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LAWRENCE FRIEDMAN: SPEAKING OF ANALYSIS

BY HENRY F. SMITH, M.D.

Rumor has it that there was once a writer who had given an honorary address, which he sent to the editor of the journal required to publish such events. (Requirements like these, I might note, are the bane of editors' lives, and we at the *Quarterly* are blissfully free of them.) Now, this particular writer was something of a poet, in addition to being a psychoanalyst, and the editor in question told him that his manuscript needed to be revised. A scientific paper, the editor explained, had to follow a particular format. It should begin with an introduction, followed by a review of the literature, and then a statement about the author's specific contribution; next should be the presentation of the data, and then a discussion and, finally, a conclusion. This author's manuscript, on the other hand, was, the editor wrote, constructed like a symphony—meaning, one supposes, with movements, themes, and variations on themes. The author thought about the attribution, considered various responses, and then, somewhat flattered if truth be told, and recognizing that the hapless editor had no say in the matter anyway, wrote back that a symphony was just fine by him. The paper was published without alteration.

Rest assured, we do not intend—nor do we have the opportunity—to publish very many symphonies. For most articles, some version of the standard format is probably the clearest mode of communication, one that allows for considerable individual creativity. Rare, moreover, is the oral presentation that can successfully make the bridge to the written page; too gestural or too limited in scope and detail, most cannot stand on their own. But

neither should we overlook the fact that the world of psychoanalytic publishing was not always so strict. Essays, including Freud's, were once the order of the day. And even though some analysts (like Freud) write for publication with the same declarative simplicity and lucidity that characterizes their presentations—they write the way they speak—there are others who communicate ideas in their spoken work that are lost in translation to the printed page. Conversion from one form to another is always, I suspect, a difficult task. Once a child of the imagination has been fully fashioned in one medium, it is hard to conceive of it as a different species.

These are not simply considerations of style and editorial policy. There is an intimate and complicated relationship between an analyst's mode of writing and his or her mode of analyzing. One may be quite different from the other; and the style of the writer may reveal, or hide, the nature of the analyst. An analyst who is declarative and dogmatic in his or her writing may be questioning and open-minded in analyzing, and vice versa. Just as a supervisee may imitate the supervisor's certainty, or verbosity, or some other character trait evident in teaching, and convert it into an analytic attitude far from the supervisor's intent, so an analyst's readers may be led astray by his or her rhetoric on the printed page.

In particular, we are intrigued by a small group of writers who have developed distinctly different—and equally successful—styles for presentation and for publication. Despite the fact that both forms of communication are effective for them, each in its own way, some of the ideas these writers convey in speaking, and the means by which they convey them, are remembered only by those who hear them. They write *differently* from the way they speak, and however much their published scholarship adds to our intellectual and clinical understanding, something of themselves, and the way they think and practice, remains at the podium.

The writer who follows is one such. Perhaps more than any other major author in our field, Lawrence Friedman, while prodigious in his published scholarship, has, unbeknownst to many, invented a unique and personal style of presentation, full of prov-

ocation, confrontation, hyperbole, and, at times, invective. Using rhetorical devices most of us wouldn't be able to name, let alone adopt, Larry speaks with less jargon than almost any other psychoanalytic scholar I know. This Cicero of the analytic stage wheedles, rants, apologizes (as in *apologia,* come to think of it, as well as its more contemporary meaning), and otherwise bothers us, getting under our skin and into our minds, while he puts his understandings of our work in the most personal of terms.

If all words contain a bit of the performative, Friedman's performatives are front and center. They are the be-all and end-all of his spoken prose. Thus, there is no doubt that he is pushing us to think and feel something (and no doubt as to *what* he wants us to think and feel), when he says in the paper you are about to read, "Now, I ask you: What happens in such a close relationship when one party knows that hope and protection are merely virtual, while the other party is never quite sure? As the patient probes and feigns, the analyst's answer sticks in his throat . . ." (pp. 642-643). Is there any question as to the sleights of hand by which Friedman takes advantage of the reader's innocence to cajole and seduce?

Except occasionally, Friedman has always been reluctant to publish his orations. More is the pity for those who have not heard them, for they, every bit as much as their more expository cousins, deserve studying, both for their content and their method, a method that contains more of its author, in a more direct form, than we find in some of his more "scholarly" work.

Larry once turned down an invitation I offered him to speak (he later accepted), saying that it was usually an unpleasant experience for everyone. It wasn't, as it turned out, but I knew what he meant. He sees analysis as disturbing; and he wants us to recognize its disturbances; and to get us to do so, he tries to disturb us. That is his method. And it comes across in a paper like this one better than in his other papers. Also evident, as you will discover, is his irony, his sense of humor, and his love of argument.

The paper that follows was first given as the Victor Calef, M.D., lecture in San Francisco in 1998, and has been repeated in a num-

ber of venues since then. I have been trying to wrestle it from the author for a number of years, but modesty prevented him from offering for publication something that was meant to be spoken to an audience. Like the (perhaps apocryphal) editor of my opening paragraph, he did not feel it was "scholarly" enough, too much of a symphony, perhaps—or a shout. But if it is not scholarly enough for our scholars, then I suggest it is their loss, for in this paper, which has been modified only slightly from its original form, Friedman engages us in both the sweep of psychoanalytic history and its realization in the current moment more effectively than he might in any other form, written or otherwise, his or anyone else's.

This paper might more accurately be titled "*On Behalf of* Flirting with Virtual Reality"—or even "On Behalf of Flirtation"—for, make no mistake, this is an advocacy piece. (That's the *apologia* part.) And as he flirts with his readers, Friedman defines a new aspect of his trademark theme, the analyst's discomfort and how the analyst assuages that discomfort in the name of theory and technique.

Thus, you will hear how analysts have traditionally made themselves more comfortable with the "come-on" they offer and, more specifically, with the "flickering virtuality" they have always provided, that curious and indefinable mix of the virtual and the actual that makes up the arena in which we joust with patients. Traditionally, analysts have tried to simplify things—no surprise here—by emphasizing either the actual or the virtual, or by "softening the contrast" between the two. In a characteristic tour de force, Friedman locates most of psychoanalysis under or near these three signposts.

But, until recently, the fact that there *is* a "flickering" between the virtual and the actual was not in dispute. Today's analysts, however, having made themselves more vulnerable by eliminating many of the old certainties, have now in self-defense diminished their discomfort at the coyness of analysis by trying to eliminate the tease altogether. And with that move, Friedman warns, we may be at risk of eliminating psychoanalysis itself.

Here Friedman makes an almost, in my view, unassailable argument. "Patients use virtual reality," he writes, "as a radar screen for detecting their true wishes" (p. 658), and unless analysts *invite* them to do so—tease them, in effect—the principal feature of analysis as a screen for uncertainty, possibility, expectation, and hope —in short, the ambiguity of fantasy—will vanish. As he puts it in a sentence that is bound to be quoted time and again, "Without virtual reality wishes are stunted, but without objective reality wishes are worthless" (p. 656).

Friedman has been criticized in the past for not including clinical material in his articles, and this paper is no exception. But, as the reader, what you will find if you assent to *his* tease, is that *you* become the clinical material. It is you whom you will encounter in these pages, because Friedman's presentations are, in a word, *dialogues* with analysts—uncomfortable analysts.

Curiously, I suspect you will recognize yourself in more than one of the stereotypes or "straw men" that he admittedly and unashamedly paints, because they, too, are flickering, and analysts draw on different ones at different times in order to gain leverage with patients, as well as to make peace with themselves. To what extent analysts' maneuvers are motivated by personal comfort rather than technical utility—and, for the record, it must always be a mixture of the two—is one of the most important unsolved mysteries in our work, one that Friedman places high on the marquee. Even more doggedly than usual (perhaps because he is free to speak his mind without fear of "scholarly" constraints), Friedman pursues this subject to its very essence, which, when he gets there, is—as you might imagine—still unsolved and still flickering. And so our discomfort continues.

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FLIRTING WITH VIRTUAL REALITY

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Psychoanalysis encourages patients to experience a virtual reality of the psychoanalytic relationship, in which both image and wish can be experimented with. Originally, the patient's awareness was supposed to move back and forth between the virtual and the actual, in a flickering and uncertain fashion. That is uncomfortable, and analysts have often preferred the domain of virtuality or of actuality, or have denied the distinction altogether. Recent philosophical developments and doubts about transference neurosis and reconstruction further tempt analysts to relax the flickering uncertainty of virtual and actual. Patient and analyst may gain comfort but lose something in the process.

We live very odd work lives, you and I, groping our way through mists of virtual reality. In what follows, I will recall how analysts got themselves into that vaporous landscape and how they have felt about it—how they have felt about maneuvering people to regard them as virtual objects while looking for actual truths and alternate virtualities. And I will discuss how analysts tailor their job description to make themselves more comfortable in doing that. Thus, you will mainly hear about how analysts prefer to picture themselves, but I will also mention a kind of motive in the patient that might be best exploited by the old-fashioned custom in which the analyst, and not just the patient, flirts with virtual reality.

This paper was first given in a slightly modified version as the Victor Calef, M.D., Memorial Lecture on February 8, 1998, at San Francisco Psychoanalytic Institute, San Francisco, CA.

A couple of warnings: I love scholarly writing, but I hate fussy speech, so be prepared for rough and facetious characterizations. And most unwelcome to your ears, I confess that you may come away from my harangue none the richer in treatment ideas. The reason for this is that I don't know to what extent the analyst's own sense of what he's doing (which is what I describe) leaks out into his behavior and technique. Maybe it leaks a lot; maybe just a little. If you like, you may regard this as merely a gallery talk for voyeuristic analyst watchers, rather than a technical deliberation. But as I go on about the analyst's attitudes toward virtual reality, I rather suspect you will find yourself thinking about practical issues of neutrality, abstinence, and self-disclosure, as well as relativism, constructivism, objective reality, and so on.

I begin with the fact that, long before the advent of the computer, Sigmund Freud invented an instrument for studying virtual reality. Catharsis was achieved by hallucinating an event that no longer existed. It was an experience of a virtual reality. At first, it happened in a trance. But some patients couldn't be hypnotized, and those patients, therefore, could not be made to reexperience the past as a virtual presence.

Then Freud discovered that even without catharsis, the virtual world could be made to appear in the actual world. It only needed to be given the chance. (The chance was the transference.) There was a difficulty: there is no simple way of telling which part of the patient's behavior is virtual and which is actual. It isn't clear-cut, like the difference between a trance state and waking, or between a memory and a current perception, or the obvious difference between a dream symbol and its meaning. On the couch, it's all blended together—virtual and actual.

Nevertheless, even if it's hard to draw a line around what's only virtual, Freud did find that the virtual world would come alive if patients abandoned their customary self-protection. Then they would begin to live in the virtual reality of their childhood, to the point of dragging their analyst into it. Freud thought that when patients were forced to flip attention back and forth between their virtual world and the actual world of treatment, they would ex-

perience something equivalent to catharsis, though without the mighty cataclysm that had formerly blasted cathartic memories into the present. In both cases, the trick was to make the patient feel both realities at once—the virtual and the actual, in competition with each other (Freud 1914, pp. 155-156).

But that is easier said than done, because virtual reality is the stuff of *wishes*. Indeed, as Freud observed, virtual reality is everybody's most intimate reality, as witness the phenomenon of romantic love. Why would anyone give it up?

Mindful of that question, Freud, as early as 1914, was forced to admit that memories and affects were not the whole story of treatment. Something new had to be factored in. It was something that philosophers call *conation* and we might call *striving* (Freud 1914). Strivings mark the values in a person's world. Strivings now became as important as emotion and memory. The problem wasn't just a sick memory here and there; patients were doing their entire living, struggling, and wanting in terms of virtual reality. So it was not sufficient for patients to remember and emote. Their *wishes* had to be changed along with their reality. And then they had to compare and contrast the one kind of wanting with another. (That was the first meaning of "working through" [Freud 1914].)

In those early days of 1910 – 1920, something powerful was drawing Freud toward a frank understanding of the situation. He was captive to an extremely odd encounter with virtual reality—an odd encounter that became known as *psychoanalytic treatment*. Freud's "Papers on Technique" (1912-1915; Friedman 1991) show what a tough meeting it was. As I mentioned, Freud discovered that virtual reality infiltrates actual reality in all the important scenes of life. To be psychoanalyzed one had to stop the normal mixing of the two. Patients were required to separately incubate virtual and actual worlds in pure culture for study, while suffering the dislocation of their wishes. Not illogically, Freud supposed that the only way people could be made to do that is under the influence of the transference, since it, like all virtual worlds, has strivings already built into it. Thus, in designing psychoanalysis, Freud

set up a mixed state in which the virtual experience of the analyst as a transference figure intermingled with the actual experience of him as a professional technician. The two would later be sorted out (although Freud recognized that some virtuality always remains —for example, a virtual father dwelling forever in the professional technician).

Some will say we are more sophisticated nowadays. We know that you can't eliminate a transference by using transference. Or do we? Some would say that Stone (1961) didn't accept that principle, nor do most analysts, according to Gray (1994). Indeed, the question of how to use the power of wishes without confirming them remains the great puzzle of all talking treatments. But there was no need to wait for us clever moderns to perceive the contradictory requirements of this weird occupation. The paradoxes were carved into the foundation stone of treatment. The very act of defining psychoanalytic treatment, Freud's "Papers on Technique" (1912-1915), consisted precisely in a display of paradoxes. I would call them the three great paradoxes of virtuality:

(1) Transference is a virtual reality, but it's hard to tell it apart from the actual relationship.

(2) Transference is universal, but there's a sense in which it's peculiar to analysis.

(3) Transference is a retreat from actuality, but it's also what engages people in actuality—it's what makes actuality valuable.

The nubbin of Freud's inaugural report was these three paradoxes, which suggests that they, and the problems that spin off them, are the essence of treatment insofar as it is psychoanalytic. As a result of these paradoxes, analyst and patient are in a state of uncertainty. For instance, patients never know how much and in what way the analyst is attached to them. Will the analyst love the patient? Will the analyst protect the patient?

Now, I ask you: What happens in such a close relationship when one party knows that hope and protection are merely virtu-

al, while the other party is never quite sure? As the patient probes and feigns, the analyst's answer sticks in his throat: "No: I will not protect you; I will not stick by you for your whole life; I will leave you more easily than you will leave me; I will walk out on you if I am not paid; I would not respect you in every way in other contexts." How does one person feel when he encourages uncertain illusions in another?

And the analyst has his own uncertainties: He cannot easily determine what in himself the patient is seeing, a virtual or an actual aspect, especially since he, too, partly sees himself as a virtual figure—as a figure of his own fantasies, for instance, or at least as a socially defined virtual figure, such as a parent surrogate, as Freud saw a virtual father in the physician (Freud 1912, p. 100). And the analyst must ask himself whether and how much he is responsible for what the patient thinks he is. Is he deliberately misleading patients (for example, to see him as passionately engaged with them)? Is he, perhaps, actively impersonating a virtual figure, either inadvertently (as in an enactment), or because he really fancies the role (for instance, of a mother)?

The uncertainty crackles in the air. There's bound to be plenty of challenge going on, inward and outward, by both parties at all times.

Psychoanalysis tends toward a critique of the virtual (though not a complete escape from it). And nothing could be more awkward than waffling between virtuality, loaded as it is with human meaning and wishes, and nonvirtuality, with its cold-blooded critique of meanings, its disappointment of strivings. No wonder psychoanalysis has been said to be a process of loss and mourning, and thank heaven there is a limit to how far that can go (Tarachow 1963).

Even faced with this unpleasant tension, Freud disdained a facile solution, though later analysts were not always so tough-minded. As mentioned, Freud allowed the analyst to retain his virtual image alongside his actual image during treatment. He permitted virtuality to reign (in the unobjectionable positive transference) as long as it allowed him to direct the patient's attention. He hoped

to exchange a virtual for a real appearance at termination, but modern analysts nevertheless fault him for exploiting his virtual image en route. (Suggestion is nothing but the power of the virtual.)

Beginning with Ferenczi (1933; Ferenczi and Rank 1925), experiential analysts have made themselves more comfortable with their virtual come-on by declining to distinguish sharply between virtual reality and actual reality (while in the meantime stretching the blurred virtual-but-also-real image to cover the mother role). Gitelson (1962), Stone (1961), Racker (1968), Winnicott (1971), Zetzel (1966), and others have continued that tradition. To be sure, this softening of the contrast between virtual and actual captures a deep truth of human life—the overlap between imagination and brute fact. My point is that relaxing the distinction also serves to ease the burden on the analyst; it reassures him that he is not tantalizing the patient with an illusion, an illusion that he himself secretly sees through—an illusion, moreover, that he is secretly sworn to back out of. Instead, he can feel that actuality and illusion blend harmoniously, with promise and fulfillment united. (Here I am deliberately oversimplifying these theorists.)

That's one way the analyst can make himself comfortable, but it's not the only way. Ego psychologists can comfort themselves not by blending the two worlds, but by downplaying the analyst's virtual image and emphasizing his objective reality. They may assume the role of foreman in an ongoing work project. They look beyond virtual illusions to the actual job at hand; they summon the patient's actual exploration and investigation, and emphasize their own objectively real act of pointing things out and directing attention, as well as the patient's objectively real acts of weighing and scrutinizing the findings. (One thinks of Gray [1994], and especially of Busch [1996].)

Those are two ways of being more comfortable. For a third, we can turn to the older Kleinians, who opted for the one remaining alternative: Instead of emphasizing the overlap of virtual and real, in the fashion of Ferenczi and other experiential analysts, and instead of emphasizing the actual work-project as the ego

psychologists were inclined to do, the older Kleinians imagined themselves to be moving entirely in the virtual world (Spillius 1988). You could see this attitude in bold relief when they argued with Anna Freud about whether the child analyst was a real or a transference figure.

The Kleinian choice was also Kohut's (1977). In fact, self psychologists are even happier to think of themselves as wholly virtual figures in the patient's mind. Indeed, Kohut's contribution was to catalogue the universal virtualness of all human relations and human strengths, and he alone, among contemporaries, criticized Freud for using his virtual powers too little rather than too much.

Let me recapitulate. Analysts who didn't want to flirt with virtual reality had three logical alternatives: They could blend virtual and actual; they could stay entirely with the actual; or they could stay entirely with the virtual. I don't say that analysts adopt these views simply to make themselves more comfortable. But neither do I think that comfort is a negligible incentive, or, indeed, an unworthy one. And, for the purpose of this talk, I will artificially treat comfort and discomfort as the main issue (earning, I fear, the enmity of most of my friends). So let me speak loosely and say that what I've outlined are the ways that analysts pictured the scene in order to diminish the discomfort of a flickering virtual reality.

If I may mix art-historical and cultural metaphors, I would put it this way: There is the baroque portrait painted by Freud (not classical in this context), in which the ornate complexities of treatment are emphasized and played off against each other. There is a clear, simple, Enlightenment model in which treatment is flattened out as a plain, straightforward inquiry, with no murky depths. And there is a romantic vision of treatment as an inspirational creation that is unique to each couple (similar categories have been used by many commentators). To some extent, the Enlightenment and the romantic portraits were painted to ease the discomfort of living with the uncertain virtuality of the baroque

model, with its deep shadows. But I have the impression, and this is the crux of my talk, that many contemporary Anglo-American analysts are still not sufficiently comforted even by these easier ways of thinking, and they wish to get rid of the last vestige of ambiguity.

The earlier analysts allowed themselves to flirt with a flickering virtuality in order to study it, but today's analysts, though naturally happy to study virtuality when it occurs in the transference, are less willing to actively flirt with it, by which I mean that they model their beliefs, and perhaps their actions, on a steadier image of their role.

Why now? What is it about our times that has made a flickering virtuality more uncomfortable than it used to be?

To begin with, philosophical and social assaults have demolished the old tools that analysts relied on to help them live simultaneously in both the actual and the virtual world. Let's look at those bygone tools. Obviously, the most important was the very distinction between virtual and actual reality. As I mentioned, the slipperiness of the distinction has been known since Freud's time (Freud 1912). Nevertheless, the older analysts thought it possible in principle to separate what they were really offering from what the patient *thought* they were offering, though they recognized that they might be mistaken in any particular ruling. That certainly made them less uneasy about the patient's expectations.

Secondly, the old-time analyst thought he could rely on his patient's lawfully functioning mind to do a real—nonvirtual—work of recognition. That machinery would ultimately correct the virtual image of the analyst and vindicate the real one. Together, these two pillars of strength—the philosophical distinction between virtual and actual, and the psychological belief in a lawfully functioning mind—propped up the analyst when the patient saw him differently than he saw himself.

Have these principles been challenged? Have they ever! Nothing is more characteristic of our age than the critique of objective reality. Personally, I find it ironic that just when mankind has learned to control the objective world, some of its sages have de-

cided it isn't really there after all—there are only social constructs to be reconstructed. And if real, physical objects have disappeared from view, how much more unavailable are objective features of persons and minds. An analyst today who would protest that he isn't *really* behaving as the patient thinks would be laughed out of our enlightened conference rooms. The so-called positivistic analyst used to smile indulgently at transference "distortions." When the new analyst feels himself misunderstood, as he inevitably will, he can only squirm and subject himself to interminable self-inquiry. Nor can today's sophisticated analyst reassure himself that his patient's mental machinery will eventually vindicate him: we are told that there is no such structure to the mind. In short, the modern analyst has made himself much more vulnerable.

Indeed, if I may say so, the modern analyst positively prides himself on his humility, because doubts about objective reality are endorsed by our new social norms. The modern analyst is required by our respectful, antielitist mood to avoid manipulative, authoritarian—and even authoritative—posturing, and to *embrace* the vulnerability to which his relativistic philosophy, in any case, has already condemned him.[1]

Now, back to our loss of the concepts that used to make us comfortable working in the vineyards of virtuality. Today, interpretations are thought to be just like any other interpersonal action; they are thought to funnel into the patient not items of information, but the analyst's whole human perspective, including much that he's not aware of. And the patient is thought to react to interpretations roughly as he would to any other personal action on him. Without the possibility of a clean interpretation—*clean* as in nuclear weaponry—the analyst, along with his interpretations, has become helpless to control his self-image in the strobe light of the virtual images the patient plays over him.

[1] A side comment is called for here: I'm counting on you to appreciate that setting up mock battles between straw men is not a logical error; rather, it is the easiest rhetorical way to contrast general trends. If you're allergic to straw men, well, you may call my generalizations Ideal Types in the fashion of Max Weber, and let me get on with my talk. As to my occasional snide tone, please bear in mind that I personally share some of the views of these modern straw men.

So far, I don't think you'll disagree with me about the reasons for our new, cognitive vulnerability: There are no more mental objects and there are no more surgical interpretations. And you might also agree that their absence makes us more uncomfortable with what we used to think was a playful costume party of transference images. Now I'd like to further suggest two more debatable reasons for our growing disinclination to mix virtual and actual worlds.

I cannot escape the impression that one reason yesterday's analyst was comfortable being misrepresented was that, in the privacy of his own mind, he could imagine the possibility of a precise decoding of each virtual role and relationship that he appeared in, tying it to a specific aspect of the patient's childhood. There would be, at least theoretically, a concrete and specific historical actuality that corresponded to each of his virtual appearances. That made the virtual seem much more clearly defined. Even the bare possibility of making a one-to-one translation gave hope that the virtual reality of the analyst's appearance could be lifted up by its edges and delicately removed from his underlying actuality. Or, to mix the metaphor, it would be by shaving off the childhood reality that the virtual present would give way to the actual present. We recall that Freud (1904, p. 260) thought of psychoanalysis as sculpture *per via di levare*.[2] (Stereotypes were what was needed —stereotypes of loving, stereotypes of childhood relationships, traumas, and so on.)

I think analysts have lost confidence in the specific details of pathogenesis. Reconstruction has fallen into disfavor. The repression paradigm is no longer paramount (Anna Freud 1936, 1954). And so the analyst is less sure that virtual reality can be translated simply into a specific, earlier actuality, leaving the real present to be seen for what it is.

And I think there's been one more loss that has sapped the analyst's ability to tolerate the mixture of virtual and actual: I mean the vanishing of the transference neurosis. Maybe the older analysts could comfortably entice virtual images onto themselves

[2] In Italian, *by means of lifting out.*

because they supposed that those virtual images would coalesce into a sharply outlined transference neurosis, which could then be dissolved. In a comment that a book by Wallerstein (1995) drew to my attention, Anna Freud (1954) said:

> We see the patient enter into analysis with a reality attitude to the analyst; then the transference gains momentum until it reaches its peak in the full-blown transference neurosis which has to be worked off analytically until the figure of the analyst emerges again, reduced to its true status. [A. Freud 1954, p. 618]

With their belief in childhood prototypes fading, and the transference neurosis as well, analysts may have lost their heart for playing out virtual roles. Let me summarize why analysts may now be disinclined to flirt with virtual reality while holding onto objective reality:

(1) Analysts no longer believe in an objective reality that would offset their virtual appearance.

(2) They have lost confidence that they can define what is merely virtual by reducing it to what is biographically actual.

(3) They don't believe any more that amorphous virtuality gets sucked up into a neat transference neurosis that can then be discarded.

And when you add to these deficits the positive ethical commandment to judge not thy neighbor's accuracy, we may have the recipe for the current rebellion against the early Freudian paradigm.

And the results? What has it all led to? The logical possibilities are limited: Maybe everything is virtual. That is what Schafer (1992) says in his narratology. Since there is no actuality to contrast it with, the analyst need not flirt with a flickering virtuality. That also seems to me the implication of object relations theory —as, for example, in Fairbairn (1958). (Perhaps the Kleinians pioneered this option?)

Turning that around, if everything is virtual and objective reality is a myth—if there is no reality that can be misperceived—we may just as well say that everything is actual. That, I believe, is the tendency (if not the detail) of social constructivism and intersubjectivism. According to these accounts, images that used to be labeled as merely virtual turn out to be all the reality there is; the virtual has been made actual by the very perceptions and interactions of the two people involved. And if that is the case, then it makes no sense for the analyst to play a double game; he has no real self to hide away from the virtual images that play around him. He might as well, it is argued, be straightforward in his dealings with his patient, for the alternative—that is, trying to be mysterious—would simply establish another real (constructed) relationship, and in that case an unhelpful one. The analyst is thus relieved of the burden of encouraging virtuality to play out around himself.

You can see how I differ from Renik (1995, p. 476), who holds that analysts revel in idealization. I think they sweat under it.

I believe that there's comfort for all if the analyst is straightforward. Staying on one level is more respectable—it's literally "being on the level"—whether that level is a smooth, undiscriminating blur of an analyst who is both virtual and actual, or a plain, flat-out actual investigator, or an analyst comprised entirely of virtual images with no reference to objective reality. Such consistency is far cleaner, more reliable, more collaborative than the shadowy, old dodge which seemed to say, "maybe what you see is virtual or maybe it's really me." Being honestly one thing or another rids the analyst of the onus of mystification. An unmysterious analyst has no secrets, and his reward is to be less alone in his work. Best of all, he is morally in the clear. The advantages are numerous; the relief is demonstrable.

Is there a downside? I warned you that I don't know the answer. Now as before, every analyst—even a perfectly straightforward one—will always be *interested* in the patient's virtual experiences. But if the interplay of truth and illusion sits less well with the analyst—if he goes out of his way to be unmysterious—it seems

to me that patients may have less investment in their own flirtation with virtual realities. To speak bluntly, psychoanalysis may soon dangle less teasing bait. Nobody ever enjoyed saying, "Maybe I really am what you think I am," when he knows perfectly well that he's not. Nobody ever *liked* the teasing aspect of analysis. But analysts now have a new excuse for avoiding it: The new analyst doesn't think there is a "really." Or, if he does believe in reality, he doesn't feel it's right to fish for guesses by hiding his truth.

Patients might respond to the new, on-the-level analyst differently than to the old one who used to coax virtual worlds into tormented life by a notoriously coy stance—a stance that conveyed the following messages (and here I speak the old messages):

- "Although I know who I am and I know how I want you to be with me, you may regard me any way you like; you may be right; you may be wrong; and you must take your chances."
- "I don't want to be spared any request or demand, so I will give you few hints of the shape and limits of our relationship; perhaps I have decided to rigidly limit my involvement, but you may hope that there are loopholes."
- "You may risk counting on me for all sorts of things, but I may content myself with passively witnessing your fortunes; you may rely on me for anything, but I may have already excused myself from fulfillment."
- "I don't want you to view me in any one way rather than any other, even though I may regard some ways as more correct."

In these attitudes, the analyst used to make it clear that he disdained to be pleased or protected, despite his natural craving for an agreed-upon working relationship and a recognized professional identity. He did not used to say, "We can investigate your virtual images of me, but please, while we're doing it, recognize

that what I really am is just an investigator of those virtual images." Instead, the older analyst just toughed it out.

At this point, the new analysts among you might issue a strong objection. You can make a powerful argument that it doesn't matter what the analyst declares himself to be or not to be, to want or not to want, implicitly or explicitly. Even if he shouted it out loud, isn't it just pretense? Don't patients respond instead to the analyst's inner wishes? If, as Hoffman (1983, 1991) has cogently argued, patients know there's an ordinary person under the uniform, what's the point of trying to be mysterious?

That's a pressing, good question, and the profession will have to run through many practical and phenomenological considerations before we can say what patients know and what analysts are able to conceal. But here I want to mention only one consideration.

I believe it is not enough to think about what the analyst actually reveals (deliberately or inadvertently). We must also always consider what his *gestures* say, especially what they say about his deliberate *intentions*. For the older analyst, the gesture was his flirtatious mysteriousness (flirtation being defined by the possibility of dire error). By this gesture, the analyst announced an *intention* to provide (or maybe to enforce) dangerous freedom, dangerous because it was freedom within a field of possible error. The analyst did not suggest that he was with the patient wherever the patient was. He made it clear that he could tolerate—and would ask the patient to tolerate—misidentification and misplaced hopes. So even if the analyst's persona turns out to be all playacting and easily seen through by the patient, it remains to be said whether something might be gained by the analyst's *act of attempting* to hide his judgments.

Now, I take it as axiomatic that features of treatment are effective only when patients see them as opportunities. If patients don't see them as opportunities, they won't take advantage of them. Thus, the analyst's gesture of secret judgmentalness (his reserved judgment of actual versus virtual) will be useful if, and only if, it answers to some need of the patient. If patients *only* wanted to be se-

cure, then the analyst's hidden judgmentalness would not only be arrogant and threatening, it would be *only* arrogant and threatening, and nothing good would come of it. A blank screen is useful only to the extent that it tempts some of the patient's wishes for blankness. Likewise, the analyst's flirtation with virtual identities and virtual relationships is effective *provided* that there is something in the patient that finds the offer irresistible—something that happily welcomes the mere *offer* of uncertainty by a mysterious partner, never mind how *actually* mysterious the analyst turns out to be.

Do patients, in fact, find that gesture useful? They certainly seem to. The same Hoffman who told us that patients always know how the analyst is really reacting also tells us that, despite that knowledge, patients insist on squinting a double vision of the analyst. They know full well that he is an ordinary person, but they go on attributing something virtual to him anyway. Despite the discomfort of that double vision, and despite the ordinariness that analysts betray at every turn, patients go on regularly and involuntarily accepting anything that passes for a virtual flirtation. That is the most banal fact of psychoanalysis. Maybe analysts should fuss less about their failure to achieve anonymity and ask themselves why the patient is so ready to pretend that the analyst has succeeded. Renik (1995) implies that they do it to please the analyst, but the magnitude of the effect suggests something more profound. Why should patients find satisfaction in an imperfect simulacrum of anonymity? Or, more precisely, what *sort* of satisfaction do patients get or even look for in such a situation? Heaven knows that patients, like everyone else, *mostly* want a *real* companion. In what part of their souls do they also want a deliberately teasing, mysterious analyst—not just an open-minded one, but a mysterious analyst?

For an answer, we can round up the usual suspects. The unconscious wants realization in the present, and finds it especially easy to hang that on a flimsy, teasing framework (Freud 1912). People want to deny the passage of time and to re-create the past in the present (Klauber 1987). Patients want an opportunity to idealize a selfobject (Kohut 1977). There is a need for sheer exercise of cer-

tain capacities such as love (Ferenczi 1933; Klauber 1987; Lichtenberg 1992), and a teasing framework is an ideal gymnasium for the exercise.

Then there's a wish to obtain ownership of one's mind, to deliberately conjure up versions of social virtuality that intimidate one, and then to show oneself that they can be blown away. Many analysts have counted on those self-liberating motives implicitly, and some explicitly (Gray 1994). Patients would be motivated in these ways to utilize even make-believe mysteriousness for a kind of counterphobic or implosive therapy to test themselves and rid themselves of hobbling dependency. Add to that the human zest for invention of meanings, the wish to find more possibilities in the world, the exhilaration of writing and rewriting one's own inner novel, and you have accounted for an appetite for the analyst's teasing. Lichtenberg (1992) counts on that, as do the deconstructionists, and possibly Winnicott (1971) and Schafer (1992) as well. Come to think of it, even common sense says that patients might wish to be free of our interference as they explore their own imaginings; they may prefer to deal with ghosts that they can manipulate, and they might welcome mysteriousness for that reason.

Opportunities like these might be what the patient sees in the analyst's otherwise annoying flirtation with virtual reality; these objectives might exist quietly alongside the louder demands for a genuine relationship. Pulling toward autonomy, patients may accept the analyst's flagrant invitation to a flirtation so that they can finally dispose of the analyst (a Winnicottian notion, I suppose).

But when we rhapsodize about esthetic and autonomy motives, we've got to be sure we haven't lost psychoanalytic motives. We would be on safer ground if we also found some more earthy motives. After all, psychoanalysis is only partly a playful activity; patients aren't looking for wonderful, new experiences the way youths in the '60s tried out LSD. Treatment starts from pain and proceeds through struggle. I mentioned Freud's discovery that treatment was not just a matter of perceptions; it turned out to be a wrestling with strivings. If gut wishes oppose change, wouldn't it take other gut wishes to promote change?

And yet, in the final reckoning, hermeneutics, creativity, playfulness—these are not unconnected with desire and lust. We don't need to suppose that we explore virtual worlds just for the adventure. We do it because we know—or we learn in treatment—that wishes connect with the world only when both the wishes and the world are elaborated in detail, along with their dangers. That's the origin of secondary process, isn't it? Even when we read a novel, we're not just vicariously living out somebody else's fantasy life; we are expanding the horizon of our own world to encompass a plausible scene in which our fantasies might become realities. And when we play with appearances in treatment, we don't just multiply virtual realities; we search for a larger reality—call it a better narrative, or a selfobject, a higher plane of integration, a more reliable vision, a more satisfiable self, a sense of integrity, or a less reproachful reality. In short, we look for a universe in which what is genuinely in us can be more at home. It has to be a real universe or it won't serve the purpose.

Love may be an illusion, but illusion is not what love is looking for. Autonomy is worthless without a sense of personal solidity and a negotiable environment. Winnicott's (1971) famous playfulness is actually designed to connect a true self to a true world. Waelder (1934) wisely said that realisticness requires more than mobile perspectives; it requires also libidinal rootedness. The two go together, and we don't have to separate motives of independence from motives of attachment, even if they often seem to pull in different directions.

The analyst speaks. The patient wonders: "What larger horizon does that comment emerge from?" Regardless of what the message *is,* if the patient can think of it as coming from a more objective world, its *origin*—that is, the perceived domain of ultimate truth—will by itself orient his own pursuit.

The analyst is attentive. The patient wonders, "How much does he like me?" It is the sense that the analyst might or might not *really* be attached to the patient that makes the question important. And that, in turn, would matter little if the analyst didn't seem somehow a bit extraordinary.

That leads me to my next-to-last message, which is that a flirtation relies on the possibility of objective truth. Flirtation says, "What you imagine may be true (or it may not be)." Much as a golfer plants a flag in the next hole to guide his swing, patients plant their analyst in an imagined spot from which they suppose their true nature can be seen. That's why they feel so much is at stake. That's why they insist that the analyst be "the one who is supposed to know" (to misuse Lacan's phrase). The analyst represents the possibility of an ultimate truth, and with that, the possibility of being lovable despite the truth. Even when the analyst's limitations are blatant, even when he shrugs off the grandiose mantle, even when patients feel misunderstood, even when they recognize the analyst's humility, they persist in looking on him as a knower whose favor is worth cultivating. You may call it an infirmity, a human failing, a wish for magic, a quest for superdaddy. It might be related to the Kantian ideal of Reason. It may even be the sort of significance-generating mechanism that builds a notion of God. Of course, none of these meanings will delight an analyst.

But can't we also say that this idealizing is a way of constructing an image of achievement, like imagining a home run and then trying to hit one? I am not referring to the patient's imitation of the analyst's wonderful way of thinking—a self-image that we would be well advised to keep at a distance. By *image of achievement,* I mean that if a person can imagine the possibility of being truly known, he can steer himself toward knowing truly. (That is Loewald's [1960] message, in a nutshell.) We must remember that one of the reasons a parental transference has such power is that the truth of our nature once seemed to lie in our parents' perception of us. Patients set the analyst up to represent the possibility of a true judgment, even if eventually they actualize that possibility within themselves.

All of which is to say that without virtual reality wishes are stunted, but without objective reality wishes are worthless. That's why analysts have customarily invited wild imagining, but also hinted that they know about truth and falsity.

Am I, then, concluding with a shameless idealization of the analyst? That would be to ignore one main reason that we maintain virtuality—namely, to dodge parentalizing idealization. All of us here will agree that analysis is supposed to free people from the bondage of idealization. What I am doing is to connect that old truth with its old partner, the principle that analysts don't force autonomy by *refusing* the patient's attributions. Every analyst allows—indeed, wants—patients to flirt with virtual reality, including the analyst as a virtual superior knower and as a virtual lifetime partner.

Well, then, if *every* analyst wants patients to indulge their virtual worlds, to whom am I preaching at such painful length? Ah, now you have squeezed me into what I promise is my very last task. Let me answer this way: People naturally scout for the role or image their partner seems to prefer. They ask, "What is he trying to come across as?" I maintain that people won't *freely* burden an intimate partner with idealizations and awkward and uncomfortable expectations just because these are not prohibited. If it's virtual images he wants, the analyst has to make at least some subtle gestures of invitation. If an analyst doesn't in some small way exhibit *positive* readiness to be seen in various merely virtual guises, I think he will, in fact, be covertly asking to be seen in a more determinate way, a more "realistic" way—that is, he will subtly invite patients to see him for who he really is (or thinks he is).

I say *subtly,* for, as mentioned, no good analyst *blatantly* tries to de-idealize himself, any more than he tries to idealize himself. But since analysts today rebel against the uncertain role they used to play, and since they are ashamed of the mystifying relationship they used to enforce, I believe they are now in danger of leaning away from—rather than into—psychoanalytic illusions. They chart a more straightforward course. They set their behavior in a clearer context. They picture their doings more simply. I cannot imagine that this will have no effect on treatment—though in all honesty, as I said at the start, I do not know how big an effect it will have, or what the cost/benefit ratio will be.

Now you have only to sit through my peroration and you will be free. Here it is: Patients use virtual reality as a radar screen for detecting their true wishes. One can give their exploration of virtual worlds either little support or much support. Projects that give virtuality the least support are called cognitive or behavioral therapy. There is no mystery about the cognitive therapist's image, his job description, or his relationship to the patient. These are all spelled out in bold print. It is an unambiguous social situation, where an interpretation of transference, for example, would be as inappropriate as in a dental office. If patients need more exploration of their virtual world, they must turn to psychoanalysis, which supports virtual worlds by the deliberate unclarity of its roles and relationships. But within psychoanalysis we now have a choice of *how much* to support virtuality. We make that choice by determining how vigorous an *invitation* to extend to the patient's ambiguity quest (Bird 1972).

That, in turn, depends on how much uncertainty we can tolerate in what it is that we seem to be promising our patients. Patients will use us as they must, no matter what. They can be relied on to flirt with virtual versions of us, more or less freely. But how about us? Are we willing to do a little flirting ourselves—for instance, by being noncommittal about our plans? We must ask ourselves: "Can I live with myself as an eternally undefined partner, refusing to be clear about what I'm up to, yet beckoning my partner to take his chances?"

There's no mistaking the cost. If we choose to be amorphous we will be more vulnerable to self-doubt and to our patient's reproach. We will have only our theories to justify us, since neither custom nor common sense will countenance such social misbehavior. Nowadays, we will suffer the additional curse of being out of step with our culture, which demands that caretakers lay their cards on the table.

We don't have to pay that price. In all kinds of ways, we can say, for instance, "I'm just an investigator, ma'am." And that will be fine. The fate of psychoanalysis does not hang in the balance. I have been dwelling on marginal differences among analysts.

Whether we lean a little this way or that, our universal trademark remains the willingness to let patients invest us with virtual identities and burden us with personal expectations that we did not ask for. That will continue to connect us with a powerful and progressive tide in patients—one that draws fuel from their every wish, and moves ultimately to freedom. I content myself with this conclusion: After 100 years of psychoanalysis, it is not a simple or settled question how best to exploit the strange encounter with the virtual world.

Thank you.

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NESTED IDEATION AND THE PROBLEM OF REALITY: DREAMS AND WORKS OF ART IN DREAMS

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This study uses seven well-analyzed dreams to establish three empirical generalizations about dreams and works of art nested in dreams: (1) Those dreams attempt to deny a painful reality in some way depicted in the nested element; (2) they present an antithetical view of that reality (both denying and affirming); and (3) they are consistently associated with the problem of reality (the problem of deciding what is real or true). The explanation of these empirical generalizations is based on a hypothesis derived from Freud's 1911 formulation of the dream within a dream.

INTRODUCTION

This paper is devoted to dreams that contain other dreams or works of art as part of their manifest content. The contained dream or work of art within the dream has a distinct boundary, demarcating it from the surrounding, containing dream. The contained dream or work of art, in its entirety, is an integral element, a complete entity, within the containing dream. It has its own particular content, divorced from that of the containing dream. These qualities of the contained dream or work of art will here be comprised under the term *nested.*

This investigation derives from a paragraph Freud interpolated into *The Interpretation of Dreams* in 1911 on the dream with-

in a dream (Freud 1900, p. 338). Without giving empirical evidence, Freud addressed the question of

> . . . what is meant when some of the content of a dream is described in the dream itself as "dreamt"—the enigma of the "dream within a dream". . . . The intention is . . . to detract from the importance of what is "dreamt" in the dream, to rob it of its reality. What is dreamt in the dream after waking from the "dream within a dream" is what the dream-wish seeks to put in the place of an obliterated [*ausgelöschten*] reality. It is safe to suppose, therefore, that what has been "dreamt" in the dream is a representation of the reality, the true recollection, while the continuation of the dream, on the contrary, merely represents what the dreamer wishes. To include something in a "dream within a dream" is thus equivalent to wishing that the thing described as a dream had never happened. In other words, if a particular event is inserted into a dream as a dream by the dream-work itself, this implies the most decided confirmation of the reality of the event —the strongest *affirmation* [*Bejahung*] of it. The dream-work makes use of dreaming as a form of repudiation [*Ablehnung*], and confirms the discovery that dreams are wish fulfilments. [1900, p. 338, italics in original][1]

Freud's formulation of dreams in dreams representing reality refers to the common paradox that one must know reality in or-

[1] This paragraph has had its own particular career within the literature of psychoanalysis, most of which does not modify or extend Freud's formulation. I am indebted to Silber (1983) for his review of the literature on this topic:

> The literature on the "dream within a dream" is not extensive and fundamentally involves a reiteration of Freud's (1900) remarks. Thus, Grinstein (1956), Kligerman (1962), Babcock (1966), and Wilder (1956) emphasize the repudiation of an unpleasant reality experience. Jones (1949) expresses a similar idea. Moore (1960) comments on the reassurance of its only being a dream; so does Hendrick (1958). Allen (1974) feels that those relatively few who dream within dreams tend to do so recurrently . . . . He also feels that, at its deepest level, the phenomenon represents the wish to sleep at the maternal breast after nursing. Altman (1975) emphasizes that "the dream work [makes use of] 'a dream,' to

der to deny it. Or, seen another way: the very denial of reality is, implicitly, an affirmation of it. Freud took as given the conventionalized, waking view of dreams as representations of *nonreality* ("It is *only* a dream! And *not* reality."). He then asserted that dreams, having this conventional meaning, are used to repudiate painful reality during dreaming. And so he *inferred* that the significance of dreams in dreams is their representation of reality.

Of importance here is that the convention of waking life that dreams are the antithesis of reality depends on the effective functioning of reality testing—the reality testing that distinguishes dreaming from reality. Thus, seemingly paradoxically, *in dreaming, the repudiation of reality by transforming it into a dream requires effective reality testing,* within the more widespread regressed dream state. The dream within a dream is thus a defensive maneuver mounted against distressing reality that must employ relatively mature reality testing. It bespeaks some defensive *limitation to the regression* characteristic of dreaming. (See Arlow and Brenner 1964, pp. 136-139.)

However, during dreaming, reality testing must also be regressively degraded to some degree. Reality testing, in this kind of dream, then, exists in an "intermediate" state of regression. The participation of reality testing in denial is only partially effective. And so denial by making reality into a dream can only be partially successful. Besides being denied, the painful reality must also be "nondenied"—that is, affirmed—to some degree. Accordingly, *the dream within a dream is an antithetical combination of the two conflicting attitudes (denial and affirmation) toward distressing reality.* It is both *a representation of reality* (as Freud stated) and *a (conventionalized) representation of nonreality.* Just as every defense is successful to a greater or lesser degree, the relative validity of

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detract from the importance of a wish or actual past event that was being forcefully repudiated." [p. 907]

Since Silber's summary, there have been three other references to Freud's formulation: by Berman (1985), Reed (1993), and Mahon (2002). These papers will be discussed in the present study.

each opposed orientation toward reality ("It *is* real!"; "It *isn't* real!") varies from instance to instance. The two opposed orientations toward unpleasant reality are "mixed in unequal proportions in different cases, so that the one or the other is more clearly recognizable" (Freud 1927, p. 157). The present empirical investigation will confirm this formulation and expand upon it.

Another finding would be expected. The antithetical presentation of a painful reality—especially, its affirmation—would motivate some effort to resolve the contradiction through obtaining some clarification of the reality involved. This would be an instance of Freud's (1911) view that obdurate painful reality turns the mind *away* from the narcissistic and egoistic pleasure principle and *toward* the exploration of reality characterized by the reality principle and reality testing. Accordingly, dreams nested in dreams tend to be accompanied by some concern with the problem of deciding what is real, or what is true—termed here *the problem of reality*.

"The problem of reality" is to be distinguished from the denial of painful reality through the latter's being nested in the dream as a dream. Ascertaining what painful reality is being denied through the nesting maneuver can only be accomplished through the analysis of the dream. The problem of reality would be an empirically observed element in the containing dream's manifest content, associations, and/or day's residue. The problem of reality would ultimately refer, implicitly or explicitly, to the reality being denied.

Unfortunately, I have not observed dreams within dreams in my own clinical work. Toward the end of establishing these expected qualities of dreams within dreams, I have culled from the psychoanalytic literature instances of extensively analyzed dreams that contain nested dreams. But also, in the present investigation, I have extended Freud's 1911 interpolation into *The Interpretation of Dreams* (1900). I hypothesize that *works of art* are also conventionalized representations of nonreality. Thus, any work of art with ideational content nested in a dream would be endowed with the same denying function and meaning regarding distressing reality as have been adduced for a nested dream in a dream. And so

I selected from my own clinical experience three well-analyzed dreams that contain nested works of art. I have also found another such instance in the psychoanalytic literature. As will be seen below, my assumption of a homology between nested dreams in dreams and nested works of art in dreams was confirmed.

Accordingly, the following empirical observations would be expected:

(1) *Nested dreams and works of art in dreams bespeak the maneuver of attempted denial of unpleasant reality represented in some way in the nested dream elements.*

(2) *Opposite orientations toward the reality of the nested contents (denying and affirming) would coexist, with varying proportions of validity in different instances.*

(3) *The problem of reality (i.e., the problem of deciding what is real or true) would be closely associated with nested dreams or works of art in dreams.*

NESTED DREAMS WITHIN DREAMS

The following three dreams that contain dreams were gleaned from the psychoanalytic literature. However, some preliminary remarks are relevant. The analyses of these dreams will not be rendered here in the richness of detail they deserve. The reader is well advised to address their original descriptions. Also, "the dream" in psychoanalysis is not only the manifest content of the remembered dream, subject as is its recall to the vagaries of conflict and distortion; the "complete dream" also includes the dreamer's associations to that manifest content and the emotional context in which the dream was dreamt (i.e., the day's residue). All these parts of the complete dream are *(pre)conscious* mental phenomena. All three are very much on a par with each other. The manifest content has no privileged position. Indeed, as Freud (1933) stated: "The dream [that is, its manifest content] is seen to be an abbreviated selection from the associations" (p. 12). The three aspects of the complete dream are all closely derived from

the *unconscious* dream thoughts, thus allowing inference of the latter. Viewing the dream in this more comprehensive context, the following investigation will demonstrate that the three predicted phenomena do obtain in dreams with nested dreams (and works of art).[2]

Further, the denial of painful reality that Freud referred to in his remarks about the dream within a dream pertained to the external (i.e., extrapsychic) world. However, there are painful conscious and preconscious realities about the *intra*psychic world that psychoanalytic patients may also strive to deny. The everyday work of psychoanalysts testifies to this. Hartmann (1956) termed these facts about the mind "inner realities" (pp. 265-266). As will be seen in the clinical descriptions below, *psychoanalytic patients* in their dreams do indeed deny reality pertaining to the *external* world. (See in the following sections Dreams II, III, V, and VII.) But also, the analytic work itself provokes patients to attempt the denial of the reality of the dreamer's own *inner* world of the mind. (See Dreams I, II, IV, and VI.)

And, in fact, Jacobson (1957), using clinical data, asserted that "denial presupposes an infantile concretization of psychic reality, which permits persons who employ this defense *to treat their psychic strivings as if they were concrete objects perceived"* (p. 80, italics added). She also pointed to the same partial regression, as hypothesized here for dreams within dreams, to be correlated with denial of inner realities.

The present investigation of nested dreams (and works of art) within the dreams of psychoanalytic patients demonstrates the defensive denial of those unpleasant inner realities. Not surprisingly, the inner reality denied by the patient is closely associated with, or even experienced as identical with, the analyst's interpretive statements about that reality. The negative transference and the denial

[2] In *The Dream in Psychoanalysis* (1969), Altman described two dreams with nested dreams, both from the analysis of the same patient (pp. 94-95, pp. 166-169). Those two dreams are not included in the present study because their analyses, as reported, are not extensive. Nevertheless, they do evince the three correlated phenomena predicted above.

in the dream may thus be intertwined. Accordingly, Jacobson (1957) pointed to "the ease with which the denial of external and the denial of internal reality collaborate in the area of interpersonal relationships" (p. 81). The patient's being in a psychoanalytic treatment may then become a factor in the dreamer's struggle with unpleasant—inner as well as external—reality. Instances of dreams (and works of art) within dreams discussed below will demonstrate this.

Because the dream work is carried out principally by the primary process, the problem of reality would not *necessarily* be directly and logically associated with the antithetical presentation of reality—though it often is. Their empirically observed correlation in the complete dream will always be *coincidental*. Their *causal* relation, however, may most often be *inferred* through the analysis of the dream itself. As will be seen, the problem of reality may refer to the world depicted in the nested dream (or work of art), the world of the containing dream, the dreamer's intrapsychic world, and/or the dreamer's extrapsychic world.

Dream I

Berman (1985) published a clinical report on a dream containing a nested dream. The problem of reality was integral to a character trait of the dreamer, her naiveté, which was the focus of the analytic work.

The patient was a divorced woman in her middle thirties and the mother of an eight-year-old boy. She had visually vivid dreams, but her waking life was blurred, confused, and full of blind spots. She was extremely provocative sexually toward her analyst and her son, but had no conscious experience of this behavior until her analyst pointed it out. Instead, she "affected the wide-eyed innocence of a bewildered child" (p. 75). The transference was marked by a consistent and intense curiosity about the analyst. While struggling with conflicts around these issues in the analysis, she reported the following dream:

> I'm in bed with J (her boyfriend). He's caressing my vagina and it feels very exciting. Then I feel another hand there;

> I think it belongs to M (her son). I wake up [in the dream], terrified, and I'm in the bedroom with J. I demand to know if that was M's hand. He answers evasively. Then M walks into the bedroom and I scream at him to get out. [p. 75]

This dream depicts a nested dream *in statu nascendi*. The dream work made the initial (sexual) events in the containing dream retrospectively into a nested dream. From the distress evident in the manifest content, it is clear that making the initial sexual events into "*only* a dream!" was an effort to deny a disturbing "reality" for the patient in the world of the dream: namely, that her son's hand (besides her boyfriend's) was caressing her vagina; and, more generally, that she had an incestuous relation with her son. However, that denying effort failed horrifically. For, even after it, the patient in the dream did not accord to that nested dream the unreality for which it was evidently constructed. In the containing dream, she demanded from her boyfriend clarification about the nested dream's content, assuming that he also should know the content of her dream. And finally, even with the nesting denial, she (the dreamer) had her son actually enter the bedroom in the main containing dream anyway—again, much to the patient's nightmarish distress.

In the containing dream's world, there was thus a disturbing manifest insistence on a passive sexual (essentially masturbatory) incestuous relation to her son—an insistence that overrode various defensive maneuvers, including the denying construction of a dream within the dream. That prevailing insistence graphically affirmed the inner reality that the patient was struggling *not to acknowledge* (that is, *to deny*)—in herself and in her analysis.

In this dream, the same antithetical presentation of painful inner reality (viz., the patient's incestuous relation to her son) obtains in the worlds of both the nested and the containing dreams. And so does the same problem of reality—that is, whether the other hand caressing her vagina is and was her son's. The antithetical presentation of reality and the problem of that reality are here in-

timately and logically connected in the dream's manifest content. The dream thus manifests the qualities predicted.

However, the full analysis of the dream revealed its deeper aspects. The patient's associations to the nested dream referred directly to a painful intrapsychic reality—the patient's incestuous feelings toward her son as elucidated in the analytic work itself (p. 75). Further associations led Berman to connect the containing dream with the childhood primal scene and to the patient's childhood problem of reality: her intense curiosity about her parents' sexual activity and their condemnation of her wish to know about it (pp. 75-76). Still further analytic work on the dream in subsequent sessions allowed analyst and patient to establish that the "other hand" caressing the patient's vagina represented her own when she was a child, and that it referred to discharging excitement about the primal scene through guilty masturbation. This ultimately led to an analysis of the childhood conflicts over sexual curiosity—the wish to know and the need to deny—that subsequently shaped her antithetically pseudonaive character style (p. 76).

This dream containing a nested dream both affirmed and denied ambivalently charged inner realities—all within the investigative context of the analysis, concerned as it was with the dreamer's mental life. However, because the denying effort was so ineffective, it produced in the dream an antithetical view of the patient's own sexual proclivities that tended toward *an almost complete affirmation* of her incestuous inclination toward her son. The resulting emotional distress approached that of a nightmare. The patient declared through her dream: "I am trying to deny my analyst's interpretations about my sexual inclination toward my son by presenting it as *only* a dream, but my desire is too strong or my denying efforts too weak."

Dream II

Shortly before Berman published his report, Silber (1983) published an extensively analyzed example of a female patient's dream

that contained a nested dream. The dream was described by the patient as follows:

> I go to group therapy and David B. is the therapist. He looks stronger than he does in real life. I feel anxious about revealing my feelings in the group. I want to talk about the dream I'd had that night—in the dream *David's wife, Martha, tickled me.* Then I begin to get feelings about this [group] therapy being second best because it is in a group and not one to one. [p. 900, italics in original]

Silber first described the day's residue, the patient's current emotional problem. It was centrally concerned with the problem of reality and referred directly to two elements in the manifest content of the containing dream: the *group* and *David B.* As Silber explained:

> The dream took place while the patient was struggling with feelings about being part of a church discussion group. This group was composed of devout individuals, and *the patient was conflicted about the realization that she had lost her belief in God and in Christ.* These beliefs, shared with her parents, were a source of comfort and reassurance in her life. Her loss of faith was most awkward at this time since she also earned her livelihood in church-related work. For economic reasons, she needed to maintain her church-affiliated activity. At the same time, *she viewed her life from a new perspective provided by her analysis* (a transference neurosis was well established). [p. 900, italics added]

The patient was thus in an acute *conscious* conflict about a *religious* problem of reality in her external world (her loss of faith in God and Christ). That faith was antithetically presented, on the one hand, as having been held in the past by the now-skeptical patient, and, on the other hand, as being held currently by her devout coworkers, whose economic support she needed. She was also *consciously* in an awkward position about a *social* problem of reality in her external world that was closely associated with the religion's antithetically perceived validity—that is, she felt she had to keep

her current views about religious truth a secret from other people in her church.

It was this compound of antithetical views and problems of reality, so embedded in the day's residue, that prompted the presence of David B. in the dream. For David B. was a clergyman and the leader of the church discussion group that appears in the dream represented as a *therapeutic* group. As Silber explained: "She respects his intelligence but feels he ignores the emotional side of life" (pp. 900-901). The patient in her dream thus pitted David B. *against* the analyst, who certainly did not ignore the emotional side of life. But her dream also had David B. *condensed with* the analyst, qua therapist.

All this allows the inference that, unconsciously, the whole containing dream—except the nested dream itself—was concerned with *the patient's doubts (loss of faith) about the analyst and the analysis*. There was thus an *unconscious* (possibly *preconscious*) transference dimension to the antithetical views and problems of extrapsychic reality in the day's residue—that is, the patient antithetically viewed the analysis and the analyst as having, and not having, validity. This problem of inner reality, which lay at the heart of the transference, was expressed in the containing dream. But the patient's antithetical views about the analyst and the analysis *were not analytically addressed at all.* Silber stated as much (pp. 912-913).

Further, there was no indication of any very distressing reality in the world of the manifest dream. It was only through the psychoanalytic investigation of the dream within the dream that a painful reality and its denial could be elucidated. Suffice it here to summarize by noting the following sequence of analytic events: The analysis of the nested dream led *from* the nested dream image of David B.'s wife's tickling the patient, *via* a memory from adolescence of a sexually stimulating episode of being tickled by another female who concurrently pressed her body against the patient's, *to* a whole series of sexually charged, closely associated memories of the patient's mother's having directed her attention to her own and to the patient's genitals, *to* claustrophobic anxiety

in the immediate analytic situation, and, *finally, to* a sexually excited fantasy about the analyst there and then: his reaching over and touching her moist genitals as she permitted her thighs to move apart (pp. 903-904).

Silber showed that the problem of acknowledging the extrapsychic reality about the patient's sexual anatomy was intimately connected with acknowledging inner reality about the analytic endeavor. And the latter was associated with sexual transference feelings manifested at that moment and place: "I [the analyst] was experienced as her intrusive mother who forces her to look. At the same time, she saw me as her analyst who had consistently encouraged her to recognize, accept, and examine all of her feelings" (p. 902). Silber demonstrated that, in this dream, the *unconscious* conflict about knowing and not knowing concerned that universally enigmatic object: the female genital—specifically, the female genitals of the patient and of her mother—with all the accompanying incestuous excitement and emotional pain (pp. 910-911).

Silber's extensive analysis supplies the explanation of how the erotic transference and concern with the female genital anatomy were expressed through the (pre)conscious antithetical presentation of reality and the problem of reality concerned with loss of faith in religion and in the analysis. The analysis of the nested dream also indicates the profound nature of the *unconscious* conflict about the patient's acknowledgment of the very existence and emotional/instinctual nature of her vagina. This nested dream was then closely associated with a highly specific problem of reality that was extrapsychic (anatomical), but also inner (sexually excited).

That unconscious conflict about her sexual anatomy was both mobilized by, and also gave intense impetus to, the *conscious* problem of reality concerning the patient's loss of religious faith and her *preconscious* (or *unconscious*) problem of reality regarding her antithetical views and doubts about the analysis itself. The dream stated: "My analyst encourages me to examine my feelings, but that excites my vagina and its sensuality in the analysis. I repudiate the reality of that anatomy and that excitement, not only by translating them into my difficulties in my church, but also by making them into *only* a dream!"

Dream III

Recently, Mahon (2002) published an extensive analysis of a dream containing another dream. Mahon stated that the dream "occurred in the eighth year of an analysis, a clinical context that allowed the topic [of termination] to be viewed through the lens of a complex transference neurosis" (p. 119). Mahon described the patient as particularly clever, a character trait that posed many opportunities for resistance and, in this case, showed itself both in the dream and also in the slippery, casuistic complexities and subtleties of the first associations.

> The dreamer is 56 years old . . . an ex-priest, a professor of philosophy, recently married, with one child. The analysis could be portrayed as the deconstruction of a conscience so Jesuitical in its brilliant mixture of menace, mischief, and multiple ambiguities as to be almost unreachable, its mental quicksilver visible, touchable, but hard to pick up or hold onto. [p. 119]

Thus, the character style of this patient would predispose him to antithetical views of reality in multiple spheres.

Mahon then retold the dream in the patient's voice:

> I awake at the sound of a car pulling into the driveway of our Connecticut house. It is pitch dark but a child is being dropped off, as if our home were a nursery school. All this seemed natural in dream experience even though the time, the darkness, would have been highly unusual for such a drop-off in real time. The scene shifts, I am now outside my house but lost, trying to find my bearings. A child on a bicycle guides me home. Then I walk from my house in Connecticut to Greenwich Village, which in dream geography seems no more than a hundred yards. I am so surprised by the spatial novelty of Connecticut's [being] a stone's throw from Greenwich Village that I wake up, an illusion, as I will discover on actual awakening. In Greenwich Village I walk into a wood-lined office in a townhouse. A bearded man, not unlike the young Freud in the Freud-Fliess era, greets me. I start to tell him

> the unusual dream I've just had about being lost and how it was a child who guided me home. [p. 120]

As with Dream I, the nested dream's world is here antithetically presented *both* as the reality of the dream's world (before the dreamer wakes up) and *also* as nonreality (after he wakes up). Then, immediately upon actually awakening from the containing dream, the patient *acted out* the manifest content of the last part of the dream by telling his wife about the dream. He thus *transformed the dreamed scene into extrapsychic actuality*. (See Sterba 1946.) And this was intimately related to a special (symptomatic) form of the problem of reality—a *déjà raconté* phenomenon—in which he uncannily *experienced* having already told the dream to his wife, but *knew* that he had not.

Mahon then described the patient's most immediate associations. They were infused with the problem of reality in the extrapsychic world, manifestly pertaining to the *actual* nested/containing structure of the dream just reported.

> Which part of the dream was within the other? If the totality of the dream is looked upon as one text, the illusion of waking up and telling the dream to a bearded man in Greenwich Village would seem to be the part of the dream that is within the other, larger, earlier part. However, looking at the dream as a total text, one could argue that the first part is being told again in the later dream and is therefore "within" it, making the analysand's question not as "intellectual" as it seemed at first blush . . . .
>
> Which actuality was being disguised, the experience of being lost or the telling about it? This led to a series of intriguing sessions. [p. 121]

For the present purposes, it is sufficient to note that the *déjà* experience and the initial associations to the dream substantiate the empirical generalization of this investigation: the close coincidence of the dream within a dream, the antithetical presentation of reality, and the problem of reality.

However, the ensuing analysis of the dream showed that the dichotomy and combination of *loss/being lost* and *telling* were

pivotal to its meaning and were crucial conjugate (historical and inner) realities in the patient's life. The content and formal structure of the dream thus reflected deep and abiding conflicts in the patient.

> That his life was about being lost and telling people about it had become more central to the analysis than ever before, thanks to *the double vision of the dream* and the insight it afforded about the meaning of loss and the meaning of communication (telling) and how both could be corrupted by a defensive psychology that would attempt to keep them apart. "It will be important for me to tell you how much I hate you as termination reprises this sense of loss for yet another time," the analysand said, stepping into *the reality of the analytic journey's end* with very genuine affect. [p. 123, italics added]

The retroactively constructed, nested dream referred to an actual event when the patient was around five or six years old. The repeated previous references to this event over the course of the analysis indicated that it must have been traumatic. But also, many important conflictual issues in the patient's subsequent life converged upon that single event, recounted by the patient as follows: His mother had given over his care to some older boys; however, they went about their own business and, in effect, abandoned him. *"A kind gentleman on a bicycle rode him home to his house."* This incident (represented in the world of the nested dream through a reversal between *a child* and *a kind gentleman*) condensed into itself the painful extrapsychic reality that the patient's *mother* had, in effect, abandoned him. And that abandonment referred to the historical fact that she was (literally) too busy with her own business; she had become the breadwinner of the family because the patient's alcoholic father was inadequate in fulfilling his responsibilities as supporter of the family (and also as husband to his wife). The patient's mother aided and abetted these qualities in his father. There was a familial conspiracy of silent denial (no telling) about all these real matters.

The analysis had brought to light the intense hatred the patient felt toward both parents and how his very ruthless conscience motivated the repression of these hating feelings (no telling to himself). The dream with the nested dream highlighted that psychological fact, especially the denial of his mother's abandonment—the actual, true event antithetically represented and denied qua nested dream in the first part of the containing dream.

This dream with a nested dream became the vehicle by which the patient obtained a more emotional understanding of his childhood past and of the transference. It was in that analytic context, with the inclusive containing dream constantly in focus, that the problem of reality recurrently came up in multiple ways. As Mahon recounted:

> [The patient] . . . was *puzzled* that the reality of being lost as a child, which had received much scrutiny in the analysis, could still show up in a dream within a dream, as if to insist that it still needed to be disavowed intensely! We had reconstructed pretty well. *Which* stone had been left unturned? As [the patient] pursued this issue associatively, overwhelming "new" affects appeared genetically and transferentially. Deep-seated anger toward mother emerged. *How* could she have entrusted a five-year-old to careless older boys? *What* did that reveal about the whole ramshackle structure of early care he must have received from a harried young mother starting her own business on the ruins of her husband's psychological and fiscal collapse? *Who* was this makeshift father; *what* made him tick? The genetic current of intense affect could turn transferential from hour to hour. *What* kind of an analyst could have reconstructed so intellectually, leaving the deepest affects untouched? *Was* the analyst lost in some dream within a dream of his own to have overlooked the most significant meanings? This analytic volatility, genetic and transferential all at once, led to the revelation that *the reality of childhood loss* had not been fully analyzed, *if* it ever could be. It was clear that affect would always remain. Sorrow, pain, anger, memory could be *understood* in analysis but not eliminated, not exorcised. The confes-

> sional offered absolution, the wipe-out of sin. The couch could offer only *understanding*, the sober dignity of *truth* rather than the appeal of *illusion*! [p. 124, italics added]

Of importance to the present investigation, the inclusive dream structure was intimately associated with the problem of extrapsychic reality in three different ways: (1) in the immediately subsequent acting out of the dream by the patient's telling it to his wife, accompanied by the *dejà raconté* phenomenon; (2) in the casuistic associations that asked which part of the dream lay within which part; (3) and in the intense questioning about the nature of the patient's childhood past and of his current therapy in the further analysis of the dream.

In all these ways of configuring the problem of reality, the extrapsychic reality was in some way presented antithetically. But the patient's inner realities were also antithetically presented, and were problematic. In effect, the patient's dream stated: "My hatred toward my terminating analyst evokes yet again all the hatred I still feel toward my irresponsible, abandoning parents. I deny the reality of these (past and present) abandonments by making them into *only* a dream and correcting them there!"

NESTED WORKS OF ART WITHIN DREAMS

Freud stated that "the dream-work makes use of dreaming as a form of repudiation" (1900, p. 338)—i.e., "It is *only* a dream!" However, dreams are not the only entities that are conventionally considered in diametric contrast to reality. Works of art have classically been positioned in that manner also (Freud 1908). There is then the possibility that, in containing dreams, nested works of art may serve the same repudiating or denying function regarding painful reality, extrapsychic or intrapsychic. "It is *only* a work of art!"

The following four dreams with nested works of art will evince the same phenomena demonstrated in dreams having nested dreams. The first three of these were derived from my own clinical

experience, while the fourth was obtained from the psychoanalytic literature.

Dream IV

In the first instance of a work of art within a dream, my patient was a married man whose sense of moral excellence was of great emotional importance to him. This took the form of ruthless criticism of his own badness. In the session before the one in question, I had pointed out that he avoided any mention of his sexual relationship with his wife. In the next session, after some meandering discourse, he remembered a dream of the night before, describing it as follows:

> There are people who, in a joking way, try to persuade me to enter into a building. I refuse. Then I am inside. There is nothing in the building except pictures. The pictures are of myself. I feel depressed and resigned about this. I knew it would be this way.

Thus, in the world of the dream's manifest content, there were nested pictures, but there was no problem of deciding what was true or real and no antithetical presentation of a painful reality. The patient immediately associated to the dream:

> Last night, I was doing work where I had to dictate into a tape recorder. I then listened to myself on the recording. I developed a loathing for my voice and felt depressed about it. The feeling remained with me through the rest of the evening and night.

I commented:

> Your reaction to your recorded voice and the dream you had later that night both refer to yesterday's analytic session. They both concern my bringing up your feelings about your wife. Your hatred of your recorded voice pertains to yourself, and particularly to your feelings about your wife that I had asked about. Your sadness and resignation in the dream express your realization that the analy-

sis—the "building" I invited you to enter—"would be this way."

It was in response to this interpretation that the problem of inner reality came to the fore in the patient's associations. He said:

> I guess you're right. But my voice on the tape recording was sort of strange. It was like in *The Picture of Dorian Gray*. I found myself intrigued and repelled by my voice —just like Dorian Gray had been about his portrait that told the truth about him. The pictures in the dream may have alluded to something like that.

The patient then shifted to talking about how he perceived his feelings; he doubted the sincerity of some of them. I commented that this doubting served the purpose of making his feelings seem unimportant or irrelevant for inquiry and understanding. We then did not have to take them seriously—for instance, his feelings about his wife. As the patient responded to this, the problem of inner reality—and the antithetical (ostensible and hidden) presentation of that reality—emerged still further, as he elaborated:

> I always feel separate from everyone else. I have a need to be alone. There is a real difference between what *seems* to be true about me and what *really is* true. Other people see me as very altruistic. But my motives aren't really to help. People to some extent don't bother me or pester me if I'm generally helpful—*that's* why I help other people.
>
> That's the trouble with my wife: she wants to wait on me. I actually hold her in contempt because of this, and that bothers me. I'd feel better about her if I were sure she does it for abstract ethical reasons. But if she does it because she loves me, then I find it contemptible. She should have a self-interested ulterior motive.

In this example, the analyst's prompting about the patient's *sexual* relationship toward his wife provoked a dream with pictures in it (that pertained, instead, to his *hateful* feelings about his wife). The associations to the nested pictures express the wish to deny

the conscious, secret reality about himself that the patient condemned ("They are *only* pictures!"). But they also sadly *declare* that secret reality in some way. The experience of hearing his tape-recorded voice appears to have determined the "choice" of the nested pictures in the containing dream: there was a regressive shift from a hateful *acoustic, verbal* "portrait" of the patient to the hateful *pictorial* ones. Both kinds of portraits were associated in the patient's mind with the problem of his inner reality: the hidden secret about his detestable feelings toward his wife.

Thus, the dream avowed: "My analyst wants me to take a good look at myself, but I interpose pictures. They are *only* pictures! However, in spite of their being merely pictures, as in the case of Dorian Gray, they tell the secret real (and sad) truth about my evil nature." The nested pictures did not *manifestly* present the patient's ostensible or inner reality; it was the psychoanalysis of the affect of resigned sadness and of his associations to the nested pictures that told the antithetically presented reality about himself.

Dream V

The second example is a dream that contains a literary work of art—a novel. The patient was in his late thirties. He had come into analysis because of performance anxiety at work. The analysis showed that success in his work constituted for him an unconscious triumph over his father, whom the patient consciously saw as kindly, affectionate, and lovable, but also as inadequate and ineffectual. He shared this depreciating view with his mother. She constantly berated her husband for his lack of initiative and resourcefulness. She complained especially that he was not handy around the house.

At the time of the session to be described, the patient had been separated from his wife for six months. He experienced her leaving him as a severe blow to his masculinity, though in fact by the time of the dream, he was very much in love with another woman, whom he wanted to marry—and eventually did. Several days before the session to be reported, the patient found out something

about his father that he had never known before. A distant relative told him that his father had had a previous marriage, and that the first wife had died. She showed the patient photographs of his father and this woman together.

The patient began the session by announcing that he had two dreams to report, both dreamt the previous night. The *first dream* contained the nested novel whose very content presented its own reality antithetically and was preoccupied with the problem of reality. He described it as follows:

> I'm reading a novel in my apartment. The story is of a young man who finds out that his father is not really his father. The young man goes off to a war—like World War II, but with trenches. There, he meets the man he once thought was his father and finds out that, in fact, the man really *is* his father. In the dream, while reading the story, I notice that the book has been underlined and marked on the margins with green ink at various points by someone else. I also find crossword puzzles worked out with the same green ink. I think my wife may have been in the apartment. I worry that she might know about my having an affair with my girlfriend. I reason to myself that I shouldn't feel defensive because it was my wife who first started having affairs after our separation.

The patient then immediately went on to report the *second dream*:

> I notice that the door leading from my apartment to an unused fire stairwell is open and can't be closed. This is ominous because the door is set up to be locked and unlocked from the inside only. I tell this to the superintendent, who doesn't do anything about it.

The patient began his associations with the first dream and, specifically, with the novel in the dream—clearly referring to the new information about his father.

> It's about the recent information that my father had been previously married to another woman who died. In the

> photographs of my father and this woman, my father had a contented expression on his face, which was somewhat uncharacteristic. Because of these disclosures, I now see my father from a changed perspective. He now seems more masculine, closer to what I always wished him to be.
>
> The underlining and marginal notations in the book correspond to how I and my wife actually *do* mark our reading material. But this practice only pertains to professional material, regarding things we want to remember. It indicates what is important. We never do it with fiction.
>
> My wife did, occasionally, use green ink for writing letters. I received two picture postcards from her recently, from Europe. The first one was signed "Love, M." The second, just "M." Maybe she's pulling away from me. She hasn't called me lately.

The manifest content and the associations to the first dream display the problem of reality in three ways. The nested novel entails the problem of reality in the world of the novel: Was the protagonist's *ostensible* father his *real* father? Both views are antithetically presented. And the containing dream itself embodies a problem of reality in the world of the dream: Had his wife been in the apartment? The green ink antithetically suggests it, inconclusively. Also, there is a problem of extrapsychic reality: Does she still love him? Her postcards antithetically suggest and deny it.

There were two trends in the associations to the first dream. One was about his newly enhanced view of his father; the other was about his continuing, or revived, interest in his estranged wife. Thus, both trends referred to first marriages: his father's recently discovered first marriage (which bolstered his father's masculinity) and the patient's own failed first marriage (which diminished his own masculinity). It may well be that the element in the nested novel—"World War *II*, but with trenches [like in World War *I]*"—referred to *second and first marriages*, respectively. This would equate *marriage* with *war;* not altogether surprising, given the dreamer's current preoccupations.

In the patient's ensuing associations to the second dream, there was reference to the other side of his attitude toward his father—that of disappointment, criticism, and derogation:[3]

> The door, open to the stairwell, would indicate some mismanagement on the part of the apartment building's employees. The superintendent, porters, and elevator men in my building are actually quite good and dependable. My mother had been much more distrustful of that kind of person. This was related to their having been black or Puerto Rican. I remember Willie, the black porter (or handyman) of my childhood building; he was a local hero to the boys in the neighborhood. When a gang of boys from a nearby section of the city came to beat me up, I ran to Willie and stood beside him—expecting him to protect me. Willie did nothing. I was greatly disillusioned with him—and this tended to confirm my mother's view of these people as lazy.

I commented:

> You seem to be alluding, as well, to your mother's critical view *of your father* (another not-so-handy man), a view that you shared to some degree. The story in the novel may indicate that in your childhood, you had wishful fantasies that your disappointing father was not really your father.

In reconstructing the formation of these two dreams, the following may be inferred. The patient had responded to the information about his father's first marriage with a mobilization of oedipal ambivalence about his father, and also about his own first wife. The ambivalence toward his father centered around whether he wanted his father to actually *be* his father. His father had appeared disappointingly unmanly and defeated in the past. This provided the patient with a guilt-ridden oedipal triumph. But now his father appeared more ideally masculine and more formidable in comparison to the patient, who had recently suffered an oedipal defeat at the hands of his first wife.

[3] For ambivalence isolated by two dreams, see Freud (1923), p. 113.

The patient thus harbored unconscious hostile feelings toward his first wife. And one may plausibly speculate that, in equating his first wife with his father's *dead* first wife, he had unconscious death wishes toward the former. But he also had positive attitudes toward his first wife. He wished to promote his own sense of masculinity through her return to him. However, he felt that this would jeopardize his current hopeful relationship with his girlfriend—and future second wife. He wished that his own first marriage had been like his father's first marriage, and had fostered his masculinity rather than depreciating it; but he also saw his possible future second marriage as correcting all that.

Further, the following facts demonstrate the intimate relation of the nested novel in the first dream with the dream's pervasive problem of reality. The patient himself associated the nested novel with his discovery of the hidden and secret extrapsychic reality about his father. Not only did the *nested* novel within the dream pivot around the problem of a fictional reality, an antithetically presented one (specifically, about a father), but so also did the manifest content of the *containing* dream as a whole, about the "objective" reality of the world in *it*. The first dream was full of *conundrums*: *whether* the dreamer's wife still loved him and *where* she was; *whether* his wife knew about his girlfriend; the presence of the crossword *puzzles*; *whether* someone had been in the apartment. Antithetically associated with these extrapsychic enigmas in the dream's world were the pieces of *inconclusive evidence* for their solutions. The green ink marking the novel embodied the problem of reality: green ink signified *reality*—i.e., nonfiction—to be remembered, thus antithetically imputing reality to the fiction of the novel.

The problem of the extrapsychic reality of the patient's wife's love for him was central: What did she now feel about him? The clues and evidence to this mystery, her valedictions in her two postcards, were inconclusive. This latter connection between *picture* postcards, with their ambiguous *written text,* and the *pictorial evidence* about his father's previously unknown past (the photographs), may well have provided the models for the nested *literary*

text in the first dream. If so, the manifest problem of reality in the nested novel thus came to represent, through allusion, the patient's preconscious problem of extrapsychic reality concerning: whether his estranged wife still loved him, or whether she menaced his hopes for masculine fulfillment; whether he was more masculine, as his father now seemed, or less so, in comparison; and whether he was humiliated by his more masculine father or still guiltily triumphant over him.

The two dreams together asserted: "I wish evidence showed that I and my father were—and were not—more masculine through our first marriages. But I deny the ambivalently painful reality of my father's past by making it fiction, *only* a novel!" In this instance, the painful reality about the patient's father did not refer to the psychoanalytic investigative effort toward the elucidation of distressing inner realities, but rather to the unconsciously connected external realities of his father and his estranged first wife.

Dream VI

In the next example, the patient was a divorced man in his late twenties. Many of his emotional conflicts revolved around his conscious and valued identification with his mother, who was cultured, cultivated, cosmopolitan, educated, and artistic. However, he also suffered from an unconscious and repudiated identification with his father, who was a businessman—self-made, ruthless, canny, and enormously successful.

Much of the patient's early ambition had revolved around making himself financially independent of his father as soon as possible. And in this he succeeded. The patient deprecated his father's slick business practices, his slippery cunning, and, especially, his cynical contempt for fair-mindedness in all spheres of life. The patient himself was a morally upright, just, and kind young man—except in his monetary relations with me. Over periods lasting months, he managed to find all sorts of reasons not to pay his bill for his sessions. Occasionally, these excuses seemed legitimate. But more often, they appeared unconvincing, and when I

voiced my incredulity, the patient vehemently protested his innocence.

Shortly before the session in question and on the basis of various clinical indications, I had begun to interpret the patient's nonpayment behavior with me as indicating an ideal of masculinity based upon the financial defeat of rivals and deriving from an unconscious childhood idealization of his father, the ruthless businessman. On the basis of other clinical insights, I suggested that he saw the analytic situation as a homosexual battleground in which one of the two male participants "rapes" the other financially—the only question being who would do it to whom.

The patient objected to the notion that he admired his father, even unconsciously, let alone that he identified with him in any way. But soon afterward, confirmatory analytic material began to emerge indicating the weakened repression of his paternal identification. He imparted this material reluctantly, with difficulty, and accompanied by sophisticated arguments. He told of insecurity about feeling masculine, in his present-day life and also as a latency boy. He could intellectually see, but not emotionally accept, that being like his crude and unscrupulous father would assuage anxieties about his masculinity.

In the session before the one to be reported, the patient complained that ideas were spontaneously coming to his mind, seemingly "for" me, to be used by me "against" him. Thus, he was beginning to feel submissive and feminine toward me in the analytic work itself—and this frightened and irritated him. These transference feelings prompted the following session, in which the patient told of a dream that had a nested work of art.

He began telling the dream with a comment, an association in itself, already heralding the problem of reality:

> I don't know what this dream is about. There is a photograph showing a row of round balls receding into the distance. It's not clear whether the balls are of gradually diminishing sizes, or whether they are all the same size but just appear smaller due to their progressively greater distances. Then the picture becomes real—the row of balls

> is actually there. But there is a frame around my view of this scene. So it's as if I am looking through a sort of window. The frame is like the picture frame [in the analytic consulting room] directly in my line of vision from the couch.

Here the problem of extrapsychic reality is inherent in the world of the nested photograph. For the content of the photograph is itself ambiguous; it is not clear whether what is depicted is an optical illusion. Further, the problem of extrapsychic reality is also inherent in the containing dream. For the photograph itself changes its ontological nature from *representing* reality to *being* reality. This dual nature of the photograph-turned-real is thus itself antithetical—reality and nonreality.

But, still further in the narrative of the containing dream, the patient likened the frame of the picture/window in the dream to the actual picture frame in the analytic consulting room—the picture frame at which he was at that very moment looking. The picture/window frame in the dream thus had a transference significance, and so did the nested photograph itself. (As will be seen below, it was important to the patient that the picture frame in the consulting room was also in *my* line of vision from behind the couch.)

The patient had several immediate associations—all of which indicated unacknowledged hostility toward me:

> It's a puzzling dream. It may have been stimulated by the movie *Spellbound*. I saw part of it on television last night. There are dream sequences in the movie. It's about psychiatrists; one psychiatrist kills another. I don't know why I would dream about that movie.

After some digression, the patient's hostility toward me became conscious and took on a mildly paranoid cast. Here the problem of reality in the patient's inner world made an appearance in regard to the transference, for he questioned the validity of my interpretations about his mental life. He also challenged the apparent extrapsychic reality of my sincerity and integrity:

> Last night I thought about you and the analysis—about how I try to argue against your contention that I'm worried about my masculinity. Maybe I can find some kind of proof that would refute what you say, proof that you would accept. You're just like my father. Both of you are *really* dishonest, exploitive, menacing and inscrutable. My father would push me to be athletic because that was his simplistic idea of how his son should be masculine. I react to you in the same way I did to my father—with defiance. I wasn't so sure that my father *really* believed athleticism indicates virility. And I'm not so sure you *really* believe what you say about my concerns about my masculinity. My father was hung up on things like that. You are, too. You're trying to see how I react to these interpretations; you're toying with me. You do these things to annoy me, to stick it to me.

The associations that immediately followed tended to confirm my interpretation of the patient's identification with his father. He told for the first time of a homoerotically tinged relationship with his father, in which they had shared an interest in athletics (prize fighting)—in secret and collusive antagonism toward the patient's mother.

As the patient did not pursue the dream further, I asked about the balls in it. While talking about this particular aspect of the dream, he became uncharacteristically playful. The associations to the ambiguity of the photograph in the dream reevoked the problem of extrapsychic reality within the world of the dream. He elaborated:

> The balls were white or gray. Like marble . . . [he chuckles] . . . like death. [The imagery of *death* will be elucidated later.] It was hard to say how big they were. Maybe a foot in diameter and working their way down in a row. It was like a trick—not knowing if the difference in size was an illusion or real. It was a picture frame that then became a window or a shelf.

The patient next made a reference to an episode from his youth that I already knew about, involving a slightly older cousin

who clearly resembled his father. One summer evening, this cousin threw a baseball full force at the patient from out of the darkness. It narrowly missed his head and crashed into the screen door behind him. The patient's father, on the scene a moment later, could easily reconstruct what had just happened . . . and said nothing. The incident passed without anyone's ever mentioning it. But it remained something to which the patient's thoughts frequently returned.

And with this reference, the hostility to me, so much in evidence earlier in the session, turned out to have been one of the motives for the dream itself. In "throwing" the balls of this nested photograph at me, to find "proof" that I was wrong about my interpretations, the patient was acting toward me just as his cousin had acted toward him. It was as if to say: "Since this photograph (like your interpretations) is an illusion, so is the 'truth' or 'reality' (of my mental condition) to which it refers!"

He continued:

> The balls in the dream remind me of the baseball my cousin threw at me. I've thought about that incident often, but not lately. Did the balls in the dream look like baseballs? Actually, in the dream, the balls were of marble. Are there ball shapes on tombstones? Maybe this image was something I saw. It's a mystery.[4] [Sarcastically.] Could I actually have a dream that you can't figure out? [More seriously.] In the past, I have always been impressed by your interpretations of my dreams. I really admired that. Was I trying to play "Stump the Analyst"?

At this point, the problem of truth and reality in the negative transference came even more prominently to the fore:

[4] In fact, a television program titled "Mystery!" had aired on the previous evening. (The patient had watched television at that time.) The program began, as always, with an animated cartoon by Edward Gorey, showing satirical renditions of anxiety-provoking horror. Among the images were a tombstone and a large spherical marble decoration around it. I did not mention this to the patient, as it might have distracted him from his immediate associations.

> I'm reading a novel called *The Name of the Rose*. It's in the Sherlock Holmes fashion. [The novel, by Umberto Eco, pointedly models the protagonist, an English monk in the Middle Ages, on Sherlock Holmes.] Sherlock Holmes impressed me as a child. In this book, the hero impressively explains to people the truth about what is really going on. This novel is somewhat heavy-handed; Conan Doyle did it better. In the analysis, I now bring something in for you, "Holmes," to figure out—and you can't. This recalls an image from my childhood, a sort of puzzle I received as a gift. It was a set of dolls that open up and there is a succession of dolls within dolls. The balls in the dream could be like that.

The idea that the dream had a nefarious purpose (that is, to discredit me as his interpreter) became clearer as his associations continued:

> There's something fake about the dream. There's a "set-up" in it. It's not just a dream; it's contrived. [Chuckles.] It's as if I were really not asleep when I had the dream—that I was just lying there with my eyes closed. But I actually *was* asleep.

The associations to the dream indicate that watching television the night before the dream—specifically, the movie *Spellbound,* which contained dream sequences nested within it, and the opening cartoon of the television program "Mystery!"—may well have influenced the dreamer's "choice" of a *photograph* by which to deny a painful reality. However, the analysis of the dream demonstrated what terrible inner reality the ambiguous nested photograph bespoke for the dreamer. It was one he had been denying in the analysis. It expressed, through affirmation and repudiation, his identification with his sly and ruthless father in the context of a hostile transference. His hostility toward me had been intensified by my interpretation of the negative (ultimately, sexualized) transference and its identificatory basis.

The content of the photograph derived very much from the grisly, enigmatic but actual incident of the patient's early adoles-

cence. For the dream image of *the static line of marble balls progressively receding into the distance* recapitulated through a defensive directional reversal *the single baseball moving progressively closer* toward the patient's face. The patient resurrected the passive, frightening experience of familial betrayal from the past and, in horrific identification with the aggressor, directed the same sort of aggression actively toward me, the intended viewer of the photograph. The problems of reality, inherent in the nested photograph and in the dream as a whole, were then to be externalized onto my interpretive analytic function. The dream denied and antithetically expressed the distressing inner reality by proclaiming: "It's *only* a photograph! And *certainly not* a covert, almost murderous attack on my analyst and on the validity of his wretched interpretations!"

Dream VII

As stated, the preceding three dreams containing works of art were taken from my own clinical practice. I have since come across in the psychoanalytic literature another instance of a dream containing a work of art. Reed (1993), exploring the indications and nature of explicit reconstruction in clinical work, reported an extensively analyzed dream that contained a movie in the process of being made. Her patient, Mr. M, suffered from strong depressive and self-destructive trends. His brother had been killed at the age of three by being catapulted out of a neighbor's open convertible during an otherwise minor accident. Mr. M, aged five years at the time, was not present. The analytic work on the transference led to the insight that he wanted the analyst to make him suffer due to his survivor guilt. She could then make the interpretation that "You want to be the dead baby." To which he burst out: "He got attention without doing anything. He got off easy!" The patient was shocked that he felt that way toward his dead younger brother and was angry at the analyst for making him aware that he wanted to die (pp. 59-61).

Shortly thereafter, Reed's patient reported the following dream:

> He was riding in a cab with friends trying to do errands in preparation for a concert. He was late for a rehearsal and went home to a house he was living in rent-free because "there'd been a murder in it and they were making a movie about it. I could live there free during the production of the movie, even though I wasn't in the movie. Robin [a friend of the patient's] was there. *He had done the murders, or they were using him in the movie to act the part of the murderer.* The producer wasn't there. He had another house that he was living in. He had two brothers. I was one. One was shadowy. I went over to the producer's house. They said that he might not forgive me for being late and making him angry. I had to explain I was a space cadet [that is: someone with a 'spacey' sensorium; someone with distracted attention]." [p. 61, italics added]

Thus, there is a nested movie in the dream that, in itself, presents an antithetical orientation toward the reality of a murder in the world of the dream: Robin, the dreamer's friend, is either the actual murderer or artistically represents, qua actor, the murderer. The patient immediately associated to his brother's fatal accident. "He felt very guilty and fervently wished that his brother had held on inside the car" (p. 61). Material later came up indicating that the patient had resented the birth of his brother. He had seen his brother as an intruder who robbed him of his mother's attention—i.e., distracted her attention away from him.

In a later session, the "space cadet" dream element was elucidated. The patient felt that the analyst's attention was distracted away from him. He had an image of himself going through space, like an astronaut attached to the *mother ship* by a line—a line seen as an umbilical cord. Then followed the idea that such connections could be violently broken.

At this point, a very dramatic turn of analytic events took place. The patient came into immediate touch emotionally with the death of his brother:

> "I didn't drive the car! I didn't kill my brother!" he burst out. I interpreted his wish to get rid of his brother. Fanta-

> sies of guilt, retribution and self-punishment followed, including: " . . . I picture taking my head and bashing it against the floor. How that must have hurt to be thrown out and crushed on the street." I told him he now wanted to make himself into his brother to take the impact of the pain himself. [p. 63]

As the analysis of the dream proceeded over the ensuing sessions, *the distinction between wishful fantasy and historical actuality —the problem of inner reality pertaining to the world of the patient's own mind*—came progressively to the fore in the interpretive work. The analyst "told him that when he was little he had believed that his *thoughts* [italics in original] of wanting to kill his brother had [*actually*] killed his brother" (p. 63). The patient responded to this work with guilty anguish.

Reed notes that later, and while they were still working on the dream, a previously unconscious childhood memory became conscious.

> Two sessions later, . . . he . . . imagined *himself* projected off a car seat. Then, for the second day in a row, he had a rush of memories of a place . . . that looked like an underground garage [as in the Batman-Robin comic-book stories] and his basement playroom at the same time. Suddenly he remembered: "I had a Batman car with an ejector seat! I'd totally forgotten about it until now. You pushed a button and Robin got popped out through the roof. No wonder *it's so cemented in my mind I did it. I had a toy that did it.* I loved doing it! I was pushing that button all the time! (pause) It's so wild, thinking about how . . . It seems so blatant, it was so satisfying. It was fun. No wonder life isn't allowed. It makes me cry." [p. 64, italics added]

Thus, Mr. M felt remorse about a repressed fratricidal childhood fantasy. However, very young children make little or no distinction between wishful fantasies and deliberate deeds. The repression of those fantasies maintains that effective equivalence, and may even consolidate it. And so, the chronic guilt Mr. M suffered

all his life was the same whether or not he had actually performed the murder. Only after the repressed content had become conscious through analytic work could adequate reality testing be applied to it. Of interest, in his dream, Mr. M attempted to deny his guilt *before* he had achieved his exculpatory insight. His dream declared: "I may be guilty of minor offenses (e.g., being late for appointments), but I am *not guilty* of killing my brother/Robin. It was *only* play (a Batman toy or a movie)."

Reed indicated that the form and function of the nested movie in the dream was indicative of a more general phenomenon, related to that of a dream within a dream:

> The form of the dream suggests that it might be related to a dream within a dream, which, as Freud remarked, frequently represents an actual memory which is being denied. The actual memory *denied* was the child's play pushing the button which activated the ejector seat of the Bat car. Greenacre (1956) added, as possible formal criteria for dreams within dreams, the play within the dream. To include this dream in that category, we would need to add *the movie or movie rehearsal within the dream* to the variants Greenacre listed and to understand that the historical *uncertainty* of the child about whether he had actually [magically] killed by ejecting Robin over and over from his toy car was represented [in the dream] by the *uncertainty* about whether Robin had committed a murder or was going to be used in the murder that was going to be played. [p. 65, italics added]

Accordingly, Reed closely approximated my thesis in this paper. The nested artistic dream element (a movie) denied a painful, real event (joyfully ejecting brother/Robin from a toy car). There is a close relation between the formal quality of nesting as seen in this dream and the problem of reality (the "historical uncertainty") about the patient's having actually killed his brother. This uncertainty was represented in the world of the dream by the antithetically described role of Mr. M's friend Robin in the nested movie. The problem of reality and the antithetical presentation of

that reality in this instance are the result of the childhood difficulty of distinguishing magical fantasy from real deeds.

SUMMARY AND DISCUSSION

The seven dreams presented here demonstrate the three qualities anticipated in the introductory section: When dreams contain dreams or works of art, the analysis of the dream shows that

(1) a distressing reality, represented in the nested element in greater or lesser disguise, is very often denied—albeit only partially;

(2) such a painful reality is consistently antithetically presented—both denied and affirmed; and

(3) this nested/containing configuration is frequently associated with the problem of reality, that is, the problem of deciding what is real or true, as explicitly or implicitly related to the partially denied reality.

The latter two predicted qualities are (pre)conscious and may be found in the nested element, in the containing dream's manifest content, in the dreamer's associations, and/or in the dream's day's residue. The empirical demonstration of the predicted phenomena lends some validity to the assumptions at the base of those predictions.

The three correlations established here can only be demonstrated when dreams of this particular type are investigated in a psychoanalytic manner. This is because one or several of the correlated phenomena may not appear in the dream's manifest content, subject as it is to conflict and defense. (See Dreams II, III, IV, and VII.) If any one of the correlated phenomena is not present in the manifest dream, it is nevertheless present in the analysis of the dream, which necessarily entails the dreamer's associations and/or the day's residue.

Also, the dreams investigated here demonstrate that the problem of reality is not an epiphenomenon of the dreamer's being a

patient in a therapeutic psychoanalysis, where the problem of determining the dreamer's inner reality is a crucial concern in the dreamer's life. Rather, the analytic work may indeed mobilize the correlated phenomena. (See Dreams I, II, IV, and VI.) However, the dreams showed that the problem of reality may pertain also to *other* issues besides the distressing inner realities of analytic patients. (See Dreams II, III, V, and VII.) But also, the problem of reality, in this specific denying context, does not necessarily pertain to a pragmatic problem of actual, waking life. (See Freud 1925, p. 127.)

Psychoanalytic investigations of these seven dreams demonstrated how *diverse* were the conscious and unconscious preoccupations of the dreamers. And the seven dreams also demonstrated that the *manner* by which the problem of reality is associated with the nested/containing configuration is *enormously variable.* The problem of reality may exist in the world of the nested element (see Dreams I, V, and VI), in the world of the dream itself (Dreams I, V, VI, VII), in the world of the dreamer's own mind (Dreams I, III, IV, VI), and/or in the dreamer's extrapsychic world (Dreams II, V). Therefore, the *locale* of the problem of reality in the "complete" dream clearly depends on a vast multiplicity of idiosyncratic factors in the synthetic task of the dream work.

Thus, the problem of reality, as an integral element in the complete dream, is itself subject to the obscurantist machinations of the dream work. What is remarkable in this study is that the problem of reality retains not only its (pre)conscious presence but also its very nature (qua problem about deciding what is real or true) in vastly different people, with vastly different psychologies, having vastly different personal concerns, using vastly different processes in the dream work. Given the tremendously plastic versatility and creative inventiveness of dreams, the stability of the problem of reality and its consistent correlation with nested dreams and works of art are truly surprising.

There is then reason to posit the existence of a relatively specific and basic impetus mobilizing the problem of reality in regard to this nested/containing dream configuration. The following ex-

planation is tentatively proffered. As hypothesized in my introduction, the nested/containing configuration in a dream using dreams or works of art constitutes a partially unsuccessful effort at denial of a distressing reality. This produces the antithetical presentation of the denied painful reality, thus creating an ambiguity about that reality. Now, antithetical ambiguity about reality does not *eo ipso* mobilize a need to resolve that ambiguity. Indeed, people tolerate ambiguity about reality (in dreams and while awake) with remarkable nonintellectual casualness. However, there will be an impetus to resolve a *painful* ambiguity. This specific situation appears to be relatively stereotyped. Distressing reality, previously something to escape, now becomes something to understand. The result is reality qua problem, instead of reality qua danger or calamity. *The impetus to solve the problem of reality is a measure of the persisting pain of the reality that is not completely or effectively denied.*

Thus, the urgency of the problem of reality continues the distress of reality that has disturbed the dreamer's sleep in the first place. But now the pain of reality has been somewhat reduced in intensity through (partially effective) denial. It has also been *transformed* into a cognitive, epistemological concern—a concern about something *intellectual* instead of something *situational.* The problem of reality, with all its attendant urgency, is then handled by being represented somewhere in the complete dream itself. In this way, the pain of reality can be transmuted—just like any other irritating, sleep-disturbing stimulus—into a form that has a greater chance of allowing the dreamer to continue sleeping. This causal sequence may often be adequately inferred from a relatively extensive analysis of the dream.[5]

The correlation between the nested ideation, on the one hand, and the problem of reality with its antithetical presentation, on the other, may then be described logically as follows: *If* (but not *only if*) dreams contain nested dreams or works of art, then there is a high probability that a painful reality inherent in the nested ele-

[5] See Freud's (1900) analogous discussion of somatic sources of dreams and disturbers of sleep (pp. 220-240). See also Sandler (1976), for a discussion of just why these disturbers of sleep *must* be represented in the complete dream.

ment is partially denied, that it is presented antithetically somewhere in the complete dream, and that the problem of reality is also present. The converse is not true. The antithetical presentation of reality and/or the problem of reality may be present in a dream *without the presence of any nested ideation in the manifest content.* Nested dreams or works of art are *sufficient* causes for the two conjugate reality phenomena to occur in dreams, but they are not *necessary* causes. *Other* reasons and motives (often to express ambivalence) may also cause one or both elements in the conjugate pair of reality phenomena to occur in dreams.[6]

The generalizations established above do not apply to just *any* sort of nested mental process or communicative vehicle manifestly present in dreams. They do *not* apply to nested ideational content conventionally assumed to be factual, informative, or pragmatic. The correlations demonstrated above apply only to nested mental processes and communicative vehicles *conventionally taken to represent nonreality: just* a dream, *just* a novel, *just* a movie, *just* a photograph, *just* a picture. The correlation occurs only when the reality is an unpleasant one, something bothering the dreamer, something he or she would prefer to deny.

For example, in Freud's (1900) dream of the (nested) botanical monograph (pp. 169-176, pp. 282-284), the nested ideational element is *not* a conventionalized representation of nonreality. It does not inherently deny the reality of its content. And so it has no ambiguous, contradictory, or antithetical presentation of reality, and no associated problem of reality. The same considerations apply to Freud's (1923) report of a girl's dream in which "she was reading her own case history, which she had before her in print.

[6] Dreams without any nested dream or work of art in the manifest content, but nevertheless containing an antithetical presentation of reality, were described by Altman in *The Dream in Psychoanalysis* (1969, p. 111; pp. 136-137; pp. 139-140). Dreams without the two kinds of nested elements, but containing the problem of reality, are described in the same edition of the book on pp. 57-58, pp. 113-114, pp. 126-127, pp. 173-174, and pp. 198-200. The dream of Irma's injection (Freud 1900; pp. 106-120) was obsessed with the problem of reality (deriving from the urgent and painful waking problem of reality, Irma's diagnosis); that dream also lacks any denying nested ideation.

In it was a statement that 'a young man murdered his fiancée—cocoa—that comes under anal erotism'" (p. 119). Her nested, printed-out case history did not have a conventional denying meaning. Accordingly, in the (pre)conscious associations, the reality of her case (whatever its content) was not problematic, and it was not antithetically presented (pp. 119-120).

The correlation of this particular sort of nesting with the antithetical presentation of reality is not consistently present when regression does not occur at all—as in most of the reality-oriented, pragmatic mental states of everyday, alert waking life. And if dreams and art are nested in waking mental life (where reality testing is intact), dreams and art are most often seen to categorically represent nonreality, absolutely denying the reality of their content, and not necessarily having antithetical meanings or functions. Some regression—especially of reality testing—thus seems to be necessary for these correlated phenomena to consistently appear together.

Nested denying elements, like dreams or works of art, are not the only strategies by which to deny disturbing reality in dreams. Others are well known. Further, regarding the "choice" of dreams and works of art to accomplish this, there are presumably many determinants (often unknown) to "choosing" them. This is homologous to the still-unsolved problems in psychoanalysis of *choice of symptom* or *choice of defense.* Even so, some effort has been made in this paper to explore the determinants of that choice. (See Dreams IV, V, and VI.) Once that choice is made in the dream work, it apparently sets into motion the fairly stereotyped set of psychic events suggested above that eventuate in the problem of reality's appearance in closely related (pre)conscious mentation.

This is not the first correlative study of dreams addressing manifest content. Isakower (1954) investigated spoken words in dreams and correlated them with internal moral injunctions. Lewin (1946) studied blank dreams and connected them with manic denial of depression. The list could be extended, but these contributions must be distinguished from the cataloging of simpler, "typical" dreams (Freud 1900, pp. 241-276), and even more so

from symbolism (Brenner 1973, pp. 52-53; Freud 1916-1917, pp. 149-169). Typical dreams and symbolism are direct, unmodified derivatives of archaic, infantile experience and thinking. The present study of dreams, like the previous ones by Isakower and Lewin, deals with relatively complex stereotypic aspects of manifest content and associated (pre)conscious phenomena—along with their unconscious dynamics.

In general, the study of manifest content of dreams is an awkward situation for psychoanalysis. (See Babcock 1966.) Nevertheless, the consistency of the data presented here speaks for itself. The explanation put forth, I believe, is the one that best fits the facts and is in agreement with well-established psychoanalytic propositions.

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KNOWING AND NOT KNOWING: THE ANALYST'S PREGNANCY

BY LYNNE M. ZEAVIN, PSY.D.

The author examines some of the dynamics associated with the shifting experience of knowing and not knowing as it arises in response to the pregnancy of the analyst. This experience, as well as the thinking process behind it, is ubiquitous in psychoanalytic work, but is particularly apparent in the work demanded by the analyst's pregnancy. An in-depth case history is presented to illustrate the ways in which pregnancy in the analyst may powerfully revive important dimensions of the patient's past.

INTRODUCTION

Potentially, the pregnancy of the analyst uniquely and unmistakably represents in distilled form aspects of the patient's psychic history that heretofore have remained guarded and out of awareness. I say *potentially* because the problem of contending with the analyst's pregnancy—consciously and with conscious knowledge—is enormous.

That the pregnancy exists as a feature of rational perceptual awareness does not by any means guarantee the patient's ability to perceive it, much less to think about it. All that is guaranteed is that the patient will perceive something—some change in the analyst's bearing, physicality, clothing, and that the patient must do something with this awareness. What the patient does, how she or he makes sense of this knowledge, tells us a great deal about the patient's capacity for symbolic thought. I think of this capacity as

linked to the patient's capacity to explore and tolerate separateness, loss, the sexuality of the other—ultimately, the facts of the Oedipus complex.

Via the detailed clinical case discussed in this paper, that of A, I mean to show the ways in which pregnancy in the analyst can act as a catalyst to revive important dimensions of the patient's past. These include previously unrecognized or unacknowledged aspects of the patient's childhood experience of parental sexuality, internalization of the parental relationship, identifications with the mother, traumatic losses due to miscarriage or death, and/or the presence of new siblings. While I believe that these tensions are always present in analyzing the analyst's pregnancy, in the case that I will discuss these themes were particularly central and poignant. The patient's history was revived and relived in correspondence with her traumatic discovery of the analyst's pregnancy. Knowing and not knowing were of central importance to the patient and to the analyst in ways that I will describe.

A psychoanalysis conducted while the analyst is pregnant is exceptional. For the analyst, the experience is marked by anticipation, heightened anxiety, and perhaps a renewed sense of engagement with one's work. For the patient, there may well be curious lapses and hesitations, disturbing and often inchoate recollections, and prescient dreams—all in the context of information that can simultaneously be seen and not seen, realized and not realized, known and not known.

In the crisis that the analyst's pregnancy seems often to represent, the patient rarely knows what she or he knows or does not know, and rarely feels free to say it. There is confusion about perception. There is often an internalized interdiction regarding seeing the analyst's body, looking closely at it and inferring information regarding her person, particularly when the perception carries personal, indeed intimate, information about the analyst's private life. For the analyst, it is not always clear how the patient is struggling with this information. Because the struggle is often with an as-yet verbally unacknowledged bit of reality, the analyst's sense of what is going on and why is likewise potentially obscured.

Undoubtedly as well, the analyst has her own distinct feelings about being pregnant, and these interact with the patient's conflicts, often exerting subtle pressure on the analyst to act or to behave in particular ways.

Simply the fact of the analyst's being pregnant—particularly if she has not directly disclosed this information to her patient—provides a stimulus that potentially revives early oedipal themes and fantasies. Now more than previously, the analyst's office merges in fantasy with the parental bedroom. The analyst's body recalls the body of the early mother, a mother whose presence evoked fantasies concerning her power to make and destroy babies. The mother's body was also presumably the site of the child's own urgent wishes to possess her. These foundational experiences are now more likely to be given representation through the patient's reactions to the analyst's pregnancy—reactions that are themselves often inchoate, preconscious, and without an immediate verbal expression. In the face of the pervasive, insistent reality of the analyst's body, pregnancy, and sexuality, the patient's own psychical capacities for contending with and ordering foundational experience make themselves apparent.

What is revived for the patient will of course be highly individualistic, and how it is ordered will be particular. The patient is now presented with an analyst/mother who is not only a loving or benign caregiver, but is also sexually involved with someone else. *What* the patient makes of this exclusionary involvement, *how* the patient sees it and makes sense of it, are as important as the content that is revived.

What I am here calling *knowing and not knowing* is a feature of what Klein (1930, 1945, 1957) thought to be a major task of working through both the Oedipus complex and the depressive position—the capacity to tolerate loving and hating the same object, and the wish to possess the object and the capacity to realize the impossibility of that wish. I am assuming here that, even if affects and meanings are denied—as they certainly can be—there will be derivatives of the patient's experience that can be picked up, albeit in disguised forms, in both transference and countertransference.

The patient's envy and competitive feelings, though previously held in check, may now be more in play. Issues of abandonment may suddenly express themselves more prominently in relation to brief separations. The patient might be more irritable or more silent. Maybe the patient becomes a bit paranoid, thinking that the analyst is willfully excluding him or her, feeling slighted, targeted, or purposefully made to feel "bad."

KNOWING AND NOT KNOWING: THEORETICAL UNDERPINNINGS

Britton (1998) makes the claim that an epistemophilic instinct should be considered on a par with and independent from other instincts:

> In other words, the desire for knowledge exists alongside love and hate. Human beings have an urge to love, to hate, to know and a desire to be loved, a fear of being hated and a wish to be understood. [p. 11]

What happens with each of these wishes is subject to the workings of the unconscious and to our relationships with our objects. Britton states that the belief is "clearly cast in the language of a relationship" (p. 12). That is, we hold beliefs and let them go; we hold, abandon, betray, relinquish, and move on from our beliefs, much as we embrace or relinquish our objects. For Britton, belief is not the same as knowledge, in that when one holds a belief, one accepts the possibility that it may not be true. However, belief is subject to disorder and can be held as true—as in an unconscious belief that leads to a neurotic resolution. Finding the disparity between one's beliefs and truth requires work—and in analysis "constitutes part of working through" (p. 9).

Beliefs demand confirmation in order to become knowledge. Knowledge, however, does not necessarily stick, despite the presence of sensory confirmation. As Britton (1998) says, "seeing is not necessarily believing" (p. 13)—and here I think he also means that knowing is not necessarily a function of perceptual awareness.

Other processes intervene, at least potentially, to disrupt the acquisition of knowledge. If one does not believe that which one is seeing, one will not know it to be real or true.

Discounting what is seen is a form of not knowing it. Discounting or denial, along with disbelief, serves to obfuscate knowledge. For Britton, this might arise in part as a result of a need to counter otherness; when any "cognitive tie outside the existing belief system of the self is treated as a dangerous link to something alien, then all such mental links may be destroyed" (p. 13).

Klein's work is relevant here as well. For Klein, the early Oedipus conflict and the resulting depressive position are intimately bound up with the capacity to bear knowledge. During the depressive position, several important tasks become possible, each developmentally crucial. First, the child is newly able to conceive of a whole object. This whole object can be lost, and, for the first time, the child can mourn its loss. This ability to mourn is the key to introjecting a whole object. As Freud argued in "The Ego and the Id" (1923), such introjection is vital to ego integration. The capacity to conceive and to introject whole objects generates a concurrent capacity to conceive the parents as separate figures who combine in sexual intercourse. The fantasies concerning this intercourse have important repercussions, not only for general psychic development, but also and specifically for the development of symbolic and creative thought.

The Contemporary Kleinians have elaborated upon this relation of the capacity for symbolic thought to the Oedipus complex. In addition to internalizing maternal and paternal figures, the child also establishes in his or her mind an internalization of the parental couple, along with the couple's particular qualities and modes of relating. This parental couple constitutes an ongoing fantasied internal object relation. Feldman (1989) persuasively elaborates on that relation:

> The phantasy of the oedipal couple is closely related to the way in which the patient is able to use his mind to create links between his thoughts and feelings, and to tolerate the anxieties that result from such links. [p. 125]

Excess anxiety will interfere with the patient's capacity to make connections between the various elements in his or her mind. By considering how the oedipal configurations exist in the patient's mind, it becomes possible to think about their impact on mental functioning—the patient's capacity to think and the patient's ways of relating to his or her objects. According to Feldman (1989): "If the patient negotiates the Oedipus complex in a relatively healthy way, he has an internal model of an intercourse that is, *on balance*, a creative activity" (p. 106, italics added). On the other hand, "the phantasy that any connection forms a bizarre or predominantly destructive couple seems to result in a damaged, perverse or severely inhibited form of thinking" (p. 106).

Britton (1998) characterizes the depressive position (which, like the Oedipus complex, is never resolved but always reworked, throughout each phase of life) as arising in infancy as a consequence of the developing capacities of the child to "perceive, to recognize, to remember, to locate, and to anticipate experience" (p. 32). It is one's knowledge of the object that both provokes and establishes the depressive position. Both knowledge of the object as it exists outside the subject's awareness—how it occupies space and time—as well as its relation with others in the world, including a sexual relation, is implied in the deepening knowledge that the child gradually gains. "The Oedipus situation exemplifies that knowledge" (p. 33).

The setting of the analyst's pregnancy revivifies these early oedipal currents. How the patient contends with the analyst as a separate and sexual object will be under the influence of the patient's early oedipal fantasies and residual beliefs about those strivings and their resolution. Knowing and not knowing can be thought of as the recapitulation of an early struggle—to accept the otherness of the other, to bear separation, to know about the exclusionary aspects of the parental relation, to bear hating and loving at the same time. Knowing and not knowing can be seen as a remainder of the difficulty encountered in arriving at a stable oedipal resolution or a firmly rooted depressive position.

TECHNICAL CONSIDERATIONS OF THE ANALYST'S PREGNANCY

Most of the literature on the analyst's pregnancy has focused on the timing of the analyst's disclosure of her condition and the patient's often unwittingly revealed awareness of it. This work has contributed to a growing appreciation of the various nuanced meanings of pregnancy to the analytic relationship. With this appreciation have come a number of papers whose aim it is to describe the meanings that the analyst's pregnancy can hold for a patient during analysis (Bassen 1988; Lax 1969; Uyehara et al., unpublished). All agree that pregnancy presents a special challenge to the analytic relationship. It is a burden to patients that has been foisted upon them, unbidden.

As Stuart (1997) points out, "The pregnancy's first showing is of particular interest because it presents the patient with a visual stimulus that can be assumed to have the same liminal quality for any individual whose reality testing is grossly intact" (p. 350). Nonetheless, patients differ widely in their capacity to perceive this stimulus and in the ease with which they can discuss it.

A Brief Clinical Example: B

Some of these aspects of knowing and not knowing were demonstrated to me during a pregnancy of my own. I was in my eighth month when I interviewed a prospective new patient, B, who was requesting analysis. Because my due date was so near and consequently had implications for beginning an analysis, I said to this woman, "As you can see, I am pregnant," to which the patient replied, "Oh, I didn't see—that is really terrifying!"

Only much later, after B had been in analysis with me for a period of time, did I learn some of the aspects of her history that might have made registering pregnancy in her prospective analyst so fraught. When the patient was three, her mother had lost a pregnancy in the seventh month. This led to the mother's decision to send the girl away for two weeks, which was followed

by the mother's withdrawal and depression. B's difficulties centered around her own highly destructive sexuality, which she felt to be both frightening and necessary. She could not fathom a cooperative, caring, sexual, and emotional bond with a lover. Pregnancy incited a near-psychotic-level anxiety, necessitating radical psychical measures for eradicating its presence.

As we talked over her initial visit much later in B's analysis, many of the links between her fantasy life, her conscious conflicts, and the ominous perception of my being pregnant could be discussed. Here, seeing the pregnancy was insufficient to confirm its reality and engage my patient's ability to believe. What became clear later on in analysis was that to know of pregnancy meant to revisit—and eventually to reclaim—B's fantasies of her destructive power over her mother's body, and particularly her fantasy of killing the unborn sibling.

Disclosure of Pregnancy

Discussions of psychoanalytic technique regarding the analyst's pregnancy usually turn to discussions of the timing or necessity of disclosure. Ordinarily, the analyst is herself preoccupied with the fact of knowing that she is pregnant and of wondering how this information will impact her patient and the treatment. What the patient does and does not know is always ambiguous. The analyst must decide when and whether to tell her patients of the pregnancy and of the leave time it will entail. Decisions to tell or not to tell are informed by several considerations. The received wisdom (Goldberger 1993) is that, with more disturbed patients, one might be inclined to tell rather than to wait. In the case of A that I describe in detail later in this paper, I found myself occupying three different positions, despite a theoretical bias to wait for the patient to come to the awareness on her own.

Curiously, knowledge does not always follow from explicitly willed disclosure. Decisions to disclose can be arrived at unwittingly, brought about by the pressures on the analyst to relieve the patient of psychic discomfort. The analyst, sensing what seems to be

the patient's struggle with something inchoate and painful, may feel moved to tell the patient in advance of the patient's readiness. Premature disclosure seems to afford relief and to provide reassurance. But does it?

In the third instance of pregnancy that I will describe with the same patient, there indeed was a temporary illusion of relief following disclosure, but the ramifications were in fact significant. Such relief can lead patient and analyst away from the heated, confused, and disturbing material that would have surfaced in a different manner, preceding conscious awareness of the analyst's pregnancy. In a way, early disclosure wrests from the patient the possibility of defensive measures by which he or she could come to terms with the information—in his or her own way and time. I will discuss this further in later sections describing the case history of my patient A.

Waiting implies sitting with the ambiguity of the patient's responses and trying to glean the meanings of their associations. I have approached this issue in any number of ways in my clinical work, depending on the patient and the material. If the patient has not acknowledged that I was pregnant when it was obvious, I have brought it up. Clearly, my anxiety about running out of time, and/or concerns about my own destructive effect on my patient, have played a part in these situations when I have intervened. One always rationalizes these moments—for example, by noting that it is because the patient is fragile or has had particular losses that it is perhaps therapeutic to intervene.

Two Additional Brief Examples: C and D

Another patient, C, whose mother had been violently murdered and who had occasional psychotic episodes, began talking about my being pregnant at what seemed like the very moment that I learned of it myself. Ordinarily, I would have listened longer before addressing this as a fact—but with this patient, who demonstrated a capacity to become fearfully paranoid, I acknowledged that indeed I was pregnant. For a while, this seemed to al-

low C a sense of her own capacity to perceive reality—and to work both on her reactions to the pregnancy and to her mother's death. Of course, I cannot know how it would have played out if I had kept quiet and allowed more time to elapse. There is always a sense, I think, of protecting oneself—one's baby, as it were—particularly when one anticipates the chaos that might be stimulated by a lack of structured response on the part of the analyst.

Changes of mood in the patient can precede conscious, cognitive acknowledgment. For example, in the context of a certain lengthy analysis, that of D, I was pregnant for the second time. This patient, a woman in her early thirties—whose difficulties revolved around being central, feeling easily disparaged as a woman, and intense competitive feelings—began over several weeks to exhibit a decisive change in her mood. D was vaguely resentful of interpretations, caustic, dismissive; generally, she seemed irritable and reluctant to allow me to reach her.

As I contemplated this change in mood, it occurred to me that perhaps the patient "knew" that I was pregnant. Around this time, D introduced material about her boss, who was also pregnant, but, well into her second trimester, she suffered a miscarriage. My patient confessed with great difficulty that, partially, she felt glad. I sensed that D was struggling with similarly unacceptable feelings toward me and my pregnancy, which she had not yet mentioned, though I was well into my sixth month. I decided to address this directly—linking her mood, her reactions to me, and her awareness of my pregnancy. I said, "I think that you are struggling with—," and before I could finish my sentence, she interrupted to fill in "—that you are pregnant."

Disclosure and Knowing/Not Knowing

The ambivalence of knowing and not knowing characterizes a moment like this one, when a patient imagines vaguely—or even specifically permits herself to wonder—but then takes it back, extinguishes the awareness. Knowledge of the analyst's pregnancy fades. Others' predicaments, more easy to bear, come to dominate

the analytic material. The analyst, perhaps sensing this, can begin to hold the knowledge in a kind of trust for the patient. It is not that the patient does not know, but that the patient cannot afford to know just yet. The patient described immediately above, D, referred to herself as "asleep at the wheel"—somnolent, but still in the driver's seat; aware, but preferring oblivion. She was teetering on the brink of depressive knowledge, knowledge as yet too difficult to sustain.

When the analyst is able to sit with the information, the analysis is often deepened. The analyst has an opportunity to witness how her patients manage what is heavy, difficult material. She can address not only the meanings of what is perceived, but also how they came to be perceived, to be owned or disowned, taken on or discounted and denied. The analyst is able to put into the larger context of the patient's mental life and functioning how she or he has become cognizant of the pregnancy and what this dawning awareness means.

CASE HISTORY: A

I will now turn to a detailed case discussion in order to provide a clinical illustration of the issues that arise with regard to knowing and not knowing. This patient, A, a young woman poet, came to treatment as a late adolescent in her second year of university. Her presenting complaint had to do with wanting to be more comfortable with herself, and wanting to work out issues that she saw as related to separating from her parents. She had been an only child. Her parents were in a stable but not happy marriage; she described feeling much closer to her mother than to her father. She told me that her mother had struggled with breast cancer, but only gradually did I learn that this struggle had punctuated much of A's life, beginning when she was five. Initially, this feature of the patient's history was not uppermost in her mind; it was not the reason for her seeking help. However, she did say that her mother had recently been diagnosed with a recurrence of breast cancer, and that she wanted the "support" of therapy.

I choose to discuss this patient in particular because her treatment (two years of psychotherapy and seven years of analysis) spanned three pregnancies of my own. With each pregnancy—variously by her own perception, or by my directly telling her—A became aware that I was pregnant. Each of the three occasions was handled differently, and each mode of handling had implications for the treatment. Taken together, these three pregnancies constituted a revival of A's own past—in particular, of elements regarding her mother's breast cancer—that ultimately proved too much to bear. The pregnancies not only evoked this forgotten past, but also, by coincidence, coordinated uncannily with it.

A had lived through her mother's discovery of breast cancer on three different occasions. The thrice-repeated experience of her analyst's being pregnant at times took on a sinister dimension. As noted, analysts' pregnancies almost always have deep resonances, and for A, these resonances became stark, intermittently overwhelming reminders of actual experience and were associated with dreadful states of mind.

From the perspective of treatment, the emergence of these states was a hopeful development. From early in her life, the patient had developed a rigid system for managing her awareness of threat. She was extremely guarded, albeit pleasant and compliant. The analysis—because of the cumulative effect of the analyst's pregnancies—now stood a chance of getting to this in a vivid, affectively alive way. Initially, stimulated by the analyst's pregnancy, A was able to voice fantasies and thoughts related to her mother's body—including the enduring and perturbing question about the reason for the mother's having had no further pregnancies.

For A, ordinary strivings—for independence or for triumph—dovetailed all too closely with beliefs about her own murderousness, occurring as they did in the setting of her mother's frequently grave diagnoses, illness, treatment, and seeming recoveries. My pregnancies awakened long-repressed fantasies about bodily change and bodily damage; stimulated wishes for union with and submersion in the analyst/mother; evoked terrible, disquieting

feelings about betrayal, abandonment, and loss; and made clear the links that A had established between pregnancy, sex, and cancer. As the analyst's pregnancies accumulated, gathering increased momentum each time, they took on the impossible "*this-is-happening-again*" cast that was the traumatic valence of her mother's illness.

Her mother's illnesses had occurred at crucial junctures in A's life:

(1) Her mother's first diagnosis occurred when A was five, and her double mastectomy when A was around seven years old. After the mastectomy, "everything returned to normal."

(2) This normality ended abruptly when A was eleven and her mother found new indications of cancer. She was treated with chemotherapy and radiation, and the cancer again remitted for several years.

(3) When A was eighteen and preparing to leave home for college, the cancer recurred.

I first met the patient one year later.

A's memory of events immediately following her mother's mastectomy was cloudy. The only recollection she had from this period was of having dinner with her mother in the mother's bedroom. What was special about this memory was the fact that they ate in the mother's bedroom. The oral cast of this early (possible screen) memory returned in later fantasies, fantasies that clarified A's idea that she had damaged her mother's body by her own hunger and greed. She wondered about breast-feeding. Had she taken too much as an infant?

A remembered that she had been fearful of being separated from her mother—that she would cling to the banister, refusing to go to school. A very bright girl, she had trouble learning to read in first grade. Perhaps she was expressing her fear of information, of taking in—a manifestation of the capacity to know. Subsequently, she became and was consistently a meticulous student.

This sequence of regressive, urgent demand and need, followed by a sealing over that itself derived from internal resources and resolve, was characteristic. After a brief period of expressing her feelings, A would experience these same feelings as dangerous, unreasonable, and impossible to express. Rather than burdening her parents, she learned to master her need of them. This same trend marked her transference to me. Need was imagined to be dangerous, and she quickly marshaled her resources to guard against it.

The patient's hypercompetence seemed, on reflection, to have served both her omnipotent strivings (she could control everything) and her yearning for normality and stability. The precocious independence that A marshaled at this very early age concealed unmet needs and consequent feelings of helplessness and loss. The vestiges of this were played out in her treatment with me. She presented herself early on as so capable, so reasonable. Moments of merely describing unruly feelings gave way to a sense that she herself was unruly and had to be contained.

Over the course of the analysis, A came to appreciate how deeply her mother's cancer had affected her: "It never really did go away. I was supposed to act like it did, but it never really could. As I was becoming more physical and more in the world, my mother's presence in the world was diminishing. As I was looking forward to developing breasts, my mother had lost hers. As I was beginning to menstruate, my mother was reaching premature menopause. As I was becoming sexual, my mother's sexuality was waning."

This theme was a part of an intrapsychic duet that the patient played out with her mother: the ascendancy of one, the decline of the other; one thrived, the other was depleted. An illustrative example: When A finally decided to leave home, her mother's diagnosis was once again established. This seemed to confirm her sense that her own wishes to thrive and flourish independently could not exist without doing irreparable damage. She also felt the inverse—that her mother's illness could do irreparable damage to her: "I think that's how I felt growing up—that not only was

my mother sick, but *I* was sick by association. You could catch cancer. I felt deprived of a mother and jealous of people who had mothers whose lives were happy and vital. I am afraid of having anyone be real in my life. My existence and her death are connected. I am afraid that people potentially can influence each other that much—I don't want that connection. Distance protects the person from being destroyed and the relationship from being destroyed."

I thought that A could not tolerate experiences that surprised her or for which she felt unprepared. She commented that feelings were dangerous. She monitored her words carefully, adjudicating what could be let in, what must be kept out. Thus, she was able, she believed, to minimize sudden or unexpected occurrences from within or without. She was living her affective life as an equivalent of her mother's unpredictable body: affects were invasive. They had to be guarded against lest they infiltrate and cause her undoing. The element of surprise, which she and I had discussed a great deal, would in fact come to play a crucial part in the analysis of my pregnancies. Neither she nor I was able to foresee this.

The patient fantasized that her mother's womanhood was responsible for her vulnerability to cancer. Being vulnerable, equated with being feminine, increased one's risk. A made various attempts to deny her own femininity and thus to fortify herself against cancer, against surprise, against whatever might penetrate her; this led to a markedly thwarted sexuality. With each recurrence of the cancer, this precarious organization of not letting anything in was shattered. But A would say, in a wan effort to console herself, that she always knew it would return. "I was not surprised," she observed, indicating her resolve to keep at bay all evidence of disturbing knowledge.

She knew in advance what she, in fact, could not bear to know in the present. Knowing about the cancer's eventual recurrence was not *true* knowing, but rather a defensive posture that resisted what could not yet be known. In other words, A's helplessness in the face of what she could not know about her mother's future,

her mother's prospects, led her to *have* to know in advance: knowing so as not to know—a kind of artificial omniscience that staved off real dependency. She believed her mother would be all right, drawing on a fantasy, common enough, an illusion. She could not allow herself to see, to take in, to gain knowledge about her mother's condition or her mother's real coordinates in space and time.

After one year of A's treatment with me, her mother died. The mother's condition had radically worsened over the summer, and she died just after her birthday. Everyone had been drawn together for a celebration. Just after that the party, she suffered massive organ failure, became comatose, and died a few days later. My patient was twenty at the time. She had lived her life both anticipating and eradicating the possibility of this moment.

The First Pregnancy

Shortly after A's mother's death, I became pregnant with my first child. For various reasons, I decided to tell A directly about this news. What I thought at the time was that she had been through a terrible disruption, and I wanted to cushion the further disruption that I imagined my pregnancy would bring. There were doubtless other, more unconscious reasons as well—more about rage, I think, than fragility. In response to my telling her, A blanched. She said, "I don't know which is worse—that you are pregnant or that you have a husband."

I think the patient meant that my being pregnant would allow her to keep feeling that I was hers, but my having a husband positioned me outside her possession and her control. Perhaps the presence of a husband was particularly troubling because it evoked dreadful ideas about my sexual relations with him—fantasies that led her to feel excluded, and that also brought up the dreadful equation *sex* = *cancer* = *death* (which was elaborated in the analysis much later). The presence of a husband evoked fantasies of sexual damage and sexual competitiveness, which at this point she could not tolerate, leading her to prefer the husband's non-existence. She could not contend with the ideas stimulated

by his presence. A husband would inscribe her in an oedipal relation to me, whereas without a husband, she, the baby, and I could constitute an uninterrupted union of our own.

A liked to talk about how she was able to sense the baby growing in the room, something we shared. She assuaged the injury of not knowing about me with the idea that she *did* know, that she would watch it happening and thus be part of it (no surprises here). Thus, during this first experience of my being pregnant, A consoled herself with the idea that the baby was something we were doing together. It was with us, and as such was at least partly, if not wholly, hers as well. Sometimes she felt it was the sibling whom she had wanted. This fantasy was reassuring—for she had always worried that her mother's inability to conceive again had to do with her own destructiveness.

A's response to my first pregnancy stayed at the level of our closeness, a fantasy that guarded against loss (and the hovering, insistent loss of her mother), rivalry, separation—and it guarded her against depressive anxieties about the limits of her access to me. She could see/know the pregnancy because what she inferred from it was not yet threatening to her sense of belonging to me and of my belonging to her. Nor did it arouse the fiery sense of competitiveness or destructive feeling that would come up later.

At this point in A's treatment, I interpreted her fantasies along the lines of how reassured she was by the feeling that she could see the baby develop, how comforted she was by imagining that this was the product of our relationship and that there were no interfering others. Her mother's death was also very much a subject of discussion. In the context of feeling that she knew about my pregnancy, and that what she knew was a source of pleasure and commiseration, A remembered and worked on her childhood reluctance to know information about her mother that might have been available to her. It might be that she was actually only able to know about my pregnancy within the self-proscribed boundaries of what she deemed worthy of knowing. Beyond that, as with her mother, there were various dimensions that of course she could not know—nor could she contend with not knowing.

After about a year, I recommended that A enter a five-day-per-week analysis and begin to use the couch. I suggested this because of the persistent pall over much of A's affective life. Her relationships were limited; her access to her own mind was rigidly controlled. She readily accepted the recommendation and we soon began.

In analysis, A would at times feel stymied about not being able to have me in sight. At this point, her experience of me intensified as feelings of helplessness and smallness began to emerge. This caused her to be vigilantly aware of me—my every movement, sound, or change in tone of voice. All gestures that she could peripherally grasp were carefully put to use.

We often compared the way the patient titrated her experience in analysis to her early dollhouse play, in which, rather than actually playing with the dolls, she obsessively reordered the furniture. In her adult life and in her analysis, knowing and not knowing came into focus as a specific way of managing perception—of monitoring and rearranging the material elements of the analysis, its furnishings, and the shifting elements of her mind. Here we see an illustration of Britton, Feldman, and O'Shaughnessy's (1989) point regarding the need to segregate and split off various aspects of mental awareness due to a frightening fantasy of parental intercourse. A had played with her dollhouse during the time that her parents were together in their bedroom. It was as though she could not bring persons into play, but had to keep elements separate lest they threaten to overwhelm her.

This need to manage perceptible detail was especially prominent in relation to my pregnancies. For A—whose mother's body had been intangible and strange, present and gone, intact and coming apart, revealed and then hidden—the fact of bodily change was disorienting. The subtle changes of early pregnancy resonated with the memory of her mother's cancer-filled body, arousing fantasies of damage, invasion, and greed. Her responses to my pregnancies were a reenactment of her early attempts at omnipotent, omniscient management of her worlds, both affectively and perceptually.

As the analysis proceeded, A entered a state of melancholic detachment and self-blame. She struggled to feel alive in the aftermath of her mother's death. Identified with the mother whom she unconsciously believed she had killed, A was stalled. For the first time in her life, she could not decide on a direction of academic pursuit. Her relationships felt unrewarding. She described herself as "carrying a burden strapped to my back"—the burden of her mother's body, the burden of memory—that she could not as yet engage for fear of dissolving. Remarkably, A had never cried in her analysis.

At around this time, I became pregnant with my second child.

The Second Pregnancy

A preconscious awareness of my second pregnancy came in the early weeks via a series of associations about A's parents' bedroom. At the start of each hour, when A would enter my office, she would find herself awash in the sense of having interrupted me—me at work, me perhaps on the phone with a friend. She felt she was interrupting something and likened it to entering her parents' bedroom, where she often felt unwanted. She said she felt that she was "entering the metaphoric bedroom, and I am jealous, uncomfortable. Don't really know why. I feel I need to decide whether to let myself know my desires, something about what I want. Perhaps what is disturbing to me about you is that I think you know about your sexuality . . . . I know things and I pretend that I don't, and I don't tell you."

Such words, by both their vagueness and portentousness, aroused in me a sense of bewilderment. I felt out of touch with A, with what was really stirring in her, and that I could not make adequate contact. Often I felt sleepy or irritated. I said to her that she seemed to want to enter my room and feel that it was entirely open to her—that, in effect, she could live here with me. She associated to this with a recollection from early childhood. Her parents would close the door to their bedroom—often in the middle of a weekend day. She was told to play by herself. She would

occupy herself for hours (so it seemed) with her dollhouse, arranging the furnishings, presumably to manage the overwhelming feelings she had at that point. I said to her that I thought as much, and also that I thought she was trying very hard here to put her unruly feelings in order so as not to disturb me.

The patient replied that she felt shut out when coming into my room. She wondered what I had been doing behind my closed door. She brought up the subject of pregnancy, remarking that pregnancy is a sign of good health and therefore not disturbing. She told me that she had always believed that her mother's decision/inability—she was not sure which—to have only one child was a sign of her being unwell. She added that she worried that perhaps she had negatively affected her mother's body and vitality.

During this early phase of the pregnancy, A had thoughts about my sexuality (she assumed I was heterosexual) and hers, which at the time was oriented toward another woman. Seeing a male colleague of mine, she wondered if he were my husband. Coming into the office, she would be uncharacteristically unable to meet my greeting, looking away in apparent discomfort. She started one hour by speaking of her mother's body—especially in the days after surgery or chemotherapy. She spoke of her unease in looking at her mother. I commented that she seemed now to be having difficulty looking at me, perhaps at my body. She said, "My mother's body was the measure of everything. I have to cancel out my perceptions—I cannot really look at your body."

A's inability to know was thus present in our work together. In the countertransference, I felt shut out, precisely as she described feeling. I felt acutely all I could not know about A, and felt frustrated and maddened at this experience. Often sleepy, I thought I was struggling against my own sadistic wishes to penetrate into her control over me, a control that I found palpable in her responses to every one of my interventions, with each of her movements on the couch, with her sideways glance that kept me carefully monitored.

I interpreted A's unease about what she might see, what she might know. I talked with her about her conviction that the knowl-

edge she might possess could have dangerous consequences, both for me and for her. Eventually, she began to talk about her suspicion that I was pregnant. She countered this with self-critical remarks about her own lameness and inability to accurately perceive what was around her. She made connections to her mother's body, to its deteriorations, to her mother's sense of pride and privacy regarding her body. She would not permit herself to land on an awareness that I was pregnant, but instead went round and round it. By late in the sixth month of this pregnancy, A was grappling more with her uncertainty about what she knew and could see than she was with pregnancy per se.

At this point, I was saying, "You cannot permit yourself to see my pregnancy, for it seems to set off so many terrible feelings about my potential unavailability to you"—in other words, at this stage my interventions did not countenance her uncertainty, but aimed to analyze it. What made it so impossible to really know what she knew? But each time I would make this effort, A would counter it, reasserting the pregnancy as merely hypothetical: "If you are pregnant, if you *really are* pregnant . . ."

Over the next weeks, A would put forward her knowledge that I was pregnant and attempt to grapple with it, only to become confused and full of doubt. Sometimes she declared, "I can see you are really *not* pregnant!" She was frozen, attempting to monitor and control her world and my world—from the couch, with her little bit of peripheral vision. I felt her wanting to hold me, to freeze me, in a sense, so that none of my actions might thwart, hurt, or surprise her. She needed the pregnancy to be her doing: to declare it real or not real, to determine its power to affect her, and in so doing to not let it affect her. A husband was absent from her associations; she could not yet admit him into her awareness of me. She spoke of feeling that she had to keep everything in; any leaks of feeling could be messy or destructive. She worried aloud, and I concurred that she was worried about the explosive nature of her feelings.

Pregnancy now brought out many of A's ideas about being a woman. She talked about how dangerous it was to be a woman,

how vulnerable to cancer women are. Women have openings, and they can catch cancer; men are invulnerable. Penises protect them. Her mother got cancer because she "did not have a penis to protect her." Cancer was a devouring, contaminating presence; sometimes it was linked to having a penis penetrate into the inside of one's body, while at other times it was linked to oral aggressive impulses and greed. Wanting to take, consume, and possess the mother, as she now wanted to consume and possess me, aroused the unspeakable dread of having destroyed her/me.

It became clear that my pregnancy and my having cancer were confused. Partly, it seemed that cancer, as horrendous as it was, protected the patient from the horrible experience of contending with her mother's sexual life—and from the intense sexual feelings and fantasies that as a girl A had engaged. At this point in the analysis, she was involved in homosexual relationships that were not altogether satisfying to her, but they were less conflicted than sexual relations with men had previously been for her. A's strategy at this point was to keep quiet. She became silent, and when not silent, stilted. It was as though she would not give away her impressions or her insights. Her unspoken words seemed to constitute a private, secret thing that bolstered her against longing, vulnerability, and loss.

Secrets loomed large in her life more generally, even in her work; she said that her writing was a "secret possession," something she "kept inside." She felt cut off, but this was a price worth paying for maintaining the "secret = words = phallus" inoculation that offered her abiding consolation. The secret phallus was her protection, both against cancer and against needing to rival her mother.

My pregnancy destabilized all of this. It was an enunciation of my sexuality, and it put her in contact with her fantasies about coupling more generally. Far from being given to imagine sexual intercourse as a creative, generative endeavor, A at this point saw it as directly linked to bodily damage and demise. She could not acknowledge the pregnancy as mine. Her going round and round, knowing and not knowing, was a way to make it hers. She

had gradually and painstakingly made it her own, incorporating it into a private world where it could not hurt her—it could not exclude, seduce, or threaten. Shutting herself in, not knowing, protected her from this disturbing and exciting awareness of me as a sexual person and from her own feelings of smallness.

Finally, after weeks of going back and forth in her knowing and not knowing, A said poignantly, "I suppose I could just ask you, but I am enjoying the drama of this. I like this cloud of smoke around myself. Everything is confusing, and there is safety in the sense of that. Not knowing—I think that is how I live my life. I think you are pregnant, but I have to think you aren't."

I said, "And somehow, you have to have me not know what you know. This makes it feel much more tolerable, even satisfying, if you are in control."

She said, "You are pregnant, you are having a baby, and I am not part of your family. I cannot say, 'Don't be pregnant. *I* want to be your baby. I want to be your lover—I want to be your husband. I want to be the one who decides if you are pregnant or not pregnant.'"

With this statement, I was aware of a sense of huge relief. With this greater contact between us, it was possible to explore some of what had led to the impasse A felt about knowing. Once again, images of her mother's distorted body, postsurgery and posttreatment, came to A's mind. She felt she could never trust what it was she saw. Did her mother look ill? Was she in fact better? Was it an illusion or a self-delusion? The patient did not feel that she could trust her own perceptual capacities. She likened this to her reactions to my pregnancy. "Just as I am often not sure whether or not you have changed your hairstyle, I was not sure whether your body was different. Maybe you had gained weight. Maybe I just hadn't noticed before."

Once A had happened in on her mother without her wig. She was entirely bald. Subsequently, A was never allowed to see her mother in that state, and consequently wondered if she had imagined it. The same was true regarding her mother's body postmastectomy. She recalled a chest without breasts, but this was too horrific to believe; she preferred to think she had imagined it.

Perhaps A preferred to think her perceptions originated in her mind, were of her own making. It was a relief to believe that she could construct and hence control the painful events surrounding her. But that idea had its own terrors—for if she was imagining her mother's deteriorating state, did that mean that she wanted it? Such questions left her paralyzed with anxiety and dread, unable to get outside her own mental universe and engage the world for what it might offer her. "I didn't want to accept it; I didn't want to live it as real. If I did, it was too much. I couldn't live in the world, see it, and live my own life. I had to avert my gaze. My mother's illness was a blanket thrown over everything, every corner of my life. It is terrifying to think that you have the same effect on me, that this is what comes of really letting you into my life."

What became clearer as we worked to understand the patient's responses was how woven into her perceptions of external reality —my body/her mother's body—was her own sense of bodily instability. What was conveyed were her own wishes to supersede and outlive her mother, her rage at her mother's leaving her—marking her in this way—her sense of an impossible choice that always had to be made between her own survival and the survival of the other, her guilt over her murderous wishes, her sexual possessiveness and rivalry.

The Third Pregnancy

A little over one year later, I became pregnant again. I was concerned with how this news would impact A. I now think I did not think it through fully enough, but I decided to inform A about my pregnancy in the fourth month. I already had an inkling that she was on to something. We had had the occasion of riding up to my office in the elevator together. Though the ride was silent, she was looking at me intently. In her session, she began to talk about the shirt I was wearing, recalling that it was something I had worn the last time I was pregnant. She said, "But I am sure you cannot be pregnant again."

I responded by remarking on A's certainty, and by saying that the idea that I might be pregnant again seemed intolerable. She was in accord with this. By the end of the hour, I had told her that I was pregnant.

Looking back, I suppose *I* could not bear the work of *not* telling A. I suppose I could not tolerate her not knowing and the surprise that another pregnancy would entail. The previous analytic year had been so demanding, and I felt guilty thinking about the consequences of going through this again. I think I felt I was doing both of us a favor—I think I thought it was technically the right thing to do.

Subsequently, I view my decision to tell A just then as an enactment. Of course, I knew (but did not access) that her mother's third diagnosis had been the fatal one. By telling her that I was trying to get around the problem of surprise, I was playing into her need to have me and to be able to control my activity. I think that my telling her may have reflected my own reverse oedipal guilt. Might I have been enacting a dimension of her relationship with her mother, in which she felt she was the mother's true confidante and ally, instead of the father? I think that I might have unwittingly played into A's wish to be special, to privilege my relation with her, in acting in this way.

Initially, A registered relief at having been told. I thought—again consciously—that it was a relief to have me tell her directly, thus avoiding the labyrinth of her doubt. Still, A came to feel that this pregnancy, combined with the others, constituted a betrayal. I now wonder whether my telling her and not giving her the opportunity to find out for herself might have contributed to this experience. The third pregnancy/the third recurrence of cancer—these came together in her mind.

A said repeatedly: "Three children—that is really too much. I can't believe you are doing this to me again." I do not really know that there was any way around this. Had I not told A, she may well have come to the same conclusion that three children were too many.

In retrospectively thinking about my decision to tell A, I have wondered whether I was responding to the kind of pressure that Britton, Feldman, and O'Shaughnessy (1989) describe as often present when entering into a patient's oedipal configuration. Perhaps I was telling her to eliminate the father from the picture—that is, to privilege her relationship to me and mine to her, as though that was all that counted, despite the fact of the pregnancy, which itself insists that there is another. A often did feel herself to be the true love of her mother—that she was preferred to the father, and I wonder if my telling her was somehow in keeping with this belief.

It seems that, without the protective filter of knowing and not knowing, without the comfort of having not been surprised, with the information presented to her directly, A was brought back to the moment of hearing of her mother's final diagnosis. It had happened particularly brutally during the summer before A was to leave for college. She had been away at a summer program. She returned to her house, which was empty; she did not quite know where her parents were. She took a shower, feeling particularly giddy with the upcoming experience of being away and the anticipation of her time at college. The telephone rang. It was her mother's friend. She told A (and this seemed abrupt, a violation) what A was not prepared to hear: that her parents were at the doctor's office because her mother was sick; the cancer was back.

This was how the patient felt about my telling her of the third pregnancy. She had felt sure that the second would be the last. Aren't two children what most people have? Isn't it excessive to have more? Isn't there something wrong with that? Now, as then, just as she was experiencing pleasure in her own future, her own abilities, as well as pleasure/safety in her work with me, this news came as a stunning blow.

A left analysis about one year after the birth of this third child, that is, two years after the initial disclosure of this pregnancy. She decided that she wanted to move back to her home town; she was tired of the demands of life in a different city. She had decided

to pursue graduate work, and the program she was most interested in was there.

It seemed to me that this decision was inspired by an incident that occurred while I was on maternity leave. A saw me on the street. I had my new baby in a snuggly and was with my husband and friends, talking. The image of me—"surrounded," as she put it—was the final straw in what had been a lengthy struggle. In seeing me with baby, husband, and friends, A experienced me as a "unit, complete unto yourself." She felt hurt and betrayed.

She put it this way: "I wasn't taken into account—either with my mother and her choices of treatment, or by you and your decisions to have these babies. I am profoundly affected by it, but powerless and unimportant. I am not wonderful enough to make a difference. I am not factored in. I am left with all these feelings. I never knew how my mother felt. I want to know how *you* feel. The most painful thing about analysis is knowing that you are more important to me than I can ever be to you. It's true with my mother, too; she is dead. I am left. She is not missing me. I feel severed."

She exerted various efforts to have me—as well as others around her—feel the pain that she could not stand. She resorted to various modes of projection and stonewalling, in which her analyst would suffer while she herself would appear icy and calm. She became frightened of her own vindictive feelings. She recalled that when she was small, she never got angry with her mother. Instead, she would orchestrate events that would torture her—for example, hiding her wallet or her keys. She watched as her mother grew frantic. Perhaps this was her way of inducing in her mother the experience of loss and disorientation that she herself was perpetually attempting to master. She wanted reactions; she wanted a sense of control. She wanted access, a way in to those central to her.

In reaction to overwhelming wishes to be *in* me, the patient resorted to "boxing myself in." This sense of being cut off, detached, was perilous, however, and led to associations to her mother's corpse. She felt that she could not survive the intensity of her

wishes for me, that these wishes would kill one of us. She believed that the only way to survive was for her to leave the analysis.

During this time, my interventions had mostly to do with naming A's experience of betrayal and fury—her overwhelming feeling of being helpless, excluded, and alone—as she had felt for so much of her childhood. I talked about her need to have me feel the pain and isolation that she could not quite stand. I did feel acutely shut out at times and maddeningly unable to reach her. I made interpretations about her experience of needing to get back at me, to wall herself in, in order to manage the intensely chaotic and mad feelings that were now coming to the surface.

At around this time, A found a puppy and brought it home to her two roommates. Both were surprised; both felt intensely imposed upon. It was an action that engaged much attention, both in the household and in analysis. The patient thought that she, too, wanted a baby of her own, and wanted to impose it unpredictably on others. Or maybe she wanted the feeling of being the one in control of the environment, as I was, as her mother had been. But A felt toward this puppy a kind of love that she had not felt since childhood, when she had brought home the class gerbil that had died in her care. That death seemed to crystallize into a conviction of her murderousness, especially with respect to her mother and her having no siblings. This was conveyed in a dream in which she acquired a puppy that turned into a lion and ate everything in sight.

In her final year of analysis, A went round and round her decision to leave the analysis with much the same rhythm that had accompanied her coming to terms with my second pregnancy. For several months, I found myself unsure what she would do, whether she was leaving or not. I hoped she would find a way to stay. I did have the sense that she felt she had made up her mind, but was enjoying some satisfaction by keeping me guessing, that it was she who now held the cards.

I interpreted A's wish to leave the analysis in a few ways. I thought that now, for the first time in her life, A was able to acknowledge and to feel very intensely what had for so long been

locked away. I think this was a crucial effect of working through the impact of my pregnancies and their link with her mother's illness. She was also able to uncover a genuine desire to be closer to her father, a desire that was often conflicted while her mother had been alive. But I also think that A could not fully bear to work this through more completely. Leaving restored some sense of her having control, of having the upper hand, which I think was vital to her. She only partially worked through her destructive wishes to hurt me by ending the treatment.

In the final months of her analysis, A dreamed frequently of murder. In one dream: "I found an ATM card and kept it. Then I used it, only to find that the person whose card it was was a murderer, and I knew I was a suspect." This dream, as did the others, conveyed A's sense of having destroyed her mother/analyst by consuming us. Her sense of greed, her wishes to take, were riddled with anxious guilt, ultimately associated with a fantasy of her own murderousness. In the analysis, wishes to have me all to herself were frustrated by her knowledge that I had children. Furthermore, she imagined that I was nursing the new baby, and this infuriated her, causing her to recall that she herself had been nursed only briefly.

A continued her struggle to terminate. She experienced conscious feelings of envy and an urgent need to separate, to flee. In many dreams, I was represented as having a lavish life, and she was a visitor or trespasser in it. She spoke of the guilty wish that her leaving would ruin things for me, and she told me that she hoped my life would be ruined. We spent months in the midst of these tumultuous, explosive, furious feelings that A had always dreaded, had always carefully guarded against. This tumult felt to her like the breaking of her deal with her mother—that she would renounce her fury if her mother would stay alive.

All of this formed the backdrop of her termination. The feeling of time slipping away aroused anxiety that had once been associated with the loss of the patient's mother. As the analysis approached its end, A spoke of not feeling, or of feeling only relief. She entered a period of silence. Gradually, this silence gave way

to expressions of grief and sadness. She cried for the first times in her analysis, and voiced feelings of gratitude.

Just before her final week of sessions, A pierced an eyebrow, causing her to be bruised around the eye. This seemed a strange, concrete marker that emblematized the violence, the literally bruising dimensions of seeing. We were not able to fully analyze all that this piercing meant—but it seemed to have something to do with differentiating herself and with marking, quite concretely, her own existence.

My own sense of loss after the final session was great. In the last hour, A expressed her appreciation of my efforts to understand her without needing to keep her. She gave me a book of her poetry—a harbinger, perhaps, of her recognition that traumatic memory can be transformed into valuable human experience.

CONCLUSION

In this paper, I have hoped to show the ways in which vicissitudes of knowing and not knowing function as a marker of the capacity to tolerate separateness, as well as to engage in the development of the capacity for symbolic, creative thought. This patient, A, used knowing and not knowing to titrate painful, stimulating, initially unacceptable information—in this case, information brought into focus by the analyst's pregnancy. For A, the belief that her analyst was not pregnant provided her with a safety zone, a margin in which she could feel in command of her world. Rather than being assaulted by information, as she had felt in relation to her mother's illness, she found a way to make the information something of her own doing.

As previously noted, Britton (1998) cautioned that seeing is not necessarily believing. This became abundantly clear in my work with A. The fact of her seeing my pregnancy did not in any way guarantee her ability to transform her experience into knowledge. She did not believe what she saw. As though they were pieces of furniture, she could place dangerous mental contents into a far corner of her mind, moving them into fuller view at her own pace.

As Britton (1998) stated:

> Disbelief can be used as a defence against both phantasies and perceptions and it plays a familiar role in everyday life and neurosis, where it is usually called denial. It can also be a manifestation of aversion toward otherness. [p. 13]

My patient's "aversion toward otherness," depicted in her difficulty with knowing, had to do with the threat to her own sanity that otherness produced. The otherness of the other carried with it the catastrophic possibility of loss. Coming to have knowledge of the other was extremely precarious. Could A withstand what she did not already know? Could she tolerate realization of the limits of her knowledge? To do so required her to stand up to the reality of separateness and the limits of her own omnipotent struggle to be one with the analyst.

Relinquishing beliefs involves the ability to mourn one's beliefs. To realize one's beliefs about the other as contrasted with one's knowledge of the other involves mourning. The ability to tolerate one's curiosity about the analyst's life (which means not being able to say, "I already know") involves a necessary blow to one's sense of control over the object and one's wishes to possess him or her.

In encountering my pregnancies, A mobilized different ways of organizing belief and knowledge. She believed that the knowledge she had of my pregnancy was self-promoted, self-regulated. She believed that she could, potentially, either know it or not know it, and each would have equal validity. The point was that she generated this as her belief and her knowledge, refusing to have that reality imposed upon her. With the third pregnancy, when I *did* impose this on her, A's belief (and defensive system) was challenged. In its place was knowledge, a fact, which she had to come to—not on her own terms, as she had been able to do previously, but on mine. This, perhaps paradoxically, served to further the dimension of surprise rather than to eliminate it.

The analysis of the third pregnancy evoked the sort of feeling in A that she had long struggled to detach herself from. She was able to come to terms with aspects of her murderous feelings, and I believe that she was able to work through some of her unresolved mourning of her mother's death. The long-standing stalemate of her melancholy gave way to tumultuous feelings of betrayal and loss, vengeance and attack, and, ultimately, there was gratitude.

I was left with the feeling that things might have gone further, that we might have worked through the issues to the point that the patient could tolerate knowing more about her separateness from me, rather than having to demonstrate it through terminating. At the same time, she had clearly become more able to tolerate knowing her own mind and contending with the awareness that such consciousness entails.

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THE THERAPEUTIC EFFECTS OF THE FREE-ASSOCIATIVE STATE OF CONSCIOUSNESS

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Free association is therapeutically helpful in the regulation of states of consciousness. A person who free-associates enters a particular state of consciousness characterized by increased subjective self-awareness and disregard for reality, together with implicit pulls for objective self-awareness and reality adherence. Free association facilitates the patient's learning to integrate and to shift flexibly among points on these dimensions. Tensions existing in the free-associative state are embedded in a similar tension between free associating and reacting to the analyst's interventions, so interplay between free association and intervention also facilitates regulation of states of consciousness.

A patient who free-associates enters a particular state of consciousness. It is generally understood that free association is therapeutically helpful because it is a route toward exploration and understanding of unconscious resistances, drives, and object relations. In this paper, I will develop the idea that experience of the free-associative state, together with regulation of the interplay between the free-associative state and the more usual state of consciousness, is also therapeutically helpful.

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The therapeutic effects of the free-associative state, and of its interplay with the more usual state of consciousness, are background factors that are operative in all well-conducted analyses, even if they are out of the conscious awareness of both patient and analyst. Understanding these effects can go part way toward explaining why analyses conducted from a wide range of theoretical positions can all be helpful. It is simultaneously both well known and not carefully thought about that analysts of different persuasions all claim success (and generally claim better success than they attribute to analysts of other persuasions). Although I do not believe that "anything goes," I do believe that, at least within a broadly Freudian perspective, analysts may have quite different theories and approaches and still do effective work.

This phenomenon can only partly be explained by assuming that analysts of different persuasions are working with different types of patients. The success of analyses conducted according to different theories indicates that something else is therapeutic in analysis, in addition to what the various theories have been explicit about. I think that the therapeutic effect of the free-associative state of consciousness is part of this "something else," alongside the relationship factors that we are more familiar with considering as the "something else."

Before proceeding, a terminological point: When I write about "free association" and "the free-associative state," I am intentionally writing about ideal points that a patient rarely, if ever, completely reaches. In a broader sense, all of a patient's communications may be considered free associations, and all states of mind that a patient enters during psychoanalysis may be considered free associative, in one way or another (Kris 1996). In moment-to-moment process, patients constantly oscillate between states of mind more characterized by ideal free association, and states of mind more characterized by features of the ordinary state of consciousness. But to guide our understanding and our interventions, it is both necessary and inevitable that analysts have an image of an ideal form of free asso-

ciation (Smith 2004). This helps us to consider for every communication of the patient how and in what ways it is free associative, and for every intervention of the analyst, how and in what ways it facilitates or hinders free association (Kris 1996). I believe that the ideal form of free association that I describe in this paper is general enough to fit with the understandings of most analysts of a broadly Freudian perspective.

Here is a brief clinical vignette to begin orienting us to the underlying effects of the free-associative state: A successful businessman, who entered analysis troubled by frequent anxiety and by inhibitions of aggression and assertiveness that were limiting him both at work and in his family life, muses about how much better he is doing now. "It has to be the analysis that is helping, although I can't fathom how. [Any thoughts?] It can't just be that I'm coming and talking. There are certain themes that keep coming up, like my theory that I'm a delicate flower and how realistic is that, or the question of whether I should feel guilty about feeling angry, so we've gone over those themes a lot and that's helpful, but it's not like I've had the experience of learning something and saying 'Oh, *that's* what my problem is!'—like in a bad movie. It's like a haven. This isn't such a good metaphor, but it's like when I used to travel to Europe, got on the plane and couldn't communicate with anyone, there was no e-mail or telephone, so I could read a book and think some thoughts and just be there. I know that when something is stressing me, I can come here and talk about it."

Although the patient mentions insights and aspects of his relationship with me, he seems to be alluding to something additional in his metaphor about plane flight, something that has to do with thinking and being, and with an awareness that in that moment he cannot communicate with anyone in the standard social ways that interfere with thinking and being. Although insight and relationship factors are part of the experience captured in the metaphor, they are configured in a way that produces a certain state of consciousness.

THE FREE-ASSOCIATIVE STATE OF CONSCIOUSNESS

For Freud, free association was a means to the end of uncovering unconscious meaning. In taking this position, Freud did not recognize the full power of the technique he created. An extension of Freud's metaphor that psychoanalysis is like archeology is apt here: the full meaning of archeological finds can only be determined by their stratigraphic context; similarly, the therapeutic value of psychoanalytic insights is dependent on the contextual state of consciousness in which they occur.

Let us more closely specify the state of consciousness of a person who is free-associating. Freud (1900, p. 102) stated that, when free-associating, a person enters a psychical state that resembles both hypnosis and the state before falling asleep. Additionally, free association was for Freud part of a broader therapeutic method, which also included the recumbent position and frequency of sessions. Ellman (1991) pointed out that Freud's therapeutic method was designed to engage the patient in an altered state of consciousness that facilitates therapy.

Frequency of sessions and recumbency are synergistic with free association in producing an altered state, but I will focus in this paper on free association because it is the most crucial of these technical procedures. For Freud, the rule to free-associate was the *fundamental* rule. A therapy in which a patient uses the couch four or five times per week, but in which there is no concern that the patient speak freely, looks less like a psychoanalysis than does a therapy in which the patient sits up and/or comes less frequently, but aims to speak freely. Sitting up, or meeting less frequently, decreases the distance between the free-associative state of mind and more usual states of mind, but does not eliminate the difference.

Here are two quotations from Freud describing free association and the fundamental rule:

> Ordinarily you rightly try to keep a connecting thread running through your remarks and you exclude any intrusive

> ideas that may occur to you and any side-issues, so as not to wander too far from the point. But in this case you must proceed differently. You will notice that as you relate things various thoughts will occur to you which you would like to put aside on the ground of certain criticisms and objections. You will be tempted to say to yourself that this or that is irrelevant here, or is quite unimportant, or nonsensical, so that there is no need to say it. You must never give in to these criticisms, but must say it in spite of them—indeed, you must say it precisely *because* you feel an aversion to doing so . . . . So say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside. Finally, never forget that you have promised to be absolutely honest, and never leave anything out because, for some reason or other, it is unpleasant to tell it. [1913, pp. 134-135]

> The treatment is begun by the patient being required to put himself in the position of an attentive and dispassionate self-observer, merely to read off all the time the surface of his consciousness, and on the one hand to make a duty of the most complete honesty while on the other not to hold back any idea from communication, even if (1) he feels that it is too disagreeable or if (2) he judges that it is nonsensical or (3) too unimportant or (4) irrelevant to what is being looked for. [1923, p. 238]

Freud specified that whether or not something is nonsensical, unimportant, or irrelevant should have no influence on the associations. Thus, the patient must disregard whether his or her thoughts are instrumental or attuned to reality. Freud's descriptions also show that the free-associative state establishes a unique and subtle interplay between what Bach (1994) has called subjective and objective self-awareness. Bach stated:

> Here we can be either totally lost in our own subjective awareness and oblivious to others and to our location in time and space, or we can be acutely aware of observing

> ourselves as if we were another person, sometimes to the extent of losing the sense of our own reality. Normally we are engaged in a dialectic between these two poles, a dialectic dependent upon and appropriate to circumstances. [pp. 101-102]

In the quotations from Freud, we see that on the one hand, the patient is to observe him- or herself attentively and dispassionately. On the other hand, this self-observation is to take place without a critical/evaluative dimension, and is to disregard factors such as purpose and rationality. Thus, it is a self-observation that lacks both superego and ego components that typically accompany objective self-awareness. In fact, it is a type of self-observation that discourages attention even to the fact that it is the self that is being observed.

To further complicate the picture, free association involves two other features that pull strongly for objective self-awareness, but, by mutual agreement between analyst and patient, are "bracketed" or pushed into the background. One of these features is that free association is reported to an other—the analyst—potentiating objectifying thoughts about how the associations will be understood or received. The other feature is that even though the patient is admonished not to be concerned with whether the associations are relevant to what is being looked for, this admonition is only necessary because in fact something *is* being looked for—therapeutic help. Freud (1925) stated that free associations are not truly free because they are always under the influence of the analytic situation.

Thus, patients are always to some extent both subjectively and objectively self-aware, and they are always oscillating among degrees of relatively subjective self-awareness and degrees of relatively objective self-awareness. The free-associative state of mind is shifted toward subjective self-awareness as compared to ordinary consciousness, because elements of objective self-awareness are "bracketed" or implicit.

This shift toward subjective self-awareness is what my patient quoted above was noticing in his experience of just thinking and being there. But the elements of objective self-awareness are still powerfully present in their "absence," as in my patient's *awareness*

that while on the plane, he could not communicate by e-mail or telephone. These elements of objective self-awareness introduce tension into the free-associative state, tension that ranges in intensity from a preconscious glimmer to anxiety strong enough to disrupt and make at least temporarily impossible the free-associative state. The intensity of this tension rises and falls according to both momentary and characterological features of the patient, as well as behaviors of the analyst.

Patients may modulate experience of the free-associative state by orienting themselves more toward subjective or objective self-awareness. A patient's emphasizing one or the other of these is often taken as evidence of a resistance against unconscious drives, object relations, or affects. For example, a heightened worry about the listening analyst's opinion may signify a superego resistance; heightened concern with whether something is or is not therapeutically relevant may signify intellectualization and avoidance of emotion and experiential immediacy. Alternatively, pushing awareness of the analyst and of therapeutic goals entirely out of mind may signify histrionic or narcissistically grandiose defenses.

I suggest that all these resistances not only protect against unconscious drives, object relations, and affects, but at the same time protect against experiencing alternate states of awareness. Experiencing the analyst as a punitive superego prevents subjective self-awareness; pushing the presence of the analyst out of mind defends against looking at oneself objectively, whatever the specific conflict may be.

THERAPEUTIC EFFECTS OF THE FREE-ASSOCIATIVE STATE

As I described above, tension is inherent in the free-associative state because it involves intensified subjective self-awareness and disregard for reality and instrumentality, and at the same time includes, in the forms of the presence of the analyst and the desire for therapeutic gain, bracketed pulls toward objective self-awareness, reality adherence, and instrumentality. Although these factors are

bracketed during free association, they remain as powerful background influences.

Therefore, the experience of free association is in and of itself therapeutic because it gives the patient the experience of managing the tension and potential transition among states of relatively objective self-awareness and reality adherence and states of relatively subjective self-awareness and disregard of reality. Bach (1985, 1994) argued that difficulties in regulation of self-states, and transitions between self-states, are central aspects of many narcissistic disorders, so that a crucial aspect of therapy is to help such patients attain better self-state regulation. One way this is done is by creating conditions during sessions that help patients manage transitions between states of consciousness (Aron and Bushra 1998; Bach 1985, 1994); these conditions include creating space for free association.

Although careful regulation of the oscillation among states of consciousness is most central in treatment of the narcissistic disorders, it is also important for patients who are not primarily dealing with narcissistic issues in that moment. Subjective self-awareness and tolerance of ambiguity, objective self-awareness and relative certainty—each pair is an aspect of the human condition that is more or less appropriate to different psychic moments (Bach 1994). Each is involved in developing a different aspect of self experience: subjective self-awareness develops and strengthens the sense of agency, of being a free center of initiative; objective self-awareness develops and strengthens the sense of the self as embedded in and responsive to the object world.

Each pair of qualities may involve both gratification and suffering. Subjective self-awareness and tolerance of ambiguity may involve dimensions such as absorption in the moment, expansiveness, disregard of the needs of the object, grandiosity, omnipotence, and isolation. Objective self-awareness and relative certainty may involve dimensions such as regard for the needs of the object, realistic assessment of self and other, accurate performance, caution, and low self-esteem or concern about failure.

Since each of these states develops a different aspect of self-experience, and each has potential for gratification and for suffering,

each may be sought or defended against, and each may defend against the other. Loewald's (1951) ideas about two potential relationships between ego and reality clarify this dynamic. Loewald pointed out that Freud's, and subsequently psychoanalysis's, standard view of the relationship between ego and reality is one of conflict and threat: the ego arises out of conflict with reality, and continues to experience reality as a demanding taskmaster. But Loewald amusingly pointed out that in taking this relationship with reality as a given, rather than as only one possibility, psychoanalysis was taking as a given the reality of the world view of an (obsessional) neurotic—the defensive stance that reality is separate, alien, and hostile. Within Freud's writings, although less prominent, is the understanding that ego and reality are originally one—what Loewald understood as the state of primary narcissism—and that after they separate, ego and reality can retain a loving affinity.

Bach's ideas about self-awareness, and Loewald's ideas about ego and reality, appear to be getting at different aspects of the same phenomena: Bach at the level of self-experience and Loewald at the level of psychic structure formation. In the defensive relationship with reality, one is in a state of objective self-awareness; in the unified relationship with reality, one is in a state of subjective self-awareness. Objective self-awareness, together with concern for reality and instrumentality, is a normal, everyday manifestation of the objective relationship between ego and reality; subjective self-awareness, together with unconcern for reality and instrumentality, is a normal, everyday manifestation of the undifferentiated relationship between ego and reality.

Loewald described a dynamic relationship between these two poles of relating to reality, and I think this dynamic comes alive in the experience of tension between states of relatively subjective self-awareness/unconcern with reality and states of relatively objective self-awareness/concern with reality during free association. (Loewald, like Freud, uses the male Oedipus complex as the paradigm for a relationship that is differentiated and competitive; for my purposes, it is the qualities of differentiation and competition that are important, rather than specifically the male Oedipus complex.)

Loewald stated that just as the ego needs to defend itself from reality and from the castrating father, the ego identifies with the father as a source of differentiation, strength, and protection from engulfment in the mother and primary narcissism. And just as the ego longs for a libidinal relationship with reality and with mother, and can use this to defend against alienation and the father, the ego dreads engulfment in primary narcissism. The danger of too much primary narcissism is a loss of reality, whereas the danger of too much differentiation is a loss of object relationships. The free-associative state of consciousness provides the opportunity to experience and regulate shifts between these pleasures and dangers.

As an illustration of free association being experienced as a loss of reality that was both wished for and feared, consider a patient who dreamt that she talked and talked on the couch until she fell into a trance and could not stop talking. Many factors contributed to the dream, including her wish/fear to surrender to me sexually, her wish/fear to stay with me forever, and her wish that I would direct her and fear that I would manipulate her. But most immediately, in her experience, were her excitement and fear that in the previous session she had spoken more freely than usual, without constantly monitoring me as a potential critic.

FREE ASSOCIATION AND PLAY

Psychoanalytic free association is unique, but it shares important qualities with the state of consciousness a child enters during play. Because a child's naturalistic play can be "therapeutic," and a child's play during psychoanalysis can be directly therapeutic even without interpretation (see below), the commonalities between the free-associative state and the state of mind of a child engaged in play illuminate the therapeutic effects of free association. An assumption of continuity in development supports the idea that the playlike qualities of adult free association may be therapeutic even without interpretation.

The commonalities between the free-associative state and the play state include both the disregard of instrumentality and reality,

and the shift of self-awareness in the direction of subjective self-awareness. Winnicott (1968) conceptualized play as naturally developing out of earlier transitional phenomena and as occurring in transitional space. A central quality of transitional phenomena is that the questions of "Is it real or not real?" and "Is it me or not me?" cannot be meaningfully asked, because both answers are simultaneously true and not true. As described above, a free-associating adult is similarly in a state of consciousness characterized by disregard of whether something is realistic, relevant, important, nonsensical, or unpleasant, and where subjective self-awareness is prominent but in tension with bracketed objective self-awareness. Indeed, Winnicott (1968) extended his concept of a transitional play space from child analysis to adult analysis, and believed that at any age, genuine change had to emerge from mutual play between analyst and patient.

Steingart (1983) drew a developmental line between play and adult ego qualities that are involved in free association. In normal, healthy play, the child is able to pleasurably and flexibly symbolize his or her thoughts and feelings. Steingart sees this type of play as a developmental forerunner of adult verbalization that flexibly symbolizes the object of discourse. "Pathological play" is play that does not effectively symbolize, but remains psychically very close to the thoughts and feelings concerned. Such play is rigidly maintained, both in that the particular content of the play is not varied, and shifting from the play state to a state attuned to consensual actualities is difficult. Steingart understands pathological play to be a developmental forerunner of adult needs for enactment rather than verbalization. Thus, normal play is a forerunner of ego qualities that are a part of free association, and pathological play is a forerunner of difficulty in free associating.

One way of understanding the therapeutic process in child psychoanalysis has been analogous to understanding adults' free associations as useful in providing data for interpretation and insight: that is, the child's play is recognized as providing data for interpretation and insight. In child analysis, however, the limitations of verbal interpretations when compared to those of adult analysis, due

to the child's developmental level, are well known (Rees 1978). Furthermore, play is easily recognized as a natural childhood activity that serves developmental ends (Abrams 1993; Neubauer 1987, 1993). Therefore, the supplementary understanding has been developing that play itself can be directly therapeutic, even prior to interpretation, and that in some situations, interpretation can even get in the way of the therapeutic effect of play (Cohen and Solnit 1993; Mayes and Cohen 1993; Rosegrant 2001; Scott 1998; Winnicott 1968; Yanof 1996).

I have previously argued (Rosegrant 2001) that the above understandings of why children's play is therapeutic, while accurate, do not go far enough in elucidating how psychoanalytic play is therapeutic, because psychoanalytic play can be therapeutic even for children who are not helped by naturalistic play. The analytic play state introduces tension into the transitional experience that is typical of play, while providing the opportunity to resolve this tension in enhanced transitional experience. In transitional experience, the internal world and the external object are not clearly distinguished. During analytic play, the psychic power of the internal world is intensified via transferences and displacements, and the psychic power of the external object is intensified via the play taking place with a special, important grown-up—the analyst. The resulting heightened tension between internal and external may be resolved through mutual play. Such enhanced transitional experience may be therapeutic in its own right, and may facilitate numerous other therapeutic functions of play. For children who have difficulty creating transitional experience, the heightened tension between internal and external realities motivates greater development of this capacity.

To summarize this brief review of the relationship between free association and play: free association is on a developmental continuum with play, and the free-associative state of consciousness, like the state of a child playing during psychoanalysis, takes place in transitional space. Both are characterized by a relative disregard for reality and a shift toward subjective self-awareness that nevertheless continues to oscillate with objective self-awareness. When we ask

our adult patients to free-associate, we ask them to do something playlike. And free association for adults, like play for children, provides space for managing tensions between self-states, and therefore has therapeutic value beyond its value in leading to interpretation.

THE EFFECTS OF THE ANALYST'S INTERVENTIONS ON THE FREE-ASSOCIATIVE STATE OF CONSCIOUSNESS

Interventions tend to engage a state of consciousness that is more objectively self-aware, and less tolerant of ambiguity, than is the free-associative state. Therefore, the tension between subjective and objective self-awareness that is found in the free-associative state is embedded in a larger tension between the relatively subjective self-awareness of free association and the relatively objective self-awareness of response to the analyst's interventions. How the analyst intervenes influences how and to what extent the patient resolves the tension inherent in the free-associative state. The analyst by necessity behaves paradoxically in regard to the value of the free-associative state. On the one hand, the analyst encourages the patient to enter this state; on the other hand, with every comment, the analyst is interrupting this state. Thus, the analyst's choice and timing of intervention contain a commentary on the value in that moment of the patient's particular narcissistic equilibrium. Interventions also require or encourage the patient to make an adjustment of that equilibrium.

Interventions, compared to the free-associative state, always pull toward objective self-awareness because they serve as a reminder that there is another person in the room, with a viewpoint external to the patient's. This shift in state can be seen most dramatically in patients who find such a shift painful. For example, during a period of her treatment, a woman patient could not tolerate silence on my part, but also found any discrepancy between my thoughts and hers agonizing. We reached a point where this agonizing discrepancy appeared to inhere almost exclusively in the fact that *a person*

different from her was having the thoughts, rather than in any discrepancy in the thought contents, because even if I said to her precisely what she had just said to me, she would wail, "No, no, no, how can you say that?! It's not like that at all!"—with no apparent recognition that she had said the same thing.

Furthermore, interventions shift a patient toward objective self-awareness in the moment, even when their purpose and eventual effect (as with good resistance interpretations) is to help the patient associate more freely—to engage in more subjective self-awareness. Sterba (1934) described the necessity in analytic therapy of helping the patient develop a dissociation in the ego between an experiencing part and an observing part, and then strengthening the observing part. This part is then able to develop judgments about the meaning of one's own behavior. Sterba explicitly compares this newly dissociated observing ego to the superego, which makes its capacity to enhance objective self-awareness even clearer. Sterba's clinical example is of a patient who was unable/unwilling to free-associate, due to her need to defend against a positive transference. As a result of her increased ability to observe this resistance subsequent to his interpretation, she began to associate to emotionally charged fantasies and memories. Nevertheless, the moment of interpretation itself was located in objective self-awareness, and served to increase objective self-awareness, as Sterba emphasized.

We have some control over the extent to which our interventions cause the patient to shift into objective self-awareness. In two classic papers, Lewin (1954, 1955) explored the similarities between the analytic situation and sleep/dreaming. These papers are particularly relevant to my thesis because dreaming is a state of consciousness with a high degree of subjective self-awareness and disregard for reality and instrumentality. Lewin conceptualized the free-associating patient as similar to a sleeper or dreamer, and stated that an interpreting analyst always serves as an awakener. But Lewin also stated that the analyst's interventions may serve to soothe —to move the patient toward sleeping/dreaming—as well as to awaken. I believe that this seeming contradiction results from the fact that all verbalizations of the analyst immediately increase ob-

jective self-awareness by pulling the patient toward awareness of the analyst as a person with separate intentions, but that some of these verbalizations (like Sterba's cited above) may be designed to enhance subjective self-awareness in the slightly longer term.

Lewin stated that resistance interpretations can be seen as soothing the patient because they help the patient understand that free associating is safe, whereas id interpretations are more purely awakening because they involve telling the patient about something that will alert his or her ego to the possible need for defense. I think that whether an intervention soothes or awakens is less a function of its being directed toward the resistances or toward the id than it is a function of how close the analyst stays to the patient's experience. Considerations such as tact, timing, dosage, using the patient's words, and not moving beyond what the patient can understand—all usual parts of Freudian technique—are helpful not only because they further insight, but because they optimize shifts between the free-associative state and more objectively self-conscious and rational states—that is, good timing takes into account when and to what extent to facilitate such a shift.

I think that attitudinal elements are also very important in keeping brackets around the presence of the analyst. A stance of striving for empathy (Kohut 1984) and mutuality (Aron 1996) is more soothing in Lewin's sense than is a stance that emphasizes the differences between patient and analyst, or emphasizes the analyst's more accurate view of reality or of the patient's psychic life.

TECHNICAL SUGGESTIONS

Ordinary, good Freudian technique has always been responsive to these aspects of free associations, but without keeping them explicitly in mind. Having them explicitly in mind can make it easier to recognize potential problems and advantages of intervening at a given time in a given way. I have the impression that our technical literature is biased toward the importance of "awakening" interventions, emphasizing what we do or say that has an immediate effect on the patient—demonstrating our impact. Greater appreci-

ation for the complementarity of the free-associative and more usual states of consciousness can lead to greater appreciation of technique that is "soothing," as well as of how we help the patient integrate these states.

To elucidate how our choices to "awaken" (to encourage objective self-awareness and rationality) or to "soothe" (to encourage subjective self-awareness and disregard for rationality) come into play with every intervention, let us look at three clinical vignettes. The first, from my practice, illustrates the value of this viewpoint when working with patients who are unable to associate with much freedom. The other two, from the work of Paul Gray and Evelyne Albrecht Schwaber, show how this viewpoint can help us understand work with patients who are able to associate more freely.

A Patient of Mine: Carly

Carly was a divorced editor and essayist seen in four-times-weekly analysis. From the beginning, treatment involved her closely monitoring my behavior for signs of "countertransference" (her word). She often praised me for how much more helpful, straightforward, and respectful of boundaries I was than her therapists had been in previous failed treatments. At moments when she observed countertransference, however, she would accuse me of it over and over, and demand that I do something to restore the earlier treatment equilibrium.

What Carly experienced as countertransference were comments or silences on my part that she felt challenged her way of understanding an interaction. For example, one time after she spoke about confronting a colleague for his rude behavior, she became momentarily silent and then began berating me for also being silent, when I must have known that she needed me to validate her behavior, since it had occurred in the context of our discussing over several weeks her inhibition of anger and assertiveness. Maybe I thought her confrontation of the colleague had been crazy and inappropriate. In these situations, any attempts on my part to encourage the patient to explore her feelings and fantasies met

with contemptuous accusations that I was imposing my reality on hers, in a way that repeated what she had experienced in all important relationships, with her boyfriend, her ex-husband, her father, and especially her mother. These impasses yielded only when I stated in some way that my behavior had come from something in me, and had not solely been determined by Carly—in her words, that it was not all her fault.

In the example described, I stated that it was true that something in me had contributed to my not speaking in a way that would have been helpful. The first times we had this type of interaction, Carly interrogated me as to what specifically my countertransference had been, but was relieved by my saying that although I needed to think that through, I did not think it would be helpful for me to reveal it.

Carly's pinpointing of countertransference problems gradually lessened, and simultaneously she began gradually to talk about how much I meant to her. She felt blissful when she thought about me between sessions, and she especially felt blissful during sessions. If we were misattuned, she usually no longer demanded that I confess to countertransference, but she would talk about needing to drink alcohol or to exercise to the point that she caused herself pain, instead of depending on me. On rare occasions, she did drink heavily or exercise until she vomited or strained a muscle. The drinking relaxed her from stresses, somewhat as my good influence relaxed her, whereas the physical pain relieved her feeling hopelessly enmeshed in feelings for me.

She began to muse about how nice it would be if I would sing to her from time to time. My singing would maintain contact with her, and would be the kind of thing that she never got from her befuddled mother. One day, Carly said that, although she knew I could not sing to her, it gave her comfort to think that I *wanted* to sing to her. She then said that she needed me to say that I wanted to sing. When I asked about the importance of this, she said that it would make her feel special and vibrant. She did not want to explore more; my questions were once again a way of my imposing my reality on her.

Carly demanded with more and more urgency that I tell her I wanted to sing to her, saying that she knew I wanted to do so. She sometimes yelled about how important it was, sometimes wept silently. She also demanded to know why I would not answer. Encouragement on my part to talk about what the singing might mean, why it had become so pressing now, if our impasse was a reliving of something, resulted in her saying that she did not know. I interpreted that she was re-creating past experiences with depriving people, and that she was trying to induce in me the helpless, controlled feelings with which she struggled. Carly said these interpretations made sense, but at the same time were irrelevant and pained her. Nor did sympathetic comments about her suffering help. The one comment that seemed to engage Carly enough for her to reflect upon it was when I simply explained that I would not answer that question, that I wanted to help her and did not think such an answer would be helpful. Carly said that she disagreed with me and she might have to quit analysis, but she seemed less frantically anxious. We cycled through such interactions several times.

Carly then said that she was no longer sure if I wanted to sing to her or not, and described this uncertainty as quite painful. If I would not answer whether I wanted to sing, I had to at least explain which analysts I read to justify my approach. She had done enough reading in psychoanalysis to know that self-disclosure is advocated by some. Would I be willing to read and discuss with her articles that she suggested? By now it was clear that exploration in the moment would be unproductive, so I simply explained that I thought this kind of engagement would also be unhelpful. Again, Carly yelled and wept. But after a briefer time, she became quieter, and said that as misguided as I was, she could see that I wanted to help.

Gradually, Carly's demands that I state that I wanted to sing to her, or that I discuss theory around this issue, dropped away. She never directly explored the meaning of her demands, or why they became so urgent when they did. But rather than returning to her previous style of relating, she began approaching something much more like free association as usually conceived. She more flexibly

shifted back and forth in her associations between current extratransference material, feelings about me, and memories. She began to associate more deeply to dreams. She began to tolerate painful affects for longer periods of time. At the same time, I began to feel that I was no longer under such intense scrutiny, that I was not being held to impossible ideals of tact, timing, and attunement in my comments or silences, that failures on my part would not result in attacks on me or on Carly herself.

Carly also made gains in her life over the next months that were very important to her. One of her major complaints had long been a pervasive feeling of befuddlement, which she also identified as a quality of her mother's. In particular, Carly felt befuddled about what her boyfriend needed from her, with the result that their interactions were often strained and unsatisfying, and about her writing, so that she had been blocked in her writing for some time. She now began to report greater clarity of thought—not always, but enough so that her boyfriend began to make sense to her and they had more fun together, and so that she was able to publish a well-received article. Many unresolved issues remained, but the period of analysis described above appeared to have been a turning point.

My interventions that helped Carly during this period may be understood as attempts on my part to strike an optimal balance between soothing and awakening her. At the beginning of treatment, Carly was unable to associate freely because she so readily experienced states of persecutory objective self-awareness that she could not let down her guard and immerse herself in the process. At moments when she experienced me as seeing reality differently than she did, she felt that I scorned her viewpoint, leading her to demand that I acknowledge that my reality did not represent pure objectivity. Subsequent developments indicated that, in addition to a reliving of one aspect of early experience, this constituted a defense against intensely longed-for but frightening states of subjective self-awareness—her blissful period.

However, interpretation or exploration of this or any other possibility was not what moved us along, because it was experi-

enced merely as another imposition of my reality. What moved us along was my acknowledging some personal responsibility for the misattunements, together with not specifying what my personal issues were. I see the acknowledgment of my partial responsibility as a soothing intervention, since it somewhat lessened the patient's feeling that I was persecuting her. Not specifying my personal issues was also soothing, or, more precisely, was a refusal on my part to awaken her by becoming too "real" an object.

Carly's struggle with soothing and awakening continued during the period when she found me and the analysis a blissful environment, but were not played out as directly with me. Instead, she used alcohol to soothe herself, and exercise to the point of pain to awaken herself—since painful exercise freed her from being so glued to me.

These issues then were enacted on a deeper level with me in the form of demands that I say that I wanted to sing to her, followed by demands that I engage in theoretical discussions about my refusal to do so. Her wish that I would want to sing is readily seen as a wish for me to want to soothe her, especially as she talked about it as the kind of soothing that her mother never gave. My sense was that, in addition to more traditional reasons to preserve neutrality, telling Carly that I wanted to sing to her would have been overly soothing, a collusion with avoidance of states of objective self-awareness. On the other hand, telling Carly that I did not want to sing to her would have been a devastating confrontation of her fantasy—an overly abrupt awakening. Carly's ensuing painful uncertainty about whether or not I wanted to sing showed tension that resulted from her simultaneous holding of objective and subjective self-awareness about this issue. Carly then asked me to move with her into a more purely objectively self-aware state by discussing theory. In addition to more traditional reasons not to engage in theoretical discussion, to do so would have been too awakening, confirming me as an alien and nonsupportive presence. It was as if Carly first demanded a lullaby, and then demanded that I completely awaken her—and my job was not to collude with either wish.

The changes wrought in this period of analysis did not result from interpretation and insight, and, in fact, interpretation of the relevant issues seemed to be too awakening, too much an imposition of my reality. At best, interpretations made sense to Carly but were irrelevant and pained her. Interpretation leading to genuine insight requires a comfort in state shifts that allows something approaching free association to take place. Because what occurred during this vignette was relatively independent of interpretation leading to insight, it both shows a way of regulating state shifts to help the patient develop the ability to associate freely, and highlights how regulation of state shifts can be helpful even without interpretation leading to insight. In more standard periods of treatment, insight and state regulation are intertwined.

Gray's and Schwaber's Patients

Now let us turn to vignettes from Paul Gray and Evelyne Albrecht Schwaber, showing their work with patients who were more comfortably able to free-associate. Choosing these vignettes allows me to show how the concepts of awakening and soothing are important in understanding a wide range of clinical work within the broadly Freudian tradition. Gray and Schwaber are highly respected psychoanalysts who have directed our attention to the importance of careful, moment-to-moment clinical listening. Yet significant differences in their stances will be readily apparent—Gray is more of an awakener, and Schwaber more of a soother.

First, Gray (1994):

> Near the end of an hour, a woman permitted a new, less guarded level of recall and reexperiencing of resentment against a brother . . . . She recounted an episode during which she had observed an inappropriate, "crazy" behavior of her sibling. With this material, an edge of bitter resentment emerged. Although her memory had reached a new degree of vividness, she finally interrupted the flow with a form of defense—in essence, a reaction-formation, consisting of breaking off the description of the sibling's provocative behavior and moving quickly to recall instead

> the sibling's sad remorse subsequent to his behavior. This latter recollection was accompanied by a feeling of sympathy, rather than the previous growing resentment, and did not provide the analyst with any further disclosure of the bizarre, perverse cruelty of the sibling. The analyst then intervened to point out how the sympathetic feeling she was experiencing *now*—although also a part of her relationship with her brother—had come to mind in this instance and in a familiar way, interrupting her recall of the behavior she had described as "crazy." He pointed out further that the resentful feelings had vanished. The analyst drew her attention to the implied risk associated with the presence of the listening analyst, had she continued to pursue the original train of thought, imagery, and feeling. . . .
>
> During this particular hour, however, her resistance was especially heightened because of an approaching, longer than usual weekend interruption, and she regressively gave up some of her previously gained observing ability. Instead of exploring what had occurred during the hour, she continued to insist that her brother had "in fact" not "meant" to behave so badly and should have been better treated by those about, including the patient, and that further there was nothing more that had happened. "That was all."
>
> In view of the heightened resistance of this analysand, the analyst could have made a less burdensome, more useful choice of surface by selecting and speaking only about her need to stop exposing the observed details of the sibling's egregious and bizarre behavior she had always kept in protective secrecy. Alternatively, he might have spoken only about her need to stop aggressive feelings that were mobilized in relation to the traumatizing events she was recalling and describing. In other words, it would have been more useful if the analyst had referred to one defended derivative at a time, rather than to two. [pp. 79-80]

And here is a vignette taken from Schwaber (1998):

> I had a patient who would "whistle in the dark," smile when she spoke about subjects that seemed hard or painful. I

asked about this apparent discrepancy, and as she reflected on it, we learned then of the many ways she had found to feel cheerful; it was for her a *modus vivendi.* She loved flowers, especially those which are longer lasting and most brightly colored—with "spectacular blooms." One time, before she was to leave on a winter vacation, she dreamed of growing her plants in a greenhouse, so that even in the cold, they might bud and flower . . . .

And so, I could try to help my patient see how, in repeated, conflict-laden moments, stirred perhaps especially before a separation, she would take on a more cheerful state, her lifelong defense. One day, she told me a dream about moving into a house that was being painted.

> *I said to this woman that I want the color of this room to be yellow. The woman said "yellow?" I said, "Yes, because the other room was blue." The woman said she'll take white and add little bits of yellow.*

The patient associated to "the whole feeling of blue versus yellow, and your parceling out yellow in microdrops; that's a feeling from my mother . . . . Why, when I cry, do you not see that as potentially a defense against feeling good? Why is only the good feeling a defense?"

One time, speaking with eagerness and excitement, she told of plans for her forthcoming rafting trip. This was to take place before a summer interruption; I knew how hard it was for her when we didn't meet, and so found a way to bring this up . . . . She felt devastated. There I was (again) not appreciating her pleasure in this anticipated adventure . . . .

Gradually, she came to show me . . . how I had almost naturally brought up the defensive aspect of the cheerful and the good-humored . . . . It was not that I was mistaken in pointing to it, or in understanding that she needed to address this issue further, but I did tend to go . . . to the defense first, putting a damper on her liveliness (and perhaps also, her sense of autonomy) in keeping with my clinical stance. Wittingly or not, I was enacting a recreation of her mother . . . .

> Perhaps my tendency to highlight defense in the patient's playful manner when the content was more complex—however much the pull on me may have been evoked by something in her character—also reflected an aspect of my own character . . . . We speak of our interest in fantasy, but how much do we value its fanciful components? Something in me was moved that would not have been so if all I saw was what I had already seen: retreat from pain, anger, or conflict. Listening to what she was telling me about me, I had discovered another way of thinking about the matter—and about myself: how can we help sustain a patient's life-affirming pulls while yet recognizing there may also be defense? [pp. 645-648]

Before continuing, I want to emphasize that in the discussion that follows, I am referring only to the positions put forward in the particular vignettes that I have quoted, and I am not drawing conclusions about how Gray and Schwaber work more generally. Indeed, I consider both Gray and Schwaber to be effective analysts, and as I will point out, an effective analyst must have (to some extent) both the qualities that I have picked these vignettes to illustrate.

Gray's work is perhaps the epitome of technique designed to develop an objectively self-observing ego. Gray (1994) has written cogently about how to focus interpretive effort exclusively on the interpretation of resistances. For him, the target of analytic interventions is exclusively the patient's moment-to-moment presentation of material, and specifically the changes, breaks, or lacunae in this presentation that manifest the operation of resistance. This is well illustrated in the foregoing example of his work.

More usual Freudian technique interprets preconscious drive derivatives as well as resistances; Gray critiqued this approach by stating that interpreting drive derivatives amounts to suggestion, because drive derivatives cannot be truly understood until resistance to them is interpreted, and they will automatically push themselves into consciousness after resistance has been adequately interpreted. In terms of self-awareness, this technical shift makes the analyst's role more exclusively one of breaking the subjective self-

awareness of the free-associative state, and interacting with the patient only in moments of unambiguously objective self-awareness. The illusions that what the patient is observing is not him- or herself, and that the experience is purposeless, are broken. This is true even though Gray clearly intends his interventions to help the patient associate freely.

Perhaps this point can be made clearer by extending Freud's metaphor that free association is like gazing out the window of a train, reporting what one sees. Interpreting a preconscious drive derivative that a patient has shied away from is like saying to the train passenger, e.g., "In those trees over there is an ape." (I am borrowing the ape metaphor from a patient who used it to signify something simultaneously startling, disruptive, dangerous, exciting, and comical.) Interpreting the resistance alone is like saying, e.g., "Did you notice that you turned away from those trees?" An interpretation referring to both resistance and drive derivative might be "You turned away from those trees because you glimpsed an ape that startled you."

The first interpretation maintains a gaze outside the window, whereas the second draws attention directly to the passenger in the compartment; the last example points inside and outside the compartment at the same time, and thus is intermediate in its position vis-à-vis objective and subjective self-awareness. Therefore, an exclusive reliance on the type of intervention advocated by Gray may be seen as a particularly strong shift of the interplay between free association and more usual objectively self-aware states of mind, in the direction of objective self-awareness. In Lewin's terms, Gray is an awakener.

The vignette from Schwaber (1998) illustrates a style of working that is oriented toward staying as close as possible to the patient's experience and the patient's point of view. Note that this is not the same as staying close to the patient's material, as Gray skillfully does; rather, it has to do with staying close to the material and striving to see the material as the patient does, even if the analyst has another point of view about it. To return to the train metaphor, it is more like saying, "How do you see what is in the trees over

there?" or "What was happening when you stopped looking at those trees?"

Schwaber also illustrates using close attention to her own ongoing psychic processes in order to better understand the patient's viewpoint, by understanding how her own thoughts may be shaping her perception of the patient's viewpoint. Contrast this with Gray's comment above that, at one point, the patient's recollections "did not provide the analyst with any further disclosure of the bizarre, perverse cruelty of the sibling." Where Schwaber is monitoring herself to learn more about what the patient is experiencing that was not encompassed by her previous approach, Gray is monitoring himself to learn what the patient is not providing according to the approach he already has in place. Schwaber's stance makes it more likely that she will learn things that keep her close to the patient's experience. And there is also an attitudinal difference here that is likely to be communicated nonverbally: Gray is standing at a greater distance from the patient's material, as an authority, whereas Schwaber is creating an atmosphere of mutuality by treating her thoughts as something to be understood as much as her patient's thoughts are.

By staying as close to the patient as possible, Schwaber facilitates the state of subjective self-awareness. And in her comment above that "we speak of our interest in fantasy, but how much do we value its fanciful components?", she is advocating a greater privileging of the disregard of reality and instrumentality that typifies the free-associative state. In Lewin's terms, Schwaber is a soother.

To further highlight their differences on the dimension of awakening/soothing their patients, let us consider how Gray and Schwaber respond to the mistakes they perceive in their work. Both patients are facing a separation from the analyst. Gray notices that after he makes a resistance interpretation that refers to more than one defended drive derivative, the patient regressively loses her ability to observe herself; since at other times she has used such interpretations effectively, he believes that her resistance was heightened by the upcoming break. Schwaber notes that after she makes

an interpretation of resistance to the upcoming separation, her patient responds by feeling devastated, feeling that Schwaber is pushing her toward the heavy and away from the light. Gray concludes that it would have been more tolerable to the patient if he had made a resistance interpretation that referred to only one drive derivative at that time. Schwaber concludes that it would have been better not to make a resistance interpretation at all at that time.

Consider the reactions that the analysts noted in their respective patients: Gray notices a regressive lack of self-observing ability; Schwaber notices devastation. Gray notices whether his patient can achieve a state of objective self-awareness; Schwaber notes what the patient experiences in her state of subjective self-awareness. And consider the analysts' ideas of how to rectify their errors: Gray wants to shift to a milder resistance interpretation; Schwaber wants to listen more closely to her patient. It is as if Gray wants to awaken his patient more gently, and Schwaber does not see the need to awaken her patient at all at that moment.

Therefore, Schwaber's technique in her vignette is more devoted to maintaining the free-associative state of consciousness than is Gray's technique in his vignette. Experiencing the free-associative state of consciousness can be, in and of itself, therapeutic for patients. Our usual psychoanalytic rationale for free association, that it provides material needed for insight, is correct but is not the whole story, and I think it is important that we supplement this rationale with respect for the value of the free-associative state even when it is not interpreted. The vignette from Schwaber is an excellent example of one way of doing this.

Recognizing the therapeutic value of the free-associative state is not our only gain when we pay more attention to state aspects of psychoanalysis. It is also important to help patients shift flexibly between the free-associative state and more ordinary states of consciousness, something that cannot be done if the analyst values only the free-associative state. Gray's work is an excellent example of carefully and precisely shifting the patient out of free association to engage in more objective self-awareness. Furthermore, Gray's

work embodies the interplay that I am discussing, because his interpretations, although they pull for objective self-awareness in the moment, are designed to facilitate free association and subjective self-awareness in the longer run.

More often than not, an approach like Schwaber's will be more soothing and an approach like Gray's more awakening. Nevertheless, it is easy to think of moments with patients who would be "awakened" by an approach like the one Schwaber took in her vignette, because they would feel the need to pull back from too much closeness, and moments with patients who would be soothed by an approach like the one in Gray's vignette, because they would feel calmed and protected by him. Interventions that are usually soothing or awakening may have different effects depending on the treatment context. The questions must always be: what would the patient experience as soothing or awakening *in this moment?* And would soothing or awakening be more helpful to the patient *in this moment?*

In order to help a patient shift flexibly between the free-associative and more ordinary states of consciousness, it is necessary to have both awakening and soothing types of intervention in one's repertoire. Here I will give only some very general thoughts about how to integrate the two types of intervention, as ideas for further study: Different patients probably benefit from differing mixtures of the two types of intervention. The same patient is likely to need different types of intervention at different stages in his or her analysis. Similarly, different analysts are probably better at one type than the other, and thus will be more effective with different patients, but those analysts who are more able to vary their technique are likely to be able to work effectively with a wider variety of patients.

The regulation of the interplay between the free-associative and more ordinary states of consciousness remains important throughout analysis. In part, this is because the regulation of these states is a lifelong process (Bach 1994; Loewald 1951). But it is important, more specifically, because analysis enables these states to be integrated again and again in deepening ways. As the patient develops

deepening insight into psychic life, and correspondingly develops a deeper relationship with the analyst, experiences of the self and the self in relation to the object are continually destabilized and restabilized by analysis.

CONCLUSION

In closing, I will summarize by noting that free association is in and of itself therapeutic because it facilitates the patient's learning to integrate and to shift flexibly among states of relatively objective self-awareness and reality adherence, and states of relatively subjective self-awareness and disregard of reality. By becoming more aware of this therapeutic value of free association, we will be more likely to let free association continue when it is to the patient's benefit. The tensions existing in the free-associative state are embedded in a larger tension between the relatively subjective self-awareness and disregard for reality of free association, and the relatively objective self-awareness and adherence to reality of reacting to the analyst's interventions. Therefore, the interplay between free association and intervention also facilitates the patient's learning to integrate and shift flexibly among states.

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THE FUNDAMENTAL IMPORTANCE OF SIMPLE OPERATIONAL DEFINITIONS OF INTROSPECTION AND EMPATHY

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Instead of asking why psychoanalysis has lost its central position in mental health, one might marvel at its longevity when considering that psychoanalysts have not attained agreement about basic methods for observing unconscious mentation, either their own or that of others. Ambiguity abounds regarding the operations involved in, and the usefulness of, introspection, and even more so of empathy. Simple operational definitions of introspection and empathy are proposed in this article, definitions that are sufficiently abstract to transcend particular theories of mental organization (e.g., ego psychology, object relations, and self psychology) and concrete enough to be practicable.

> All physical theories . . . ought to lend themselves to so simple a description that even a child could understand them.
>
> —Albert Einstein [Hayden 2003, p. 48]

> I remember one of my college professors—a man very much admired as a teacher of medieval history—confessing that the more he learned about the period the less he was prepared to say: the epoch was so complex, so diversified that no general statement could safely be made about it. The same thing can surely be said about the theory of mental illness . . . . Today we need simple-mindedness in order to be able to say anything at all . . . . The reason is precisely the advance of specialization, the impossibility of making safe general statements, which has led to a general "imbecility."
>
> —Ernest Becker [1973, p. 208]

I believe that psychoanalysis is threatened with being deemed anachronistic because we have not come to agreement about basic methods of observing our subject matter. Some of us may agree with Freud (1914) that the foundation of psychoanalytic science is observation alone, but many of us have not taken seriously the rest of his statement, that theoretical ideas "are not the bottom but the top of the whole structure, and that they can be replaced and discarded without damaging it" (p. 77). Indeed, psychoanalysts appear so anchored to their favored theories of mental organization that they readily accuse proponents of other theories of being nonanalytic. The folly of such disputes becomes obvious when we realize that we have no generally accepted set of operations specifying *how we observe* our subject matter. We do not even have a generally accepted *name* for our basic subject matter that would facilitate direct communication about psychoanalytic observations.

Given such lack of agreement about basics, it is surprising that psychoanalysis has survived as an organized discipline. Some attribute its longevity to the idealization of Freud (e.g., Kohut 1976), some to the therapeutic efficacy of particular psychoanalysts (e.g., Renik 2003), and some to the scientific nature of psychoanalytic inquiry (e.g., Brenner 1980). The latter position, especially, seems difficult to justify if my assertion is accurate—that is, that we have no general agreement about how we observe our subject matter. I believe that psychoanalysis has survived because our subject matter, albeit elusive, is one of the most important aspects of being human, and because analysts have found ways to utilize unconscious mental activity while being unable to agree about how they do it.

What I have written so far could be described as audacious given the literature on analytic listening, technique, and metapsychology. The topic has received considerable attention, and I make no claim of presenting solely original ideas in this paper. Instead, I shall attempt to reconfigure and reemphasize some central ideas that appear to be lost in webs of complexity. Hopefully, my reworking of ideas will highlight the importance of clarifying how we make observations that we call *psychoanalytic*.

CONCEPTUAL FRAMEWORK

I propose the following conceptual framework as preparation for considering the main thesis of this paper.

First, I propose that we use the word *mentation* to signify mental activity, the basic subject matter of analysis. My reason for doing so is to include in standard analytic nomenclature a basic term that refers to what we observe. Although not found in most dictionaries, including *The Language of Psycho-Analysis* (1973) by Laplanche and Pontalis, *mentation* is defined as "mental action" in *The Compact Edition of the Oxford English Dictionary* (1971, p. 1770), with the first cited usage occurring in 1850. Interestingly, the *OED* gives the following usage as having occurred in 1900: "Successive mental images, successive 'mentations' if I may be allowed to introduce a most useful word, made in America."

I am curious about why *mentation* has not been granted central status in analytic nomenclature. A search for the word *mentation* on Psychoanalytic Electronic Publishing's Archive 1, Version 4 (archiving analytic materials from 1920-2000), yields 935 hits, relatively low usage given that a search for *behavior* yields 34,861 hits.[1] As comparative markers, consider the number of hits for other PEP searches: *ego*—92,999; *superego*—23,714; *id*—14,279; *unconscious*—65,652; and *brain*—6,457. The usages of *behavior* and *brain* far exceeding that of *mentation* is interesting, given that PEP catalogues *psychoanalytic* writings. Mentation, in fact, seems an apropos word to signify mental activity, the basic subject matter of psychoanalytic investigation.

Second, I propose that we accept forthrightly the problems imposed by mentation existing in a dimensional system that has no identified space or locality, and that is not restricted to conventional ordering of time (Brenner 1994; Freud 1915). The impossibility of locating *mentation* within the grid of coordinates usually

[1] In PEP Archive 1, Version 4, *word hits* represent the number of records (blocks of text approximately corresponding to paragraphs) in the archived literature that contain the word.

used for observations of material objects and events (e.g., verticality, horizontality, depth, and time) can generate anxiety, a perceived need to find "solid ground" and an "itch toward objectivism" (Klugman 1999, p. 438). Presenters of analytic cases often cite behavioral or physiological change as evidence of a successful treatment (e.g., the analysand was able to marry and have children, and to advance in his or her professional work, after symptoms of a mental disorder diminished). Behavioral and physiological changes are presumed to occur secondary to, and as manifestations of, changes in mentation that require adequate description (e.g., the analysand was able to modulate excessive degrees of affective tension, to experience and explore the impact of repressed memories of feeling belittled that had been obscured by a contemptuous attitude toward others, and thereby become more receptive to what others tried to communicate in intimate and professional relationships).

The words *affective tension, experience, explore, repressed memories, feeling, attitude,* and *receptivity* refer to mental activity. Changes in mentation described in the example would be expected to affect behavioral and physiological functioning. However, presenting behavioral and physiological data as evidence of changes in mentation is to present circumstantial evidence at best, and bypasses the required task of describing changes in mental activity occurring as a function of psychoanalytic treatment (cf. Schafer 1981; Schlessinger and Robbins 1983).

Third, I propose that behavior, language, experience, and mentation are best conceptualized as separate entities, each having unique organizing principles. I believe that behavior, language, experience, and mentation may be rank-ordered from lower to higher complexity of organization and processing capacity (cf. Polkinghorne 1988). I can speak, read, and write (i.e., symbolize linguistically) about activities I cannot do behaviorally. What I experience in any moment exceeds what I can describe. And my experience in any moment is determined by mental activity that I cannot observe directly. Maintaining firmer boundaries to separate the conceptual fields of behavior, language, experience, and

mentation may help clear up muddles created by indiscriminate usage, such as Skinner's (1957) conflation of behavior and mentation in referring to thinking as *covert behavior.* This conceptual conflation obscures the understanding of *thinking* by imposing upon it the lower capacity and organizational complexity of *behavior.*

Of course, activity in one entity can affect activity in other entities. Unconscious mentation may organize experience (Stolorow, Brandchaft, and Atwood 1987) and affect language and behavior, just as behaving in particular ways may affect language, experience, and mentation (Renik 1993). However, it would be a mistake to assume isomorphic covariance among these entities. Keeping in mind that behavior and mentation are separate entities, we know that modifying behavior does not guarantee an isomorphic change in mentation, and that a change in mentation may affect behavior in complex and unanticipated ways.

Simple examples suffice to illustrate the differences. If I want to modify a person's destructive behavior, I might arrange to punish hitting and positively reinforce socially appropriate, alternative behaviors. The person whose destructive behavior is modified might appreciate the experiences of new mentation evoked by more harmonious social relations and become philanthropic, or the person might feel increasingly resentful toward authority and employ the newly acquired social skills to disguise further harmful aims. Conversely, helping an analysand understand that his or her resentful attitude toward authority is motivated in part by a history of feeling unjustly treated by his or her father carries no guarantee that the analysand will become more cooperative with an employer or anyone else.

Fourth, I propose that we maintain firmer boundaries separating the concepts of *me, myself,* and *I.* Failing to do so creates confusing statements in the psychoanalytic literature, such as:

> It is the self of the child that, in consequence of the severely disturbed empathic response of the parents, has not been securely established, and it is the enfeebled and fragmentation-prone self that (in the attempt to reassure

> itself that it is alive, even that it exists at all) turns defensively toward pleasure aims through stimulation of erogenic zones, and then, secondarily, brings about the oral (and anal) drive orientation and the ego's enslavement to the drive aims correlated to the stimulated body zones. [Kohut 1977, p. 74]

Although I am inclined to agree with the basic ideas conveyed in this sentence I find it difficult to decipher. The usual Kohutian grammatical complexity is not the problem. What I find disconcerting is the semantic looseness. Kohut (1979) defended his taking semantic liberties in the interest of theoretical creativity, warning that the meanings of psychoanalytic terms should not be overly restricted by a priori definitions. Although I appreciate his position, I wonder if the importance of his ideas might have received broader acceptance among analysts if he had adhered to the conventional semantic usage of *me, myself,* and *I.*

I try to keep the meanings of these words separate by recalling a simple phrase attributed to William James: "The I observes the me" (cited in Reik 1948, p. 5). I combine James's statement with some playful mentation, imagining that I am looking into a mirror: *I* look at a mirror that reflects a visual image of *me* and appraise *myself.* In this mental image: (1) *I* denotes a subjective experience of agency, initiation of action, and observation; (2) *me* denotes an objective representation, the reflection that can be seen by others; and (3) *myself* denotes subjective judging of qualities I possess, qualities that may be physical or mental.[2]

Returning to Kohut's sentence cited above, we see that he begins by referring to something a child possesses, a *self* that is feeble and prone to fragmentation. So far, so good. But the meaning of the sentence becomes obscure when he refers to the "enfeebled . . . self" reassuring "itself that it is alive, even that it exists at all," turning "defensively toward pleasure aims." Here, a mental posses-

[2] For an introduction to some of the philosophical and psychological complexities inherent in differentiating *me, myself,* and *I,* see James (1890), Kilborne (2002), Ogden (1994), Meares (2000), and Rizzuto (1993, 2003).

sion of the child is imbued with powers of agency resulting in conflation of the meanings of *I* and *self*. I can appraise myself when I look into a mirror, but *myself* cannot appraise *I*. Also, *myself* cannot convince me that I am alive. I am—or I am not. It appears that Kohut attempted to correct this conflation when he referred to "the ego's enslavement to the drive aims."[3]

Some qualities of *self* described by Kohut (1979), such as a sense of continuity (extending from the past to the present and into the future) and cohesion (varying from fragmentation of parts to parts working together harmoniously), may be consistent with defining *self* as a mental possession. Other attributes of *self,* such as being an active recipient of impressions and an initiator of action, fall within the definitional territory of *I* as a sense of subjective agency.

Attempting to maintain the conceptual distinctions among *me, myself,* and *I* is difficult when referring to other persons. We have no equivalent word for *I* to use when referring to the subjective agency of other persons. Although I will not address this in further detail here, for the interested reader, I recommend Buber (1958), Fromm (1998), and Orange (1995).

TOWARD OPERATIONALIZING INTROSPECTION AND EMPATHY

> The time seems to have come when psychology must discard all references to consciousness; when it need no longer delude itself into thinking that it is making mental states the object of observation . . . . Psychology as the behaviorist views it is a purely objective, experimental branch of natural science, which needs introspection as little as do the sciences of chemistry and physics. [Watson 1913, p. 163, p. 176]

> The inner world cannot be observed with the aid of our sensory organs. Our thoughts, wishes, feelings, and fantasies cannot be seen, smelled, heard, or touched. They

[3] Freud's *I* was translated as *ego* by Strachey (Bettelheim 1982).

> have no existence in physical space, and yet they are real, and we can observe them as they occur in time: through introspection in ourselves, and through empathy (i.e., vicarious introspection) in others . . . . The only fruitful definition is operational. We speak of physical phenomena when the essential ingredient of our observational methods includes our senses; we speak of psychological phenomena when the essential ingredient of our observation is introspection and empathy. [Kohut 1959, pp. 459-460]

Although espousing diametrically opposing views about the proper subject matter of psychology, Watson and Kohut were wedded by their steadfast adherence to unalloyed epistemological positions, positions that I consider prototypes of behaviorism and mentalism. The crucial difference between Watsonian and Kohutian epistemological realms of psychology lies in the methods proposed for observing subject matter.

Watson eschewed the introspective methods characterizing the advent of experimental psychology at around the beginning of the twentieth century. Wundt (e.g., 1894) and Titchner (e.g., 1909) launched scientific psychology with experimental investigations of attributes of experience as reported by trained introspective observers when exposed to discrete physical stimuli. They argued that conscious mental contents per se differ from physical objects, as the former are "processes, fleeting occurrences, in continual flux and change" (Wundt 1910, p. 4), and therefore not amenable to scientific investigation. They addressed this problem by standardizing specific properties of simple physical stimuli that were presented to trained introspective observers, who reported attributes of their experience while attending to the stimuli in controlled laboratory settings. The ultimate goal of the research was to develop a taxonomy of basic attributes of experience, analogous to the periodic table of the elements used by the natural sciences. This approach was referred to as *structural psychology*.

Watson (1913) highlighted a shortcoming of structural psychology: disagreement among introspective observers about basic attributes of experience evoked by simple physical stimuli.

> There is no longer any guarantee that we all mean the same thing when we use the terms now current in psychology. Take the case of sensation. A sensation is defined in terms of its attributes. One psychologist will state with readiness that the attributes of a visual sensation are *quality, extension, duration,* and *intensity*. Another will add *clearness*. Still another that of *order*. [pp. 163-164.]

Watson pointed out that attempts to account for such discrepancies often took the form of ad hominem attacks on the skills of introspective observers, rather than examining experimental conditions as a possible source of variability (as was done in physics and chemistry). His solution to the problem of variability in the data was to jettison introspection and consciousness from psychology and to proclaim it a "purely objective experimental branch of natural science" (1913, p. 176). As will become clear later in this paper, Watson was correct in refuting introspection as a method to observe sensory data.

The epistemological work of Skinner (e.g., 1953), an ardent admirer of Watson, so firmly secured psychology's allegiance to the methods of the natural sciences that mentation is now being attacked in "mental" health by fundamentalist appeal to so-called experimentally validated treatments (e.g., Nathan and Gorman 1998). I use the term *fundamentalist* because, again, this approach carries the threat of jettisoning forms of mental health treatment that are not amenable to the objective methodology of the natural sciences. Although this view may be considered polemic, a current threat to the professional status of mentation exists in proposals to designate as unethical any mental health treatment that is not experimentally validated. Fox (2003) offers a cogent critique of this myopic movement.[4]

[4] Of historical interest, Waelder's (1962) summary of a symposium on "Psychoanalysis, Scientific Method, and Philosophy" includes mention of one contributor who advocated "legal or other action against the practice of psychoanalysis" (p. 623), because experimental evidence of the effectiveness of its methods had not been produced. Waelder aptly pointed out that requests for experimental evidence with "adequate statistics undertaken on the material of sense perceptions" made "no allowance . . . for the data of introspection or empathy" (p. 623).

Being drawn into attempts to illustrate the efficacy or effectiveness of analytic treatment by focusing on "objective" behavioral and physiological indices will only add to the confusion created by avoiding the necessary work of specifying how we observe the phenomena we assume to be fundamental: unconscious mentation and psychic determinism (Brenner 1973). I believe that a necessary task for psychoanalysis to ensure its survival as a professional and scientific discipline is to legitimize our subject matter and therapeutic approach by operationally defining our methods of observation in ways that attain general agreement among analysts. Fortunately, the requisite epistemological framework exists in the analytic literature (e.g., Agosta 1984; Arlow 1979; Basch 1983; Beres and Arlow 1974; Bucci 1997, 2001; Goldberg 1987; Kohut 1959, 1971, 1977, 1981, 1982, 1984; Ogden 1994; Orange 1995; and Reik 1948—among numerous others). Unfortunately, much of the literature pertinent to introspection—and, especially, to empathy—has become obtuse and laden by terminological preferences and disputes stemming from separate psychoanalytic theoretical camps.[5]

Apparently, the word *empathy* is now so readily associated with self psychology that analysts affiliated with competing theories avoid using it. At least, this has been my personal experience. An analyst who uses the word *empathy* in conversation with other analysts will often be met with an emotionally charged rejection of the word and a disclaiming of the work of Kohut and his followers. I believe this is an unfortunate state of affairs for psychoanalysis, a case of throwing out the baby with the bath water, of turning against the word that best describes the method of observing our subject matter, the observational method that distinguishes our work from that of other disciplines. Doing so undermines the foundation of psychoanalysis, leaving the enterprise vulnerable to collapse.

[5] Smith (2001) addressed this communalism through a wider lexical lens: "Certain key words become catch phrases to establish affiliations. Like secret handshakes, the passing reference to such concepts as intersubjectivity, on the one hand, or conflict, on the other, not to mention the time-honored face-off between interpersonal and intrapsychic, demonstrate loyalties and outline territories" (p. 487).

The epistemological writing of Kohut can be separated from the rest of his theoretical work on self psychology. During a public presentation in 1981, while suffering from an illness that would end his life a few days later (see Strozier 2001), Kohut lamented that his most important contribution to analysis was misunderstood. He was referring to "Introspection, Empathy, and Psychoanalysis: An Examination of the Relationship between Mode of Observation and Theory," published in the *Journal of the American Psychoanalytic Association* in 1959. In this paper, he proposed that the subject matter of the physical sciences is defined by observations made via sensory organs, whereas the subject matter of a psychology of complex mental states is defined by observations made via introspection and empathy.

Some time after writing his 1959 paper, Kohut (1981) introduced the word *extrospection* to signify observations made via our sensory organs. This operational differentiation of the epistemological realms of the physical and mental sciences was clear to Kohut, and he expressed puzzlement as to why his readers had misinterpreted his main thesis. In his 1981 presentation, and in a book published posthumously in 1984, Kohut addressed some of the reasons why readers had misunderstood his ideas (e.g., confusing empathy as a mode of observation with sympathy and acts of kindness, and with the beneficial personal impact of being empathically understood—which he considered orthogonal to the observational role of empathy). Although he insisted that the psychoanalytic use of empathy entailed both the analyst's understanding and explaining (i.e., interpreting) mentation of and to an analysand, his other comments about empathy seemed to be more the reflections of a man struggling with the developmental task of dying than clarifications of the epistemological roles of introspection and empathy (Horowitz 2003).

Kohut ended his last public presentation with a vignette from an analysis that had occurred fifteen years previously, in which he extended two fingers to the analysand, who was gravely depressed, and silently observed that her clutching was like "the toothless gums of a very young child clamping down on an empty nipple."

He did not state this observation to the analysand, but concluded that his understanding helped overcome "a very, very difficult impasse at a given dangerous moment" and led to "a reasonably substantial success" (1981, p. 535).

I believe that Kohut's work on introspection and empathy was not as influential as he had hoped because he did not provide adequately specified operational definitions. He preferred to conceptualize introspection and empathy as "attitudes," rather than as specific operations employed by observers. The closest he came to operationally defining empathy was in his posthumously published book:

> The best definition of empathy—the analogue to my terse scientific definition of empathy as "vicarious introspection". . . is that it is the capacity to think and feel oneself into the inner life of another person. It is our lifelong ability to experience what another person experiences, though usually, and appropriately, to an attenuated degree. [Kohut 1984, p. 82]

But before I address the inadequacy and inaccuracy of this definition, I want to call attention to Kohut's (1981) illustration of his working knowledge of empathy in the clinical example at the conclusion of his final public presentation:

> I gave her my two fingers. She took hold of them, and I immediately made a genetic interpretation to myself. It was the toothless gums of a very young child clamping down on an empty nipple. That is the way it felt. I didn't say anything. I don't know whether it was right. But I reacted to it even there, to myself as an analyst. [p. 535]

Experiencing his analysand as a toothless child nursing an empty breast occurred *spontaneously* to Kohut. The poignancy of this story being told among the final public words of a dying man may overshadow Kohut's striving to clarify what he meant by the word *empathy* and the fact that he did so allegorically in lieu of an accurate definition. A spontaneous mental occurrence informed his understanding of the mentation of his patient.

Reik's *Listening with the Third Ear: The Inner Experience of a Psychoanalyst* (1948) may be the most underutilized and informative work on introspection and empathy in the psychoanalytic literature. Interestingly, Reik shared with Kohut the dubious distinction of being influential and controversial to the point of being dismissed by many psychoanalysts. Reik championed the unconscious mentation of both the analyst and analysand as the fundamental determinant of analysis: "The employment of the unconscious as a vital organ of apprehension constitutes *a peculiarity of the analytic method, which differs in that particular from other scientific methods"* (p. 389, italics in original). *Introspection* was defined as an individual's receptivity to manifest derivatives of unconscious mentation, the depth and breadth of which could never be fully observed.

Like Kohut (1984), Reik viewed exclusive adherence to particular theories of mental organization as misguided impositions on the psychoanalytic task of understanding the unconscious mentation of our patients. He preferred not to use the word *empathy* to describe his analytic observations because including it in schemas of observation like extrospection, introspection, and empathy ran the risk of equating the mechanics of empathy with those of sensory receptors. His equivalent to empathy required the following operations in the analyst: suspending the voluntary search for meanings in an analysand's presentation, and being receptive to manifestations of derivatives of unconscious mentation (cf. Freud 1912). In other words, while listening to the analysand, the analyst uses her or his own introspection as the method for observing the unconscious mentation of the analysand. This is quite different than thinking or feeling oneself into the life of another person, since "thinking or feeling into" denotes an active, guided, cognitive effort by the analyst while relying on secondary process (Freud 1911)—conscious mentation.

For Reik (1948), the mechanics of empathy consisted of introjecting what was projected by the analysand and reprojecting the introject in interpretive efforts (see p. 471). The projective, introjective, reprojective process was considered to be resonant

and attenuated. In other words, the analyst does not develop an isomorphic representation of the mentation of the analysand, but rather uses an unconsciously driven approximation via unconscious resonance to inform inquiry and interpretation. Reik used the words *conjecture* and *comprehension* to refer to two stages of working empathically in analysis. *Conjecture* denotes the manifestations of derivatives of the analyst's unconscious mentation that occur while he or she listens to the analysand, spontaneous occurrences that are often subtle and usually not isomorphic to what the analysand is saying at a given moment. *Comprehension* is the interpretive exploration of the potential significance of what has occurred to the analyst, in terms of the analysand's quest for understanding unconscious determinants of his or her experience. Comprehension involves the secondary-process mentation of making logical sense of the unconscious data gleaned by conjecture. Reik warns, however, of the dangers of trying to comprehend before conjecturing: "There is less danger that analysts will be too little logical than that they will be too little psychological in their thought" (1948, p. 392).

Holding firmly to secondary-process, intellectual use of theoretical concepts to explain an analysand's unconscious mentation "amounts to a misapplication of reason" and throws a "wet blanket" on psychoanalytic inquiry (Reik 1948, p. 392). Reik attributed many psychoanalytic impasses to the analyst's working in a so-called card-index fashion of categorizing the analysand's productions to fit theoretical concepts, while avoiding the surprises that often accompany analytic insights, moments during which derivatives of unconscious mentation become conscious and illuminate new material and novel configurations of previously comprehended material.

It may be important to reemphasize an idea about unconscious mentation inherent in Kohut's and Reik's schemas of empathy. Both believed that unconscious mentation is ultimately unknowable in its entirety, and that unconscious mental contents transcend repressed memory. Theoretical divisions of mentation, such as ego, id, and superego, and grandiose and idealizing poles

of the self, are guidelines with which to organize thinking about unconscious mentation, not definitive maps of a domain. In psychoanalysis, unconscious mentation is usually portrayed as problematic and in need of "taming" or "mastery" by conscious mentation. That analysis is a clinical endeavor as well as a scientific one influences our caricature of the unconscious. People enter analysis because they want to solve problems; we look into unconscious determinants of these problems. However, the influence of a therapeutic focus may hinder our appreciation of unique resources inherent in the organization of unconscious mentation, which provide powerful alternatives to conscious logic and reason as systems of informing and knowing.

Bucci's (2001) metapsychological schema offers an enlightened perspective regarding both the resources inherent in various organizations of mentation and operations involved in introspection and empathy. She approaches mentation from the dual perspectives of psychoanalysis and cognitive science, dividing it into categories of *verbal symbolic, nonverbal symbolic,* and *subsymbolic* modes of organization and processing. *Verbal symbolic* mentation is organized, experienced, and expressed via language, whereas imagery is the organizing and experiential medium of *nonverbal symbolic* mentation. *Subsymbolic* mentation underlies symbolic modes and has powerful processing capacities by virtue of "connectionist or Parallel Distributed Processing" organization that is described as "formally analogic and holistic, [and] computed as variation on continuous dimensions, rather than generated from discrete elements" (p. 48).

There are interesting parallels between Bucci's subsymbolic mentation and Freud's (1911) depiction of primary-process dynamic organization of unconscious mentation. However, Bucci's (2001) subsymbolic mode is not restricted to repressed mentation, as it is derived from cognitive science that considers it "experientially immediate and familiar to us in the actions and decisions of everyday life" and "accounts for highly developed skills in athletics and the arts and sciences, and is central to the knowledge of one's body and to emotional experience" (p. 48.) Here we have a

view of mentation that is not symbolized, but that can inform symbolic knowing via derivative transformations to imagery and words. Imagery, nonverbal symbolic mentation, occupies an intermediate, pivotal position between subsymbolic and verbal symbolic mentation. In other words, imagery may be derived from subsymbolic mentation and converted to verbal symbolic mentation via descriptive language. Bucci refers to the "connecting of subsymbolic experience to words" as "the referential process" (p. 51). Psychopathology is attributed to disconnections among the three systems of mental organization, a dissociative model.

Although Bucci did not use the terms *introspection* and *empathy* in her writing referenced above, I believe she has described mental operations involved in these methods of observation as I am presenting them for consideration in this paper. *Introspection* corresponds approximately to the referential process, attending to spontaneously occurring imagery considered to derive from underlying subsymbolic mentation, imagery that can be described with words. *Empathy* corresponds approximately to what Bucci calls "the circle of emotional communication" (p. 53), in which an analyst attends to his or her experience of subsymbolic and symbolic mentation evoked while listening to an analysand whose subsymbolic and symbolic mentation is disconnected, thereby producing affective tension that cannot be symbolized. The analyst uses a resonant "referential process" as a guide to interpretations that aim to evoke imagery in the analysand, thereby helping the analysand develop connections among symbolic and subsymbolic mentation, with formation of these connections being the therapeutic action.

I refer to the conceptual relatedness of Bucci's work to introspection and empathy as approximate correspondences because my clinical experience suggests that the progression from subsymbolic, to nonverbal symbolic, to verbal symbolic may represent one but not all possible routes of connection among various modes of mental organization. At this time, I think it prudent to remain open to other possible routes of connection among the modes. Bucci's integration of psychoanalytic and cognitive con-

ceptualizations of mentation carries much promise for bolstering the science of psychoanalysis and for reciprocal illumination between the disciplines of psychoanalysis and cognitive science.

Among the writings on introspection and empathy with which I am familiar, "Empathy and Intersubjectivity" (Agosta 1984) describes most clearly the operational definitions that I want to clarify and simplify. Agosta distinguishes among various linguistic usages of empathy, such as a "particular, concrete occasion" of observation, a "general interhuman competence," "a form of receptivity," and "a form of understanding" (p. 46). For the sake of brevity, I will focus on his deciphering of Kohut's definition of empathy as *vicarious introspection*. Agosta proposes that two representations are necessary in a "concrete occasion" of empathic observation:

(1) a "representation of another's feeling," evoked in a resonant manner and manifesting as a derivative of the empathic observer's own unconscious mentation, and

(2) a "representation of the other as such as the source of the first representation" (p. 55).

Both representations are required for empathic receptivity to occur. In other words, when I observe empathically, I experience a feeling or thought or image or some other mentation that comes from within me, which I identify as a resonant representation of the mentation of the other. This explanation helps clear up some of the confusion of other attempts to define empathy. For example, merely experiencing a feeling while listening to another person, and not identifying the feeling as a resonance to the mentation of the other, is referred to as *emotional contagion* by Agosta. Conversely, trying to feel or think oneself into the experience of another is an intellectual exercise devoid of the resonant mentation evoked by the other.

In Agosta's (1984) words, "a representation of the other by itself is a mere empty concept, whereas a vicarious experience in itself is a blind sensation without relational significance" (p. 59).

Agosta describes two operations that should not be confused with empathy, but that analysts may use to "institute or reestablish an empathic connection" when "empathic receptivity has gone astray" (p. 58). These are *analogical recollection* and *analogical apperception,* and refer to the analyst's recall of personal experiences similar to those described by the analysand, and the analyst's imagining him- or herself as *like* or *together with* the analysand, respectively. Agosta considers these operations supplements to, not substitutes for, the primary task of empathic observation, which entails the analyst's concrete experience of representations of the analysand's mentation, experiences evoked by the analysand's mentation and manifesting as derivatives of the analyst's unconscious resonance to the analysand's mentation.

If I correctly understand Agosta's writing, he considers *empathic receptivity*, as described above, as distinct from *empathic understanding*, which evolves from intersubjective dialogue between analyst and analysand, dialogue that Agosta conceptualizes as occurring in a hermeneutic circle.

> The circularity—which is arguably not a vicious but rather a productive kind—occurs because the expressions of human life in question are composites consisting of many aspects that take their meaning from the whole of which they are a part and, in turn, lend meaning to that whole. [1984, p. 45]

I believe that Agosta's empathic receptivity corresponds approximately to Reik's *conjecture,* and Agosta's empathic understanding to Reik's *comprehension.* Also, Agosta's empathic receptivity is similar to Bucci's *referential process* when engaged with the intention of grasping the mentation of another, the so-called circle of emotional communication. The inaccuracy of Kohut's proposed two stages of empathy, *understanding* and *explaining,* is clarified, since he bypassed the task of operationalizing empathy as a mode of observation. His definition of empathy as vicarious introspection is too vague to be usable.

PROPOSED SIMPLE OPERATIONAL DEFINITIONS OF INTROSPECTION, EXTROSPECTION, AND EMPATHY

Even a cursory survey of the philosophical complexities entailed in distinguishing extrospection, introspection, and empathy is beyond the scope of this paper. In the midst of such complexity, however, a simplified set of operations for defining introspection and empathy may be gleaned from the work of Agosta, Bucci, Kohut, and Reik, among others.[6] I propose a reconfiguration and restatement of these authors' ideas in terms that are sufficiently abstract to transcend particular theories of mental organization (e.g., those of ego psychology, object relations, self psychology, and so forth), and concrete enough to be practicable.

Specifying mental operations involved in making observations requires some general schemas of functional mental organization. Kohut and Rubovits-Seitz's (1963) revision of Freud's structural model of mind will suffice, though I will make some further modifications. Let us assume the usual distinctions between conscious and unconscious mentation, with availability to experience roughly delimiting these distinctly organized processes. Like Kohut and Rubovits-Seitz, let us posit a gradient of repression instead of a discrete repression barrier. In other words, derivatives of various levels and areas of unconscious mentation are available to experi-

[6] The authors included in this small sample from the literature reflect my idiosyncratic selection of readings while developing the proposed operational definitions. Many other authors' writings with which I am familiar could be presented in detail to substantiate these definitions (e.g., Arlow 1979, 1981; Beres and Arlow 1974). Also, the literature on Isakower's concept of "the analyzing instrument" is directly applicable. The entire second issue of the 1992 *Journal of Clinical Psychoanalysis* was devoted to Isakower's previously unpublished writing on the topic and commentaries by others. Especially, see Spencer, Balter, and Lothane (1992) in that issue and in earlier papers (Balter, Lothane, and Spencer 1980; Balter and Spencer 1991; Spencer and Balter 1990). These authors approach observation in psychoanalysis in a manner strikingly similar to my proposal, but arrive at very different conclusions.

ence.[7] Kohut and Rubovits-Seitz called this the *area of progressive neutralization,* which is contrasted with an *area of transference.* The latter refers to traditional conceptualizations of repressed unconscious mentation (e.g., traumatic memories), firmly separated from experience because of unpleasant affect, but *components* of which can breach repression and interfere with conscious mental functioning. This is a metapsychological representation of transference that is manifested functionally in idiosyncratic assumptions, beliefs, values, expectations, observational sets and opacities, and so forth. The area of progressive neutralization informs observation, whereas the area of transference can obscure observation.

Next, let us call the observing function in this simple schema of mental organization *I,* the subjective experience of agency. *I* can focus on information conveyed via sensory activity, or *I* can observe other kinds of mentation, such as memories, fantasies, and ideas. The observing capacity of *I* is usually referred to as attention, but it is important to maintain a broader conceptual frame for defining the mental function of observation. Most of the empirical research on attention pertains to observation of phenomena via sensory organs. Sensory activity is not required for observing other kinds of mentation. Kohut's (1981) introduction of the term *extrospection,* as distinct from introspection and empathy, accentuates important differences in operations entailed in making observations of physical versus mental phenomena.

Extrospection

Experiencing sensory activity is the defining characteristic of extrospective observations. Our sensory systems provide information about phenomena that we call *physical.* What can be perceived about physical phenomena is ultimately restricted to what can be

[7] This is consistent with Freud's (1915) suggestion that "an idea may exist simultaneously in two places in the mental apparatus" (Ucs. and Cs.), and that, "indeed . . . if it is not inhibited by censorship, it regularly advances from one position to the other, possibly without losing its first location or registration" (p. 175).

gleaned from sensory experience. Even so-called hypothetical constructs (MacCorquodale and Meehl 1948) require some validation by observation of material phenomena via sensory organs. Making objective extrospective observations requires that we suppress idiosyncratic impressions and focus on accurate descriptions of sensory representations of physical phenomena. In other words, the objective extrospective observer has to distinguish between sensory representations and other kinds of mentation, and furthermore to avoid the latter, which are considered sources of observer error or bias.

The distinction between sensory representation and other forms of mentation is what mental health clinicians refer to by the term *reality testing*. When observer bias is sufficiently controlled, two or more observers should be able to agree about the sensory representations of particular phenomena. To be more precise, observers agree about the linguistic or mathematical signifiers they use to describe sensory representations. Scientists call this *interobserver agreement* and have devised methods for calculating its degree.

Introspection

Experiencing manifest derivatives of unconscious mentation is the defining characteristic of introspective observations. In this mode of observing, *I* experience memories, imagery, thoughts, and feelings that do not require sensory activity. These phenomena originate in my mind. I do not need retinal stimulation to experience a mental image. When psychotherapy patients engage in introspective observation, they usually withdraw from eye contact with me and often cover their eyes with their hands. They are inhibiting visual sensory stimulation to enhance observation of what occurs to them from within their minds.

Maneuvers to reduce sensory input may occur when concentrating—say, while reading or thinking, as well as when introspecting—but the mental activities are different. Actively thinking about a particular topic involves mentation that is organized in ways that we call inductive or deductive reasoning, logic, mathematics, and so

on, all subsumed under the category of secondary-process mentation. In contrast, when I make introspective observations, I try not to think of anything in particular. The requisite mental operation is to enhance *receptivity* to whatever occurs to me, what is available to experience, whatever appears in my mind's *I*. When I can establish introspective receptivity, I find the "processes, fleeting occurrences, in continual flux and change" that Wundt (1910, p. 4) deemed inappropriate for scientific investigation.

If I can suspend disbelief while remaining introspectively receptive, meaning emerges from what is observed, from the images, fragments of memories, partial thoughts, melodies, feelings, desires, and so on. I assume that constellations of mental phenomena available to introspective observation are determined by unconscious mental organization that will never be completely observed, just as I will never observe all of physical reality via sensory activity. Therefore, I call what occurs to me while observing introspectively the *manifest derivatives of unconscious mentation*. Introspection may be the most direct method of observing psychic reality.

Empathy

Empathy requires the combining of extrospection and introspection, observing the sensory activity evoked by the presentations of another person while remaining receptive to what occurs from within. The operations I believe to be necessary to form an adequate definition of empathy are: (1) engaging in the task of comprehending the unconscious mentation of another person; (2) taking in what the other person is communicating about his or her experience—extrospection; (3) being receptive to manifest derivatives of one's own unconscious mentation—introspection; (4) discerning whether these derivatives are resonant representations of the other person's unconscious mentation; and (5) considering how these derivatives may be useful in comprehending the other person's unconscious mentation.

I will briefly discuss each of these operations.

(1) *Engaging in the task of comprehending the unconscious mentation of another person.* Although empathic observation may occur involuntarily, my experience is that intentional effort is usually required—that is, that I engage in a particular task. During much of my waking time, I am not striving to be empathic; I am doing something else. Sometimes it is difficult to engage empathy, such as when I am tired or distracted or under the sway of some particular transference. When I do actively engage in the task, my explicit intention is to glean something of the unconscious mentation of another person. I do not strive to be empathic with physical objects or with organic entities that are not human beings. I may use inference, analogy, or intuition in trying to understand nonhuman entities, but not empathy because I have no reason to expect that they have unconscious mentation. Of course, I may use inference, analogy, and intuition to attempt to understand another person, but these should not be confused with empathic observation (Goldberg 1987; Kohut 1959).

(2) *Taking in what the other person is communicating about his or her experience—extrospection.* Observing empathically requires taking in via sensory representations as much as possible of what the other person is communicating about his or her experience. In my clinical practice, I think of this as *tracking*. Of course, persons emanate a wealth of information that can be processed sensorially, in addition to the consciously intended meanings of the words they speak. Much has been written about verbal and nonverbal communication. However, merely taking in all the sensory cues presented by another person and thinking about them or categorizing them involves secondary-process mentation and does not constitute empathy. For empathy,

the importance of all the available cues emanating from the other person is to provide data, if you will, to be processed outside awareness by the observer's unconscious mental organization.

(3) *Being receptive to manifest derivatives of one's own unconscious mentation—introspection.* Being introspectively receptive while tracking what the other person is communicating requires disciplined effort and can easily be disrupted. For example, some persons seem to require overt affirmation of such close tracking that there is little opportunity for observing derivatives of unconscious mentation. Others seem so focused on extrospection and defended against introspection that resonant derivatives of the observer's unconscious mentation may be sparse. In such situations, the observer may use what Agosta (1984) calls *analogical recollection* or *analogical apperception,* in an effort to engage or reengage empathy. The clinician's anxiety about not knowing readily, or not having something that seems therapeutically important to say, seems a common source of interference with empathy. Using one's introspection in the service of empathy requires confidence in an informative process that is outside the direct control of the observer.

(4) *Discerning whether these derivatives are resonant representations of the other person's unconscious mentation.* An assumption here is that the unconscious mental organization of the empathic observer is affected in a resonant manner by the unconscious mentation of the person being observed. This is what Freud (1912) described in his metaphor of unconscious communication: the observer's unconscious is likened to a telephone receiver decoding the electrical vibrations in the telephone line set in motion by the speaker. My clinical experience of empathic observation is that de-

rivatives of my unconscious mentation that come to awareness are usually abbreviated or condensed memories of what a patient has communicated previously. This is no guarantee that particular derivatives are resonant representations of the patient encoded in my unconscious, but I can test this by telling the patient what has occurred to me and asking if it seems significant to her or him. It is not unusual for a memory to occur to me and soon thereafter be mentioned by the patient.

For example, while listening to a patient talk about a recent argument with a spouse, I might recall a previous instance in which the patient was annoyed with me, or a memory from the patient's childhood of being disappointed by a parent. I might choose not to comment on what has occurred to me, and yet the patient begins to speak of the same content.[8] If I do comment about what has occurred to me, the patient often says, "Yeah, I was thinking of that, too."

I consider these instances to be evidence of *empathic attunement* or intersubjective agreement, the parallel to interobserver agreement about physical phenomena. When I mention something that has occurred to me while listening to the patient, and this seems insignificant to him or her, the patient will usually let me know this by disregarding what I have said, or acknowledging that it might be connected but that he or she was emphasizing something else—among a host of other responses. These may be taken as instances of *empathic failures* (although it is possible that

[8] A clinical example of this is found in Smith's (2000) illustration of the complexities of his analytic listening during an hour with a female analysand. While she laments not taking family members on a vacation because they fight among themselves, Smith notes that "I start to say, 'It deprives you,' think better of it, afraid she will hear it too critically for this point in the hour, and then, *to my surprise,* hear her say it herself: 'I feel deprived of that immediate pleasure of being with my grandchildren and giving them a really nice holiday'" (p. 122, italics added).

I may have resonated to unconscious mentation that the patient is unable or unwilling to entertain at the moment).

(5) *Considering how these derivatives may be useful in comprehending the other person's unconscious mentation.* Including this mental operation as one of the defining characteristics of empathy allows us to distinguish empathy from intersubjective dialogue. For empathy as a mode of observation is directed at comprehending the unconscious of another person. Intersubjective dialogue involves unconscious resonance between two persons speaking spontaneously, persons who experience attunement to one another. Such dialogue may flow, feel enlivened, and be creative, but does not require a focus on comprehending the unconscious mentation of the other. Also, conscious deliberation about derivatives of unconscious mentation of the empathic observer brings these observations into the realm of secondary-process mentation, where they may inform, and be subjected to, logic and reason.

CONCLUSION

> If we could return to the level of observation and description, not only the description of what we see in the patient but of what we observe ourselves doing, we might begin to agree on what is fundamental in the dilemmas we all face and what, in their solutions, we hold in common. In any case, I suspect that rather than recreating old turf wars, we would be surprised by what we found. The beneficiaries would be our students and our patients. [Smith 2001, p. 511]

The simple operational definitions proposed in this paper are a step toward clarifying how we use introspection and empathy to observe unconscious mentation, our own and that of other persons. The proposed operations need to be critically and empirical-

ly evaluated by psychoanalysts and revised as necessary, or perhaps discarded. If they hold up to scrutiny, they may facilitate dialogue among different psychoanalytic communities and foster the development of systematic investigations that are directly pertinent to psychoanalytic process. A necessary task for such research is the construction of systematic measures of empathic attunement—or, if one prefers, of intersubjective agreement.

I believe the methodological challenges inherent in this kind of research are surmountable. At the least, simple operational definitions should put into perspective the folly of proclaiming that a preferred theory of mental organization delimits psychoanalysis. The foundation of psychoanalysis is observation alone (Freud 1914, p. 77), and testing the relative explanatory value of different theories of mental organization requires some generally accepted operations for observing the phenomena to be explained.

My conclusion will likely be viewed by some analysts as based on outdated ideals of a bygone era of logical positivism, positing something "real" out there (e.g., the unconscious mentation of another person)—aspects of which, at times, can be accurately observed. Such positivistic thinking leads to hierarchies of concepts pertaining to psychoanalytic knowledge, such as the levels of abstraction proposed by Waelder (1962), based on distance from actual clinical practice: observation, clinical interpretation, clinical generalizations, clinical theory, metapsychology, and philosophy. Waelder saw observation and clinical interpretations as indispensable to psychoanalysis, while viewing the higher-order concepts as dispensable. According to Waelder, the more abstract concepts (e.g., "cathexis, psychic energy, Eros, death instinct" [p. 620]) were the most common targets of criticisms of psychoanalysis, often levied by persons with no direct clinical experience.

More recently, compelling questions have been raised from within our profession that challenge the ideal of observation as the foundation of psychoanalysis. One argument is that analysts' preferred theories and personal mental organizations permeate acts of observing in idiosyncratic ways that obviate the ideal of

making accurate extrospective, introspective, and empathic observations. An obvious example of the imposition of preferred theory is Reik's (1948) card-index caricature of categorizing the analysand's productions to fit theoretical concepts while avoiding surprises that can occur during empathic observation.

Clinical case reports in the analytic literature often give the impression that the author went into the analysis looking for something in particular and found it—whether "it" be wishes and defenses, selfobject needs, or complex object matrices. I have no estimate of how many analysts work in this way, but I do recall some lore I learned as an analytic candidate: that analysts of disparate theoretical persuasions are more similar than different when supervising.[9]

An obvious example of the analyst's mental organization imposing on observation would be the analyst's transference functioning as an interference with empathic observation—just as the analysand's transference interferes with introspection. Requiring training analyses as part of psychoanalytic education may be viewed as a means of gaining experiential knowledge of unconscious mentation, including areas of transference, and of developing the capacity to work with it. Of course, there are no guarantees that a trained analyst will have developed sufficient capacities to work with his or her unconscious mentation, as transference may wax and wane. One indication of problems in this area would be persistent or acute difficulty in empathic observing.

Epistemological and theoretical positions proposing the *inevitability* of analysts imposing their subjective mental organization on what they observe come wrapped in many different conceptual packages, which I will not review here because my attempts to unwrap these conceptual packages with equanimity usually generates the state of "general imbecility" referred to by Becker (1973, p. 208). My goal in this paper is simplification, hopefully not to the point of naiveté. I may need to emphasize that the

[9] See Smith (1997, 2000, 2001) for a detailed and convincing look into the reasons why analysts talk past each other, and how doing so may obscure similarities in their clinical practice.

operations I have proposed for empathy include the use of the analyst's own unconscious mental organization in a disciplined, systematic attempt to observe and understand that of another.

Of course, the difference between "using" and "imposing" the unconscious mental organization of the analyst is important in regard to the accuracy of observation. I am confident that we can observe physical and mental phenomena and devise methods for assessing interobserver and intersubjective agreement—methods that can be used to increase repeatability or reliability of our observations, which in turn can be taken as indirect indices of accuracy of representation of what is observed. Doing so requires established descriptions of the operations involved in observing phenomena, and this holds true for extrospective as well as introspective and empathic observations.

As an academic and experimental psychologist, before becoming a psychoanalyst, I taught experimental methods and statistics. To my surprise, one of my more challenging tasks was teaching students to write accurate descriptions of their methods of extrospective observation and of what they observed about their subject matter, and to distinguish these from inferences about, and conclusions drawn from, their observations. Looking back from my current vantage point, I am amused that I was surprised. The organization of our sensory experience is imposed on the phenomena being observed. In turn, language is used to describe observations, thereby imposing linguistic structure on experiential data of observation. Writing accurate descriptions of observational experience is difficult work, partly because so much of our conventional language is metaphoric (Lakoff and Turner 1980). Nevertheless, it can be done to a degree of precision that allows both interobserver agreement about the qualities of phenomena observed extrospectively and repetition of the observations by others.

My hope for psychoanalysis is that we can work collaboratively to establish agreement at least about the operations involved in making introspective and empathic observations. My clinical experience is that, when I am able to employ the operations I have

proposed for empathic observation, empathic attunement increases, as does the analysand's familiarity with derivatives of unconscious mentation and his or her capacity to work with these. If other analysts find this as well, confidence in the applicability of the proposed operations would be increased. If not, the proposed operations would need revision or replacement.

In moments of fanciful speculation, I imagine an even more compelling test of the proposed operations. Imagine, if you will, that three analysts from disparate theoretical camps (say, for example, an ego psychology analyst, a self psychology one, and an object relations one) agree to employ the operations I have proposed for empathic observation while listening to a single analysand attempting to describe introspective observations (to freely associate) over an extended period of time. I predict that we would find more instances of congruence of empathic attunement among the three analysts (i.e., concordance of manifest derivatives of unconscious mentation resonant to the unconscious mentation of the analysand) than would be expected on the basis of reading theoretical papers and case reports written by these analysts. I would not be surprised, however, if the three analysts continued to disagree about what to interpret, when to make an interpretation, and the dynamic formulations of the analysand's mental organization. Competing interpretations of data enliven scientific exploration, but do not define the field of study.

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LOEWALD'S APPROACH TO PSYCHOANALYTIC THEORY

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The author suggests that part of the legacy of Hans Loewald is the nature of his approach to psychoanalytic theory. Loewald carefully considered and selectively utilized the work of theorists from a number of psychoanalytic schools of thought: id psychology, object relations theory, ego psychology, self psychology, and the interpersonal tradition. In addition, he helped pave the way for the current widespread interest in intersubjectivity, and also positioned himself in relation to those who embraced hermeneutics. Through all of this, he maintained a skeptical attitude, embodied in his belief in the complexity of the phenomena to be explored and his commitment to the perspective that psychoanalytic ideas should be open to revision.

INTRODUCTION

One of the characteristic features of Hans Loewald's assessment of the history of psychoanalysis was his appreciation of the "independent mind . . . [that embraced] both psychoanalytic tradition and innovation" (1988b, p. 49n).[1] His belief in the importance of innovation periodically brought him into conflict with many people in his field. According to Fogel (1996), "For years, Loewald was vilified, and he paid dearly for his single-minded, deeply thought-through challenge to the analytic truisms of the time" (p. 899).

[1] These comments are part of Loewald's dedication of his essay to Samuel Lipton.

Loewald was not content with the tenets of any particular school, but utilized a variety of theoretical perspectives as a platform from which to launch his ideas. To equate any one of the platforms that he utilized with his vision is to miss the complexity of his views. As he himself stated: "Truth is not absolute or one-directional. Contradiction, conflict, spiraling, reconciliation, a dissolving of achieved reconciliations, new resolutions of dissonances —these are at the center of life and the mind's life" (1988a, p. 8). He suggested repeatedly that the results of theorizing must be called into question, since any theory may be viewed as problematic and supplanted by a better one. It was concrete experience that he believed to be the foundation from which one could build a more adequate theory. At the same time, he argued that the vitality of psychoanalysis could be lost if we do not acknowledge that its development depends fully on the "presence of abstraction and theory" (p. 15).

Loewald (1973a), then, spoke of the importance of "the standpoint we take" (p. 69) in relation to inner experience. For him, that standpoint was embedded in the various psychoanalytic models pertaining to human nature and development:

> Much can be said for an oscillation between such various standpoints, as perhaps in their juxtaposition and combination lies the secret of success in understanding more about the conflicted and ambiguous creatures that we are. The richness and imprecision of psychoanalytic psychology are, to an extent, due to such oscillations, implicit as they have for the most part remained. It also is one of its characteristics that psychoanalytic psychology does not view the psychic life of the individual in isolation, but in its manifold relations and intertwinings with other spheres and aspects of life, such as social-cultural life and the somatic-biological sphere. [p. 70]

Since he sought to remain open to the broadest range of human experience, even as he recognized the tendency to privilege some dimensions over others, Loewald tried in much of his theorizing to acknowledge the limitations of any one school of psycho-

analytic thought. This is most obvious in the way that he both utilized and critiqued the work of Freud. In utilizing Freud's theories, Loewald often sought to expand the meaning of concepts. He refused to be weighed down by what he called "certain theoretical-scientific preconceptions" (1971a, p. 115). Therefore, Loewald amended Freud's work by, in part, assimilating directly and indirectly the work of others in the psychoanalytic tradition. At the very least, Loewald drew heavily upon the work of Hartmann, Mahler, Winnicott, and Kohut in order to come up with his own unique blend of ideas. He drew less heavily on the work of Rapaport, Spitz, Erikson, Klein, and Schafer. In addition, it could be argued that some of his work dovetails with the ideas of figures such as Balint, Sullivan, Fairbairn, Guntrip, and Bion, so that it is as if he has woven a tapestry out of existing theories.

Descriptions of Loewald's work have acknowledged his indebtedness to past theoreticians and have tended to encompass either of the following perspectives: first, that his ideas fall solidly within the realm of ego psychology and/or object relations theory; and second, that he has successfully synthesized the ideas of many central figures of the psychoanalytic movement, some of whom are not aligned with these two schools of thought. I will suggest that it might be useful to view Loewald's work in another context. For he was concerned that psychoanalytic theorists tend to emphasize one particular set of issues and thus often lose sight of the larger picture.

For example, Loewald (1973b) complained that there is sometimes a focus upon "the Oedipus conflict, and thereby the transference neurosis, in terms of instinctual and object-relation problems, without sufficient consideration of their implications for psychic structure building, that is, for superego formation" (pp. 333-334). Loewald's implicit critique here of the limitations of both id psychology and object relations theory was matched by his critique of the limitations of ego psychology, when he went on to state that "we are apt to view psychic structure without keeping clearly in mind the instinctual-energic side of structure formation" (p. 334).

I would argue, then, that according to Loewald, none of the psychoanalytic models pertaining to metapsychology or clinical process that were available to him were without problematic features. In laying out what I believe are his major frames of reference, I will try to indicate that he could never situate himself fully within any one school of psychoanalytic thought.[2] In referring to specific models, he called into question certain elements, even as he embraced others. Therefore, he could never rest securely either in his attempt to synthesize these perspectives or to put forth his own views.

In saying this, I do not intend to suggest that Loewald employed a loose eclecticism. Rather, I believe that he utilized ideas from a variety of sources, subjected these ideas to careful scrutiny, transformed the meaning of some of them, and jettisoned others. Finally, at times, he provided a compelling synthesis without settling for closure. In the end, for Loewald, all perspectives—including his own—were contestable. In choosing to describe how he utilized theories about instincts, object relations, ego psychology, self psychology, interpersonal relations, intersubjectivity, and hermeneutics, I will suggest that, in the manner in which he explicated and critiqued the ideas of others, he tended to be generous but also cautious.[3]

In his openness to the views of others, Loewald provided a model, perhaps, for the way in which ideas about psychoanalytic theory and technique can be creatively appropriated. This is especially important in light of pressures that can be exerted periodic-

[2] According to Lear (2003), who had "a weekly conversation with Hans Loewald that spanned about six years" (p. 229), Loewald "devoted his life to a certain kind of questioning—of himself and others—a kind of questioning that was itself a form of life. It was his life. Its point was not to come to an end in a body of doctrine, a fixed set of answers. Indeed, coming to such a resting place would itself be a failure, a betrayal of that form of life" (p. 24).

[3] I am aware that others might suggest that Loewald's approach reflects, at the very least, an additional set of perspectives. I might have included, for example, developmental theory, systems theory, linguistics, and existentialism. I have singled out the perspectives specified here because I believe that they are the most central to his psychoanalytic vision.

ally in some psychoanalytic institutes to adopt, in a rather doctrinaire manner, the thinking of one particular figure or school of thought (Kernberg 1986, 1996; Kirsner 2000). Rather than swallowing whole or unequivocally rejecting a particular body of psychoanalytic theory, Loewald, in general, attempted to very carefully tease out certain perspectives that he then utilized to fashion his views. This is very much in keeping with his conviction about "the complexity of, as well as a degree of confusion in, psychoanalytic thought beginning with Freud in regard to fundamental matters of theory formation" (1988a, p. 15n).

THE INSTINCTS

Loewald struggled in his attempt to conceptualize the nature of instincts. Central to this struggle was his ambivalence about whether instincts are better understood in a biological or a psychological context. At the end of one of his many discussions of this issue, he said that, in psychoanalysis, "we integrate our experience as psychic, not in the form of what we call physical reality. I question this commitment with all its implications, but for the time being it remains a—somewhat shaken—fact of intellectual life" (1988a, pp. 34-35).

Like Freud, Loewald believed that the psychological dimension could not be adequately understood without recognition that somatic activity is a constituent of psychic life, something that can be underemphasized by those who are intent on focusing upon other aspects of experience, particularly the interpersonal and the intersubjective. Nevertheless, in considering psychoanalytic theory, Loewald (1971a) echoed Freud by suggesting that it was best viewed as a psychological science (p. 115). Therefore, he quoted Freud, who stated that "an 'instinct' appears to us as a concept on the frontier between the mental and the somatic, as the psychical representative of the stimuli originating from within the organism" (Freud 1915a, p. 121; quoted in Loewald 1971a, p. 117).

Loewald (1988a) distinguished this view, which he preferred, from the perspective also found in Freud's work whereby an in-

stinct is thought of as "an organic stimulus operating on the psyche" (p. 34). Loewald (1981) stated that "soma and psyche—superficial appearances notwithstanding—signify not two different items of reality but two different modes of experiencing or ordering reality" (p. 34). The somatic dimension, then, diminishes in significance for Loewald, as organismic stimuli become important insofar as they are represented psychically. For Loewald, instincts become mental stimuli and appear to lose some of the direct connection with the body that they have for Freud. But in thinking of them as mental stimuli, it is important to remember that instincts are "the most primitive level of human mentation and motivation" (Loewald 1978a, p. 208).

As psychic representatives, instincts have immense force. Loewald did not do away with Freud's concept of energy. For example, in speaking about the use of repression, Loewald (1973a) stated that "the libidinal-aggressive object cathexes of the Oedipus complex . . . are kept in a deficient mode of discharge processes with objects" (p. 76). His use of the term *discharge processes* suggested his belief in the economic model of the mind, with its emphasis on quantities of energy. But here, too, he was committed to reformulating Freud's ideas by viewing this energy primarily in psychic terms. What is stimulated is the individual's capacity for representation. For Loewald (1971a), this capacity, though it "is in some way correlated with (or powered by) neurophysiological activity" and "stimulated by the organismic needs," is also "inherent in the mind" (p. 118).

Loewald, therefore, took issue with Freud's idea that the mind functions primarily to reduce the tension caused by organic stimuli. In fact, Loewald (1960) pointed out that, in his instinct theory, Freud moved beyond a reflex arc conceptual model (p. 236), with its emphasis on instinct as an intrapsychic stimulus, and toward a view in which instinct is "an expression of the function, the 'urge' of the nervous apparatus to deal with environment" (p. 234). Loewald, then, utilized Freud's concept of Eros to describe how the individual seeks relatedness to objects, attempting to join with others both internally and externally (p. 234).

Here the emphasis is not on the search for satisfaction through the elimination of stimuli.[4] In Freud's final instinct theory, it is the death instinct that embodies the desire for inertia or a tensionless state of complete rest. But Loewald did not elaborate on this idea significantly. Instead, he stated that the work of the mind "consists in 'representing'. . . the stimuli that reach it" (1971a, p. 118). Loewald's emphasis here—on the way the mind is involved in generating mental representatives—is very close to Bion's (1962) formulation of the need for a psychic container to process the raw elements of experience.

For both Bion and Loewald, that psychic container can only be developed to the extent that the mother is there to help the infant process its experience. It is her "advanced level of mentation" (Loewald 1978a, p. 208) that allows this to occur. The result of this process is not so much the reduction of a quantity of excitation and a movement closer to a state of rest as it was for Freud, but in fact, quite the opposite, it is an expansion of the possibility for greater experiencing in the search for more life (Loewald 1973a, p. 74).

According to Loewald (1978a), what the mother must help the infant contain is a set of "undifferentiated, libidinal-aggressive processes" (p. 209). Under the best circumstances, these will "bifurcate into what we can eventually distinguish as instinctual-affective life and cognitive functions" (p. 209). Nevertheless, the "original global functioning" will still operate, so that sexual and aggressive currents remain the unconscious motivational source for perception and memory, considered as ego functions (pp. 209-210).

In the context of his discussion of human development, Loewald (1951) stated that the first instinctual move by the infant is toward the mother and takes place because of the infant's desire to restore an "original unity" (p. 6). In the beginning, for the infant, there is no differentiation between self and object. Uniformity and

[4] Unlike Freud (1923, 1933), who conceptualized Eros in a multifaceted manner, pointing to its rapacious and conservative qualities in addition to its binding properties, Loewald tended to stress its positive, integrative nature.

homogeneity predominate in a condition in which the unconscious completely holds sway, as in Matte Blanco's (1988) conception of the symmetrical relationship between things, which does not allow for the ability to distinguish one item of experience from another.

For Loewald (1951), there was always the possibility of not developing sufficiently beyond this earliest state, or of sinking back into it (p. 14). This possibility restricts development only to the extent that it becomes the principal mode of experience open to the individual; the aim of therapy is not to promote the abandonment of this position. Therefore, Loewald challenged Freud's formula that "where id was, there shall ego be." Loewald noted that the triumph of the ego can result in impoverishment, to the extent that the primitive roots of human experience remain untapped. He indicated that Freud's emphasis on channeling and controlling id impulses was the result of his immersion in the culture in which he lived, which Loewald (1952) called a reflection of "the obsessive-neurotic's experience and conception of reality" (p. 30).

Thus, Loewald did not stress the opposition between the biological and the cultural, which is so evident in much of Freud's work. In fact, unlike Freud, who at times pointed to the biological dimension of the id (which was assumed to be present from birth), Loewald, in keeping with his view of the instincts as mental representatives of organic stimuli, believed that the id comes into being as a psychic structure as the infant comes into contact with the mother. In addition, Loewald (1978a) stated that the infant does not possess "a ready-made 'psychic apparatus,'" but rather exists as a set of "interactional biological processes that find higher organization on levels we have come to call psychic life" (p. 208), through interaction with the mother.

While Loewald acknowledged that the nature of the organization of the id is different than that of the ego, he did not subscribe to Freud's idea of the id as a seething cauldron of excitation, but suggested instead that it is a mode of organizing experience, and emphasized its affective, interchangeable, and timeless elements. For development to proceed, this mode of experience must not

preclude the development of rationality, differentiation, and historicity, all of which require interaction with other people.

OBJECT RELATIONS

Loewald (1971a) called the nature of "the relation of instincts to objects . . . possibly the most complex and most important problem for psychoanalytic theory today" (p. 126). He was concerned about the widespread reluctance to acknowledge that object relations are "not merely regulative but essential constitutive factors in psychic structure formation" (1970, p. 299). And he suggested that this began with Freud, who did not adequately account for the importance of the human environment in shaping inner life, "including the organization of instincts as psychic phenomena and of the subject's developing 'object relations'" (1971a, p. 127).

It was the psychological relationship between mother and child that became Loewald's focus as he tried to understand the way that instincts are created and organized. For him, instincts arise because of the manner in which the mother stimulates and responds to the infant. More specifically, Loewald (1971a) stressed that the "pressure . . . of uncoordinated urges that become instincts" (p. 131) depends upon the fact of separation from the mother, especially the experience of birth. Finally, he differentiated instincts from what he called uncoordinated urges, which give rise to instincts by stressing the role of the mother in providing organization and structure, thus allowing these urges to become psychically represented.

Unlike Freud (1915b), who placed less emphasis upon the importance of the particular object of satisfaction than upon the search for pleasure (which involved primarily the reduction of tension), Loewald was more concerned with the impact that the actual mother could have upon the child's inner experience. The object, then, for Loewald, was as crucial an element of the instinct as its source and aim. With regard to the experience of satisfaction, the mother not only provides a vehicle whereby excitation can be reduced, but she also "engenders and organizes excitation proces-

ses" (Loewald 1971a, p. 130). It is through this course of events that "mnemic images" become "constituents of instincts" (p. 130). At first, this is a global phenomenon, since mother and infant are merged; in the beginning, there is no difference between urge and response (Loewald 1971a, p. 131). Utilizing the language of Mahler (1967), Loewald (1978a) spoke of early symbiotic fusion, a condition in which there is "only one global structure, one fleeting and very perishable mental entity that was neither ego nor object, neither a self nor another" (p. 215). On this level, there is no anxiety about separation. Like Winnicott (1956), Loewald (1978a) believed that, when the unity between mother and infant is threatened, there is a "danger of annihilation, of disruption of functioning" (p. 215).

Strictly speaking, object relations do not come into being, according to Loewald, until some differentiation between self and other has occurred. This is because psychic interactions (p. 216) must be distinguished from actual interpersonal interactions, though the latter certainly contribute to the former and vice versa. It is this specific kind of inner relatedness that constitutes "the psychic matrix out of which intrapsychic instincts and ego, and extrapsychic object, differentiate" (Loewald 1978a, p. 216). Echoing Freud (1911), Loewald (1971a) described the process of differentiation as bound up with the repeated experience of "recurring need-tensions, environmental responsive actions, and satisfaction events . . . in alternation with delays and temporary absences of the experience of satisfaction," because of the limitations of environmental provision, all of which "lead[s] eventually to a subjective differentiation of mnemic 'image' and 'actual satisfaction'" (p. 131).

Under the best circumstances, the early lack of differentiation between instincts and objects is gradually left behind. For Loewald, human development involved the formation of psychic structure. The early experience of merger between mother and infant, in which the infant swims in an undifferentiated state, gives way to a condition in which the two become more psychologically separate. This takes place through the process of internalization,

whereby through interactions and relationships an "internally bound force field" is created, one that constitutes intrapsychic structure (Loewald 1970, p. 291). Within this dynamic, early libidinal and aggressive investment in others and rudimentary forms of total identification give way as the child becomes more intrapsychically differentiated from the human environment. It is not that these early, more primitive modes of mentation and relatedness are given up entirely, but that they become woven into higher modes of organization in which both subject and object are reconstituted and a more "depersonified" relationship comes into being that contributes to a sense of "self sameness and individuality" (Loewald 1973a, pp. 83-84).

This is the level on which object relations are possible. For Loewald, technically speaking, there are no object relations before the oedipal stage.[5] Loewald (1973a) stated that in the earliest period, "reality is pre-objective" (p. 81), because the infant and mother are too merged. In this condition, internalization consists of processes by which "inner and outer are being differentiated by recurrent sortings and resortings" (p. 81). This, in part, allows the ego to come into being as a psychic structure. Loewald (1973a) distinguished between these primary internalizations and later secondary ones that occur once the oedipal level has been reached (p. 81). Under certain conditions in adult life, these primary internalizations may be brought to life, as a blurring or loss of ego boundaries occurs that can have creative or destructive consequences (p. 82).

According to Loewald, when subject and object have been more fully differentiated as the oedipal level is reached, object relations come into being that involve a major transformation of the child's inner life. As one who is more capable of having experien-

[5] At the very least, a separate, additional paper would be required to show how the use of the term *object relations* differs when one explores the work of other major psychoanalytic theorists, such as Klein, Winnicott, and Fairbairn. I am suggesting that a principal distinguishing feature of Loewald's perspective from that of his forebears is his insistence on the idea that object relations do not take place in the preoedipal phase of development.

ces as an autonomous agent, the child can begin to initiate action and to respond to the world in ways that both preserve its own emerging distinct sense of self, and at the same time acknowledge the independent status of the other.

EGO PSYCHOLOGY

The perspectives of ego psychology held a special place for Loewald (1960), since he believed that "ego psychology is not concerned with just another part of the psychic apparatus, but is giving a new dimension to the conception of the psychic apparatus as a whole" (pp. 222-223). He was particularly influenced by Hartmann, whose explorations provided a framework that Loewald both utilized and critiqued.

Like Hartmann (1939), Loewald believed that both id and ego emerge out of an undifferentiated matrix in the early phase of the infant's life. Therefore, he challenged Freud's (1930) belief that the ego was simply an extension of the id. In addition, Loewald differed with Freud, who argued at times that the external world is felt by the newborn infant to be primarily frustrating, if not hostile. Rather, Loewald (1951) subscribed to Freud's idea that "to start with, reality is not outside, but is contained in the pre-ego of primary narcissism" (p. 8), a condition where "there are no boundaries . . . between ego and external reality" (p. 11). But there is a nascent ego, an *ego-subject*[6] that "is an instinctual one" (Loewald 1971a, p. 135).

The ego comes to fruition as the child interacts with others at the same time that it is seeking to become a separate individual. According to Loewald (1978a), this takes place in the preoedipal phase through the formation of primary identifications (p. 209). The purpose of these identifications is to reinstate the earlier sense of unity, although—hopefully—as one grows older, this occurs "on more and more complex levels of differentiation and objectivation of reality" (p. 211). Loewald (1978a) made it clear that he

[6] This is a term employed by Freud (1915a, p. 134).

did not accept the idea put forth by Hartmann that "there are ego apparatuses with primary autonomy" (p. 209), and that part of the ego utilizes a noninstinctual form of energy (Loewald 1988a, p. 21).

For Loewald (1978a), such phenomena as perception and memory were rooted in unconscious instinctual activities that were aspects of libidinal processes (p. 209). As development proceeds, perception and memory "gain a comparatively autonomous status" (p. 209). In addition, unlike Hartmann, Loewald (1988a) was less interested in ego functions, defenses, and adaptations, but instead wished to focus upon the "genetic-dynamic construction of psychic organization or structure" (p. 16).[7]

This points to Loewald's belief that the ego should "not . . . [be] defined as a structure" through its functions, such as "memory, perception, reality testing, etc., but by its being a coherent organization on a certain level of functioning" (1978a, p. 210). As a psychic structure differentiated from id and superego, the ego "perform[s] mental functions in differently organized process-patterns and configurations" (p. 211). He was particularly concerned with the degree to which the ego is capable of differentiation and integration.

Loewald's interest in these processes was woven into his concept of internalization. In utilizing an ego psychological perspective, he (1973c) was less interested in exploring the nature of defense, "the ego's protection of its own status quo," and more interested in examining the "expansion, further and richer organization of the ego" (p. 176). The idea of internalization allowed him to intertwine his conception of the instincts with object relations, in order to provide a model for understanding the creation and development of the ego. For with the advent of the oedipal phase, "internalization implies a transformation of object cathexis into narcissistic cathexis, that is, more complex ego organization" (1973a, p. 76).

[7] Although Loewald claimed that he was not particularly interested in adaptation, his discussion of the early global unification of the ego and reality points to Hartmann's belief in the biologically based fit between the ego and the average expectable environment.

In saying this, Loewald, I believe, was referring to the way that, under the best circumstances, early passionate involvements, as well as identifications, are transformed. They are assimilated by the coherent ego, so that the "libidinal-aggressive as well as the identification elements in object relations" are relinquished (1973a, pp. 82-83).[8] Drawing upon Freud (1920), Loewald (1988a) focused upon the way that the binding and uniting power of Eros, reflected in early libidinal bonds with parents, becomes internally displayed as these bonds are desexualized (p. 20). In this process, the child's internal world changes as object relations are transformed into what Loewald called intrapsychic interactions (p. 19).

With regard to early identificatory processes, Loewald stated that the child's initial attempts to become completely like the parents are modified as internalization takes place. For, with internalization, the child reconfigures him- or herself on the level of fantasy by utilizing certain attributes of the parents without becoming totally merged with them. This allows the child to create a novel organization of inner experience that, in turn, can lead to expanded opportunities in the external world, through the mediation of the ego (Loewald 1988a, p. 19). That is why Loewald (1973a) stated that internalization, if carried to completion, allows for a "redifferentiation" to take place, "by which both subject and object have been reconstituted, each on a new level of organization" (p. 83). Both child and parent are allowed to preserve their self-sameness and individuality as their relationship becomes "less colored by identifications and less passionate" (p. 84). Echoing here the observations of Erikson (1950) on ego identity, Loewald indicated that the process of internalization is central to ego development.

SELF PSYCHOLOGY

According to Loewald (1971a), the term *self* has been used "far too loosely and equivocally" (p. 134n) in psychoanalysis. Utilizing a de-

[8] Loewald (1973a) may have been too definitive in his belief that both these elements can be so thoroughly destroyed (p. 83).

velopmental perspective, he stated that the emergence of the self is a relatively late phenomenon. It is embedded in the process of individuation, which is bound up with the establishment of psychological boundaries between the child and its earliest caretakers.

However, during the evolutionary history of psychoanalysis, the concept of the self has been utilized to explore developmental phenomena that precede the emergence of adequate psychic structure. Loewald was very interested in this preoedipal phase of development, where the boundaries between self and object are porous; therefore, he was drawn to the work of theorists like Kohut, perhaps best known for his exploration of the narcissistic dimension of human experience. Because Loewald (1984) did not subscribe to the idea of a rudimentary self, instead emphasizing the extent to which, in the beginning, all infants are submerged in a "transindividual field" (p. 166), he could not fully embrace Kohut's conception of the self. Loewald rejected Kohut's (1971, 1977) metapsychological formulation as described in both *The Analysis of the Self* and *The Restoration of the Self*. Loewald regarded the self as neither a content of the mind nor as a separate agency. Instead, he suggested that the self should be viewed as "the mind as cathected in its totality" (1973d, p. 351). Finally, he stated that it would be most useful to use the term *self* "for a stage in the individual's development" when id, ego, and superego have been "rather definitively established" (1976, p. 153).

Despite these criticisms, Loewald did find Kohut's exploration of states of self-object merger very useful in understanding the process of human development. It was Kohut's concept of the "grandiose self, omnipotent object, mirror transference, and idealizing transference as clinical concepts" that Loewald (1973d) found "most illuminating and valuable" (p. 351). The fact that these concepts dovetail in certain ways with Loewald's own ideas about internalization, and perhaps even shaped his formulations, allowed him to conclude this. In this context, Loewald emphasized Kohut's belief that the formation of the ego and the superego involve in part the "transmuting internalization" of the "narcissistically experienced archaic self-object" (1973d, p. 344) into inner functions that allow for drive regulation, integration, and adaptation.

With regard to the baby's earliest experience, Loewald (1985) stressed the importance of mirroring, since he believed that the "gleam in the parents' eyes, at least a minimal degree of prideful parental joy, is indispensable for individual development of any viable coherence" (p. 438). He suggested that a similar process must take place during an analysis, especially when patients descend into "vulnerable levels of experience" (1981, p. 29). Like Kohut, Loewald (1981) believed that failure on the part of the parent or analyst to provide adequate mirroring could lead to unbearable fragmentation or to arrested psychic development (p. 29).

Having acknowledged what he found valuable in Kohut's work, Loewald (1973d) nevertheless indicated that Kohut may not have been sufficiently alert to the way that the analyst can become overly identified with the patient's narcissistic needs (p. 346). The archaic ego may become so much the focus that object-libidinal issues, as well as ego defenses, may not receive sufficient attention. In addition, Loewald challenged Kohut's belief in the idea that there are two separate lines of development, one pertaining to narcissistic needs and the other to object relations. Loewald (1973d) believed that the two are interrelated: "Object love is not in opposition to or in place of narcissism. Rather, mature narcissism, mature cathexis of the self in Kohut's terms, and mature object love are tied together" (p. 350).

Moreover, in keeping with his commitment to a perspective that acknowledged both the complexity of clinical phenomena and the importance of finding a correspondingly comprehensive clinical theory and metapsychology, Loewald (1973d) stated:

> Whether one interprets given material in terms of the self and its fragility, or of self-esteem, as against interpreting the same material in terms of castration fear . . . or goes back and forth between one and the other, depends on subtle shifts signaled by the patient between more and less developed layers of the personality, but also on one's point of view regarding the interrelations and interdependence between narcissism and object-libido. [p. 349]

In its recognition of the need to shift one's focus with regard to the leading issue in a given session with a patient, Loewald's perspective calls to mind Pine's (1985) desire to contain and integrate what Pine called the "various developmental theories that psychoanalysis has thus far produced" (p. 54). Pine stated that one of these theories pertains to the self and issues related to "boundaries, self experience, and esteem" (p. 55). Loewald's approach was also similar to Pine's in that Pine did not lift the concept of the self to the "level of general theory" but stayed within an experience-near developmental framework (p. 54). It was the movement out of the early matrix in which self and object are undifferentiated that formed Loewald's principal focus, even as he recognized the need throughout life to retain access to this primitive state without becoming submerged in it.

THE INTERPERSONAL APPROACH

In the history of psychoanalysis, the work of Harry Stack Sullivan is most clearly associated with the concept of the interpersonal. Loewald rarely referred to the work of Sullivan. Like many others in the psychoanalytic movement, Loewald suggested that Sullivan was too preoccupied with overt manifestations of personality, and therefore failed to explore sufficiently the deeper intrapsychic dimension of human experience.[9]

Nevertheless, aspects of Loewald's work reflect his interpersonal concerns. Sullivan's emphasis upon the importance of the external world, particularly the impact on children of parents' spoken and unspoken behavior, was of continuing interest to Loewald. It is for this reason, in part, that he was drawn to the work of Winnicott and Kohut, who have often been cited as having embraced a perspective that allowed for a greater consideration of the way people affect one another through their interactions than is present in some of Freud's work.

[9] Greenberg and Mitchell (1983) challenged this criticism of Sullivan by providing an interesting analysis of his exploration of the intrapsychic.

For Loewald, the individual could be understood only in an interpersonal context. Like Winnicott, he believed that, from the beginning of life, the infant is thoroughly intertwined with the mother. Furthermore, he indicated that this condition provides the template for the psychoanalytic process. Neither patient nor analyst is a closed system (Loewald 1970, p. 278). Speaking of the way in which psychoanalysis is grounded in the idea that "whatever transpires is personally motivated," Loewald (1971a, p. 103) stated that this occurs in an interpersonal matrix. For "motivations, while residing in the person motivated, have something to do with relations with other persons who themselves are centers of motivation" (p. 103). He was even more explicit when he stated that "what from an external (i.e., nonpsychoanalytic) observer's point of view are called objects, are indispensable and crucial factors in the organization of psychic functioning and psychic structure" (p. 127). Loewald (1971a) thus challenged Freud's early view of the relationship between instincts and objects, in which the former are equated with "somatic needs which primarily have nothing to do with the environment" (p. 128).

Loewald emphasized the extent to which the analyst and analysand enter into a psychoanalytic investigation only by virtue of being open to one another. Not only does the analyst observe the analysand, but the analysand is also continually observing the analyst, so that transference and countertransference are ongoing. Loewald (1970) compares the analysand

> . . . to the child who—if he can allow himself that freedom —scrutinizes with his unconscious antennae the parents' motivations and moods and in this way may contribute—if the parent or analyst allows himself that freedom—to the latter's self-awareness. Internal communication, on which self-understanding is based, and communication with another organization of the same rank of reality—the psychic reality of another individual—are inextricably interwoven. [p. 280]

In addition, each member of the dyad is investigating him- or herself. Loewald made it clear that not only the analysand, but

also the analyst, can gain clarity about the self by investigating the other. Each is changed through communication with the other. As this occurs, each person's sense of feeling organized or disorganized is affected (though Loewald stressed that, under the best circumstances, the analyst has achieved a higher level of organization). In fact, it is through interpretation, central to the psychoanalytic process, that "both the unconscious experience and a higher organizational level of that experience are made available to the patient" (1960, p. 242).

Loewald (1971a) placed great emphasis upon the nature of the impact of the analyst on the patient by going so far as to say that "the momentum, the dynamic power of an interpretation, in psychoanalysis manifests itself as personal influence" (p. 105). While Freud tried to find ways to distinguish between the power of suggestion in psychoanalysis and the power of interpretation (thereby emphasizing the importance of neutrality and the necessity of approaching the analytic task with the skills of a surgeon), Loewald believed that suggestion and interpretation were so intertwined that they could not be easily demarcated.

Finally, Loewald's understanding of the nature of psychic structure reflected his belief in the importance of the interpersonal. Unlike Freud, for whom the id was such an enormous force—whose contents and energy were more impervious to the external world—Loewald (1970) stated that the major psychic structures outlined by Freud, including the id, "have been formed and they are maintained and, within limits, can change by intercourse with other persons: they are not only mutually interdependent but also interdependent with the psyches of others" (p. 282). This is an ongoing process (p. 282), he added, which continues after adolescence, although at a slower pace.

THE INTERSUBJECTIVE VIEWPOINT

The term *intersubjectivity* did not become a major part of the vocabularies of some psychoanalysts until relatively recently. According to Teicholz (1999), during approximately the last twenty years,

this term has often been utilized to describe the nature of mutual regulation and the possibilities for mutual recognition, especially between mother and infant, as well as between analyst and analysand. Teicholz also suggested that Loewald's work, along with Kohut's, has provided some of the groundwork for the new focus on intersubjectivity.

One of Loewald's (1960) major concerns about traditional psychoanalysis was the view of the psychic apparatus as a closed system (p. 223). He contested the stance of those who privileged the intrapsychic to such an extent that analysis became essentially a one-person psychology. For Loewald, the image of the analyst as a reflecting mirror did not do justice to the analyst's role as "a co-actor on the analytic stage" (p. 223). He stated that this is more than an interpersonal process that points to the impact of the actual behavior of the analysand and analyst upon one another. It is also an intersubjective process, according to Loewald (1970), since

> . . . to discover truth about the patient is always discovering it with him and for him as well as for ourselves and about ourselves. And it is discovering truth between each other, as the truth of human beings is revealed in their interrelatedness. [pp. 297-298]

He went even further when he stated that the importance of preoedipal phenomena, especially in work with more seriously disturbed patients, points to the complexities of transference-countertransference phenomena and the possibility of "direct communication between the unconscious of different persons" (1979a, p. 399). All this led him to wonder "whether we are justified in simply equating as we do, psychic life with the intrapsychic" (1979a, p. 399). Perhaps that is why he stated in the preface to his *Papers on Psychoanalysis* that, in psychoanalysis, *"interactional* processes—those that are intra-psychic and inter-psychic ones, and these two in their interactions—are the material of investigation" (1980, p. vii, italics in original).

With regard to human development, Loewald's belief in the importance of intersubjectivity is evident in his emphasis upon

the "inextricable intertwinings with others in which individual life originates and remains throughout the life of the individual in numberless elaborations, derivatives, and transformations" (1986, p. 276). In this context, his conception of the nature of the relationship between mother and baby is particularly revealing. Pointing to the issue of mutual regulation, he referred to the "mutual correspondence and responsiveness, a reciprocal heightening and decrease of states of pleasure and unpleasure" (1971a, p. 134n) that occur in the course of the interaction between mother and infant. He was interested not only in the infant's modes of relating to the mother, but also in what he called the "libidinal forces on the part of the mother toward the child" (1951, p. 6).

According to Loewald, the earliest state of merger between infant and mother is the template on which is built future intersubjective exchanges. Full psychological recognition by the infant of the mother can only come about when the condition of merger gives way to a degree of separateness. It is through the process of moving out of this symbiotic matrix that the child learns to "gain distance from himself" and to view others more objectively, as he or she begins to experience the "higher-order cathecting activity" of the parents (Loewald 1970, p. 296). Moreover, as object relations develop, they take place "between mutually cathecting agents, and the cathecting of each partner is a function of the other's cathecting" (p. 296).

In analysis, then, not only is the patient invested in the analyst, but the analyst is also emotionally invested in the patient, though in a different manner. The analyst's interpretive activity is the principal difference here, since it is through this process that the analyst expresses on the highest developmental level his or her caring for the patient. To the extent that this interpretive capacity can be internalized by the patient, the psychoanalytic process can be furthered. Nevertheless, especially when working with patients with narcissistic disorders, the analyst must be able to access his or her own primitive states, which involves to some extent the temporary dissolution of ego boundaries (Loewald 1978a, p. 215), in order for the analyst to enter more thoroughly the patient's inner world, in preparation to interpret.

But even with patients who are functioning on a higher level, Loewald (1986) suggested that the analyst must become emotionally immersed. He stated that: "For most if not all patients in analysis the analyst's emotional investment, acknowledged or not by either party, is a decisive factor in the curative process," though "by no means the only decisive factor" (p. 285). The analyst, then, should not function as a detached spectator, but as a responsive presence whose tact and timing with regard to interventions are crucial elements in the therapeutic process (Loewald 1975, p. 356). In fact, all relationships, including the analyst's experience of the analysand, are imbued with transference reactions. According to Loewald (1960), "there is neither such a thing as reality nor a real relationship, without transference . . . . [It is the] transfer of unconscious images to present-day objects" (p. 254) that provides a sense of fullness and vitality in present-day experience.

This process is central to the psychoanalytic situation. Consider Loewald's (1975) observation that

> . . . in the mutual interaction of the good analytic hour, patient and analyst—each in his own way and on his own mental level—become both artist and medium for each other. For the analyst as artist his medium is the patient in his psychic life; for the patient as artist the analyst becomes his medium. But as living human media they have their own creative capabilities, so that they are both creators themselves. In this complex interaction, patient and analyst—at least during some short but crucial periods—may together create that imaginary life which can have a lasting influence on the patient's subsequent actual life history. [p. 369]

Here Loewald suggested that patient and analyst provide for each other that contemporary object that can serve as a catalyst and repository for unconscious experience. Out of this interaction, something new is created. Loewald's formulation here points to Ogden's (1994) idea of the analytic third, which is "the intersubjectively generated experience of the analytic pair" (p. 94), an experience that results from "a unique dialectic generated by/be-

tween the separate subjectivities of analyst and analysand within the analytic setting" (p. 64).

According to Loewald, then, the analyst is constantly having an impact upon the patient. The patient's transference is not simply a re-creation of the past, with the analyst functioning as a reflecting mirror (Loewald 1960, p. 223), but it can be "called forth and shaped by present actuality (including the mental life of the analyst)" (Loewald 1975, p. 370). Moreover, Loewald (1979b) suggested that for interpretation to be effective, it must involve a form of understanding that includes "some sort of mutual engagement, a particular form of the meeting of minds" (p. 382), which "is impossible unless the patient lends himself and is open to our understanding" (p. 381).

Loewald (1979b) contrasted this with "understanding"—that is, with "a storehouse of knowledge that we make use of for our understanding" (p. 381). Though he seemed to be merely echoing Freud, who was concerned that analysis could turn into a sterile intellectual process, Loewald's emphasis on the need for deep and ongoing rapport between patient and analyst suggests a different level of emotional involvement than that which is conveyed in Freud's discussion of the importance of the analyst's neutrality and anonymity.

It is not that Loewald did not recognize the importance of Freud's concerns. For example, in speaking of clinical work with patients with primitive narcissistic transferences, Loewald (1986) was concerned that the analyst could become overstrained, so that "his own ego boundaries become blurred" (pp. 284-285). But he was equally concerned that such narcissistic transferences might "call forth rigid defences in the analyst that make significant communication difficult" (p. 285). More generally, Loewald (1971b) believed that if the analyst did not remain in contact with his own instinctual-affective currents, he might "play into . . . character defenses and reinforce them" (p. 307).

Nevertheless, Loewald was less interested than are many today in exploring that dimension of the analyst's subjectivity that might be utilized to transform the therapeutic process through self-dis-

closure.[10] For him, intersubjectivity did not mean a continual expression by the analyst of his or her feelings about the patient's process (although the analyst could make great use of the range of thoughts and feelings stirred up in the course of the therapeutic encounter, in order to further the aim of understanding the patient). Loewald, then, tended to confine his interest in countertransference to an exploration of the analyst's inner process as it unfolded in the course of an analysis, something that he acknowledged had just begun to be examined within the field of psychoanalysis even as late as 1986.

HERMENEUTICS

Because its major concern is with the inner experience of each of the participants in the analytic process, psychoanalysis has been entangled in debates about whether it should be viewed more as a natural science or as a science of interpretation and therefore as a form of hermeneutics (Steele 1979, p. 389). Freud (1933) generally advocated the former point of view. At one point, he stated that psychoanalysis is a science because the "intellect and the mind are objects for scientific research in exactly the same way as any nonhuman things" (p. 159). Loewald (1980) challenged this perspective. He thought of psychoanalysis as a unique scientific discipline whose methods must be suited to its observational field—the "intra-psychic" and "inter-psychic" experience of two interacting individuals (p. vii). In his commitment to this point of view, he emphasized the degree to which the observer of inner experience is more deeply implicated in that which is observed than is the case in the natural sciences.

Unlike Freud, Loewald did not believe that the analyst is an objective observer in a manner comparable to that of a traditional scientist in the field of physics, biology, or chemistry. Loewald's

[10] Balsam (1997), one of Loewald's supervisees who worked with him for many years, states that "he stood for abstinence in technique, in the sense of restraint in speaking of one's personal reactions" (p. 7).

(1988a) view was embedded in a philosophical context, since he drew upon the ideas of Kant—particularly the notion that acts of perception, even of the objective universe, are bound up with the "schemata . . . [of] our mind" (p. 66). For Loewald, then, as for many who embrace hermeneutics, the analyst is a participant observer whose subjectivity shapes that which is observed. The meanings that he or she can ascribe to that which is perceived are multiple, shaped by a variety of factors. Under the best circumstances, the analyst will be alert to his or her own preconceptions, as they are constituted by personal life, training, and the larger social, political, economic, and cultural context in which the analyst has lived, so that he or she can meet the patient on the basis of the latter's needs.

Therefore, Loewald challenged the idea that the interaction of patient and analyst can be understood through the use of scientific neutrality (1960, p. 226) when he indicated that the patient slowly becomes "an associate, as it were, in the research work," and therefore is "increasingly engaged in the 'scientific project,' which is, of course, directed at himself" (p. 227). In addition, an identification is promoted by the analyst, so that the patient's observing ego is strengthened. None of this occurs "in the vacuum of scientific laboratory conditions" (p. 228). Loewald (1971a) also stated that, unlike in the traditional sciences, "the 'object' of investigation can never truly be made to stand still and be an object" (p. 104). In saying this, Loewald was not discarding the idea that psychoanalysis is linked to science; for he also stated that psychoanalysis "has opted for regarding its material of experience as 'psychic,' while remaining cognizant of, and in communication with, the biological perspective" (1988a, p. 34). In addition, he believed that it was possible for the analyst to try "to observe objectively the patient and himself in interaction" (1960, p. 226).

For Loewald (1979b), the issue was how to describe the nature of this objectivity. This is why he came to ask:

> Is the psychoanalytic process one of objective investigation of psychological facts, or is it interpretation of mean-

> ings? If the latter, are the meanings there, to be uncovered by us as analysts, or are we, although not arbitrarily, providing meanings? Are the patients providing the meanings, or the psychological facts, as a function of our active receptivity as analysts? Are "meanings" something that arise in the interaction between analysand and analyst? [pp. 373-374]

Like many analysts practicing today, Loewald struggled to answer these questions and, I believe, never arrived at clear, definitive responses, which is why he continued to wonder whether psychoanalysis should be placed more squarely within the realm of science or art. That he tried to embrace a position that acknowledged both dimensions is implied in his observation that transformations in the manner in which truth is constituted in the modern world, as well as changes in the way in which we view the relationship between objectivity and subjectivity, have led to the recognition that "science and art are not as far apart from one another as Freud and his scientific age liked to assume" (1975, p. 352).

Loewald suggested that the practice of psychoanalysis, involving work with a specific person, is a therapeutic art, while the psychoanalytic theories utilized by the analyst to understand the patient are rooted in science (1975, p. 353). Here Loewald appeared to corroborate the views of Steele (1979), for whom psychoanalysis provided "quasi-naturalistic explanations . . . [that] treat symptoms and dreams as objects to be observed and interpreted, but their explanation in terms of an interpretation to the client serves to transform them from the objective to the subjective" (p. 396). In this process, such phenomena are brought into the "human sphere of meaning and intention" (p. 396)—the world of hermeneutics.

Utilizing a metaphor drawn from the theater, Loewald (1975) stated that "the psychoanalytic situation and process involves a re-enactment, a dramatization of aspects of the patient's psychic life history, created and staged in conjunction with, and directed by, the analyst" (p. 353). Despite the fact that the transference neurosis is modeled upon an action that occurred in the past, ac-

cording to Loewald, it is impossible to be absolutely certain about the nature of the original action sequence (p. 353). For as in the case of a play, where there is (at least implicitly) a reinterpretation of an "action from certain points of view and in certain directions," in the life of the patient, preoedipal, oedipal, and adolescent action sequences (pp. 358, 359) are reawakened and left to be interpreted in a variety of ways. These interpretations are not simply invented, but meaning is created, by interactions between patient and analyst (Loewald 1971b, p. 311). Nothing is more important to interpret than the patient's fantasies, according to Loewald. But Loewald (1975) was concerned that some analysts would lose empathic contact with this source because of their commitment to standards of objectivity and rationality. At one point, he went so far as to say that psychoanalysis "is still affected by the disease of the age and especially of official science—the disruption between fantasy and rationality which it is intended to cure or ameliorate" (p. 364). Loewald felt that Freud "does not appear to have recognized that the objective reality of science is itself a form of reality organized . . . by the human mind and does not necessarily manifest the culmination of mental development or represent any absolute standard of truth" (p. 364).

Loewald, then, presented an alternative set of perspectives that often appear to embrace the idea that psychoanalysis is a hermeneutic science. Steele (1979) described hermeneutics as "the art or science of interpretation" (p. 389), which "is devoted to examining the nature of human understanding" (p. 390). This understanding involves language as it is utilized when people interact with each other or create their own texts. In a similar manner, Loewald (1975), in speaking of that part of the psychoanalytic process that involves "memory . . . as recollection" (p. 364), referred to the "repetition of action in the form of narrative" (p. 365), comparing this to a novel or a historical account. He highlighted the "fractionated accounts of episodes" (p. 365) that patients present, thereby suggesting the multiple nature of the narratives that may be provided.

In speaking this way, Loewald stressed the role of language in shaping the events described. He was particularly drawn to Freud's (1915b) analysis of the way that the contents of the unconscious can become conscious as "thing presentations" linked to "word presentations" (p. 202). Here Freud held out the possibility for the development of greater psychological organization through the use of language and the creation of meaning. For Loewald (1988a), this was central to the process of sublimation, which involved, in part, an increasingly sophisticated use of words whose primary function and intention is "to provide, to *be,* bridges between items of experience other than themselves and to bring out connections between them" (pp. 57-58, italics in original).

Loewald (1988a) emphasized the manner in which words can be used imaginatively to help order experience. In this context, the analyst must remain aware of the possibility of being "misled . . . into unfounded assumptions about a patient's experience and motivations" (p. 67). In saying this, Loewald was appealing to the values of science, with its emphasis upon accuracy and objectivity. As he elaborated:

> If psychic reality is a legitimate area of systematic scientific study and if the investigator's concordant activity of symbolizing is the instrument through which man's symbolizing activity and its productions become available, then there is nothing unscientific or nonobjective involved here. [p. 68]

Nevertheless, Loewald (1971a) also acknowledged that psychoanalysis is primarily an interpretive discipline, a hermeneutic activity, that makes it possible for an individual's psychic life to assume "meanings and an inner coherence which heretofore were not apparent" (p. 102).

CONCLUSION

The manner in which Loewald utilized many psychoanalytic models points to the tentativeness of his vision. He was aware that each

of the models I have discussed was not seamless, and he presented his views as a set of possible perspectives on each of them. In addition, while attempting to synthesize the work of others, in general he presented his own point of view as one more possible perspective. Having said this, I believe that at times one can read him as if he thought he had discovered some firm foundation—as, for example, when he repeatedly stressed the tension between the search for union and the urge to differentiate as the central psychological conflict.

Nevertheless, the overriding spirit of his work suggests that he constantly struggled to understand psychological experience, only to be aware that any set of meanings could be contested, even if some were more useful than others. So, with regard to the motivational pull toward higher organization through a process that seeks a "textured totality" (1978b, p. 196) through greater differentiation, Loewald at times stated his views cautiously. For example, after acknowledging that Freud referred to "the 'struggle against passivity' in men and penis envy in women as the bedrock we reach when 'we have penetrated through all the psychological strata,'"[11] Loewald (1973b) wondered whether "the great riddle of sexuality, of sexual differentiation," might be "at the same time the great riddle of individuation, of becoming a separate biological and psychological entity" (p. 338). In his attempt to suggest another bedrock for psychological experience, Loewald demonstrated his commitment to the value of multiple perspectives and to the principle of uncertainty in theory formulation.

He also did this in considering the work of others. That is why, despite his great debt to ego psychology and his respect for its proponents, he could say of *Psychoanalytic Concepts and the Structural Theory* (Arlow and Brenner 1964) that it left the reader

> . . . with the impression that in their [the authors'] view issues are settled, concepts well defined and precise, problems well understood and in no need of further inquiry, many of which are neither as clear-cut nor as simple and

[11] Here Loewald was in part quoting from Freud (1937, pp. 251-252).

> one-dimensional as they are represented to be. [Loewald 1966, p. 54]

Loewald's belief that ideas should be presented less definitively was reflected at times in the tone he employed to express his own views. For example, in the beginning of his essay entitled "Superego and Time" (1962), he noted: "My approach to the problem will thus be one-sided. It is an experiment in thinking and should be taken as such" (p. 43). Then, at the end of the same essay, he acknowledged the "fragmentary and partly speculative nature of this presentation and . . . the fact that it raises rather than solves problems" (p. 52). The spirit evident in these comments about the work of Arlow and Brenner and about his own essay permeates Loewald's thinking. I would suggest that this dimension of his work can sometimes get lost in the claims made by some that he presented a comprehensive vision.

Very little in Loewald's work is clear-cut, and that is why any exposition of his ideas, including my own, tends toward oversimplification, and must necessarily miss certain ambiguities or even misgivings that Loewald had when trying to present his point of view. I have tried to capture some of his doubts about his formulations and those of others in my effort to understand his approach to psychoanalytic theory. In the end, it is tempting to believe that Loewald provided us with his own internalization of those elements of psychoanalytic theory that he found most compelling (Kaywin 1993, p. 113). Loewald worked these elements over, absorbing, critiquing, and transforming them in order to devise his own perspectives.

Although he took in the ideas of others and identified with certain of their ways of thinking, Loewald could also metabolize these ideas and provide at times a novel point of view. This might even include changing the meaning of a term, which led Schafer (1991) to imply that Loewald periodically employed "word magic to treasure words as containers of mysteries and, as such, to relish them as occasions for poetic theorizing and in that way to legitimate one's own personal constructions" (p. 88). However, I would argue that when Loewald changed the meaning of a given

term or concept employed by another theorist, most often, he was very clear about what he was doing. He changed the meaning in an attempt to find a better way to explain certain phenomena. By doing this, he suggested that, as a theoretician, he was achieving a higher level of integration, albeit one that was inconclusive.[12] For each of Loewald's acts of identification or differentiation with regard to the use of existent theory tended to serve his need to create a personal vision.

In presenting this vision, Loewald often revealed his commitment to a belief in "the evolutionary, developmental tendency toward disorganization and reorganization at higher levels" (Fogel 1991, p. 169). I would suggest that one of his great strengths was his awareness that he was offering a personal perspective, which was both an elaboration of past theory and sufficiently innovative to provide a novel platform that others might find useful—and perhaps eventually supplant.

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[12] Lear (2003) stated that: "Loewald's strategy is to help us grasp from the inside that we are not in fact prisoners of fixed concepts with absolutely determinate meanings. This does not mean that anything goes, but it does mean that we need to look at the various ways we live with a concept, rather than assume that a fixed meaning is forever imposed on us" (p. 52).

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GENERATING WORDS: ONE APPROACH TO TEACHING CLINICAL WRITING

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Language is our means of reaching our patients and our means of describing the process of analysis to others. The task of the case history is to show the evolution of consciousness in both analyst and patient. It will be more effective if written in a lively engaging way. The author describes one method of teaching clinical writing, introducing candidates to techniques of fiction writing and poetry. Her class has involved both focused reading and writing exercises; examples are given of both.

Day One: The third-year candidates enter late, laugh nervously, one says, "Why do we have to do this?" The struggle is on. I express my hope that this class in clinical writing will not only help them complete their overdue case write-ups, but will give them more confidence in how they express themselves, sharpen their psychoanalytic thinking about their patients, increase their attention to how words work, and, mostly, will be fun. I observe an exchange of dubious glances.

We have read an essay for the first day, Joan Didion's "Goodbye to All That" (1968). I ask what moments stood out for them. One candidate focuses on the scene in which a young woman stands on a New York City street corner in a swirl of traffic among scents of garbage and perfume, eating a peach. I ask them *why* the moment has an impact. One notes the smells, another the colors, another comments on the arrested moment of self-awareness, how time stops both for the speaker in the essay and for the reader, fused in

a memory and an experience. The moment is intensely sensuous and puts the readers inside the writer's skin, evoking each one's memories of her own youth.

Why isn't psychoanalytic writing full of moments like this? Couldn't analytic reading be almost as pleasing as a good essay or novel? Since the task of the case history is to show the evolution of consciousness in both analyst and patient, why not do it in a lively, engaging way? As a group, psychoanalysts seem well aware that the only effective work is unique, alive in the moment, and responsive to the individuality of both participants. The deadness of language is often a clue to something going on in the transference or countertransference (Ogden 1995). The necessity of crafting an interpretation with well-chosen words is widely recognized. So is the impact of our particular words, their music and tone, beyond their content and meaning. Why don't we have the same criteria for writing about clinical experience?

In the seminar, one candidate points to a scene in the speaker's apartment:

> All I ever did to that apartment was hang fifty yards of yellow theatrical silk across the bedroom windows, because I had some idea that the gold light would make me feel better, but I did not bother to weight the curtains correctly and all that summer the long panels of transparent golden silk would blow out the windows and get tangled and drenched in the afternoon thunderstorms. That was the year, my twenty-eighth, when I was discovering that not all of the promises would be kept, that some things are in fact irrevocable and that it had all counted after all, every evasion and every procrastination, every mistake, every word, all of it. [Didion 1968, pp. 232-233]

The class discussion focuses on Didion's method of conveying a realization. The character sees the bloom is off the rose and off herself. Time has passed: omnipotence fades. Both the narrator's former sense of life as unreal and her sense that possibility is eternal dissolve. Her shift in consciousness is conveyed deftly in the image. The silk curtains become a metaphor for the dramatic, ten-

der, unsubstantial self of youth. The first sentence lasts for half the paragraph, slowing time, drawing things out. Then the pacing at the end of the paragraph, the incantatory list of *everys*, emphasizes the downbeat, so that when she changes to "all of it," Didion makes us feel that an adult has landed, her feet now on the ground.

After going through the essay, we turn to several pages I have brought for the class. This material consists of first paragraphs of novels, personal essays, and analytic articles. I change the packet each year, depending on what reading I have done that has caught my eye. Most are selected for the speed with which they introduce the reader to a world. For example, the unsettling first paragraph of Toni Morrison's *Beloved* (1987) conveys all the novelistic information of time and place, but also starts with the words "124 was spiteful" (p. 1; 124 is the house). A bald statement, an act of projection, brings us into this world. Or, we start with Holden Caulfield saying: "If you really want to hear about it, the first thing you'll probably want to know is where I was born, and what my lousy childhood was like, and how my parents were occupied and all before they had me, and all that David Copperfield kind of crap, but I don't feel like going into it, if you want to know the truth" (Salinger 1951, p. 1). We can talk narrative strategies, and how character is made vivid in tone of voice.

Everyone is looking engaged by now. But one candidate asks what relevance this has for psychoanalytic writing with our technical language. I say that's a good question, because we are looking at language at its most vivid. But it does raise a question: Why, given that Freud began there, has personal and quirky aliveness faded from the forefront of our writing tradition? Freud's case histories were, for many of us, our first look at psychoanalytic thinking and writing. His writing engaged our curiosity and sparked the desire to know more.

Creative writing employs language for pleasure and impact; in a poem, words work at intensity to move and delight us. Freud found himself making use of what he had learned from poets and fiction writers in order for his descriptions of analyses to make a compelling case for his new science. Kris (1975) quotes Freud:

> I have not always been a psychotherapist. Like other neuropathologists, I was trained to employ local diagnoses and electroprognosis, and it still strikes me myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the true stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. [p. 475]

While Freud seems to apologize for the form his work takes, it is easy to imagine he is also quite conscious of wanting the work to have an appeal for the reader.

The teaching approach described here tries to make use of creative writing techniques, not apologetically, but in a forthright way. All the elements of my method are borrowed from writing workshops. I imagine that many teachers of psychoanalytic writing apply similar techniques. Even so, I think it is worth articulating this method in order to be explicit about the wish for our professional writing to be lively and engaging, to not get caught within our field as Freud was, thinking we should sound scientific, when that notion often brings with it a formality and intellectualization of expression that flattens the prose. Candidates often complain that they are not fully engaged by the reading they do for the seminars. So I want to think with them about why this is the case, and wonder about writing in a way that would be enjoyable for both reader and writer.

The class turns to personal essays:

> One holds the knife as one holds the bow of a cello or a tulip—by the stem. Not palmed nor gripped nor grasped, but lightly, with the tips of the fingers. The knife is not for pressing. It is for drawing across the field of skin. Like a slender fish, it waits, at the ready, then, go! It darts, followed by a fine wake of red. The flesh parts, falling away to yellow globules of fat. Even now, after so many times, I still marvel at its power—cold, gleaming, silent. More, I am still struck with a kind of dread that it is I in whose hand the blade travels, that my hand is its vehicle, that yet

> again this terrible steel-bellied thing and I have conspired for a most unnatural purpose, the laying open of the body of a human being. [1]

Because I present all the paragraphs to the class without the author or genre identified, those in the room who have not had an experience like the one described often find the tone ominous. Reading without knowing the author heightens attention to the words on the page. (Here the sources of the paragraphs, indicated following the quotations by bracketed numbers 1-5, are listed in the Appendix at the end of the article so that the reader can have a bit of the candidates' experience.) I do this so that there is no preformed transference to the writer; there is no burden of "Am I supposed to admire this, to agree or disagree?" In reading this romantic description of the knife drawing across skin, the candidates don't know whether we are listening to a murderous psychopath or to a surgeon. My method allows the language to lead the way. The students focus on the tactile experience, on the quick shifts of metaphor, how the scalpel mutates from flower to fish to personified steel, how the speaker's sense of surprise in relation to his own action creates a strange and fruitful space for self-observation within the essay.

Then we turn to clinical writing:

> Lawrence came in with his black brief case and put it down at his side. He wore a gray suit with a gray shirt and a dark brown tie with emblems of a church tower embossed upon it in light gold. He was of Italian extraction. His hair was dark brown and neatly brushed. He was a tall man with a long nose and wavy brown hair. He was the director of a small but prosperous advertising agency. He looked at me piercingly as he came in. It was the last session of the month. [2]

The case begins, marching along, detail by detail in rapid fire. By the second sentence, one starts to wonder who is more obsessional, the patient or the observer. The colors are monotonous, everything is of a piece; the reader starts to feel a bit claustropho-

bic by mid-paragraph. Because each sentence begins with *he,* there is a repetitiveness to the diction. The unvarying quality of how the details are reported already gives us a feel for the countertransference. On a visceral level, the reader has begun to feel a regimented presence. And then, suddenly, there's that word, *piercingly*, and the neutral façade breaks open. It's as if we've been observing a statue and are alarmed to find it now looking back at us. And we see how the analyst feels penetrated by his patient, and we've already begun to feel him get under our skin, too. Then we're set on the edge of a precipice: the break.

By now, the class is excited about seeing what in the writing works, what doesn't, what makes them want to read an entire essay, what makes them want to avoid it. Then we turn to theoretical writing. First, there is a fall in mood, a disappointment that this is not so much fun, is harder work, with concepts to convey and digest. But the candidates quickly gravitate to the analytic essays that have an engaging voice, an interesting prose style, dynamic usage of language, or that raise thoughtful questions in a way that seems to welcome the reader into their pages.

> The silent patient presents special challenges to the analyst. I am not referring to patients who are quiet and reflective people, and who need spaces for thinking out what they are saying, and pondering on interpretations received, but who nevertheless, in their way, maintain a flow of communication. Silent patients are not common; I have treated only eight in thirty years. I would define the silent patient as one who speaks for approximately ten percent of the time, and often less. Nor is the speaking regularly spaced; there might be more sense of flow if there were. No, sometimes two or three sessions, or many more, may pass in silence. My record was one who did not speak for three and a half months, and this in spite of intermittent considered remarks from me. There is one other record which I will refer to later. [3]

Here, a very personal voice leads the way into the question at hand. Three months of silence—is this admirable patience or lun-

acy? The writer's terms are set forward in a simple and precise way; the reader feels them not as pronouncements, but as lived experience. There are no images, no fancy language, but a low-key and engaged tone. The voice sounds wise, without arrogance, though there may be some quiet pride in the announcement of "my record." Speaking from years of intense involvement in the work of analysis, the writer's matter-of-fact tone and the mysterious offer at the end of the paragraph make us want to read on.

As the reading material becomes more theoretical, the struggle for a personal and lively voice becomes greater. Part of this has to do with the shift from play to work. As readers, once the candidates see they are within their own field, the pressures to be smart, competent, and knowing reappear. It takes an inviting voice to overcome the trainee's tendency to go on automatic pilot when doing professional reading.

> Freud's description of the unconscious shows us new ways of keeping secrets, and a new rationale for doing so. A dream is enigmatic—it invites interpretation, intrigues us —because it has transformed something unacceptable, through what Freud calls the dream work, into something puzzling. It is assumed that the unacceptable is something, once the dream has been interpreted, that we are able to recognize and understand. And this is because it belongs to us; we are playing hide-and-seek, but only with ourselves. [4]

Secret, enigmatic, puzzling—these words intrigue and tantalize. Their allure is part of why each of us enters the field of analysis. We all want to discover what it is that is known but that we haven't been told. And so this writer is doing exactly what he is talking about: engaging us in the process of hide-and-seek, giving us an example on the page of what the mind is doing with itself. This piece takes a familiar starting point, Freud and the dream, and asks us to think differently about what dream work inheres in the image of hide-and-seek. The familiar has become new and whimsical: who is hiding from whom and why? The writer's condensed statements make us want to pursue him.

Another excerpt I might use in class:

> Because of significant shifts and changes in modern understanding of what constitutes truth, in our insight into the relations between reality and fantasy or imagination and between objectivity and subjectivity, we begin to recognize that science and art are not as far apart from one another as Freud and his scientific age liked to assume. Science's dignity is not so readily offended today by the suggestion that both art and science make use of creative imagination. Neither do we take for granted that creative imagination per se is unscientific, nor do we assume that art may not and does not ever employ the stringency of scientific or scientifically informed objectivity . . . . Insofar as investigations and interventions are intended to have curative effect on the patient's psychic life, psychoanalysis is a therapeutic art. [5]

This is less condensed language; the content is largely abstract. But the reader still feels a personal voice at work, particularly in the sentence in which science is personified and the writer considers its dignity. The author makes us take seriously his inquiry into how psychoanalysis is and is not an art, and how this distinction has become blurry. In this paragraph, though the speaker is invisible, one senses an acute mind at work and feels the writer's willingness to think in front of the reader. The author is explicit about the flexibility he perceives in the lines between science and art, and suggests the need for more room here. In the concluding sentence, the writer makes the leap he has been tiptoeing toward, landing on the side of art. He offers us a place in which to think about the precision of art. The reason these examples I've given of opening paragraphs are affecting is not because they are poetic in the sense of fuzzy or vague, but because they are sharp and clear in image and word choice. And the author introduces appropriate questions into the discussion of how creative writing can inform analytic writing.

The candidates in the class would happily spend more time at this game, but it's time to focus on our first assignment for next

week: bring one to two pages about anything that means something to you; the topic has to be nonclinical. There are groans; the anxiety is back. Then, for five minutes near the end of the class, I have them do a "free-write" exercise. I explain, adapting from Natalie Goldberg's (1986) method: "Free writing is like free association —you write down very fast and casually every thought that comes into your head. You go toward, not away from, what is uncomfortable. You don't lift the pen from the paper. The rule is, you keep going no matter what." I participate as well, modeling the exercise and calling time at the end. Some become more engaged than others. It's clear from initial reactions that some are surprised by what they have produced and will use it to generate next week's assignment.

Although many of the candidates have written dissertations and some have written professional papers, there is a particular anxiety attached to the clinical writing required for progression in analytic training. The candidates feel that the level of scrutiny of their work and of themselves is high. While the particular anxiety may shift depending on context—whether writing for progression or certification or publication—the writer is aware of the pressure to appear polished. Often, beginning writers take this as a signal to become more formal and rigid, to lose the peculiarities in their modes of self-expression.

For the more experienced writers in the group, case writing is not so filled with tension. These students could probably make good use of any of the possible methods for teaching a clinical writing class. Nevertheless, they seem to enjoy the exercises in focused reading and in writing with increased ease and speed. This subgroup is more ready to use the writing class as an impetus to generate or to complete new work.

The purpose of the free-write exercise is to break the ice, so that by the time the candidates leave the first class, they have already begun work on the first assignment. The exercise is done together, relying on group momentum. And it helps the more skeptical students see they are always full of things to say and to notice, to realize that the process of beginning the assignment is not so different from the generative impulse at work in their own analyses.

There is one more necessary piece—setting the tone and the frame for the following week. I try to make clear that the focus of our discussions will be on the writing process more than on the product. The aim is to get everyone writing more fluently. I make the task clear, hoping to arrive at a working group as quickly as possible. There will be brief, weekly writing assignments of one to two pages, double spaced; each assignment is due, even if the candidate is ill or otherwise unable to attend a class. I ask the candidates to bring enough copies of the piece for everyone to read, but these will be handed back to the writer at the end of the class. Each person will read her assignment aloud, and we will respond as if we were at a writing workshop where certain conventions hold. One is that we will spend equal time on each piece—ten minutes, since this class has eight members. We will point out what in the writing is most alive and effective, and why. In the first weeks, our job is not to point out weaknesses or to critique the prose or the personality, but to understand what works well. This requires not only enthusiasm, but attentiveness and respect for the work. I say that as the class progresses, we might spend more time on parts of the writing that feel like obstacles, but that is not where we will begin.

I explain that we will use the convention that there is a "speaker" in each piece, because we have no idea in the first assignment if this is an autobiographical "I," a fictional character, or a persona. This allows each candidate to feel some sense of distance between what is on the page and her most private self, lowering anxiety about exposure. And one final statement: We will treat the material with confidentiality, and not share content or other comments about the work outside the group. Our confidentiality applies both to the patient in the clinical writing and to the writer. Being clear about this framework and about the attitude of acceptance of whatever arrives opens the door.

In order for each candidate to breathe life into her writing, a sense of safety is essential (Jones 1997). Candidates are very aware of being constantly evaluated and of the necessity to jump a number of hurdles in order to graduate. For the writing to feel alive, it

has to feel genuinely connected to each individual's self and internal voice. This means allowing the idiosyncrasies of one's private observations to come forward, while the larger context of training all too often works toward the suppression of individual style. Beginner's anxiety has one searching for "the right way" to "do" analysis. As if there were one. Just as candidates often say they don't find their own voice in doing analysis until they begin unsupervised cases and experience the sense of freedom of "no one's watching," so the beginning clinical writer needs to feel a sense of privacy and security even while the group is watching.

At the second meeting of the seminar, I am delighted and amazed by what this group of self-declared "nonwriters" has produced. One candidate has written a page of funny dialogue between mother and teenage daughter in the car, showing the daughter's intolerance of her mother's bopping along to the girl's music. Another talks about his experience of marriage and the birth of his son, speaking of all that has happened since his brother died. A third brought in a piece in which a grown daughter returns to the family home after her mother's funeral; she knows it will be her last time in this house. To describe intense emotion, she employs a personified wind sweeping through the windows. The wind comes to embody both rage and grief—a howl. Another candidate has written a page describing her feeling on receiving the diagnosis of breast cancer: "I want my Mommy." She experiences a paradox because her mother is described as a cold and absent figure, while her father is seen as a warm and caring man. She imagines turning to him, then remembers his telling her a giant ladybug would drag her by her ponytail into the ocean if she failed to keep her hair clean.

I've learned to bring Kleenex to hear these first assignments. Several bring people to tears, both writers and listeners. I don't think this intensity would be so easily possible if I had asked them to bring these pages to the first meeting. People are willing to bring very personal material because a frame has been set, because they have gotten to know me and my method a bit, and because a group task and momentum have been established.

Perhaps in response to the feeling of permission to write, one candidate brought in an angry page: "Nothing like being commanded to be creative; it's like being told to be spontaneous. The SS of the writing police." Strong stuff. I take it on in terms of how this writer has responded to the assignment. I talk about the prose and how it conveys its intent—which adjectives and verbs convey a bite. And I also acknowledge the anger, try to make it clear that I and the group can tolerate this; and at the same time, I want to cast a little doubt on the coerciveness of my intentions.

As a working writer, I explain my sense that one needn't, shouldn't, wait for inspiration to strike before one starts to write. The practice is more fluid the more regular and common it is. I once heard Carolyn Forché (1986) say at a poetry workshop: "If you are not sitting at your desk and working, the muse will simply go down the street and visit the next writer who *is* at her desk."

So, we are off. For the seminar's third week, the assignment is to write a case vignette, choosing a moment when something out of the ordinary happens, and to include the physical presence of the patient, or perhaps the patient's way of getting on the couch. I ask them to select the patient after considering who is most in mind lately and which write-up is overdue. I tell them I want them to focus on the same patient for the next several assignments. We go around the room, spending ten minutes on each piece. While I allow time for general comments and digressions, the time frame feels important, so no piece gets overly praised or neglected.

For today, we have also read a short story from the *Paris Review* by Joanna Scott, "The Borderline Case" (1993), in which an analyst, K, patterned after Masud Kahn, meets a patient, B, for their first session.

K hasn't even had time to pour himself a drink. He looks up as the secretary knocks again, and a drop of perspiration slides into his eye.

> B's first sight of the famous prince is of a thin young man behind a sprawling mahogany desk rubbing his fist against his eye. And from his side of the room K sees a blur, a

> watery ghost—uncharacteristically, he wants to see more. He rises abruptly from his chair and bumps his knees against the desk drawer, recognizes then, as the sharp pain travels along the nerve up his thigh, that this man B is extremely dangerous. B, despite the verdict from the referring analyst, already has the upper hand. [p. 14]

The transference/countertransference is portrayed in tactile details, each seen though the mind of the other character, forming a rich and complex texture. From B's point of view, the doctor looks like a boy pretending to be a grown-up, wiping his eye like a child; even the furniture seems too large for him. From K's position, the furniture is also wrong, in a way that irritates him. The reader is put inside K's skin—the blurry eye, the pain in his thigh, the experience of danger and of being knocked off balance. With no abstract language, a vivid psychoanalytic drama has begun to unfold.

Other reading assignments have been chosen to represent a variety of forms and methods for conveying internal experience. We've read the beginning of a poet's memoir, Li-Young Lee's *The Winged Seed* (1995):

> In my dream my father came back, dressed in the clothes we'd buried him in, carrying a jar of blood in one hand, his suit pockets lined with black seeds. His gray wool suit seemed hardly worn, except for the shoulders and elbows, which were buffed smooth, I guessed, from rubbing against his narrow coffin. And then I saw his shoes. They were completely wrecked; their leather cracked, nicked, creased, cross-creased; their puckered seams, where the stitching came unraveling, betrayed his naked feet. Sockless, his ankles were frightening, and only the thinnest soles kept him from walking in bare feet. I began to cry, realizing *He walked the whole way.* [p. 11, italics in original]

This book moves between narrative and internal prose-poem associations in telling the story of a family of exiles and of a father–son relationship. The opening paragraph introduces us to a story and to the mind of the writer, which we sense mostly through

textures: *wool suit, buffed smooth, leather, puckered seams, naked feet, sockless.* Lee has set up a tension between restrictive containment inside the coffin, and naked feet, unclothed—the father moving from too covered to too uncovered. As the son recognizes the naked skin, his emotion breaks through and he cries. So we are also seeing the son's own containing layers and the lack of them through this experience wrapped in sleep, inside a dream. The story elements are accessible and engaging, the meditations are darker, stranger, and disquieting. Together, they evoke multiple layers of the subject's life.

Among the readings, I've also included Annie Sweetnam's "Talking about Talking about Patients" (2001) for the dizzying form in which it presents case material, at times making it hard to tell who is the patient and who is the therapist. Quite bold in its willingness to offer a level of self-exposure uncommon for clinical reports, the piece has a visceral impact that brings the reader immediately inside the transference-countertransference sphere.

I've often assigned Jonathan Lear's preface, "The King and I" (1998), because it is a piece of writing that begins as a memoir and then drifts into philosophy in a seamless way. The abstract ideas are brought to life by being situated in a personal realm. My hope is that the readings will stretch the candidates' ideas about how insight, character, and internal experience can be represented in a condensed form.

Over the next weeks, class assignments include writing a description of a difficult moment near the start of a case, followed by one a year later, in order to show what is different in the patient and in the way the two characters are talking. By the end of the class, students have written three or four separate assignments, focused on different periods in the same case. I talk about how to support these vivid moments with connective tissue in order to complete a case summary. We talk about the flow of looking at a scene in a vivid, experiential way, and then speaking in an omniscient narrator's voice, describing the movements of a mind and a relationship over time.

Each candidate has an opportunity to see how the others are working and to experiment with her own methods, her own abili-

ties. The class puts emphasis on momentum—how quickly a scene moves, how the passage of time is conveyed. One candidate observes the process of her own hair going gray while watching the bald spot on the top of her patient's head widen over the course of the analysis. Another names the series of vehicles on which his patient arrived at the office (by bus, bicycle, old car, new car) as a way of showing the passage of years and the patient's shifting sense of himself.

Experimenting with technique is a process all the students can engage in, whatever their level of comfort with writing. For more experienced writers, the exercises help to push the frame of their accustomed styles and to try out modes of expression that are less familiar. The writer who is used to preparing professional articles for publication may still be ill at ease in writing in dialogue or scene. If a candidate is more comfortable with her work, it lets the group offer more particular and detailed criticism of what does not add to the liveliness of a piece.

For one assignment, I ask the students to work in an experimental form and to speak about countertransference. One candidate responded with music. She conveyed her internal states by naming the tunes going through her mind as the patient spoke or as she thought of her patient after sessions. Another brought his assignment in the form of a letter to his patient, saying everything he was unable to tell the patient about himself—his caring for his patient, his fears for him.

In some of the classes, we have read poems in order to talk about form and how the piece is laid out on the page. The candidates in the class play around with detailing their own thoughts in italics while the page is laid out in dialogue. One chose to use all capital letters to reveal his wish to scream at his patient. The freedom to experiment and to be received thoughtfully by the group brings increasing conviction to the style in which each candidate is working.

And there was an unexpected feature of the process. In the evaluations I received after the course, several years of candidates spoke about the influence of the writing class on their group pro-

cess. They often learned details about each other that they had never known—for example, about the death of a parent or sibling, or about an illness. They felt closer to each other, seeing how each struggled with the work and with her own identity as an analyst. Having a task more concrete than those of many discussion seminars often moved the class more toward the model of a working group. The emphasis on making the class a safe and confidential space enhanced this development.

One of the deadening forces in analytic writing has to do with not wanting to appear too idiosyncratic. People worry that the same quirks we find delightful in a poet or fiction writer would, in an analyst, seem too crazy. And candidates feel that to meet the requirements for graduation, they have to twist themselves into approved or homogenous forms. Case summaries have to be acceptable to supervisors, to committees, to journals. The candidates often feel these expectations as a force pulling them back toward rigidity and away from inventiveness.

Lately, there has been much talk among analysts about our place in the wider community of psychotherapists and thinkers. If we are serious about our wish to be better understood by nonanalytic therapists, lay readers, academic colleagues, and potential patients, we need to look at the ways in which we communicate what it is we do, how the unconscious is expressed, how people change, and why we love our work. I think this means attending to the liveliness and evocativeness of our written communications. Since we believe in the power of the word to reach a patient's affect and unconscious through interpretation, we could well learn more about employing this power in writing about our work. This means becoming more artful in how we describe our art. If we can make use of the techniques of fiction writers and poets to bring more pleasure to the reader, we will be further along on that path.

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APPENDIX

Quotations Not Identified in Text

[1] Selzer (1994), p. 708.
[2] Symington (2004), p. 253.
[3] Coltart (1992), p. 79.
[4] Phillips (1996), p. 64.
[5] Loewald (1980), pp. 252-253.

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BOOK REVIEWS

AGGRESSIVITY, NARCISSISM, AND SELF-DESTRUCTIVENESS IN THE PSYCHOTHERAPEUTIC RELATIONSHIP: NEW DEVELOPMENTS IN THE PSYCHOPATHOLOGY AND PSYCHOTHERAPY OF SEVERE PERSONALITY DISORDERS. By Otto F. Kernberg, M.D. New Haven, CT/London: Yale Univ. Press, 2004. 272 pp.

Psychoanalysts today are often called upon to evaluate and treat patients for whom treatment in psychoanalysis proper is inappropriate because of the severity of the presenting psychopathology, but who seem able to benefit from a sophisticated, dynamically informed treatment of some sort. In this book, Otto Kernberg provides a detailed guide for the analyst's thinking about such patients. He offers a carefully elaborated theoretical framework for their evaluation and the determination of which forms of treatment are likely to be beneficial, as well as specific technical suggestions for structuring and conducting such treatments and for dealing with many of the complex and difficult clinical problems that commonly arise in working with severe psychopathology.

The book is comprised of four major theoretical chapters, seven chapters addressing special clinical situations, two concerning countertransference issues, and one devoted to the detailed presentation of a clinical case. In the first theoretical chapter, "A Psychoanalytic Theory of Personality Disorders," Kernberg argues for the value of a dimensional model for the classification of personality disorders. He sets out such a model based on the level of development of internalized object relations, with particular attention to the stability of self-object differentiation and the attainment of object constancy, as well as to the level of superego integration and the use of primitive defenses. This developmentally based model leads to a linked network of personality disorders defined

by their placement on a grid as determined by assessment of the level of functioning within each dimension being considered.

Kernberg argues that this model is superior to a categorical one based on superficial behavioral manifestations in that it has greater predictive value in terms of the quality of change possible for each patient, and that it is a better guide to intervention, since similar surface manifestations may occur at varying levels of personality organization, and the effectiveness of particular interventive strategies is more a function of level of organization than of specific symptoms. In making this argument, Kernberg unites findings of empirical research from fields outside clinical psychoanalysis with clinical observations drawn from the psychoanalytic situation.

In the second theoretical chapter, "Hatred as a Core Affect of Aggression," the author puts forward a theory of motivation based on both drives and affects, and considers the interrelation between the two as he describes the organization of affects into the drives. Here again, Kernberg incorporates the findings of empirical research (including neurobiological findings) on the ways in which constitutional predispositions, organically based cognitive deficits, and trauma all contribute to basic, underlying affective patterns within individuals. These basic patterns then drive, and are in turn modified by, the unfolding of internalized object relations, which become the foundation of character.

Because patients with severe personality disorders (those falling within the range of borderline personality organization) are organized around the development of inordinate aggression and psychological structures built around such aggression, Kernberg prescribes a clinical approach to manifestations of severe aggression in the transference, including negative therapeutic reactions, sociopathy, excessive envy, and ego-syntonic sadism. He vividly describes the inner worlds of such patients and typical transference-countertransference constellations that arise in their treatment, offering specific technical recommendations for structuring and conducting treatment in a way that allows for the elaboration and interpretation of these constellations. Finally, he realistically con-

siders the limitations of, and indications for, different modes of treatment with such patients, indicating clinical features that define a group of patients who are unlikely to benefit significantly from any form of psychoanalytically informed therapy.

The third major theoretical chapter, "Psychoanalysis, Psychoanalytic Psychotherapy, and Supportive Psychotherapy: Contemporary Controversies," raises a number of politically charged questions. The author acknowledges the controversial quality of his assertions, and, while clearly making arguments for his position, also gives voice to the potential objections of his critics and attempts to respond to them.

Kernberg believes that it is important to define clear boundaries between psychoanalysis proper, psychoanalytic psychotherapy, and supportive psychotherapy in order to make systematic treatment recommendations to patients based on the structural assessment of their psychopathology. He draws these boundaries according to technical features of the treatment, rather than features of the frame around which battle lines have traditionally been drawn, such as frequency of sessions or use of the couch.

For Kernberg, psychoanalysis is distinguished by the technical centrality of interpretation, the analysis of transference, and the strict maintenance of technical neutrality. Its clinical goal is structural change realized through resolution of the transference neurosis. He believes that this definition is possible and may be comfortably used by adherents to a variety of theoretical orientations because of the growing technical convergence of American ego psychologists, Kleinians, British independents, and mainstream French psychoanalysts, with differences among these groups being mainly about interpretive emphasis, rather than general technical principles. Kernberg acknowledges that this definition might have the effect of marginalizing proponents of other schools of psychoanalysis, such as intersubjectivists, interpersonalists, and self psychologists, whose technical approaches may be more divergent.

He sees psychoanalytic psychotherapy as very similar to psychoanalysis proper, but as having a greater emphasis on clarification and confrontation over interpretation as central therapeutic inter-

ventions. When used, interpretation is more focused on the here and now, and the analyst more explicitly links transference developments to related experiences in the patient's external life. A greater necessity for limit-setting and the analyst's more liberal use of this intervention limits the analyst's capacity to maintain strict technical neutrality, but efforts are made to rapidly return to a position of neutrality by exploring and interpreting the patient's reactions to the analyst's limit-setting. The primary clinical goal of psychoanalytic psychotherapy is resolution of the syndrome of identity diffusion.

Kernberg's vision of supportive psychotherapy is one that remains firmly grounded in the theoretical and some of the technical precepts of psychoanalysis. In this form of therapy, clarification and confrontation remain central, as in psychoanalytic psychotherapy. Interpretation of the transference recedes as a major intervention, though the analyst remains mindful of the transference, both in its moment-to-moment manifestations and its broad sweep. This awareness remains a guide for intervention, but interventions must be aimed at the reduction of destructive behavior in the transference and the explicit linking of these behaviors to the patient's experiences and behavior in his or her external life. Neutrality is abandoned more readily in supportive therapy, as the analyst actively shifts his or her alliance among different psychic agencies and varying defensive configurations, according to the analyst's assessment of what is most adaptive for the patient in external life at any given time. The primary goal of supportive psychotherapy is to foster the patient's improved adaptation to external reality.

Kernberg argues convincingly for the importance of teaching psychotherapy as well as psychoanalysis in psychoanalytic institutes. Certainly, if psychoanalytic theory has expanded to encompass an in-depth understanding of a group of patients for whom psychoanalysis per se is not the most desirable form of treatment, we can be more thorough by teaching technical approaches that are, based on our psychoanalytic theory, more likely to be helpful to this broader group of patients. Yet my own sense is that this argument rests on an assumption that the primary educational goal of psy-

choanalytic institutes is to teach psychoanalytic theory and its application to clinical situations. This goal, in my view, is in close relation to, but not identical with, the goal of teaching, through firsthand experience, the nature of the unconscious and its power to shape the experience and motivate the behavior of individuals. It is in relation to psychoanalysis proper that such experience is most likely to be had in a way that stirs conviction in the analyst.

While in an ideal world, there would be time within the confines of a single training program for meaningful clinical immersion in all forms of psychoanalytically informed treatment, from a practical point of view, the pressures on training programs are to shorten rather than lengthen their duration. My concern would be that introducing training in psychotherapy at the expense of immersion in psychoanalysis may have the effect of weakening our ability to convey not just a theoretical understanding of the unconscious, but real conviction about its existence and our ability to observe it in action and to continue to make new discoveries about it.

Kernberg makes it clear that he believes that psychoanalytic psychotherapy as he defines it is an effective treatment for a broad range of patients with very severe psychopathology, including many with drug dependence, suicidal behavior, eating disorders, and antisocial features. In this book's fourth theoretical chapter, "Psychodynamic Psychotherapy for Patients with Borderline Personality: An Overview," he sets out his theoretical rationale and technical strategy for interpretive work with these patients. The essentials of this work are: (1) the analyst's recognition of the patient's primitive internalized object relations as they manifest in the transference, (2) the repeated demonstration of how these relations are *enacted*, with frequent and rapid role reversals, and (3) the bringing together of idealized and persecutory manifestations of these object relations and the demonstration that these seemingly antithetical experiences occur in relation to the same object.

Important technical features that permit such work to occur are: (1) the analyst's explicit establishment of a realistic treatment setting, ground rules, and boundaries, (2) the focus on the patient's behavior as an important source of data for interpretive explora-

tion, in addition to his or her verbal associations, and (3) the ongoing analysis of countertransference.

In two chapters focusing on countertransference analysis, "Acute and Chronic Countertransference Reactions" and "Omnipotence in the Transference and Countertransference," Kernberg provides a structure for helping the analyst organize his or her thinking about the complex countertransferences stirred by such patients. He describes various components of countertransference and the ways in which the analyst may process these components, both internally and in interaction with the patient, so as to transform them into interpretable transference enactments that permit focus on underlying primitive object relations. Here he stresses the importance of the analyst's patience and capacity to tolerate chronic countertransferences and to allow them to come into sufficiently full bloom to enable their detailed analysis. He emphasizes that, although role responsiveness and projective identification are important contributors, they are by no means the only component of countertransferences. In this regard, he makes the important point that when the analyst's own unresolved conflicts are mobilized, withdrawal of attention from the patient and self-analysis are not sufficient to handle the situation; the analyst must also focus on which factors within the patient, and in the interaction between patient and analyst, have mobilized these unresolved conflicts.

In these chapters, the author stresses the importance of the analyst's actual emotional involvement with the patient; he believes that the patient must be able to see that the analyst is both emotionally affected by the patient and struggling to understand these experiences. Analysts who try to maximize the clinical usefulness of their countertransferences will find these technical suggestions not only useful, but also extremely reassuring and confirming. Kernberg makes it clear that this level of emotional involvement and lack of opacity is not only technically acceptable, but of considerable therapeutic value.

Kernberg's emphasis on countertransference analysis is also at the center of two of the chapters on special clinical situations: "The Psychodynamics and Psychotherapeutic Management of Psy-

chopathic, Narcissistic, and Paranoid Transferences" and "The Management of Affect Storms in the Psychoanalytic Psychotherapy of Borderline Patients." In the former, Kernberg addresses transferences encountered across the spectrum of narcissistic disorders, with particular attention to the level of superego integration. He offers specific technical suggestions for working with patients with antisocial features, emphasizing the importance of the transformation of psychopathic transferences into their underlying paranoid transferences, as well as the analyst's capacity to tolerate the intense aggression associated with these transferences.

In the latter of these two chapters, technical suggestions regarding affect storms are offered, including those precipitated by the analyst's interpretive focus on defensive organizations that initially manifest as chronic emotional detachment in the transference. Here again, Kernberg warns against the temptation toward emotional detachment in the countertransference during these storms, emphasizing the desirability of the analyst's emotional responsiveness and intensity in working with them.

Other chapters on special clinical situations include concise guidelines for the evaluation and management of a variety of commonly encountered clinical problems. "Pathological Narcissism and Narcissistic Personality Disorder: Theoretical Background and Diagnostic Classification" provides a guide to the differential diagnosis of varying levels of narcissistic pathology and their prognostic implications. It also contains a concise comparative review of major theories of narcissism.

"The Diagnosis of Narcissistic Pathology in Adolescents" helps the analyst sort out the normal developmental upheaval and fluidity of identity and self-experience of adolescence from the chaos and identity diffusion of borderline personality disorder. Symptomatic pictures that are prognostically less significant in adolescents than in adults are identified, and a guide to the evaluation of antisocial behavior in adolescents is provided.

Two chapters, "The Risk of Suicide in Severe Personality Disorders: Differential Diagnosis and Treatment" and "A Technical Approach to Eating Disorders in Patients with Borderline Personal-

ity Organization," offer recommendations for conceptualizing patients who present with these dangerous, commonly encountered, and often recalcitrant clinical features, as well as useful technical suggestions for structuring their treatment in such a way that minimizes danger to the patient and maximizes chances for clinical improvement.

In "Perversion, Perversity, and Normality: Diagnostic and Therapeutic Considerations," Kernberg addresses a topic that often engenders emotionally charged debate. He attempts to lend clarity by identifying what he sees as the conceptual problems that have resulted in the tendency for such debate to veer away from the scientific and toward the polemical. These are: (1) schemes of diagnostic classification that appear to confuse pathology with unconventionality, and (2) the historical lumping together in psychoanalytic discourse of homosexuality and perversions in ways that deny differences between them, both clinically and dynamically. Kernberg takes the position that sexual "normality" is defined not in terms of conventionality, but in terms of the capacity for flexibility of enjoyment of sexual fantasy, the ability to integrate sexuality with tenderness in an ongoing relationship, and the successful integration of aggression so that it exists in the service of object-libidinal aims.

The author describes different features of perversions as they present across the diagnostic spectrum. He distinguishes perversion from perverse psychic structure, and emphasizes that, as with all manifest behavioral symptoms, it is the underlying personality organization in which the symptom is embedded, rather than the symptom itself, that carries prognostic and treatment implications. Kernberg's thinking in this area certainly lends clarity to the clinician's thinking, but it is not clear whether his argument fully resolves inherent political problems, which concern the potential use of any kind of nosology that divides sexual behavior into *normal* and *abnormal* as a means of marginalizing some individuals in the larger society.

Although throughout the book, Kernberg takes on a variety of current controversies in our field, taking an explicit stand on them

and justifying his stand, I think he does this less effectively when it comes to the question of the relation between the science and the art of psychoanalysis. Kernberg—implicitly rather than explicitly—adopts the position that science must take precedence over art in the clinical situation. In discussing critiques of his diagnostic schema and his delineation of indications for different modes of treatment, he states:

> Precision of categories in the analyst's mind should not interfere with his free-floating attention once he is engaged with the patient. Clinical experience . . . has demonstrated that a well-defined technical approach leaves ample room for variations in individual approaches to patients and for very different styles within the same general intervention. [p. 111]

Although Kernberg seems to give a tip of his hat to the "analyst's free-floating attention" and "very different styles," I think he is reducing the analyst's creativity in listening to the patient to mere lagniappe, rather than placing it at the center of the clinical experience. This seems not quite right; my own sense is that the analyst's art and the analyst's science must occupy side-by-side positions in the analyst's mind, each constantly informing and giving feedback to the other. Analysis dominated by science runs the risk of becoming operationalized and formulaic; analysis dominated by art runs the risk of being about expression rather than understanding, and of losing its grounding in the world of objects beyond the analytic dyad.

It is in the single full-length clinical case presented in the book, in the chapter entitled "A Severe Sexual Inhibition in a Patient with Narcissistic Personality Disorder," that we get a glimpse of Kernberg the artist, who in this book has otherwise remained hidden behind Kernberg the scientist. Here he grapples with the painful and only dimly understood aspects of his inner experiences as he sits with his patient, and struggles to understand how and why the patient is able to affect him as he does, and to imagine the forces in the patient's inner life that drive him to do what he does.

Without question, Kernberg's theory gives shape to his musings, but it is his internal struggle and his efforts to imagine his patient's inner world that make the analysis come alive and ultimately have an impact on his patient. Perhaps Kernberg so emphasizes his science over his art because he wants to teach what can be taught. But his art and its capacity to inspire, as well as his science and its capacity to inform, is an important part of his legacy. We need to pay more attention to that man hidden behind the screen, and Kernberg needs to allow us to do so.

That said, this is an enormously useful book, one that the experienced clinician will repeatedly turn back to as a theoretical refresher when approaching a difficult clinical situation. It is also useful as a teaching tool, and I have already incorporated a number of its chapters into my own teaching in different settings. Turned to as a reference rather than as a bible, it deserves a place in the library of all psychoanalytic clinicians who work with patients with severe psychopathology.

RICHARD ZIMMER (NEW YORK)

PSYCHOTHERAPY FOR BORDERLINE PERSONALITY DISORDER: MENTALIZATION-BASED TREATMENT. By Anthony Bateman and Peter Fonagy. Oxford, England: Oxford University Press, 2004. 382 pp.

Psychotherapy for Borderline Personality Disorder: Mentalization-Based Treatment provides a comprehensive overview of the authors' ideas about the theory and treatment of patients with borderline personalities. Using a development framework that emphasizes a reformulation of attachment theory, focusing on research regarding mother–child interaction, and utilizing concepts in neuroscience, this treatment approach concentrates on a core defect in the borderline patient, the difficulty in mentalization.

This book will appeal to at least two groups of readers: those interested in learning more about the developmental concepts of Fonagy and his colleagues, and those interested in the understand-

ing and treatment of borderline patients. The book is highly recommended for both groups.

Mentalization refers to the capacity to conceive of conscious and unconscious mental states in oneself and others. An individual is able to mentalize if he or she can conceptualize another person as having a mind separate and distinct from that of his or her own. The capacity for mentalization is brought about by an intersubjective process in which the caregiver continually focuses on the child's mental states. The caregiver behaves toward the child in a way that helps the child understand his or her behavior (and that of others) in terms of ideas, beliefs, feelings, and wishes. With the attainment of mentalization, the child can understand that another can have a perspective different from one's own.

Prior to the development of this capacity, the child uses two more primitive modes of relating, the *psychic equivalence mode* and the *pretend mode*. In the psychic equivalence mode, the child experiences the external world only as a reflection of his or her own internal world. The pretend mode becomes noticeable in play, when the child realizes that internal experiences may not reflect external reality. In this mode, there is little correlation between internal experience and external reality. The child gradually integrates these two modes at around age four or a little later, and is then able to mentalize.

In normal development, mother and child are involved in an intersubjective process involving affective communication, in which the mother plays a vital role in modulating and regulating the infant's emotional states. This involves a process of parental affect mirroring, enabling the child to form *second-order representations*. Second-order representations are those influenced by the mirroring responses of the mother. These second-order representations are essential for affect regulation, impulse control, and self soothing. To be effective, the process of parental affect mirroring must be done in a manner that is contingent, congruent, and displays markedness.

The child has an innate *contingency detection module* that registers contingent responsiveness right from the start. This module is

switched by the infant at around three months from perfect contingency to high but imperfect contingency. The latter is characteristic of the kinds of responses typical of the usual caregiver, thus aiding in obtaining contingent responses. *Congruent mirroring* reflects an accurate picture of the child's emotions. *Markedness* is achieved by producing an exaggerated but playful version of the infant's affect, similar to the "as-if" manner in pretend play. A marked response reflects both the infant's emotion and a contrasting emotion (exaggerated and playful), conveying to the infant that the affect is manageable. This response occurs in contrast to emotional displays of the mother that are exaggerated and not marked, seen as realistic by the child and producing more anxiety and negativity.

Fonagy and his colleagues believe that borderline individuals and patients with other severe characterological difficulties have the most problems with mentalization. Two factors are significant here. The first is the lack of caregivers who related in ways that enhanced mentalization, and the second is psychic trauma, causing a defensive inhibition of the capacity to mentalize. Borderline patients typically experience insecure attachments, lack of congruent and marked mirroring, deficient second-order representations, and lack of integration of the psychic equivalence and the pretend modes, with ultimate deficiencies in mentalization.

In instances in which mirroring is basically congruent but not marked, the mirroring is attributed to the parents as their actual emotions, causing increased anxiety in the child. Secondary representations are not established, and problems in affect regulation and impulse control ensue. This situation leads to traumatization rather than containment. The authors feel that this constellation corresponds to the clinical conditions for projective identification, which is subsequently established as a dominant form of emotional experience.

In instances in which mirroring is noncongruent, the child establishes a false-self structure, where representations of internal states do not reflect an accurate picture of the child's real emotions. These representations, although felt to be part of the self, are not experienced as authentic. An alien experience within the self is created, causing a disruption in the sense of coherence and

identity, which can only be restored by constant and intense projection. Aspects of the alien self are projected onto the attachment figure, enabling the child to feel some semblance of coherence. Projective identification here reflects the child's inability to contain the incoherence of his or her self structure. Formation of alien aspects of the self is not seen as an identification *with* the parents, but as a colonization *by* the parents.

Self-harm can occur when there is an absence of someone who can serve as a vehicle for the projection of alien aspects of the self. Here, self-coherence is attained through externalization of alien aspects of the self onto parts of the body. Self-harm and suicide attempts are seen as acts of ridding the self of these externalized alien parts, experienced in the psychic equivalence mode. Additionally, suicide attempts are often decoupled from reality (in the pretend mode), with the consequence that the patient thinks he or she will survive the attempts.

Regarding treatment of the borderline patient, the authors elaborate in great detail. Throughout the book, there is an intermingling of standard treatment principles, techniques, and strategies for dealing with borderline patients and interventions that focus on mentalization and parental affect mirroring. In regard to the former, the book is similar to other excellent texts on borderline patients. Interventions are basically well thought out, well explained, and elaborated by examples. The difference between this text and others, however, is its focus on interventions highlighting mentalization and parental affect mirroring. Here, the idea is for the therapist to relate to the patient in an analogous way to that of a secure mother relating to her child—that is, in a contingent, congruent, and marked way, focusing on the intentional stance of the child, and with a playful ambience. Additionally, the therapist must be prepared to receive projected parts of the patient's alien self with containment and without untoward countertransference reaction. The therapeutic process here provides a type of reparenting, through which the patient acquires the capacity to mentalize.

It is the focus on enhancing mentalization that is deemed most important in the psychotherapy process. In fact, the authors note

that the common factor that makes varying therapeutic approaches successful (including Kernberg's transference-focused psychotherapy and Linehan's dialectical behavior therapy) is the creation of an interactional matrix of attachment in which mentalization can develop. Bateman and Fonagy feel that this occurs in the work of all excellent, experienced therapists, regardless of theoretical persuasion or conscious intent. It is this process that is most important—not the content of interpretations, education, or other interventions. It occurs implicitly in a natural way, and also explicitly via a conscious focus on maintaining a mentalizing stance, with continual focus on the internal mental states of both patient and therapist.

Features of mentalization-based treatment that involve larger issues—thought to be applicable to all treatment approaches—include a clear structure, consistency/constancy/coherence, a primary focus on understanding relationships, flexibility, an intensity sufficient to stabilize social chaos and to reduce dangerous and impulsive behaviors, the consideration of each patient as a separate individual, and the appropriate use of medication. Strategies of treatment include those enhancing mentalization, bridging the gap between affective experiences and symbolic representation, viewing the transference as cocreated between patient and therapist while accepting the patient's view of the transference as real, maintaining mental closeness through appropriate affect mirroring, maintaining a primary focus on the present versus the past, keeping in mind the patient's deficits involving mentalization and not being fooled by "false" psychological mindedness, and responding appropriately to the patient's desire for a real relationship.

Use of the techniques outlined by Bateman and Fonagy can help the patient to identify, understand, and express affects appropriately, with special focus on troublesome affects leading to impulsive acting out, suicide attempts, and self-harm. The end result is the establishment of a stable representational system, a coherent sense of self, and the capacity to form secure relationships. All this is elaborated at length in this book, with many clinical examples.

The authors view the core problem of the borderline patient as a defect in mentalization. Kernberg, by contrast, views the core problem as a difficulty in integrating positive and negative introjects and the corresponding failure to attain libidinal object constancy. Adler, by further contrast, views the core problem as the inability to adequately establish a specific kind of positive introject, the holding introject. Others view the core problem as emotional dysregulation. I mention Kernberg and Adler in particular, because I have viewed them as the theorists most helpful in both my theoretical understanding and my clinical work with borderline patients. Although they offer theoretical perspectives and treatment approaches that are very different from each other's, I am easily able to integrate their ideas. Bateman and Fonagy provide yet another very different theoretical model and clinical approach; their ideas are also quite useful, especially for those patients with obvious problems in mentalization. I am now prepared to integrate the core ideas of all three—Bateman/Fonagy, Kernberg, and Adler—in my work with borderline patients, both theoretically and clinically.

Bateman and Fonagy make a good case for their theory, yet I do not know how to judge its validity. At present, I am inclined to view difficulties with the attachment process as primary in borderline patients, with all other problems being secondary. Other difficulties include problems in reality testing and the adaptation to reality, problems in thinking, in interpersonal relations, impulse control and frustration tolerance, use of primitive defenses, introject formation and identity, self-esteem and self-cohesion, and affective instability. Mentalization fits under the category of thinking. Relevant to the attachment process in borderline patients are various defects in attunement and empathy, neglect, overindulgence, trauma and abuse, and all the problems described by Bateman and Fonagy in regard to parental affect mirroring. Constitutional and neurobiological factors certainly play a role, as well, in how the attachment process unfolds.

WILLIAM N. GOLDSTEIN (CHEVY CHASE, MD)

A SPIRIT OF INQUIRY: COMMUNICATION IN PSYCHOANALYSIS. By Joseph D. Lichtenberg, M.D.; Frank M. Lachmann, Ph.D.; and James L. Fosshage, Ph.D. Hillsdale, NJ: Analytic Press, 2002. 210 pp.

A Spirit of Inquiry is the third book written collaboratively by these three highly prolific authors, who have made significant contributions, singly and together, integrating and expanding our clinical as well as theoretical understanding of relational, self psychological, developmental, and systems approaches. The breadth and scope of this integration, drawing upon their further elaboration of a novel motivational theory that proposes five innate motivational systems, utilizing data of infant research and neuroscience while offering detailed clinical illustrations, are auspicious. Though a relatively slim book, it is by no means a quick read. It requires a fair amount of careful study, which would be aided by a knowledge of their other works, to absorb and grapple with the wealth of information and extensive formulations offered.

Introducing their central thesis, the authors underscore their notion of the salience of a spirit of inquiry deriving from the early, infantile "exploratory motivational system"; in turn, this is to serve as "a guiding attitude, a world view that unites analysts across a spectrum of theories" (p. 2). They state further:

> We propose that all communications in analysis, whether about physiological regulation, attachment, exploration, sexuality, or aversiveness, require an underlying persistent spirit of inquiry to give the therapeutic enterprise its guiding purpose . . . . A spirit of inquiry establishes an ambiance that persists when direct exploratory efforts are prevented by enactments and overwhelming affect states. A spirit of inquiry provides vitality to the psychoanalytic search for subjective and intersubjective awareness. [p. 2]

They continue their introductory thesis, indicating:

> We believe that human subjectivity and intersubjectivity cannot be accounted for without an adequate theory of

> motivation and communication. Attachment theory, through its robust integration of strange situation strategies and the linguistic analyses of the Adult Attachment Interview, provides overwhelmingly convincing evidence for the link between crucial relationships and communication. [p. 10]

The eight chapters that follow begin with two on what they term *the development of communication with self and other in infancy,* and include extensive theoretical and direct observational description—the first chapter illuminating these matters up to the age of eighteen months, and the next to six years. Drawing upon the neuroscientific work of H. Damasio, the authors explicate a particularly interesting notion of the four- to six-year-old child's formation of two kinds of stories: one that creates the sense of who the child feels him- or herself to be, "an autobiographic self," and the other creating a plan for the future, "an illusory-to-become self such as found in the oedipal fantasy" (p. 48). Thus, the suggestion is made that, within the oedipal phase, a "time line" is established to "our sense of self" (p. 52).

> From this period on, we live our experiences more or less "realistically" as they unfold (the now or core consciousness), but guided by an illusion of a future. The triangular fantasy provides the power or impetus for the story of an identity plan the child creates that he or she organizes along the plot line of "when I grow up." The compelling nature of the drama of the projected oedipal plan lies in the child's being able to integrate stories of attachment, rivalry, gender, and body and relational exploration. [p. 52]

The next five chapters describe the authors' approach to clinical work, further elaborating their particular emphasis on the nature and modes of communication of patient and analyst. The richly detailed clinical examples, each apparently reflecting the individual work of the authors, enhance illumination of their theoretical views, offering data for fruitful discussion. Specifying a relation-

al as well as insight-oriented approach, and denoting these as separate therapeutic dimensions, they posit an interactive exchange that responds to "the emergence of different attachment needs and forms of relatedness" (p. 94). Where indicated, it is suggested and illustrated (perhaps to some controversy) that touch as well—aptly and appropriately employed—can be a "form of communication that can be integrated into the spirit of inquiry in facilitating understanding and communication in the analytic encounter" (p. 103).

The final chapter, entitled "Controversies and Answers: Communication and a Spirit of Inquiry Reconsidered," offers a summation and reflection on the views presented here. The concept of *provision* is discussed as a way of further conceptualizing psychoanalytic work that occurs in a spirit of inquiry, while accounting for the centrality of relational elements. Proposing an interesting shift from a notion of *deficit* to one of *regulation* in the experience of and search for provision, the authors state, "Insecure attachment is not a deficit, it is a strategy to make the best of a less than ideal situation" (p. 178). The search and regulatory effort, in other words, are directed toward maintenance of attachment.

In recent years, there has been much renewed emphasis on the relational dimensions of psychoanalytic work and theorizing, to which the authors have made a significant contribution and which they are attempting to flesh out with much added nuance, in uniquely posited ways. To be sure, many questions are more broadly raised concerning this particular turn in our theorizing and its clinical ramifications. Among these questions, I would add here that of how to understand the notion of knowledge that is implicit—*implicit relational knowledge*. From an epistemological perspective, how can it be known if it cannot be stated? In their use of this concept, the authors cite the work of the Process of Change Study Group, with whom they are in agreement.[1] This group sug-

[1] Stern D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Bruschweiler-Stern, A. C. & Tronick, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: the "something more" than interpretation. *Int. J. Psychoanal.*, 79:903-922.

gests further that implicit or procedural memories are not verbalizable, a position that I have questioned.[2] Indeed, in earlier writings,[3] I have noted the "moments of meeting," as posed by Sander,[4] as ones in which something affectively meaningful has been *explicitly* articulated, in contrast to the nonverbal conceptualization of this phrase offered by the Process of Change Study Group. It is my view that there are more dimensions of nonverbal expression that can yet be articulated and mutually observed—and where they are not, their psychic meanings must by necessity be left in the domain of hypothesis or conjecture.

Thus, in the work of Lichtenberg, Lachmann, and Fosshage, concern may be raised that in placing *relational* in opposition to *insight* (e.g., "In relational theory, the goal shifts to a therapeutic interaction as opposed to the singular pursuit of insight," p. 76), inner experience may necessarily be left outside psychoanalytic inquiry—inferred but not explored; and, further, emphasis on enhancing the patient's capacity for self-observation is diminished. Insight, or *recognition*, it seems to me, includes that of the experience and perception of the relationship and interaction.

The authors do make some statements that contrast with the quotation in the preceding paragraph and with the concerns I have raised, such as (italics added):

- "The remapping *in verbal form* opens the way for exploration of the subjective and intersubjective domain in which the motivation exists" (p. 123);
- "The sequence of events culminating in the specific interplay of this hour reveals the *powerful effect of recognition and naming*" (p. 126);

[2] See the following two references: (1) Schwaber, E. A. (1995). The psychoanalyst's mind: from listening to interpretation—clinical report. *Int. J. Psychoanal.*, 76: 271–281; and (2) Schwaber, E. A. (in press). The struggle to listen: continuing reflections, lingering paradoxes, and some thoughts on recovery of memory. *J. Amer. Psychoanal. Assn.*

[3] Schwaber, E. A. (1996). The conceptualization and communication of clinical facts in psychoanalysis: a discussion. *Int. J. Psychoanal.*, 77:235-253.

[4] Sander, L. W. (1992). Letter to the Editor in response to "Countertransference: the analyst's retreat from the patient's vantage point," by E. A. Schwaber. *Int. J. Psychoanal.*, 73:582-584.

- "The analyst's inner communication risks an idiosyncratic reading based on theory or personal proclivity" (p. 159); and
- "We believe that *verbal communication* is essential to the resolution of the effects of trauma" (p. 188).

These comments reflect a position with which I would more strongly agree.

In summary, then, while the theoretical views posed here and the literature background offered may require several readings in the employment of a vocabulary and particular perspective that may be unfamiliar to many, the clinical material is illustrated in sufficient detail to permit a reasoned and nonconjectural debate on these important matters—inviting a *spirit of inquiry,* whatever one's agreements or differences may be. The authors are open and illuminative about how they work, as well as how they think about it. One can learn much in reading this book.

EVELYNE ALBRECHT SCHWABER (BROOKLINE, MA)

PSYCHODYNAMIC TREATMENT OF DEPRESSION. By Fredric Busch, M.D.; Marie Rudden, M.D.; and Theodore Shapiro, M.D. Washington, DC/London: American Psychiatric Association, 2004. 204 pp.

In this volume, the authors have provided an extremely useful, lucid, symptom-focused guide to the psychodynamic psychotherapy of depression. It translates, for therapists, clearly enunciated, central dynamics of depression into timely recommendations for interventions. A central feature is the admonition that depressed patients in particular are in need of clear, rapid interventions. This reflects this reviewer's experience that these patients may discontinue psychoanalytically oriented treatment because they view a therapist's wait-and-see approach as an unhelpful and intolerable cat-and-mouse game. These patients are, to varying degrees, immobilized by self-blame, the hallmark of depression, and all too eas-

ily project it onto therapists who underappreciate their inability to wait.

Another emphasis in this book is on therapeutic activity to help these patients deal with what the authors delineate as the core dynamics of depression—narcissistic vulnerability, reactive rage and guilt, and shame. The headings of each section invariably begin with verbs. A partial recounting here not only demonstrates the point, but also summarizes the authors' primary concerns: "Forming a Therapeutic Alliance," "Establishing a Therapeutic Frame," "Introducing the Exploratory Process," "Clarifying the Central Depressive Dynamic," "Working with the Central Themes," "Addressing Narcissistic Vulnerability," "Understanding Distortions of Self-Image," "Identifying Specific Angry Fantasies," and "Recognizing Anger Directed Toward the Self."

Each section is brief and contains at least one example of how the therapist intervenes. In all, there are over fifty clinical vignettes.

Among the recommended interventions is that

> . . . dynamic therapists educate their patients about the biopsychosocial dimensions of depression throughout their treatment. Accomplished early in the treatment, it may help them to see themselves as having a distinct syndrome rather than as being needy or weak. Later it may provide encouragement . . . to tackle an exploration of painful events in their lives and to distinguish the pain and sadness stirred up in the process from the feared recurrence of an actual depressive episode. [p. 55]

There are no clinical examples given to support this approach, but it requires no apologies in regard to the resultant skewing of the transference. On the contrary, appropriate educational interventions reduce the mystery of the treatment and the accompanying exaggeration of the therapist's power and the patient's helplessness. Openness to questions and to sharing relevant information empowers patients.

In a sense, a syndrome is the persistence of a once useful and appropriate response. This definition could include the idea that

depressive affect, like anxiety, has a signal function that is necessary for self-righting behavior following loss, guilt, submission, and shame. Recent findings in neuroscience demonstrate that the emotional brain, mature at birth, with its own memory system, continues to react—even to hyperreact—after the thinking brain becomes functional.

A cogent sociocultural example introduced in the section on idealization and devaluation in depression could benefit patients as well as therapists. The authors here refer to a study that compared Eskimo and neighboring Ojibwa child-rearing practices in an environment of severe physical hardship.[1] According to Busch, Rudden, and Shapiro, Eskimo children were "treated with patience, tolerance and gratification, with expectation of joint work for community survival slowly introduced" (p. 124). In contrast, Ojibwa children were early toughened, even starved, to face difficult lives on their own. Ojibwas had much higher rates of depression than Eskimos.[2]

Such information can help patients who are parents clear up what have been for them confusing parenting expectations, resulting in unnecessary struggles with their children and subsequent guilt. Frequently, patients feel that their most helpful treatment has been that which helped them in their relationships with their children.

The results of the Eskimo/Ojibwa studies say as much about character as about depression, particularly about rigidity and concreteness. In regard to character, the authors of *Psychodynamic Treatment of Depression* refer to the difficult patients described by Rothstein[3] as devoid of an ego ideal, which likely refers to an in-

[1] Arieti, S. & Bemporad, J. R. (1978). *Severe and Mild Depression: The Psychotherapeutic Approach.* New York: Basic Books.

[2] It should be noted that Arieti and Bemporad (1978) were responding to cultural tendencies occurring closer to home than in the Arctic; at the time of their study, there was a widespread belief that because depressed patients suffered from guilt, assigning them onerous tasks would help them expiate it—a practice supported by a number of highly regarded mental institutions at the time.

[3] Rothstein, A. (1984). *The Narcissistic Pursuit of Perfection.* New York: Int. Univ. Press.

ternalized sense of achievement via contribution to family and community. These patients are fixed on concrete aspects of self-representations, such as beauty, wealth, or power, to confer value. Depression follows losses in these representations.

Here the authors again urge hard work on the part of therapists, as well as their acceptance of limited goals. Surely, these goals begin with the patient's evolving recognition of transferential fear of rejection and the wish for approval and love. Again, the therapist's activity, including education of the patient, becomes indispensable in fostering identifications expressive of greater human potential.

Concreteness plays a role in conditions such as gender identity disorders and sexual dysfunctions. These disorders, driven and limiting, reflect the conditions, real or fantasized, that historically did not allow for parental acceptance. From the traumatic histories of significantly depressed patients, one can infer that fantasy and infantile sexual confusion leading to castration fears, for example, play a lesser role when compared to the potential dangers in early relationships. Often, only total commitment to parental needs was acceptable, leading to the child's guilty failures. There are cases where even masochistic adaptation was unacceptable to parents. In more severe cases, including those leading to suicidality, it becomes apparent that there was little these patients could have done to convince parents of their right to exist.

The view that significant depression arises out of damaging early relationships, secondarily resulting in guilt and other injury to the self-image, is the core concept that guides interventions in this book. Following one typically elegant clinical example, the authors add that a patient's angry fantasies can be understood to occur in response to

> . . . the anger and guilt that had flourished in her family environment. Further, the therapist's non-judgmental stance helped Ms. U to reveal her childhood wish that her sister might successfully commit suicide and to begin to experience this vengeful wish as understandable, and hence as less guilt provoking and toxic. [p. 95]

While many therapists' activities can counter parental deficiencies, the therapeutic workhorse, for Busch, Rudden, and Shapiro, is accurate genetic interpretation (that is, *genetic* in the sense of relational developmental causes). Genetic interpretations have a dual function: First, they demonstrate that current troubling responses are not the result of deficiencies of the self, but are inevitably the carry-over of past reactions to traumatic events. Second, they support the recognition that the present differs from the past. Patients can thus grow in the trust that the therapeutic relationship is affirming and not critical, abandoning, exploitive, or otherwise harmful.

Healthier patients who enter treatment with salvageable relationships recognize the transferability of this reality. Those without them usually reveal great needs, and may experience being pointed to a life in the outside world as a rejection. Often, only a therapeutic relationship, with its sensitivity to patient needs, prevents reinjury and further withdrawal. This usually necessitates a lengthy treatment.

In the majority of clinical examples in this book, patients are seen to be highly receptive to genetic interpretations. It is clear, however, that the authors do not limit themselves to "easy" patients. They include a section on special topics that addresses the highly sensitive patients described above, as well as those with impairments in basic trust, severe trauma, negative therapeutic reactions, and increased acting out, especially suicidal behaviors. Always sensitive to patients' needs, the authors recommend allowing them to set their own paces of treatment—which probably means not forcing genetic interpretations, in most cases. In some cases, the authors recommend a temporary respite from therapy (although they do not give a clinical example of this). Again, for the most part, the most reliable intervention in the above situations is considered to be genetic interpretation.

Genetic interpretations have the effect of reducing dependency on the damaging relationships begun in early life. For highly vulnerable patients, the loss of these relationships, accompanied by guilt and fear, can be destabilizing. Therefore, genetic interpreta-

tion should be given a trial in which the patient's response is carefully weighed. Difficulties in the treatment can always be explored in the here and now, without reference to past relationships.

Caution is also in order in regard to a respite from therapy, because patients may experience a recommendation for this as a failure or rejection, and consequently become traumatized. The authors' suggestion of a respite as possibly beneficial probably refers to situations in which the patient initiates the interruption. Yet even in these instances, careful exploration is in order, because depression-prone individuals are very quick to withdraw, to quit before they are rejected. In my experience, it is helpful for the therapist to explicitly state a position of acceptance of the patient, whatever the patient's manifest communications may be. Here the anticipation of rejection cannot be overemphasized, I believe.

The book's section on countertransference touches on the therapist's own sense of rejection, leading to a reluctance to let go. But there are also problems when the therapist defensively agrees too quickly to an interruption, in order to avoid a deeper rejection by the patient. A treatment respite may be advisable for a patient who experiences a sense of submission and needs the reality of being set free.

The authors seem to deliberately steer clear of the issue of bending the frame that the patients who are discussed under "Special Topics" tend to demand. I am referring here to concrete issues of time, money, therapist self disclosure, and so on. It is not that the authors of *Psychodynamic Treatment of Depression* are inflexible, but their flexibility tends to be in the direction of clinical intervention—be it medication, couples therapy, cognitive therapy, consultation, or hospitalization. I suspect that they have no intent to manualize the debatable, let alone the controversial. I note this because the book appears to be intended as a preliminary to a manual for the psychodynamic treatment of depression. Indeed, two of the authors have already contributed to a similar manual on the psychodynamic psychotherapy of panic disorder.

While the distinction between *guide* (my word) and *manual* may not be clear to many readers, I find that a manual for thera-

pists seems to be a required inclusion in the meta-analysis of efficacy studies of particular diagnostic entities. In these studies, psychodynamic psychotherapy has made an impressive showing. However, presently, there is no manual for applying this modality to the treatment of depression.

Perhaps the authors, on the way to preparing a manual, decided that they could better serve therapists and their patients in coping with this pervasive condition in the present larger and more flexible format. If this is so, they are to be commended on a wise choice. Purists would be remiss in expecting the insights offered here to be of the cookbook variety. They are not. Yet, the format —"pre-manual," as the authors state—provides a clarity that might otherwise not be achieved.

With that in mind, the authors have fulfilled their goal in providing a symptom-focused guide to the psychodynamic treatment of depression that is profound in its broader strokes, yet always attentive to individual variation.

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FAILURES IN PSYCHOANALYTIC TREATMENT. Edited by Joseph Reppen, Ph.D., and Martin A. Schulman, Ph.D. New York: International Universities Press, 2002. 302 pp.

WAY BEYOND FREUD: POSTMODERN PSYCHOANALYSIS OBSERVED. Edited by Joseph Reppen, Ph.D.; Jane Tucker, Ph.D.; and Martin A. Schulman, Ph.D. London: Open Gate Press, 2004. 301 pp.

Two of the most respected and conscientious editors in psychoanalytic publishing are Joseph Reppen and Martin Schulman. In their most recent collaborations, they bring to our attention two extremely important and timely topics that will likely be of interest to anyone concerned with the clinical efficacy of psychoanalytic practice and the future of psychoanalytic theory. *Failures in Psychoanalytic Treatment* is a candid, long overdue, and unpre-

tentious look at the pitfalls, disappointments, technical blunders, countertransference reactions, patient–analyst mismatch, and the personal vulnerabilities all analysts are likely to encounter to some degree during their professional careers.

This book is unique and bold for its attempt to honestly face a topic that is both unpopular and not readily talked about in professional space. Each contributor highlights a specific aspect of what he or she means by psychoanalytic "failure"—some questioning the concept itself, others focusing on elements of therapeutic impasse, the patient's deficits as an inability to do analytic work (such as in the phenomena of resistance, defense, and transference enactments), and failure in the analyst's self-reflectiveness, as well as militant external forces that precipitate the collapse of treatment. Some chapters focus on eroticized elements of the treatment, destructive transference manifestations, and homosexual panic as underlying treatment failure, thus pointing to the intensity of these processes, resistances, countertransferences, and so forth, and not necessarily to the psychoanalysis itself. No discussion of therapeutic criteria or outcome measures, such as patient satisfaction or symptom improvement, is included—only alliance failures and the questioning of patient analyzability are salient throughout this project.

This is a book almost entirely devoted to case studies exposing the intimate details of life in the consulting room, and for this reason alone, it merits serious praise. Many chapters are by senior psychoanalysts representing the major schools in psychoanalysis, including classical, Kleinian, interpersonal, and relational traditions. Let me speak to some of these chapters that stand out for me.

Marvin Hyman draws into question the whole concept of failure due to the subjective nature of determinate judgment that negates an objectivist epistemology, owing instead to the intersubjective negotiation of the psychoanalytic dyad. Furthermore, Hyman argues that as long as the analyst is committed to analyzing per se, then any talk of failure becomes an oxymoron and is thus illegitimate. Of course, this begs the question of what analysis

is all about, but this is the subtext of almost every chapter. The real pestering question that revisits the reader is: What constitutes psychoanalysis? In this regard, Hyman's points are well taken, particularly in the context of treatment assessment, patient change, and the question of methodology.

Many other chapters focus on the analyst's experiential sense of failure, such as Judith Vida's review of her first psychoanalytic control case, underscoring our lessons in humility and how we fail to live up to our own ideals. She also points to the way in which her classical training and supervision may have led her astray when working with certain patients, which points more toward the danger of maintaining a rigid identification based on group narcissism that potentially leads to bad treatment dynamics. Ann-Louise Silver highlights another type of failure: namely, the organizational history and closing of Chestnut Lodge. She thoughtfully chronicles the legacy of Freda Fromm-Reichmann and engages the analyzability of the psychotic patient through a poignant case study. Having worked for years in inpatient psychiatry, I find this chapter particularly meaningful, evoking as it does a real sense of sadness over the loss of the value of psychoanalytic work in institutional settings, which have all but succumbed to the modern era of psychopharmacology.

Cecilio Paniagua addresses the notion of failure by examining the treatment and intrapsychic life of an unsuccessful painter, rather than the treatment itself. This is an extremely well-articulated contribution, with lovely prose that mirrors the aesthetic properties of its subject matter. Johanna Krout Tabin and Alan Skolnikoff, in their chapters, nicely illustrate the sense of failure in their work with highly disturbed patients with schizophrenia, borderline and schizoid organizations, and attachment pathology; thus, they demonstrate sensitivity to problems in the alliance, transference-countertransference enactments, and the treatment frame, as well as recognition of the limited nature of the analyst's or therapist's internalized presence when there is such structural pathology. Skolnikoff provides an interesting case of a quasi-delusional young man who felt he had body odor, a symptom enacted in the treatment during a breach of the analyst's attunement.

W. W. Meissner thoughtfully addresses the premature termination of a case that, from my assessment, appeared to be due both to the patient's defensive posture and to Meissner's inability to establish a secure working alliance. R. D. Hinshelwood nicely examines the question of "fit" in the analytic dyad, and particularly illuminates the difficulties of countertransference, mismatch, impasse, and the analyst's own defensiveness, which produces a failure to understand the patient. This is a particularly useful and candid contribution that is likely to appeal to any psychoanalyst of any persuasion.

Taken as a whole, this book allows for a comparative analysis of the different schools and therapeutic attitudes of what constitutes the task of psychoanalytic practice, the role of the analyst, and how some approaches are naturally at odds with others, which underscores the uncontestability of the unique subjective contingencies underlying all therapeutic engagement. As already stated, this is a book about case studies: The lingering question implicit throughout the volume is what exactly composes the nature of psychoanalytic practice. There are some cases included here that I would not judge to be treatment failures; instead, failure can become an issue of incompleteness, while other cases may fail in terms of the goals we have assigned, and/or what we see as the purpose of psychoanalysis. If there is a general failure that permeates the consensus of this project, then, it may be the dogmatic assumption that the psychoanalyst still sees his or her primary role as interpreter of unconscious experience, rather than as co-participant examining the process of the treatment relationship itself. Here, failure is psychoanalysis's insistence on seeing its sole teleology as the aim to analyze even when other interventions are more optimal or pragmatic.

Many chapters leave the reader with the question: Did the analysis fail, or is the patient too disturbed? Most of the patients discussed throughout the book were indignant narcissists, borderlines, schizoids, psychotics, and the like—therefore, severely disturbed—which points more toward the recalcitrant nature of these disorders than to the limitations of the psychoanalytic method, an

observation reminiscent of Freud's ambivalence with regard to the efficacy of treating severely disturbed patients. When one is screamed at, intimidated, manipulated, devalued, and emotionally abused, it is no surprise that countertransference abounds. As in any edited collection, some chapters are stronger than others, but each contributor is to be congratulated for offering an intimate look into the ways in which he or she works clinically and conceptualizes case material.

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Way Beyond Freud examines the postmodern turn in contemporary psychoanalysis in recent years. Analysts unfamiliar with postmodern sensibilities that largely comprise current discourse on the self, subjectivity, the intersubjective dyad, meaning construction, and the illegitimacy of the analyst's epistemological access to truth and reality will find this book informative, challenging, and balanced. Chapters are broad in scope and specific in content, hence delineating a range of topics from the areas of empiricism, objectivity, and the biological sciences to conceptualizations of the subject, consciousness, agency, phenomenology, gender, clinical technique, trauma, and authenticity.

Robert Bornstein shows how psychoanalysis has been marginalized by academic psychology while being pillaged and co-opted by mainstream paradigms such as CBT—frequently passed off as new discoveries, when such models are merely revisions and reinventions of psychoanalytic theory. He eloquently shows how psychoanalysis has been imprecisely and inaccurately portrayed in the behavioral sciences, while "new" perspectives continue to plagiarize psychoanalytic insights that have long been established. Bornstein admirably offers an appeal and strategy for reconnecting psychoanalysis to mainstream thought that integrates the biological and psychological sciences.

Donald Spence questions the very legitimacy and heuristic value of the nature of fact, truth, and interpretation, and demonstrates how these impact data reporting and clinical practice. He questions the verity of psychoanalytic case reports due to myriad

conundrums that arise in part due to the distorted nature of subjective observations, perceptual inaccuracies, the ambiguity of memory, contextual variance, and the validity of information processing, as well as the dubious reliability of their measurability. Spence also demonstrates how conventional research has not been successful in providing measuring instruments that capture the true essence of psychoanalytic work, suggesting that "reality" itself cannot be recorded in pristine form by observation or in anecdotal case reports.

Spence's chapter is a very good introduction to the greater dilemmas of narration, construction, and objectivity, and the philosophical question of the one and the many. Like Bornstein—although conceiving it differently—Spence has a vision of psychoanalysis that approaches systematization via an attempt to scientize hermeneutics. This is later echoed in Frank Summers's chapter, where, after a criticism of the objectivist and relativist positions, the author advocates for a human science model based on hermeneutics.

There are a number of chapters that overlap in thematic content, yet they illuminate different aspects of current theory that have postmodern overtones. For instance, Michael Miller advocates for a dynamic systems theory of dyadic communications, represented in contemporary trends that derive their clinical technique from the work of infant observation research, neurobiology, and attachment perspectives. M. Guy Thompson provides a beneficial overview and criticism of the impact of German existentialism, and particularly the work of Heidegger, on the postmodern position and its implications for psychoanalysis. He cogently outlines the key postmodern propositions that stand in opposition to much of traditional psychoanalytic thought, which he then subjects to a scholarly critique.

W. W. Meissner surveys past and current views of the self, which he ultimately equates with the whole human person. Negating contemporary perspectives of selfhood that equate it with multiplicity, he examines the various facets of selfhood—structural, agentic, representational, and relational. This is in contrast to the

chapter by Barnaby Barratt, who sees the self as illusory. The question of the self is further taken up by Kimberlyn Leary in her exploration of multiplicity in cyberspace, in which she looks at how subjects construct their personal identities through virtual reality. She examines two case studies of patients who use the Internet as a medium for the elaboration of their fantasy lives by taking on imaginary self-states, personas, and alternative roles, lifestyles, and gender identities. Leary nicely engages this current phenomenon in popular culture and supplies parallels to contemporary theory and practice.

Because the postmodern turn elevates language, culture, consciousness, and constructivism at the expense of one's personal historicity and identity, Paul Roazen champions the primacy of the past, which is none other than an ontological defense of the a priori logical nature of unconscious facticity. Other chapters are not so much postmodern in focus as they are interesting in their own right, such as Doris Silverman's intriguing reexamination of symbiosis and the myth of female development, Arnold Rachman's revisitation of classical psychoanalytic technique through a superb engagement of Freud's texts, and Barnaby Barratt's delightful (if at times abstruse) cacophony of metapsychological theory viewed through a revisionist lens, heavily indebted to poststructuralism and French continental philosophy. Peter Shabad provides a theoretically refined and original contribution to the understanding of trauma and defense.

The real gem in this book is David Pincus's stellar essay on the notion of universals through the engagement of neuroscience and evolutionary biology. He lays a firm foundation for the debate between modern and postmodern tenets on knowledge, meaning, and being, persuasively arguing for the inherent limitations and contradictions carried by both objectivist and subjectivist models. By examining various subdisciplines in neuroscience, he unquestionably upholds the notion of universals, despite contingency, particularity, variation, and contextual complexity, thus showing the intimate connection between the subject and the object. The point he indirectly makes (although he does not say so in this

fashion) is that there are certain invariances to human experience that transcend context, gender, culture, history, and time, and this postulation directly challenges the postmodern platform.

In his ten years of editorship of *Psychoanalytic Books* and in his tenure as editor of *Psychoanalytic Psychology*, Reppen has devoted his career to promoting the virtue and value of psychoanalytic pluralism. Schulman, in fifteen years of service as editor of the *Psychoanalytic Review,* has shepherded through many noteworthy publications that would surely not have seen the light of day, were it not for his principled reluctance to participate in partisan psychoanalytic politics. And Tucker's years of editorship at Harcourt Brace and devotion to nurturing quality scholarship surely come through in this last volume. The field owes a great debt to these people.

JON MILLS (TORONTO, ONTARIO, CANADA)

PRIMITIVE MENTAL STATES, VOLUME 2: PRENATAL DEVELOPMENT GETS ITS DUE. Edited by Shelley Alhanati, Ph.D. London: Karnac, 2002. 278 pp.

Thought provoking, sometimes controversial, this volume explores what the editor describes as primitive mental states that originate not in the cauldron of mother–infant interaction—so frequently covered in the object relations and intersubjective literature over the past fifty years—but rather in "early (pre- and perinatal) trauma" (p. xvii). This book, therefore, represents a radical departure from what could now be described as mainstream psychoanalytic thought. Who among us has recently made a clinical interpretation that contains an allusion to prenatal or perinatal states of mind, much less experience? It is this element of subversiveness that I found so intriguing, and yet problematic.

Nearly all the authors are affiliated with the Psychoanalytic Center of California in Los Angeles—Ground Zero for contemporary thinking inspired by the work of Wilfred Bion. James Grotstein, himself analyzed by Bion and an unabashed apologist over

the past twenty-five years for Bion's ideas, has left his deliciously quirky fingerprints all over this volume, and also contributes a chapter on projective identification.

Although nowhere explicitly stated, *Primitive Mental States* seems to be attempting to accomplish four goals: (1) to provide a neurobiological context for projective identification, specifically, and all forms of intimate communication that rely on intuition, generally; (2) to argue for the emergence of states of mind prior to the physical birth of the human infant; (3) to supply the reader with clinical evidence of the efficacy of using interpretations that incorporate an understanding of primitive states of mind whose origins can be putatively attributed to experiences in utero; and (4) to extend some of Bion's theoretical ideas in new directions. The authors partially accomplish all four goals. I will briefly summarize each of the ten chapters with respect to these goals.

In their chapters, both Allan Schore and Shelley Alhanati discuss some of the recent neurobiological and molecular genetics research that they claim not only supports the concept of projective identification, but also holds the potential to account for what the psychoanalytic literature generally refers to as constitutional factors. Building on Freud's idea that the analyst's unconscious could be used as a receptive organ for understanding the patient's unconscious,[1] Schore cites numerous neurobiological studies that he believes suggest that this form of receptive communication, first described by Freud, can now be characterized as the right brain of the analyst communicating with the right brain of the patient, and that this communication can go on outside the awareness of both parties primarily through nonverbal cues. He views so-called primitive defense mechanisms, such as projective identification and dissociation, as methods used by the infant "to cope with interactive forces that induce intensely stressful states that traumatically disorganize the infant's homeostatic equilibrium" (p. 7). Such a view would appear to presuppose a highly disturbed dyadic matrix.

[1] See Freud, S. (1912). Recommendations to physicians practicing psychoanalysis. *S. E.,* 12.

Yet this view of projective identification seems to contradict a central thesis of this volume—that projective identification, while a primitive (i.e., early) method of avoiding extreme discomfort, is used normatively among all infants and constitutes the primary mode of emotional communication for the young infant. In fact, Schore later argues that projective identification is a bidirectional process used by both members of the dyad (p. 11). Mothers and infants, just like analysts and patients, engage in right-brain-to-right-brain communication.

Later in this chapter, Schore seems to reconcile this apparent contradiction by drawing a distinction between "defensive" and "adaptive" projective identification. At this point, Schore could have relied on the attachment research literature to help make his point. Maltreated infants, for example, tend to have mothers who lack an *alpha function* (the psychological awareness to interpret the infant's signals of distress without feeling overwhelmed or blocked from thinking clearly) and are therefore unable to metabolize their infants' *beta elements* (split-off objects associated with highly distressed states of mind) into *alpha elements* (more integrated objects associated with more modulated emotional states of mind). These infants, often classified as having a disorganized attachment to their mothers, have actually been observed during reunion episodes in what have been described as dissociative-like states known as "freezing" or "stilling"[2]—what Schore would describe as the outcome of an evacuation of the entire self (defensive projective identification). Mention of this literature would have grounded Schore's conjectures in empirical observation.

This criticism, unfortunately, extends to the entire volume: in spite of its mandate to "integrate psychoanalysis with other disciplines" (p. xvii), there is a conspicuous absence of any integration of these authors' work with psychoanalytically based empirical studies that, while falling outside the broad Kleinian tradition, might

[2] See Liotti, G. (1999). Disorganization of attachment as a model for understanding dissociative psychopathology. In *Attachment Disorganization,* ed. J. Solomon & C. George. New York: Guilford, pp. 291-317.

nevertheless support some of its cherished theoretical conceptualizations.[3]

In her chapter, Alhanati follows the same line of thought regarding a putative biological basis for the concept of projective identification. Like Schore, Alhanati mentions attachment, but fails to use any attachment findings in support of her theory. Instead, she cites just one study[4] that suggested that children with right-hemispheric, nonverbal learning disabilities can misinterpret parental responses and affective cues. Using this single study as a platform, Alhanati speculates that communication via projective identification begins in utero and could influence mother–infant bonding prenatally (p. 223). According to Alhanati, this possibility is supported by the influence of stress on human biological structures as diverse as messenger molecules and stem cells, which could influence the fetus's ability to engage in projective identification and, later, in bonding. Although not articulated, a suggestion seems to be made that maternal stress, communicated via the intrauterine climate, could affect the coloration of the fetus's earliest projective identifications, which in turn could influence neurological and perhaps even temperamental development that directly impacts on mother–infant interactions.

While these are intriguing possibilities, something appears to get lost when a *psychological* form of communication is postulated in utero. Klein seemed to conceptualize projective identification as, among other things, a fantasy.[5] Assuming that the fetus is capable of having fantasies, how are these fantasies transmitted from the fetus's right brain to the mother's right brain for processing

[3] For this kind of integrative approach, see the following sources: (1) Fonagy, P. (2001). *Attachment and Psychoanalysis.* New York: Other Press; and (2) Goodman, G. (2002). *The Internal World and Attachment.* Hillsdale, NJ: Analytic Press.

[4] Palombo, J. & Berenberg, A. H. (1997). Psychotherapy for children with nonverbal learning disabilities. In *The Handbook of Infant, Child, and Adolescent Psychotherapy: New Directions in Integrative Treatment,* ed. B. Mark & J. Incorvaia. Northvale, NJ: Aronson.

[5] See Klein, M. (1946). Notes on some schizoid mechanisms. In *Envy and Gratitude and Other Works, 1946-1963,* ed. R. E. Money-Kyrle. New York: Delacorte Press, 1975.

(fulfillment of the alpha function)? And, conversely, how does the mother transmit the metabolized communication back to the fetus? Curiously, these questions are not addressed in this chapter.

I could imagine a fetus, out of some fantasied frustration (perhaps based on a real experience, such as violent jostling), kicking inside its mother's uterus, felt and interpreted by the mother as a communication, which might in turn elicit from the mother a soothing (singing) or hostile (yelling) response, depending on her ability to serve as an alpha function for the beta elements communicated through the kicking behavior. This maternal response is then heard by the listening fetus and interpreted as confirmation of either a soothing or persecutory Other. Alhanati is puzzlingly nonspecific, however, when she mentions the fetus's capacity "to send out or receive positive or negative signals to and from mother" (p. 223); thus, it is left to the reader to speculate on the precise mechanisms of intrauterine communication implicated in the earliest projective identifications. The net effect for the reader is that a highly abstract concept like projective identification seems to get concretized and emptied of its original associations with fantasy material.

The emergence of states of mind prior to the physical birth of the human infant is given attention in two chapters, the first written by eight members of a psychoanalytic institute in Buenos Aires, and the other by Erna Osterweil. The Argentine analysts rely heavily on Bion's work from his final years in the 1970s to argue that the horizon of psychoanalytic thought can be glimpsed through the walls of the uterus. The prenatal thinking that takes place from this earliest period of development is so primitive, so qualitatively distinct from postnatal thinking, that it gets walled off from awareness and ultimately needs to be reintegrated with postnatal thinking. According to the authors, prenatal thinking is what psychoanalytic theoreticians have traditionally referred to as "psychosis"—the prenatal parts of the total personality that constitute each person's psychotic core, to use Loewald's (1979) term.[6]

[6] See Loewald, H. W. (1979). The waning of the Oedipus complex. *J. Amer. Psychoanal. Assn.*, 27:751-775.

The problem for psychoanalytic treatment is not, as has been traditionally thought, the reconciliation of the infantile with the adult personalities, but rather is here seen as the reconciliation of the prenatal with the postnatal personalities. One implication of this idea is that envy would no longer hold such an esteemed position vis-à-vis clinical work with primitive personalities, because the fetus can respond only to "an excessive intolerance of frustration and/or pain, and not to an envious and greedy attack on the good object" (p. 105). It is implied, but not articulated, that envy must therefore originate from postnatal thinking, and does not belong to this walled-off, psychotic part of the total personality. Later, the authors nonrhetorically ask, "Do fetuses recognize frustration?" (p. 105). It seems that the authors' entire argument, however, relies on a positive answer to this question.

In what I consider to be the most provocative and fascinating chapter of this volume, Osterweil makes a persuasive case for the psychological impact of intrauterine life on the fetus, which in turn reverberates throughout the postnatal life span. First, she cites medical studies, somewhat dated but nevertheless relevant to her argument, that support her contention that prenatal sensory capacities not only function, but also create somatically based, remembered experiences that she believes form the building blocks of mental activity. This mental activity, Osterweil writes, coalesces around nascent "images" that ultimately become the fetus's first object relationship—"that which is established between the fetus and the 'interior' of the mother's body, and that [which] is the forerunner of those established after birth" (p. 228).

Osterweil mentions three intrauterine companions to the fetus —the umbilical cord, the placenta, and the amniotic fluid—that live on as mental representations long after birth. Osterweil gives considerable attention to ancient cosmologies and mythologies to make her point that these first mental representations retain their primordial hold on us across generations. Particularly intriguing is her reinterpretation of the snake metaphor, so prevalent in nearly all of history's creation myths, as a metaphor for the umbilical cord—the first object relationship. In the history of psycho-

analysis, only Mott[7] has made the analogy between the snake symbol and the umbilical cord rather than the phallus. Later in the chapter (p. 253), however, she correctly attributes to Rank[8] the idea that birth anxiety, or the conflict over whether to live separately from the womb or still inside it, is the central human anxiety —not castration anxiety, as Freud believed. In fact, castration anxiety could be interpreted as a later variation of the anxiety surrounding the loss of the umbilical cord severed at the time of birth, together with the secure feeling of the intrauterine environment.

Finally, Osterweil suggests that these prenatal experiences with the umbilical cord and the other two companions of intrauterine life (early transitional objects?) necessitate thorough revisions in both the theory and practice of psychoanalysis. Constitutional factors, even Klein's concept of the death instinct, could be seen to have an environmental basis if the infant's delivery is experienced as a murder of its objects and a robbery of its home. She suggests that perinatal complications, such as a loss of oxygen via the umbilical cord's wrapping around the infant's neck, could produce annihilation anxiety, whose constitutional basis Osterweil also seems to be challenging.

These ideas, while provocative, return us to an emphasis on the vicissitudes of intrauterine life and a corresponding lack of emphasis on the vicissitudes of intrapsychic life, particularly the motivational systems that act on both intrapsychic and intrauterine life. What made Freud's bold move from the seduction theory to a theory of infantile sexuality so important was that it gave humans ultimate ownership over their desires and anxieties. Osterweil's theory seems to reverse Freud's discovery in favor of returning to a view of psychopathology as the inevitable consequence of trauma—in this case, traumatic pre- and perinatal complications.

Empirical studies from the attachment literature[9] suggest that infants, and even toddlers, removed from their biological mothers

[7] Mott, J. F. (1964). *The Universal Design of Creation.* London: Mark Beech.

[8] Rank, O. (1924). *The Trauma of Birth.* New York: Brunner, 1952.

[9] E.g., Howes, C. (1999). Attachment relationships in the context of multiple caregivers. In *Handbook of Attachment: Theory, Research, and Clinical Applications,* ed. J. Cassidy & P. R. Shaver. New York: Guilford, pp. 671-687.

because of abuse or neglect and placed with emotionally responsive and predictable caregivers can convert from insecure to secure patterns of attachment in as little as two months. In the absence of intervening major life events, these attachment patterns remain stable throughout the life span.[10] If the quality of attachment can be considered a critical risk factor or protective factor in the development of psychopathology, then the effects of pre- and perinatal development seem dubious.[11] On the other hand, prenatal exposure to substances such as methadone and heroin do increase the risk of infantile attachment disorganization.[12] The relative contributions of these phases of development could be settled with empirical work that takes into account both postnatal (e.g., attachment) and prenatal (e.g., neurotoxicology) factors in the prediction of early psychopathology.

The authors of four chapters—Alhanati, Jane Van Buren, Sandra E. Fenster, and Michael Ian Paul—discuss their clinical work with seriously disturbed patients using a conceptualization of primitive mental states that draws from Klein's and Bion's theories of transference, projective identification, and countertransference. All four authors illustrate that the analyst's reverie in sessions can be used to understand aspects of the patient's experience considered by these authors to be ineffable—nameless and unsymbolized. For example, Alhanati describes a patient who is beginning to talk about a traumatic surgery for the first time and instructs the analyst to close her eyes. With eyes closed, Alhanati then daydreams that

[10] See the following reference sources: (1) Hamilton, C. E. (2000). Continuity and discontinuity of attachment from infancy through adolescence. *Child Devel.,* 71: 690-694; and (2) Waters, E., Merrick, S., Treboux, D. Crowell, J. & Albersheim, L. (2000). Attachment security in infancy and early adulthood: a twenty-year longitudinal study. *Child Devel.,* 71:684-689.

[11] See the following references: (1) Carlson, E. A. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Devel.,* 69:1107-1128; and (2) Sroufe, L. A. (1997). Psychopathology as an outcome of development. *Devel. & Psychopath.,* 9:251-268.

[12] See Goodman, G., Hans, S. L. & Cox, S. M. (1999). Attachment behavior and its antecedents in offspring born to methadone-maintained women. *J. Clin. Child Psychol.,* 28:58-69.

she is holding the patient like a little baby. She wonders aloud whether that is what the patient is wishing for, and he acknowledges that she understands him. A lucky guess? Alhanati instead suggests that "what we often call 'intuition' can be harnessed and integrated with other modes of understanding" (p. 124).

At other times, however, this intuition seems completely ungrounded. For example, Alhanati daydreams a version of a patient's traumatic birth experience in which his mother died (p. 127). The patient acknowledges that he wants to press himself into the analyst and is feeling the texture of that fantasy in his mind. Based on her daydream, Alhanati then asks whether he is fantasizing about feeling the texture of his father's beard (his bearded father had been present at the patient's traumatic birth). Miraculously, the patient concurs. The implication is that the patient has actually begun to remember his birth experience and is recovering a piece of that memory in the session. Indeed, in all four chapters illustrating clinical work from this perspective, these patient communications are treated as legitimate memories of pre- or perinatal events, rather than as fantasies born out of family myths told to the subjects at an older age, or as self-constructed fantasies of what the patients' primordial histories might have been like.

Finally, Grotstein and James Gooch contribute theoretical chapters that present both a history of Kleinian and Bionian thought (Grotstein) and an original application of this thought to family systems theory (Gooch). Grotstein, in particular, does a masterful job of explaining the complex and often misunderstood concept of projective identification, and this clarification in itself is worth the price of this volume.

I was surprised to learn that Kleinians, according to Grotstein, make no distinction between *projection* and *projective identification*. Projective identification is used instead of projection because projective identification implies an object relationship, whereas projection does not. Like the other authors of this volume, Grotstein unfortunately ignores other theoretical contributions, such as that of

Kernberg, who places these two concepts on a developmental continuum.[13] Gooch's chapter serves to explain the father's and other caregivers' roles in performing the alpha function, which serves the purpose of integrating the infant's internal world. The clinical implication of this theoretical extension is that the analyst can help the patient to identify those aspects of the family system that can perform the needed alpha functions for the successful emotional containment of the infant's fragmented beta elements.

In spite of its flaws, I recommend *Primitive Mental States* as a worthy contribution to the literature on seriously disturbed patients who seek psychoanalytic treatment. The authors are contemporary Kleinians and Bionians who have carefully considered those aspects of human development not yet given a proper birth in the psychoanalytic literature (pre- and perinatal development). All these authors tend to concretize these early experiences, however, rather than treating them as fantasies having later origins, which perhaps limits this book's usefulness for the clinician. Westen has criticized object relations theories for equating earlier development with more primitive psychopathology and for assuming a unitary developmental line of object relations; and I wonder if these authors might benefit from heeding Westen's advice and reframing some of their creative ideas to take into account these criticisms.[14]

GEOFF GOODMAN

[13] See Kernberg, O. F. (1987). Projection and projective identification: developmental and clinical aspects. *J. Amer. Psychoanal. Assn.*, 35:795-819.

[14] See Westen, D. (1990). Towards a revised theory of borderline object relations: contributions of empirical research. *Int. J. Psychoanal.*, 71:661-693.

THE INTERNAL WORLD AND ATTACHMENT. By Geoff Goodman, Ph.D. Hillsdale, NY: Analytic Press, 2002. 339 pp.

It all started with Bowlby, all of it: *attachment*—the discipline and the phenomenon—and its *detachment* from psychoanalysis, resulting from this British psychoanalyst's disenfranchisement after he

put forth his new ideas. Put off by Kleinian words and ideas, unconvinced by the language of libido theory and challenged by the World Health Organization to establish general principles for healthy child-rearing across cultures, Bowlby turned to ethology. After studying Tinbergen and others, he did his own field work, observing children who had been left in pediatric hospitals (before the days of parents' rooming in) and those at play in Kensington Gardens. He developed concepts such as internal working models of attachment, the balance of security and exploration, and reactions to loss. When he presented these ideas in the *International Journal of Psychoanalysis*[1] (the journal bold enough to publish his work), he came up against withering criticism from Anna Freud. Abandoned by psychoanalysts—but with a new student, Mary Ainsworth, who put his ideas into practice in Uganda and then in the United States—Bowlby and his attachment theory found a new home in academia, nurtured by subsequent students such as Waters, Sroufe, Main, Cassidy, and others.

Only in the last few years have analysts returned to attachment and returned attachment to its home of origin, psychoanalysis. Several psychoanalytic thinkers, such as Fonagy,[2] Szajnberg and Crittendon,[3] and Main,[4] have tried to bridge apparent conceptual gaps (which may actually be more gaps of language) to integrate the work of attachment, particularly with object relations theory.

The Internal World and Attachment is a recent effort to bring clarity and integration to two fields that deal with our inner lives and intimacy, attachment theory and object relations. Its author, Geoff Goodman, is systematic, summarizing briefly both fields and

[1] Bowlby, J. (1958a). The nature of the child's tie to his mother. *Int. J. Psychoanal.,* 39:350-373.

[2] Fonagy, P. (1999a). Points of contact and divergence between psychoanalytic and attachment theories: is psychoanalytic theory truly different? *Psychoanal. Inquiry,* 19:448-480.

[3] Szajnberg, N. & Crittendon, P. (1997). The transference refracted through the lens of attachment. *J. Amer. Acad. Psychoanal.,* 25(3):409-438.

[4] Main, M. (1995). Discourse, prediction and recent studies in attachment: implications for psychoanalysis. In *Research in Psychoanalysis: Process, Development, Outcome,* ed. T. Shapiro & R. Emde. Madison, CT : Int. Univ. Press, pp. 209-244.

then both fields' views of each other—points of comparison and contrast. He rises to the challenge that eluded Bowlby: to integrate libido theory and attachment. His book is an exhaustive summary of the literature in these areas. He cites Lieberman and Zeanah's (1999) observation that attachment theory frequently does not consider some of the major systems that motivate and move us, such as sexuality, dominance, and aggression. Words such as *fantasy, dreams,* and the *unconscious* are not typically part of the vocabulary of attachment theory.

The strength of this book is its completeness, that is, the author's detailed review of the literature. It will be a boon to those who seek a careful assessment of previous writings in attachment theory, and in object relations theory particularly.

Goodman also offers descriptions of empirical studies that aid clinicians. For instance, Sroufe and colleagues observed that boys whose mothers were overly seductive in toddlerhood also tended to hit the boys; later, these mothers were both unresponsive in intimacy and crossed generational boundaries. In a later prospective study, Massie and Szajnberg[5] reported that those boys whose mothers or fathers had been overly sensual to them as young children later became teens who were particularly vulnerable to predatory men. Goodman offers clinical examples from Otto Kernberg, Alicia Lieberman, and others to support his integration of psychoanalytic clinical work—either from an object relations or libido theory perspective—with attachment.

The author begins to get bogged down in his own language at times, such as in this passage:

> If a consistent caregiver provides oral-libidinal and attachment pleasures simultaneously without significant interruptions in delivery, then simultaneous with ego maturation, the self-representations based on experiences of each of these two forms of pleasure—and, separately, the object representations based on experiences of each of

[5] Massie, H. & Szajnberg, N. (in press). *Growing Up: Roads to Emotional Health from Birth to Age 30 in 76 People.* Philadelphia, PA: Xlibris.

> theses two forms of pleasure—become integrated some time during the first six months of life. [p. 238]

This is too wordy, to my taste, too removed from our experience —let alone from that of a baby.

Goodman is bold enough to design a table demonstrating the integration of object representations and self-representations in the first year of life. He states that certain psychopathologies take root at certain ages (e.g., borderline disorders have their genesis before the age of six months). I find these postulations complex and confusing; like Winnicott,[6] we might do well to be more cautious about assigning dates of etiology to psychopathology, as there may be multiple pathways and regressions for manifestations of disorders.

Overall, this book is a scholarly review of the literature, with proposed theories that are amenable to empirical study. Those looking for a fine review of attachment literature and of related psychoanalytic literature will find it here. Such knowledge strengthens our clinical abilities.

NATHAN SZAJNBERG (SAN FRANCISCO, CA)

[6] Winnicott, D. W. (1965). *The Maturational Processes and the Facilitating Environment*. New York: Int. Univ. Press.

INFANT RESEARCH AND ADULT TREATMENT: CO-CONSTRUCTING INTERACTIONS. By Beatrice Beebe and Frank M. Lachmann. Hillsdale, NJ: Analytic Press, 2002. 232 pp.

The richness and complexity of this book make it a pleasure to read and a challenge to review. The overall objective of this ambitious volume is to "explicate the value of infant research and a systems view for psychoanalysis" (p. 232). The authors organize the book into a review of the relevant infant research and the delineation of a *dyadic systems model,* derived from infant research and illustrated with clinical cases of adult psychoanalytic patients.

Beebe and Lachmann succeed in many important ways, particularly in their comprehensive review of the literature on infant research and in their presentation of a sophisticated and meticulously crafted systems model of developmental and therapeutic dyadic processes. In fact, the excellent review of the infant research literature provides a concise summary for the expert in the field, as well as a superb introduction to the reader interested in developmental psychology and the relevance of new findings in this field to the practicing psychoanalyst. Although the authors make major strides, an integration of infant research and adult psychoanalysis remains elusive.

The authors' dyadic systems model builds upon a secure foundation in infant research. A central element of this model is Louis Sander's set of concepts about the generation of agency in the infant–caregiver relationship through self and interactive regulatory processes.[1] The model is presented in concise form in chapter 2, and is elaborated in relation both to research data and to clinical cases in the chapters that follow. These additional elaborations add new complexity, which the authors attempt to deal with in various ways, such as by emphasizing the organizing principle of ongoing regulation. Yet, in developing a systems model applicable to psychoanalysis, the authors must strike a balance between complexity and *coherence;* this proves difficult to achieve and to maintain, particularly as one moves from theory to practice. The value of complexity in this model is that it allows the clinician to organize a greater amount of information, and includes the flexibility to change the theory in response to emerging complications in the clinical situation. Such complexity also guards against the reductionism of one-person psychoanalytic theories, which the authors strive to move beyond. On the other hand, coherence is necessary to make the model useful.

[1] See the following references: (1) Sander, L. (1977). The regulation of exchange in the infant–caregiver system and some aspects of the context-content relationship. In *Interaction, Conversation, and the Development of Language,* ed. M. Lewis & L. Rosenblum. New York: Wiley, pp. 133-156; and (2) Sander, L. (1983). Polarity paradox and the organizing process in development. In *Frontiers of Infant Psychiatry,* ed. J. D. Call, E. Galenson & R. Tyson. New York: Basic Books, pp. 315-327.

The first example of how the complexity-coherence issue arises in the clinical cases concerns the authors' formulations of pathology, which in some of the cases seem to retreat from the complexity of the "bi-directional" systems model—as described in the authors' dyadic systems model—to a simpler "uni-directional" theory of linear causality. The case of Karen illustrates this situation. The authors appear to conclude that the root of Karen's inability to make a secure object tie is the fact that her mother did not really want her and was going to "dump" her. They note that "Karen's lifelong experiences of rebuff led to a premature reliance on drastic and restricting self-regulatory measures" (p. 61). This explanation for the patient's symptoms loses the bi-directional feature that stresses active roles for both partners in the interactive process, and instead returns to a one-person model in which Karen's parents were doing or not doing something to her. This seems particularly at odds with the clinical data, since those data include many behaviors on Karen's part, which seem—at least to this reader—expressive of significant hostility and aggression, suggesting complex interactive processes between the patient and her parents. The authors' simple formulation has also lost the richness of the conscious and unconscious meanings of Karen's private world of fantasy, a world in which she is the agent of creative process. Thus, two important attributes of the dyadic systems model—bi-directionality and agency—are not elaborated in the clinical case.

The second example of how the complexity-coherence issue arises is that the clinical cases involve adult patients with different age-possible capacities than those of infants, such as language. The authors address the feature of language in their model by acknowledging that "the addition of language makes the conceptualization of process more complex" (p. 34). Yet, the important issue of how language and other age-possible capacities of adults influence insights gained from infant research, as they apply to adult psychoanalysis, needs more attention.

According to the principles of dynamic systems theory, the acquisition of language involves a phase change of inestimable significance in human development. It not only affects the way we com-

municate with others; it also transforms the way we organize our inner thoughts and create the meanings that make sense out of our experience. The presence of language competency and other sophisticated capacities in the adult's repertoire of adaptive functions even affects the meanings that the adult makes of non-language-based procedural knowledge. In other words, infants experience procedural knowing differently from the way adults experience it. From the point at which language is obtained, language and nonverbal meaning-making processes are inextricably linked.

The significance of age-possible competencies in the creation of the adult's private world represents another difficulty of translating infant research into relevant clinical insights for adult patients. While the infant also possesses a private world, the adult's private world is different—for example, in the adult's capacity to represent experience in conscious and unconscious fantasy. The authors are not unaware of this; they emphasize their intention of filling in the gaps of psychoanalytic theory with concepts about nonverbal interaction, and they include fantasy and defenses in the self-regulation domain of their model. Yet, these inclusions are peripheral in the diagrams and discussions of the model, and the reporting of the fantasy material—patients' and analysts'—is not fully integrated with nonverbal material in the case reports.

A third example of the coherence-complexity issue concerns the key objective of illustrating theory with clinical material by assessing the usefulness of a theoretical model in practice. It is thus desirable that the clinical data be drawn from materials that can be verified, or at least assessed. Although common to most discussions of clinical cases, the authors' use of post hoc reconstructions makes it difficult to assess the observations, especially in the context of the relatively more objectively observable data of infant research. Consider, again, the case of Karen. How can we know that Karen's mother really did not want her and was going to reject her (leaving aside the issue of whether this was the root of her difficulties)? The short answer is that we do not know, or at least we have no confirming evidence. What we *do* know is that this is the meaning she and her analyst made of the recollections

she brought to her analyst (a meaning that took into account unconscious fantasy), and that she and the analyst used this meaning to make sense of her reactions in the transference.

Note that this more complex formulation, which appears truer to the authors' model, may not seem as useful to the clinician as the simpler one. But the main point here is that we do not have any means of verifying these "facts" in the materials presented.

Another example of the difficulty of obtaining information to assess elements of dyadic systems theory is raised by the authors' reconstructions of the psychoanalytic process. They state that the "treatment of Karen emphasizes the analyst's and patient's interactive affect, mood, arousal, and rhythm. We track the interaction at the micro-level of rhythm matching, modulating of vocal contour" (p. 47). Yet Karen's analyst states that it was "mostly in retrospect" that he became aware of the important role of the nonverbal process (p. 52). He goes on to say that he "assume[s] that through these interactions, Karen felt some sense of validation leading to the tentative engagement of a self-object tie" (p. 52). That is an assumption that the reader of the clinical material cannot assess, and, indeed, it must be a difficult one for even the analyst to maintain with comfort.

Reading this book makes one aware of a need to develop bridging concepts of various types—including connections of the observable with the subjective, connections of what we observe in infants and their caregivers with psychoanalytic theories about the private, inner world of our patients and ourselves. Examples of such bridging concepts include Tronick's idea of a systems approach to the co-creation of meanings and meaning-making processes in age-possible ways throughout the life of an individual. Once developed, these bridging concepts and others can be subjected to clinical investigation.

Subjecting models to clinical investigation presupposes the emergence of data that can be used to assess usefulness. Here infant research provides a useful guide. One of the major contributions of this field is the use of videotape microanalysis to study interactive processes; this method could be applied to older indi-

viduals. Beginning with efforts with young children, who could be considered to offer a greater variety of data than either infants or adults—visual data from physical activity, relatively undisguised facial expressions, and imaginative play, as well as language—and then including adults, videotape data of psychoanalytic cases might be gathered to provide more reliable information.[2] There may be greater difficulties with adults, where issues of confidentiality and considerations of the effect of filming on the psychoanalytic process may be more problematic. Nevertheless, videotape is a powerful tool that could be developed further, under appropriate circumstances, to provide more "objective" data to supplement reconstructions and other clinical observations.[3]

In sum, this book is notable for a comprehensive review of the literature, a sophisticated attempt at devising a systems model, and illustrations of the way in which the authors apply their model to clinical cases. This very serious and thoughtful effort demonstrates the difficulty of the task of integrating infant research with adult psychoanalysis, as well as how much more work must be done in this regard.

A project that will lead to important new information in the field is more direct observational research, such as that conducted with videotaping. Finding the relevance of new knowledge gained from the microanalysis of infant and caregiver observation to the work of the practicing psychoanalyst is a fascinating and difficult quest. This book is absorbing reading to anyone interested in trying to understand the intersection of infant research and psychoanalysis, a field that promises to be of increasing importance to both theoreticians and clinicians. And because the exact use in clinical work of new information derived from direct ob-

[2] See the following: (1) Harrison, A. (2003). Change in psychoanalysis: getting from A to B. *J. Amer. Psychoanal. Assn.,* 51(1):221-257; and (2) Harrison, A. & Tronick, E. (unpublished). Now we have a playground: emerging new ideas of therapeutic action.

[3] Beatrice Beebe has videotaped an adult psychoanalytic case; future presentations of this material will contribute to the available data.

servation of infants is still unknown, this is also compelling reading to anyone who is interested in psychological mysteries.

ALEXANDRA MURRAY HARRISON (CAMBRIDGE, MA)

DISAPPEARING PERSONS: SHAME AND APPEARANCE. By Benjamin Kilborne, Ph.D. Albany, NY: State University of New York Press, 2002. 192 pp.

Shame may be described as "the painful feeling arising from the consciousness of something dishonorable, improper, ridiculous—done by oneself or another";[1] it is useful to distinguish it from embarrassment, which "usually refers to a feeling less painful than that of shame—associated with less serious situations, often of a social nature."[2] In the same realm, mortification "is a more painful feeling, akin to shame, but also more likely to arise from specifically social circumstances . . . [as in] 'His mortification at being singled out for rebuke.'"[3] Yet another similar but distinct feeling is that of humiliation, which may be understood as "mortification at being humbled in the estimation of others."[4]

Are these distinctions significant? I believe that they are of immense clinical value in understanding, with exquisite clarity, exactly what a patient is feeling at a given moment and in helping her sharpen her own awareness of her feelings. In the difficult journey of identifying patients' affects, defining them correctly, and understanding them, *Disappearing Persons: Shame and Appearance* provides useful theoretical and technical concepts, rather like beams of light brightening a murky path.

From his vantage point as a clinical psychoanalyst, and drawing richly upon his background in anthropology, history, and literature, Kilborne has written a complex book, illustrating his thinking with regard to "shame phenomena" (p. 3) and to "establishing the relationship between oedipal shame and appearance

[1-4] *Webster's New Universal Unabridged Dictionary.* (1992). Avenal, NJ: Barnes & Noble/Outlet Book Co., p. 1310.

anxiety" (p. 3). He argues that in Sophocles' *Oedipus Rex,* Oedipus struggles not only with guilt about having killed his father and married his mother; he also wrestles painfully with the shame he experiences over his oedipal victory, and about

> . . . his inability to slay the monster of the plague and so demonstrate to the people of Thebes that he is a capable defender. His shameful defeat and humiliation as a king echoes the grief and humiliation he suffered as an infant. It is this grief, humiliation and pain—the pain of having had cruel, abandoning parents who left him to die—which makes his oedipal shame impossibly toxic, and that summons the depths of his rage. [p. 2]

Kilborne wants to establish a relationship between oedipal shame and appearance anxiety (i.e., how one appears to oneself and to others), asserting that Oedipus blinds himself because "he cannot bear himself in the eyes of others, and therefore must blot them out by 'really' making himself blind" (p. 2). The author's thinking is that the emphasis on appearance in our current cultural climate has to do with a belief that if we can control how we appear to others, we can modulate and control how we appear to ourselves. He contends that this is an effort to deal with oedipal shame.

While I have found many of Kilborne's ideas fresh, original, and useful, I was puzzled by his insistence on the term *oedipal shame* in this book. In an earlier paper,[5] he wrote:

> In my experience, shame does not entail any particular theoretical orientation itself . . . As such, shame dynamics are as pertinent to a theory of drives and to an understanding of transference and countertransference phenomena as they are to a theory of deficit. [p. 363]

Along these same lines, then, one could argue that Oedipus experienced both preoedipal and oedipal shame, as the tragic events of his earlier and his more recent life came together in his mind, prior to his blinding himself. By the same token, a focus on

[5] Kilborne, B. (1999). Wrestling with Proteus. *Psychoanal. Inquiry,* 19:362-372.

external appearance could be a way of covering and dealing with oedipal shame, but also with shame about preoedipal longings, rejections, and narcissistic wounds. Kilborne does helpfully consider that there is a shame/guilt continuum, and that "guilt and shame exist side by side, as do aggression and deficit, in a range of combinations" (p. 3). Perhaps he uses the term *oedipal shame* simply to sharpen the focus on this concept, since he writes, "I will be concerned with establishing the relationship between oedipal shame and appearance anxiety, oscillating in my analysis from individual psychodynamics to cultural phenomena" (p. 3). As I read his book, the material in many of the clinical vignettes seemed to me to point to shame related both to oedipal and to preoedipal issues.

The ten chapters of this book, each one rich and lyrical, hold many gems of clinical value. Kilborne's concept of "psychic size" (p. 10) is very useful in understanding patients as they struggle with narcissistic issues and try to regulate self-esteem through various maneuvers. He defines this concept as "an internal or shared experience of relative size, dependent upon standards of judgment and comparison" (p. 10), and uses Swift's *Gulliver's Travels* to elaborate. For example, he notes that, during the course of his travels, Gulliver visits Lilliput, where the inhabitants are one-twelfth the size of ordinary human beings, and Brobdingnag, where the inhabitants are twelve times the ordinary human size. Kilborne adds:

> In Lilliput, he [Gulliver] is envied; in Brobdingnag, he is constantly humiliated and made to feel utterly insignificant. The envious Lilliputians try to put Gulliver's eyes out . . . . If he does not see how small they are, then they can be as large as they wish, avoiding the humiliation of seeing themselves through his eyes. [p. 14]

Kilborne feels that Swift's own oedipal shame (related to his particular childhood history) led to a need for self-magnification and "metaphors of size instability" (p. 14). This concept of *psychic size,* first mentioned by Kilborne in his 1995 paper,[6] is a very help-

[6] Kilborne, B. (1995). Of creatures large and small: size anxiety, psychic size, shame, and the analytic situation. *Psychoanal. Q.,* 64:672-690.

ful tool in understanding particular clinical situations. In thinking about it, I was reminded of a 45-year-old man in the third year of his analysis, who asked me one day how I timed the beginning of his analytic session: did I start from the moment he lay down on the couch, or when I opened the waiting room door for him, or did his session actually begin as the previous patient left? He thought that if I started the clock prior to his lying down on the couch, he must be losing thirty seconds to a minute of each session. I wondered what that might feel like, and he responded, in a rather superior tone of voice, that such a procedure would be wrong of me, "sort of being cheap."

Later associations in this same session with the patient had to do with memories of his beautiful, brilliant mother, who was so involved with her career in music that she often did not come to see him perform in school plays. These thoughts led to his observation that he would never do that to his four-year-old son. He felt so much in tune with his son's need for him. I replied that I thought it was very painful for him to clearly recognize how hurt he had felt by his mother's lack of attention, how important it was to him to have every possible moment of his time with me, and how weak he felt at being so needy of me. Perhaps he felt stronger if he could deal with this fragile, needy feeling by pointing out the error of my ways and showing me the flaws in the way I worked and kept track of time. It must also be easier when *he* could be the one who was needed by his little son, and he could feel that he was giving, rather than desperately wanting, attention.

"I did feel angry at my mother," the patient acknowledged. "And hurt," I added, "and perhaps something else?" "Ashamed," he said. "So ashamed—like I feel with you, as if I'm begging for things. And then I think—if one of us has to feel ashamed, better that you should; so I take this superior attitude."

In the chapter entitled "Of Fig Leaves Real and Imagined," Kilborne weaves together his ideas about how clothes and plastic surgery lend themselves to altering one's appearance as a way of dealing with intense feelings of inadequacy and shame. "Clothes provide the illusion that we can 'vest' our being, and by control-

ling the way we appear in the eyes of others, control our own feelings" (p. 109). He believes that plastic surgery promotes the illusion of many people that they can actualize a persona that they imagine to be ideal. He points out that some plastic surgeons "fail to grasp the toxic shame that can be unleashed by their promises and skill," encouraging "potentially devastating pathologies of appearance" (p. 114).

Kilborne draws upon the works of Pirandello, Rilke, Kafka, Rushdie, and many others, as well as on Greek mythology, to illustrate his ideas. He revisits many of Freud's papers and suggests a newer understanding of them. In the last chapter of *Disappearing Persons*, called "These Weeping Eyes, Those Seeing Tears," Kilborne outlines the struggle between Freud and Ferenczi, the latter of whom "suffered from Freud's insensitivity to the underside of oedipal struggles" (p. 121), leading to Ferenczi's ultimately declining the presidency of the International Psychoanalytical Association in 1932. This action made Ferenczi's rift with Freud definite and permanent. Kilborne hypothesizes that Freud, because of his own narcissistic problems, could not comprehend Ferenczi's oedipal shame and sense of injury.

In summing up his rich work, Kilborne writes: "Grieving and mourning, together with an understanding of oedipal conflicts and shame dynamics and the ways in which they increase reliance on appearance, are, I think, essential in working through toxic shame cycles" (p. 130). He certainly helps us in this effort with our patients, by collating materials from a world of diverse resources and weaving them together with psychoanalytic theory and clinical material.

AISHA ABBASI (WEST BLOOMFIELD, MI)

WHEN THE BODY IS THE TARGET: SELF-HARM, PAIN, AND TRAUMATIC ATTACHMENTS. By Sharon Klayman Farber, Ph.D. Northvale, NJ: Aronson, 2000. 580 pp.

Already an experienced clinician, Sharon Farber chose to return to school to get her Ph.D. in clinical social work. This ambitious first

book is the product of her prior clinical experience and more recent doctoral thesis research. The book, divided into four parts, provides a survey of the almost infinite number of ways human beings can harm their bodies; the psychic determinants of this behavior; what these behaviors communicate; and, lastly, how we as clinicians can be useful to patients who perform these acts.

Part One, "The Borderland of Self Harm," comprises three chapters, each with multiple subsections. Here, Farber describes the many varieties of body manipulations she has encountered. Her sources vary from popular magazines and television to academic works in history, anthropology, psychiatry, and psychoanalysis. The breadth of her survey is informative and impressive. As clinicians, we have all had experience with some of these behaviors. However, few of us have been exposed to them as extensively as we are in these first 107 pages.

Part Two, "Neglect, Violence, and Traumatic Attachments," is a valiant attempt to recount what is known about the etiology of self-harm behaviors from a variety of perspectives. The author invokes attachment, object relations, instinct, family systems, and ego, self, and evolutionary psychological theories, as well as the newer neuroscientific findings, to further an understanding of the determinants of self-harm. Throughout, she presents material to support one of the important themes of this book: that as destructive as these behaviors are, they are also creative attempts at self-preservation.

Part Three, "The Body Speaks," attempts to explicate the various functions and meanings that self-harm behaviors can be designed to serve and express. Again, Farber reaches to some nontraditional sources to investigate this topic. Her research, described in the appendix, has helped to substantiate the notion that self-harm behaviors serve "to regulate states of mood, affect, and consciousness" (p. 265). She continues:

> From my study, my clinical work, and from the media, I have heard repeated thematic undercurrents . . . outer scars as expressions of inner feelings. Others have to do

> with doing and undoing, good and evil, purity and filth, fear of sexuality and expression of sexuality, pain and pleasure, physical pain and emotional pain, having control and losing control, self-protection and self-harm, sadism and masochism, wish for success and the fear of success, wanting to be invisible and wanting to be seen, shame and purification, deadness and aliveness, and self-destruction and self-healing. The theme of punishment to achieve a sense of justice was pervasive, as was the theme of balancing the scales between good and evil, justice and injustice, right and wrong. Often several such themes were woven together. [p. 276]

The author then elaborates these themes, and again emphasizes the potential risks of giving up self-harming behavior too soon.

Part Four, "Clinical Implications," is unequivocally the best part of this work. It is here that Farber's years of clinical experience, intellectual flexibility, and pragmatic sophistication are manifest. I would assign this part of the book particularly to all young clinicians beginning to work with these difficult and frightening patients. Clarity and cogency differentiate this section from those before it in Farber's explanations of what the clinician should do or say and why. We hear less from the authors she has read in this section, and more from her directly. The clinical vignettes are touching, revealing, and instructive.

I would have liked the author to elaborate more about how to determine when to press a patient to give up self-harming behaviors. Those of us who have treated these patients have heard their expressions of gratitude for our having found their self-harming behavior unacceptable. They needed to feel the affects that self-harm took away, to let us (and sometimes medications) help them bear them, and to talk with us about their determinants. How has Farber thought about the optimal timing of these interventions?

Throughout the book, the author does not distinguish between those claims that have been or could be subject to refutation and those that have not or cannot. It is as though all have equal epistomologic valence. One such example is her uncritical report-

ing of the assertion that "pulling out the hair represents an attempt to separate the self from the maternal body, while saving or eating the hair represents an incorporation of and identification with mother and reassurance against her loss" (p. 266). Is this true for all patients who pull out their hair, and how do we know that? Our field has been justly criticized for such omissions, and I think it is incumbent on us to make these distinctions.

In the book's last twenty pages, Farber briefly describes the research study she undertook that furthered her understanding of working with these patients. The brevity of this account and the omission of her investigative questionnaire puzzled me. Overall, however, *When the Body Is the Target* is an impressive exploration of a disturbing part of the human experience; the book has the potential to help many clinicians, and by extension their patients.

PAULA WOLK (BOSTON, MA)

THE HEART OF ADDICTION. By Lance Dodes, M.D. New York: Harper Collins, 2002. 258 pp.

In a field rife with misinformation, obfuscation, intimidation, and exploitation, this book represents a bright beacon of light that can pierce the fog and help save lives. It is full of good sense, accurate information, and helpful guidance for those who would like to free themselves from addictive behavior involving alcohol, gambling, prescription or nonprescription drugs, food, sex, shopping, and the like. I recommend it wholeheartedly.

Lance Dodes is a psychiatrist and psychoanalyst with a wealth of experience working in or running programs dealing with alcoholism, substance abuse, and compulsive gambling. He also treats addicted individuals in private practice. What he has learned from his experience is epitomized in his assertion that:

> *Virtually every addictive act is preceded by a feeling of helplessness or powerlessness. Addictive behavior functions to re-*

> *pair this underlying feeling of helplessness . . . because taking the addictive action (or even deciding to take this action) creates a sense of being empowered of taking control—over one's emotional experience and one's life.* [p. 4, italics in original]

Dodes goes on to say that *"rage at helplessness . . . is the nearly irresistible force that drives addiction"* (p. 5, italics in original). The addictive behavior, he emphasizes, is not to be looked at as reprehensible weakness, but, on the contrary, as an effective, albeit destructive, action that serves to restore a needed sense of power by providing the capacity to do something. Dodes grants that Alcoholics Anonymous and its offshoots can be helpful to some people, but he seriously questions the usefulness of requiring people to declare that they are helpless and have to turn themselves over to an external power to control them. He cites studies indicating that only a very small percentage of people who join AA stay with it and remain sober. For the rest, he advocates the use of a therapeutic approach that coordinates exploring each patient's unique personal history with recognizing that addictive behavior is a reaction to an infuriating sense of helplessness. He decries the tendency in some programs to label alcoholism or other addictive constellations as "diseases" afflicting people whose individuality and uniqueness are then scanted.

The book is written in a very personal and personable, conversational style that makes it as convincing as it is easy to read. In one chapter after another, Dodes introduces the reader to people whose stories are informative and illustrative of his observations about the meaning of addictive behavior. He makes a strong case for defining addiction in psychological rather than in physical terms. He points out, for example, that people become addicted to such activities as gambling, eating, exercising, and shopping, and that they often switch back and forth between behaviors involving physical substances and ones in which no such substances are involved. He cites experience with returning Vietnam veterans, ninety percent of whom stopped their use of hard-core narcotics after their military service had ended:

> *Addiction is a burning problem that resides in people, not in the drug or in the drug's capacity to produce physical effects.* For the returning soldiers, even when they had used drugs as physically addictive as heroin . . . once they were out of their abnormally stressful setting, addictive behavior could not be created in them. [p. 73, italics in original]

The author encourages his readers not to succumb to exploitation by drug rehabilitation programs that moralistically seek to depict them as weak, helpless individuals who lack willpower and therefore need to be taken over by the programs' directors and staff as their new slave-masters. He urges them instead to regain the self-respect they have lost; to acquire understanding of the depression, self-denigration, disempowerment, and impotent rage within them that have pushed them toward addictive behavior; and to become able to find new and better ways of obtaining power over their lives.

Dodes punctures various myths about addiction. Among these is the idea that addiction is genetic or is the result of faulty brain chemistry. He disputes the idea that people with addictions are necessarily self-destructive, have to "hit bottom" before they can recover, have an "addictive personality," and can be successfully treated only by someone who personally has been an addict. He maintains that it is a fiction that it is the external substance or activity that has the power to turn someone into an addict:

> An addiction may be directed at nearly any object or activity, so long as . . . [it] can serve as the displaced focus for the drive behind the addiction. The Internet or shopping are perfectly good candidates. So are eating, exercising, playing sports, or many other activities . . . virtually anything may become the focus of an addiction because it is the *person* who endows the object of activity with the property of being "addictive." In truth . . . what is being described is not "addictiveness" of the activity at all but its attractiveness. [pp. 116-117, italics in original]

The author does not neglect the role of physical addiction in making it difficult to free oneself from the psychological phenomenon of being addicted to certain substances:

> Anyone can become physically addicted to those drugs capable of producing physical addiction if those drugs are used in large enough quantities over a long enough time . . . [Although] physical addiction cannot "hook" a person into having a true addiction . . . the presence of cravings, or a fear of withdrawal symptoms—both due to physical addiction—while not "hooking" people in the popular sense of rendering them helpless, clearly does make it more difficult to stop using those drugs that are capable of being physically addictive. [p. 104]

There are chapters in the book that deal with couples, teenagers and their parents, sexual addiction and the relationships (and interrelationships, at times) between compulsions and addictions. These chapters are informative, heuristically stimulating, and quite practical, even if they are somewhat too short to satisfy the professional reader. The book is intended to be read primarily by those who are struggling with addictions, rather than by those who treat them, so this is understandable. Dynamic explanation is one of the book's strengths, while genetic formulations, as variable and complex as they tend to be, are rather skimpy, which is, again, appropriate in a book aimed largely at a lay readership. Neglect and abandonment by unavailable or totally self-absorbed parents and siblings, deep feelings of narcissistic injury at the hands of abusive family members, and alexithymia as a result of emotional impoverishment during the formative years all receive mention, albeit with the provision of relatively little detail.

My first professional job was in an alcoholism clinic, as a part-time group therapist, while I was a senior resident in psychiatry at the University of Rochester. I was struck by how few of the patients I was assigned to work with were there primarily because of alcoholism. Almost all of them impressed me as having more fundamental emotional difficulties, of which the drinking problem was

only one of multiple symptoms. This has been so with regard to the many people with addictions whom I have helped since then.

I also realized as I read this excellent book that a very large percentage of the patients I have been treating since I have been in practice either have had addiction problems as a part of their clinical picture, or have been significantly affected by the addiction problems of spouses or other family members, past and present. Addiction is pervasive and pernicious. This volume, which contains eminently sensible and practical observations and conclusions, is a very welcome addition to the literature on the topic.

It is appropriate to mention that I have successfully treated a number of addicted individuals who have made excellent use of the kind of dynamic psychotherapy that Dodes espouses, but for whom psychotherapy alone was not enough. They have experienced so much neglect and so much abuse at the hands of parents, siblings, and spouses that the concern, caring, respect, and willingness to be of assistance as fellow human beings that can be found within the right AA group has proven invaluable to them, in addition to what they were able to gain from individual therapy. For them, the combination of the two has been very effective. I expect that Dodes would agree.

The only question I have about this book involves the extent to which it might neglect or minimize the importance of the very serious and deadly primary addictions that contain elements of truly genuine self-destructiveness. There are drug addicts, alcoholics, and gamblers whose core depression is so strong and whose rage is so deep-seated and intense that they are determined to destroy themselves, and, Samson-like, pull down others with them. They are not likely to avail themselves of the kind of assistance that Dodes offers. I have tried in vain to help such people.

There are also the hard-core addicts whose inadequate personalities and deficiencies of psychological structure make it impossible for them even to understand what Dodes is getting at. Methadone programs can keep some of them from ending up dead or in prison, but others are beyond assistance. *The Heart of Addiction* is not addressed to these unfortunate people, however; its appeal

is to those who do have the capacity to reach inside themselves and make use of good treatment to restore their self-respect and dignity, as well as true control over their lives. It is they who will benefit from reading this book.

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WHAT ABOUT THE KIDS? RAISING YOUR CHILDREN BEFORE, DURING, AND AFTER DIVORCE. By Judith S. Wallerstein, Ph.D., and Sandra Blakeslee. New York: Hyperion, 2003. 380 pp.

Wallerstein and Blakeslee's latest volume, on an immensely important and troubling aspect of human relations, is impressive as well as eminently readable. It "cuts to the chase" in regard to the emotions and behaviors families face once the decision to divorce has been made. The two parents, facing the end of their marriage, with all the disappointments and anxieties that this engenders, must navigate the problems attendant to raising children in two separate households. This book seeks to help them do it, and it is organized in such a manner that parents can select the topics pertinent to their needs. It is written in a style that seeks to make it as easy as possible for divorcing parents to understand the central points the authors seek to make.

Repeatedly in the book, parents are encouraged to gain control of their emotions and to think through the issues. The introduction advises them that they will be facing three major, interlocking challenges: getting one's own life under control, preparing the children for the breakup, and supporting them through it while creating a new relationship with the ex-partner. At first, I was skeptical about the authors' apparent attempt to sound like Spock and Brazelton. Early in the book are such statements as "I can tell you exactly what to say to your children and how, depending on their ages, they are likely to respond . . . . The danger points are unexpected, but so are the opportunities. I will be your guide" (p. xiii). At first, they tended to impress me as authoritative and even

grandiose. As I read further into the book, however, I came to appreciate these initial comments. The volume is addressed, after all, to families that are distraught, are falling apart from anger and fear, and are faced with negotiating uncharted waters.

Throughout the book, one finds the theme of metamorphosis. Divorce is an end, but it is also a beginning. Advice is offered for letting go of rage and avoiding becoming "stuck in your pain," in order to focus on being a good parent, although the authors do not thoroughly elucidate how to do this. The strength of this volume is the hands-on help it offers, beginning with how to tell the children what is going on in the family that has led to the divorce. Clear guidelines are provided as to how to discuss with them the fears and worries they can be expected to experience.

Challenges that the children face are addressed in chapters dealing with different developmental age groups. Divorcing parents can pick and choose which chapter(s) best fit their situation. The authors provide practical guidance about age-related developmental issues that children encounter. They address such practical issues as the "best" time for the divorce, how to set routines and provide structure during a very turbulent and often chaotic time, and what to tell other family members and friends. These chapters are well thought out and are comprehensive enough to give parents a sense of direction in assisting their children.

A noticeably less comprehensive section deals with custody and co-parenting issues. In my opinion, the divorcing couple would be better off finding other resources to help them with this often contentious aspect of the process. What is likely to be very helpful to parents, however, is the idea that no matter what co-parenting plan is chosen, it will both benefit, and exact a price from, each parent and child. A high price is typical for couples in high-conflict divorce situations. The authors identify such situations as those involving "tormented parents who can't stop fighting in the courts over your children after you decide to divorce" (p. 203), and couples who are "convinced that your ex-partner is not fit to parent" (p. 207). The authors correctly conceptualize such situa-

tions as reflecting one or both of the partners' inability to complete the divorce and emotionally separate from the other. Volumes have been written on high-conflict divorces. Wallerstein and Blakeslee offer positive guidance, suggesting that parents in these circumstances secure long-term psychotherapy for themselves and their children.

The authors accompany readers through the changes they encounter over several years following the divorce. They encourage parents to observe how their children are doing, and to seek professional guidance for them if they see struggles with education, emotions, or behaviors. The parents are encouraged to reflect upon their new roles. The authors correctly point out that multiple transformations occur during the postdivorce years, and that parents and grandparents must work on their new roles in the children's lives. What works today may not work tomorrow, the authors note, as children pass through various developmental stages.

Parents also pass through developmental stages after the divorce. Dating, sex, remarriage, dealing with holidays, stepparenting, and blending families are some of the challenges addressed in this book. Rivalries, jealousies, and conflicts abound throughout these stages, and the authors indicate that "a wise, caring parent" (p. 237) is required to surmount them. Such an achievement is, of course, easier said than done.

The final chapter is a gem from which parents and children alike will benefit. It derives from the lengthy research Wallerstein has carried out. The authors emphasize the theme of continuing conversations with children to convey both parental hopes for a happier future for them, and confidence in their ability to create committed, successful love relationships. Wallerstein and Blakeslee emphasize honesty and candor. They encourage parents to be increasingly open with their children as the years go by and the children move toward adulthood.

I warmly recommend *What About the Kids? Raising Your Children Before, During, and After Divorce.* Only time will tell if this volume will rival the contributions of Spock and Brazelton, but,

in the meantime, I believe it will be a valuable resource for families going through divorces. Both parents and children will be richly rewarded for reading it.

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ABSTRACTS

ISRAEL PSYCHOANALYTIC JOURNAL

Abstracted by Peter Dunn, M.D.

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The year 2003 marked the first volume of Israel's first international psychoanalytic journal. Its articles are published in English, to encourage wide dissemination, and there are abstracts in six languages—including, optimistically, Arabic. The journal's Editor-in-Chief is Dr. Moshe Halevi Spero, a psychoanalytic scholar who has written widely about the intersection of psychoanalysis and Judaism. The Editorial Board has broad international representation, consisting of thirteen Israeli members and sixty-five from outside Israel. The journal's content is eclectic, utilizing contributors and editors from each of the main psychoanalytic schools, including authors such as McDougall, Stolorow, and Meissner. There is also a first English translation of Green's influential paper, "The Double Limit."

None of the issues of Volume I of the *Israel Psychoanalytic Journal* were formally designated as topical, but the subtextual theme of each is the plasticity of the human response to trauma—whether that trauma occurred during the Holocaust, the Intifada, a recent explosion in a café, or the earliest stages of the patient's separation-individuation. Indeed, the effects of Israeli history come through so starkly that there is no question that Israeli psychoanalysis is as distinct a variant as is, for instance, French psychoanalysis.

This abstracter's opinion is that the *Israel Psychoanalytic Journal* particularly merits international support on the basis of the

high quality of its papers and editing, as well as the contents of papers on trauma by Israeli contributors that are not duplicated in other psychoanalytic publications. The field would be poorer indeed in the absence of this journal, since the wider psychoanalytic world would lose a distinctive voice.

I, 1, 2003

Inaugural Communication: On Writing in the Land of the Book. Moshe Halevi Spero, pp. 7-31.

The Editor-in-Chief of the *Israel Psychoanalytic Journal* reflects on the logic of founding a new journal and concludes that its function is primarily psychological. The difficult act of psychoanalytic writing is viewed as an interaction between writer and editor. Just as Winnicott wrote that there is no such thing as a baby without a mother, Spero reasons that there is no such thing as a writer without an editor.

Viewed in this context, the journal is the Israeli analyst-writer's facilitating environment. While it is true that one can be published elsewhere (just as one can be raised by someone else's mother), there is something potentially enriching about being raised within one's own culture by someone who speaks (and embodies) one's mother tongue.

The author goes on to explicate elements of Bion's and Lacan's theories of thought and how they apply to his understanding of how an editor serves as a container for tensions within the author as thoughts are transmuted into scientific writing. He draws a comparison between the notion of Moses's two tablets (one written directly by God, without words, and one transcribed by Moses) and the Lacanian notion of a double inscription.

Love of Psychoanalysis: A Personal Note. Michael Shoshani, pp. 33-43.

The Executive Editor writes a personal essay, recounting how he came to develop a broad and inclusive view of psychoanalysis. While psychoanalysis began with Freud as a subspecialty of psychiatry rooted in the natural sciences, the work of Fromm, May, Win-

nicott, Bion, Ricoeur, Lacan, and Kohut has influenced the author to regard psychoanalysis as a broader discipline akin to art and the humanities. He draws an analogy to the body of thought that can be used either for the narrower purpose of art therapy or for the broader purpose of comprehending aesthetics. In such a dialectical view, psychoanalysis has the power to be used in various ways and to synthesize various disciplines.

Shoshani expresses his hope that the *Israel Psychoanalytic Journal* will incorporate contributions from diverse disciplines. Publication of articles by Israeli analysts in English is desirable, as it may discourage the unfortunate tendency of some Israelis to assume a stance of self-sufficiency and to turn away from discourse with the wider world.

The Double Limit. André Green, pp. 45-70.

The author takes up the theory of thought that was begun by Freud and elaborated along mathematical lines by Bion, both of whom were inspired primarily by the study of psychosis. In more recent years, this theory has garnered renewed interest in relation to the analysis of borderline patients.

Four elements are essential to the theory: (1) The *double limit* is established in development, first as the division between internal and external (self and object), and then as the boundary between conscious and unconscious; (2) *Representation*—that is, of intra- and intersubjective processes; (3) *Binding,* as it applies to the nature of instinctual energies and the contents that convey them; and (4) *Abstractions,* which assume a progressive modification of drive and affect, so that thought has the double task of moving beyond the drive from which it derives, while also retaining some contact with its source of affective vitality.

Notes on Some Transference Effects of the Holocaust: Unmentalized Experience and Coincidence of Vulnerability in the Therapeutic Couple. Judith I. Mitrani, pp. 71-88.

A young woman named Mirium, arrested by police for stalking, turns out in analysis to be enacting scenes from the Holocaust

past of her parents. As the analyst became able to envision the horrors of the parents' past as recounted by relatives, so did the patient. With the development of her capacity to think, there was an abatement of her need to act.

This positive transference-countertransference coupling is contrasted by the author to several treatment misalliances, in which both patient and analyst were children of Holocaust survivors, and the coincidence of vulnerability led the analyst to turn a deaf ear to the patient's transference complaints. For the patients, this repeated experiences with the parent who was too filled with his or her own unbearable and undigested suffering to bear hearing of the baby's suffering in relation to the parent's own failings. The result was a deadening of the treatment.

The Therapeutic Process and the Analyst's Self-Disclosure: The Good, the Bad, and the Ugly. Robert D. Stolorow, pp. 89-101.

The author approaches the topic of self-disclosure within the context of his intersubjective theory of transference. Transference represents a person's unconscious organizing activity, and has two dimensions: the *repetitive dimension,* which organizes the object's actions along genetic lines, and the *developmental dimension,* which organizes the object's actions according to longed-for, developmentally facilitative lines. Good interpretations (and other good interventions) strengthen the developmental dimension of the transference, and bad interpretations (and other bad interventions) strengthen the repetitive dimensions.

An example of a self-disclosure that heightens the patient's sense of being understood by the analyst and of understanding herself is contrasted to one in which the analyst's self-disclosure leads the patient to reexperience an early sense of empathic failure. The author thoughtfully reflects on the reasons he made the second intervention and why it failed.

Empathy as an Aspect of the Therapeutic Alliance. William W. Meissner, pp. 103-146.

The author addresses the essential nature of the analyst's empathy toward the patient in the establishment of a therapeutic alli-

ance, and the equal importance of the patient's empathy for the analyst. The analyst's empathy will fall flat if the patient is unable to see the analyst as well intentioned and helpful. The author differentiates empathy in the therapeutic alliance from empathy within the transference and the real relationship, and maintains that it is mutual empathy within the therapeutic alliance that is crucially necessary for interpretation to be mutative. The author disputes the current wide usage of the term *intrasubjective,* suggesting that *interpersonal* would most often suffice.

Trauma and Environmental Disaster. Joyce McDougall, pp. 147-162.

Four months of process notes are presented to demonstrate the efficacy of psychoanalytic treatment in the face of environmental trauma. The patient was a man in his late forties who became suicidal after nearly dying in an avalanche. The relief of his acute depression during the course of weekly sessions was accompanied by the surfacing of long-term obsessional and phobic symptoms. Direct, early interpretation of primitive oedipal and anal fantasy provided dramatic partial relief and the desire for continued treatment.

I, 2, 2003

Containing the Container: Some Experiential Aspects of Narcissism and the Problem of "Primary Undifferentiation." Charles Levin, pp. 167-202.

This paper argues against the view that development proceeds from an original state of objectlessness to symbiosis and progressive differentiation with possible states of arrest along the way. According to Levin, the primitive symbiotic and quasi-symbiotic transferences of narcissistic and borderline patients reflect early fantasies, rather than actual infantile states.

Transference fantasies of merger allow the patient to feel that his or her life and the analyst's life are intertwined. Fantasies of omnipotence are aimed at getting under the analyst's skin so that

the analyst responds in a way that proves the patient's existence in the analyst's internal world. The author concludes that the basic narcissistic motive is to actualize the fantasy that "I have inside me the one who has me safely inside him or her." Put differently, "I contain the container." The difference between functional and pathological narcissism is that, in the former, this fantasy is deeply rooted in the symbolic fabric of the psyche, while in the latter it is not grounded in this way and must be enacted in relationships.

Autistic Encapsulation for Preservation in Holocaust Survivors and the Problem of Symbolization. David Rosenfeld, pp. 203-224.

Autistic children avoid feelings of helplessness and terror by withdrawing into a shell, a process that Tolpin has termed *autistic encapsulation*. Rosengeld applies this concept to the maneuvers of Holocaust survivors who avoid mentalization of overwhelmingly traumatic experiences of danger and loss by putting their memories into psychic capsules in order to safeguard those positive identifications that are central to their sense of self. While such efforts forestall the resolution of mourning and full psychic integration, they may preserve vital identificatory links with family members' memories.

A case is presented in which the encapsulated early experiences of a middle-aged Holocaust survivor gradually return in analysis. The patient regains some familiarity with German (her mother tongue) and is able to mourn her parents and grandparents.

The Sense of Transience in Transferential and Transitional Phenomena. Sotiris Manolopoulos, pp. 225-245.

Pathologies in the sense of time, apart from déjà vu, have received little psychoanalytic attention. This paper address the sense of transience, exploring its appearance in early development and its various disturbances. Psychopathologies in the sense of transience include the inability to imagine an affectively alive past or future, the relative failure to appreciate the preciousness of ob-

jects in the present, and the failure to mourn. Transference interpretations, by their very nature, further the development of the sense of transience, since they confront the patient with the difference between the analyst in the here and now and the analyst as an imagined primary object from the past.

Geheimnistrager—The Secret Bearers: From Silence to Testimony, from the Real to Phantasm. Ruth Golan, pp. 247-273.

The author calls attention to stereotyping that has entered many accounts of Holocaust tragedies. She suggests that there is an innate limitation to linear narrative, and speculates that the suicide of Primo Levi bespeaks the affective unsatisfactoriness of such forms of testifying. Basing her argument on the work of Lacan regarding reality and fantasy, she reasons that there is a need to adopt more evocative eyewitnessing, or the testimony of the gaze. An example is given of such a form of eyewitnessing.

The author provides a one-paragraph account of a story, both uncanny and horrifying, that was told to her by a relative who spent a night guarding the Nazi concentration camp commander who had imprisoned him.

Psychoanalytic Education Revisited. Isidoro Berenstein, pp. 275-300.

The author critiques psychoanalytic education, arguing that it limits creativity in psychoanalytic candidates, just as primary school education stifles nonconformity in children by its design. Freud saw the main effects of education, apart from the transmission of technical information, to be the reinforcement of repression and the enforcement of the child's adoption of societal norms as an aspect of the superego.

By making personal analysis part of the tripartite model of analytic training, Max Eitington (the founder of psychoanalysis in Israel) ensured that the candidate was deprived of the ability of using the analysis to free him- or herself from neurotic inhibitions that dictated blind obedience to group values. The author argues

that this tripartite model of training has limited creativity and congealed outmoded ways of thinking. An analogy is drawn to the educational methods of the city-state of Sparta in ancient Greece.

I, 3, 2003

Reflections on the Foundations and Development of Thinking. Anna Potamianou, pp. 311-330.

This paper interprets the Greek myth of Theseus and Ariadne as symbolic of the process whereby the child attains the capacity for thought. According to the myth, Ariadne, daughter of the king of Crete, falls in love with Theseus and offers to help him find his way out of the labyrinth by giving him a coil of thread. Theseus escapes and slays the minotaur, the fearsome half-man, half-bull. In the author's reading, the dark and formless labyrinth represents the original state of the child's drives, the minotaur the original mindlessness of the infant, and Ariadne the early mother whose wise ministrations (the thread) artfully assist Theseus (the developing, beloved child) in emerging from the darkness of pre-thought/pre-speech via the erotic tie to the mother. Theseus, the human child, thus attains the capacity for thought and reasoned action.

A selection is presented from the analysis of Mrs. H, a 47-year-old patient who sought treatment for panic attacks, deep confusion, loneliness, and depression, in order to show the parallel between the mythic process portrayed by Theseus and Ariadne and the psychoanalytic process that occurred between Mrs. H and the author.

Implicit Memory and Unrepressed Unconscious: Their Role in Creativity and Transference. Mauro Mancia, pp. 331-349.

The author proposes that what Freud termed the *unrepressed unconscious* derives from the encounter that takes place between the fetus or neonate—with all its innate preconceptions—and the earliest relational realities of prenatal and early postnatal life. The unrepressed unconscious may account for the musical element of

the transference—the patient's tone, timbre, and volume of voice, as well as rhythm, prosody, and syntax. Psychoanalysis may allow the patient to recover early fantasies and to work through unremembered infantile traumas. Thus, the author speculates that poetic, musical, scientific, and visually artistic creativity can be understood as the capacity to re-create the unrepressed unconscious fantasies and defenses of early life, and to evoke reciprocal fantasies and affects in others.

Our Science and Our Scientific Lives. Waldemar Zusman, pp. 351-377.

The author describes a set of difficulties common to all psychoanalytic institutes, which he calls the "Eitington Syndrome." Administrative structures and curriculum are rigidified, and theoretical change is doggedly resisted. Candidates and members alike perceive a continual risk of committing heresy, so they avoid creative efforts.

The author evokes the name of Max Eitington because Eitington was the first to advocate the tripartite system of psychoanalytic education, and also because Eitington's relationship to Freud has been described as submissive and idealizing. The resolution of the Eitington Syndrome in psychoanalytic institutes is a precondition for the evolution of the science of psychoanalysis, according to Zusman.

Some Remarks about Analytic Abstinence and Neutrality. Siegfried Zepf and Sebastian Hartmann, pp. 379-402.

The authors review the utility of the concepts of neutrality and abstinence, and ultimately find them lynchpins for defining proper psychoanalytic technique. *Neutrality* is defined as the analyst's attitude of non-interference in regard to the patient's wishes, aims, values, and attitudes. *Abstinence* refers to the analyst's commitment to not act out the countertransference. The analyst practices abstinence in order to put his or her personal self to use as an instrument to gain knowledge about the patient.

All schools of psychoanalysis implicitly endorse abstinence and neutrality insofar as they offer guidance to analysts in training about which behaviors the school believes to be, in some sense, utopian. Negation of the rules of behavior signals to the analyst that his or her countertransference may be undergoing neurotic distortion. This observation suggests that there is common-ground agreement on the concepts of neutrality and abstinence, despite recent challenges offered by Renik and other intersubjectivists.

Autistic Enclaves and Somatization. Bianca Lechevalier-Haim, pp. 403-434.

This paper presents the analysis of a young man named Thomas who develops Crohn's disease in the course of his analysis, providing the analyst with a rare opportunity to observe the illness *in statu nascendi.* The author utilized the work of Frances Tustin, whose theories about autistic enclaves and somatization in very disturbed young children have been applied by others to the psychopathology of Holocaust survivors and their children. The author traces the development of Thomas's disease in part to the impact of his father's traumatic Holocaust past. In Thomas's treatment, thawing out autistic enclaves and somatizations involved the lifting of repression and the emergence of preconceptual elements that were never successfully symbolized, and that had resulted in a particularly aggressivized oedipal situation. The countertransference played a significant part in enabling these aspects to be understood by the analyst, and eventually to be represented mentally and affectively worked through by the patient.

Mysticism and Epicureanism in Psychoanalysis: Michael Eigen and Adam Phillips. Carlo Strenger, pp. 435-461.

This paper pursues Ellenberger's proposition that Freud's most important contribution was to revive the tradition of the Greco-Roman philosophical schools, whose centerpieces were "mental training." Students were inculcated in systems that promoted particular ways of life, based on the differing ideals of each school.

The author suggests that Freud's espoused views were much like those of the Stoic's in their emphasis of instinctual renunciation and dignity. In contrast, contemporary analysts embody more of the ideals of alternative ancient schools. For example, Michael Eigen idealizes the capacity for extreme emotions, such as agony and ecstasy—ideas in line with those of Neo-Platonists. Adam Phillips emphasizes so-called interesting hedonism—a notion central to Epicureanism.

I, 4, 2003

"Through the Unknown Remembered Gate": The Unconscious Reconsidered. James Grotstein, pp. 467-505.

This essay reconsiders Freud's concept of the *unrepressed unconscious.* The author sees the unrepressed unconscious as wisps of mentality waiting to come into being—hard-wired knowledge that exists in the infant prior to birth, forming the essential core of the unconscious upon which the repressed sits. The author links the concept of an unrepressed unconscious to other ideas central to Western thought, such as Plato's ideal forms, Kant's *a priori noumi,* and the Judeo-Christian image of the sublime. In the author's model of the mind, the unconscious is personified—a second self, entirely distinct from the Freudian id. The goal of psychoanalysis is for the patient to become acquainted with his or her unconscious, just as one becomes acquainted with another person.

Working-Through, Substitutive Formations, and Resistance. Siegfried Zepf and Sebastian Hartmann, pp. 507-535.

This paper argues that Freud's concept of *substitutive formations* (1915) is critically useful in understanding working through. Substitutive formations (also translated as *compromise formations*), as Freud first conceptualized them, are complexes of partially expressed, repressed impulses and the defenses that keep them at bay. Working through takes time and work because the analyst is working against the patient's resistance. The resistance is a mani-

festation of the defense motivated by the threat of the unpleasure evoked at the potential emergence of the repressed impulse. The patient first attempts to hold onto his or her substitutive formations, rather than finding better solutions for neurotic conflicts. In contemporary terms, working through refers to the process whereby the patient comes to relinquish a pathological compromise formation for a more adaptive one in the face of repeated interpretation.

Creative and Clinical Transformations of Trauma: Private Pain in the Public Domain. Danielle Knafo, pp. 537-563.

The creation of art when one is facing death involves the adaptive aesthetic response to human emergency. Three aesthetic responses in the face of extreme trauma are considered in this paper. One is Michal Heiman's; she was a young Israeli woman who used video art to record her own terrified face as she drove her car past sites of suicide bombers. Another response described is Charlotte Salmmon's; this woman experienced the suicides of her mother, aunt, and grandmother, and proceeded to draw 1,325 pictures of her family before she was taken to Auschwitz and killed at age twenty-three.

The author explores how creative expression provides meaning, connection, and continuity in times of social turmoil and rupture. The case of K, a photographer whose sadistic father was blinded by the Nazis, is presented as an instance in which the transference took the form of a sadomasochistic artistic performance, satisfying aesthetic functions and allaying the patient's reaction to trauma.

Image Formation of a "Frontal Spine" in Work with Autistic Children. Tami Pollak, pp. 565-603.

The author gives a vivid, detailed description of the successful psychoanalytic treatment of a severely autistic child who progressed over a number of years from a nonverbal and nonsocialized state to become verbal and well related, despite all prognos-

tic indicators. The author adopted a Bionian framework in which she regarded herself as the boy's container, providing for him the mental structures she intuited that he lacked. Based on countertransference constructions rather than on any concrete anatomical references, she imagined the boy to be missing a "frontal spine," and herself as replacing it section by section. The paper details her conception of the function of each missing part of the spine and her therapeutic efforts at repair.

A Preoedipal Representation of the Analytic Breast as Illuminated by a Patient's Use of Rabbinic Legend. Moshe Halevi Spero, pp. 605-641.

The analysis of Tikvah, a borderline woman with hysterical features, is presented to support the author's contention that we may conceptualize two levels of breast function. In contrast to patients for whom the breast's meaning tends towards the symbolic range of interpretation, and whose conflicts are at an oedipal level, patients such as Tikvah use concrete metonymic representations and struggle with pregenital needs. The analyst's careful attention to the patient's use of metonym as opposed to metaphor provides a valuable guide to detecting the patient's level of developmental arrest or regression.

For example, Tikvah developed the transference fantasy that the analyst was akin to the rabbi of the Talmudic legend, in which "the man's breasts opened forth like a woman's breasts and he thus suckled his child." While aware that she was offering a conceptual idea rich with emotional meaning, rather than presenting a concrete fact about the analyst's having breasts, the patient clung to the legend to emphasize her literal need for maternal care in analytic treatment. Thus, she was still rooted in metonymic representation, not yet on the road to a more fully symbolic metaphoric representation of the breast.