the patient's associations" (Smith 2003, p. 68, italics added). This approach to analytic listening is termed *close process attention* by Gray, according to Smith. Smith himself speaks about a kind of filter that all analysts use in listening to the patient's associations—a filter that varies from one analyst to another.

But, by definition, this makes it improbable that different theories producing different methodological empirical bases can be considered compatible in sharing Waelder's (1962) initial three levels. This would imply affirming, as has been done in the past, that we psychoanalysts are divided by theory and yet have a common empirical basis. For the reasons expressed above, this proposal is contestable. Although I am not excluding the possibility that the different theories discussed by Smith may be compatible, they should be so at a "high" theoretical level, and not at the observational or interpretive level of Waelder's schema.

4. It can always be argued that these are different *vertexes* (Bion 1965) of observation, and one can continue to try to integrate them. We do this daily in our clinical work, consciously or unconsciously. But in my opinion, the compatibility of these theories cannot be determined at the levels of observation or interpretation of data (Canestri 2001, 2003a).

5. If we agree with what has been said thus far, we must ask ourselves whether we can use a concept taken from one theory in the context of another theory, without altering it or modifying it into something else, and without a particular concept's entering into obvious contradiction with the theory into which it has been imported. I must say that, looking again at the available material on this theme, it is difficult not to notice that, in certain uses, the concept of *conflict* is ren-

dered unrecognizable and incompatible with its guest theory, as well as incoherent.

6. Any concept of psychoanalytic theory cannot be formulated, discussed, and put into practice outside a more general hypothesis incorporating the development of the psychic apparatus. Whether consciously so or not, every concept is embedded in a theory of development and cannot exist if intrinsically in contradiction with it.

CONCEPTS AND DEVELOPMENTAL THEORIES OF MIND

Probably, the last of the foregoing statements is the one most likely to prove decisive for matters concerning the concept of conflict and its use in clinical practice. My opinion is that finding compatibilities among the different theories on conflict is relatively easy, as long as there is no great difference in their hypothetical descriptions of the development of the psychic apparatus. From a certain viewpoint, and taking into account the previously formulated objections, the four positions analyzed by Smith (2003) could become compatible at a higher theoretical level than is conveyed by his discussion, to the extent that, although they postulate different theories of the mind, they do not diverge too much in their hypotheses about the development of the mind itself.

But the situation becomes significantly different when the theories of the development of the psychic apparatus—or, one might say, of the mind—include the hypothesis of a preconflictual period. This is what Smith implicitly admits when he notes: "Some analysts, including some self psychologists, focus primarily on defects, deficits, and dissociations—or 'vertical splits' (Kohut 1971, p. 176)—considering conflict to be a later developmental achievement, and in certain cases, a later focus for analysis" (Smith 2003, p. 49).

This is clearly the case with Winnicott (1965, 1971) and with those theorists who, using different emphases, are oriented toward

the formulation of theories of development that are congruent with the theories of British psychoanalysis. I shall take as an example the Italian analyst Eugenio Gaddini, because some of his ideas are useful in reflecting on the clinical example that I shall present later. Gaddini—like Winnicott and Greenacre (1969, 1971), although independently and with sometimes quite noticeable differences—is among those who, contrary to Klein, do not accept the existence of an ego that has functioned since birth. Gaddini develops the notion of self—a concept shared to a certain extent with other authors—by taking as a starting point what he sees as the existence of a *psychosensory area* that precedes the perceptions *stricto sensu*, inasmuch as those perceptions presuppose structures that the author believes will develop later on.

In Chapter 11 of *A Psychoanalytic Theory of Infantile Experience* (1992), entitled "The Presymbolic Activity of the Infant Mind," Gaddini introduces his main concept, the *basic mental organization* (BMO), which corresponds to the period between biological birth and psychological birth, and is characterized by separateness. During this period, the central task is to manage the relevant and intense demands that the body makes of the as-yet undeveloped mental structure that we will subsequently call the *mind*. In other words, a *mental* sense is given to an experience that is conceived at first as sensorial and only later as perceptive.

This BMO results from sensorial activities that Gaddini considers to be mainly of *contact,* although he includes in this category all the modalities of the sensorial world, noting that they will contribute to the formation of what will subsequently become the self. However, the BMO is of a fragmentary nature, even though, after separation has occurred and before integration takes place, it serves to keep together the fragments that compose it. The prevailing anxiety is of the loss of self, a type of anxiety that can either promote or obstruct integration—an integration that in some serious psychopathologies may not succeed, or at least not in such a way as to allow the subject a sufficiently satisfactory structuralization of the psychic apparatus. It is evident that all this will impact the psychoanalytic process in different ways, and will, in any case, represent a serious obstacle to the cure.

There are two main fears or anxieties resulting from a damaged BMO and from an inadequate separation-individuation process: the fear or anxiety of *integration,* and the fear or anxiety of *disintegration.* The patient fears every change as one that could annihilate him or her, and, consequently, the patient will "choose" to remain in a state of non-integration. These anxieties lead the patient in one of two possible directions: either toward a greater integration, or toward the hypothetical disintegration of the psychic apparatus (i.e., Bion's [1965] so-called catastrophe).

In this brief note about Gaddini's ideas, I certainly do not intend to give a full explanation of his theoretical frame. I merely want to emphasize that conceiving a development of the psychic apparatus that incorporates the hypothesis of a preconflictual period, as Gaddini does, has consequences. First, in order to analyze conflict, whatever theoretical conception one uses, it will be necessary to resolve, if possible, the problems connected to defects deriving from a deficient BMO, from a separation that did not take place or took place defectively, or from an individuation that was absent or incomplete. From this point of view, the resulting conflict will remain "a later developmental achievement, and in certain cases, a later focus for analysis" (Smith 2003, p. 49).

Let us try to find some possible solutions to the theoretical challenge of rendering compatible theories that at first seem noticeably different. One might suppose that the fundamental Freudian principle of *Nachträglichkeit* (retroactive resignification) should help us to recompose the picture. Do we not say that the subject goes through all the hypothetical phases of development in his or her own way, but that each of them will be resignified a posteriori according to subsequent experiences? Could we not say also that the preconflictual phase in the development of the psychic apparatus will, in any case, become integrated and resignified according to what the subject subsequently experiences? This is a possibility, but it does not solve a fundamental problem about the preconflictual area, i.e., that it is described as one in which the concept of conflict has no specific meaning, since the structure that would make it intelligible is missing. It is a prestructural state of the mind.

Instead, one could postulate a situation in which distinct areas of the mind coexist, some of which are preconflictual, while others obey the rules governing conflict. Conflict would then need to be categorized into preconflictual and conflictual types; but this is very much like suggesting what epistemologists call the construction of ad hoc hypotheses, whose purpose, in most cases, is to keep an unsatisfactory theory alive at all costs.

It is pertinent here to review our ideas on the concept of development, pointing out that it can never be conceived as exclusively linear; in the same way, we should abandon the unlikely image of stages that follow each other in a certain order and with a certain rhythm, replacing one another as the previous one is overtaken. Inderbitzin and Levy (2000) present some ideas on development and, consequently, on the concept of regression, that are in agreement with what I have said previously. I have favored the possibility of considering the phenomenon of temporal regression as a quantic state of overlapping states that, at a given moment and in certain conditions, precipitates into one particular state (Canestri 2004).

But this updating of our ideas on development (and many other viewpoints are also possible) does not answer the question at hand. The hypothesis of a preconflictual state continues to be incompatible with other hypotheses that suggest the existence of conflict from the very beginning. This preconflictuality must be defined, in any case, in the absence of conflict, since the structure that would make this possible and conceivable is absent. Certainly, hypothesizing the absence of a structure, of a self-object—of differentiation already outlined at the beginning, a separation-individuation that exists at birth (even if in an embryonic state), an incipient ego, and so on—will have many repercussions on theory, and, certainly, not only concerning the concept of conflict. Another such concept is projective identification: it is not conceivable unless self-object separation is postulated right from the beginning. A mother–child fusional state, such as that described by Winnicott (1965, 1971), does not authorize the introduction of a concept like projective identification from birth, not even as a very early and

normal mode of communication (Bion 1965). One could postulate a mode of communication with characteristics similar to those suggested for projective identification, but those essential theoretical presuppositions that define it as such would be missing.

It is understandable that accepting these ideas will have repercussions not only on the theoretical field, but also, inevitably, on technique and on how the cure is conducted. If the analyst is dealing with a preconflictual area, his or her interpretation of the phenomenon cannot be made in terms of conflict, whatever theory the analyst may choose to inform his or her conceptualization of conflict. Instead, the analyst will turn to identifying the prevalent anxieties of the patient who is fighting against loss-of-self anxiety, trying to determine whether the prevailing anxiety is connected to fear of integration or to fear of non-integration. The patient does not conceive of him- or herself as separate, and sometimes, for the patient, separation is synonymous with psychic death; at other times, the patient tries desperately to oppose any form of progress, which would be represented by an increase in the level of integration of the fragments of the BMO, in order to make way for an autonomous self who is capable of developing an individual mental life. The fear of integration prevails and the patient backtracks, remaining in a state of non-integration that seems more reassuring. Interpreting in terms of conflict—if one moves within this theoretical frame—proves to be inadequate and in some cases damaging, unless the analyst interprets a conflict between preconflictual aspects and conflictual aspects of the patient's mind. This is possible from a clinical point of view, but, as I mentioned earlier, it is unsatisfactory from the viewpoint of the integration of theories.

This is the reason why I consider that the theory of development favored by the analyst becomes—in this case, and perhaps in many others—a discriminating element between different psychoanalytic theories and models; and, in some ways, that favored theory of development is the main reason for the noncompatibility among theories. The fact that these theories of development of the mind (I am not talking about development in observational terms) are purely hypothetical (Freud would say *speculative)* does not change the essence of the problem at hand.

In his analysis of different theories of conflict linked to certain North American authors, and in discussing Bromberg's ideas in particular, Smith (2003) proposes a solution that resembles the one I have been discussing. Quoting Bromberg, Smith writes:

> Thus, Bromberg (1998b) posits a "structural shift from dissociation to conflict" (p. 283) and advocates that "part of the work in any analysis . . . is to facilitate a transition from dissociation to conflict" (p. 275). More recently, Bromberg (2000) suggests that in a typical analysis, there is a shift from "a mental structure in which self-narratives . . . are organized primarily dissociatively" to one in which they "will be able to engage one another conflictually." [Smith 2003, p. 82]

I will not further enter into Smith's discussion of Bromberg's premises, except to say that Bromberg's hypothesis of a shift from dissociation to conflict is very similar, from the point of view of logical presuppositions, to those of Winnicott (1965, 1971), Gaddini (1992), Greenacre (1969), and others who predict the existence of a primary preconflictual phase, with a subsequent shift that leads to the constitution of the structure and ultimately of the conflict. Smith proposes that the activity of dissociation, when it appears in clinical work, is a compromise formation and can be analyzed as such, and that self-states that have been dissociated must be brought back to a state of conflictuality between them. Smith accepts the fact that, despite similarities of logical structure between the statements made by Bromberg and those who postulate a preconflictual stage, the statements are really of a different nature (given that, from the viewpoint of the development of the mind, a dissociative state is not the same as a preconflictual state). Smith's solution is to bring conflict back to the interaction between various areas—to which I have already objected, since, to me, this is always an ad hoc hypothesis intended to salvage the theory of conflict as an organizing principle omnipresent in the mind. However, as Smith (2003) rightly points out in his introduction, this solution belongs to a different level of analysis and of generalization than that characterizing the classical concept of conflict.

In clinical work with patients, the various dissociated self-states must be brought back to integration, and perhaps to reciprocal conflictuality among states, and this is definitely a therapeutic task for psychoanalysis; but this in itself says nothing about the theoretical status of conflict. With the same end in mind (progress toward cure), Gaddini (1992) postulates the importance of working with the patient on the need to generate a process of integration that will lead to the separation-integration of the subject and to the consolidation of the structure; but this desideratum does not illuminate us about the validity (or lack of it) of different conceptions of conflict, or on the inexistence of conflict in certain areas of the mind or during certain moments of the analytic process. These issues must be resolved at another level of abstraction.

The idea of the omnipresence of compromise formations (Brenner 1979, 1982) deserves reflection. The theoretical status of this concept, in its turn, brings different levels of possible analysis, according to which level of abstraction is taken into consideration. The meaning, use, and relevance of this concept of compromise formation are clear in Brenner's theorization. Also clear are the problems created by the generalization of the concept, as Goldberg (quoted by Smith 2003), and Smith himself, rightly point out.

It is, however, possible to think of compromise as a general principle of mental life, and not only in terms of a necessary articulation between wishes, defenses, and self-punishments. In the Freudian theoretical vocabulary, the term *reconciliation* (*die Versöhnung*), prematurely fallen into disuse, was initially used to indicate a mechanism of acceptance of repressed material (the homosexual fantasies of Schreber[1]); but already by 1911 (the year of Freud's "Formulations on the Two Principles of Mental Functioning"), the term *reconciliation* is used to describe a regulating principle of the overall functioning of the psychic apparatus at work in the artistic mediation between fantasy and creation of a new reality. Ego psychology, although not explicitly including the term or

[1] See the first section of Part III of "The Project" (Freud 1895) and section E of chapter VII of the *Traumdeutung* (Freud 1900), among other examples.

its theorization, interprets *die Versöhnung* as a function, an activity of the ego that depends on the relative strength of its organization. On other occasions, I have believed it useful and reasonable to consider *die Versöhnung* as a principle specifically linked to the functioning of the entire psychic apparatus (Canestri 2003b), one not limited to the ego agent, and as one of the elements regulating the "solution" that the apparatus permits for the subject—a neutral principle that does not necessarily function in the name of progress and growth.

We know that subsequently, with Klein, the concept of reparation appears on the psychoanalytic conceptual scene. Though Freud (1926) homologates reconciliation with restoration, Klein initially uses *Wiederherstellung* to indicate *reparation,* a term replaced in her later writings by *Wiedergutmachung.* Klein thus abandoned the concept of reconciliation and introduced a concept that, despite its initial relationship with Freudian ideas, is without doubt very different.

It then fell to Bion to create something that bore a relationship to Freud's original concept—which he did, as was his habit, with very original proposals. In *Transformations* (1965), Bion emphasized that, if psychoanalysis has to be a science, "it must be a science of at-one-ment" (p. 463). *Webster's Third New International Dictionary* (1993) gives various meanings of the expression *at one:* "(a) in a state of unity of feeling, in harmony; (b) of an identical or sympathetic frame of mind; of the same opinion" (p. 139). To the word *atone,* it attributes the archaic meanings of: "(a) to bring from a state of enmity or opposition to a state of toleration or harmony: reconcile; (b) to make reparation to: conciliate" (p. 139). Lastly, the word *atonement* (Bion's "at-one-ment") means: "(a) restoration of friendly relations: reconciliation; b) reparation especially for an offense or injury" (p. 139). I will leave the reader to ponder Bion's construction, mentioning only my belief that Freud's idea of a general principle regulating the functioning of the psychic apparatus reappears therein.

Something similar, although originating from a different theoretical point of view, is proposed by Botella and Botella (1992,

1996, 2001): a *principe de convergence-cohérence* (principle of convergence-coherence) that has the function of rendering intelligible to the subject what occurs in psychism. These various theoretical formulations give the idea of another and higher level of generalization, in which the concept of *compromise* can be conjugated —without one's necessarily having to think about the omnipresence of the compromise in clinical work—in terms of the relationships among wishes, defenses, and self-punishments.

But these brief observations are made only to convey that, in my opinion, it is necessary to consider a higher level—Waelder's (1962) fourth level, i.e., metapsychology—in order to highlight the points of congruence and/or divergence of certain theoretical concepts in the different models or theories offered by psychoanalysis today. After the presentation of a clinical example, I will comment on some possible derivations of these ideas.

MS. A

The two sessions that I briefly describe here belong to the sixth year of analysis of a patient who is now forty years old. The analysis was conducted in a traditional setting, at four sessions per week. The patient consulted me for a variety of problems: difficulty in her relations with her partner, dissatisfaction with her work, problems in her family relationships, fantasies of self-wounding (rarely carried out), and a tragic past history. Since her clinical history is long and complicated, I will omit it except for one central episode in her past that still returns in her present sessions and that certainly conditions her life.

The patient came from a city in Italy, and when she was two and a half years old, she fell ill with a form of pulmonary tuberculosis that was at that time considered serious and highly contagious. Her mother had had a second daughter—the patient was the first-born child—and the doctors suggested (and, in a certain sense, insisted) that Ms. A be sent away from home. The patient was therefore sent to what was called a *preventorio* (a kind of sanatorium rather like a boarding school), run by nuns, where children were

kept for years without being able to go out. Ms. A was there until she was six and a half, after which she returned to her own home, speaking in a dialect that was used at the sanatorium. For this reason, and because of her habits that were very different from those of her hometown, she was laughed at by everyone.

For reasons connected with the type of process that was gradually created in the analysis, it is important to know that, even when she was very small and was visited by her parents or other relatives at the sanatorium, Ms. A never spoke, nor even opened her mouth. The visits took place with her parents asking questions, getting answers, speaking to the nuns, but without the patient's saying anything at all. I emphasize this point because, in analysis, the slightest lack of empathy on my part caused catastrophic reactions, in which the patient reexperienced all her latent hatred for her parents and her guilt for her behavior at that time—which, in the present, became transformed into fantasies of self-wounding. She imagined cutting her body into strips with a razor blade. But on the few occasions when she actually enacted her self-mutilating fantasies, she merely punched herself on the head until she felt pain and burst into uncontrollable tears.

Ms. A was extremely intelligent, polylingual, and held a university degree in Oriental languages; she spoke Chinese and many other languages. When she first came to me, she lived in a perfectionistic world that she handled omnipotently. There was nothing that Ms. A could not do and, generally, she did it. This situation was artificially maintained through negation of her profound helplessness. At first, I was genuinely worried about this and was very hesitant about taking her into analysis, because I was sure that it would lead to a long period of collapse of her omnipotence, without any certainty of the reconstruction of a more normal structure. And this is what happened for a long time: separation of the marital couple, the abandonment of the patient's managerial job, a period during which she was unemployed and had great difficulty in paying for the analysis, and so on. However, I had the hope of being able to count on an ego structure that, although distorted, had enabled this woman to achieve a great deal, consi-

dering her past history. In fact, even in the most tormented phases of her analysis, she managed to survive, pay the analyst, find another and more creative job, write (something she had not been able to do before), and establish another and more satisfactory love relationship.

Because it appears in the second session I will present, I must briefly mention a work relationship—really a love relationship never enacted—that Ms. A had for many years, between the ages of eighteen and thirty-seven, with someone of her own age: Maria, a woman on whom Ms. A was entirely dependent. Nothing could be accomplished without this Maria coming into it in one way or another. Maria had obtained her degree in Oriental languages with Ms. A, and they shared many work projects. The patient considered that everything she knew and could do was thanks to Maria, even though in reality, it was exactly the opposite. Maria had taken the place of the patient's cousin, Carla, who had played the same role for Ms. A during her childhood and adolescence. The relationship with Maria changed radically after two to three years of analysis, and the patient was able to organize her work and intellectual activity differently.

First Session of the Week

Ms. A tells me that she had a nightmare last night. "I was in a closed place and was trying to get out. There were lots of women wearing brightly colored uniforms. I managed to get out, but I had to leave my boyfriend. It was a very peculiar situation: there was always something between me and him—either a train or a bus went past, and we were strangely confused (stunned, dazed), but the problem was that something always had to be passing. If there stopped being something between us, then we would die. I had the feeling that I must wake up in order not to die." And she awakened feeling anguished, but as though she had liberated herself from something worse.

After a short silence, the patient says she thinks the dream is linked to a squabble she had with Cristoforo (her boyfriend) the

evening before. They were talking—she does not know why—about the sanatorium where she had spent her early childhood. While she was criticizing the nuns, Cristoforo said, "Don't blame them; it was your parents who had you shut up there." The patient adds that she also argued with her sister, who said to her: "Of course your financial situation should improve quite a bit; soon you will finish paying your mortgage, and I imagine that before long, you will also finish your analysis."

I make the following comment in response to the patient's words: "In fact, by thinking back to the sanatorium [the brightly colored clothes seem to represent the opposite of the black habits], it would seem that you felt this separation [in the analysis, occasioned by the immediately prior weekend] like a death, even more so because your sister suggested to you a separation even more final than that of the weekend. I have the impression that you were angry with Cristoforo because he said something that it is very painful for you to think, and that you hesitate to say: that I, your analyst, have abandoned you, in the same way that you feel your parents did in the past."

The patient agrees. In the mean time, I think about the particular situation described in the dream, in which the objects that came between her and her boyfriend must not stop passing because an interruption would have meant death.

After a pause, the patient continues, "I was wondering what connection there is with the topic of sex in the last session? Because I was very struck by the fact of having discovered that not even in dreams would I allow myself to have an orgasm." (The patient does not have an orgasm during sexual relations. Originally, she was very afraid of sexuality and almost never managed to have sexual relations with penetration. This situation has recently improved, but at the present time, when she begins to feel "deeply" during coitus, she draws away, frightened, and interrupts the contact.) "In my dreams, like in reality, when I begin to feel pleasure, I wake up in a panic about dying if I go on. Also, in last night's dream, I woke up so as not to die."

I say, "Remembering the previous session now helps you to reestablish with me the interrupted contact—and consequent feeling

of death—of the weekend; it helps to eliminate the separation. I feel that, as in the dream with the trains and buses, you have the impression that only a permanent contact—when you bring up your past in the sanatorium—can save you from death. I think that you see orgasm as a fusion, as a total contact, from which, however, at some stage, you must break away. Viewed in this way, in your dreams as in reality, you must not have an orgasm; you must wake up and separate before that can happen."

"There must be something true in that," Ms. A replies. "As I left from the last session of last week, I was worried. I thought to myself, 'Just wait and see—probably, if we analyze this thing about sexuality, and if by chance we resolve it, then will he [the analyst] begin thinking about the end of analysis?'"

"I think that what I said to you before is likely, but incomplete," I say. "It seems true that your memory of the previous session was functioning as an attempt to do here what the trains and buses were doing in your dream. But it is also true that you had already discovered the feeling of sexual pleasure. What happens is that your comprehension becomes swept away by the terror of separation experienced as death. If you understand, and if something of me functions inside you, I as a person external to you then abandon you, and you find yourself once again among the nuns' habits in the sanatorium."

Second Session

PATIENT: Yesterday they telephoned me again about China. I didn't tell you on Friday that they had mentioned an interesting and remunerative offer. They have suggested that I go to China as a consultant with a group of businessmen; I would be away for twenty days. I am discussing it, but I am very worried; twenty days is a long time, and I would lose more than two weeks of analysis. I haven't been away for some time, and it is years since I have been in China for a long

period . . . . perhaps I shall have to leave at the end of April.

ANALYST: This news and your mission were missing yesterday in our understanding of your anxiety of death about the separation at the weekend. I wonder if you know why you left it out . . .

PATIENT: Apparently, I had forgotten it . . . . I didn't think about it myself until after yesterday's session . . . . and also, afterward, I tried not to think about it. It worked in the same way as the thought about the analysis of sexuality: another move toward separation and toward emptiness, nausea. I prefer not to think . . . and perhaps I thought that you were thinking, "Look, now she is earning money, she is going to China . . ."

As could be expected, I dreamed about Maria last night: we were working together. She was talking about the Chinese as though she knew them all by name. I didn't. The Chinese were all looking for her because she really took an interest in them and I did not. I thought that without her, I couldn't do anything. Afterward, Maria got mixed up with my cousin Carla, and I thought I wanted to stay by her all day long in order to feel good. The Chinese said, "This is *Tsamu Malia*"—"Holy Mother Mary" in Chinese; sometimes they say it to me because they continue confusing me with her.

The topic of saintliness also comes from my Tsi Kung teacher: saints are those people who are capable of giving to others. Like the Chinese, I am convinced that Maria is Tsamu Malia. Why did I dream about Maria? Because of yesterday, because of the separation. Carla was the Maria of my childhood, especially from

the ages of seven to fourteen, when we were inseparable.

Yesterday evening, I had an unpleasant telephone conversation with Cristoforo. Sometimes his aggressive tone hurts me. I hung up on him. Maria is opposed to Cristoforo. We used to sing a song together in the Peking years . . . . "A prisoner dreams about distant places". . . prisoners in Peking.

ANALYST: I think that what you imagined I was thinking could have introduced a new element: I can be the poor Chinese in need and you are Tsamu Malia, the powerful one. I could feel myself abandoned, envious and angry, saddened and nauseated, as you well know one can feel in such circumstances. I am also Cristoforo, who was hung up on so as to permit a return to Tsamu Malia. Probably, you created your Tsamu Malia during your imprisonment in the sanatorium—your Holy Mother who omnipotently knows the name of all the Chinese, one by one.

PATIENT: [She dries her tears, which are falling fast, then speaks after a pause.] Recently, it has been very difficult for me to work at my Tsi Kung exercises. My teacher says that I took a step forward and then a step backward.

ANALYST: Perhaps, sometimes you feel that both the teacher and the analyst are too demanding . . . . Sometimes going backward helps one to then go forward in a different way.

The patient subsequently talks about some Tsi Kung exercises, through which one learns to feel one's breathing on one's own skin; the delicacy of this sensation is discovered. But before beginning to talk about the exercises, Ms. A is in some way miming

them. Discovering that she is doing this induces her to talk about them, and the almost imperceptible movement of her hands creates a particular atmosphere. Her movements are much more significant than the words with which she tries to describe their meaning.

Commentary

My comments here represent an attempt to point out certain elements that could orient us toward a hypothesis of preconflictuality and its corresponding anxieties. But first, I would like to mention that what stimulated me most from these two fragments of sessions—and about which I still ask myself—is the final fragment of this second session. I was struck by the patient's use of her body in gestures and the particular atmosphere created by these. Interpretation of the reborn, omnipotent narcissism—thanks to which one cradles oneself, recuperating the sensations of a prematurely abandoned body—seemed to be called for. However, it is Bion's (1965) concept of *transformation in hallucinosis,* in a wider version, that appears to me to be the most promising tool for understanding phenomena of this type.

The most intriguing aspect of Bion's reasoning—an aspect that follows Freud, as far as a possible theory of thought (and therefore of symbolization) is concerned—is its paradoxical and counterintuitive character. If the "noughtness,"[2] the nothing, is eliminated, then, instead of the "normal" but counterintuitive formula of "a breast + no breast = no breast," we find ourselves confronted with hallucinosis: "a breast + no breast = a breast." The character of this

[2] I use the term *noughtness* here as an allusion to Bion's (1965) quotation of P. B. Shelley's note to his poem "Hellas," because I think it is consistent with the events at the end of the second session with my patient, as described earlier. According to Bion, Shelley wrote that there is a "state of mind in which one could suppose that ideas assume the force of sensations, through the confusion between thought and the objects of thought, and the excess of passion that animates the creations of the imagination" (Bion 1965, p. 133).

transformation makes the task of the analyst very difficult, and certainly different from making conscious that which is unconscious.[3]

I would here like to make two short observations. The first is the fact that Bion himself mentions that transformations of this type need not be exclusively psychotic, but can also be neurotic or normal (as in the case that I have suggested). There is an analogy with Freud's (1938) reflections in chapter VIII of "*Abriss der Psychoanalyse,*" when he admits that the splitting of the ego is not exceptional, nor must it be limited to a psychotic or perverse pathology. I think the reflections of Botella and Botella (2001), in their work on *l'hallucinatoire,* are oriented in the same direction.

My second observation is about the updating of models. In chapter 10 of *Transformations* (1965), Bion finds it hard to explain clearly the transformation into hallucinosis, not only because of the difficulty of the topic, but also, I think, because the model of projective geometry that enables him to illustrate rigid transformation and projective transformation does not allow him to as easily explain transformation into hallucinosis. The model of projective geometry allows for combined topology, but not for topology of sets. I would suggest that the application of the theory of sets to transformations would clarify certain aspects of this intricate problem; however, I shall not deal with this problem here.

Let us take into consideration two or three elements of the second session with my patient, as previously described, that will enable us to reflect on the concept of conflict and on preconflictuality. As can be deduced from that session, the patient is a liar by omission, a type of lie that is of great psychoanalytic interest, but on which I will not dwell on this occasion. I am interested only in

[3] The foregoing refers to Bion's (1965) theories, as follows: (a) that "some personalities cannot tolerate frustration," and (b) that "primitive thought springs from experience of a non-existent object, or, in other terms, of the *place* where the object is expected to be, but is not" (p. 51, italics in original). These theories explain why Bion believed that, for thought to exist, it is necessary for the subject to tolerate frustration and to admit the absence of the object; in other words, for thought to exist, it is necessary that "a breast + no breast = no breast."

emphasizing that the psychic tempest of these sessions is, for the most part, the result of the offer that the patient received (and implicitly accepted). We can see that this offer—together with her sister's comments and the issue related to sex—initiated a process of separation-individuation for the patient. The analysis might end—or, at least, this idea appears on the patient's symbolic horizon—and, for the first time, she will separate from the analyst for a long period of time (twenty days) if she accepts this offer. Accepting it is a sign of her growth and of her increasing capacity to state her own autonomy—this time, in a different way than in the past, when narcissistic omnipotence reigned. It is also a sign of her awareness of her dependence on the analyst, now characterized as a more separate object and therefore in a less fusional way.

We hear about all this in the second session. In the first session, the patient talks about a nightmare in which she wants to run away from the *preventorio* (sanatorium), but if she does so, she will have to separate from her boyfriend. There is always something that interposes itself between them, but if this contact were to be interrupted, death would carry both of them away. From my point of view, we are facing a regressive process here, in which Ms. A feels she has to turn to fusional modalities of relationships that favor *contact* with the other, which in reality is still not the other, but a *continuum* necessary for survival.

If I were to explain these phenomena in terms of a preconflictual situation, I would say that the patient is facing the options I described earlier: an obvious loss-of-self anxiety that could hinder or favor a greater integration and lead, or not, to a state of separateness. The weekend separation from the analyst (that had as background a job offer—unknown to the analyst until the following session) is experienced as a return to the sanatorium from which the patient knows she has to escape. However, interrupting the fusion and opening herself to a greater level of integration (exemplified also in her reflections on sexuality and orgasm) provoke an intense fear or anxiety of integration. Ms. A is dealing with the two alternative, characteristic anxieties of survival of the mental catastrophe: the fear or anxiety of *disintegration,* and the fear or anxiety of *integration.*

We must not forget that the patient is at this point in her sixth year of analysis, which allows the analytic couple to explore more deeply the vicissitudes relative to this process through modalities that would have been unthinkable earlier on. It is, in fact, possible to see how the anxieties mentioned above appear in the transference (see the three interpretations of the first session and the interpretation of Tsamu Malia in the second). Finally, it is possible to determine that Ms. A is clearly inclined toward separation-individuation, even though, in these sessions, she had to confront a real mental challenge that would functionally bring her back to a reproposal of the initial dilemma—the dilemma of either moving toward a greater integration or remaining in non-integration.

It is evident that this dilemma has presented itself hundreds of times in the analysis, but never with clarity and the possibility of giving the patient a progressive solution, as at this time. Clearly visible on the horizon are elements with object relationship qualities (among them, sexuality) and changes in the transference in the same direction; however, the regressive references present in these two sessions relate to a preconflictual area, in my belief, in which Ms. A still has to negotiate the constitution of a structure and of a self-object separateness (the step forward and the step backward evoked by the Tsi Kung teacher's words). Her subsequent dream is proof of this, in which Maria/Tsamu Malia reappears, the omnipotent mother of all the Chinese, without whom the patient loses the absolute omnipotence of the early stages of analysis. She is a Holy Mother Mary whom Ms. A has progressively learned to do without. Now the analyst can be like the patient was earlier, the poor Chinese who needs Tsamu Malia.

As I mentioned earlier, I find the end of this session particularly interesting; something new appears for the first time that does not relate exclusively to indulging oneself, as Ms. A says. Someone who defends conflict as the central focus of mental functioning could argue that, in this case, conflict is demonstrated between the two anxieties or the two alternatives of integration and non-integration. I think this would be a questionable statement, since it is based on the use of the concept of conflict at a very low the-

oretical, descriptive level. Used in this way, *conflict* could be replaced by another, semantically similar term—for example, *alternative.*

CONCLUSIONS

From what I have said, I think it is clear that, in the first place, I do not consider all theories on conflict to be compatible; moreover, the comparison between different theories cannot be put into practice at Waelder's (1962) low levels (those of clinical observation, clinical interpretation, and clinical generalization—seen as leading to clinical theory). I think that, inevitably, the theoretical discussion must be proposed at a metapsychological level.

From the viewpoint of the development of the psychic apparatus (theories of the mind), the hypothesis of an inaugural, prestructural, and presymbolic existence of a preconflictual state (regardless of whose ideas the hypothesis is based upon—those of Winnicott, Gaddini, or of other authors) traces a clear demarcation line relative to those theoretical positions that, conversely, place conflict at the center of mental functioning, all the way back to the dawn of life. And this is why many of the authors quoted earlier—Winnicott and Gaddini, for example—believe that, between the time of the biological and the psychological births, there is a fairly long period that subsequently leads to the psychological birth, characterized by self-object separation and by the constitution of the structure.

Environmental deficits and other factors connected to the complementary series of Freudian principles could create obstacles to the full realization of this process, and leave areas of nonconflictuality where the presence of fear of integration and/or fear of disintegration could oppose change and the consolidation of separateness and of the structure itself. In these areas, the loss-of-self anxiety is predominant and forces the subject to defend him- or herself from change in order to survive.

From a clinical point of view, I agree that one can verbalize these vicissitudes in terms of conflicts between different areas of

the psyche, as Smith (2003) proposes relative to Bromberg's theory, for example (conflict between dissociated parts); but I think that this postulation is unsatisfactory from a theoretical point of view. It would once again entail a descriptive use of the concept of conflict and, from an epistemological viewpoint, the use of an ad hoc hypothesis designed to keep alive the idea that, in mental life, conflict is always and in every case the fulcrum of the organization of the psychic apparatus.

There remains one very important issue that Smith mentions in his discussion of Bromberg's position, as well as in other parts of his paper. Of necessity, I must be very brief in discussing it. Smith wonders whether, in Bromberg's case, "we are talking about different organizations of mind or different ways to address the patient" (Smith 2003, p. 83). In reality, the question already implies a way of thinking about the problem that could give rise to divergences. Smith is fully aware of this when he says:

> I am arguing here, as earlier, for a looser coupling of theory and practice than we are generally taught in our institutes. This habit of mind is promoted in our literature by those who would support their technical recommendations with theories of mind to make it look as though the practice followed necessarily from the theory, rather than, more loosely, the other way around. [p. 83]

I fully agree with Smith concerning the advisability of a looser coupling of theory and practice. For many years, in a "working party" of the European Psychoanalytic Federation, a group of us have been carrying out a qualitative research project on the relationships between practice and theory and the use of the analyst's implicit theories (private, preconscious) in clinical practice (Canestri 2002; Canestri et al. 2002). In this project, we use as our definition of theory the premise that psychoanalytic practice is the sum of public theory-based thinking, plus private theoretical thinking, plus the interaction of private and explicit thinking (the implicit use of explicit theory). We think, as did Sandler (1983), that the exploration of the analyst's private theories, when used as I have specified

above, has significant heuristic potential. We also agree with Smith that the relationship between theory and practice is not as close as we infer, or as is taught in psychoanalytic institutes, especially in light of the fact that the analyst at work, as Sandler asserted, creates systems or partial constructions that try to take into account in the best way possible whatever the analyst's experience with *that* specific patient suggests.

Having said this, I believe that the interdependence between practice and theory is not to be eliminated; at most, the latter might be more strongly subjected to the effective modalities of what we are *really* doing in practice. A different theory of conflict that derives from a different theory of the mind—e.g., the theory that hypothesizes a preconflictual phase—will naturally produce differences in our ways of confronting clinical problems of the kind I have tried to illustrate in my brief presentation of Ms. A.

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DIALOGUES ON CONFLICT: TOWARD AN INTEGRATION OF METHODS

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If anyone needed verification of the disparate ways in which the concept of conflict is used in contemporary psychoanalysis, this set of thirteen exceptionally clear papers should settle the question. While some of the authors in this issue dispute the centrality of the concept itself (although no one is willing to dispense with it entirely), those who agree on its utility, and who even share aspects of a common theory, present divergent views on (1) the location of conflict in the patient's mind, (2) its location in the clinical hour, (3) the inferential processes used to determine its presence, (4) its units—that is, what is in conflict with what, (5) its historical and developmental timetable, (6) the methods by which analysts should address it, and (7) how closely those methods are tied to the theories with which they are associated.

In short, while conflict as an analytic focus appears to be alive and well, it is discussed on so many different levels of abstraction that one might wonder if any of these authors is truly talking to any other, whether any of their views can be integrated, and whether there is any benefit in attempting to do so. In order to develop these themes more fully, I will emphasize certain papers over others. Reading through the issue as a whole, a series of dialogues begins to emerge between one author and another, some of them surprising.

ABEND AND SCHAFER

Abend outlines his version of modern, or contemporary, conflict theory, acknowledging his debt to Brenner's (1994, 2002) proposal

to eliminate the three agencies of the mind (id, ego, and superego) and replace them with the familiar and, as Harris suggests, more "experience-near" (p. 275) components of conflict: wish, defense, self-punishment, and painful affect. This would seem to be an effort at eliminating reified structures and the technical pitfalls they encourage, something Brenner has devoted many years to achieving, a sparer and more useful clinical theory, with less emphasis in the clinical moment on more abstract levels of theory.

Schafer integrates his own modification of ego psychology with certain contemporary Kleinian clinical approaches and with his view of conflict as a narrative device. Schafer's warning against reification, however, also long argued on his part, would include, one infers, a warning against the reification of even the "nonreified" terms of conflict that Abend and Brenner have adopted. At the end of his paper, having knitted together a number of strains on which he has been working over the last several decades, Schafer reaffirms his commitment to conflict theory.

While I fully endorse Schafer's warning against the reification of the very concept of conflict, it cannot be that conflict as a term is any more vulnerable to reification than, say, projective identification or empathic rupture. In fact, one would need to assume that his warning applies to the naming and even the mere observation of any entity in the work, no matter how small. Once named, any entity, or, for that matter, any phenomenon within the ongoing process of the work, begins to have a life of its own, and will inevitably become a focus around which patients, in collusion with their analysts, can and will externalize their inner lives to the detriment of their sense of ownership. This seems to me the essential conundrum of analytic work and the core of the task; that is, if the patient is continually attempting to avoid the pain of ownership or the ownership of painful experience, as many theories would have it in one way or another, and if the analyst is inevitably a participant in the disavowal of that ownership, as I believe the analyst to be—in this case, simply by naming something and thus placing it out-

side the patient's agency—how do the work and its therapeutic action proceed?

If I understand Schafer's position, it would seem that the continual analysis of the disavowal and disowning of personal responsibility is the avenue to therapeutic action. This is a position he shares with the contemporary British Kleinians, well illustrated in Steiner's paper in this issue. I would suggest, however, that while the analyst is interpreting the patient's disavowals—and for the very reason Schafer outlines—the identification of disavowal will itself be the seed for further disavowal, reification, and enactment. This is a corollary of the notion that the process of interpreting the patient's wishes will inevitably lend itself to the enactment of the wishes (or fantasies) being interpreted (Smith 2004).

With such principles at work, we will see repeatedly in these papers that the degree to which the analyst advances or retards the work—and all analysts are always, in my view, doing both at every moment—depends not only on the theory one holds, but, more importantly, on how it is used.

BUSCH AND THE ORNSTEINS

It may surprise readers that Busch—who, for some, represents a different branch of ego psychology than that of either Abend or Schafer, one derived from the ideas of Gray (1994)—adopts an aspect of both the clinical technique and the developmental assumptions of self psychology to describe patients who were inadequately "mirrored," thus creating interferences in healthy narcissistic development and resultant secondary conflicts. In saying he never saw a patient who did not illustrate such a sequence, he recommends an integrated approach: namely, that the analyst should first emphasize the empathic understanding of the patient's sense of narcissistic injury before focusing on his or her conflict over the expression of aggression. This latter focus on aggression was a particular contribution of Gray's (2000), although Gray ar-

gued that he was not overemphasizing the analysis of aggression, only giving it equal time. It is striking that Busch, with Schmidt-Hellerau and the Ornsteins, if I read him correctly, implies, in sharp contrast to Gray, that he no longer views the aggressive drive as a "primary" one (p. 36).

Compare, too, Busch's position in this paper with that of the Ornsteins. They agree with him that conflicts develop secondarily to deficits (as well as alongside them) in response to inadequate caregiving; but, in contrast to Busch, the Ornsteins see those conflicts as non-drive-related, and, more importantly, argue forcefully that one cannot integrate the theoretical assumptions of self psychology with traditional conflict theory, nor the observations and interventions associated with each. In fact, of all the authors in this volume, they, along with Canestri, make the strongest case that a system of theory should be cohesive and internally consistent, from the highest metapsychological assumptions to the most specific clinical interventions, and that the latter are shaped by the former and hence cannot be combined with other approaches. I will say more about this below, and note here only that, while I agree that theory has a major shaping influence on observation—as Friedman (1988) puts it, "We cannot think without theory" (p. 7)—and that at the highest levels of abstraction the assumptions of most theories are incompatible with one another, I question whether this is true at the lower levels of clinical theory used by most analysts in the consulting room, or at the level of clinical methods.

Both Busch and the Ornsteins begin with A. Freud's (1968) distinction between symptoms based on intrapsychic conflict and symptoms based on environmental interference, a distinction that A. Freud (1974) later argued was not so critical in practice, as both forms of psychopathology are so "totally intertwined" that they are usually "treated as one" (pp. 70-71). In contrast to this later position, both Busch and the Ornsteins appear to agree that what Busch calls "interference[s] in healthy narcissistic development" (p. 27) need to be addressed in their own right, and that manifes-

tations of conflict and deficit are, therefore, clinically separable, a position that sets Busch apart, once again, from conflict theorists such as Brenner, Boesky, and, I would infer, Abend. Moreover, while Busch speaks of interferences in narcissistic development leading to unconscious fantasies that *result in* intrapsychic conflict —by which he means, I believe, conflict-based inhibitions regarding aggression—Abend would consider unconscious fantasies to be conflictual structures in themselves, a method by which the child has organized his or her early experience, including traumatic experience.

On the other hand, while Busch has incorporated some of the theory of self psychology ("mirroring") and the notion of secondary conflict, the Ornsteins' view of conflict diverges significantly from his. When Busch speaks of conflicts resulting from narcissistic interferences, such secondary conflicts appear to be unconscious and drive related, whereas the conflicts, both primary and secondary, to which the Ornsteins refer, are not. For them, primary conflicts—which they consider to be unconscious and pathogenic—arise when the needed caretaker is also feared, and secondary conflict is a more conscious phenomenon, such as the conflict that may arise over an everyday decision because of an underlying "deficit" in "self-esteem regulation" (Ornstein and Ornstein 2004). Repeatedly, the Ornsteins disassociate themselves from drive theory.

Kohut's Views

I might add that my reading of Kohut's 1977 paper on the Oedipus complex, which the Ornsteins cite throughout their contribution, is not as categorical as theirs. Rather than that the self psychological point of view should *replace* drive theory, Kohut suggests that the two are *additive* and *complementary*. He seems to have no difficulty combining his way of listening, along with the phenomena to which he listens, with classical theory: "It does not

indicate any lack of respect for the great explanatory power of the classical formulation . . . when I affirm now that it is possible . . . to enrich the classical theory by adding a self-psychological dimension" (1977, p. 227).

Moreover, while the Ornsteins state that Kohut in his paper argued that "the dramatic, conflict-ridden Oedipus complex . . . is not a primary developmental necessity" but the "result of frequently occurring failures of caregivers" (p. 235), this seems at odds with Kohut's own position:

> To state explicitly what has been implicit all along: the presence of a firm self is a precondition for the experience of the Oedipus complex. Unless the child sees himself as a delimited, abiding, independent center of initiative, he is unable to experience the object-instinctual desires that lead to the conflicts and secondary adaptations of the oedipal period. [1977, p. 227]

In other words, the Ornsteins themselves argue that oedipal conflict is a result of inadequate earlier development, but Kohut reasons the opposite, namely, that a strong self is necessary to experience the conflict of the oedipal period. I am not disputing that at other times Kohut may have taken the position the Ornsteins suggest, but it is striking to me that, at least in the paper cited, he presents a more integrated point of view, which is of considerable importance historically, as it suggests that in the early and mid-1970s, theories that today have become polarized were more integrated *before* they split off and became cottage industries. Some of that splitting may have taken place in the name of theoretical consistency.

And so, while Busch demonstrates at the level of clinical intervention an integration of some of the teachings of self psychology, he does so in a way that I believe the Ornsteins would find theoretically inconsistent; and yet, would the Kohut of the mid-1970s have objected to this? Would he have argued, as the Ornsteins do in their clinical material, that in interpreting the patient's wish to kill his analyst, the analyst has to choose whether to focus on the

patient's bitter disappointment in having a father he could not idealize, or to focus on the patient's competitive, phallic wishes to outdo such a father?

To be sure, the analyst must select a strategy and might interpret one aspect and not the other at any given moment, but I find many male patients are caught in a complex and escalating rage at *both* a disappointing father *and* a father whom they want to outdo —in fact, one with whom they may have been thwarted from freely competing because of a sense of the father's vulnerability. Sometimes the patient's very competitiveness seems only to have exacerbated the father's own sense of inadequacy, thus further frustrating the patient's wish to idealize him. Rage then builds on multiple fronts as the patient tries to establish a sense of phallic competence, bodily integrity, and distance from such a father, who, from the patient's perspective, not only failed him in his effort to feel effective as a growing male and to separate from his mother, but this same inadequate father, defying all reason, also possessed the mother, precipitating yet more rage and sense of aloneness on the boy's part.

This is not to invoke the concept of overdetermination, as the Ornsteins imply, but rather the integration of different sorts of wishes that coincide in the life of a child or an adult at any given moment. In order to get the job done, it seems to me, the analyst needs to appreciate all the components of the conflict I have described, narcissistic aspects of the period intertwined with triadic ones, just as Kohut indicated. To his credit, Kohut made the narcissistic and developmental issues so abundantly clear that they have readily been incorporated into many analysts' work. To argue as the Ornsteins do in the name of theoretical consistency seems to me to risk missing, as Busch suggests, half the patient's experience. I am not recommending that the analyst shift from theory to theory at will—I agree with the Ornsteins about how confusing this might be to the patient—but I am suggesting that there are different and compatible aspects of a patient's experience that can

and must be addressed on different descriptive levels within an integrated model of practice.

KERNBERG AND GOLDBERG

No less surprising than the similarities between Busch and the Ornsteins are those between Kernberg and Goldberg. While deriving their ideas from very different theoretical assumptions, they speak similarly about conflicts encountered in more troubled patients, conflicts, that is, between conflicting "configurations of the self" (p. 253), in Goldberg's terms, and conflicting "affectively invested . . . internalized object relations" (pp. 72-73) in Kernberg's. Goldberg confirms Kernberg's observation that the patients each discusses appear to have no unconscious conflict over their behavior. In this regard, they resemble those patients whom Bromberg (1998) describes as organized by a process of dissociation rather than by unconscious conflict.

Goldberg leaves scant room for unconscious conflict underlying such dissociative processes when he suggests that his patients' conflicts appear not to be "internal, oppositional, and unconscious" (p. 255), but when he adds that they suffer from "parallel selves in a struggle (a conflict) to dominate and gain control of the psyche and the motoric mechanisms of behavior" (p. 257), it is a little difficult to see how this latter conflict between selves is *not* "internal, oppositional, and unconscious."

While Kernberg speaks of similar conflicts that are "apparently conscious rather than unconscious" (p. 70), his view of "unconscious intrapsychic conflicts" between "primitive internalized object relations" in such patients, or their unconscious fear that "primitive hatred and envy will result in the loss of all love and ideal object relations" (p. 68), clearly suggests an underlying conflict that *is* "internal, oppositional, and unconscious."

In either case, it would seem that when one "configuration of the self"—or one set of "internalized object relations"—is predomi-

nant, the other must be descriptively unconscious, and we might ask what keeps it that way, what fuels the dissociation, if not some conflictual process, some effort to minimize psychic pain. I am thinking here of conflict in its broadest and simplest sense: as a conflict between an unconscious wish and the defense against the resultant psychic pain.

I question one point Kernberg makes, although, I suspect, Goldberg might agree with him. When Kernberg notes that some interpersonal conflicts are easily resolved because, while they have "an unconscious resonance" (p. 77), they are not themselves neurotic, he is speaking, as the Ornsteins do, about the conscious conflicts of everyday life. But, while there is no question that some conflicts are more difficult to resolve than others, if one accepts the ubiquity of unconscious conflict, it becomes increasingly difficult, in my opinion, to distinguish between neurotic and so-called nonneurotic conflict on qualitative grounds alone.

Steiner and Goldberg on Disavowal

It may be useful to introduce Steiner's paper at this point, for, while their theories, their patients, and the "moral" issues to which they both refer are different, there are some instructive parallels between Goldberg's position and Steiner's. Whereas Goldberg argues with the notion of unconscious conflict, while Steiner takes it as a given, both authors focus on disavowal and the manner in which the patient involves the analyst in his or her own internal experience. Both speak explicitly of the disavowal of bereavement, but Steiner makes this his primary focus in a way that has universal significance for all patients—the necessity to mourn in order to grow, rather than succumbing to melancholia, which he sees as mourning gone awry.

Both Goldberg and Steiner also describe the manner in which the patient's disavowal of reality involves the analyst in moral issues. But while Goldberg advocates that the analyst must genu-

inely experience the moral dilemma, Steiner (more in keeping with Schafer) focuses on the patient's effort to deny the reality of loss, and thus avoid owning any conflict over grieving, by drawing the analyst into a moral conflict or grievance. I find Steiner's description of this human process, like Greenberg's to follow, particularly moving, rewarding several readings.

GREENBERG

While I do not believe that they would disagree with each other, there is a subtle difference in emphasis between Schafer's insistent intrapsychic focus on the patient as agent and Greenberg's equally insistent focus on what he terms the *middle voice,* in which he seeks to preserve a delicate tension—he calls it conflict—between seeing oneself as an active agent and as a passive recipient, or, more specifically, the dilemma of being both actively desiring and the object of desire, both subject and object simultaneously.

In describing this particular dilemma, Greenberg integrates the assumptions of relational theory with those of contemporary conflict theory, the interpersonal and the intrapsychic, around a linguistic term now metaphorically employed: the *middle voice.* Note that he can do so only if he does not force a confrontation between the drive-based assumptions of Freudian metapsychology and the non-drive-based assumptions of relational theory, a polarity he and Mitchell established in their 1983 book.

The conflict that Greenberg describes is in fact a set of conflicts generated by the subject–object dilemma. It bears some resemblance to Kris's (1984, 1985) view of divergent conflict; and the technical recommendation to which his argument points, as I infer it, is also similar to Kris's effort to stay with the patient at the fork in the road, not to interpret the conflict prematurely, and thus, like Goldberg, to share the dilemma. But, to these, Greenberg adds the inevitable active participation by the analyst, who is also both subject and object. My sense is that he is in fact making an intel-

lectual push toward a new and valuable theoretical entity that will inevitably have its potential benefits and risks, including the risks highlighted by Schafer.

If I read him correctly, Greenberg is as much concerned about the patient's agency as Schafer is, but if one of the terms of the conflict is to accept one's historical fate of having been "done to" (p. 108) and to "submit to the agency of others" (p. 120), we might ask ourselves: Will this not subtly undermine the pursuit of the patient's own need to keep this fate and this submission alive? If he is telling us to slow down and appreciate the dilemmas of the middle voice, rather than collapsing the focus prematurely onto the patient's conflict over agency, will he be more effective or less so in facilitating the patient's awareness of her responsibility for creating her own experience and for her own disavowals? Will it not ultimately be necessary to pursue the unconscious fantasies, wishes, and fears that Freud felt were at the heart of a patient's conflicted aims and inhibitions, analyzing, in turn, the risk imagined in desiring and in being desired? These would seem to be the fantasies that underlie the entanglements Greenberg describes, and, in that sense, his conflict in the middle voice designates a partly conscious, partly unconscious, conflictual dilemma that, as it is analyzed, breaks down into the components of conflict that Abend has described.

Greenberg challenges us all when he says that Freud omitted the unconscious experience of being acted upon by others, and when he suggests that, to our own conflicted intentions, we need to *add* the "conflicted experiences of being the object of the intentions and reactions of others" (p. 119)—but this latter conflicted experience, no matter how interpersonal its origin, is still an intrapsychic conflict *as experienced by the patient*, the intrapsychic registration of an interpersonal experience, replete with its amalgam of unconscious fantasy. If middle-voice conflict were not ultimately analyzed in terms of what is stirred intrapsychically in the patient, I should think that intrapsychic conflict and interpersonal conflict

would forever remain on different playing fields, at different levels of abstraction, no matter how neatly they fit within the middle-voice metaphor.

But has Greenberg got it right when he says that Freud left no room for the unconscious experience of being acted upon by others, or that Freud's theory requires a patient with a "stable psychic structure" and a "considerable degree of personal agency" (p. 118)? While he is capturing certain nuances in Freud's thinking, my sense is that he overstates them. Not only were the drives never seen to develop in isolation from objects, but, with his shift away from the seduction hypothesis, Freud set the stage for the sort of concerted effort at uncovering the patient's sense of agency that Schafer and Steiner demonstrate in their way (and Busch and Abend in theirs)—an effort made necessary precisely because agency, while an envisioned potential, was never a given, but always disavowed and otherwise defended against, with the patient considerably compromised in his or her sense of personal agency.

Throughout his work, Freud kept alive the duality between subject and object in the notion of the complemental series, a theoretical (and more limited) forerunner of Greenberg's more highly articulated middle-voice conflict, wherein, as Freud described, what was internal to the patient was an equal partner with what was externally imposed. Freud, then, was adding something to what was already a social given, making it possible henceforth to begin to speak of patients' responsibility for their own suffering as agents of their own lives, in contrast to the context of the era, in which neurasthenic patients felt themselves to be victims of their environment, while their physicians, in turn, felt victimized by them and their illnesses.

Greenberg is right, I believe, when he implies that the patient's unconscious experience of being acted upon has never been fully theorized, but the seeds for middle-voice conflict were surely there from the beginning. When Breuer and Freud (1893) wrote, "*Hysterics suffer mainly from reminiscences*" (p. 7, italics in original),

the operative word *suffer* is, I submit, offered in the middle voice, or would be if such were the linguistic convention, much as in the prophecy that Odysseus will both suffer and inflict pain. Hysterics suffer, but, as Freud was to show us, they create their own suffering and make others suffer as a result. The analysand, then, need not yet have a developed sense of personal agency in this, only unconscious desires and the potential for recognizing them, as Greenberg's patient has. In this regard, psychoanalysis in its origins was itself a middle-voice endeavor.

It may be that part of the ambiguity in Greenberg's argument is a subtle conflation of conscious conflict with unconscious conflict. When Greenberg says of his patient, "In contrast to Freud's dreamer—consumed by wishes—she wants nothing at all" (p. 113), he is comparing a dreamer's plenitude of *unconscious* wishes with his patient's absence of *conscious* wishes. Surely, his patient's *conscious* experience of wanting "nothing at all" tells us little about her unconscious desires, which we might assume are complex and powerful, thus contributing to her paralysis, whether they underlie her own inhibited wanting or the fearfulness with which she anticipates the desires of others.

Greenberg closes his paper ambiguously when he says, "Freud's narrow vision of the nature of conflict—that it always involved inner impulses and defenses against them—shaped his reading of *Oedipus*" (p. 118). In using the word *always,* Greenberg suggests that, in contrast to Freud, he has in mind conflicts that do *not* involve inner impulses and defenses against them. If he is referring to those interpersonally based conflicts over the desires that others impose on the patient, does this not fly in the face of the subtle intertwining of the intrapsychic and the interpersonal that he has just detailed? What conflicts, however interpersonally informed, however middle voiced, do not *also* involve inner impulses and the defenses against them? Isn't conflict *always* a mixture of the two? Isn't that precisely what makes middle-voice conflict conflictual? In fact, just a bit further on, he argues this very

point when he says that we must consider "*more than* just our own conflicted intentions" (p. 119, italics added), suggesting that he means the two points of view to be additive.

Similarly, when Greenberg notes that, in Freud's theory, "both agency and conflict are developmental achievements" (p. 118), I am not entirely clear what he means. Once again, the boundary between conscious and unconscious conflict is a bit blurred. Is he speaking of the conscious experience of conflict as a developmental achievement, referring, as Kernberg does, to the capacity for conscious ambivalence, or does he truly mean that in his view —or Freud's—unconscious conflict is something not yet achieved by such patients? This latter view would place him in the company of Bromberg (1998), Canestri, and others who argue on behalf of a preconflictual phase of development, with conflictual organization to follow. This is, in fact, very different from Freud's position that unconscious conflict underlies all experience.

Despite my debating aspects of Greenberg's argument, his concept of the middle voice seems to me to underscore in a profound way the manner in which we as individuals continually attempt to simplify middle-voice experience in an effort to avoid psychic pain and confusion. In short, throughout life, we try to reduce one pole of the conflict to the other. Thus, we turn internal sources of experience into external ones and external ones into internal ones; we turn passive into active and active into passive, subject into object and object into subject. I would argue that Greenberg is tapping into universal defensive and adaptive solutions that stem from our earliest attempts to think about the world. Perhaps this is why the concept of projective identification is so enduring, for at every stage of life we perceive the world in terms of our own internal experience, projecting it outward (as well as taking in our experience of the outside), and then enlist the other to participate in our own creations, as Greenberg illustrates so beautifully with his clinical material.

SCHMIDT-HELLERAU

Whereas Greenberg defines a unique view of conflict predicated on the assumption that Freud shifted too far from the external in abandoning the seduction hypothesis in 1896, Schmidt-Hellerau elaborates a view of conflict that asks: What would have happened if Freud had not made his major theoretical revisions of the early 1920s, beginning with his introduction of the second dual-drive theory and its newly fashioned aggressive drive? What if psychoanalysis had continued to evolve with Freud's first dual-drive theory, the opposition between the libidinal instincts and the self-preservative ones, the latter a notion she says Freud borrowed from Darwin (although some would argue that Darwin's ideas about the struggle for life, the primal horde, and the elimination of the unfit owe as much to an aggressive drive as they do to a self-preservative one)? Nevertheless, this is Schmidt-Hellerau's challenge, which she thinks through with striking consistency to produce a unique view of the psychoanalytic landscape. As we can see, it takes her to a version and use of drive theory that is very different from the one that has evolved from ego psychology.

In contrast to Abend, for example, who sees wishes, defenses, self-punishments, and painful affect as the units of conflict, all of them set in motion by a forbidden wish, for Schmidt-Hellerau it is the drives or their objects that are in conflict with each other (depending upon whether she is dealing with what she calls *binary* conflicts or *monolithic* ones, respectively); and she organizes the clinical material around the separate aims of each drive, the drive for preservation and the drive for libidinal excitement.

The idea that drives are in conflict with each other is much more commonly expressed in Europe than in North America—albeit the drives that are usually thought to oppose each other are those of Freud's later dual-drive theory, the libidinal and aggressive drives, or life drive and death drive. We hear this latter position

reflected in several other papers in this issue: by Gibeault, for example, and by Reed and Baudry in their interpretation of Green, who sees the life drive and the death drive reflected in the dual processes of objectalization and disobjectalization, representation and nonrepresentation, linking and delinking, and in the making of meaning and nonmeaning.

In contrast, Abend speaks of drive derivatives or "manifestation[s] of the libidinal and aggressive drives" (p. 10), by which he means, simply, wishes. Drives and drive derivatives are two aspects of a single concept at different levels of abstraction, requiring different inferential processes and a different focus of attention. Moreover, in contrast to those who see conflict as situated between two drives, Brenner (1982) argues that aggressive and libidinal drive derivatives are never in conflict, except when one is used as a defense against the other, all compromise formations containing mixtures of both libidinal and aggressive drive derivatives. Schmidt-Hellerau leaves room for one drive defending against the other in certain binary conflicts, but monolithic conflicts consist of only one drive and its competing objects.

On this matter of the drives in conflict, some authors take a middle position. Steiner, for example, notes the traditional Kleinian view of the conflict between life and death instincts, but adds, "Fortunately, these deeper issues need not concern us in the everyday task of following a patient in the to and fro of an analytic session" (p. 85), which speaks to the way in which many contemporary Kleinian analysts focus on the immediate here-and-now data of the clinical hour. In Kernberg's paper, too, we hear echoes of his Kleinian training and an interest in life and death struggles, but he, like Abend, focuses on "manifestations of drives" (p. 72). For Kernberg, however, following Jacobson (1964), these manifestations are "affectively invested self- and object representations" (Kernberg, p. 72), which constitute the entities that are in conflict with each other—internalized object relations. Kernberg, we might note, sees all the components of compromise formation in terms

of internalized object relations, thus describing impulse and defense, for example, as "impulsive and defensive internalized object relations" (p. 65). It is this consistency that provides him with a seamless theory of conflict, from the healthiest neurotic patients to the most disturbed borderline ones, in direct opposition to Canestri's assumption of a preconflictual state.

Although she may draw on the distinction between drives and drive derivatives in her clinical work, Schmidt-Hellerau does not make it explicit, and we hear little about the other components of conflict—defenses, for example, or the self-critical functions traditionally attributed to the superego. In Schmidt-Hellerau's metapsychological mise-en-scène, the drives and their objects are the dominant players, and in posing the conflict between the preservative and libidinal drives, she takes as her model Freud's (1912) spare paper, "On the Universal Tendency to Debasement in the Sphere of Love," which she develops into a complex metapsychology, extending Freud's specific theory of a split between the affectionate and the sensual into a general theory of drive conflict.

As the domains of the two drives define the territory of the clinical hour, with many of the functions formerly distributed elsewhere now subsumed under their jurisdiction, the architecture of mind and development, along with many familiar clinical landmarks, begins to shift under our feet. Thus, oral, anal, and "urinary" references seem largely to reflect the self-preservative drive, rather than their more familiar psychosexual functions, giving the interior of the body a cloacal quality. In this scheme, rather than all aspects of bodily experience serving multiple functions and having multiple meanings (erotic, aggressive, defensive, and self-punitive), each organ system tends to be assigned to the custody of a single instinct.

We are talking here of major differences not only in the content of theory, but also in its use. Thus, the drives, in addition to whatever else they do, perform a descriptive or classificatory function in Schmidt-Hellerau's theory, organizing the words and details of the clinical hour. And, in the other direction, the material that

the analyst observes in the hour becomes a kind of window through which the drives can be seen quite directly. This contrasts with the way in which Abend infers the workings of the four components of conflict, behind which the drives lie in abstract obscurity. If there is a counterpart in contemporary conflict theory, it might be Gray's (1996) conviction that he can observe the workings of the defensive functions of the ego through the manifest details of the clinical hour, in order to intervene at moments of conflictual interference—but, even so, we are talking about vastly different inferences as to what intrapsychic entities are accessible through the patient's spoken words.

This sense of transparency in the manifest material of the hour, behind which the analyst can "see" the drives, thus moving directly from the most specific observations to the highest level of generalization, is more reflective of analytic listening in the European, especially Kleinian, tradition—when, historically, life drives and death drives were often described as playing themselves out in the manifest details of the hour. I do not mean this as a criticism of such views, but rather as an observable contrast in cultures —one that has become less polarized in contemporary psychoanalysis, to be sure.

Notice in this regard that Schmidt-Hellerau makes it explicit that the patient's very words are linked to one drive or the other: these words bespeak *this* drive, and those, the other. Her theoretical explanation for this is that whatever comes to mind can be viewed as the "representative of an ongoing drive activity" (p. 194). Surely, she is right in a general way, and this constitutes a practical demonstration of how she listens in the clinical hour. But I cannot help feeling that there is a degree of concreteness in Schmidt-Hellerau's reasoning, as if only a small leap of inference were required to appreciate which drive is speaking the words at any given moment, not to mention a literalness in her interpretation of the various fantasies subsumed under the self-preservative drive: fantasies of engulfing, stuffing, starving, suffocating, and dy-

ing; paranoid fantasies of being infected or poisoned; and obsessional symptoms normally associated with anal-erotic wishes and defenses. It seems a tall order for a single preservative drive.

I know of no one besides Schmidt-Hellerau who conveys so personal a relationship with, and understanding of, the drives she embraces, especially the self-preservative one. She animates it, caring for it in her own—dare I say—preservative way, as we hear when she explains her choice of the term *lethe* to characterize its energy: "It seemed to fit the inwardly directed, digestive, quietening and sleepy tendencies of this drive" (Schmidt-Hellerau 2004), as if she were speaking of a kind and gentle friend, although, as she makes clear, one who can also turn deadly.

This very immediacy and animation of the drives, however, reminds me again of Schafer's comments on reification, and I wonder: If the desire for care and the excitement of sex can be collapsed so directly into a conflict between drives, might it be more difficult to find the patient's agency in the creation of his or her own experience? If one is viewing conflict at the level of compromise formation, it is the *patient* who is wishing and defending, as well as self-criticizing and suffering; these are the units of conflict, not the drives that operate within, which is why Harris refers to this approach as "experience-near" (p. 275). To be sure, in the despair of some clinical hours, or in the throes of the negative (Green 1993) or of a profoundly self-destructive state, what Schmidt-Hellerau describes may be precisely how it feels to the patient—not to mention to the analyst—both of them helpless in the face of warring drives, whether they are the preservative and libidinal or life and death drives. But could such a focus on the drives themselves, rather than on more specific components of conflict, run the risk of blunting our clinical edge?

The absence of an articulated system of defenses and self-punitive functions in Schmidt-Hellerau's theory may be attributable in part to the fact that she is basing her work on a pre-1920 version of Freud's theory—that is, one that pre-dates the advent of

the structural model by several years. It was a time when repression was the only recognized defense, and the superego had not yet been formulated. Freud had flirted with the notion of *dissociation* in his work with Breuer, but was not to speak of *disavowal* until 1923. While Schmidt-Hellerau makes her commitment to Freud's topographic theory explicit, it, too, is more commonly kept alive outside North America as an adjunct or alternative to the structural theory—the latter known to the French, tellingly, as the *second* topographic theory. And in this issue, we hear it reflected in the writings of Gibeault, Green, and Kernberg. The latter comments that he is "in consonance with the French psychoanalytic approach that sees an essential compatibility between . . . the topographic and the structural models of the mind" (p. 73).

The echo of French psychoanalysis in Schmidt-Hellerau's work makes sense, not only because of her Swiss psychoanalytic training, but also because, when the French rebuilt Freudian psychoanalysis in France after the devastation of the Second World War, they placed a major emphasis on the same period in Freud's writing that most interests her, the period before the conceptualization of the structural model. Green was an important part of the study group that set out to do this rebuilding, and the French—and especially Green, as Reed and Baudry point out in this issue—took pains to integrate the later Freud, along with Winnicott and Bion, into the earlier frame, subscribing to the notion that Freud did not abandon earlier theory when he elaborated a more precise explanation.

I am not suggesting that subsequent models are *not* integrated into Schmidt-Hellerau's thinking, but it is striking that, if we turn back the clock and reject Freud's later revisions, including, explicitly, the aggressive drive, and, more implicitly, the structural model, we must also reject Freud's reasons for introducing them in the first place—among them, as Abend notes, the frequent and persistent self-destructive impulses and unacceptable unconscious aggressive wishes that Freud found so bedeviling in his clinical work.

What, then, are the potential clinical gains and losses in Schmidt-Hellerau's request that we not only reconsider the self-preservative drive, but also abandon the aggressive one? I am not suggesting that we debate the developmental origins of aggression. Whether it is innate or develops in response to frustration (or, as Schmidt-Hellerau [2002] has written, represents an intensification of one of the two underlying drives) seems less important than that we see manifestations of aggression from earliest infancy onward and in every clinical moment—sometimes, in my experience, in response to clinical frustration, and sometimes as if with a life of its own, including its own wishful/pleasurable, defensive, and self-punitive functions.

I find that Schmidt-Hellerau is calling our attention to aspects of the clinical material, and to the Oedipus complex in particular, that enrich our appreciation of the patient's experience and remind us that the wish for care and the wish for sexual excitement are frequently at odds with each other. Moreover, her position has a clinical payoff, as she asks implicitly that we linger over these dilemmas, much as Goldberg, Greenberg, and the Ornsteins do, and not collapse them prematurely into familiar dualities. But in the clinical hour, does her stance ultimately increase our effectiveness and appreciation of the complexity of the material? Again, I am sure the answer depends on how the theory is used—but, at first pass, I feel confined as I try to follow her request *not* to consider the press of aggressive wishes, including self-attack, on the same footing as the push for erotic pleasure, with some mix of the two always present. When I am asked to focus so exclusively on the playing out of preservative and sexual desires, I am unclear how best to address those deeply self-punitive patients who led Freud to posit the death drive and the superego, and those devastatingly bleak patients whom Green has left us to consider.

In respect to these concerns, Schmidt-Hellerau subsumes depressive and self-destructive instincts under the same category as

preservative ones, which becomes for me a bit confusing. In so doing, isn't she asking the drive of choice—in this case, the preservative one—to do double duty, much as she feels the libidinal or life drive was asked to do when Freud incorporated self-preservation under its aegis? Try as I might, I still cannot make the leap she does when the self-preservative drive suddenly becomes responsible not only for careful planning, solace, and the capacity to be alone (one of Winnicott's [1958] profound contributions), but also for hopelessness, depression, and suicidal thoughts, including that most negative of states, Green's *absence*. Clearly, the great life support system has here turned into its opposite.

I would add that I am in full agreement with the way Schmidt-Hellerau uses her own theory when she argues that one can interpret both the wish for caring and the wish for sexual pleasure, rather than setting up the two as truly opposed, but in suggesting that aggression is not in itself a motivating factor, I fear the loss of another focus for interpretation—namely, the expression of aggression, both self- and other-directed, as a source of pleasure and a locus of familiarity in the creation of painful affect (Valenstein 1973).

CANESTRI

I am grateful to both Harris and Canestri for describing the overall problem of conflict from within their distinct psychoanalytic traditions, and for taking so seriously a number of my own proposals (Smith 2003a). Such responses from outside one's own perspective not only reveal points of agreement and disagreement between one approach and another, but also allow us to see ourselves through a different lens, a gift I very much appreciate.

Because of the nature of his argument, I will focus much of the rest of my discussion on Canestri's position. His is precisely the sort of challenge for which one hopes as a writer, one that makes a strong case for my being exactly wrong on several points

—in particular, my suggestion that it is possible to disentangle the levels of abstraction with which we work in a way that might allow for an integration of methods, regardless of any contradictions between the higher levels of theory with which they are associated. I take a cue here from Havens's (1973) work, in which he outlined the methods of four different schools of psychiatry: objective-descriptive, Freudian/psychoanalytic, existential, and interpersonal. Havens argued for a pluralism of methods, as opposed to theories, and demonstrated how one might separate one level of discourse from another. Pointing out that psychoanalysis began as an "investigative method" (p. 5), he further posited that the "facts" we learn clinically are revealed by different methods of observation, and that these methods can be taught and shared.

Canestri takes the opposite approach in his exceptionally clear analysis of the nature and levels of theory. The clarity of his thinking, in fact, makes his argument even more appealing and more difficult to refute—in particular, that a theory is lawful and consistent from its most abstract metapsychological and developmental assumptions to its most specific observations and interventions. While it is a point of view that stems, I would argue, from a predominantly European intellectual tradition (in contrast to Havens's more pragmatic orientation), it is surely not limited to Europe. In this issue, for example, the Ornsteins argue similarly against the notion of mixing interventions that derive from different theoretical assumptions. And it was once the hope of ego psychology to construct a theory of mind, development, and technique that would be a seamless edifice from the highest level of metapsychology to the details of clinical observation; hence, the development of Waelder's (1962) levels of theory—despite Freud's own opinion, and Waelder's agreement, that the metapsychological level was the least essential aspect of the theory and could be "discarded without damaging it" (Freud 1914, p. 77).

Canestri's discussion of the preconflictual phase is a clear illustration of his position, namely, that an interpretation of conflict

cannot be made, given the developmental assumption that no such conflict exists. His reasoning here is inarguable—unless we question whether this view of theory, appealing as it is in its consistency, is an accurate description of how theory and method operate in the clinical situation.

In suggesting that this may not be what we see in practice, I do not mean that we can function without theory or with a series of disconnected methodological devices, nor am I suggesting simply that we all have contradictory bits of theory in our heads, as Sandler (1983) wrote and Canestri reaffirms. Some of us do, and some, I surmise, may not. I would argue that every analyst is best served by a relatively consistent core of clinical theory, to which he or she returns, as long as it allows for a variety of interventions according to the needs of the patient. These interventions—or, more broadly, methods—may derive not from the analyst's core theory but from a mix of lower-level bits of theory, part-theories, and even that dreaded term, *rules of thumb*. Many of these methods and theoretical fragments were once associated with other core theories, but, now disattached, have become part of the public domain, free to take up residence in the practice of analysts of different persuasions. If we trace them back to the core theories with which they were originally associated and compare the higher-level assumptions of those theories, as do the Ornsteins in their paper and Canestri in his, we find obvious incompatibilities, but if we leave them at the level of clinical method, we find alternative observations and interventions that are not necessarily contradictory.

Canestri argues that metapsychological assumptions affect the data of observation, and I agree. As a result, he believes that Waelder's levels of theory are no longer applicable to my position, because with different theories we arrive at different observations. It is a compelling argument. In my paper (Smith 2003a), however, I proposed that we use Waelder in a somewhat different way to suggest: (1) that within any one theoretical system, Waelder's levels

are applicable and can be used as tools to clarify the different levels *within that particular system;* and (2) even granting that observations are shaped by theory, at the levels at which we work clinically, our approaches may be more compatible than we have heretofore considered.

Busch's interventions are a case in point. I have some difficulty when Busch uses the developmental theory of self psychology ("mirroring") to explain his clinical approach to narcissistic vulnerability, but not with his observation that the patient's experience of injury needs to be addressed and understood. The observations and methods of intervention he describes, which are frequently linked with self psychology, are not, I believe, incompatible with his later, conflict-based approach. An overarching theory that might integrate the two approaches is not yet written, but in recognizing this, it is also premature to argue that one precludes the other, something Kohut did not need to posit. If we look carefully enough, we can find similar clinical integrations in most of the papers in this issue—in particular, those by Kernberg, Schafer, Greenberg, Goldberg, and even Canestri—as I will try to demonstrate below. It may be that these are flaws based on mixing frames of reference, but, if so, I suggest that some of our best work stems from just such flaws.

Moreover, while theory, including the highest levels of theory, affects some of what we observe and how we interpret it, it is a mistake, I believe, to attribute all of an analyst's observations to his or her theory. How else do we make sense of the fact that what an analyst observes and how that analyst intervenes is highly idiosyncratic, even within a single theory? One analyst's interpretation of conflict, for example, may seem to be, in its attunement to the patient, frankly self psychological in its method. Is it possible that the words of an interpretation may address one aspect of the patient's experience, while the nonverbal components address another? For those who fear that, if we were to succeed in further integrating our methods, we would gradually be

reduced to a pallid, common approach, I suggest that the degree of personal idiosyncrasy in how we each practice would always prevent this from occurring.

Canestri argues that because observations and interventions are theory based, they may be incompatible, but then suggests that the evidence for their incompatibility can be shown only when we compare the developmental or metapsychological assumptions of the different theories from which they derive. This is precisely what I suggested in my paper: that if one argues about what is going on in the mind of an infant—or whether, for that matter, a particular developmental phase is conflictual or preconflictual—our theories are clearly incompatible. But to prove the incompatibility of observations at the most specific level of clinical detail by arguing the incompatibility of the larger generalizations on which they are hypothetically based seems to me a circular argument, one that is predicated on the preexisting assumption that different observations and different methods cannot be compatible if they stem from different theories. I believe we argue in this fashion because it is far easier to study the incompatibilities of different theories than it is the potential fit (and strain) between different observations, interpretations, and methods.

Consider how we would distinguish Canestri's preconflictual state from the one the Ornsteins call a *deficit,* with its associated non-drive-related conflict, or from Green's state of *absence*, derived from the conflict between the life and death drives and the disobjectalizing function of the latter, or from the most primitive states Kernberg describes, based on conflicting internalized object relations. Are there any psychoanalytic data to support the notion that a preconflictual state exists in the absence of unconscious conflict? If we examine the data of the consulting room, is there any *clinical* evidence that would suggest that any one of these theories is more correct than any other in its *developmental* assumptions? And if not, are we not putting the cart before the horse if we suggest that clinical observations are incompatible because they are hypothetically based on unproven developmental assumptions?

I would suggest that any developmental theory about the first year of life has little clinical evidence to support it. We are able to construct various such theories from clinical observations, but we are still speaking of theories based on reconstruction, not developmental evidence, and the two have no evidentiary connection. Thus, Brenner would argue that, based on psychoanalytic data, there is no way of establishing any evidential certainty about the preverbal years, and Reed and Baudry quote Green to the effect that "no clinical argument for the force that creates voids can be conclusive" (p. 131).

Canestri makes it clear that he is not asking us to accept his developmental assumptions. He notes—and I agree—that the hypothetical nature of our developmental theories does not change the essence of the epistemological problem he outlines. But it might lead one to question his reliance on developmental theory as the criterion by which to judge the compatibility of observations or interventions. Might there be another way to evaluate the compatibility of our methods that would ultimately lead us to a new and more genuine theory of practice and of therapeutic action?

Canestri would be the first to point out that the developmental assumptions of the theories I have mentioned address different orders and uses of the term *conflict,* and he might consider some of them to be stretching the concept beyond its capacities. But suppose that the inferences about preconflict, absence, conflict, and deficit—as drawn, respectively, by Canestri, Green, Kernberg, and the Ornsteins—are attempts to explain clinical observations that are not in themselves incompatible. Semantically, terms such as *preconflict* and *conflict* are mutually exclusive. But to the extent that these authors are speaking about similar patients, they may be using theory to define and describe different aspects of a single patient's experience at any given moment, in which case the apparent incompatibility of their theories may be quite misleading.

In my view, just as it is impossible to think without theory, so it is impossible to think without a theory of development: even in everyday life, we operate with many implicit and descriptively unconscious theories of development—and in the analytic situation, this is certainly no less true. We cannot help but hypothesize how patients got to be the way they are, but etiology is an entirely different subject of inquiry either from methodology or from the simple description of what is going on in the clinical moment. The patient suffering from *absence* suffers in the here and now. The patient's current compromise formations are simply that: current. Contemporary conflict theory in the Brennerian tradition is in that sense *adevelopmental*. Why, then, is it so difficult to limit ourselves to the data we observe and around which we intervene, without buttressing our observations with developmental conclusions? Once we have decided on a developmental model—a preconflictual one, for example—that model can then be used to direct us further as to how we should and should not intervene. Using theory in this way is, in my view, one consequence of tying practice too tightly to theory.

One of the benefits of our pluralistic era is that it challenges us with multiple clinical observations and multiple methods for eliciting what Havens (1973) calls clinical "facts." And it allows us to begin to integrate methods, observations, and, more loosely, the theories with which they are associated. This integration makes most sense at lower levels of theory, as we see from several of the vignettes in this issue. Notice, for example, that if Schafer were to compare ego psychological assumptions with Kleinian ones at the highest levels of abstraction, or to compare their views of development, it would be no more possible at this point to integrate the Kleinian view of infantile cognition with the Freudian one (or the timing and origins of the Oedipus complex) now than it was at the time of the Controversial Discussions. But at the level of the patient's wishes, fears, and the defenses mobilized against them, it is not difficult to integrate a view of projective identification as a

defensive process, along with the countertransference responses it evokes, with a more ego psychological view of intrapsychic conflict and defense. In that respect, one can begin to picture an integrated practice even in the absence of an integrated theory.

At another level, some of us, including myself, have little difficulty organizing our thoughts around a core theory of conflict and compromise, onto which we may graft various hypotheses about earlier development. For the most part, these grafts are clinical ones, determined by the exigencies of the clinical situation. They may relate to what some call deficits and what others call deficient functions, but they do not claim to know (or need to claim) specific developmental assumptions about infantile life. A number of authors in this issue have adopted such a graft. Kernberg grafts the conflict between internalized object relations onto a model of conflict derived from the structural theory and then organizes both under the former umbrella; as Reed and Baudry point out, Green grafts a notion of conflict between objectalizing and disobjectalizing functions onto a complex mix of structural and topographic conflict; and, as we have seen, Kohut (1977), historically, grafted a different way of listening onto the explanatory reach of drive theory.

Rules of Thumb

Gardner (1991) has argued that our theories are ill-suited to the working analyst. But in recent years, in the United States in particular, we can begin to see the evolution of just such an emphasis on theory that is adapted to the clinical situation, and on clinical method. Brenner's (1994) model, which in his view is the best fit for the clinical data, is also, because of a spareness that reveals multiple clinical options, especially durable in the consulting room. And there are other examples: Schwaber's (1983) effort to follow the patient's experience of the analyst, the self psychologist's attention to empathic ruptures, Gill's (1982) focus on how

the analyst's behavior might plausibly be fueling the patient's transference experience, Gray's (1991) attention to the "conveyer belt" of drive derivatives (Smith 2003a), Bionian/Kleinian clinical approaches that closely monitor the oscillation between the paranoid-schizoid and depressive positions in the hour—all of these bear the marks of theory that has evolved in the consulting room, inevitably influenced by the experience and needs of the working analyst.

And this may be not only a North American trend. Notice, for example, that many contemporary British Kleinian analysts stay attuned to the clinical moment, to the patient's use of the analyst's comments and the analyst's experience of the patient, using a clinical method that—in contrast to the stereotypically deep, early interpretations of their past—may bear more resemblance to other contemporary approaches to interpretation of the transference in the here and now than to analysis as Klein herself practiced it. Like Brenner's modern conflict theory, it is a clinical theory and a clinical method wherein metapsychological assumptions, as Steiner suggests, seem quite remote. Such methods do not require developmental theory to explain their utility. I would suggest that the same is true for some of the clinical methods of self psychology, which do not require a developmental theory of environmental failure to explain their clinical usefulness.

This loosening of our methods from the theories that spawned them (or which, in some cases, we have secondarily built around them) coincides with the discovery that our current clinical theories, diverse as they are, no longer effectively explain either pathogenesis or psychopathology. We have learned this from clinical observation. Once one recognizes the ubiquity of unconscious conflict, for example, it is much more difficult to define what is pathological and what is not on the basis of conflict alone. Similarly, if empathic ruptures are the units we observe in clinical work, we find them in all analyses and in every developmental history. As for projective identification, it appears to be a condition

of thinking, by no means limited to primitive psychic organizations.

I have noticed that analysts who subscribe to a particular theory may in their clinical practices use simplified notions of their theory—rules of thumb—that are frankly inconsistent with the more complex theories on which they are based. Consider, for example, the maxim to "interpret defense before drive." Many contemporary conflict theorists take this principle quite literally in ensuring that they do not bypass the patient's defenses. But such a notion suggests that defense and drive derivative are separable—Schafer would say *reified*—entities. The concept may be useful from a practical point of view, but if the theory of compromise formation on which many of us base our work is valid, there is no way to parse out the individual components of conflict so neatly. All defenses are themselves compromise formations, with drive derivatives and self-punitive elements built into their very structure.

Or consider empathy and identification, two concepts that bridge all theories, the privileged domain of none, and yet in the consulting room, they are used in frank contradiction to what we have been taught about the theory of representation. Sandler (1987) reasons, for example, that we do not identify with a patient but with the patient's self- or object representations. Others would add that self- and object representations are themselves never separable but are always admixtures of the two. And Schafer (1968) reminds us that the representations with which we identify are not a patient's self- or object representations at all, but rather our own representations of that patient; in Schafer's words, we identify with "one or more representations of the person," with our own "conception or experience" of that person (p. 142).

Now, is this what we experience in the analytic hour? Not only do many clinicians still follow Racker's (1968) teaching that we identify either with the patient or with the patient's internal objects, but I dare say there is scarcely an analyst who, immersed in the clinical moment, does not feel that he or she is identifying

with the *patient,* rather than with the patient's self-representation —let alone with the analyst's representation of the patient. Such trial identifications are what we call empathy, and they are a staple of our clinical diet. Clearly, this way of thinking, however useful clinically, flies in the face of a more complex and more accurate theory of representations. The latter may be a check against clinical excess, which is how Sandler intended it, but it is frequently and necessarily violated in the clinical moment. It has, in fact, led some of Sandler's co-workers to try to rescue simple empathy from the complexity of his theory (Smith, in press).

Canestri's Vignette

I would now like to return to Canestri's argument that it is inconsistent to integrate observations, interpretations of the clinical data, and interventions—in a word, *methods*—if the metapsychological and developmental assumptions on which those methods are based are contradictory. What if the practices of any given analyst are not so tightly bound to these more abstract theoretical notions? As I have suggested, I think there is evidence that this is the case, even in Canestri's own beautifully presented clinical vignette.

For example, when, in illustrating his view of a preconflictual interpretation, Canestri says to his patient that she feels the weekend separation to be a death and that she is angry with her friend for suggesting something to her that she is hesitant to tell her analyst—namely, that he has abandoned her—I would suggest that Canestri is describing accurately and sensitively a familiar conflictual issue: the patient's terror of abandonment and her fear that, in confronting her analyst, she risks precipitating the very thing she fears. I have no quarrel with his calling this a *preconflictual state,* but it is not clear to me why it is necessary to do so, nor does it seem to be stretching the theory of conflict too far to call it, alternatively, *conflictual.*

Similarly, when he says to the patient, "sometimes going backward helps one to then go forward in a different way" (p. 317),

he seems to me to be, once again, interpreting the patient's defensive movement with great sensitivity, noting that she wanted something and then retreated for fear of the consequences. I consider this the interpretation of conflict at its most fundamental level. While Canestri and I might each be simply calling it as we see it, might what I have outlined be evidence that different theories allow for similar interventions? It would not be the first time a useful intervention could be explained after the fact by any number of theories.

Consider another example. At an earlier moment, Canestri says in response to his patient's dream:

> I think that what you imagined I was thinking could have introduced a new element: I can be the poor Chinese in need and you are Tsamu Malia, the powerful one. I could feel myself abandoned, envious and angry, saddened and nauseated, as you well know one can feel in such circumstances. [p. 317]

Canestri's intervention seems to speak to his patient's defensive use of projective identification, broadly defined, and he frames his interpretation in the clinical language we have been taught by contemporary Kleinian and Bionian analysts. But is it lawful for him to do so? He might argue in response that his comment has nothing to do with projective identification, or, alternatively, that the patient is just beginning to develop such a capacity. But in the absence of such arguments, and following his own logic, if we were to compare Kleinian metapsychological and developmental assumptions regarding intrapsychic conflict in earliest infancy with Canestri's conviction of a preconflictual stage, we would have to question whether he is at liberty to make the interpretation he does, given that the assumptions of the two theories are quite clearly contradictory.

Canestri's right to do so, however, which I fully endorse, is consistent with my view that we borrow observations and methods from different theories and use them even when we do not sub-

scribe to the precise metapsychological or developmental theory from which they are drawn. They are in the public domain. Moreover, given how promiscuous analysts are in identifying with analytic teachers, mentors, and supervisors, it would be nearly impossible *not* to do so (Smith 2001). Thus, I would argue that one can observe a patient's use of projective identification without accepting the developmental assumption that infants exist in the throes of the paranoid-schizoid position, or that they are tormented by conflicting internal part-objects. The latter two developmental hypotheses are based on reconstructed data, and it should be enough to try to observe projective identification at work in the activity of the clinical hour without reifying either the theory or the observation itself.

Because we feel we are on much more solid ground with a consistent theory, combining terms from different frames of reference troubles us. Hence, when we hear Schafer speak of projecting "into," or Busch of "mirroring," at the same time that they use the language of ego psychology, these terms may grate, but if we are working toward an integration of various methods that seek to identify and address different aspects of a patient's experience at any given moment, their mix of terminologies is less jarring.

I am not advocating an indiscriminate eclecticism, nor suggesting that we apply different theories for different patients, nor even that we are speaking to different "psychologies" in the patient (Pine 1990), but rather, I am arguing for a looser linkage between theory and practice and for a measure of theoretical imprecision —or, more specifically, that we not assume a degree of theoretical consistency and conviction that our current clinical data cannot justify (Smith 2003b). I am also suggesting, following Havens (1973), that in building our theory of practice, we would do well to consider the methods of our different schools as part of a potentially shared repertoire. I suspect that I am merely acknowledging here what is already in place, if we but had the tools to observe it.

In concluding his remarkable paper, Canestri agrees that theory and practice need a looser coupling, but if he means this, I am not sure how it fits with the tight epistemological argument he has offered to that point. Perhaps he and I meet on this ground, as we do on many others. Given his support for Sandler's (1983) observations of preconscious theories in the mind of the working analyst, Canestri may be trying to reconcile his understanding of the consistency of theory with his own observation—and Sandler's —of the complexity of practice.

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Once again, I want to express my gratitude to the thirteen authors in this issue for so faithfully fulfilling their task and contributing such exceptionally lucid papers. I offer my discussion in the hope that both the papers and my response will further the dialogue among us, toward the goal of sorting out the crucial questions of where our approaches are similar and where they must remain distinct. Our readers are invited to respond with their own papers on the subject.

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