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OBITUARY

CHARLES BRENNER (1913-2008)

It is an honor and a privilege to write an obituary for Dr. Charles Brenner. Actually, I wish to write about three Charles Brenners: Charlie the scholar and polymath; Charlie the man, sometimes endearingly known as Bud or Buddy; and Dr. Charles Brenner, the psychoanalytic institution, theoretician, clinician, and teacher. I am not going to review his curriculum vitae, his voluminous contributions to the psychoanalytic literature, or his numerous positions at the New York Psychoanalytic Society and Institute, the American Psychoanalytic Association, the International Psychoanalytical Association, or his role at *The Psychoanalytic Quarterly,* nor will I list the numerous honorary lectures he delivered. These are well known and recorded elsewhere.

I will begin with Charlie the scholar and polymath. Reared by a schoolteacher mother and a lawyer father in an intellectually stimulating environment, he went to the venerable Boston Latin School, Harvard College before his fourteenth birthday, and Harvard Medical School before he was eighteen. He was determined to become a psychoanalyst, having read Freud in German as a young man. He realized that he should have a thorough grounding in medicine and neurology and became a house officer at the Peter Bent Brigham Hospital, studying neurology at the Boston City Hospital with Drs. Denny-Brown and Houston Merritt. At the same time, he trained in psychiatry at the Boston Psychopathic Hospital and in psychoanalysis as a Sigmund Freud Fellow at the Boston Psychoanalytic Institute. He accompanied Dr. Merritt to Columbia College of Physicians and Surgeons and to Montefiore Hospital in New York.

Dr. Brenner joined Drs. Jacob Arlow, David Beres, and Martin Wangh in a study group that was mutually stimulating and produc-

tive. Dr. Arlow described what it was like to have Charlie in the group:

> Here was a mind which was always in high gear, naturally, inherently avoiding trivia, gossip, or personalities, always independent, objective, inquiring and judicious . . . . We observed how he could strip away non-essentials, make clear the most complicated concepts and see through the flaws in our reasoning . . . . A turn in the conversation could evoke a succinct explanation of the theory of numbers or a detailed exposition of the intricacies of early Renaissance Florentine politics, perhaps the complete lyrics of a Gilbert and Sullivan operetta or the engineering problems involved in irrigating the San Fernando Valley. [Arlow 2002, p. 3]

Indeed, Charlie's knowledge of so many subjects was prodigious. It was even hard to tell him a joke. He would laugh and say that he had heard the same joke in Yiddish many years before. Often, when someone asked a question that no one in a group could answer, the common refrain was "ask Charlie." He chuckled as he once told me that one of his grandchildren asked him, "Grandpa, when I ask you a question, couldn't you answer in a sentence and not in a paragraph?"

Now let me turn to Charlie/Buddy the man. My life and the lives of many psychoanalysts of my generation took a major turn when Sandy Abend moved into Charlie's Manhattan office suite. For many of us, that move created an opportunity to have group lunches with Charlie, filled with stimulating discussions—psychoanalytic and otherwise. I found myself drawn into Charlie's orbit via the Kris Study Group on borderline patients. That lasted for four years, and for the next more than twenty years, Charlie and several colleagues met monthly, discussing a broad range of psychoanalytic topics. These meetings cemented wonderful friendships for all of us.

One cannot speak of Charlie/Buddy the man without speaking of his wife, Erma. That dynamic duo touched our group in a most profound way. They entertained first in Scarsdale and later in New York, simply and lovingly. Erma was always the more voluble, but

they were a true team. Evenings might include the two of them playing piano pieces for four hands.

My wife and I had a special view of Charlie and his wife when they visited us at our summer home on a tiny island in a lake on the Maine–New Brunswick border. Sharing life in such close quarters was a treat. They took to our place as if revisiting an earlier time, when Erma ran a girls' camp in Maine. They canoed together for long hours and read poetry to each other while standing on the dock in the early evening, the consummate loving couple. After dinner, we would watch the sunset and listen to chamber music on a portable CD player. We once roasted a turkey, and Charlie, ever thorough, carved it for us, surgically removing every piece of meat from the bone (to the consternation of some of our children).

Charlie, Erma, and my wife and I shared Guarneri and Beaux Arts tickets for many years. I recall Charlie's sweet generosity. When I heard Schubert's Opus 100 piano trio for the first time, I told him that I felt chills. Within a week, I received a cassette of that trio from him. I'm sure that many others have similarly experienced his generous nature.

His self-discipline was legendary. We all know the woes of taking minutes at a professional meeting of some sort. Usually, one receives minutes of the last meeting just before the next one, but when Charlie was responsible for them, you had the minutes within a week. I once complained to him about having to work on a monograph over the summer. He said, "Mike, it's all a question of priorities." To the end of his life, he exercised this discipline—keeping in shape, writing, teaching, and regularly attending concerts. He loved chamber music and kept up with many friends while frequenting the various concert halls of the city.

Finally, a tribute to Dr. Brenner, the psychoanalytic institution: author, teacher, and clinician. When he was invited to give a series of lectures to psychiatric residents at Yale University, these were so well received that they became the basis for his first book, *An Elementary Textbook of Psychoanalysis* (1955). For many young people both within and without the field, this text has been the basic introduction to our discipline. My own first exposure to Dr. Bren-

ner occurred when he taught a course on the drives while I was a first-year psychoanalytic candidate. I had heard that he was conservative, even doctrinaire, but as I came to know, this could not have been further from the truth, since his inquiring mind was always searching and reformulating psychoanalytic theory and technique.

In 1964, together with Dr. Arlow, Dr. Brenner published *Psychoanalytic Concepts and the Structural Theory.* It contained a heretical deviation from what we were then taught in psychoanalysis. The authors wrote that

> Probably most analysts today consider the structural theory and the topographic theory to be equally valid . . . . Nonetheless, it is our conviction that the topographic and structural theories are neither compatible nor interchangeable . . . . We shall . . . attempt to show that where the two theories do differ from each other, the structural theory is the more satisfactory of the two. [p. 2]

In 1974, Dr. Brenner reexamined the state of psychoanalytic affect theory. He observed that most analysts had two assumptions about affects. One was that affects are constant and identifiable, are the same from person to person, and are easily defined. The other was that they are discharge phenomena. He disagreed with both: "It is not possible to differentiate affects from one another . . . sharply . . . nor to assume that they are uniform from one person to another" (1974, p. 533). In *The Mind in Conflict* (1982), he added that:

> Any affect includes (a) all sensations of pleasure, of unpleasure, or of a mixture of the two plus (b) thoughts, memories, wishes, fears—in a word, ideas. *Ideas and sensation together constitute an affect* as a psychological phenomenon . . . . It is the ideational context that changes progressively and accounts for the differences between primitive affects and those that are more mature. [p. 41, italics in original]

Equally revisionary were the changes he recommended in the psychoanalytic theory of anxiety. In 1974 and 1975, he expanded his ideas in that regard to include depressive affect: anxiety is a re-

sponse to a calamity that is anticipated, while depressive affect is related to a calamity that has already occurred. For him, depressive affect in the psychoanalytic consulting room should be analyzed as such. Some have criticized this view of depressive illness, believing that it neglects biological and genetic bases, but in fact there is no way that Dr. Brenner, the neurologist and scientist, would give short shrift to the role of the brain in mental illness.

Working into his early nineties to leave us his accumulated wisdom, Dr. Brenner published *Psychoanalysis or Mind and Meaning* (2006). In this summary based on his many years of critical thinking, writing, and practicing psychoanalysis, he covers many facets of psychoanalytic therapy, such as the issue of authority, the sequence of interpretation, inexact interpretation, and the aims of analysis. Also included are interesting sections on morality, creativity, religion, atheism, and politics. And in summarizing his views on psychoanalysis as a natural science, he eloquently states that:

> What the scientific credo requires is not freedom from personal bias when it comes to theory formation. What it does require is that the theory fit the facts, that it is the best conclusion that can be drawn, the facts (= data of observation) being what they are. [2006, p. 7]

This credo led him to strongly disagree with psychoanalysts who espouse psychoanalytic pluralism. It also led him to the full repudiation of the structural theory he had once admired in favor of what Abend (2007) has called *modern conflict theory*. Since id, ego, and superego are all compromise formations, the structural theory is anachronistic. Dr. Brenner also took issue with the idea of dreams as the royal road to the unconscious and questioned the usefulness of the special meanings of the terms *transference, countertransference, transference neurosis,* and *defense mechanisms*. He viewed all these as compromise formations brought about by the wish to maximize pleasure and minimize unpleasure.

He also questioned the importance to psychoanalysis of the attention given to the mind of the child who is not yet three years old, noting that:

> There is no reason to doubt that, during that time [birth to age three], the mind functions in such a way as to achieve as much satisfaction of its wishes as it can and to avoid as much as possible in the way of unpleasure . . . . Nor is there reason to doubt that some events must inevitably occur during the first three years of every child's life that affect the functioning and development of the mind, either adversely or for the better. But at about the age of three, there is a major change . . . . The child's sexual and aggressive wishes for pleasurable satisfaction become progressively more extensive and explicit, and so do the fears and miseries that, in every child's mind, are associated with those wishes. Conflict and compromise formation make their appearance to an increasingly significant degree. They gradually become the rule in mental functioning and remain so throughout the rest of life. [2006, pp. 73-74]

Let me now summarize Dr. Brenner's extraordinary role at the New York Psychoanalytic Society and Institute. He graduated from psychoanalytic training at this institute in 1946 and became a training and supervising analyst in 1957. He was invited by Dr. Ernst Kris to co-teach the Kris Study Group, formed to help recent graduates continue their clinical education. After Dr. Kris died, Dr. Brenner continued to teach one of the four ongoing sections—an activity he kept up until only a few years before his death. He taught courses on theory and technique throughout the curriculum and was much admired as a teacher. He was always a much-sought-after supervisor as well; one of my colleagues described Dr. Brenner's supervision as having made the supervisee feel that he or she understood the material in just the way Dr. Brenner described it. He attended almost every scientific meeting and many study groups, and was always generous with his time in reading drafts of papers by more junior colleagues and giving his sage advice. It is no surprise that every year, the New York Psychoanalytic Society and Institute bestows the appropriately named Brenner Award. For many of us, Dr. Brenner's absence feels akin to the disappearance of the institute building, its library, the busts of Freud and Brill, or other treasures of our psychoanalytic memorabilia.

I will conclude with some of my favorite quotations from Dr. Brenner, the consummate clinician and teacher. He noted that all of us have the wish to make perfect, precisely timed interpretations,

> . . . but an analyst can . . . be secure in the knowledge that if he is pretty much on the right track with a patient, if his conjectures about the relation between past and present are reasonably correct, any interpretation he makes is likely to be helpful in furthering a patient's knowledge of himself, even if it is not the best and most precise interpretation that could be made. [1976, p. 51]

Dr. Brenner also gave us the following critical perspective:

> Important as it is to realize that analysis cannot do what is impossible, i.e., to eradicate or eliminate psychic conflict, it is equally important to realize the great value of what analysis can do . . . . It can make the difference between crippling inhibition and successful functioning, between misery and happiness or between life and death. [1976, p. 175]

Speaking of his own psychoanalytic perspective, he wrote:

> When I analyze, I always think about what it was like for my patient as a child . . . . The child he once was lives within him, with all the passions, the fears, the misery, the defenses that the words "psychic conflict" denote . . . . Analysis tries to . . . reveal as fully as possible the little child who once was and still is, despite all the changes that have taken place . . . . One often sees the child in action with special clarity in the transference . . . . [When a patient is] childishly demanding, childishly complaining, childishly unreasonable, childishly fantastic, or anything else, angry, stubborn, tearful—or whatnot—one should neither be surprised nor critical. How else can one expect a child to behave? That's the way children are. [1976, pp. 197-198]

In 1973, Dr. Brenner published an appreciation of Dr. Rudolph Loewenstein on the occasion of the latter's seventy-fifth birthday. It included the following comment: "When a man is fortunate

enough to become fascinated for a lifetime by a field of endeavor for which he has great talent to begin with, he cannot fail to excel" (p. 3). These words certainly apply to the special mentor that Dr. Brenner himself has been for psychoanalysts around the world for a great many years.

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A RENAISSANCE FOR FREUD'S *PAPERS ON TECHNIQUE*

BY LAWRENCE FRIEDMAN

The analyst depicted in Freud's Papers on Technique *(1911-1915) struggles to split the patient's stubborn desire by reframing it as memory. In contrast, after the structural theory was adopted, analysts could picture themselves as liberating rather than struggling with patients, since their design was to show that the patient's fears are unrealistic. But North American analysts have come to doubt their ability to rule on what is and isn't realistic. They thus find themselves again struggling with stubborn desires, not just easing fears. Their solution has been to emphasize—and thus detach from —enactments. These analysts would seem to be even more in need of the old ideals of procedure than were "classical" analysts, who thought they could use "reality" as a standard.*

It is one of the great peculiarities of psychoanalysis that Freud's *Papers on Technique* (1911-1915)—a work finished in 1914—is still the backbone of treatment. Here, between 1911 and 1914, the shape of psychoanalytic treatment was definitively mapped. Here the concepts were named that made the immaterial stuff of practice tangible and teachable for the profession's lifetime. There is no other

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way to talk about psychoanalytic treatment than with the vocabulary born in the *Papers on Technique*, and that is as true for those who would modify or reject it as for those who take it as canonical. *Papers on Technique* floats the buoys that mark out psychoanalysis from other human relationships. You can argue about whether to steer this way or that around those markers, but without them you have nothing but open sea.

RECOGNITION OF DESIRE IN THE FIRST MODEL

I want to emphasize that Freud crafted these crucial terms to cope with painful, practical problems that entangled him as he tried to sustain the strange new treatment. The terms mold a cognitive style for an unusual inquiry, but also an attitudinal posture for unusual stress. Bitter experience taught Freud that this style and posture are what keep the peculiar treatment going. Writing these papers, Freud is in the process of discovering something, not inventing something. Moreover, what he is discovering is not at all what he wanted or expected.

To begin with, Freud had to give up his main ambition, which was to read out the hidden meaning of dreams. That was his claim to immortal fame. That was what he considered his competence. That was what psychoanalysis was supposed to be in the early days. And Freud had to just junk it. His first lesson, then, was: "Don't be so interested in dreams!" From there, the admonition broadens to the starkly shocking: "Don't be so interested in anything!" Why did he write that? His account shows that it is not because he wanted to, and not because theory told him to, but because he had discovered the trouble he got into when patients were able to use his own interest against him, so to speak—that is, against the process of analysis.

Freud was discovering that the analyst's strange power was connected to his will-less-ness and role-less-ness. And he saw the ramifications: the patient should try to give up purposes, and the

analyst was supposed to do that, too. We have become so accustomed to it that we may not realize how odd is this mysterious requirement of nondirectiveness—the requirement that the analyst leave the patient to his own natural devices. Freud could not have reached that peculiar principle without a stepladder, though it was one that had to be kicked away after it was used. The stepladder was the old, simple memory-retrieval model of treatment. The irony is that Freud's overwhelming wish to hear memories is what had made it possible to discover the effect of suspending all searching.

What I mean is this: Freud's early ideas about how memories are processed allowed him to sit back and wait for memories, of their own accord, to make themselves evident. By supposing that the patient produces memories through a natural process and heals himself by disgorging them, Freud automatically crossed the threshold into a nondirective treatment. If memory and healing are like that, all the analyst need do is nontendentiously clear away obstacles (resistances) to natural self-healing.

The trouble is that remembering isn't so natural after all. In fact, analysis isn't natural, and patients don't really want to be analyzed (Freud 1912, p. 108). As Freud writes *Papers on Technique,* psychoanalytic treatment is shaping up as a giant paradox. Think about it: it is a nondirective treatment directed against the patient's will! You can see Freud glimpsing that paradox out of the corner of his eye from the first of the *Papers* onward, trying over and over again to push it into a closet, until it simply would not fit there any more. At that point, he faced a choice: one option was to picture the patient as being opposed to the aims of treatment, in which case the analyst would have to fight back, giving up the power of his neutrality, together with his free-floating attention and abstemious, nonmanipulative posture. Freud tried out that option at the end of the second paper, "Dynamics of Transference" (1912), where we see him battling with the patient to force her to get well (p. 108). Alternatively, he could go on as before, supposing that patients *really* want to cooperate, and what *seems* to be their un-

willingness is the almost impersonal protectiveness called "*the*" *resistance*—something that sounds like the inflammatory reaction a doctor has to shrink in order to free a patient's airway (see Freud 1912, p. 105).

Looking at the interaction in this second way, Freud was able to retain his neutral position, but now he was at a loss to say why, among all the many things that could obstruct memory, transference was so often the culprit. Nor could he say why the transference —so helpful in eliciting memories in his previous, suggestive practice—functioned instead as an obstruction in the new treatment (Freud 1912, p. 101). And after making several efforts to answer the question in just those terms, he realized he could not do it.

There was only one path left. If Freud wanted to maintain his nondirective role as facilitator of a natural process (remembering), while nevertheless acknowledging that patients naturally want something else altogether, he would have to *redefine* memory, remembering, transference, and resistance. He would have to redefine them in a way that would make what uncooperative patients visibly want coincide in some way with the very different, natural process he thought he was liberating. The labels had to be changed if the nondirective attitude was to be saved. The well-known result is that passionate action in the transference is now labeled "memory," and "resistance" now refers to the patient's refusal to admit that his wants are (in a sense) only what he used to want (Freud 1914, p. 155).

Now, viewing what one *wants* as really a memory of what one *wanted* is to place a momentary desire in a past framework. And that, in turn, amounts to separating oneself from one's momentary desires by objectifying them. This wrench is called *working through* (Freud 1914, p. 155). (That is the first meaning of working through, not quite understood by Strachey—who, therefore, in his translation, rejected Freud's own clarification in his second edition [Freud 1914, p. 155n].[1])

[1] Ellman (1991), in his excellent comparative exegesis of the *Papers on Technique*, is one of the few to recognize Freud's intention here.

In working through, the patient has to work against interest—against the interest of the moment—and forfeit the advantage of insistence aimed against the analyst's neutrality. The patient is required to tear himself away from effective, wholehearted effort, right in the middle of wishing, and observe the inappropriate, unintegrated longings as though they were mere memories. In that position, he will feel both the current wish or need and his analytic obligation to treat it as though it were currently invalid. The outcome is that he will know the wish more articulately, but will no longer press for its gratification.

The violence of that self-alienation was sufficient to satisfy Freud that he had at last found what it was in this new, undramatic treatment that had a power comparable to the old, cataclysmic catharsis—a treatment force capable of shaking a mind (Freud 1914, p. 156; see Friedman 1991). Instead of a liberation of memory, there was now a transformation of desire.

Like the patient, the analyst reacts to the scene as though it were a display of memories, even while he honors the reality and genuineness of the current feeling (Freud 1912, 1915). This strange fractured vision results from insisting that memories are slyly hiding, while at the same time acknowledging that they are straightforwardly seeking—seeking out the analyst in a most vigorous manner (called transference). The patient is and is not expected to be on the side of the analyst. A hundred years later, we recognize our enduring commitment to that paradox in our work.

With the retreat from the naturalness of the simple memory-retrieval paradigm, this first novice discovered, like all who would follow, that some forcible means was required to effect the treatment. We are all familiar with Freud's view that treatment is propelled by attachment to the analyst. Yes, a split in the ego was needed, but it was not something to be assumed (as many modern analysts do when they consider playfulness to be a prerequisite for treatment rather than its effect). Freud taught that patients are drawn forward by transferential longing. Desire would be used against desire.

DESIRE OBSCURED IN THE SECOND MODEL

At this point in my account, the reader may object that a hundred years have, after all, made a significant difference. True, you may say—the physical set-up prescribed in *Papers on Technique* has remained in place, but our sense of it shifted after the 1920s. Informed by the structural and signal anxiety theories, we now find it easier to sympathize with resistance. We can visualize the patient's fears more specifically and see the reasonableness of his defense more concretely. We no longer believe that a single, protean enemy ("the" resistance) is always waiting in the wings to scuttle our enterprise. We can empathize with the immediate, particular causes of treatment difficulty.

In point of fact, those changes represent less a theoretical shift than a clarification of what was already implicit. But taken together, the structural theory did bring about a genuine reorientation toward patients. After the 1920s, analysts would think of themselves as dealing primarily with fear (anxiety). In contrast to the analyst of the *Papers on Technique,* the later analyst is a liberator—not just in his aim, but in the actual conduct of treatment. The analyst is not curing the patient by administering bitter medicine. The ongoing procedure itself consists in constantly freeing the patient from the unnecessary grip of unrealistic fears. The analyst brings the good news that danger situations are not really dangerous.

In contrast to the analyst depicted in Freud's early paper "The Dynamics of Transference" (1912), the analyst who has read *Inhibitions, Symptoms, and Anxiety* (1926) is really working with his patient, not against him, and he doesn't have to fudge his definition of memory in order to persuade himself that he is being unqualifiedly kindly. He has discovered a genuinely organic, natural process that he can fit right in with, and needs no contrived, paradoxical physiology as an imaginary ally in his work. He can tell himself that he is actually the patient's buddy. Nobody wants to live in fear, and so, in principle, everybody will welcome analytic help.

To be sure, some attachment to the analyst may be necessary to persuade patients to look at their fearful fantasies in the first place, but once the dangers are seen in their infantile context and shown to be harmless to adults, they cease to be fearsome. The protection of the transference will then not be needed; the patient's discovery of his own adult strength will be incentive enough to draw him forward, and he can, without regret, relinquish the transference bridge that brought him to freedom. A therapeutic alliance is now a reasonable expectation en route.

What is played down in this picture is desire. That is the first part of my argument.

After the 1920s, the emphasis on anxiety allowed practicing analysts to believe that infantile wishes are infantile only because repression has not allowed them to mingle with the rest of the personality. The popular formula is that overcoming the fear leads to conscious awareness, which in turn leads to an automatic modification of infantile wishes.

From this point on, analysis develops in directions that vary theoretically, practically, and geographically. I shall deal mainly with North American ego psychology. But I do want to observe that British Kleinians and French analysts such as Laplanche (1989), each in his own way, retain the older emphasis on desire. Neither of those traditions encourages the idea that patients suffer simply because they fail to understand their currently safer position in the adult world. In both Kleinian and French traditions, some essential aspect of the patient's striving is itself considered troublesome, and will remain troublesome until it is given up. When French analysts criticize North Americans for being too practical, and when Kleinians fault North Americans for being distracted by external reality, it may be their way of saying that Americans do not appreciate the stubbornness of desire (though they put it in terms of "forgetting the unconscious" or of promoting social adaptation).

My second thesis, then, is that later analytic theory made treatment seem more harmonious, at least in principle, at the cost of muffling the insistence of the patient's wishes in the analysis.

RENEWED RESPECT FOR THE PATIENT'S DESIRE (ENACTMENT THEORY)

But times are changing in North America. American analysts are rediscovering the phenomenon Freud described in his first model of treatment, namely, the patient's passionate and not-entirely-defensive cross-purposes with the analyst's efforts—in other words, the struggle in treatment. Analysts today are just a little less inclined to view patients as fearfully hiding, more inclined to see them as greedily grabbing. What is responsible for that shift?

One influence is the large body of holistic elaboration of Freudian theory that goes by the name of ego psychology. Contrary to popular opinion, that holism has made it harder for American analysts to discount the patient's approach as purely defensive. Instead of supposing that the patient's demands on the analyst are merely protective maneuvers just waiting for a safe chance to turn into objective introspection, ego psychologists actually join the English and French in thinking that every act and gesture has its wishful significance. This tough-minded view of the patient's thrust brings them straight back to the *Papers on Technique*.

The sense of a genuinely oppositional patient also comes from the new appreciation of countertransference. Hyperalertness to countertransference has led directly—some would say, inevitably—to America's current preoccupation with *enactment,* which is further aggravated by an epistemological crisis that has gripped the nation. The obsessive, self-critical skepticism so characteristic of contemporary American psychoanalysis saps the analyst's confidence in his readings, and demands more acceptance of the patient's own experience of the relationship. The new American analyst is shy of judging what is real and what is not—shy even of supposing that there is an objective reality. If the patient takes the analyst to be mixing with him in a social rather than a psychoanalytic way, well, it is not easy for the American analyst to say he isn't. If the analyst doesn't admit to an enactment, he can be sure that his colleagues will pounce on him for his defensiveness.

When today's analyst calls something an *enactment* rather than a *transference*, he is implicitly acknowledging that the patient has not merely sought or imagined a satisfaction, but has in fact been granted actual satisfaction by the analyst's response. In this way, today's analyst accords "reality" to the patient's current experience of the relationship, just as Freud granted that transference love is as real as any other, and just as he observed that patients want from the analyst what they want from anyone else. And when today's analyst deconstructs the enactment, he is sharing the same experience Freud reported in *Papers on Technique:* he finds himself asking his patient to give up something valued, not just something feared. Like Freud back in 1914, he vividly experiences the full force of the patient's wanting and the patient's demanding, and he acknowledges the patient's primary interest in obtaining satisfaction from the person of the analyst.

Indeed, today's analyst registers that pressure for satisfaction even more vividly than Freud did (if that is possible) because he believes patients actually succeed in obtaining it from the analyst. For that reason, you will hear American analysts speak of enactment almost as frequently as they speak of transference. (Some, in fact, seem to think it a logical error to regard these two as separate.)

But analysts are hired to make something new out of the old. And it has to be done without overt manipulation. Even before conceiving of signal anxiety, Freud expected that his struggle with unrenounced wishes would be less arduous when patients are finally brought to see the contrast between the archaic context and the current reality. But many of today's postmodern analysts cannot hope for that. When they rediscover that they are struggling not just with blindness but also with passion, they cannot hope for reality to come riding to their rescue. Sophisticated transference theory makes *everything* in life seem to be a memory in the form of action, and analysts cannot argue that transference wishes and entanglements are cut from a different cloth. (For example, see Brenner 2006.)

An analyst who no longer believes he is solely in the business of disproving infantile dangers must find an alternative, nonmanipulative way of changing infantile desires. Faced with the same adversarial pressure Freud reported in *Papers on Technique,* today's North American analysts grope for their own way of translating the patient's heedless wishes into something therapeutic, and mapping the analyst's therapeutic demand onto the patient's inclination. In other words, they need to find something that will serve them the way working through served Freud.

I suggest that North Americans hope to achieve this negotiation of cross-purposes by the disruption of enactments—that is, by repeatedly dislodging covert relationships. This episodic sidestepping of inadvertent roles is designed to avoid what Fairbairn called being *press-ganged* into the patient's relational world. The rationale is the same as it has always been in psychoanalysis, namely, to objectify what has happened in the relationship. But today many analysts hope to accomplish that by simply wriggling out of the relationship, by unmasking it and failing to play, rather than by treating the relationship as a misplaced memory. Of course, these analysts will go on from there to delineate the organized fantasies that inform the enactment, and most of them will trace the patient's participation in the enactment back through mnemic representatives and personal history. But they will be doing that for the purpose of understanding the passions, not in order to unmask their inappropriateness to "reality." For postmodern analysts who no longer have confidence in a contrasting reality, the thrust of current enactment theory is to deprive them of all complacency, subjecting them over and over again to the sudden awareness of the satisfactions they are inadvertently providing the patient (see Smith 2006).

This sudden awakening shocks both parties and fuels the treatment. In order to achieve this sort of disruption—this pulling oneself free from a role enactment—it is not necessary to claim authority over truth and reality, or even to re-label action as a memory. To critics, it may seem that today's introspective analysts (e.g., Jacobs 1991; Levenson 2005) turn Freud's instruction on its head, as though it is less important for the analyst to see the patient's ac-

tion as a memory than to view his own participation as a memory. What such critics often fail to appreciate is that the analyst who looks on an enactment as his own memory not only recognizes details that might have escaped notice; he is probably also disrupting the patient's thrust more effectively than he would by observing it from the "outside," and managing to do that without depending on rhetorical appeals to reality and appropriateness.

So my third conclusion is that postmodern North American analysts have again allowed themselves to boldly confront cross-purposes of the patient's desire, just as Freud did in *Papers on Technique.*

RENEWED RECOGNITION OF CROSS-PURPOSES ENTAILS NEW RECOGNITION OF CLASSICAL IDEALS

It is not at all my purpose to argue for the postmodern skepticism about reality. I have explored that issue critically elsewhere (see Friedman 1999, 2000a, 2000b, 2002). Here I am engaged in description and inference, not advocacy. I refer to a revival on the current scene of the earliest and therefore rawest experience of psychoanalytic treatment as it was recorded in Freud's *Papers on Technique.* I describe a psychoanalytic trend in North America that has revived Freud's original sense of the work, but with a changed epistemology—or rather, has revived it *because* of a changed epistemology. That restoration of awareness of the patient's desire—and not just his fear—would seem to call for a restoration of Freud's earliest principles of technique.

I think that implication has been overlooked because of a paradox in postmodern thinking. In view of American doubts about reality and the analyst's ability to define it, it is not surprising that the old ideals of anonymity, abstinence, and neutrality would come in for heavy criticism. If the analyst cannot know what he is really doing or what the patient is really doing, let alone how to compare it with a memory and with current reality, how can he pretend to be a blank screen?

And yet once it is acknowledged that patients want something different than analysts provide, as early reported in *Papers on Technique* and newly recognized in current enactment theory, the original ideals of detachment that were framed to deal with that cross-purpose would seem to be even more crucial than they were during the long interval after the '20s when analyst and patient were thought to share a common interest in a reassuring reality. Of course, ideals such as neutrality persisted during those intervening years, but they were not especially linked to the structural model or the theory of signal anxiety. If one doubts that, one need only trace the reasoning of Alexander (1925), who, having learned that the superego's distorted view of reality is responsible for neurosis, could first seek to abolish the superego, and then go on to fit himself out with specific, tailor-made roles and relationships to calm his patient's fears and correct his vision of reality (see Alexander 1956). You may fault him for this approach on clinical grounds, but you cannot say that it is, strictly speaking, illogical on the basis of his model. But if (as today) there is no reassurance about reality to be had, and all one has to go on is the disruption of fixed roles (by calling attention to enactments), then clearly, no clarifying role will fill the bill, and only neutrality, anonymity, and abstinence will serve as beacons.

This has been hard for many analysts to accept—partly, I think, because they have forgotten, or never understood, the original function of these ideal terms in *Papers on Technique.* If you take anonymity, neutrality, and abstinence as free-standing terms, they will absorb their meaning promiscuously from whatever context you currently have in mind. You may suppose that the ideals derive from an antiquated "drive theory," a mental mechanics, a hydraulic apparatus, or whatnot. If, however, you look again at the actual *birth* of these ideals in the *Papers on Technique,* you see that they are not derived from theory. They are warning flags planted on thin ice; they record Freud's bitter experience. He was telling us that if we disregard anonymity, abstinence, and neutrality, patients will use us as they wish. (See Friedman 1991.) Absence of these ideals puts

the analyst at the mercy of the patient and subverts his ability to introduce newness.

That is the message of the *Papers on Technique*. And where do these ideals show up in today's treatment? Aren't they the silent self-images that an analyst implicitly reaches for as he tears himself loose from an enactment? Always visible in Freud's striving, though mostly absent from his lips, the ideal principles of 1914 have become even more indispensable to the contemporary analyst. The original ideals are the analyst's sole remaining leverage in a treatment that once again struggles to take patients' wishes seriously, but this time without a contrasting reality to offset them.

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PRIVACY, REVERIE, AND THE ANALYST'S ETHICAL IMAGINATION

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The author illustrates varying ways of using and thinking about forms of analytic reverie and the analyst's privacy. He discusses a few different registers from which the analyst can illuminate points of transference-countertransference enactment. The modality by which the analyst communicates these formulations of unconsciously held object relations and defenses varies and includes verbal interpretation through symbolic speech, interpretive action (Ogden 1994a), and, at times, interpretations that involve a construction of the analyst's subjectivity put forward to enhance the patient's understanding of enactments of the transference-countertransference. The author develops a concept, the analyst's ethical imagination, *defined as the ways in which we consider and anticipate the implications of our interpretations.*

Clinical papers illustrating aspects of expressive use of countertransference have often addressed points of impasse and stalemate in psychoanalytic work. For example, within relational theory, clinical vignettes have tended to focus less on quotidian aspects of analysis, including the analyst's and patient's privacy and solitude during the analytic process. In contrast, contemporary analysts from outside the relational tradition (e.g., Boesky 1990; Busch 1993; Gray

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1973, 1990; Kris 1990; Smith 2000, 2003) have often described moments of more "quiet" work, such as defense analysis and use of countertransference within these models. It is the dimension of privacy and reverie in the everyday work of psychoanalysis that I will explore in this paper.

My thinking about the analyst's privacy and reverie in clinical analysis is substantially influenced by Ogden's many contributions (e.g., 1994a, 1994b, 1997, 2004). Ogden has become one of the frontier cartographers of the analyst's privacy and reverie, particularly in understanding the specific unconscious, intersubjective relationship with each patient (Ogden 1997, p. 588). Like Ogden, I formulate reverie as a road to the unconscious, intersubjective objects in the mind of the patient and analyst. In my view, the interpersonal is interfused with the "unconscious, intersubjective," internalized object relations described by Ogden. I will try to demonstrate how I expressively make use of reverie, particularly the register from which I sometimes speak to a patient about the bearing of my own experience on intersubjective objects in the mind of the patient.

THEORETICAL BACKGROUND

Freud's suggestion that the analyst "should simply listen and not bother about whether he is keeping anything in mind" (1912, p. 112) is a common marker for most analysts who are interested in the reverie process. For Ogden (1996, 1997), like Freud, the analyst's privacy and reverie afford him a psychic space and actual time in which to make associational linkages and largely unconscious contextualization for listening to the patient. Ogden's (1996) helpful translation of Freud underscores the importance of the analyst's creation of conditions in which the analyst can maximize his or her capacity for a receptivity and play of the mind.

It is interesting and a bit paradoxical that, in many ways, most psychoanalytic models have more procedural transparency regarding maintenance of the analyst's privacy than does the relational model. For most models, the injunction to be anonymous is quite clear and unambiguous to the patient, regardless of how much the

patient might protest that anonymity, or seek to change, affect, or even destroy it. For Freud, the analyst's privacy ensures an ideal canvas for the patient's freedom of association and secures maximal opportunity for the analyst's associational drift.

In contrast, in the relational model, there are instances when the analyst might make use of and even reveal aspects of his or her experience. Moreover, while many models of analytic work agree with Hoffman's (1983) observation that the patient is often reading the analyst in many ways, the relational model emphasizes the analyst's technical proclivity to follow up on the patient's perceptions as a mode of bringing the transference into more conscious experience (e.g., Aron 1991; Gill 1983).

Ogden (1996) draws connections between Bion's (1962) characterization of reverie as the *absence of memory and desire* and Freud's notion of *simply listening*. In both states, the analyst does not try too hard to remember or even understand very much, instead using his or her own capacities or states to catch the drift of the patient's mostly unconscious experience. In part, Bion's (1962) magnificent poetic of the analytic space—"we're both in this alone"—was his way of describing his own requirements for having access to the patient in ways other than those permitted in conventional forms of interpersonal exchange.

Ogden's efforts are to bring into focus the dialectical interplay of states of reverie of both analysand and analyst, resulting in the creation of a third analytic subject. The asymmetrical experiences of the analytic third by patient and analyst promote understanding, verbal expression, and symbolization of the "drift" of the analysand's unconscious internal object world. *Reverie* is the state of mind that allows for experiencing and expanding the analytic third.

Like Ogden, I find that many experiences of my reverie are not immediately translatable in a one-to-one fashion about what is going on in the analytic relationship. In my experience, many of the images and associations that come up in response to the patient are just as likely to be defensive as clarifying, and a judicious process of filtering and considering these experiences over time seems well justified. Reverie, like much countertransference data, can be entic-

ing as an invitation to more quickly elaborate confusing and contradictory information or problematic affective states in the analyst and analysand. Ogden is correct to emphasize that these experiences need to accrue in order for us to discover whether and how they are meaningful, and to note that we need to let ourselves be adrift without forcing our forms of reverie into interpretations.

I also like Ogden's commitment not to automatically dismiss our reverie as somehow idiosyncratically personal. While we may have experiences during reverie that suggest a failure to be receptive or understanding of the patient, we usually cannot know that without obtaining more data. At first glance, I find many instances when my thoughts go in directions that seem pressed by my own needs and are not immediately useful to understanding the patient, or are active obstructions to understanding the patient (see, e.g., Schwaber 1992). Sometimes, however, closer examination might suggest useful connections to points of unconsciously held transference-countertransference phenomena. Thus, I do not subscribe to the notion that countertransference is always best understood as an obstruction to listening to the patient's experience. Time and repeated experience afforded by the intensity and continuity of analytic work are of great help in the process of deciphering what might be an impediment or an aid in elaborating points of unconsciously held transference-countertransference experiences.

Obviously, the experiences of privacy afforded to patient and analyst are a part of what allows for the analyst's experience of reverie. Bion (1959) noted that the analyst's abstinence produces what he described as the sense of isolation within an intimate relationship. Reverie within the analyst is intimately, intersubjectively related to the privacy and solitude afforded for the analyst.

It is in order to preserve the place of privacy for both patient and analyst that Ogden (1996) criticizes the fundamental rule of association—that the patient be urged to say whatever comes to mind. Ogden questions this rule because it minimizes the dialectical interplay of the capacities of both analyst and patient for reverie. He fears that it poses the danger of becoming a kind of "frozen injunction" for any analytic dyad. Ogden is concerned that a long-standing

appreciation of the place of solitude and privacy—particularly as espoused by the independent tradition of psychoanalysis (e.g., Winnicott 1958)—can be overlooked or even violated in the invitation to say whatever comes to mind. Ogden adds to this invitation his statement or reminder to the patient who begins analysis that each of the two participants needs to maintain a place for privacy.

I have always had a rather complex reaction to this recommendation to the patient. I have concerns that telling a patient that "we must both have a place for privacy" may run the risk of unnecessarily conveying something about my own wishes for distance or of emphasizing my attunement to the patient's need for distance. In my experience, patients are quite adept at maintaining privacy and editing their thoughts, despite my invitations to tell me what is on their mind.

Moreover, I am concerned that I might be construed as issuing a kind of non-impingement promise—that is, that I am saying I will try not to invade the patient's privacy. While I think that respect for the patient's privacy is paramount to analytic work and even a precondition for analytic exploration, I cannot promise not to impinge on or invade the patient's privacy. I have referred to forms of *good enough impingement* (Cooper 1998a, 1998b, 2000) as an inevitable part of analytic work involving various forms of misattunement, countertransference enactment, or what Balint (1968) termed the *poverty of interpretation*. I have little doubt that, in advocating the analyst's reminding the patient of his or her own and the patient's need for privacy, Ogden is not promising that he will not impinge. I do wonder, however, whether for some patients this reminder might unconsciously or consciously resonate with either a fear of invading the analyst's privacy, or a fear of the analyst's process of getting to know the patient.

My use of reverie is usually associated with an interspersing of images, fantasies, and recollections, which alternate with a very conscious form of thought and formulation. My mind is rarely adrift for an extended period of time. Instead, I somewhat reflexively move from forms of reverie into much more formulated, private interpretations, often imagined into dialogue with a patient about my formulations.

To put it another way, it is my sense that, in comparison to Ogden's descriptions, my reverie is a more fleeting, more imperfect, and a more porous vessel. My reverie often leads immediately to private, imagined interpretations of what has been and perhaps is being enacted. These imagined interpretations are, I suppose, a kind of associational linkage, but they are often tried on and then discarded. Sometimes this post-reverie thinking leads me quite productively to anticipate how these formulations might also involve particular kinds of enactments, such as truncating various kinds of elaboration of meaning or repeating various patterns of objects in the patient's life. But often my reverie and post-reverie thinking are what allow me to productively explore how I am enacting patterns of the transference-countertransference, as well as the potential meanings and enactment that might accompany an interpretive transition with a patient.

These forms of post-reverie thinking all make up what I call the analyst's *ethical imagination*. The term *ethical imagination* refers to the analyst's modes of thinking about various forms of enactment of the unconscious transference-countertransference or psychic entanglement between patient and analyst. The analyst's thinking that sometimes follows associational drift is often a precondition for clarifying the unconscious intrapsychic-interpersonal implications of an interpretive shift or transition in the analyst's understanding of the patient. While this thinking is only a part of the analyst's imagination, I think it is worth trying to distinguish it in relation to particular ways that the analyst anticipates the patient's experience of the analyst's formulations and interpretive directions.

The analyst's ethical imagination covers territory that lies partially outside the kind of maternal reverie described by Bion. However, within this imaginative form of contemplating or formulating reverie, the analyst is adrift in a different kind of way, allowing him-/herself to imagine the usefulness of a form of understanding or the potential impact of such an intervention. The impact might include particular fantasies of helping a patient understand something new. The impact might also include fantasies of hurting or impinging upon a patient—a kind of collateral damage of sorts.

Since it is an unconscious aspect of transference-countertransference enactment that I am pondering, it is never entirely possible to know in advance either its usefulness or its accuracy about what we are intending to illuminate. It is because of this uncertainty that I find it useful to think of our imagination, our ability to formulate something, as related to an ethic of responsibility or accountability. What characterizes our ethical imagination is the attempt to think about what we are doing and what we are about to do in our participation with the patient.

Since my imagination is often directed toward the ubiquitousness of enactment as a feature of analytic process, it is, of course, a construction of what I *imagine* I am enacting; it is never entirely possible to know this in advance. This privacy, reverie, and the subsequent formulations I refer to as the analyst's ethical imagination might seem like a kind of injunction that the analyst *should* try to think about what he or she is doing and is about to do in participation with the patient. I do not view this as a form of technical advice or a conscious attempt to leave no clinical stone unturned, however; instead, I believe that, to a large extent, this is what most analysts do as they utilize forms of reverie and associational linkage, absorption of affect, transference attributions, and the like. We think about the various kinds of collateral damage that have and will result from the choices we make, either through acts of extending or constricting interpretive range, through shifts in interpretive focus, or sometimes in the holding back of an interpretation.

Ogden's (1994a) fascinating discussion of his use of *interpretive action* within the analytic third is an example of moments I refer to as the analyst's ethical imagination. Ogden describes a series of patients with whom he conveys his understanding of the transference-countertransference through what he calls *interpretive action.* The latter might include self-conscious forms of silence at times when he would usually make an interpretation, or a refusal to engage in invited activities elicited by the patient that he had previously enacted. These are self-conscious efforts to stand outside particular forms of repetitive transference-countertransference enact-

ments and are accompanied by the analyst's silently formulated interpretations. These examples are very close to what I have in mind in describing the analyst's ethical imagination, though I am not referring to "actions" in Ogden's use of the term. Instead, my formulations and interpretations are primarily verbally based understandings about new formulations or interpretations.

One of the most important ways that I differ from Ogden in his use of reverie in making interpretations is that I sometimes say something about a construction of my own experience, or about how I am implicated within points of transference-countertransference enactment. Ogden's use of reverie does not include instances when the analyst uses conscious or deliberate attempts to reveal a construction of the analyst's experience to illuminate the unconscious transference-countertransference.

My intention at these moments of more direct statements of countertransference experience is not to provide gratuitous, exhibitionistic, or diversionary statements of personal feeling. Instead, on those occasions, my intention is to express something from the register of my countertransference experience as it relates to particular points of unconscious transference-countertransference. In fact, I do not consider moments of speaking from this register to be best described as "self-disclosure" at all, instead preferring to term them *analyst disclosure* (Cooper 1998a, 1998b). This register relates very little to the analyst's person or self, and, instead, when used judiciously, it is the result of highly formulated experience (Stern 1983).

I have suggested the distinctions between *analyst disclosure* and *self-disclosure* because the subjectivity of the analyst is central to all kinds of interpretive processes in analytic work. I view the register from which the analyst speaks of countertransference experience as embedded within particular aspects of the transference-countertransference, and as no more expressive of the analyst's "self" than any other kind of analytic intervention or interpretation. Like all interpretations, it is partially motivated by unconscious experience. To be sure, there are varieties of countertransference disclosure that emanate more from *unformulated experience* (e.g., Stern 1983), but

these are not the variety of interpretations I am focusing on in this examination of the analyst's use of reverie.

I view analyst disclosure as quite similar to Ogden's formulation of the paradox at the heart of our personal and private reveries in clinical work. Ogden (1997) highlights his belief that, as personal as our reveries feel to us, they are *not* best understood as personal creations because reverie is at the same time an "aspect of a jointly (but asymmetrically) created unconscious intersubjective construction" (p. 569). Ogden (1994b, 1996) refers to these constructions as the *intersubjective third*. Similarly, Symington (1983) refers to these phenomena as *corporate entities*—points of shared transference-countertransference that are jointly but asymmetrically held by patient and analyst. These phenomena both illuminate points of unconsciously held transference and can serve as obstructions to better understanding points of transference-countertransference impasse.

Through a series of brief clinical vignettes, I will try to focus on the analyst's use of reverie in the area I refer to as his or her *ethical imagination*. I will present vignettes that vary in whether and how the analyst makes use of his or her own countertransference and expresses that countertransference.

CLINICAL ILLUSTRATION I: THE ANALYST'S PRIVACY IN THE PATIENT'S MIND

The following material is from the third month of a four-times-a-week analysis. Sam lies down on the couch and begins the hour: "Your haircut makes you look younger this week. I think it's your haircut. You look younger than your stated age." Sam starts laughing, and behind the couch, I, too, am smiling. He has immediately come to the awareness that I have never stated my age to him. We start looking into what the notion of my "stated age" means to him.

Sam, a man in his mid-twenties, often comes into analytic sessions looking at me intently as he makes a probing survey of my mood and dress. He is prone to comment on my appearance, par-

ticularly on whether or not I am wearing a tie or a suit jacket. Sometimes I am dressed more formally and sometimes more informally.

Sam believes that he is gay, though he is confused about the fact that he is emotionally drawn to women for his closest relationships. He feels that he is not and has never been sexually turned on by women. His best friend is a woman and they feel that they love each other. She wants to be with him—to live with him and potentially get married and have children, despite her knowledge that when they have tried to have sex, he has found it unstimulating. Sam has been honest with her about his sexual liaisons with men, though he has never had a male boyfriend, instead preferring the companionship of this woman friend and, earlier, of other women. When Sam masturbates, he thinks exclusively of men. Sam and his woman friend agree that their infrequent lovemaking is not occasioned by his sense of passion and excitement. He has never fallen in love with a man nor longed to have a man as a life companion as he has with this woman, despite his lack of sexual excitement with her.

As we start to look into Sam's beginning statement, "You look younger than your stated age," what emerges in the session is how much he idealizes many of the people around him, including me. He says that he always wants to think the best of his friends and professors at graduate school. As he speaks, I am aware of having some new, hostile feelings toward Sam as he explores "my stated age." I realize that his attempts to idealize others and me never feel quite positive to me; instead, they have a competitive and somewhat aggressive feel to them, and I realize that, in fact, I sometimes find it patronizing and more antagonistic than I have previously realized. Then I ask myself: is this evidence of a competitive feeling coming from Sam, or am I finding that the way in which he imagines and experiences me (creating a conversation with me as one who reveals something) is a private, autoerotic process that leaves me out?

Sam continues in his associations and says that he is fascinated and amused by his creation of my private self. I privately associate to a business involving a hostile takeover. He keeps laughing, and

says that, in his mind, I *have* stated my age, and it is almost as though he is laughing at someone in his head who is me and with whom he is conversing.

My thoughts go to how he has psychically invaded my privacy and taken over a reality that is unpleasant for him—that I have not revealed many things about myself. He has always been angry about my not sharing more about my life. He wants us to be friends and to spend time together socially. He has told me that I am too old for him sexually, but he wants me to be an older friend. He has enjoyed it when we have briefly conversed together more naturally a few times. We have some areas of overlapping intellectual interest, and I imagine that I would enjoy talking to him more about our shared interests than about my sense of Sam's anger at my not stating things (my "stated age") and his attempt to take that matter into his own hands and mind.

As the hour continues, some of my private thoughts seem to become clearer. My private life, my vital statistics, and maybe my private parts, too—age, marital status, religion, my private thoughts—all exist in Sam's mind as a "stated something." He speaks more of how much he wants to have access to things he does not have control over. He associates to his tendency to find a way around feeling his usual sense of lack or deficit, and how looking on the bright side makes many of his relationships more superficial. I imagine that he co-opts my privacy into a defense against hostility. Sam knows that he finds it hard to bear my privacy as something out of his control, and that we are bringing it into the open—his piracy is something he is willing to give over to the court of therapeutic exploration and interpretation. He then associates to his girlfriend's anger at him for not making up his mind either about women or men, or about a developing, successful professional career that could lead him in one of two very different directions in the future. He needs to decide at some point soon about each of these different directions, that is, the choices available to him both romantically and professionally.

At some level, the hour is productive and interesting in that we come upon this interesting part of Sam's mind or internalized

object relation—"your stated age." The patient is in conflict about the parts of him that he is aware make for superficiality in glossing over what he knows and does not know; he has to find a way to bring himself more fully to those with whom he is intimate. He has to work with the conflict he feels and his anxiety about his anger toward me over my not stating my age, or over his not knowing me in the way he wishes to know himself and me. It is implied that we may eventually be able to explore more about why he is anxious about asking.

While I am very fond of Sam, I end the session aware that I am no less annoyed now than earlier in the hour. What is it about Sam that has caused me to feel annoyed? Over many sessions with Sam prior and subsequent to this one, I visualized him at home organizing his surroundings—folding clothes and cleaning up the house. I fell upon this kind of visual image of Sam, despite the fact that the images did not come from him. It is not uncommon for me to find that as I listen to patients, I locate them in various places, and this reverie can be very useful. Sometimes the location of a place is related to a point of transference-countertransference that helps me pinpoint a sense of unconscious fantasy or an object relation that I have not previously noticed. At other times, I am aware that I am engaging in a form of defensive distancing, a kind of isolation of affect that allows me to locate the patient outside the consulting room or somewhere other than with me.

Sam's self-sufficiency and organization were adaptations to a family life in which he felt his parents were largely laissez faire—from his point of view, to a fault. They wanted him to feel that, "on his own," he would come to his own sense of values, beliefs, and interests. He was an only child, and, while highly valued, he never felt as though he were treated as a child. Conversations with his parents seemed always pitched at an adult level with what he regarded as the expectation that he be mature before his time—in fact, pseudomature. He envied his closest friend in grade school and high school, whose parents were directive, opinionated, and sometimes dictatorial.

During one session early in his analysis, he associated to his friend's father as "dictatorial." In association to *dictatorial,* Sam said that he wished his father had had more of a dick. He wanted his father to be stronger with his mother, saying that his father often deferred to her judgment with self-effacing, cheery cooperation. He recognized some of these character traits in himself, since he often glossed over differences and sometimes his disappointment in others and in himself.

Over the course of a number of sessions, as I began to make use of these images and my continued mild irritation about Sam's use of the analyst in his mind—my "stated age"—I became aware that I felt myself to be continually "folded into," as it were, an internalized scenario that Sam held. When I made interpretations, they often seemed too immediately or too easily incorporated by Sam. In turn, his understanding would sometimes seem a bit too superficial. I realized more than I previously had that Sam often seemed quite pleased with whatever I would have to say, and that his affective range was quite focused on remaining cheery and cooperative.

At one point during a session, my mind turned toward a fantasy of making a mess of Sam's apartment, overturning things that had been neatly stacked and throwing things out of the closet. In association to the "closet" at this point in the analysis, I imagined that Sam's persistent masturbatory fantasies about men, and only men, might be a clue that he would prefer to be with men, and that his girlfriend might partially protect him from seeking more intimacy with men—thus, the fantasy of throwing things out of the closet. This series of thoughts marked a movement away from a particular form of uncertainty that had been present in my mind up to this point in the analysis—about whether Sam used men as a defense against intimacy with women or vice versa. While I was still quite uncertain about whether Sam would ultimately decide to be with a man or a woman, I began to believe that his confusion served his purpose of not getting too close to anyone in an intimate relationship.

These associations initiated a slight shift in my mode of formulation and interpretation with Sam. I realized that I had been quite

content to have Sam work with "my stated age" in his head, the internalized representation of me, because it would help us elaborate aspects of his unconscious fantasy life. His idealizations of me and of senior colleagues seemed too easy to accept, and I realized that I could easily slide into his prescribed roles for others and for me. He also seemed so consistently unassailable in relation to his girlfriend. He would say to her that he "just couldn't figure this out yet": whether he wanted to be with her or with men. He felt guilty that he was making her wait, yet he needed to know what he wanted to do. It was clear to me that he was waiting for her to decide what they would do—or perhaps for me to tell him what to do about her, about men, and about his career choices, and even to volunteer my age (though he continued not to ask). He would create a private, unstated/"stated age" or stated position of uncertainty about object choice until pushed to do otherwise.

I realized that I had been enacting a form of compliance with Sam's unconscious, quiet, but tyrannical hold on my asserting something about my independence from the analyst in his mind. Indeed, in my continued passivity in relation to taking this up, I was enacting something about being a laissez-faire parent, allowing him to feel, fraudulently, at the helm of his family.

When I arrive at an understanding about something related to what Ogden refers to as the *unconscious transference-countertransference* or *unconscious object relation,* interpretations begin to form more clearly in my mind. I also arrive with more clarity at what I may have been enacting with the patient. It is at this point that I am struck with a variety of clinical choices, and this is what I refer to as the analyst's *ethical imagination.*

The phrase "You look younger than your stated age" now seems more obvious as a complaint cloaked within a compliment—a complaint that the patient did not know me more intimately, and perhaps even that I did not confront him about his wish to know me more intimately. Sam wanted to avoid expressing his own wishes and needs to know. His language demonstrated that I had enacted some process of allowing him to be a pseudomature boy—a boy who thinks he knows the facts, but does not know the facts.

I began challenging Sam more actively. I told him, "I think you're waiting for me and others in your life to give you advice and act like parents who are engaged and want to give of themselves to you. Parents should know the facts, like what to do with your penis or your career." Sam seemed relieved to be able to speak more freely about these wishes as we began to get more deeply into how insistent he was about wanting this advice. He joked, "That's the idea —so now can we proceed to the advice?"

In essence, I began to take up what in some ways had been obvious all along: Sam's wish to know my stated age without having to ask or having to show his desire to know. This was what he had been warding off—the many feelings of sadness and anger partially camouflaged by autoerotic and self-sufficient fantasy processes.

My imagination regarding these various kinds of reverie also requires me to consider the sobering prospect that, as I became more actively confrontational about these processes, I may very well have been enacting the patient's wishes for me or for someone in his life to be forceful, parental, guiding, and to tell him what to do—to be a dick, as it were. I consider it our work as analysts to ponder the inevitable, continuing aspects of enactment that are intrinsic in whatever direction our interpretive focus takes us.

This particular set of clinical observations also raises complex aspects of the analyst's interpretive imagination. I had to more actively challenge Sam's autistic attempt to experience me as stating my age when I had not, while simultaneously making no promises to actually state my age. This is a familiar place for many of us who run the risk of needing to make interpretations that may stoke the fire of the patient's curiosity about us as "real" objects, while not promising to provide any more information about ourselves as real objects. Naturally, this can become another form of enactment, including the possibility, in this case, of my enacting a retaliatory, teasing object as a response to Sam's self-sufficient antidote and private way of not wanting to be in the position of feeling his need or desire to know me more.

Note that in this clinical example, I have taken up matters quite similar to Ogden's use of reverie as "simultaneously a person-

al/private event and an intersubjective one" (1997, p. 568). I did not speak directly with the analysand about my own experiences, and instead attempted to speak to him "from" what I was thinking and feeling.

CLINICAL ILLUSTRATION II: THE CHICKEN AND THE EGG

In this clinical example, I try to illustrate how my own needs for reverie and privacy help me when I more directly express aspects of my experience during the interpretation of points of transference-countertransference entanglement.

Josh is a man in his early fifties who often gets himself into masochistic relationships with others. As a young boy, Josh felt that he could not get his mother's attention. From his point of view, she was unavailable largely because of her ambitious career and outside romantic interests. His father was more available to him, but not very easy to admire. Josh's father wore his neediness and sexuality on his sleeve. He was damaged, in Josh's view—unproductive in a career in which he never lived up to his potential. Josh's father seemed to "hang on" his mother in ways that seemed pathetic to Josh, particularly since she rebuffed his attempts to hold and to touch her; she seemed annoyed and turned off by her husband's attempts to be affectionate.

Later, in his twenties, Josh learned that his mother had been involved in a serious extramarital relationship during his adolescence and that she had had at least a few affairs during his childhood. Josh's parents split up when he went to college, and he now feels as though their marriage was held together quite precariously throughout his youth.

Josh's transference involved feeling unimportant to me and not wanting to risk knowing whether he mattered. He treated his sessions as though they were unimportant to me because they involved him, and I would be more interested in patients who mattered more to themselves and to me. He was often late to sessions, sometimes recounting ways in which he felt unworthy of the attention he wanted from me and others.

I regarded our relationship as something akin to what he had felt with his mother—believing that, for Josh, I was largely unaware of him, finding him unappealing. He seemed not to register any need or desire of my own to get to know him. He would sometimes laugh (with sadness) about this as something that he knew not to be true, but that, nevertheless, he "felt in his bones." From the beginning, I wondered if Josh's mother may not have been as inattentive as he had experienced, and also whether his identification with his father as someone rejected by mother was important to hold on to in order either to assuage his guilt or to remain close to his father.

Josh arrives at his session at the beginning of his second year of analysis and starts talking about his law partners, two female and one male, who he feels devalue his work relative to their own. He feels he sometimes does not exist when in the same room with them. I hear this as an allusion to the way he feels he does not exist for me. I find myself getting distracted, thinking about what I will be doing that night and later that day, work I have to do, and some creative writing I have been experimenting with lately.

I hear Josh say to me through the distraction of my reverie: "I want to know what you think about this." He is referring to the way in which he does not exist in the room with his colleagues and how devalued he feels when with them. Of course, I am thinking about the ways I have just made him not exist by thinking about some of my own ideas separate from him. I am struck by his very unusual inquiry about what I am thinking about this frequent complaint of being unimportant to his colleagues; I am thinking that I want to comment on the more proximate inquiry related to how I understand his experience of not existing with his partners. I am aware that by doing so, I can get myself out of the very uncomfortable position of knowing that I was enacting something in the room with him that he describes feeling all the time with others in his life. I am not sure I want to talk more directly about that yet, if ever.

I say: "I'm struck that you've asked me about your partners ignoring you in a way that is unusual. By asking, you've done some-

thing that's hard for you to do—to legitimize your own need to feel that you matter and that you have the authority to ask. In asking me what I think about that, you'd like to feel that I think you matter or that they should pay more attention to you."

His thoughts go in a direction that is somewhat typical for Josh: "I'm thinking that a part of me is glad that you'll be away soon [on vacation]. I usually think that at least you need my money, even though I don't think you need or want anything else from me. Then when you go away, I get sad because I think, 'He doesn't even need my money.'"

"You feel expendable."

"Yes, you need nothing from me, like my mother needed nothing from me."

"But you just disappeared again with me. You asked me directly what I thought about your partners ignoring you, and then you went away and said that you're forgettable to me by dint of my willingness to go on vacation."

"I was forgettable to her, but I can't help but want to be significant to her. I can't stop trying."

"And you feel like, if you ask to matter to me or to her, the less likely it is that she will be there for you or that I will be. She doesn't need you and I don't need you. So then you disappear again."

In the moment of reverie that I have described, the moment in which I am privately disappearing from the patient, I am likely enacting the role of his mother. Josh is talking about that experience with his colleagues and perhaps symbolically with his mother and me. He may also be attuned to my actual disappearance from him. I believe that I am enacting this not because it is happening for the first time, but because it is the first time that I am becoming aware of it when he is alluding to it in displacement. This way of knowing is for me private at this point, but he may feel it. I am not ready to tell him because I fear that, by telling him it is so, I might be enacting something even harder for him to deal with—which is that I am pulling away. I worry that he will conclude that

it is because he is not worthy of being memorable or loved. I know that this will have to be discussed—or do I?

My thought at this point is that I may very well tell Josh about this interaction if it happens repeatedly, but I am not ready to do so yet. I need my privacy to think about this and to see whether it continues to happen. But I suspect that he and I are caught in a chicken/egg process: a mode of reciprocal influence in which he may feel me disappearing, so he disappears. But he may also be reacting to an internalized maternal object whom he experienced as neglectful. I feel him disappearing, and when he does, instead of pointing that out to him, at times I go off somewhere else. Where it all begins is, of course, hard to say.

In these moments, I ask myself, "Why do I need some privacy?" I am aware that I am afraid of hurting the patient. By underscoring my moments of distractibility, I might be requiring of him a capacity for reflection that exceeds his ability to regulate his self-esteem. Is the risk of hurting him real or imagined by me?

Another side of my imagination is to think about whether I am protecting myself from conveying to Josh in vivid, more observable terms how I was leaving him and relegating him to the realm of the unimportant. Might this let him see more about the impact of his own self-imposed disappearance on others? Would showing him this allow him to consider the plausible reality and substance of his inner life and cognitive process, in contrast to how he often reflexively dismisses this level of experience? Will showing him the analyst's correlate experience allow him to feel something about how I, the analyst, am assailable and culpable in this way, or is it a way to unload my sense of guilt and culpability? He has a right to be angry with his mother and with me. More important, he has a right to trust himself and his own authority. Like any dilemma involving complexity, I need to be able to sit with the affective implications or fallout that will come from whatever I decide.

Outside the hours with Josh, my thoughts sometimes go in a more theoretical direction: to papers by Steiner (1993), from a Kleinian perspective, and Slochower (1996), from a relational per-

spective, in which each describes patients for whom interpretation that implies aspects of the analyst's subjectivity can be destructive for periods of time during the analysis. Steiner notes that sometimes "patient-based" interpretations feel too blaming or intrusive to some patients. Similarly, Slochower describes patients for whom the act of revealing aspects of the analyst's experience can repeat the patient's earlier experiences with parents who were overinvolved with their own experiences and neglectful of their children.

Then I think of the contrasting view of Bass (1996), who suggests that if we make this assumption about the destructive use of the analyst's subjectivity, we may be more likely to find it. In my view, this is not a debate that is possible to resolve except in the privacy of the analyst's imagination and through discoveries made with a particular patient. It is a kind of ethical imagination of the analyst in which his or her reverie and need for privacy can play and work.

I use my privacy and reverie engaged in these clinical imaginings, and I also try to think about the situation from various theoretical perspectives that matter to me—what I call the *pluralistic third* (Cooper 2007). My use of this privacy and reverie, in contrast to Ogden's wonderful illustrations of the use of reverie, may result in direct statements of affects, ideas, or behavior, which the patient would not have a way of knowing without what I refer to as *analyst disclosure* rather than self-disclosure—because they relate to the use of my privacy. I retain a strong sense of a private self when I disclose affects, ideas, and behaviors that are part of the interpretive work. Privacy and reverie are what allow my private self to bring forward parts of me that I try to help the patient understand in thinking about himself in relation to me.

On occasion, the pattern of my own distractibility matched Josh's description of important others (e.g., mother, me, and colleagues) who did not seem to register his presence. Eventually, I did in fact talk to Josh about this pattern of my inattention that accompanied his experience of others' inattention during a session when I was *not* distracted. He seemed increasingly present, telling me more directly that he did not feel memorable or important to me.

I told him: "I notice myself most likely to be distracted while with you when I experience you as giving up on yourself, particularly when you're withdrawing from alive, sexual, funny, and hostile parts of yourself." He said, "Maybe that's when I need you most." I said, "Yes, I imagine that *is* when you need me most—to show you what you're doing or encourage you to do otherwise."

At the point that I chose to talk to the patient from this register, I could do so particularly because I was not in the middle of feeling overwhelmed by my own feelings of guilt about my withdrawal from him. Josh was becoming much stronger, trusting himself more, and was willing to talk to me more directly about what he wished for from me.

I do not want to suggest that this is a necessary technical prescription for anyone else. While it was my guess that Josh would have had a hard time with a more direct disclosure at the moment when I initially became aware of this confluence of intersubjective events that I have described, it is quite difficult for me to know this for sure. Instead, I made my clinical decisions based on my sense of what I was able to convey about how his tendency to feel forgettable might sometimes engender or augment that experience in others. In fact, we discussed how much his growing awareness of feeling unimportant to others and recognition of these feelings in others, while not always correct, were probably part of a process of a growing trust in his own mind and experience. This clinical moment began a process by which Josh became aware of trusting some of his own experiences of neglect, and also became more cognizant of his own agency in seeing that, unconsciously, he tended to disappear from others before they could withdraw from him.

CLINICAL ILLUSTRATION III: SOME PARADOXICAL ASPECTS OF BEING ONESELF AS PATIENT AND ANALYST

In this brief example, I aim to illustrate a register close to what I have previously referred to as *analyst disclosure* in the analyst's use of privacy and reverie. While it is a different register than that uti-

lized and elaborated by Ogden (1994a, 1994b, 1997), I think it shares his appreciation of the paradoxical interplay of private yet deeply personal reveries, as well as the awareness that these reveries help us create unconscious intersubjective constructions that illuminate points of transference-countertransference engagement.

Susan is a very effective and in many ways satisfied mother and attorney in her early forties. Her main complaint is an inability to stop feeling a relentless pressure about making everyone in her life happy. She is hypersensitive to disappointing her husband, her two children (an eleven-year-old girl and a seven-year-old boy), her colleagues, the partners at her firm, and—now in our analytic work—particularly me. During the third year of her analysis, we have come to a point at which she feels, very problematically, that I do not smile at her enough when she is entering and leaving my office.

Susan has some potent and durable theories about this. In fact, at the time of this vignette, she is worried that her concern about whether she pleases me is privately off-putting. In her mind, I am drawn to a very secure and strong woman who is beyond the need for affirmation.

I admire Susan and think of her as smart, funny, and physically attractive. In my view and Susan's, she is partly experiencing me as her father who withdrew from her when she was fourteen. She felt that he was critical of her as she diverged from him in terms of becoming somewhat iconoclastic in her intellectual and artistic interests. She felt that her mother silently approved of her choices, but would never speak out on Susan's behalf or her own. Her two older sisters worked in the family business during high school and after college. In particular, her oldest sister was regarded by Susan and her parents as being almost the same person as their father.

As Susan's adolescence continued, both sisters became critical of her, and she felt that she lost their interest and pleasure in her as the youngest, cute little sister. They saw her interests as constituting a betrayal of the family's ideals, particularly regarding her growing interest in art and left-wing politics. She married a man from a different religious background than hers (Susan is Catholic and her husband Jewish), which seemed to cement her status as an outsider.

During the first year or so into this analysis, I often felt a kind of ease with what I regarded as an "empathic" attunement about Susan's longings to have her father's approval, despite her being different from him. She had struggled throughout her life with a conflict between wanting and not wanting to show herself, often trying to camouflage those of her interests that diverged from those of her family. She seemed to feel relieved that she could show herself to me in the analysis. I had been taking it up in terms of how this expressed a longing for affirmation and a set of needs from her father that she was feeling and letting me know about in her analysis.

At the time of this vignette, during her third year, Susan became more vigilant about whether I was smiling, but not particularly curious about why this was so. I was not aware, initially, that this was the case, and instead thought that she was moving into a deeper set of wishes to be able to express how much more she wanted. She disagreed, instead insisting that she had reached some tipping point with me, and that I did not really like who she was. Over many months, indeed, I began to feel that my empathy for Susan's sadness and anxiety was tempered by my feeling more controlled by her. In fact, I was aware that, at times, I even felt burdened by her sense that if I did not smile at her warmly when I greeted her or said goodbye (often something that I was not aware of), she felt rejected. I was reminded of the feedback she had received at the beginning of our work, when she had just made partner in her firm: that the partners wanted her to work more independently and to ask for reassurance less frequently.

At this point in our work, during one session, I was thinking about how diminutive Susan is in relation to me. She is very petite, rather small in stature, and has a beautiful but soft voice that I can barely hear from behind the couch at times. At this moment, I felt a bit like a bull in a china shop in comparison to her. Sometimes I have visualized this. But in this session, my mind moved to Gulliver with the Lilliputians and then to Dr. Frankenstein's son, also called Frankenstein, who come to mind from time to time in my work. But I began to think less of the impact of Frankenstein or

Gulliver on those around them and more about each of them as misunderstood giants. Frankenstein did not ask to be created; he was the victim of his father's Promethean ideas and fantasies. Was I thinking that Susan had been asked to be her father's creation, and that she did not know how to be herself and still be loved by him? Then I went back to my sense of how much power I had over Susan, from her point of view, and how much I now felt controlled by her, from mine.

This reverie began a process of thinking more fully about my negative feelings about being this transference object for Susan. I *imagined* myself making something like the following verbose formulation to her:

> I'm feeling controlled by your insistence that my not smiling enough at you means something negative, that I don't like you. Maybe I'm actually not smiling at you in the same way when I greet you. You want me not to have a private life in which I might be thinking and feeling any one of a number of things about you or other matters that you won't know or can't know. I want to have that privacy, just as I think that you wanted to feel that you were loved by your father while having your individuality, privacy, and separateness. You're afraid to have your privacy and risk being unloved, and afraid to let me have mine. You're trying to make this better by (unconsciously) being like him, rather than seeing if you can feel safe in being different than him or me, with each of us having our freedom to feel what we feel.

I felicitously call this a variation on reverie: *rougherie*.

In my imagination, I am aware that, by putting Susan's identification with her father front and center, I am placing myself at a great deal of remove from her anxiety about what my not smiling in the way that she wishes might mean.

My mind goes to feeling constrained by this set of feelings and choices or lack thereof. I feel as if I cannot "be myself" as Susan's analyst—an ironically held conflict if ever there was one. I can hear the irony in the thought of an analyst who is in some ways

never "himself," yet the words seem meaningful. I imagine that this lack of choice, this conflict, may also be something like what Susan feels, and I try to talk to her about my dilemma, rather than choosing a particular side of this set of experiences and conflicts to examine.

The next time that Susan brings up her anxiety about my failure to smile at her in the way she wished as she left the previous session, I say: "It's so tough for you to be yourself at work, with your father, with me, and still feel our approval, our smile. It's tough for me to find a way to be myself with you as your analyst without making you feel betrayed, hurt, and worried about how I feel about you. It may even be making for less of a smile. You don't like your choices—why should you?—and maybe, in a way, that's similar to the way I don't like mine."

Susan had many reactions to this shift in my interpretive position. She was initially relieved that I could voice this to her, and she recognized the similarity in our positions. She also felt degraded and inadequate that she was not being a good patient because she feared that she had succeeded in creating a form of analytic impasse. We looked at how some of these feelings of inadequacy and badness were a familiar way for her to resolve differences and standstills with her frustrated love in relation to her father. I suggested that by blaming herself, she was able to preserve her relationship with her father and with me.

The complexity and layering of even this brief part of the analytic process with this patient is far beyond the scope of this paper, but it is important to say that the density of these points of transference-countertransference experience and enactment were the stuff of our work together, and allowed Susan to explore the erotic and aggressive aspects of the much-desired smile.

CONCLUDING COMMENTS

Reverie and the analyst's associational drift are in some ways components of a tracking system (Bollas 1987) that allows the analyst to continually rethink and imagine his or her patient's affects and con-

flicts. It is particularly helpful in thinking about our ways of changing in our own identifications with the patient and his or her objects. Thus, it is potentially useful—albeit somewhat schematic—to suggest that a part of our imaginations can provide a kind of check-and-balance system as we change in our identifications, and sometimes in our interpretive direction.

There is some overlap with what I call the analyst's *ethical imagination* and what Benjamin (2004) refers to as *the moral third.* Benjamin includes that part of the analyst's mind and experience that considers how to reach a patient and aspects of moral responsibility in doing so. (I do not, however, conceptualize this activity with developmental metaphors in mind.) It also overlaps with what I have earlier referred to as the *future of interpretation* (Cooper 1997), and it borrows from Loewald's (1960) model of how interpretation takes a patient simultaneously one step into regression and one step into an unknown and new psychic future. Sometimes the analyst's anticipation of this psychic future is helpful in challenging the patient to examine new dimensions of conflict or self-state experiences, while at other times it may enact too long of a psychic reach, unanticipated or underappreciated by the analyst.

These moments of repetitive transference-countertransference enactment sometimes also invite the opportunity to think outside the boundaries of our own theoretical preferences. When I have this kind of privilege in my analytic work, I also use what I have called the *pluralistic third,* which includes the opportunity to think about these choices from several differing perspectives, including theoretical choices that are different from the one I believe I have used. This pluralistic third includes my attempt to think about the transference-countertransference by trying to step outside what might be my *overvalued ideas* and *selected facts* (Bion 1963; Britton and Steiner 1994) in order to build on my understandings.

In other words, the analyst's dyadic relation to his or her own theory creates its own blind spots in integrating forms of reverie or any other form of clinical data. The pluralistic third, like the analyst's ethical imagination, is a way of thinking about spontaneously occurring events within the analyst's mind. It is a way that we

sometimes reach outside our usual modes of thinking in order to draw on our body of ideas and cumulative knowledge in clinical psychoanalysis (e.g., Pine 2006). It helps us develop what Britton (2003) termed *vulnerable knowledge* of the patient, rather than fixed belief.

I have tried to illustrate some examples of varying ways in which I try to make use of forms of analytic reverie and my privacy. I have also tried to illustrate a few different registers from which the analyst can illuminate these points of unconscious transference-countertransference enactment. The goal of using such reverie in the course of analytic work is to help show the patient specific—and hopefully rather immediate—dimensions of the analyst's understanding of transference-countertransference enactments, which have, and continue to exert, influence within the work. The modality by which the analyst communicates these formulations of unconsciously held object relations and defenses varies, and includes verbal interpretation through symbolic speech, interpretive action (Ogden 1994a), and, at times, a register of *analyst disclosure*—a construction of the analyst's subjectivity that is put forward to enhance the patient's understanding of unconscious enactments of the transference-countertransference.

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IDEAS OF INFLUENCE: THE IMPACT OF THE ANALYST'S CHARACTER ON THE ANALYSIS

BY JANE V. KITE

The fact that analysts inevitably analyze "in character" (i.e., as themselves) has been commonly assumed but unacknowledged publicly ever since Freud's Papers on Technique *(1911-1915). Analysts' implicit private beliefs about the impact of their own characters on analytic work have been addressed obliquely via theorizing about the analyst's subjectivity and the role of mutually created resistances and enactments in the transference/countertransference matrix, but these views remain largely tacit. The author suggests that the psychoanalytic concept of* character *has run aground as a moral issue, not a theoretical one, and that its deeper role as the vehicle for unconscious action remains indispensable in analytic work. An extended clinical example is presented to illustrate the author's preliminary ideas about the impact of her own character in this analysis.*

Placed at the very centre of the treatment by the analytical situation, is not the person of the doctor in its modest way comparable to the famous "unmoved mover" of Aristotle? For it is around him that the various processes are ordered and connected: processes that set the patient on the road to recovery.

–Sacha Nacht (1962, p. 211)

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INTRODUCTION

Almost fifty years ago, sitting in a routinely boring church service, I heard the minister give a sermon entitled "Where in Hell Is the Devil?" As I recall it now, I was disappointed in the answer, but the fact that there was no "good" answer did not detract from the freshness of the minister's subversive intent. It has stayed with me as a model question, hellish in its own way, translated today into the position and influence of the analyst *him- or herself* in the analysis.

My curiosity about how the analyst him- or herself, i.e., *as a particular character,* inadvertently but inevitably influences the analysand's unfolding experience of the work—and thus the nature of psychic change—has been with me since the beginning of my psychoanalytic training. More specifically, this question has grown out of a long-standing frustration with the lack of articulation between theory and the developing analyst's experience of practice, an indeterminate zone where the analyst's actions allegedly conform increasingly to something called *technique.* In a paper written some years ago (Kite 1993), I stated that we all evolve a technique that "fits our character"—having no real idea, in fact, what I was talking about, other than my own discomfort in analyzing at that time. I was reaching for something I knew but could not describe. I knew that I was somehow implicated in everything I did and said in analyzing, but the relationship of this to my "theory," such as it was, and more urgently to "technique," was mysterious.

What was the relation between who *I* was and who I was *as an analyst?* I wondered in this connection if Gray's (1982) well-known observation about the developmental lag between theory and technique may have more to do with the way in which the analyst's character gradually colonizes the theory (roughly speaking), rather than the other way around, and ultimately determines the practice more than anything else. The "lag" would then be the time it takes the analyst to feel that she *has* a technique that bears any authentic relationship to herself, on the one hand, and to what we have been taught, on the other. I know I am not alone in this: every one of us has had

the same question, either centrally or floating at the edges of our formal training. Whether we consider this to be a purely naive question or one that might be explored more systematically, it has shadowed our development as analysts.

Thinking about the character or "person" of the analyst is indeed coincident with the history of thinking about analytic technique—they are disarmingly close, and we can never quite consider one without the shadow of the other.[1] I have come to believe, bottom line, that the invariable substrate of our technique—which I also think of as our action as analysts—*is* our character. The way we analyze is who we are or have become.[2] It cannot be otherwise.

In my (evolving) view, patients *do* actively seek out and respond to the analyst's personal *attitudes* over the course of analysis in the to and fro of transference-based interactions (Friedman 1988; Hoffman 1983), but what they *experience* over time in an ongoing, mutative way is the analyst's total character. This, in turn, is the analyst's inevitable, idiomatic contribution to the nature of the therapeutic action of the analysis. In this paper, I will pull together and look at many of our ambient concepts of character—specifically, the role of the analyst's character in analysis—with the initial aim of clearing some conceptual space around this issue as well as that of therapeutic action.

CHARACTER

I use the word *character* here for lack of a better and more inclusive term for the manifestation of a person's stable, fixed, unconscious personality organization. In this I am closest, perhaps, to Schafer (1979), who describes character as "the particular way in which a person may be said to organize and stabilize his or her actions" (p. 876). Despite concerted efforts in our field to dispense

[1] Lipton (1977) has been the only writer to question the idea of technique as conceptually and existentially distinct from the personality of the analyst. (See also Grossman 2007.)

[2] Joan Didion (2005) writes: "The way I write is who I am, or have become" (p. 7).

with character altogether as a psychoanalytic term, I think that informal concepts of character have remained indispensable in psychoanalysis as in life, particularly to summarize in our minds the way a person *is* in relation to others.

I will argue here that character is deployed in technique in a way that cannot be adequately subsumed conceptually under the rubric of the analyst's unconscious conflicts—or, more recently, as part of the irreducible subjectivity of the analyst (Renik 1993). The way I am using the concept of character here is essentially where Freud left it: as "a thing [essentially] so hard to define" (1933, p. 91), but presenting in effect the final position of the person, including "permanent trends in it [the ego]" (Freud 1939, p. 75), fixed defense mechanisms, and, perhaps most decisively for our purposes, identifications with parents and other influential figures (Freud 1937). All of these features taken together are still theoretically untidy, but in my view endow the concept of character with the quality of continuous, unconscious, object-related action.

That the concept of character itself has had a checkered and ultimately problematic history in psychoanalysis is undisputed. Freud never fully clarified his ideas about character or the way he used it, nor did he ever abandon it. Boesky (1983), at the other extreme, pointed to the singular theoretical and clinical disadvantages of retaining the "supraordinate concept of character" as essentially an "inchoate model of the mind" and "nothing other than the psychic apparatus as a whole," arguing instead for the preservation of the concept of "discrete, descriptively concrete character traits" (p. 227). This approach paved the way for the idea that the analyst's observable character traits are the "hooks" on which patients hang their transferences (Baudry 1991; Kantrowitz 1993), but in my view, it also set aside the potential richness of character considered as a whole.

Due in large part to its protean pedigree, *character* was never systematically developed within psychoanalysis, and ultimately it was a flop on the psychoanalytic stage. As the formal arguments on the subject were fizzling out, Schlesinger (1992) suggested that

character has finally been sidelined as a concept without a theory because it cannot be fundamentally explained in terms of conflict —notably, unconscious conflict. "Character itself," Schlesinger stated, "apart from its neurotic coloration or distortion, is not *caused* by conflict or by unsuccessful attempts at conflict resolution, as are neuroses. Unlike neurosis, character or personality cannot be fully explained in terms of compromise formation" (1992, p. 231). While Schlesinger may have overstated his case here, particularly when it comes to current views of the ubiquity of conflict in every psychic moment (Smith 2000), I believe that he was correct in thinking that character cannot be fundamentally reduced to concepts of conflict. This is finally what makes it an unwieldy and elusive concept clinically, and difficult to get hold of in the work itself.

A quick glance at the literature since 1992 demonstrates that analytic writing about the nature of the analyst's personal involvement in the analytic situation has indeed been theorized almost exclusively through the lens of conflict, chiefly via countertransference. This saddles our current concepts of countertransference with the analyst's entire unconscious personality organization, which is unavailable to the working analyst at any given moment, via countertransference or anything else. As evocative and as clinically "true" as the growing literature on countertransference and enactment has been, it still addresses primarily the analyst's inevitably *conflictual* and ultimately *conscious* participation in the analysis.

In this sense, *countertransference* confines itself conceptually to certain features of the analyst's *neurosis* (Smith 2000) as fueling the analysis from his or her side, rather than something about the analyst's character as a whole. This is not surprising. Conflict is something we can eventually catch hold of as analysts and think about; we can eventually *see* it and *feel* it as our patients evoke it in us. Character, on the other hand, addresses primarily the constitutional or dispositional side in Freud's complemental series, and lacks the experiential nature of neurotic conflict. Character is unconscious, and its impact is blunt.

Eventually, we are aware of the nature of our participation in the analytic process, but we are never aware of our impact per se. It has to be inferred.[3] If theory "thinks inside us," as many analysts, starting with Freud, have suggested (Smith 2003a, p. 1), then neurosis "chatters" and character is dumb.

CHARACTER AND IMPACT

We are probably able to ask our best and most provocative questions as beginning analysts, full of naive curiosity, before we are domesticated by long years of training. Many of my early and persistent questions have been organized by the distinction that Sandler (1983) made between "public theory" (p. 38)—accepted official opinions, if you will—and private convictions about all aspects of psychoanalysis, including private fantasies about how it is "really done." Private theories about how analysts analyze are, not surprisingly, akin to childhood sexual theories and flourish alongside the "real" explanation. These fantasies often involve our own narcissistically tinged assessments of ourselves as analysts. A common private conviction is that we "are not doing proper analysis." Sandler points out that, paradoxically, this easily coexists with the belief that we are "better analysts than most of [our] . . . colleagues" (p. 38). "Better" on what possible basis, I have wondered—that we are "better" or more effective people? Smarter? Better trained?

To take this a bit farther, I would also guess that every one of us has privately entertained the fantasy at one time or another, perhaps typically early in our careers, that it *is* us as individuals who have really made the crucial differences in the analyses we have conducted: our way of handling things, the way we say things, our personal style—some ineffable expression of ourselves in our analyses has been the special agent. Bolognini (2006), in his continuing investigation of the complexity of empathy in psychoanalysis, re-

[3] See Aron (1991), who observes that "thinking of the analyst's experience as 'counter' or responsive to the patient's transference encourages the belief that the analyst's experience is reactive rather than subjective, emanating from the analyst's psychic self" (p. 248).

counts his realization that early on he was "cultivating within myself the fantasy of a special, innate, 'empathic competence,' as if I could count on some hidden talent for tuning in to my patients." He then realizes that some conviction of special talent was "almost a universal prerequisite for would-be analysts." The more common version of this, and the "unofficial" psychoanalytic version—that we are all trying to rescue and redeem ourselves as good people by restoring to life and curing our important early objects—does not temper the vitality of our fantasy versions: they continue to exist side by side, as Sandler (1983) suggested.

The tension between analysis as public theory and analysis as variously embodied and practiced by individual, private analysts is also buttressed by the tacit transmission of analytic mythology from generation to generation of analysts. Take the matter of analytic genealogy, for instance. How often have we heard the comment that "he was analyzed by Dr. X" followed by "oh, *that* explains it"? I don't think we are thinking here of the therapeutic action of Dr. X's theory. This may be our official public speculation, but nowhere is our private belief that we are implicitly referring to the analyst's character and influence more in evidence. We know, after all, that patients do not respond to a theory; they respond to a person (Friedman 1988). Or, take the seemingly casual observation that if someone needs a little loosening up or a little smoothing out, the choice of Dr. B or Dr. C is perfect! Is this so different from the kind of evidence we use in setting up a blind date? Given a variety of choices, how do we make referrals for analysis?

Once started down this path, the questions proliferate. Is the idea of analyst/patient match actually based on assessments of the analyst's character ahead of his or her professional skill, or are the two at some point seamlessly fused? We have all made our own version of Schafer's (1983) observation that there are

> . . . many analysts whose usual analytic competence and effectiveness you would not seriously doubt and yet who, in their nonanalytic relationships, including those with colleagues, seem to be one or more of the following: rigid, aloof, irritable, ruthlessly controlling, egoistic, flamboyant,

> shut in, timid, obsessional, paranoid, depressive, or hypomanic. [p. 37]

How do we bridge in our own minds the chasm between *analyst* and *person?* Do we even try? What about the idea of shopping for an analyst, looking for a good fit? What is being fitted to what? The problem of what we persistently think of as the analyst's character easily becomes a Pandora's box, full of our own wishes and fears about ourselves—and others—as analysts.

Anecdotal evidence of analysts' private beliefs about their impact on patients tends to crop up not in the formal literature, as a rule, but in interviews and asides. Stone (1997) was clear that "everybody wants to be a savior if possible" (p. 109). He went on to observe that patients in a second analysis do not remember anything about interpretations made in the first analysis:

> It amazes me. They have spent several years in analysis, and they hardly ever talk about that aspect of it. What they do mention are the habits of the analyst, the tones of voice, the question of whether he was considerate and reasonable, or very strict, or even said some harsh things that jolted them or whatnot. [p. 123]

In other words, patients remember their analysts' character traits. But is what is remembered an accurate measure of the enduring effect of the analyst on the patient? Stone's patients remembered the traces of their former analysts. Memory traces are evidence of impact, but not impact itself.

Other published interviews provide partial glimpses into analysts' early fantasies and fears about their ways of practicing as these intersect their personalities. McLaughlin (1997) reports that Waelder, an early supervisor, said to him, "Jamie, you have a lot of emotion" (p. 314). Before this supervisory comment, McLaughlin observes that he had been "playing out the role of a very decent, controlled, detached analyst" (p. 314), but found that he couldn't stand it. McLaughlin had been trying to be the ideal analyst, and with Waelder's remark and the reflections it produced, he was free to be

himself. His subsequent clinical writings demonstrate the conviction that the analyst always works primarily as him- or herself.

In a similar vein, but making the opposite point, Enid Balint (1993) reports that "Winnicott always warned me that I had a reassuring personality and I had better watch out. So it could be, in spite of thinking that I was not being nice to patients, that I was" (p. 229). Balint is advised by Winnicott, the kind, good-breast mother of Guntrip's second analysis, not to be so nice; McLaughlin is advised by Waelder the metapsychologist to admit his feelings into his work. It seems to me that there is and has always been much lore and little agreement about how the analyst's character *actually* works in analysis, and a lot of speculation, mostly wishful, about how it *might* work.

The twin issues of character and influence are implicit in the idea of impact as I think of it. These issues have plagued psychoanalysis since its inception, when Freud's discovery that hypnotic influence was creating resistance to the whole enterprise led him to the concept of transference and the impact of his own wishes on the work. I think it is safe to say that we have always suspected that we do *somehow* personally affect our analysands in a way that is as much outside as inside the existing transference-countertransference paradigm, and that this may be a crucial unnamed aspect of analytic work. Freud (1912) referred directly to character and specifically to influence as a problem at the very beginning of the game when he famously wrote:

> I must make it clear that what I am asserting is that this technique is the only one suited to my individuality. I do not venture to deny that a physician *quite differently constituted* might find himself driven to adopt a different attitude to his patients and to the task before him. [p. 111, italics added]

The phrase *driven to adopt* suggests that our different constitutions—the basic way in which we are put together as individuals—*drive* our technical choices and ultimately how we do our work. It is not news, in other words, that we evolve a technique that fits us:

what choice do we have? At what point do distinctions between character and technique dissolve?

Ironically, in the same paper, Freud defined the analyst's inevitable participation *as himself* in the analysis as a problem, and confined it to the insufficiently analyzed analyst. Here we have the vision of the analyst himself as a bit of an oaf, inexpertly clunking around wrecking things. Our views about ourselves as factors in the work we do have repeatedly swung from help to hindrance and back again, but it seems clear at this point that *character* is the vehicle for influence, for better and for worse—and mostly for worse, as the literature has it.

PROBLEMS WITH CHARACTER

Once we definitively parted company as a field from our largely unexamined idea of the analyst at work as an essentially "categorical person" (Fliess 1942, p. 211), we have been trying to close in on what it is that "moves" Aristotle's "unmoved mover" (Nacht 1962, p. 211) in the person of the analyst. We are indeed looking into the same philosophical abyss as we consider the underpinnings of *analytic process, technique, transference, resistance,* and *therapeutic action.* Every concept in psychoanalysis requires a theory of the total and simultaneous participation of analyst and patient. The analyst alone, however, typically has the initial requirement of being "of good moral character."

Writing on the subject of the analyst's character as a "silent partner to our practice," seventy years after Freud's technique paper, Baudry (1982) observed that we "lack a proper framework to describe the impact of the analyst's character on the analytic process" (p. 108). In addition to identifying character as *silent,* you will note that Baudry refers to *describing* the impact of the analyst's character here, not *investigating* or *assessing* it. In fact, Baudry's assertion at the end of the paper that our character shapes our work "more than we are *willing to admit,* beyond usually considered countertransference reactions" (p. 408, italics added) discloses our reluctance to continue to think about it. What is it that we are not "willing to ad-

mit"? Baudry has inadvertently, perhaps, made the most direct statement to date of our fundamental discomfort with the analyst as a person and a character. The dilemma of how to position the analyst's character in analysis, from this point of view, is fundamentally a moral dilemma, not a theoretical one. We have not yet fully parsed the idea of "good" and "bad" character (in the lay sense) out of psychoanalytic thinking about character itself.

Schlesinger (1992) suggests that the big problem with character has always been its reputation: its major role in psychoanalysis has been as an expression of psychopathology. Freud's first mention of the subject is to point to pathologically "deep-rooted malformations of character, traits of an actually degenerate constitution" (1904, p. 254) as impenetrable resistances in treatment. Character pathology and character disorders abound. There is apparently no such thing as an unqualified "character success."

In attempting to think about the merely "normal" character, Schlesinger goes on to tilt his discussion in the same direction that every writer on the subject inevitably does when he or she says that a "normal" character hopefully includes "moral dependability" (1992, p. 229). Traits such as "having (a good) character" and "possessing integrity" go to the top of the list as requirements for applicants to analytic institutes and subsequently for training analyst applications. Character, conscience, and superego are quickly and routinely conflated, both theoretically and practically, during progress through analytic training. Judgments are made. Historically, character does not have the neutrality of neurosis; it is fundamentally good or bad.

Efforts to marry character and neurosis in the hybrid concept of *character neurosis* ultimately failed, along with the effort to define what it was. This particular cul-de-sac has stymied any value-neutral examination of the role of character—of *being* a character, as Bollas (1992) puts it, in analyzing. The tendency to moralize character in analysis and the related impulse to disavow personal influence also contribute to the disarming of character as the basis of unconscious action in analyst and patient alike.

While we still do not have an official way to even begin to describe our own impact as characters, we have been unofficially sneaking up on some approximations. Hoffman (1983) captures

what I think of as the definitive turn toward the *person of the analyst,* asserting that the character of the analyst *is* in essence the framework of the analysis, insofar as the patient is continuously reacting to it and, in Hoffman's terms, *interpreting* it—an about-face of sorts.

Within ten years after Sandler (1983), Baudry (1982), Schafer (1979), Hoffman (1983), and others broached the thorny issue of the analyst him- or herself in the analysis, the frank acknowledgment of what Renik (1993) famously termed the *irreducible subjectivity* of the analyst claimed the spotlight, at least in the United States.[4] Analysts breathed a collective sigh of relief at being at last able to imagine themselves as real people in their work. The relief afforded us was that we could finally admit, without any caveats, "that everything the analyst does in the analytic situation is based upon his or her personal psychology" (Renik 1993, p. 561). It was like taking off our clothes.

Renik also captured at that time the way character works in the analytic situation:

> Even the slightest nuance of disposition influences how an analyst hears material, influences whether the analyst decides to remain silent or to intervene, influences how the analyst chooses his or her words and in what tone they are spoken, etc. [p. 558]

Note Renik's repetition of the word *influence* here. This underscores Freud's original point, never abandoned, that "differently constituted" (1912, p. 111) analysts would inevitably and expectably exercise their own brands of personal influence in the form of character.[5]

The trajectory of the concept of the analyst's subjectivity has also been a cautionary tale, however. The term generated the excite-

[4] In a less widely quoted paper that was also a commentary on Hoffman (1983), Aron (1991) writes persuasively of the patient's experience of the analyst's subjectivity, prefiguring both Renik's 1993 work and the impact of the analyst's character on the patient and the work.

[5] This view contrasts with Friedman's observation that "today's analysts are reticent about their knowledge and expertise" and in fact anxious about "*doing* the influencing" (Kravis 2006, p. 962).

ment that it did, in my view, because it became a temporary home for our ubiquitous fantasies about the action of the analyst's character. Our private speculations, in Sandler's (1983) terms, found a more public forum, and subjectivity became the new conceptual playground. Debates about subjectivity and objectivity in the analyst were vigorously pursued and never settled.

Cooper (1996), temporizing, suggested that the analyst's subjectivity might be seen as the neutral version of his character, reflecting our belief that character *needs* neutralizing. Others have suggested, in critiquing Renik's work, that subjectivity has been frankly conflated with impact (Louw and Pitman 2001), becoming in effect a kind of back-door approach to the analyst's characteristic mode of activity. A further complication of the flurry of excited theorizing spawned by the idea of the analyst's subjectivity was that the new focus on the unadorned interaction of analyst and patient also acquired a prescriptive component. This was particularly true in the relational literature, where for a time analysts aspired to "be" a certain way with patients: typically, more active, more open, and more transparent—covertly reverting once more to ideal character types more directly, and to influence. "If only they were braver, more available, or simply more decent," Greenberg (2001) writes, analysts believe that they could "revitalize relationships that have been deadened by toxic transferences" (p. 376).

Conscious attitudes trumped the analyst's unconscious organization. Analytic writing, which for several decades had been more impersonal (with the notable exceptions of Levenson, McLaughlin, Jacobs, and a handful of others), began to document the analytic situation as a confessional—the analyst's confessional, that is—and analytic interaction itself acquired a redemptive quality. None of this contributed, in my view, to any substantive understanding of the ongoing cumulative impact of the analyst him- or herself on any given analysis.

Guntrip (1975) made much the same point when he wrote:

> On the difficult question of the sources of our theory, it seems that our theory must be rooted in our psychopathol-

> ogy . . . . The idea that we could think out a theory of the structure and functioning of the personality without its having any relation to the structure and functioning of our own personality, should be a self-evident impossibility. [p. 156]

Note that Guntrip subtly conflates analysts' *personality* with *psychopathology* here. We cannot shake the myth that we must somehow subordinate our character and personalities (and their potential difficulties) to something called the *work-ego* of the practicing analyst, as if these things could actually function independently of one another.

Another unintended but inevitable consequence of more analyst-centered writing has been that as soon as our judgments about ourselves as people—specifically, our less noble qualities—come into view as we try to go public with our private speculations, clinical writing veers sharply in the direction of theory of technique, as if theorizing will purge us of the character problem. Here we have the dilemma that Smith (2003b) commented upon as the tendency of some analysts to support innovative technical recommendations—self-disclosure, for instance—with theories of mind, making it "look as though the practice followed necessarily from the theory, rather than, more loosely, the other way around" (p. 83). The dilemma of our own wishful and defensive contribution to theorizing continues to be one that beleaguers all psychoanalytic concepts.

I hope I have reminded the reader by now that the problem of the person of the analyst has always been on our minds—if not at the center, then on the periphery. At our most suspicious and inarticulate, character is voodoo, the ambient fear of a completely untoward person-on-person impact. In this mood, we ask ourselves how far we actually are from charlatans, hypnotists, magicians, and witch doctors on the family tree of healers.

Before turning to some clinical material, I would like to try to frame the distinction between the analyst's inevitable contribution to the analysis via his or her countertransference-based responses, on the one hand, and the unknown and perhaps unknowable contribution of the total person of the analyst, on the other. Ferro and Basile (2004), in discussing "the analyst as individual" from a Bionian point

of view, take the view that "the analyst's psychic apparatus causes him to function or to be dysfunctional in a certain way with patients, and with each patient in particular, and this goes well beyond countertransference" (p. 660).

Bonaminio (2008), in a paper on a related topic, extends this observation, suggesting that, while countertransference is an enormously valuable way to think about the working analyst, an overreliance on theories of countertransference has functionally interrupted our thinking about the contribution of the person of the analyst. I suggest that this has happened because clinical writing, in the United States in particular, routinely stumbles over the idea of character (the person of the analyst, the analyst as individual, etc.) on essentially moral grounds, and founders when it gets to desirable and undesirable character traits, as it inevitably does. Character as unconscious personality organization and character as the visible surface of personality are routinely conflated.

Starting with Freud, the nature of our own participation in analyzing has been the most difficult aspect of analysis to understand and to theorize, for obvious reasons.

CHARACTER AND TRANSFERENCE

The tension between the fact of the analyst's character, on the one hand, and theories of transference and countertransference, on the other, has its own chapter in the history of ideas about influence. In his watershed paper on transference, Bird (1972) pointed out somewhat critically that Freud did *not* assign the "difficulties contributed by the individuality of the analyst" (p. 275) to the countertransference, leaving them as a separate matter. (See also Gray 1990.) Friedman (1988) sees this as Freud's continuing emphasis on personal influence, perhaps even his reliance on a sense of his own impact, while others began to rely more on terms that minimize that impact—like transference and countertransference.[6]

[6] It might be useful to remind ourselves here that *influence* is defined as "the *action* of flowing in; influx" (*Shorter Oxford English Dictionary*, 2002, p. 1370, italics added).

In Bird's view, the "direct, here-and-now impact of the analyst upon the patient . . . may be the worst *enemy* of the transference" (1972, p. 284, italics added) and thus of the treatment. He also observes that attempting to separate and define the "real" analyst and the transference is "possibly the most challenging aspect of analysis" (p. 284). Bird, unlike Freud, but like most who followed him in the United States, argues away from the actual impact and influence of the analyst on the patient and toward the essential mutative power of the transference, suggesting in effect that the analyst's character is always at best an intrusion and at worst a loose cannon. Bird argues in essence against our ubiquitous preconscious beliefs and fears that we can be helpful or hurtful *as ourselves* when he suggests that we inevitably overestimate our importance as people and underestimate the power of transference. While the general observation that the prominent presence of the analyst as a "real" person may hinder the development of transference, particularly negative transference, may be true, I wonder if these distinctions can really be made so clearly.

I, for one, as I read Bird's magnificent paper, find some evidence for Bird's personal impact in the depth and conviction with which he writes. Might this quality have played a role in his analytic work?

At first glance, Guntrip (1975), writing from a distinctly different analytic tradition three years after Bird's seminal article, represents the opposite pole. He quotes Fairbairn, his first analyst, saying in an aside: "You can go on analysing forever and get nowhere. It's the personal relation that's therapeutic" (p. 145). Ironically, it was Winnicott, Guntrip's second analyst, who provided the more "therapeutic," personal relation. (And it was also Winnicott, the reader will remember, who cautioned Balint "not to be so nice.") Significantly, although Guntrip saw his two analysts as distinctly different "human type[s]" (p. 148), "totally different type[s] of personality" (p. 155), and felt that Winnicott's "type" had been more helpful to him, he saw the work in the transference in both cases as constituting the mutative analytic work.

Guntrip's view seems to be that the effect of the analyst's character on analytic work is inevitable, manifestly helpful or unhelpful, but the "real" work of the analysis goes on independently of these impressions. Work in the negative father transference in Guntrip's analysis with Fairbairn was just as fruitful as work in the more positive maternal transference with Winnicott. But if Guntrip's transference contribution made Fairbairn the hated father and Winnicott the warm mother, wasn't it something in the characters of the analysts themselves that enabled this?

Hurwitz (1986) and Simon (1993) have also made valuable contributions to the existing literature on the indelible stamp of the analyst's character on the analysis in their discussions of their own analyses, two in Hurwitz's case and four in Simon's account. They concur that "major differences in personality and temperament" among different analysts "made a substantial difference in the experience of analysis" (Simon, p. 1051), and, more colloquially, "just as different parents raise different children, different analysts produce different analysands" (Hurwitz, p. 463). Both writers point to the importance of patients' descriptions of their experience of their analysts as an important contribution to our (retrospective) understanding of the impact of character in analysis, and both describe the character of their analysts as having been more mutative overall than discrete interpretations of transference, etc.

In my view, we find a different and perhaps better solution to the inevitable dichotomizing of the roles of transference and the character of the analyst via the "total situation" concept. I am referring here to the way in which Klein (1952) and Joseph (1985) have understood transference in the context of the total situation of the analysis—i.e., a situation that includes most prominently the unconscious *action* of words and thoughts as patients express their entire psychic organization in their analyses. The unconscious action of words and thoughts is indisputably the "total situation" for *both* patient and analyst, as I see it. Significantly for our purposes, though the modern Kleinians talk extensively about showing their patients how they "use" the analyst, "alongside and beyond what (they) are saying" (Joseph 1985), these clinicians do not, at least overtly, theo-

rize the reciprocal impact of the analyst him- or herself on this process.[7] What are analysts doing "alongside and beyond" their interpretations?

In my view, it was Strachey (1934) who came closest to generating hypotheses about the action of the analyst on the patient in his seminal paper on therapeutic action, but his ideas about the nature of influence and how it works in analysis were not picked up in relation to the analyst's actual character. His paper also suffered from a confusion of tongues between structural theory and a reification of superego concepts, on the one hand, and a more experience-near object relations model, on the other. I will come back to this shortly.

CHARACTER IN CLINICAL WORK

I will now turn to some clinical material of my own in an effort to outline some preliminary ideas about the impact of character in analytic work. As you might imagine, any attempt to describe in a real way the impact of one's character on a particular analysis or analysand is at best a guess and at worst a fool's errand. Nevertheless, I will recount a vignette about a male patient of thirty-five, a writer, who has been in analysis for five years. A cardinal feature of the work has been a feeling of distance and formality between us, a feeling that to this extreme is unfamiliar to me as an analyst, and that I have had to pay attention to. I described this to myself as a feeling of being held at bay. Close at hand is the idea that attackers are held at bay, although I do not feel like attacking.

The patient initially describes himself as aloof, but also reveals this as his concurrence with his father's critical view of him. In fact, his chief complaint and difficulty in life has been his externally compliant and internally tempestuous relationship with his father. Everything he does is silently passed through the filter of his fa-

[7] Hoffman (1983) pointed out that Bion's concept of the container into which the patient deposits various parts of him- or herself is, in effect, the Kleinian equivalent of the blank screen, removing the psychology of the analyst from the field.

ther's potential evaluation. I have often said to him that I don't know where his father leaves off and he begins, and that he is continually expecting and inviting me to act like his father in relation to him. His mother appears infrequently, and is often subtly devalued as submissive to his father, without a definitive presence of her own. This feels consistent with his transference perception of me.

Although he rarely engages me directly for fear that he will appear too critical, as it turns out, the patient has consistently knit me into his dream life in many roles: exalted and devalued, sexual and nonsexual, smart and stupid; I have been tried out in every capacity. Over time, as a kind of footnote, there are dreams in which he makes an urgent mental note that he *must* tell this or that to his analyst, in a kind of dream hypertext. The urgency of these wishes to tell me something, to rush in and analyze something, were the first traces of a wish for contact in the analysis.

Despite our dream intimacies and the urgency of his communications, there is not much feeling in the room, and I continue to feel held at bay. By this time, my sense of it is not that I am being held at bay as a potential assailant, but more as if our relationship is fundamentally a secret from each of us. At this point, I begin to sense that the feeling of caution and distance in our exchanges is the negative of his father's outbursts; the room is calm. I also realize over time that the way in which I characteristically hear and experience his father through him, and the way my patient and I speak about him, has a life of its own. My relationship with his father in our minds, his and mine, largely unconscious, shapes his ongoing experience of me in one direction, and his own continuing experience of his father in another. He stops berating me for not being critical enough. I very gradually feel that I have more of a presence in the room; I am fuller.

All of this occurs slowly and undramatically. I imagine that I have in effect had a soothing and calming relationship with his father in his mind, modifying the father's direct impact, and allowing my patient to reason with himself in a way that is closer to my characteristic reactions to him. For example, at about this time, when I am beginning to feel that the patient has a sturdier and more rea-

sonable attitude toward himself, he has a dream in which he is going into *clear* shark-infested waters. The fact that he can *see* the sharks makes him unafraid. They do not attack. At this point, I begin to think of the clarity of the analytic field not as sterility or distance, but as an important use he makes of my calm in the room. We can momentarily *see* ambient aggression clearly, without anxiety.

More recently, with father now more or less calm in the patient's mind, mother has put in an appearance in the form of food. Characteristically and by history, he has never been much interested in food and eating: there were early feeding difficulties, and he reports never having had much of an appetite. I have been aware of this in the analysis in the form of his reluctance to take in very much in a literal way from me, unless it is an extremely tasty morsel—my having come up with the word *aphoristic* to describe a way he was speaking, for instance. When I get it right (which there is significant pressure for me to do), a feeling of pleasure builds up very slowly between us.

In the context of a new and exciting relationship, also a recent development, the patient dreams that he avidly eats a whole wheel of goat cheese in one sitting. He is startled after this—his girlfriend has bought the cheese to last several days. In fact, he is amazed and alarmed by how good he finds this cheese. I ask him about cheese. He quickly associates to the fact that he has never liked cheese before, but that it is a favorite food of his father's, and his father cannot eat as much of it as he wants to because he has to watch his weight. I say, "You worry about the pleasure of eating, as if it would be a direct blow to your father for you to enjoy something of his; you might take too much." As I am saying this, I am feeling very enthusiastic myself about goat cheese, and warmly imagining his new pleasure in it. Something of the sensual appeal in this dream registers in me, priming us for something different in the analysis.

In thinking over this sequence, I imagine that the patient's new enjoyment of cheese signals the memory of his very early pleasures with mother, before the hungry baby brother was born, and which he has long since abandoned in a radical oedipal act of self-

abnegation. His potential enjoyment of food and eating had long ago become enjoyment of words, images, and thinking. I also sensed that it was my having joined with and modified the patient's harsh representation of his father that then enabled him to make tentative contact with mother. I felt enormous relief at the dream of the cheese, as if the distance and thin clarity of the early phase of the analysis might now yield to a greater feeling of human contact on a regular basis.

The "Total Situation" of Patient and Analyst

How did this happen, and what does it have to do with my character? To start with, I will point out that this analysis, like any analysis, is an exercise in mutual influence. The patient's impact on the analyst is in many ways inseparable from the analyst's impact on the patient; they act as a unit. The sense I had that my patient was holding a potentially dangerous object at bay was a transference use he was making of me, as well as a communication, but it was I as an individual who *felt* held at bay, and I continued to "read" the situation that way until the patient read the "at-bay-ness" in his way as a kind of clarity. He read "calm" out of me. By this time, my calm or clarity was the medium in which the aggressive father (the sharks) could be held at bay. Without the constant internal threat of attack, he could begin to experience pleasure in eating. Having calmed the father in his mind, I could now feed the patient.

I say *I* here. What do I mean? I have elided two things.

Clinical theory emphasizes the listening and receiving function of the analyst: the analyst takes in the patient's material, processes it, and responds. The characteristic nature of the analyst's response is her technique, which is laced with all kinds of information about the analyst herself. But I also have in mind the unreflective *I* here, the idiosyncratically organized substrate of that technique. As I think of it, patients respond to the way the analyst *is* consciously and unconsciously, and very gradually a new object relation develops, having more and more to do with the character of the analyst and less and less to do in an immediate way with the archaic character of the patient's early objects.

I do not mean here that the analyst is *ipso facto* a "good" object replacing the old "bad" objects, like a new set of spark plugs, nor am I thinking of a form of "after-parenting" (Friedman 2006, p. 693). This would be closer to the "corrective-emotional-experience" model (Alexander 1950). Rather, the prolonged nature of the unconscious action in the analysis, character to character, very gradually and cumulatively, builds the new object relation in Freud's terms, largely via identification, while simultaneously actively influencing what we think of as the patient's superego in a benign way, in Strachey's terms. The analyst becomes available to the patient as a new object through, but not because of, the analyst's countless interpretations of transference distortions, and the patient's countless subthreshold experiences of him- or herself as the same but different (Loewald 1975).

The nature of the action I have in mind here is akin to Winnicott's (1945) fundamental observation that "only on a basis of monotony can a mother profitably add richness" (p. 141). In this sense, we cannot fundamentally dichotomize transference and reality, or, for that matter, enactment and reality. The analyst cannot help being available to the patient as a "real" object in completely ordinary, characteristic ways. In this way, a kind of potential for new experience is released—seeded, perhaps, in the past, but realized in the present.

Joseph (1985) writes about a patient, N, who, in response to an interpretation in the context of a lively exchange, said to his analyst, "Still, I think you have gone too fast." " 'Too fast,' " she explains, "was as if I, the analyst, had become a kind of Pied Piper and he had allowed himself to be pulled along with me" (p. 451). She interprets this, in turn, as N's having felt "pulled and seduced" (p. 451) by her as he had by his mother as a child. This is indeed interpreting in the transference, but I would also argue that there is something in the alacrity of Joseph's native style, the particular quality of the "going fast," that N experiences quite directly, which is new, and which is more characteristic of the new object relation than the old. The feeling of being "pulled and seduced" is indeed part-

ly a memory of mother, but also partly a legitimate new experience of his analyst.

Baudry (1991) suggests that our real character traits are "hooks on which patients can hang their transference reactions" (p. 928). Our character traits, whatever they are, are at the same time the legitimate basis for new experience in the analysis. Our theories "sit (or hide)" in us, as Friedman (1988, p. 9) puts it, but the new relationship being built up is with us as individuals. Analysts, too, express their entire psychic organization in their work.

The "total situation" is thus a particular analyst with a particular patient. Strachey (1934) emphasizes this when he says, "The effect when this neurotic patient comes in contact with a new object *in analysis* is from the first moment to create a different situation" (pp. 139-140, italics in original). Racker (1968), along with Strachey, pays attention to the "new" situation created by analyst and patient, and refers to the "importance of paying attention not only to what has existed and is repeated, but also to what has never existed (or has existed only as a hope)" (p. 150). The potential in this radically "different situation" lies in no small measure with the *character* of the new object, the analyst, and ways of influencing that will develop between analyst and patient. The manifest action in the room may be *interpreted* in the transference, but much of the silent therapeutic action (in Strachey's terms) lies with the cumulative impact of the way the analyst *is*—"alongside and beyond what he is saying" (Joseph 1985, p. 447).

Patients "read" the character of their analysts in the same way they have "read" (past tense) the character of their parents. As the analysis progresses, these "readings" are superimposed on each other with the newer reading of the analyst's character actively influencing the patient's view of him- or herself. Although the modern Kleinians do not theorize the analyst's contribution to the action, how could any new experience develop in analysis without the patient's making use of a particular person? A particular person, a particular character organization, is traction.

What can I say about my own character? I can imagine myself in many ways. Consciously, I can think about personality as perhaps

the visible surface of character, but I have no immediate way of reading the action of my character on another person. The level of self-observation we practice in reconstructing moments of clear countertransference bears no relation, in my view, to the quality of unconscious action in any particular analysis. In this fundamental way, my own character as agent is a stranger to me, the wild card.

Bonaminio (2008) puts this more succinctly: "the person of the analyst . . . is quite simply a fact to be taken for granted" (p. 1132). I would add to this that patients speak to us quite directly about ourselves and our effects and the use they are making of us; they are constantly telling us about what we are characteristically doing to them and with them.

Clinical Discussion

The patient I have been describing—sensing, I think, the way in which I have been putting together in my mind things that have to do with him, but also feeling that I have not been quite evenly attentive—has been talking about feeling inexplicably anxious and overwhelmed. He describes the anxiety as his having difficulty staying with one thing for more than a few seconds, and indeed he is flitting anxiously from one topic to the next in the hour.

Eventually, the patient says: "Ellen [his girlfriend] made a sauce for dinner that she was very happy about . . . but things are dark. There's a feeling of being buried inside myself, sunken back behind my eyes, in a fog. I told her about this, and she was okay with it, and we started talking about various things. It was hard to make conversation."

I think he is telling me here that I have put various things together in a sauce in my own mind that I am satisfied with, and I have put it over the top of things, and he is eating it, but at the moment it bears no relation to how he is feeling, which is buried and dark. This is somehow okay with me, which makes him feel lost and anxious.

A few days later, in another context, the patient misquotes the familiar adage about the goose and the gander, saying, "The sauce that's good for the goose is not good for the gander." Food has again

appeared, but this time it is abstract, just words, and there is no mutual pleasure in it. This does not feel to me primarily like the old feeding problem with mother. This is the patient's response to what I am doing with him: making a sauce that I am satisfied with, but having lost touch with him in the process. Is it my writing this paper, I wonder? A moment's reflection tells me that it is, and it is also a way in which my "distance," my own retreat into abstraction, has asserted itself. I begin to think that my use of distance may mirror some of his: we have some character accommodations in common, and he has woven some of me into his conflicts and his defenses, just as I have incorporated some of him.

A second patient, by contrast, also deeply engaged in his analysis, is full of feeling. He is desperate to describe to himself what is happening in the analysis and frustrated by my reserve, always looking for "the way it works." He recently commented that being in analysis is like rebuilding a boat while it is still in the water; you have to do it plank by plank. I asked him how I fit into this, and he said, "You send out signals."

This patient is much more aggressive in his efforts to find out *who I am,* that is, to quantify what Kravis (2006) dubbed "the vertiginous ambiguity of the analyst's personal investment in the analysand" (p. 954). Yet he also realizes, at the same time, that the "signals" I send out *are* who I am, to him. At this point, I have the image of a blind person tapping out the contours of another with a cane made of words, or a bat "seeing" with sonar. This patient senses who I am by impact, and this guides the process of his analysis in thousands of ways, moment by moment and day by day. Near the end of the hour I am describing, he interjects his associations: "But I hate your coolness. You're aloof. I don't know who you are ——you're blonde, you're every undateable girl in high school," and so forth. This is partly transference, but it is also partly me.

Both patients are affected, albeit in very different ways, by a quality of reserve. While I am aware of this as part of my character, I do not think of myself this way most of the time. It could also be that my reserve is an omnipresent counterpoint to a feeling of being intensely present and intensely curious, another layer

of character my patients are also aware of. It may be just these things that patients tell us about, directly and indirectly. But by the time the patient tells us about it, it has already had its effect and will continue to have an effect apart from analysis of transference.

My quality of reserve has a different impact on each patient. The first patient uses it quite actively in a behind-the-scenes way to modify his father's very *un*-reserved impact and to try out his mother's. More recently, he has been questioning the feeling of distance and formality between us, wanting to interrupt me and say, "You don't know what you're talking about. Does anyone know anything, or is my guess as good as yours?"

He is now reacting negatively to this way of mine, as is the second patient in his way, and they want to flesh out their experiences of my character, to "name" something of my idiosyncratic contribution to how they are feeling. Whether what they are after in me is a "good" or a "bad" quality is meaningless. It is part of who I am, part of the "total situation," and it will have an effect on how these patients change in analysis.

CONCLUSION: THE NATURE OF INFLUENCE IN ANALYSIS

"Native style includes all of the therapist's equipment, cognitive and affective. But nothing in native style is so influential as interpersonal appetites" (Friedman 1988, p. 550). Friedman's insistence here on appetites at the core of character brings us back to ideas of influence. Part of our conscious desire as analysts is to help: to influence and to catalyze change. Our interpersonal "appetites" will make certain that we *are* influential, but we will never know exactly how. Perhaps the best we can say at the moment in this regard is that our character is our contribution to the primary process of any analysis —the way we in particular dream undreamt dreams with our patients (Ogden 2007). And as such, character could not be further from our conscious fantasies of influence.

I realize that I have broached a colossally difficult topic here, described by one reader of this paper as "kind of the null hypothe-

sis." I have raised many more questions than can be answered, at least by me, in my efforts to glimpse the *thing itself.* But in doing so, I am trying to satisfy my own curiosity, the questions that will not go away.

In closing, I will return to the author of my opening quotation, Sacha Nacht, who chaired an international panel on psychoanalytic technique in 1958, fifty years ago. (I realize at this point that I have been continually spelling out the number of years during which we have been wrestling with ourselves as analysts *and* as people.) It was Nacht in particular on this panel who grappled with much the same question that I am raising here, in his paper on "The Curative Factors in Psycho-Analysis" (1962). He was impatient with arguing the fine points of technique apart from the analyst, and observed that "what the analyst genuinely and fundamentally is matters more than what he rationally decides to be in regard to his patient" (pp. 207-208). Nacht was concerned—perhaps more than we are today—that this kind of thinking implied an "extreme inter-subjectivity" (p. 210) that ran counter to the scientific spirit and the objectivity necessary to further the project of psychoanalysis. He finally compromised with his own version of the subjectivity/objectivity tension endemic to psychoanalysis in suggesting that real objectivity lies in "admitting the real nature of something" (p. 210).

I am convinced at this point that if we do not admit our characters into our consulting rooms as clinical fact, we will be missing the real nature of psychoanalysis. But, perhaps most importantly, until we approach the salient action of the analyst's character in full, including what is beyond awareness, as a priori fundamental to any analysis, we will not be able to understand in any meaningful way either the therapeutic power or the destructive potential of this impossible profession.

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THE PERSON OF THE ANALYST: INTERPRETING, NOT INTERPRETING, AND COUNTERTRANSFERENCE

BY VINCENZO BONAMINIO

The author focuses on the person of the analyst *and particularly how it helps shape two key factors in psychoanalysis:* clinical narration *and* the analyst's interpretations. *Freud's comments on how treatment is influenced by the analyst's individuality are briefly reviewed; and Winnicott's notion of how the individual analyst relates to the patient—including how he does and does not interpret—is also discussed. Following a detailed description of an analytic treatment, the author discusses various aspects of the analyst's attitude and functioning, including countertransference, and how these are affected by* the person of the analyst.

INTRODUCTION

The purpose of this paper is to present some personal reflections on the notion of *the person of the analyst* in contemporary psychoanalytic thinking, a topic that has long been of interest to me (Bonaminio 1997, 2001, 2003). It is worth specifying that the expression *contemporary psychoanalytic thinking* encompasses such an extend-

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ed number of contributions, of points of view and reflections, that I would appear arrogant if I even thought of the possibility of being totally exhaustive. Rather than conducting a comprehensive review of the contemporary literature, I have more modestly crafted a personal contribution that originates on the other side of the Atlantic, from Europe and specifically from Italy (although, over time, I have given close attention to American psychoanalytic thought on these themes). My references to the literature cannot but be *selected,* and as a result, they are limited to a subset of the many authors who have written on the themes discussed in this paper.

I think we all agree that, at a certain level, the expression *the person of the analyst* refers to the influence of the analyst's personal factors on the psychoanalytic process and its therapeutic or antitherapeutic effect—a factor that was present in Freud's thought from the beginning (as early as 1910, and later, as is well known, in his 1937 paper). Nonetheless, at a deeper level, we may see that this expression actually contains layers of meaning, incorporating the history of psychoanalytic thinking and its impact on technique, and in fact it has an intrinsically dialectical character.

The expression *the person of the analyst* immediately presents us with a question: is there always and inevitably a *person* "behind" the analyst? Is the analyst supposed to be able to limit as much as possible the "infiltration" of personal factors into his analytic attitude and functions with the patient? Or is there a total—and inevitable—overlapping between the *person* and *the analyst*? Or are the two terms so conceptually different, and positioned at such different levels of abstraction and clinical meaning, that it may be misleading even to consider them in the same breath?

These are only a few related questions that touch on a large territory of psychoanalytic thinking. Rather than developing a comprehensive list of subtopics, I have a more limited aim in this paper: I propose to approach this theme along two different lines of thinking that are distinct, yet in my view, are also intertwining. These two lines of thinking are *clinical narration* and *the analyst's interpretations.* To begin with, I will consider each at a descriptive level.

CLINICAL NARRATION

Clinical narration is the only means of communication that we possess as analysts conveying information to other analysts. Every piece of clinical narrative writing reflects the way the analyst has *experienced* the clinical encounter with his analysand. We recall, for example, Freud's well-known clinical account of Katharina in *Studies on Hysteria* (Breuer and Freud 1895):

> In the summer vacation of the year 189* I made an excursion into the Hohen Tauern so that for a while I might forget medicine and more particularly the neuroses. I had almost succeeded in this when one day I turned aside from the main road to climb a mountain which lay somewhat apart and which was renowned for its view and for its well-run refuge hut. I reached the top after a strenuous climb, and, feeling refreshed and rested, was sitting deep in contemplation of the charm of the distant prospect. I was so lost in thought that at first I did not connect it with myself when these words reached my ears: "Are you a doctor, sir?" But the question was addressed to me, and by the rather sulky-looking girl of perhaps eighteen who has served my meal and had been spoken of by the landlady as "Katharina." To judge by her dress and bearing, she could not be a servant, but must no doubt be a daughter or relative of the landlady's. Coming to myself, I replied: Yes, I am a doctor: but how did you know that? [p. 125]

That is how it begins, like a piece of fiction: Freud's writing crystallizes and transforms his personal experience of the moment. Of course, his talent for writing and narration has been unsurpassed in the field. And yet we know that the clinical experience of the relationship between two people talking in a room can be communicated and *transformed* only through narration and writing; Bion (1967b) observed: "I do not regard any narrative purporting to be a report of fact, either of what the patient said or of what the . . . [analyst] said, as worth consideration as 'a factual account' of what happened" (p. 1).

When I write a clinical report, or when I present my clinical work to colleagues (as I will in this paper), I do not intend to speak

about myself, wishing instead to focus on the object of my presentation and to preserve my own privacy, my own personal feelings. I can do this, however, *only up to a certain point.* If I wish to communicate something, then I must inevitably *reveal something about myself:* i.e., about my personal, idiomatic way of encountering the patient, of selecting out some "facts" in the patient's discourse—of "hearing voices" (Smith 2001), so to speak, from inside myself. Our clinical narration *speaks* of ourselves; it reveals us to the other, and through the other reveals us to ourselves.

From this point of view, the situation of talking or writing on a specific clinical subject—in which the author reveals himself to the listener or reader—is not all that different from the situation in which the analyst finds himself while at work. Seated more or less comfortably in an armchair near the analysand, who is stretched out on the couch. The analyst listens to what the patient is talking about at that particular moment, but he also listens to the patient's silences. The analyst finds himself transported to the times and places where his analysand's narration invites him to go, and he meets the analysand's objects. But he also encounters objects of his own, evoked by the analysand's, and at the same time he is listening to his own thoughts, experiencing and mentally recording the emotions stirred within him, allowing himself to be carried away by his own intimate associations as they distance him and distract him from the patient.

THE ANALYST'S INTERPRETATIONS

At a certain point in this process—as part of the "complex and unconscious ways *two people play upon each other's idiom*" (Bollas 1995, pp. 23-24, italics added)—the analyst *decides* to put in a comment, i.e., an interpretation: a comment concerning the patient and sometimes about the patient's relationship with the analyst. "We give the patient," Freud (1910) wrote (and here he appears an *ante litteram* Winnicott[1]), "the conscious anticipatory idea [the idea of what he

[1] Of course, it is Winnicott who is "Freudian" when he states that *the object is created where the other lets it be found* (1951). Interpretation thus has the characteristic of being *object presenting.*

may expect to find] and he then finds the repressed unconscious idea in himself on the basis of its similarity to the anticipatory one" (p. 142). It would be difficult not to consider this statement of Freud's an exceptional one; it is a postmodernist statement, seeming as though it could have been put forth today, and is especially remarkable when one remembers that it was written almost a hundred years ago.

At the very moment that the analyst makes a comment—that he interprets—he is interrupting the continuity of a process taking place in the patient's internal world as the analyst introduces his own viewpoint into the *analytic field*—i.e., that area or setting that is the joint contribution of both analyst and analysand. To put this in Winnicottian terms (1945), it is an area where analyst and analysand *live an experience together.* So interpretation, per se, is always something that separates and is intrinsically a vehicle of otherness.

In my opinion, Winnicott is very clear and convincing about these characteristics of interpretations when he writes:

> It is only in recent years that I have become able *to wait and wait for the natural evolution of the transference* arising from the patient's growing trust in the psychoanalytic technique and setting *and to avoid breaking up* this natural process by making interpretations. It will be noticed that I am talking about *the making of interpretations* and not about *interpretations as such.* [1968b, p. 101, italics added]

This has become one of his most famously paradoxical statements insofar as he subtly distinguishes between the analyst's "making of interpretations" to the patient and "interpretations as such." He goes on to say:

> It appalls me to think *how much deep change I have prevented or delayed* in patients in a certain classification category by *my personal need to interpret.* If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret mainly to let the patient know the limit of my understanding. [pp. 101-102, italics added]

Thus, however empathic the analyst may be while in close contact with the analysand—"identified . . . even *merged in* with the patient" (Winnicott 1960, p. 163, italics added), we may say that at the very moment in which the analyst decides to speak, he creates, through separating himself, an object to talk about.

The analyst wishes to leave the analytic field available to the patient; he wants to focus his attention and comments on the patient. The analyst has no intention of speaking about himself and quite often honors this intention. In any case, it is assumed that he is capable of not occupying the patient's own field, while nevertheless guaranteeing his "contribution to the creating and maintaining of the psycho-analytic situation" (Balint 1950, p. 121).

In this connection, the analyst's *silence* and his *not interpreting* come to the same thing. Here I refer to the technical tradition (which I share) that considers the analyst's tolerance of the patient's regression and the analyst's *not interpreting* as mutative agents for psychic change that are equally as important as, and in dialectical relation with, the act of interpreting itself.[2]

As interpretation is an interference on the part of the other (the analyst) that is potentially mutative for the patient, and since *not interpreting*—i.e., the analyst's silence—may reduce interference with the patient's privacy,[3] the analyst, in not interpreting, places himself in the service of a process that facilitates the patient's search for "a kind of intimacy" with himself.[4] In both interpreting and in not

[2] "The act of interpreting should include also the analyst's reticence—that is, his *not-interpreting* . . . . To put it paradoxically, un-interpretation is the climax only of interpretation. It is not possible to arrive at un-interpretation without interpreting. It is this that is implied by the statement often made that the basic ego-strength and complexity of psychic functioning has to establish itself in the patient before he can arrive at the point where the non-interpretation of the analyst crystallises the experience of being in the patient" (Khan 1969, p. 205, italics in original).

[3] From a technical point of view, the analyst's silence itself, of course, can also be an interference—an impingement on the analysand.

[4] See Balint (1968) on the conception of *the unobtrusive analyst;* see also Bonaminio (1993, 2003) for a further discussion of *not interpreting.* Also relevant are Winnicott's (1958) comments on the capacity to be alone and the role of the

interpreting, the analyst's individuality will emerge. In both cases—which are linked in a dialectical relationship, as noted—the analyst can manage to get in touch with the patient, can meet his suffering, can *reflect back* to the analysand what he has communicated to him, can *share* with the analysand in finding "a satisfactory definition of his true self" (Winnicott 1959, p. 50). In other words, the analyst can be for the patient the *other* who will allow him to *rediscover* himself, but only if he, the analyst, is himself, if he claims, as it were, his own boundaries and his own individuality.

We must keep in mind the *analyst's individuality,* which was so radically defined by Winnicott (1962) as follows: "In doing psychoanalysis, I aim at: keeping alive, keeping well, and keeping awake. I aim at being myself and behaving myself" (p. 166). Like this definition, Bion's (1967a) recommendation for the *suspension of memory and desire* on the part of the analyst is anything but "technical." With these comments, neither Winnicott nor Bion is describing a technical strategy, but rather *a position of the analyst in the consulting room,* in the here and now of the session—ways that the analyst may *be-himself* in order to *be-with-the-patient.*

So, in spite of his intentions and his discipline in not invading the patient's own field, whenever the analyst decides either to give an interpretation or else to remain silent, he inevitably lets *something of himself, something personal, something of his individuality* override these limits. Thus, he reduces the distance and the separation that he has deliberately created in order to communicate, and in doing so, he inevitably reveals something of himself to the patient.

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analyst in facilitating this capacity. In addition, see Winnicott's (1941) discussion of a *period of hesitation* (presented in relation to the spatula game)—a period that allows the child (and, metaphorically, the analysand) to recognize the reality of his desire, to the extent to which a sort of suspension is created: a *not-interference* on the part of the other. In the same Winnicottian tradition of technical thinking, Bollas (1995, 2007), Giannakoulas (2003), and Parsons (2000) have emphasized the analyst's trust of the unconscious process between himself and the patient, as well as the evolution of the analyst's identity.

CLINICAL VIGNETTE

Background

I have two goals in presenting the clinical material that follows. Keeping in mind that every clinical narrative reflects the way the analyst experienced the clinical encounter with the patient described, as previously discussed, my first goal is to demonstrate that my clinical narrative *speaks also of me*—even though my attention is focused, more or less successfully, on the patient's material. This may appear to be an obvious statement, but at the same time, it is, in my view, worthy of our consideration, particularly as it relates to the theme of the analyst's subjectivity versus his objectivity (see, for example, Busch 2003; Gabbard 1997; Renik 1998, 2006; Smith 2000).

My second goal in presenting this material relates to what is commonly called *self-disclosure* and its impact on analytic technique, as this theme is part of the larger topic of *the person of the analyst*. I will discuss the ways in which this clinical material illustrates the effects of self-disclosure on technique after presenting the material itself.

The analysand whom I will call Giovanni was a 29-year-old waiter who was employed in a fine Roman restaurant, but was unhappy with his job because he had completed training for a higher position, that of a *demi-maître,* at a school for hotel and restaurant management. He had sought psychoanalytic treatment following a psychiatrist's referral because of his persistent symptomatic impotence, characterized by premature ejaculation, which regularly cut off even his rather feeble erections during the preliminaries of sexual intercourse.

During my initial assessment interview with Giovanni, although I did not overlook his narcissistic-defensive personality organization—characterized by his sense of feeling isolated and not understood, both within his family and outside it, as well as by feelings of contempt and suspicion—I perhaps did not fully appreciate at the time the extent of the impact that this personality organization would have on the psychoanalytic relationship and, in particular, on the very texture of the dialogue between us. For a long time during

the first two years of analysis, I found myself focusing internally on the positive aspects, so to speak, of his decision to move to Rome permanently, which required him to confront more than a few adaptive difficulties—a decision that I thought of as signaling the patient's level of investment in his therapy. The move thus seemed to me an index of his willingness to collaborate and of the therapeutic alliance that would later be recognized as incorporating a fundamental level of trust that could sustain the analytic work —work that, for a long period of time, felt "tiresome" to him because of his vulnerabilities and his stubborn narcissism.

There is another significant element in the therapeutic alliance that must be emphasized here, one that had clandestinely sustained the patient in the analytic work, and that at the beginning guaranteed that the work would go forward. This was the idealization that Giovanni reserved for the psychiatrist who had referred him to me, which I could initially take advantage of as part of the continuity of his treatment—and which was later counterbalanced in the clinical relationship by his devaluation and criticism of me, as I began to feel myself becoming the object of these by means of the patient's splitting processes. This idealization, in fact, testified to the existence and persistence in the patient of "good aspects" of the tie with his internal father (though these were confined to a split and dissociated area), which he was capable of valuing and preserving. As would be evident later in the course of the analysis, these good and trusting areas were tied to the relationship that Giovanni had enjoyed as a child with his maternal grandfather, and more recently with a paternal uncle—a bachelor who lived with the family. His maternal grandfather, too, appeared as an object who was valued and idealized by Giovanni's mother; and that became significant in the course of the analysis in that it concerned the good and organized aspects of his relationship with his mother, allowing him, furthermore, to internalize a good relationship between a woman and a masculine object.

I think it is important to emphasize here that it was necessary to reach a certain point in the analysis, as mentioned, before I was capable of distinguishing and locating the existence of such "good"

masculine objects in the patient's internal world. Retrospectively, I can say that the earlier, limited recognition on my part may have been fundamentally attributable to the above-mentioned "disturbance" in my usual capacity to resonate that I felt initially came from this patient. But, more particularly, I think it was attributable to the fact that in Giovanni's initial narrations, the high esteem reserved for these significant persons in his life—his maternal grandfather and especially his paternal uncle, more meaningful because he was real to the patient—had been in effect camouflaged to my eyes, so subtle and clandestine was the level of positive transference toward me that nevertheless sustained the analysis. In fact, initially, the patient had made nothing more than passing references to these positive masculine characters, while all the rest of what he talked about, abundantly narrated and described, seemed inundated with scorn and criticism.

Excerpts from Our Sessions

In a session in the second half of the second year of analysis, a Monday, Giovanni enters and, after settling himself on the couch, disconsolately pronounces, "What shit, it is all shit," and goes on to recount the "usual disaster" with his family, whom he has just visited over the weekend.

When Giovanni says "shit" for the first time, I automatically think to myself, given the themes of many previous sessions, that "it is he who thinks of himself as shit," he who is rundown and demoralized. I say this to him, exactly in these terms—and too precipitously—but Giovanni is capable of correcting me, the sign of our having reached, at this point in the analysis, a *shared language,* a common ground. Actually, I was thinking at the time of an umpteenth sexual failure of Giovanni's, and I made an interpretation that is an example of interpretive *enactment* in my desire to quickly support him with my "primary paternal concern."

"It's not what you think," the patient continues in a collaborative way, but he goes in another direction, his and not mine—not the one, that is, that I "wanted to impose on him." In reality, Gio-

vanni is referring to his father, and for a few minutes there is a sort of disconnect between my internal sensation, a misleading one, and the patient's discourse. At this point, there are two divergent lines of thought going on in the analytic couple that retrospectively permit us to get a sense of how an aspect of *the person of the analyst* can interfere with the patient's discourse: that is, due to my prejudgment of the situation, my thoughts are following a particular line, while Giovanni at that moment is following another line. Such an event is not always necessarily a negative interference, but it is evidence, I think, of how imperceptibly the analyst's listening may be "disturbed"—influenced, that is, and directed by his expectations, his conflicts, and/or his concerns in regard to the patient.

At first, it was not easy for me to see that this was the cause of my sense of disconnection, of something coming apart in the analytic couple. In this session with Giovanni, I find that I have to work hard internally in order to put myself back into line with him and to once again be capable of listening.

Giovanni says that his father "is really a turd, there's no help for it . . . . He's a turd." He reports having proposed to his father that now is the time they should at last begin remodeling their family residence outside the city, at least partially—all the more so because the part where his room is located is practically empty since he has moved to Rome. The building is a sort of medieval mansion in which the family has always lived—making use of only a small part of it, however, which many years ago was transformed into an apartment, while most of the rest of the building is given over to storage areas or garages.

Giovanni continues, "If he, Papà—no, I mean the turd—would only decide to open up his wallet, I could begin to think about getting the remodeling going so that it would be finished when I return there to live. If I ever *do* return," he adds, disconsolate and angry. "Do you know what he said when I proposed this to him? He said that, as usual, I'm being a ball-buster—that I arrive with my big ideas, my delusions of grandeur. Me, a ball-buster? Well, he's a turd, really a turd."

I tell Giovanni that "there seems to be an area of opposition with your father"; between a "turd" and a "ball-buster," it does not appear that there could be any possibility of negotiation, of understanding. "Certainly," I add, "you are very disappointed and angry in feeling yourself treated this way by your father, but in the end, to consider him 'inevitably a turd' means that you, too, feel like a turd, given that you are his son."

Giovanni's narration continues almost uninterrupted, as though he puts aside what I have just said and wants instead to reaffirm his point of view, to make me understand it, to have my agreement. His father is described yet again, as he repeatedly has been in previous sessions, as a "colorless, flat, opaque person—dull, continually ready to criticize in a hidden way, but never openly." "He's missing the gift of words," Giovanni continues. "The most he does is grumble, and no one can understand what he says, what he thinks —they can't even establish contact with him."

The patient goes on to say that his father is always "closed" and "withdrawn" into his "ugly little workshop," where he makes handcrafted products to order for his clients. He is incapable of making significant decisions; thus, he has always been incapable—due to his "passivity" and "fear"—of adequately supporting the family, according to Giovanni.

I tell him, "Maybe you feel *me* to be closed and withdrawn also, into my ugly little workshop of analysis—as happened today at the beginning of the session when you didn't feel understood, and indeed even *mis*understood. You felt that I was not in contact."

"Yes, this is true; at the beginning you pissed me off," Giovanni replies, "and I thought, 'But he hasn't understood anything, this t-. . .' But at least you don't lack the gift of words, in fact you talk . . . too much . . . . I mean that I'm not really used to all this dialogue; we are rather closed as a family—few words and many deeds, you might say. My father uses few words, but he also does few deeds."

Giovanni is silent and thoughtful for a time after making these remarks. I tell him that maybe he is thinking that to keep himself enclosed, holed up and silent, uncommunicative, is a characteristic that he shares with other members of his family. Maybe he feels

that he, too, is like this, and instead he would like to be more communicative, more capable of expressing his feelings. And this is why he feels furious with his father—perhaps because his father is reflected a little in the patient himself, just as he is reflected some in me when I don't understand, when I don't immediately follow what he means to tell me, or how or when, as happened today when I invaded his field with my points of view.

The Analytic Process

In this period of the analysis, various masculine characters appeared who were analogously criticized and devalued, persons who gradually made their entrance into the narrations, as Giovanni—by now having definitively moved to Rome—continually changed jobs, passing from one restaurant to another; here the manager was an "exploiter," there "too bossy," there he was "an incompetent guy," or his co-workers "were not professional," "second-rate," or "had the brains of chickens."

My interpretations in this first phase of the analysis were aimed at relating the patient's scorn for his father and other masculine figures (and in the transference as well) with the experience of mortification and shame over his impotence—that is, for his sense of lacking an "internal penis," of being continually attacked and ruined by his own scorn. I soon realized, however, that these interpretations were basically ineffective. They were ineffective not so much because direct confrontation with themes of impotence (continually evoked by the patient) made him feel "distanced" from me, as I had at first believed. In fact, one might say that Giovanni's baseline attitude was already so scornfully distant, at least if one judged by what was most evident in the analysis, that only with difficulty could he have felt himself placed at a greater distance. On the contrary, I believe that this type of interpretation, as much as it was devalued and refuted by the patient, may have caused him to sense—as he was later able to tell me—a sort of courage and "daring" on my part, which for him was not at all something to be rejected.

The sense of shared meaningfulness in our dialogue—which had seemed to be in place since the beginning of the treatment, in an "ordinary" and apparently satisfying way (as I have tried to show up to this point)—progressively led me to feel, during the third year of analysis, that my interpretations, which earlier had seemed to succeed in linking various aspects of the analysand's narrations, in fact had had little impact. I became aware that Giovanni had taken in my words as "meaningless"—and, in like fashion, they were returned to me as meaningless. I began to realize (through "listening to listening," as Faimberg [1992] would put it) that my interpretive contribution, however "formally correct" and adequate, had in reality turned out to be quite "colorless" (a characteristic that the analysand had frequently assigned to his father) and therefore fundamentally "impersonal."

For example, I commented several times to Giovanni that he was again finding himself in a job where he was confronted by negative characters whom he could not respect; these comments had the effect of presenting him with an image of himself that he could not respect either, even though he protected himself by remaining on a level of apparent superiority ("others don't understand anything," "if I were in the place of that turd of a maitre d' I would know how to make the restaurant function well," etc.). My comments about this came back to me "reconfigured," perhaps after two or three sessions, in a mirrorlike way, anticipatory of my response: "As you would say, again this time, I find myself confronted by someone who isn't worth anything," Giovanni would begin. "But the director of the restaurant where I've begun to work temporarily really is a ball-buster—he doesn't understand anything, he really doesn't grasp it, he can't do it . . . ."

It seemed to me that in this way, Giovanni, acting defensively, actively took the meaning out of my words, stripped them of sense, and made me listen to them repeated back without logic. His "answers" to what I said—whether they took the form of silence, disorientation, dismissiveness of my comments relative to his need to keep me out (as in his eyes, I had already begun to cling to my point of view even before I could express it)—sounded just as "impersonal" to me and were progressively stripped of their meaning.

Only later was I able to realize, to comprehend, that this sense of impersonality and of an absence of meaning in our communication was the shadow on the analytic relationship of the incomprehensibility of those emotions that give sense to words. This incomprehensibility was a *reactualization*, a reproduction in toto in the transference—on a subtly "molecular" level, I would say—of a primary relationship with an other who "knew nothing" about emotions, who was quite incapable of naming them. For Giovanni, these emotions were oppressive, invasive ones, but also unnameable and therefore unrecognizable. The *maternal world*, like the world of femininity—into which he was afraid of being swallowed up—was not "ordered" and "structured" by the discourse of the father.

When I realized that this "incomprehensibility" was a structuring factor in the analysis for both of us, as revealed by continual misunderstandings between us—that is, when I realized that my interpretations were perceived as meaningless and fed back to me as such—I began to understand that my interpretive contribution was "too much" for the patient, even though my intentions were, so to speak, good ones. They were, however, a sort of continuing "interpretive acting out" on my part, aimed at a*void*ing the *void*, the lack of meaning, the impersonality that infused our relationship. I thereupon began to reduce my verbal interpretive contribution in order to "clear the field" and provide Giovanni with more space.

For example, the patient recounted that he had enthusiastically started to work as a bartender at a stylish cocktail bar because it was a prestigious place frequented by many VIPs of the "*dolce vita romana*." However, the new manager there had revealed himself to be "incompetent," "a good-for-nothing," Giovanni said, and at this I remained silent for some time. I wanted to give him the opportunity to describe the details of this, those most pertinent and specific, the most emotionally explanatory ones—and even, in addition, I explicitly asked him for more specifics: "Could you help me better understand what you intend to say, what you are really referring to when you say that the director of the *** Cocktail Bar is someone who doesn't know 'how to crucify two words'? What does that mean?"

Giovanni at first seemed to be a little taken aback and disoriented by my listening silences, or perhaps by my requests for more explanation; he began progressively to enter into a state of withdrawal, of apparently pensive silence. Then a new phenomenon presented itself in the communications between us.

The Interpretation and Meaning of Words in Analysis

My countertransference during our third year of analysis involved my "learning" to tolerate the invasion of various quirky "mental products" in the analysis, often tortuous and affected ones, that appeared to stem from the patient's internal disorientation. These phenomena left me with the impression of a certain precariousness of his mental boundaries, and there were times when I was tempted to intervene in order to "shore him up," but I resisted doing so. Pieces of his unarticulated thinking and wording were put out on the table, so to speak—which, on the one hand, tempted me to give them a meaning and return them to the analysand, but on the other hand, these unarticulated pieces caused me to feel a transient sense of anxiety because I felt responsible for letting him go on randomly without making sense. For example, in one session, he said: "I'm thinking about a rooster with colored feathers, I don't know why . . . . A memory of some writing just occurred to me, from an advertisement in the subway: 'Courses offered in computer skills, typing, and word processing—authorized by the Region of Lazio.'"

Or, again, in another session, after a long silence, he launched into the following chain of associations: "Silvia comes to mind, that waitress at the hotel last year. The one whose pants I couldn't get into—as usual. Silvia, Leopardi, Leo, lion, lone, alone, solo, trumpet [Giovanni dabbles as a performer of both the piano and the trumpet], to fuck—maybe! Sorceress, Circe, one would need a spell, pigs, the *Aeneid,* the Latin teacher in high school . . ."[5]

[5] Here the patient was indulging in a very specific series of linguistic and symbolic associations—words strung together by their assonance and double meanings—that highlighted the sexual register and the patient's preoccupation

Giovanni continued his monologue, now launching into a tirade against me: "You don't tell me anything—*nothing comes to your mind to tell me or to explain to me??* In my opinion, you don't understand me, and indeed you *can't* stand me at this point, and *do you even know what I'm telling you?* It is *I* who really cannot stand *you* with your arrogant silence, and with all this crap that you tell me every now and then. I could jerk myself off with what you tell me, and also with what you *don't* tell me but you think it inside yourself. But mostly *I don't care anything about what you think or say!*"

Despite my being strongly tempted to "reorder" or to explicate the *logic of the sequence* (Bollas 2007) (which in fact I was able to follow or to intuit, or at times to "invent" after reflecting on Giovanni's bizarre words), or even to interpret his intense apathy toward me—simply recognizing it, admitting to it—I nevertheless succeeded in remaining silent, deliberately silent, and in reducing my comments to a minimal level. For example, I said: "It seems that you delight in chaining together words for their sound, like in a game. Maybe you would like me to participate in this with you, to be like a schoolmate for you to compete with, and maybe to beat —as I produce my own sounds in spite of the Latin professor, whom you've said you thought of as inconsistent, which is a little

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with sexual themes. From the name of the woman he had dated, Silvia, he associated to the poet Giacomo Leopardi (1798-1837), whose famous poem "A Silvia" describes the poet's unrequited love and fascination for a highly idealized, attractive but sexually unattainable woman. From *Leopardi,* Giovanni moved to the Italian word for lion, *"leone."* He then dropped two syllables and easily reached the English word *lone,* then to the Italian word for *alone,* "*solo,*" followed by the Italian word for *solo,* as in a musical solo: "*assolo.*" "*Tromba,*" meaning *trumpet,* also has the vulgar connotation of *to fuck,* so that his following this with the Italian word "*magari,*" *maybe,* conveyed his interest in the possibility that *maybe he could fuck.* By subtracting two letters from "*magari,*" he arrived at "*maga,*" or *sorceress,* and "Circe," the sorceress of Ancient Magna Grecia in Southern Italy, who forced men to fulfill her sexual desires; hence Giovanni's comment that "one would need a spell" (to succeed in having a sexual relationship). His progressing from there to *pigs* referred both to Circe's habit of turning men into pigs, and the animal's Italian connotation as symbolic of a hearty sexual appetite. Thinking of Circe then made Giovanni think of Virgil's *The Aeneid,* typically studied in Italian high schools, and of his former Latin teacher.

like the analysis that you perceive as menacing, controlling, and intrusive."

I believe that it was my perseverance in maintaining a relatively silent stance that allowed me to see "beyond the mucus" (which sounds strange, but this was the image that came to my mind in relation to Giovanni's loose verbal productions), and then to understand that Giovanni's comments made sense to him—while they also reflected his search to find me.

Of course, in considering my increased interpretive distance from the patient's "meaningless" verbal productions, I must recognize that there was also something for me to gain by this: an expanded inner space in which to feel and "to hear from." But an unintended result of my choice to remain mostly silent was that I was unable to stem feelings of boredom, futility, and impotence as the patient leaped from one silly, pretentious image to another. Eventually, however, I found that as I focused less on the details of his material, his nonsense—which indeed it was—began to acquire a sense of its own. Therefore, from my point of view as well, the expansion of inner space resulted in my ability to make sense of the situation—and also reflected my search to find the patient.

Use of a Countertransference Dream

My first flash of insight into the configuration I am describing came from a countertransference dream that helped me change my emotional attitude toward the patient. The dream occurred at the end of the third year of analysis, and, significantly, during a long separation from the analysand due to a vacation of mine. I felt that the dream unexpectedly allowed a new, "pure" image of Giovanni to emerge, a sort of non-analytically biased one that came from inside myself. In analyzing this dream of mine, I felt first as though I had been "invaded" by Giovanni's presence—by the patient whom I had "forgotten" during the period of separation. The associations that followed had to do with a sense of distance, coldness, and alienation—of not feeling in touch with myself. I then associated the dream image of Giovanni to a part of me relative to the patient, to

a coldness and distance in myself; indeed, the image of the patient seemed to represent an attitude of mine, of my person, that I did not want to recognize but that had to be acknowledged in order for the analysis to proceed.

I am touching on something here that is related to what Winnicott is referring to when he states that the patient *has the right to get in touch with the real objective feeling of the analyst toward him.* He writes: "I wish to suggest that the patient can only appreciate in the analyst what he himself is capable of feeling" (1947, p. 195), and he continues, "If the analyst is going to have crude feeling imputed to him, he is best forewarned and so forearmed, for he must tolerate to be placed in that position. Above all, he must not deny hate that really exists in himself" (1947, p. 196). Here I would make an addendum: "The analyst must not deny hate that really exists in himself *as a person.*"

Here the totality and relevance of *the person of the analyst* are put out onto the table, clinically and radically, without infringements and without apology. We see this again when Winnicott writes: "Recently, for a period of a few days, I found I was doing bad work. I made mistakes toward each one of my patients. *The difficulty was in myself* . . . . The difficulty cleared up when I had what sometimes is called a 'healing dream'" (1947, p. 197, italics added).

Of course, other psychoanalytic authors have treated analogous themes and made similar clinical observations. However, the way that Winnicott puts these things out on the table seems to me particularly *subjectively* meaningful and clinically useful; rarely are such themes put forward so courageously in the analytic literature.

Now that I have given some associations about my "healing" dream and contextualized it, let us look at the dream itself. In the dream, I saw myself clambering up the snow-covered slopes of a mountain. I was breathing hard as the cold became more and more biting. I felt lost and despairing in a desolate, boundless landscape; I was standing on the peak of Mount Everest. There, in a kind of niche in the ice, I clearly made out the shape of a man covered by sleet. It was something like a *mirror image* on the ice

surface. My first impulse was to draw back in fear. Then I saw the man's head emerging from the snow—and I perceived that the face was Giovanni's. Excitedly, I started to blow the snowflakes away from him, but the feeble warmth of my breath was immediately dispersed into the freezing air. I then began rubbing his body with my hands, taking care not to rub too hard so as not to "crack" his frozen skin. His eyes slowly opened and his glassy stare became more conscious, more intense. At last I felt confident that Giovanni could be "unfrozen."

In my internal perception of the analysis with this patient, the dream became a turning point in the treatment; I felt healed from the illness that I had contracted in the analytic process due to my defense against Giovanni (Bollas 1987). The dream became for me the source of meaningful images that I could begin to propose to the patient. I started to "draw off" pieces from the dream (although of course I did not reveal the dream to him) in order to describe to the patient what seemed to me to be happening in the sessions, both with reference to our relationship and to his narrations about his external object relations.

In the third session after I had the dream, Giovanni tentatively described a sense of feeling apart from everything, including the analysis. The gist of my comment to him at this point was that I felt him to be at a very great distance—as though he were "on top of Mount Everest." He replied after a bit, "This makes some sense to me. Maybe not on Mount Everest, but at North Cape—while you are down here, basking in the sunshine of Rome, happy and content." With these words, Giovanni was able to express his feeling of envy toward me for what he felt to be my good relationship with my wife and my capacity to have a satisfying sexual life.

Approximately one month later, feeling depressed about his recurrent lack of sexual success with another girl he had dated, for the first time, instead of criticizing both the girl and himself, Giovanni recognized that he had felt "frozen" while he was with her. I replied that it seemed he felt "closed, trapped into a fridge," referring here to the dream image of the niche in the ice. I added that "it seems someone should have come to release you from that uncomfortable position." He replied that he was wondering wheth-

er the analyst had ever felt, really, what it was like to feel sexually inept and unsuccessful with a girl who was warm and appetizing—as though he were unable to "break the glass" and embrace her, or even to touch her.

In a session approximately two weeks later, I found myself sounding a bit harsh in wording a comment to Giovanni: "As usual," I began, "you have found that your family is insensitive toward you, and that even I do not understand you properly." Both *usual* and *even* were words that hurt the analysand because they were perceived as dismissive and aggressive (which they actually were, as I realized soon after). Two sessions later, when his discourse had suddenly become impoverished and he was rather withdrawn, I was able to interpret that he had perceived my words as "without warmth," as "like an icy breath," and similar to his father's criticisms of him, which were so sharp that "they could crack his skin."

It was at this point that the first *phonemes* of a new common language began to surface in the analysis. I noticed and recorded that the patient—who had evidently felt that my suggested images made sense to him—began to use similar images to describe things that bordered on emotions, or at least sensations. This, of course, occurred sporadically, over quite a long period of time—months, in fact—without the patient explicitly "letting on." It was during this period that the "mucus" in the analysis (an image of mine mentioned earlier) started to thin out and give way to more coherent communication and narrations about specific events that came up in the analytic relationship, and here Giovanni began to reveal a keen sensitivity.

For instance, a slight adjustment in the cost of his sessions, which I suggested well ahead of time, toward the end of his fourth year of analysis, aroused a deep resentment against me, expressed by his return to a state of withdrawal. He accused me of having left him "dumbfounded," "boiling with rage"—expressions that referred to sensations and feelings that were certainly no longer incomprehensible. At this point, Giovanni accepted and agreed with my interpretation of his having perceived me as like a boyhood friend of his, Giuseppe, whom he had told me about in the early stages of the analysis; at that time, Giovanni had brought me a

"memory" of having been "betrayed" by Giuseppe when the other boy suddenly asked him to pay up money won at *battimuro*.[6] This disruption of trust in the close friendship between Giovanni and Giuseppe—which, significantly, was "re-presented" in toto in the transference-countertransference—produced in the patient a deep sense of anger, resentment, and disappointment, as well as a sense of expulsion and exclusion, thereby organizing his narcissistic defenses. But, even more significantly, all these emotions could now be identified and thought about within an ongoing relationship.

THE ANALYST'S PARTICIPATION, INTERPRETING FUNCTION, AND RECONSTRUCTION

Which kind of participation by the analyst is conveyed by my comments to this patient, my interpretations to him? From a technical point of view, my clinical presentation aims to show that the analyst does not need to take anything other than a "standard" approach in order to successfully follow the many paths—both representational and nonrepresentational—that the patient takes off on in order to make the analyst understand where he is and how he feels.

For some time now, we have been aware that the field of the psychoanalytic encounter—and, in particular, the analyst's contribution to the creation and maintenance of the analytic situation (Balint 1950)—is wider than was at first thought. Our "standard," shared technique may encompass this larger field without significant variations, apart from how we meet the patient's regression and the most primitive level of his communication.

In the case of Giovanni, I think I "represented" for my patient, through my dream—which was mine and not the projection onto me of his feelings—what was not yet representable for him. It is in this sense, by the way, that I understand Heimann's (1950) statement

[6] This is an Italian gambling game that shares historical roots with the nineteenth-century English games "shove ha'penny" and "shovel-board" and with the modern game of shuffleboard. Giovanni and Giuseppe had played the game as a team against other boys, frequently beating them; but one day, when the two of them played against each other as an exercise, Giuseppe bested Giovanni and unexpectedly asked him to pay, causing Giovanni to feel excluded and betrayed.

that "counter-transference . . . is the patient's *creation*" (p. 83, italics in original). Through my interpretations to the patient, I think I reflected back to him what he had communicated (not projected) to me via the means at his disposal (bizarre associations, withdrawal, etc.). In reflecting back to him what he had communicated, I inevitably gave him something of mine, i.e., my personal, idiomatic way of representing him. This is what I consider a relational dimension of the analytic encounter, and it is in this sense that the inevitable revelation of *the person of the analyst* is implied.

I am not speaking here specifically of self-disclosure, a topic that many American colleagues have been debating in recent years, sometimes in particularly interesting ways—especially, it seems to me, in regard to the variety of clinical situations that are being reexamined against the backdrop of so-called classical technique (cf. Jacobs 1999). But, to my way of thinking, there is sometimes too great an emphasis on the *participation of the analyst* in the analytic process and on his subjectivity—factors that may seem to us, on the other side of the Atlantic, both self-evident and long established within the framework of object relations theory.

Why introduce the concept of the analyst's subjectivity when we already have the deeply entrenched concept of *countertransference?* (See Manfredi Turillazzi and Ponsi [1999] for a detailed discussion of this concept.) I will return to the subject of countertransference later in this paper and discuss it from another point of view.

Because of the enthusiastic neo-accentuation of the analyst's participation in the analytic field, some currents of contemporary American analysis appear to me to be in danger of falling prey to an excessive co-constructivist and intersubjectivist drift. The intersubjective approach—and with it references to the analysand's and the analyst's subjectivities—can thus become the privileged observational vertex that engulfs everything happening in the analytic situation. In my view, such overemphases may result in an invasion of the patient's own field in the service of establishing a parity between the two subjects, analyst and analysand. If too much personal space is taken away from the analysand, then enactment—i.e., action in the analysis, be it psychic or behavioral—becomes the only

chance the subjects have of getting to know what is really happening in the analytic situation (Green 1997).

According to Green (1997), in the intersubjective approach (in its specific meaning, i.e., as a model for the analytic relationship), this priority granted to enactment—which "dethrones" representation because it becomes subsumed in action—is influenced or guided by the neo-Kleinian concept of the ubiquitous nature of projective identification, as well as the concept of the analysand's tendency to "force the analyst's mind to do something." In approaching this from a different direction than the one from which Green's criticism stems, I will state that, in my view, the intersubjective and neo-Kleinian approaches, as well as extremist theories of the analysis as a bipersonal field, may appear to proceed hand in hand because of their common widespread insistence upon the relational here and now as the one and only place in which to consider the events of the session.

Busch (2001) expresses a similar opinion, noting the presence of a

> . . . view that analysts cannot know their own minds, let alone the mind of another. It is evidenced in the lack of interest amongst some analysts in the individual mind of the analysand, except in interaction with the analyst. We see it in the belief that analysis is primarily a co-creation of two minds, both in the clinical moment and as the agent of the change process. [pp. 739-740]

The recent brilliant observations by Friedman (2008)—who ironically asks, "Is there life after enactment?"—do not conflict with the above-mentioned, tradition-preserving position expressed by Green, in my view, but represent a way of viewing the same problem from another, more empirical point of view, which takes into account much of the debate that has occurred around this topic. In a way that I find particularly congruent with my arguments, Friedman writes:

> Having recognized their own libidinal involvement with patients, analysts could not refuse to confess their many

> subtle collusions. [My clinical presentation of Giovanni aims exactly at this: to show the presence of the *person of the analyst* as he is involved with the patient.] And having gone that far, they were bound to wonder whether enactments aren't, in fact, omnipresent . . . whether, in fact, analytic treatment isn't altogether a continuous game of catch-up . . . . But if enactment is part of the very fabric of analysis and not just an occasional snag, the question logically arises, What would *not* be an enactment? Why use the word at all? What was the error we would have fallen into without the term? [p. 436, italics in original]

In fact, I have posed the same questions in regard to what I feel has sometimes been the too-enthusiastic and uncritical substitution of the word *subjectivity* for the concept of *countertransference,* as though there is a belief that the former sounds more modern and philosophically driven. I agree that *countertransference* is not a felicitous term in the sense that the prefix *counter* seems to imply opposition between analyst and analysand, but at the same time, I do not think we need be overly literal in choosing to maintain components of our psychoanalytic lexicon that have served us well for some time. *Countertransference,* after all, contains within it layers of technical and conceptual reflection, so that the bad prefix is blurred by the many other meanings acquired by the term over the years.

Friedman's astute observations proceed as follows: "If recognizing our enactment means realizing that we have been laboring under an illusion, what was the illusion that fooled us? Given the contemporary climate, the handiest answer might be this: 'Not-an-enactment is both parties doing their proper work'" (2008, p. 436).

In a related way, the constant de-emphasis on the reconstructive aspects of analytic work in favor of careful and detailed attention to the phenomenology of what takes place in the session between analyst and patient—on understanding the here and now of the session as a projection or actualization of the patient's internal world—not only seems to devalue the importance of the patient's history, but also implies a particular view of the transference that

risks giving short shrift to the role of *Nachträglichkeit.* This important concept, also called *après-coup,* denotes Freud's articulated conception of temporality (unfortunately inadequately translated into English by Strachey as *deferred action*). It implies a movement from past to future in which something is "deposited" in the individual and is reactivated only later on (cf. Birksted-Breen 2003).

Relevant to my discussion here of *Nachträglichkeit* is a comparison of the analytic situation to the patient's repetition of internalized object relations. The *new* scene, the *new* object *created by the analytic relationship,* encompasses even the most intense repetitions of historically internalized object relations, but is, at the same time, hierarchically superimposed on them. This new scene becomes the place from which one can observe repetition, and it is the place where the analyst becomes the target of the patient's projective identifications (if we choose to use this terminology), so that the analyst is forced to enact the role assigned to him by the patient. It is the place where the analytic work occurs—a place created by the two parties, by their mutual communication, but that cannot be considered simply to overlap the repetition of internalized object relations because it is the prerequisite for these to be actualized and then analyzed.

In other words, once the patient "projects" and the analyst recognizes through his countertransference the role the patient is forcing upon him, in *what place* does this revelation occur except in the new, constantly changing object relationship to which both parties contribute and which they both create? And how does the analyst perform his analytic function *as a person relating to the analysand?* That is, how does he contribute to this relationship by meeting the patient precisely in that place, contributing his personal qualities to the object relationship—the object relationship that, once internalized, comes to life inside the patient and is brought out in the transference? Only by articulating the situation with these broader questions am I able to agree with the notion of the transference as a *total situation* (Joseph 1985).

A new realism, a new reification in postmodern guise, has appeared on the psychoanalytic conceptual scene following the demise of the justly denounced reification of the drive and structural model, and of its supposedly solipsistic structure that was attributed *tout court* to ego psychology. The inescapable relationship and the concept of intersubjectivity were summoned to emphasize—and rightly so—the reciprocal contributions, mutual influence, and interchange between the two partners in co-determining meaning. The intersubjective relationship was also called upon to highlight the constructivist dimension of reality, including psychic reality, and hence its relevance obviously depends on the relational context. Thus, intersubjectivity itself seems to escape the dimension of the relativity it claims, at least on those occasions when it is considered out of context, as a thing in itself; in fact, in the hands of its most radical upholders, it risks becoming a sort of *basic absolute reality*—at once indivisible, a prerequisite, and a prime mover.

I do not intend to discuss self-disclosure, as mentioned earlier, when I state that, whenever the analyst decides to introduce an interpretation or to remain silent, he inevitably admits something of himself into the analysis, and this something is revealed to the patient. But if I am not referring to self-disclosure, what revelation do I mean? What I have in mind is the unpredictable and inevitable *presentation of the unconscious* in the intersubjective communication—the emergence of it from within us, which Freud described in many ways and on many occasions, starting with "Jokes and Their Relation to the Unconscious" (1905). I refer here to the unconscious communication between people that lies at the base of analytic work: a communication *from one unconscious to another unconscious* within the analytic setting. To this communication, the "listening system" (which analysis essentially is—i.e., the patient's free associations and the analyst's evenly hovering attentiveness) is applied, and this system offers an opportunity for such communication to emerge into consciousness and thus provides the means for its realization.

Here we are faced with the paradox of how an "intrapsychic" model—i.e., the dream—can function in the service of an essentially "intersubjective" experience—i.e., the analysis (cf. Phillips 1989). The analyst's role in this paradoxical arrangement is to provide an environment for creating the dream space. Bollas (1995) described this oscillation from the *intrapsychic* to the *intersubjective* as a sort of *countertransference dreaming*. Ferro (1996, 2002), in an original and personal elaboration of Bion's thought, investigates the concept of dreaming activity during the waking states of both analysand and analyst.

The concept of *the analyst as a person*, or *the person of the analyst,* should be made an integral part of an approach that emphasizes the presentation of the unconscious in intersubjective communication. Such a concept is by no means a "new" fact to be taken into consideration; it has roots in the very origins of psychoanalysis and is part of its clinical and theoretical statute. In short, it is quite simply a fact to be taken for granted, but one that implies establishing a different focus as soon as we begin to discuss it directly. Of course, this change of focus—i.e., explicitly considering the participation of the analyst in the creation, maintenance, and development of the analytic process—marks a pivotal point in the evolution of analytic technique, just as changing conceptions of exactly what its therapeutic factors are become markers of other evolutionary developments in the field.

What I am emphasizing is the continuity in analysis of an awareness—stemming from the discipline's origins—of the analyst's influence as a person in the analytic process. In contemporary analytic literature, this nontraditional focus is generally listed under the register of a *paradigm shift*—a somewhat pompous epistemological expression normally employed to announce, and later to proclaim, adhesion to a "new model" of the analytic situation. My interest in this focus is primarily clinical, and it is in fact the clinical experience—and by this I mean the *therapeutic situation*—that *has provided the basis for modifications in analytic theory and technique*, just as the clinical arena, from the very beginning, gave rise to the model of mental functioning elaborated by psychoanalysis. To put it another way, the central role of psychopathology and its

manifestations in the therapeutic situation are the essential source of the data upon which the analytic conceptual model has been built —but, unfortunately, the significance of this tends not to be recognized, since there has been an effort to downplay it in order to correct what came to be considered an excessively "pathomorphic" trend in psychoanalysis.

The "dramatic" appearance of the countertransference dimension—i.e., the quality of *the analyst's participation*—has been mobilized by the acceptance into psychoanalysis of a *new type of interlocutor* who is not like Freud's original patients; these are our so-called borderline patients and schizoid, narcissistic, and psychotic ones, as well as child patients. Gradually, as countertransference has begun to reveal "the other side of the coin" in the analytic scenario, it has also compelled us to rethink and carefully redefine the entire analytic situation—and to rethink and redefine (though in a less radical way) the concepts upon which the model of the mind that derives from it is based.

This eruption of countertransference issues into the psychoanalytic scenario is one of the principal factors of change and development in the psychoanalytic model of the mind and of the relationship, in my view.[7] But I would not refer to this as a paradigm shift; rather, I regard it as a slow, progressive, and necessary change—a *quiet revolution,* to use Ogden's (1992) expression—that speaks to the vitality of psychoanalysis as a method of cure.

INDIVIDUALITY, INTERSUBJECTIVITY, AND *INTERSUBJECTIVISM*

Both intrapsychic factors and intersubjective ones participate, dialectically, in the psychoanalytic process. As Green (2000) observes,

[7] Of course, this eruption began with such notable contributors as Heimann (1950) and Little (1951). Into these relatively early examinations and elaborations of countertransference, Winnicott (1947), too, introduced important general considerations, such as "hate in the countertransference." As I have noted elsewhere (Bonaminio 1991), Winnicott emphasized the necessity for *authentic feelings* and an *authentic presence* on the analyst's part, in order for the analytic relationship to be recognized by the patient as a true relationship.

"Instead of working together, these two dimensions may become the object of a struggle for supremacy in which each point of view, while acknowledging the other's position, strives to secure its primacy, if not its hegemony" (p. 2).

The vision of the dyadic, relational, intersubjective dimension of the psychoanalytic process has become progressively more widespread (and quite fortunately so, I might add). I am aware that, in stating this, I may appear to champion the very perspective that I have been questioning. However, let me explain my belief that, because of cultural differences, the term *relational* may have different connotations to European (and, specifically, Italian) analysts than it does to American ones. From reading American psychoanalytic literature, I understand that the term refers to a theoretical orientation (and, consequently, a technical one) that might be considered the opposite of a classical or traditional approach. As distinct from this, the European, the Italian—or perhaps simply my personal—understanding is that both *relational* and *intersubjective* imply a particular attention to what is going on between patient and analyst, i.e., on both sides of the analytic couple, but without displacing the primary focus from the patient's thoughts, emotions, defenses, and overall psychic structure.

As Winnicott (1954) put it in his idiomatic way:

> In doing psychoanalysis, one is constantly on the look out for indications as to the main source of the material presented for interpretation.* [In a "note for revision," the following is added.] *Psycho-analysis starts with patient + → develop theme to unconscious co-operation process, growth and use of intimacy, self-revelation, "surprises." [p. 88]

As it has become so widespread in the analytic literature, the dyadic, "relational" vision of the analytic process has tended to transform itself into a sort of metamodel for treatment, which seems aimed at unifying, at "melting down" varying points of view that may in fact be widely disparate owing to their unique positions in the cultural and geographical matrix of the psychoanalytic pan-

orama. As a metamodel, however, this approach houses an epistemological vice that, in my opinion, resides in the confusion between the "place" of the analytic process (in which the intersubjective, analyst–analysand dimension is located and realized), on the one hand, and the "object" (as Boesky [1990] noted), on the other—or even the "aims" of the analytic process, or its "use," which, I would say, has to do exclusively with the patient's individuality.

Let us consider some emblematic (but significantly, not so recent) comments about the intersubjective dimension—i.e., the "place" of the analytic process—through an examination of what is currently unduly considered to be one of the signs of an "authoritarian" stance on the part of the analyst: the analyst's interpretations. Bion (1977)—who condensed his views on the vast clinical theme of the *therapeutic alliance* in his statement describing the analysand as the "analyst's best colleague"—wrote that interpretations are *theories the analyst makes on the theories that the analysand makes on the analyst.* Nine years earlier, Winnicott (1968a) made what he defined as a "very simple statement" about interpretation, implying a circularity between analyst and analysand:

> The purpose of interpretation must include a feeling that the analyst has that a communication has been made which needs *acknowledgement* . . . . Giving an interpretation back gives the patient [an] opportunity to correct the misunderstandings . . . . [In making an interpretation] the analyst *reflects back* what the patient has communicated. [pp. 208-209, italics added]

Both Bion's and Winnicott's remarks quoted above derive from a conception of interpretation whose central aspect is *not* the unveiling of an unconscious fantasy that is fixed and locked inside the patient, but is rather a proposal offered to the patient—an amplification of emotional and relational meanings generated by the analysand, which the analyst in turn transmits back to the analysand in what I would describe as a *semantic circularity*, a dialectical interplay between self and other.

Ferro (1996, 2002) advises that the analyst should make an interpretation to the patient only insofar as the analyst believes it will

be transformative, a position with which I agree. Whereas Ferro is essentially speaking from a Bionian point of view here, I find that Winnicott's way of expressing this view resonates more with my own viewpoint, from a clinical standpoint; that is, I have a better understanding of what Winnicott is saying because I find evidence for it in my own clinical experience, though I certainly admire the way that Bion could convey such ideas on an intellectual level.

The intersubjective dimension of the analytic encounter is therefore not only inevitable, but necessary and useful in understanding, describing, and returning to the analysand what is actually happening in the session between the two members of the dyad. Bolognini (2008) recently demonstrated this by focusing on the *intrapsychic* and the *interpsychic* as two different ways of considering the same question from different angles, while also indicating from a technical point of view what difficulties may arise if one of these is privileged over the other.

It seems to me that to assign the relational, intersubjective point of view to the highest position in psychoanalytic theorizing is to claim prioritization, at the level of theory, for what are basically the qualities of the *analyst as a person*—i.e., his idiomatic way of *being* with the patient and of tolerating his countertransference (Carpy 1989), and, specifically, how he tolerates whatever powerful emotions the patient evokes in him. In fact, once this point of view has been vaulted to the highest theoretical level (instead of being retained at the clinical level, where it more properly belongs), it seems to me that a dangerous fiction is created: that is, that the analyst's capacity for being *sensitive*, *unobtrusive,* and *aware* of his influence on the patient is *ipso facto* guaranteed.

In effect, instead of a "democracy" or a "parity" between analyst and analysand, a sort of *statism* is thereby created, it seems to me, in which everything belongs to the *state* of the intersubjective relationship, and nothing is owned by the individual parties themselves. Such a framework restricts the analyst's freedom to respond to the patient's needs and ultimately hinders his understanding of the patient. Unfortunately, once the analytic prescriptions belonging to a presumed objectivity—such as neutrality, abstinence, etc.—are

thrown out the door of the consulting room (and not all that politely, either), new prescriptions simply enter in through the window. On a clinical level, Bolognini (1997) did well to highlight a related phenomenon when he stressed the risk of the analyst's empathy turning into *empathism*.

What about Freud's evocation of the "impassive" analyst, guardian of the rules of the setting, who positions himself in relation to his patient as an "opaque mirror" that reflects back only what the patient "projects" onto the analyst? Are we certain that in this famous Freudian metaphor (1912), we can find no more than the sedimentation of rigid obedience to antiquated, formal orthodoxy? Does this metaphor present us with nothing more than a strictly "unipersonal" (one-body) perspective (as of course is often seen in more or less "classical" or "traditional" clinical accounts)?

Bearing in mind what have been defined as the lost certainties of psychoanalysis (Kohon 1999; Manfredi Turillazzi 1994), we might begin to appreciate to what use a Freudian metaphor like the "opaque mirror" might usefully be applied, and how we might consider such analogies in the light of developments that have transformed psychoanalysis since Freud's time. I believe that the "opaque mirror" metaphor offers us the chance to see, a posteriori (*Nachträglichkeit*), what Kohut defines in terms of *narcissistic mirror transference,* to give one example, or what Winnicott describes as the *mirror function of the mother's gaze,* to give another (in which the individual *recognizes himself* by means of the other). In the Freudian adjective *opaque,* isn't it possible to find a reference to the clinical concept of the "unobtrusive" analyst (Balint 1968), who refrains from invading the patient's own field and does not engage him in obsessive monitoring of the reciprocal, interactive movements of patient and analyst? Moreover, doesn't the word *opaque* also evoke the *negative capability* that Bion mentions, implicit in his recommendation "to suspend memory and desire"?

Then, too, the analyst's privacy, his personal idiom, can come under fire in the analysis. Perhaps with a touch of exaggeration, we might imagine an analyst who is intensely concerned with tracing the "relational texture" in the analytic material, with pinpointing

the reciprocal moves between the analysand and himself in the context of the session—but in the course of this exhaustive task, he may lose sight not only of the patient, but of himself as well.

What about transference? There can be no doubt that the most important developments in the concept of transference (which of course remains the central phenomenon of psychoanalytic treatment), that the amplifications of transference that have occurred in many different directions, have all accentuated the dimension of *actual, current experience* and *newness* that is inherent in the concept itself. By definition, transference has been the bearer of these ever since its original discovery by Freud, who saw transference as a *new* edition. Even in the most classical definition of the transference as a *place of repetition*, I do not believe that there is an exclusive prerequisite for the "blind" repetition of fantasy processes. Rather, such "distortion" as there is belongs to the unilateral way with which this concept has been interpreted exclusively in terms of genetic determinants.

Today, even though we do not know much more about what is "therapeutic" in psychoanalysis (that is, we lack a simple, precise statement about this), we nevertheless question our earlier certainties (see, for example, Gabbard and Westen 2003), and we know that the whole issue is much more complex than we used to think or write, as Smith (2006) notes. We know that it is not the "transference," nor is it transference interpretation, that is the sole or even the main agent of psychic change; the quality of psychoanalytic ecology (space, time, and the presence of the analyst) makes an equally important, if not more important, contribution in working with so-called difficult patients, as well as in certain phases that sooner or later occur in every analysis. The entire conception of the psychoanalytic process has changed step by step with the amplification and investigation of the transference-countertransference relationship, and this change is by no means limited to recent years.

As I have stressed, I feel that strict adherence to an excessively relational approach to psychoanalytic technique may tend to obscure the patient's individuality, his search for an intimacy with himself, as I theorized in an earlier paper (Bonaminio 1996). I also

wonder whether, in view of the progressive affirmation of a relational metamodel, we ought not to identify what we might think of as the "ideological" components of psychoanalytic theory. For example, if we consider postmodern psychoanalysis as having begun with the discovery of the importance of the countertransference—i.e., with the participation of the analyst in the totality of the analytic process—it seems to me that two fundamental movements can be seen. First, there has been a progressive *rebalancing in favor of a greater weight and responsibility on the part of the analyst,* a factor previously undervalued as far as the curative elements of psychoanalysis are concerned. But a second movement can be discerned in the opposite direction: that is, an *overreliance* on countertransference, which might be conceptualized as the "analyst's retreat from the patient's vantage point" (Schwaber 1992). This is what I have described above as the risk of a subterranean erosion of the patient's space—an erosion caused by the analyst, in the service of prioritizing co-participation and context dependency of everything that happens in the clinical situation.

CONCLUDING REMARKS: COUNTERTRANSFERENCE AND THE ANALYST'S INDIVIDUALITY

I will conclude by briefly discussing the importance of the analyst's "realness," i.e., his capacity for *spontaneity, freedom,* and *aliveness* in responding to the analysand on the basis of *his own experience* in the psychoanalytic situation, in such a way that he is not shackled by stereotypical attitudes in observing analytic neutrality (Ogden 1999; see also Renik 2006). Over a period of about forty years, Winnicott's dictum, as previously quoted, concerning "keeping alive, keeping well, and keeping awake" (1962, p. 166), may legitimately be regarded as the original source of an emphasis on the importance of the analyst's *keeping alive.*

If the analyst's act of freedom in thinking (Symington 1983), or his capacity of thinking the unthinkable in psychoanalysis (Coltart 1985), represents an important factor for therapeutic change,

then what was Winnicott referring to? Which clinical situations did he have in mind in making this arresting statement, unless we pass it off as an offhand declaration of principle? In other words, what interferences and what defenses and resistances may have cropped up in the analysis, and what "petrified language" has taken root in the relationship between analyst and patient, that stops the analyst from *being himself,* from *keeping awake,* and, generally, from *keeping himself alive for the patient?* The issue of staying alive, awake, and well is essentially a clinical one, and I wish to focus mainly on the ways that the analyst's inner process is a difficult one—labor-intensive and at times only partially realizable.

The analyst's inner process cannot be taken for granted. It is the result (if indeed there is a result) of a continuous process of elaboration, each moment of which is characterized by what Smith (2000) defined as *conflictual listening.* Smith uses this term to emphasize "an ongoing conflictual process, containing all the components of conflict and shaped in every moment by both the patient's and analyst's conflicts" (p. 95).

Of course, when Winnicott speaks of the importance of keeping alive and awake, he is referring to the work done by the analyst. He writes:

> I would rather be remembered as maintaining that in between the patient and the analyst is the analyst's professional attitude, his technique, *the work he does with his mind.* Now I say this without fear because I am not an intellectual and in fact I personally do my work very much from the body-ego, so to speak. But I think of myself in my analytic work working with an easy but conscious mental effort. [1960, p. 161, italics in original]

Here Winnicott is calling attention to the distance and the difference in position between the two partners of the analytic couple in session: one of them enters analysis mainly because he is ill and expects to be cured, while the other one is supposed to be in a position to cure him.

Certainly, the analyst has a subjectivity of his own that leads him to reelaborate what the other narrates to him, and that makes

his listening different from any other listener's. His personal history provides him with a wide range of mental contents that each of his patients organizes in a different way. To put this in the evocative words of Bollas (on whose conceptualization I am largely relying here): "Even as an unconscious subject, I am still shaped by another's effect on me. My self is given a new form by the other" (1995, p. 25).

Both analyst and patient unconsciously know that they are contributing, moment by moment, to the transformation of the other's self. Shall we conclude that no other outcome of the analytic couple's work is available to the patient? Although the analytic relationship in itself is of the greatest importance here, and although the analyst's function of *holding* (in Winnicott's term) and *containment* (in Bion's) contributes to the cure, it is through ongoing interpretive work that the analyst opposes and deconstructs the patient's pathological structure. The analyst is required to use his own analysis, training, and professional expertise to distance himself from his subjectivity, and together these guarantee his ability "to step outside it."

This is why, in my opinion, we ought to distinguish the countertransference (even, in its broadest sense, including the analyst's theories, interpretations, and unconscious responses) from *the private areas that are the analyst as a person.* In order to develop the image proposed by Winnicott, one might say that, if the countertransference is the analyst's work—"an easy but conscious mental effort" (1960, p. 161), under ordinary or standard analysis conditions, and presumably a much greater effort in circumstances of intense emotional turbulence with difficult patients or in certain phases of all analyses—*then it is the analyst as a person who is conducting this work.*

Adopting a theatrical metaphor here, we might say that the internal relationship between the analyst's countertransference and his *person* is analogous to the relationship between the actor who passionately *impersonates* and *lives,* within himself, a character on the stage, and the director who closely but *invisibly* follows the performance from offstage. From this point of view, we might say that

the countertransference is largely an unconscious work tool—at the disposal of the analyst's self who is directly involved in the action of the play, onstage—but not utilized by his whole self.

This dialectic between the analyst's countertransference and his whole self seems to me what Winnicott (1960) is alluding to in the following:

> Ideas and feelings come to mind, but these are well examined and sifted before an interpretation is made. This is not to say the feelings are not involved. On the one hand, I may have stomach ache but this does not usually affect my interpretation; and on the other hand, I may have been somewhat stimulated erotically or aggressively by an idea given by the patient, but again this fact does not usually affect my interpretative work, what I say, how I say or when I say it. [pp. 161-162]

I use this quotation here with an explicitly paradoxical intention. On one hand, Winnicott's assertion that the analyst's interpretive work is not affected "by ideas given by the patient" may be seen, indeed, as naive and outdated in terms of its description of the analytic process and of the nature of the analyst's position; today, it is hard for us to imagine that the "analyst's irreducible subjectivity" (Renik 1993) does not inevitably influence his way of interpreting and responding to the patient, who in turn communicates with him on the basis of his own conflicts, but also in response to what is coming to him from the analyst.

On the other hand, Winnicott's "outdated" statement is a single, obvious example of the analyst's need to—and, ideally, his ability to—step outside his subjectivity, to keep it separated from the work that he does "for" the patient, guaranteeing the privacy of both the patient and himself, as well as the patient's right to be "fed," so to speak, by the analyst's interpretations. Otherwise, one might imagine that the analyst's "stomach ache" (see the preceding quotation from Winnicott) would be put in charge of the patient!

Winnicott's reference to "stomach ache" is useful for another reason: it represents a *personal fact* originating within the analyst,

which belongs to the analyst's psyche-soma and is not necessarily a response, however idiosyncratic, to what the patient "has made him feel." Here I am thinking of situations that are not ordinary, but neither are they unusual; for example, we are all aware of many descriptions in the literature that describe the influence of illness in the analyst on the course of treatment. Like a litmus paper, such situations may help to make *the person of the analyst* visible.

In my view, then, the margin between the analyst's countertransference and his privacy (or individuality) is elusive and ambiguous; it represents a border that defines the analyst's activities, his technique and technical attitude, and his presence as a person. Yet these are also two separate concepts, and we will function better as analysts to the extent that we work to keep them as separate as possible in our minds.

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A CASE OF SADOMASOCHISTIC TRANSFERENCE: THE ANALYST'S CONTRIBUTIONS TO PERVERSE ENACTMENTS

BY RICHARD M. ZEITNER

A young woman who came for treatment of anxiety and depression is presented in a detailed case report. She developed an erotized transference that was predominantly sadomasochistic and included her intention to torture and castrate the analyst. The author demonstrates how the analyst's behavior, including countertransference contributions, assisted in shaping the vicissitudes of sadomasochistic transference paradigms. A collusion was established between patient and analyst in a manner that enabled the analytic dyad to work productively toward an eventual resolution of the patient's conflicts. The author discusses the case's complexities pertaining to enactments, while emphasizing the importance of carefully monitoring and addressing countertransference experiences that mold and shape such a collusion.

INTRODUCTION

Most traditional psychoanalytic discussions and studies of sadism and masochism center on the crystallized perversions or paraphilias, in which sexual arousal and gratification are contingent on the infliction of hurt on another or on being hurt by another. By *center,*

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I mean that the conception of these clinical presentations is based on a fundamental model of symptomatic perverse sexuality. In "Instincts and Their Vicissitudes," Freud (1915) conceptualized both sadism and masochism as components of all sexuality, but he stated that it is only with vicissitudes that these instincts become conditions of perverse sexuality. He added that sadism always begins with and includes the attempt to gain control and power over the other, while the need to harm or inflict apparent pain is not present in the beginning.

In "The Economic Problem of Masochism" (1924), Freud began to theoretically integrate the characterological and perverse varieties of masochism by making masochism rather than sadism the fundamental instinct, while elaborating the proposition that sadism and masochism coexist in every patient regardless of the patient's manifest presentation. Most analysts now hold that when masochism or sadism is prominent in a patient, an aspect of the disavowed variant exists simultaneously and may appear in the analysis at some point.

Contemporary literature has described sadomasochistic phenomena as forms of character pathology that are less centered on sexual arousal per se, and are instead contained within templates of intimate involvement with partners in which the individual routinely experiences a form of suffering, or makes another suffer, as a condition of such involvement. Some of these patients are considered to fall into the realm of a sadomasochistic personality structure or disorder, or into a related category of narcissistic or borderline personality disorders (Kernberg 1986, 1988).

There are a few case studies available in which sadomasochistic forms of character take center stage in the transference. Stoller's classic work on *Sexual Excitement: Dynamics of Erotic Life* (1979) stands out as an example. With his patient Belle, Stoller traced the analytic process in a woman with a perverse character structure. He emphasized the role of hostility and aggression in her sadomasochistic character style, demonstrating that people like Belle can experience excitement—and perhaps love, too—only if they hurt another or "if they have wounded—crippled—their capacity to love" (Stoller 1979, p. xiii). I might add that many of these patients can

feel excitement or love only if they feel they have crippled the other as well. I will describe such a patient.

The patient presented in this paper exemplifies many of the dynamics and unconscious processes that Stoller and others have discussed. She developed not just a sadomasochistic transference, but one in which her mockery of me stood out as a condition of her erotic life, becoming a predominant mode of relating to me in a highly charged field of transference-countertransference engagement. Her prevailing fantasy was that to oppose or attenuate what she experienced as my masculine power and authority would provide her with a power and means of control that she otherwise lacked.

The concept of penis envy is in relative disrepute in our field at present, and is even negated by some as a compelling dynamic in women's intrapsychic life. Nevertheless, it is important to report psychoanalytic studies in which such clear and consistent unconscious fantasies and symbolism, linked to an ongoing sadomasochistic transference, are worked with productively and are finally resolved.

A second and perhaps more unique feature of this study is a demonstration and discussion of my countertransference contributions to the process and to the sadomasochistic transference paradigms and enactments. I will also demonstrate how this patient's most fundamental and troublesome dynamics were displayed in such a way that I was moved into, or moved myself into, an uncharacteristic position of authority, thus enacting the role of the original objects of the patient's sadomasochism. She and I then established a collusion in which my technique and way of working played a part in shaping the form of the sadomasochistic phenomena portrayed.

What has intrigued me about this patient, from my very first contact with her and throughout our analytic work, is the manner in which a dynamic understanding and my style of working seemed to unfold in such a way that I behaved with an uncharacteristic formality and reserve that was fundamentally different from my more usual style with other patients. I will show how in specific ways I

contributed to a shaping of the analytic process and the enactments, too—but also how this allowed my patient and me to work together in a field of engagement that was ultimately mutative.

And, finally, I will demonstrate how the progression of the analysis, including specific changes in the patient, further influenced me and my technique back toward my more characteristic posture of openness and reduced formality as successful analytic work with her was accomplished. I will attempt to sort out how my patient's conflicts and characterological features met at the interface of our gender difference, my fluctuation in working style, and my countertransference, and how these all came together to effect a successful analysis.

First, my patient's constant challenges of me and provocations in the process were so persistent, pervasive, and insidious that I often felt bombarded and assaulted. As a function of this, I became consistently cautious, measured, and vigilant about my word choice, inflections, and even my appearance and body posture as I greeted her. Herein lies a first clue to how my otherwise quite open and interactive style with patients was markedly influenced by the constancy of her provocations, in such a way that I shifted to an uncharacteristic position of vigilance, from which I quite consistently interpreted transference paradigms, dream material, and fantasies with a particular formality. This will be evident in the case material I have selected.

Ironically and unconsciously, however, I was not outside the interaction or distant from the patient's experience, but instead was deeply immersed in an interactive matrix of castration (by the patient) and avoiding-being-castrated (by the analyst). This matrix, then, led me to adopt an uncharacteristic analytic stance of formality to which the patient responded with envy, assaults, and attempts to seduce me and disrupt the frame. My style then contributed to a predominating paternal-fraternal transference, further shaping the process along the lines of penis envy, castration, and sadomasochism.

By way of presenting the highlights of our interactions, along with parenthetical remarks to demonstrate my countertransference

responses, I will illustrate how a more classical formulation of penis envy emerged, was mutually shaped, prevailed for a period of time, and was ultimately resolved through a successful treatment process. I will show how my technique, including style, word choice, and other nuances of interventions, became guarded, careful, and even authority bound, partially out of my defensiveness. This style and technique thereby provided a scaffolding upon which the patient based her envy and contempt.

Finally, I will trace the manner in which the patient's anal world was revealed by way of working through the sadomasochistic enactments. Here was the fundamental infrastructure that linked early trauma with her oedipal conflicts and family dynamics, all of which had contributed to her impediments in loving and being loved.

CLINICAL CASE REPORT

Ms. B and I initially agreed that we would meet for twice-weekly consultations in order to address the anxiety and depression she was struggling with. At the time of the initial consultation, she was a 27-year-old, single woman who was employed by a company that had been relocated from another part of the state. She described herself as depressed and anxious, mostly about her professional standing.

Although well educated and having graduated from a prestigious university with high honors, Ms. B feared that she would not measure up in her current professional environment. She described herself by history as an excellent student, but now in the business world she felt less capable of the same successes she had been used to. She had worked best under the tutelage of male mentors, but described a history of frequently seducing these same men. She was now concerned that in her current company, she might again arrange such a situation with one of her current mentors.

In the beginning consultations, I felt berated by her impatience. If I was even one minute late for a session, she scurried into my office while scolding me for keeping her waiting. She commented that she wanted to get her money's worth. She spoke with

verbosity and so completely flooded the hour that it was frequently difficult to intervene or to terminate the session on time. I became aware of her control over me when I realized that I was repeatedly extending her time. I wanted to avoid being scolded by being certain to give her her "money's worth." Furthermore, I did not want to upset her while she was in the middle of some eloquent description of herself or her life experiences. (I was already attempting to avoid her attacks.)

Ms. B emphasized that she had learned from her father to be an elitist and to choose the best, whether it was schools or jobs. When I commented that she might be questioning whether I was the best analyst for her, now sensing both her devaluation of me and her desire for my help, she merely repeated that it was important that she get the best treatment possible.

After these initial weeks of consultation, I recommended a four- to five-times-per-week psychoanalytic treatment. I considered that Ms. B struggled with quite troublesome narcissistic issues and that her treatment might be difficult. But there was also a tone in the initial hours that suggested she and I might work well together in an analysis; for example, in spite of her apparent impatience and demandingness, she could hear and respond to my observations and interpretations of her difficulties while working introspectively. So, even early in the consultation, I felt that analysis rather than psychotherapy would offer her the most help, in spite of where she seemed to be on the diagnostic spectrum. Ms. B rejected my offer, however, responding that she could not afford it; she said she was nervous about her finances, leaving me with the impression that her financial situation was always on the brink of disaster. We therefore proceeded for approximately one year with twice-weekly sessions, during which time the patient did achieve a lessening of her most troublesome symptoms of anxiety and depressive feelings.

During this time, I continued to believe strongly that analysis would be of significant benefit to Ms. B if she were able to engage in a more intensive process. At a time during which she was describing her uncle's business enterprises, she casually mentioned her substantial inheritance. She said that she had been reluctant to tell me

about this because she was afraid that if she were candid about it, I might exploit her for her money. In response, I merely acknowledged her fear that I might be exploitative. I subsequently offered a reduced fee—in part to facilitate an analysis, but also, as I know in retrospect, as a countertransference-motivated desire to avoid being accused of exploiting her. (Here I was responding to the projection of her greed.)

This segment of treatment ushered in the beginning of a four-day-per-week schedule of psychoanalysis. In the opening phase, Ms. B made a number of comments about powerful men who run the government and control companies, while she was relatively powerless in a world of Herculean and indomitable males. Expressions of her anger around boundaries that she felt were arbitrarily controlled by me were manifested by frequent lateness to her sessions, while she claimed she was busy and had a schedule that was just as important as mine. She would storm into the hour late with apparent irritation at me, as if I had forced her to come. At these times, she would threaten to stop her treatment unless I reneged on my requirement that she pay for missed sessions. In reality, I had been quite tolerant of her work situation and the distance she traveled to see me. I remarked that her demands that I comply might be her way of expressing her own vulnerability, and that if she did not have to pay me, she would feel more of a sense of equality with me.

For a period of months, Ms. B continued to come late to her sessions and then to eat her lunch while sitting upright on the couch with her back to me. She said she could thereby "kill two birds with one stone." (Was I the bird she wanted to kill, I wondered.) She would drape napkins across her lap as she ate her carry-out Chinese food, cross-legged. I experienced annoyance while I sensed her desire to mock me as the embodiment of a controlling male who was forcing her into submission. I observed my countertransference feelings, yet I frequently struggled with the most appropriate intervention. Should I set a limit on her eating or instead wait to help her understand her mockery of me and the analysis? I decided to allow the "symptom" to emerge rather than restricting her action, and thus hopefully have the opportunity to expand our under-

standing. (Here my so-called decision was also my rationalization to defend against my anxiety over her assaults on me.)

Ms. B began to bring in tape recordings of her dreams, which she would record in the early morning upon waking. I invited her to consider why she felt a need to play recordings instead of speaking spontaneously. Consistent with her general attitude, she insisted that playing these during the hour would save time and permit her to get her "money's worth." Although she was technically complying with the framework of treatment—e.g., speaking about her inner experiences while reporting her dreams—after several weeks, I inquired, "Is it possible that you want to alter our way of working together just enough to rebel against what you feel is *my* structure?"

All this I asked while Ms. B was sweeping crumbs off the couch and asking me where she might deposit her trash. She paused momentarily, then replied with a slightly derisive tone that she had had a dream the night before in which she wanted to shock me by telling me, "I want to suck your dick." (Here I was stunned by her aggression.) She added that in the dream, she was aware of wanting to humiliate me.

Attempting to regain my equanimity, I responded with a trumped-up composure (which was likely experienced by the patient as "too cool"), saying that for her to suck my penis might allow her to experience herself as having more power than I did. (Here I made an interpretation that was technically accurate, but was perhaps experienced by the patient as exceptionally reserved and avoidant of the essence of her attack.)

Ms. B replied that she had had another dream in which "women were hung upside down in a freezing compartment after they had been tortured by men. They looked like pieces of meat hanging from hooks." She recognized the women as representations of herself. She added that she feared if she were tender to a man, she would most certainly be "exploited, tortured, and then hung out to dry." (Here I perhaps had not yet consciously recognized that the analysis itself was experienced by the patient as a masochistic subordination to me, even though we were working interpretively to understand her transference reactions [see Smith 2006].)

Ms. B went on to describe what she felt was an unfulfilling sexual relationship with her boyfriend. She said that instead of sex with him, she would rather possess *me* and be on top of me in intercourse, while adding, "I also want to hurt you." When I would make any intervention that was intended to expand some insight about her needs, desires, repudiated tenderness, or the analysis as experienced by her as a submission, she would teasingly make puns on my words while reducing them to a sexual parody. (Here I felt impotent with my words and what I offered her.) She commented that she enjoyed making me squirm. (And indeed I did squirm.) She laughed sardonically and wondered if I knew the etymological derivation of various words I used.

I sometimes felt that it was unnecessary for me to interpret Ms. B's desire to humiliate me when she already recognized it herself —and even flaunted it. I often felt immobilized by her, with really nothing to say or to add. (Here it was clear that I was moved by the patient into a state of avoiding-being-castrated.) I commented that she seemed to feel gratified by my silence. At one of these times in which we discussed her attempts to silence and humiliate me, she elevated herself from the couch, and proceeded to sit on the floor and begin her workout routine. Her action seemed to represent an amalgam of mockery, seduction, and provocation. When I invited a discussion of her feelings and motives, she responded dismissively that she wanted to bring me down from my "lofty position." (Here I was experienced as the lofty but castrated analyst-father, in part as a function of how I had moved, or had been moved, sometimes into immobilization, and at other times into a position of vigilance from which I was interpreting with a style of formality and even certainty, partially as a way to isolate my affect in the process.)

Following these exchanges, Ms. B reported a number of dreams that deepened our understanding of the emerging transference. She dreamed of being in a restaurant with a woman friend who had a "stump leg." In this dream, the friend's leg had been amputated. In another dream, she ran in a three-legged race. "Although one might suspect that one can run with three legs better than two," she said, "I found the third leg to be cumbersome, clumsy, and unfit-

ting." The patient preempted my response with sarcasm: she said that, quite likely, I would view her dream as a reference to a penis, but she would "remain incredulous that Freud had anything useful to offer." I responded that it seemed she wanted to be sure that I did not think I had anything useful to offer her.

Over the next number of months, the patient continued to describe experiences pertaining to being in control and having power over me, while at other times expressing her anxiety about whether she could succeed in her new employment setting while competing with brilliant people. (I was the perceived "brilliant people" with whom she must compete, I considered.) Although Ms. B had apparently settled nicely into her new job and seemed to be well respected by peers and supervisors, she felt she could only achieve the status she wanted if she were to align herself with the "older corporate giants who had all the power." She wondered, however, whether this power was really deserved. She commented that she had attended a nightclub where she had seen "a man's dick hanging out." She casually mentioned having a brother who was intellectually gifted, but vocationally incompetent; although he was well educated, he was now doing meaningless work. She further mentioned that he had been injured in an accident in which he had sustained multiple injuries, including the loss of a testicle.

In response to these associations, I suggested that she might be telling me that if she herself could align with the corporate giants, she might feel more sure of her own power and competence, while also assuring herself that she was unlike her brother. (Here I interpreted authoritatively, avoiding a transference interpretation. I was defensively immersed in a state of avoiding-being-castrated as I sidestepped the image of me as the castrated brother.) I went on to say that, based on our previous work, we had established that she also had questions as to whether men really were inherently more competent. In these series of exchanges, I wanted to emphasize that her view of herself as inferior was rooted in conflictual feelings about her own competence, linked to experiences and feelings about her brother and other males in her family.

Although Ms. B had by this time become more reflective about her mockery, her proneness for action continued throughout the second year of analytic work. One day she walked into my office and slipped off her overcoat, revealing only her underclothing beneath. She conspicuously avoided making any reference to her attire as she lay down on the couch. (I was stunned, anxious, and defensively paralyzed.) After regaining some semblance of equanimity, I remarked that she was quite clearly avoiding any discussion of what was obvious—namely, her attire. Ms. B scoffed, saying, "I would actually like to prance around in front of you. I want to shock you and make you excited."

At this moment, I felt a pronounced annoyance at this flagrant manifestation of derision. I responded, "Maybe you want to excite me as a way to expose what you hope but also fear to be my weakness." (Defensively squelching my anxiety and anger, I shifted to a more experience-distant stance, thereby avoiding these intense affects. But once again, I believe that she experienced me as too cool, unmoved, and reserved.)

With disdain, the patient replied, "Although I have made some minor gains in analysis over time, you have been useless to me in recent months." (The castration momentum picked up.) She turned around on the couch to look at me and smiled while proceeding to put on her overcoat. She commented on her actions no further.

This material was characteristic of a long mid-phase of analysis: for approximately two years, there were numerous attempts by the patient to move me into compromising situations, and to provoke me, stretch boundaries, or struggle with me around certain requirements of paying for missed appointments. (Here our dance—the matrix of castration and avoiding-being-castrated was set and would remain the predominating transference paradigm in which I now intervened primarily in an interpretive and authoritative way, in the here and now. My interventions and most characteristic style with Ms. B would thereafter represent a reserve, control, and vigilance, lacking in the spontaneity, openness, and genuineness that are more characteristic of me in working with most other patients. This patient would in turn experience me as the autocratic, re-

served, and distant father who had to be dethroned from his lofty and authoritative position.)

During this period, Ms. B deepened her relationship with her boyfriend, who became her fiancé. They began to plan their wedding, and as the wedding date approached, she commented that she was reveling in all the attention from friends and family. She said that she was like a queen bee around whom all others seemed to gather.

I commented that it seemed she rather enjoyed controlling all the drones. The patient laughed, responding that my comment reminded her that on her fee statement, there were charges for several missed sessions. Furthermore, she thought it unmannerly that I had not sent her a wedding gift. She wondered what I might do if she suddenly ripped the leaves off my plant that stood at the foot of the analytic couch. I asked her if she might want to retaliate by ripping me apart because she felt hurt at receiving no gift from me, while indeed I had even charged her for missed sessions.

These hours ushered in a series of dreams about explosions and firebombs in foreign countries. Ms. B recognized that the dreams seemed to reflect her fury. She casually mentioned a newspaper article about boys who had been restrained with shoestrings while they were brutally sodomized. I responded that she might feel as though she had been exploited and even sodomized by being charged for missed sessions. She agreed, and then commented that she had seen an interview on television with the actress Kathleen Turner, who appeared very "cocky." She went on to say that Turner behaved as though she had a "cavernous vagina that no man could fill."

Struck by this juxtaposition of symbolism, I said that she had used the word "cocky," but then commented that the actress had appeared as though she had a "cavernous vagina." Ms. B responded in a reflective way, remarking that she had never allowed herself to be a woman with her first husband because she had turned their relationship into a *War of the Roses*—the title of the movie in which Kathleen Turner starred as an enraged wife who refuses to be controlled by her husband.

Following Ms. B's wedding, it seemed as though she became less provocative with me, while she now focused more on her rela-

tionship struggles with her husband. She had become aware that their marital difficulties centered around financial struggles that were disproportionate to the couple's quite comfortable financial standing.

She expressed her concern that her father might look askance on the meager accomplishments of his daughter who had earned a degree from a prestigious university, but who had not achieved a position in life that was commensurate with her background. Yet she could express her anger at his "elitism and narcissism," which she now felt had always controlled her. She brought up a dream in which she had lost the diamond in her ring, leaving "a gaping hole." She said that she had been having her period and had been feeling "irritable and dirty." She had been preparing for a presentation in her company and feared that it would be received as "paltry."

I silently recalled a previous dream, which Ms. B had presented to me several years earlier at a time when she was making a decision to interrupt her education. I commented that the present dream reminded me of the previous dream, in which she had said that there was a "gaping hole in my head." We had understood this previous dream to refer to her anxiety about what she felt was her intellectual inadequacy. She remarked that it was another of her "hole dreams," and said that again she was feeling incompetent.

"Furthermore," I reminded her, "for you, male genitals seem to symbolize what you imagine to be the source of power, prestige, and competence, while holes seem to symbolize its absence." In response to my comment, Ms. B recalled another dream in which I, the analyst, picked her up and carried her while she said, "My, how strong you are for one of your stature." She recalled that she had frequently walked with her father and admired his "big strides."

For weeks thereafter, Ms. B spoke about her father's elitism, his high status in the community, and his harshness toward his children. It was here that I learned of a paradox in her family life: although the father was punitive with all the children, the patient experienced a clear difference between his attitude toward her brothers and his attitude toward herself. She cited numerous examples to illustrate his view of men as superior to women. Her hurt and

anger centered on the fact that she had excelled in the ways her father wanted, while her brothers had not; yet her father seemed to prefer the brothers.

There was now a long segment of work in which Ms. B explored her anger, envy, and abiding hurt experienced as a result of her father's rejection of her while simultaneously holding her to the highest standards. She recalled that she would attempt to enlist her mother's support, but the mother felt too intimidated by her husband to provide it. In one of those conversations with her mother, the patient was made aware of the father's long history of infidelity. The patient now became more able to address her anger at her mother for what she experienced as colluding with the father while enlisting the patient in maintaining a conspiracy of silence.

Throughout the third year of treatment, Ms. B's relentless drive for professional success continued to be a significant focus. At a time when her father was planning a brief visit to her home, and the patient had been exploring her mother's victimization by her father, she mentioned a dream in which "I was sitting on a toilet with pictures surrounding me on both sides, while I held a curtain tightly closed so men could not get in to see the pictures." She added casually that she had always had a problem with constipation and felt that in the dream she was waiting to defecate. She remarked, "Constipation is holding one's feces back."

I added, "You sometimes hold back when you feel that I am trying to control you." I thought of her unpaid bill as a possible precipitant for the dream. "Could you be holding back your fee?" I asked. "I wonder if you hold the curtain closed so that I cannot see the whole picture."

With these interventions, I addressed Ms. B's defensive efforts at anal sphincter control, which carried the internal representation of me as the voyeuristic and sadistic analyst-father whom she once more experienced as exploiting her. (I again seemingly interpreted from a distance, although I was actually immersed in the father–daughter transference-countertransference paradigm.) She responded that when she was approximately two years of age, she had developed a rash covering her trunk and buttocks, which was refrac-

tory to standard medical treatment. Her family physician had her encased in a body cast that covered this area, designed to restrict the scratching that had aggravated her excoriations. The rash first erupted during the time her parents were away on a prolonged business trip.

I responded to this piece of startling history with a sense of sadness. I remarked, "It is very likely that your rash erupted as a response to your parents' absence," addressing indirectly what I felt was her depression as a result of parental abandonment. "It also occurred at a time when you were learning to control your sphincter. Now, your efforts to hold your sphincter closed through constipation are likely related to your need to control your sphincters as a child when you felt you had to hold back because of the cast that encased you," I added. (I made an intellectually bound interpretation that, while technically accurate, avoided addressing the essence of her depression and other affects.)

Ms. B responded thoughtfully, recalling that her mother had told her how difficult it was for her to be in the cast, which had restricted her mobility and compromised her hygiene. I added, "And now, to give up money—which you experience as a submission to me—seems to be a revised way of holding your sphincter closed." (Again, I interpreted with a voice of authority.) Ms. B, now crying softly, said, "I really would like for Bill to have some control in our relationship."

For several months, Ms. B continued to explore her uncertainties about her professional competence. She spoke of a dream in which someone had broken into her house and stolen the artwork off the wall and left only the frames, so that there were just "remaining holes." She added that some of the artwork in her house consisted of paintings that her father had painted. She contrasted his capability with what she felt was her own "meager creativity." I invited her associations to the stolen artwork that left only holes. She said that it reminded her of previous dreams in which there were "holes": the hole in her head she dreamed of while a graduate student, and the "gaping hole" in her wedding ring.

I responded that in both these previous dreams, we had established that she viewed herself as lacking something that she felt men

possess. With this comment, I wanted to elucidate her belief that men possess competence by virtue of phallic strength, while she felt relatively powerless in her femininity. It was here that we came to understand her conflictual identification with a weak mother whom she experienced as the victim of a tyrannical father, but who was also a cruel mother who permitted the placement of the patient's cast while subsequently abandoning her.

Over the course of more than one year, during which Ms. B was working through the vicissitudes of her femininity, she commented that she had been doing more cooking at home. She baked a cake and brought in a piece for me. I felt touched by her thoughtfulness, and I told her so. Here I did not interpret and did not invite an explanation of the meaning of this gift; instead, I thanked her and remarked that she might be telling me that she was proud she had something worthwhile to offer me, something nurturing. (Here I seemed to break out of my interpretive role. I was moved by her softness and her uncharacteristic gesture of nurturance and concern for me.) I was aware at the time that I was also implicitly addressing Ms. B's increased comfort with her femininity, as well as a diminution in her penis envy. In a nonchalant way, she responded that she and her husband had been discussing their desire to have a baby. I considered her reply quite likely to represent a confirmation of my observations about her increasing comfort with her femininity.

It is important to note that the incident of the cake is merely illustrative of the gains the patient made during the long segment of work we had been doing that pertained to her conflicts around femininity. I did not regard this as a breakthrough moment per se, but instead as an illustration of how she and I now seemed to have arrived at a point of having renegotiated a more open, interactive, and spontaneous relationship. There was a more consistent tone of mutuality, with a benign sharing of political issues, current movies, books, and local art exhibitions.

Several months later, Ms. B reported a dream that seemed to usher in her first considerations about terminating her analysis. She had not previously talked about termination except in the context of some objection to boundaries. This dream, however, stood out

in contrast to the more prevailing tone of the analysis. In the dream, there were children who were separated from their parents, as she, the patient, looked on the scene while crying. In her associations, she stated that she now had a desire to spend more time with her husband and to enjoy their new home. Somewhat surprisingly, she asked, "How does one stop analysis?"

At this point, interpersonal conflicts, including those with her husband and certainly within the transference, had diminished significantly. Although the patient consciously emphasized her desire to terminate analysis, I asked her whether the dream might suggest some of the sadness she had experienced as a child while encased in a body cast at the time her parents were away from home. To leave me might represent her way of turning the tables. (Here I addressed her likely desire for revenge, which may have actually represented a healthy striving for autonomy, particularly in light of the long segment of previous analytic work in which we had worked through the vicissitudes of her envy and mockery.)

Aspects of conflict with her husband would hereinafter resurface around how finances should be properly handled. Ms. B and I continued to view these concerns as manifestations of her anxieties around power and control, and her fear that if she deferred to her husband's preferences, she would place herself in a vulnerable and disadvantaged position. In various ways throughout the termination period, I said to her, "You appear to be holding your curtain (anus or vagina) closed in order to keep control (of me or of others)." (Note again that what appear to be here-and-now interpretations actually constituted an analytic process that had coalesced into a paradigm, one that the patient and I had successfully negotiated in such a way that we are able to work with mutuality and flexibility.)

At times, we would return to various moments during the analysis, recalling certain of Ms. B's attempts to mock me or to attack the analytic setting. But we were now able to address these analytic events as her manic efforts to defecate on her analysis as an expression of her outrage about her childhood abandonment, her confinement in a body cast, and her experience of me as a transference object for revenge on her mother and father who had permitted this.

Ms. B began to express gratitude for what she described as having accomplished "quite an adventure." Her ambivalence around terminating analysis and her anxiety about saying goodbye to me were illustrated in a dream during the last three months: "I am with a blind girl while we are playing in the schoolyard. The school is closed because of vacation. There is a piano in the background, which I at first faked playing. I then play it, but the keys sound muted. I am scared and alone while I am in this vacated area, as if some menacing person might attack me," she explained. She commented that at one time, she herself had been this blind girl who felt alone. She recognized that the closed school was the end of analysis, and that she was scared to be without me. I added that the muted keys might represent her hesitation about leaving. She responded in a most tender and genuine way: "Without you, I don't think I would ever have been able to trust a man."

During the final weeks of the analysis, we came back to this dream many times in order to clarify and work through the many feelings around leaving "the playground of analysis." Ms. B periodically raised the question of whether, like the girl faking the piano performance, she had really acquired these changes, or were they instead a faked submission to me. I said that if this were true, I might then be her blind companion in the dream. She thought not, though, and joked that blind submission could never be an option for her.

For a period of time in the analysis, we continued to address what appeared to be an open question—namely, whether I might be the blind analyst who had been duped by the patient's faked performance. There were other features of the analysis, however, that suggested I had not been blind, but that Ms. B herself had been blind to the unconscious issues with which we had been working. She was now more tender with her husband, just as she was with me. She wondered, though, if her creativity might diminish as a result of her analysis, like the girl at the piano whose playing was muted. She considered whether becoming more gentle with her husband might in some way jeopardize her safety if she allowed him to take more control in the marriage. She further raised a concern as to

whether she might once again become blind, or whether her vision would continue to improve through the "performances of life."

These kinds of discussions—pertaining to the ending of treatment, Ms. B's many intrapsychic changes, changes in relating to others in her life, and her sadness over losing me, her analyst—occupied center stage throughout the termination process. There consistently remained an unswerving conviction through the ups and downs of termination that she had successfully completed a most rewarding journey that had enriched her immeasurably. After four and one-half years of analysis, Ms. B completed her final analytic session, somewhat tearfully, and with expressed gratitude.

Approximately two years following her termination date, I received a note from Ms. B that extended her best wishes, while also informing me that she had continued to be happy and productive in marriage and in work, and that she had recently given birth to healthy twins.

TRANSFORMATIONS OF SADOMASOCHISM

In this study, I have attempted to demonstrate the manner in which a patient's dynamics and intrapsychic conflicts appear to have consistently manifested along the lines of a classical psychodynamic understanding (but one now considered by many to be outmoded), while my technique and the enactments, too, were actually shaped by the patient and me through a complicated co-construction that was ultimately mutative for the patient.

Although quite clearly the analysis of penis envy was a central feature of our work, I do not view penis envy as an inevitable dynamic in the psychology of all women. Rather, its centrality in *this* patient, and its fundamental connection to her sadomasochism, perhaps called for this more classical dynamic understanding. And yet I have shown how my contributions indeed influenced the analytic process as I engaged with the patient in such a way that pulled for the father-brother transference, and even for the enactments. I contend, however, that the mutative aspects of the treatment were primarily a function of these co-constructed transference-counter-

transference paradigms as experienced by the patient and me, which when worked through in the interpretive process contributed to an eventual resolution of her sadomasochistic functioning.

The transference-countertransference paradigms unfolded in a uniquely intersubjective way, and may have developed quite differently with a different analyst—particularly a woman analyst. For example, I speculate that with a woman analyst, the compelling quality of my patient's sadomasochism and penis envy may not have surfaced, or at least not in the same form. Similarly, a woman analyst might have experienced quite different countertransference pressure, perhaps feeling less of a sense of reserve and caution, leading the analyst to speak with less trumped-up authority and associated masculinity. Might such an analytic demeanor have evoked less rage and defensively motivated strivings for power in my patient, perhaps instead pulling for her longings to be soothed or for the vicissitudes of abandonment-depression that pertained to the body cast issues?

My approach and way of listening to the patient were not, however, based on a theoretical preference or bias toward a classical formulation, but rather were a function of the consistency, coherence, and correspondence of dream material, fantasy, and transference-countertransference paradigms (the castration/avoiding-being-castrated paradigm). I maintain that in well-conducted psychoanalytic treatment, it is the patient's presentation at the interface of the analyst's presentation that sets the stage for the co-construction of the patient's most salient and troublesome dynamics, which then manifest within predominating transference-countertransference matrices. It is for this reason that analysts should be equidistantly grounded in all psychoanalytic theories, rather than allied with one preferred school of thought or belief system (Pine 1998).

Ms. B's mockery of me became the most predominant mode of her aggressive, greedy, and dispossessing self. Her contempt for me as her analyst-father-brothers-husband frequently appeared in a parodied sexualized form—e.g., her stated desire to fellate me and the exposure of her minimally clothed body. But these were thin disguises for an even more fundamental desire to expose what she wanted but simultaneously feared: that I was a contemptible fool

who, once my weakness and exploitability were revealed, would actually allow her to triumph. A manic defense, no doubt, but most assuredly she felt that a destruction of my power through seduction would prove that she possessed the real power.

Ms. B's expression of triumph through a dream in which she said she wished to shock me by telling me "I want to suck your dick" was a shining example of a complex metaphor replete with psychological meaning. Its most obvious form was, of course, the fantasy of fellatio. Yet her use of "dick" to refer to the penis—also a nickname for Richard, my first name—suggested that to suck on my penis (or to suck me in) might provide her with the power she wanted for herself, while exposing me as an egregious buffoon. Only then could she extract what she felt were the substance and source of my power while bringing me down from my exalted position. It was here that she hinted at fears of her own weakness, its equivalence to femininity, and her identification with her victimized mother.

The patient's sadism as a defense against masochism became more apparent when she openly stated that she wanted to humiliate me in order to acquire power for herself. At this moment, she recalled yet another dream in which "women were hung upside down in a freezing compartment after they had been tortured by men. They looked like pieces of meat hanging from hooks." It was at this critical juncture that we were able to begin the important work toward an improved integration of these widely disparate polarities of love and hate. It was the working through of this sadomasochistic foundation of my patient's intrapsychic life, through the living out of the enactments described while the patient and I worked together to understand them, that enabled her to finally integrate these polarities into a mature form of loving that was devoid of destructiveness (Dicks 1967; Kernberg 1995; Stoller 1979).

The previous dream, then, seemed to represent my patient's unique version of a fixed beating fantasy that Novick and Novick (1987, 1998) have found to be central in patients with sadomasochistic pathology. For example, we understood that she felt tortured by men and "hung out to dry" as an expression of parental abandonment at the time when she was confined in a body cast while her

parents were away from home. We understood her reference to the freezing compartment as representing her frozen sexuality and tenderness, and the coldness she felt from her father, linked with, of course, the relative safety she experienced while assuming a defensively sadistic position with me and with other men in her life.

Mockery and attempted sexual exploitation of me would continue to be portrayed, but now these were accompanied by her elaboration of her fears of being exploited herself, and of other narcissistic vulnerabilities—her "holes," as it were. It was here that we began to address her strong identification with her masochistic mother, whom she experienced as a victim of her father's controls and his bombastic displays of infidelity. This segment allowed us to amplify the patient's anger at her cruel and disloyal father, and her sadness and anger at a mother who, she felt, had masochistically surrendered to the father's tyranny.

The material around the actress Kathleen Turner, whom the patient perceived as having a "cavernous vagina that no man could fill," allowed us to address a perceived emptiness that was driven by the fantasy of herself as one who was castrated—that is, deprived of a penis as the perceived source of power, leaving her with only an empty hole. Here it is important to address the manner in which Ms. B and I understood the unconscious experience of the cavernous vagina and its relationship to the envy of the penis. Chasseguet-Smirgel (1976) suggests that certain women's experiences are molded not by the concretization of the penis as a physical organ per se, but instead by the penis as an imagined source of strength, power, and competence, further shaped by the unique aspects of the child's oedipal experiences. In the case described, penis envy represented the patient's desire to triumph over the powerful maternal imago who had had her encased in a cast, as well as over the father and brothers, by possessing what she felt gave them value (Chasseguet-Smirgel 1976).

Contained within this fantasy was the wish for a loving father and an attuned and adequate mother to fill her emptiness. It was, after all, the brothers whom the patient felt were truly valued. It was through this conjoined understanding of what more classical for-

mulations have termed *penis envy* that my work with this patient took its particular form.

Ms. B's fantasy of restraint (i.e., of the sodomized boys), discussed in association with dream material regarding explosions and firebombs in foreign countries, as well as her mockery of the analytic setting as she sat up on the couch to eat her lunch and spilled her food, represented the emergence of anal sadistic fantasies associated with pregenital trauma. However, it was not until the patient revealed her history of having been confined in a body cast in early childhood that we were finally able to understand a most fundamental source of these underlying anal sadistic fantasies around controlling others, her fears of being controlled and restrained herself, and, finally, her desire to defecate on her analysis and me as an aspect of revenge. To expose me, her analyst, as weak and exploitable would dispossess both me and her father of masculine power, while also liberating her from the body cast that she felt had sodomized her. She could then defecate on me to destroy my power.

Here, although the oral component—that is, her need to feed herself—was also pertinent, what appeared closer to the analytic surface was the spilling of food as her attempt to dirty the setting, which she had come to experience as a body cast—confining, restrictive, and punishing her for her rage against the parents who had abandoned her. I note here that Novick and Novick (1987) demonstrated that mothers of patients with fixed beating fantasies had often intensified the child's aggression with variations of bodily intrusions that served to inhibit age-appropriate autonomy. Certainly, my patient's body cast represented a traumatic bodily intrusion.

As Ms. B continued to portray various themes of control in the transference, and while she was anticipating a visit from her father, there was a more clear emergence of anality—the dream of herself on the toilet with the curtain held closed, for example. This material, presented around her associations to constipation and her rage at the analyst's control of her, allowed us to address her various defensive efforts to prevent exploitation by men—now, however, along these more pregenital lines. Her chronic constipation

represented the holding back of feces—a psychosomatic defense aimed at preventing the greater danger of destruction through soiling others as well as herself.

In her work with patients with sadomasochistic pathology, Chasseguet-Smirgel (1978) demonstrated the importance of exposing the fundamental motive for regression to anality in which the patient's psychosexual life becomes one of confusion. *Faecalization,* she informed us, is tantamount to reducing what is idealized to excrement in order to oppose what "nature"—or, more accurately here, the patient herself—"has made so divine" (father, mother, parental sexuality, analyst, brothers, father's love for brothers, and so on) (p. 30). Furthermore:

> The pleasure connected to transgression is sustained by the fantasy of having reduced the object to excrement . . . [having] destroyed reality and thereby having created a new one, that of the anal universe where all differences are abolished. [Chasseguet-Smirgel 1978, pp. 30-31]

She adds, "Once the anal-sadistic dimension is established, it becomes a matter of brandishing a whip rather than of genital penetration" (Chasseguet-Smirgel 1991, p. 407). With these dimensions more fully amplified, my patient could now address her fears about caring for me and for her husband as well, rather than engaging in displays of sadistic triumph.

The desire to nurture her husband and the analyst, too (the cake and the evolving interest in her home, husband, and family life), appeared as initial displays of care, concern, and tenderness for others. All of these seemed to signify that Ms. B now felt she had something to offer others. Her revelation that she and her husband wanted to have a baby represented another sign that she was moving toward a position of caring for another, as well as an increased acceptance of her femininity.

The desire to care for another, including the desire to nurture and ultimately give life to another, represents an achievement of tenderness that Kernberg (1995) considers a function of integrating libidinal and aggressive self and object representations. From

the position of intersubjectivity theory, Benjamin (1990) suggests that crucial to transformation is a continuing tension between recognizing the subjectivity of the other and maintaining an assertion of the self. This is achieved through the inevitable clash of realities between infant and mother—as well as between patient and analyst—where both survive, thereby distinguishing the other's reality from one's own inner world. It is here where the other is discovered that reparation occurs, and the capacity for concern about the love object is given expression (Kernberg 1995; Winnicott 1963, 1971).

The aforementioned transformations were manifested by changes in my patient's capacity to appreciate the individuality and gender identity of her husband and her analyst. My prevailing countertransference feelings had now changed considerably. I now felt that I was working *with* my patient rather than against her. I experienced a sense of gratification in being appreciated for my efforts. My transformation, too, seemed to represent what Benjamin (1990) considers a signal of mutual recognition. It reflected the patient's deepened capacity for empathy, an enhanced appreciation for my uniqueness and masculinity, and an enriched commitment to her husband and to the ideals of family life.

DISCUSSION AND CONCLUSION

This study addresses a topic that is of current interest and is also of some controversy in our field. In arriving at an understanding of what was ultimately therapeutic and mutative in my patient's analysis—and, possibly, what determines any analysis to be change-producing, by implication—this paper implicitly addresses several questions pertaining to this controversy:

(1) Is it the analyst's predominant theoretical orientation that determines his or her technique, and how salient is this privileged theory anyway?

(2) With well-trained analysts, does analytic understanding and the technique that follows cross theoretical boundaries and even the analyst's espoused preferred theory?

(3) Is it the patient's presentation, including his or her dynamics and character structure, that determines analytic technique? Or:

(4) Is it the patient's dynamics and character structure that meet at the interface of the analyst's dynamics and character structure that together form a conjointly determined collusion that ultimately determines technique?

Although all the aforementioned questions are addressed in the psychoanalytic literature—and with each and every patient in analysis, a case might be made for one prevailing over the other—this paper explores and emphasizes only the fourth question. Certainly, my patient's conflicts, dynamics, and character structure were salient and instrumental in the process.

My ability to tolerate the patient's relentless pressure to enact her conflicts, and my ability to simultaneously continue holding the frame, was essential for the success of the analysis. Without maintaining my reserve and caution throughout the analysis, I might not have been able to sustain the frame. Were an analyst unable to bear the constancy of the patient's provocations, or if an analyst became disrupted to the extent that analytic understanding and interpretation were not available in the face of her pressuring, quite likely, the analysis would have failed—or, possibly, the patient would have been summarily dismissed as having some form of borderline or narcissistic pathology considered unanalyzable. My tolerance for the patient's enactments, as I continued to hold the frame and manage the ebb and flow of my equanimity and countertransference, was indeed an essential ingredient in the success of the work.

As an aside, I have since wondered to what extent certain patients might be "diagnosed" as unanalyzable not so much because of their intrinsic psychopathology, but more realistically as a function of the analyst's reluctance to tolerate what might likely become a highly charged analysis that is replete with enactments. This is not meant as a criticism, since each of us must be free to determine whether or not we can work with a given patient; analysts vary in their capacity to tolerate conflicts that are enacted rather than

cognitively and affectively represented. This is an issue worth contemplating when considering the vast literature on patient–therapist match as a crucial variable in treatment outcome (Galatzer-Levy 1997; Kantrowitz 1993a, 1993b, 1995, 1997).

What I see as perhaps most important, is the manner in which the patient's conflicts and character intersect with the style, character, and even the conflicts of the analyst. It is here that the process is further molded in such a way that the patient's most compelling and troublesome conflicts are given full expression, whether enacted dramatically or not, as they are subjected to analytic and interpretive understanding (Smith 2000).

With my patient, even early in the consultation, I experienced precursors of her sadistic assaults as she expressed her impatience regarding time constraints. In my attempts to avoid her dissatisfaction, as the reader will remember, I reacted to her mild initial scolding with the ever-so-slight gratification of extending her time by merely a minute or two. It is here that we see the incipience of the co-constructed paradigm of castration/avoiding-being-castrated. Although the patient and I addressed her impatience and demandingness in various ways early in the process, the enactments and other vicissitudes of transference experiences persisted and even escalated as she and I continued working together. Smith (2006) has shown how the very essence of analytic work, including the act of understanding and other uses of the setting, can disavow insight and thereby function as a perversion while the patient persists in actualizing his or her fantasies with the analyst. Smith emphasizes the importance of the analyst and patient continuing to analyze such a process as it occurs throughout the analysis.

I will go so far as to say that with my patient, and possibly with any patient, whether the enactments are dramatic or more subtle, what yields the most potential for analytic growth is the analyst's permission for the enactments to occur, while allowing them to impact the self of the analyst, including his or her countertransference and inner conflicts. It is here, however, that the analyst must divide his or her experience and put the scenario into words for the patient through various forms of interpretation. I agree with what

Smith (2006) seems to regard as the inevitability of enactments in all analyses, whether obvious or subtle, and the importance of searching out and interpreting the ways in which the various fantasies enacted serve as resistance and disavowals of the very insight achieved through the work. It is this that constitutes the heart of therapeutic action.

I have sometimes wondered whether, had I been less permissive in this patient's analysis—for example, by setting more firm and immediate limits in insisting that she not eat in the session and not play back her prerecorded dream descriptions, and/or by instructing her to immediately put her coat on over her underclothing—would a valuable feature of the work have been lost?

I think many analysts would have done these things, and understandably so. But I have come to believe that, to the extent that actions such as these can be tolerated within the hour—assuming that they do not destroy the frame—the analyst is then in an ideal position to engage in (and is in fact empowered to engage in) the necessary cognitive and affective splitting that is especially required for patients whose character leaves them prone to pathology that is represented through action. Not all analysts can or will tolerate this kind of pressure. Whether or not analysts can, should, or can be trained to do so remains an open question, and possibly a subject for further discussion and research. For this patient, I contend that the most profoundly mutative qualities of the treatment were my permission and tolerance of this action, while I was able to simultaneously understand its meaning through its impact on me, and ultimately to engage with her in a way that demonstrated its meaning to her as well.

Although some analysts might contend that holding firmly to the frame and perhaps to one's theoretical preference is the ideal, I think that this position can represent a defense against our anxiety around the uncertainty of being drawn into areas with which we are less familiar. Actions of the patient, in contrast to cognitive-affective expressions only, are bound to be uncertain and unpredictable, and thereby anxiety laden. Indeed, setting limits restores the frame and reduces anxiety at the same time. But what is lost? I contend that

much is lost, since the analyst thereby conveys to the patient that only talking about these things is the proper subject of the work, and that the patient's "good behavior" is paramount.

Finally, I wish to address the length of this treatment, which to some might seem relatively short, at four and one-half years, for a patient such as this. Some may wonder about the legitimacy of the patient's reduced sadomasochism as she moved into a more feminine position, versus whether this instead represented a transference cure. Her dream about the blind companion and my interpretation of this as a possible reference to the blind analyst, versus the patient's interpretation of herself as having once been blind, might also raise a question about the brevity of her treatment. These considerations became salient for the patient and me as she and I worked together to understand the meaning of her dream. Just as I paid attention throughout the analysis to the correspondence between her transference paradigms, dreams, and fantasy material, on the one hand, and my countertransference fluctuations, on the other, I also paid attention to the same corresponding variables as we considered termination and its timing. Thus, her dream and fantasy expressions and their meanings were always cross-checked with the transference, my countertransference, and especially her extratransference and life functioning. It was here that the patient now seemed to flourish.

Furthermore—and this may have been partially obscured as an artifact of case-report writing—a straight-line move from sadomasochism to genuine loving did not occur. Instead, there was an expectable back-and-forth quality to this shift, both within the transference and in the patient's relationship with her husband. Yet throughout the analysis and the termination process, the integration of libidinal and aggressive trends increased as she and I worked toward the eventual ending date.

Some might wonder if there was ever an eruption of anxiety as she came to integrate these libidinal and aggressive trends. In fact, anxiety did not appear as an eruption or exacerbation per se, but I believe that her anxiety always coexisted with her sadomasochism in the form of her obsessive fears of failure in the corporate world

—fears that we continued to address throughout the treatment. These anxieties, too, were resolved as analysis proceeded and her sadomasochistic functioning gradually resolved.

Finally, there is an additional aspect of the analyst's contribution to the process that I wish to mention. As a psychoanalyst who also specializes in couple and family therapy, I am struck by a comparison between the analytic co-construction of a sadomasochistic transference-countertransference paradigm, and the troubled marriage or partnership that arrives in the analytic couple therapist's consulting room. Although I certainly do not regard every troubled marriage as sadomasochistic, I do regard every dyad that presents clinically as co-constructed. A phenomenon that is apparent to couple therapists is that, while one partner might present with the more obvious pathological component of the presenting difficulty, there is inevitably a contribution by the other partner that unconsciously enters in, influences, and/or exacerbates the reactions of the other.

Our psychoanalytic literature provides many useful concepts to help us understand these phenomena—namely, the mechanisms of projective and introjective identification (Dicks 1967; Klein 1946; Scharff and Scharff 1991; Zinner 1976), Racker's (1968) concepts of concordant and complementary identification, Bollas's (1987) principle of extractive introjection, and Ogden's (1994) description of the analytic third as an entity that defines the "intersubjectively generated experience of the analytic pair" (p. 3). Each of these describes a concept or a process that develops conjointly between intimate partners, including the analyst–patient pair—one that is co-created and maintained regardless of conscious intent or even mutual misery.

As with my comparison to the troubled marriage or partnership in which each of the partners makes a contribution to the co-constructed state of difficulty—whether this has led to complaints around, e.g., intrusiveness, neglect, or sexual dysfunction—analogously, in any psychoanalytic process, whether it includes a sadomasochistic transference enactment or not, there exists a "complex conflictual engagement with the patient that includes all the com-

ponents of conflict, including anxiety or depressive affect; defense; fear of punishment; and erotic and aggressive wishes," as Smith (2000, p. 125) informs us.

It is the manner in which all these unconscious issues of the analyst are activated and then enter into the same intersubjective space with those of the patient that gives structure and dimension to the analytic process, creating the very essence of that which must be interpreted. It is the work of the analyst and the patient, as it is for the analytic couple therapist and his or her patients, "to analyze this process as it is occurring, moment by moment" (Smith 2006, p. 713).

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PSYCHOANALYTIC AIMS AND ATTITUDES

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This paper explores distinctions and relationships among psychoanalytic aims, *psychoanalytic* attitudes, *and psychoanalytic* techniques. *The author proposes that these distinctions can illuminate a number of important tensions and problems within our clinical theories.*

THE MATCH BETWEEN AIMS, ATTITUDES, AND TECHNIQUES

In psychoanalysis, as in most enterprises, good outcomes depend on appropriate conditions. Successful analysis, for instance, depends in part on a reasonably good fit between the analyst's *aims* (what the analyst is trying to accomplish, such as "expanding the patient's self-awareness"), the analyst's *attitudes* (in the broad sense of the word, i.e., the emotional climate that the analyst creates in an analysis), and the analyst's *techniques* (such as interpretation, free association, and so on). Freud was acutely aware of the importance of each of these elements and the match among them, although during his early work he focused mostly on finding effective techniques for achieving his aims, and he assumed that a conventional medical attitude would suffice.

For instance, during the period of *Studies on Hysteria* (Breuer and Freud 1895), when Freud's clinical aim was the retrieval of

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"pathogenic recollections" (p. 267), he experimented to find the techniques—various forms of hypnotic and nonhypnotic suggestion—that were most facilitative of this aim. Later, as Freud became more sophisticated about understanding and treating neuroses, he came to realize that a specialized clinical *attitude* was also necessary in order for the techniques to be effective. For instance, in *On Beginning the Treatment* (1913), Freud addressed the necessity for establishing the proper *attitude* in analysis before using the *technique* of interpretation:

> When are we to begin making our communications to the patient? When is the moment for disclosing to him the hidden meaning of the ideas that occur to him? The answer to this can only be: Not until an effective transference has been established in the patient, a proper *rapport* with him . . . . It is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding, such as a moralizing party, or if one behaves like a representative of some contending party. [p. 140, italics in original]

Similarly, contemporary analysts generally seem to agree that most patients have to be provided with a particular clinical atmosphere—a confidential, caring relationship, for example—in order to engage in productive analytic work. (Of course, the clinical setting will not always be *experienced* as confidential and caring by the patient, and this discrepancy often becomes a central focus of analysis.) In large part, this is because analysis is a unique form of treatment that requires gaining access to frightening and guilt-ridden fantasies and experiences. Psychoanalysis is emotionally, narcissistically, and morally stressful for patients—indeed, this is among the reasons that it is not a particularly popular treatment. Partly as a counterbalance, analysts routinely try to maintain an attitude of respect and empathy to accompany their techniques of in-depth inquiry. One version of this clinical attitude was described by Poland (2002) as "respectful curiosity" (p. 812). Loewald (1960), forty-two years earlier but in a similar spirit, recommended an attitude of

"love and respect for the individual and individual development" (p. 19).

In actual practice, aims, attitudes, and techniques can, and perhaps should, blend harmoniously so that the distinctions among them blur. Poland (2002) goes so far as to suggest that "technique is attitude actualized" (p. 807). Nonetheless, there are heuristic benefits in focusing on the distinctions and relationships among aims, attitudes, and techniques in that this can enhance clarity about some central concepts and controversies within clinical psychoanalysis. In particular, it is possible to trace a number of important controversies to a tension within Freud's writings, documented by Friedman (1991), between two very different kinds of clinical aims. In Freud's early work (roughly, from *Studies on Hysteria* [Breuer and Freud 1895] up to the Dora case [Freud 1905]), his clinical aims focused on what Friedman calls a process of *ventilation*—essentially, the draining or discharge of specific, pathogenic psychic excitations through conscious verbalization of them.[1]

In the post-Dora period, Freud increasingly referenced a very different, and much more complex, clinical aim—what Friedman characterizes as the *integration of wishes.* As an analytic aim, *integration of wishes* refers to the idea that the therapeutic potential of psychoanalysis depends upon the patient learning to understand, accept, tolerate, and integrate painful, previously unacceptable desires, feelings, and ideas. Of course, the integration-of-wishes aim is much more closely related to contemporary versions of clinical aims, which emphasize significant changes in the patient's psychic organization, such as strengthening of the ego, increased mastery over developmental obstacles, establishment of more adaptive compromise formations, and other complex structural changes in the mind.

Interestingly, while Freud significantly changed his understanding of the clinical aims of psychoanalysis in this way, he gave us only

[1] Initially, *ventilation* consisted of the retrieval and verbal expression of patients' repressed traumatic memories. After Freud discarded the seduction theory, *ventilation* took the form of the discovery and verbal discharge of patients' repressed instinctual energies.

one tool kit—the techniques he most systematically described and recommended in his *Papers on Technique* (1911-1915). *These techniques, moreover, were originally developed for the ventilation/discharge aims* (cf. Lichtenberg 1994). For example, Freud's technical and attitudinal stance[2] of *abstinence* (in the form of nongratifying professional detachment) was based on his belief that transference gratification, a *behavioral* discharge of instinctual energies, would interfere with the possibility of therapeutic *verbal* discharge. Freud described one aspect of his basic clinical stance in his well-known surgical metaphor, urging analysts to "model [themselves] . . . on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (1912, p. 115)—a stance evident, for example, in the Dora case. This is Freud the mental surgeon, using a cool and austere clinical relationship in order to elicit and "ventilate" pathogenic memories and wishes.

This analytic attitude—usually referred to as *neutrality,* though this word is Strachey's questionable translation of Freud's less technical term *indifferenz* (Smith 1999)—makes most sense when seen in connection with the corresponding aims of memory retrieval and verbal discharge. An attitude like Loewald's (1960) "love and respect" (p. 19) may have been part of Freud's personal style, but it had no *theoretical* standing for Freud as a therapeutic attitude because, in his early work, he believed that clinical success was contingent more on a process of appropriate *discharge* than on processes of understanding, insight, and integration. Friedman (1991) argues that Freud's aims were shifting toward the integration-of-wishes standpoint during the period of the *Papers on Technique* (though they continued to coexist with ventilation aims, for complex reasons), but the attitudes and techniques advocated in these papers clearly originated in Freud's "ventilation" phase.

Freud, then, recommended a rather austere attitude that seemed to him compatible with and facilitative of the aim of retrieving and

[2] In my usage, a *stance*—a commonly used term—is a combination and blend of techniques and attitudes. This definition makes it possible to look at the separate components of a stance and to evaluate their compatibility, as I will do later in this paper.

discharging pathogenic memories and wishes. Indeed, those aspects of productive analytic work that involve making the unconscious visible to the analyst for "ventilating" interpretations of unconscious content may be best served by a stance of relative anonymity, abstinence, and surgical detachment, as Freud suggested. On the other hand, the match between Freud's recommended attitudes and techniques and those aspects of analytic work that involve wish *integration* by the patient is more complex. After all, an analytic stance of anonymity, abstinence, and detachment tends to *increase* the emotional stresses on the patient—exactly as it was designed to do, since Freud's early aims were best served by frustrating the patient's wishes (cf. Wile 1985). Specifically, Freud argued that frustrating patients' drives was the best way to heighten the drives' visibility and accessibility in the treatment, a prelude to facilitating therapeutic conscious discharge through verbal expression.

According to some neoclassical theorists, however, the more contemporary aim of wish integration requires different clinical attitudes—attitudes closer to "respect" and "love" (e.g., Loewald 1960; Poland 2002; Stone 1981). Of course, these sophisticated theorists take it as axiomatic that the analyst's intended attitude and the patient's *experience* of the analyst's attitude (like the patient's experience of the clinical setting, mentioned earlier) may be vastly different, and this gap often becomes a major focus of analytic work (Loewald 1960). Further, it is generally understood today that not only are patients' reactions to their analysts mediated by unconscious fantasies, but that analysts, too, are subject to the distorting influence of their unconscious processes. These caveats notwithstanding, the neoclassicists' emphasis on clinical attitudes such as love and respect suggests a historical shift in analytic attitudes related to the shift in analytic aims from ventilation toward the integration of wishes.

Given that, over time, Freud himself generally shifted toward integration-of-wishes aims (e.g., "where id was, there shall ego be"), and away from retrieval/discharge aims (e.g., "making the unconscious conscious"), why did he not revise his clinical attitudes and techniques more substantially? One might expect that Freud's later aims would have led him to revise his recommended attitudes

and techniques to ensure consistency with the new aims. A relevant factor here is the frequent observation that Freud's actual clinical stance appears to have been warmer and more gratifying than his written advice and metaphors would suggest. It is certainly possible that Freud did not feel the need to systematically revise his advice on attitudes and technique because his actual style of relating to patients was consistently personal and facilitative, even if at odds with some of his writings. Alternatively, one can see the discrepancy between Freud's written advice and his actual practice as an indication that he was in some sense aware of mismatches in his *conceptualization* of analytic aims, analytic attitudes, and analytic techniques, and was struggling to reconcile them in the consulting room.

In addition, Freud and later analysts have been able to stick with classical *techniques* in the face of shifting clinical aims because these techniques have proved to be extremely adaptable. For instance, the technique of free association was originally developed as a procedure designed to *evade* the influence of the "censor" because self-censoring interfered with the verbalization of unconscious derivatives. Freud thought he had figured out how to outfox the censor with the free-associative process; that is, by insisting that patients report every thought, analysts could bypass the censor and get access to the unconscious. This was appropriate for Freud's early aims because the analyst needed maximum access to unconscious drive derivatives so that these could be ventilated and thereby detoxified by the analyst through translation into conscious verbalizations.

But the advent of the integration-of-wishes paradigm profoundly changed the entire approach to the patient's internal censorship. Now the censor (reconceptualized as aspects of the ego and superego in structural theory) had to be *analyzed* and permanently altered in order for lasting change to occur. Fortuitously, free association turned out to be just as good a technique for *analyzing* the censor (and the myriad defensive operations at its disposal) as for *evading* the censor. One simply shifted one's interest from a primary focus on the *content* of free associations to a primary focus on the associative *process,* so that the nature and purpose of defensive disruptions in associations could be analyzed (e.g., Anna Freud 1936; Gray 1994). But, perhaps *because* of the flexibility of tech-

niques like free association, clinical techniques have not been fundamentally reexamined within mainstream psychoanalysis, despite these widely accepted changes in psychoanalytic aims.

MISMATCHES AND RESPONSES

Looking back over the history of psychoanalytic theory, it appears that analysts have frequently struggled with a mismatch between clinical aims that have tilted increasingly toward the integration of wishes rather than ventilation, and a repertoire of clinical techniques and attitudes that were designed for the latter. For example, I believe that Kohut's body of work (e.g., 1971, 1977) can be profitably viewed in this light. Consider the possibility that Kohut's journey into self psychology may have begun with his discovery of a clinical *attitude*—warmer and more responsive than classical neutrality, as he understood it—that seemed to facilitate analytic work with certain patients. Kohut's response to his discovery could have been to advocate, as Loewald (1960) had, for a clinical attitude that was a better match than classical neutrality for integration-of-wishes work. Instead, Kohut developed a new formal theory of clinical aims (e.g., *self-cohesion*), in contrast to the Freudian focus on transforming id into ego.

One reading of this history is that Kohut's awareness of a mismatch between his clinical aims and the recommended attitudes of classical analysis led him to develop a better psychoanalytic theory—a new set of well-matched aims, attitudes, and techniques. In an alternative view, Kohut missed an opportunity to identify and correct a mismatch between aims and attitudes *within* Freudian psychoanalysis, and instead created an unnecessary or problematic new metatheory to support his preferred clinical attitude.

Similarly, one impetus for the recent development of relational theories in psychoanalysis was a dissatisfaction with the austere clinical attitudes associated with classical theory, and relational theories also tend to recommend an alternative, warmer, and more responsive attitude. Accordingly, some relational theories can be viewed as having responded to a mismatch in Freudian analysis by jettisoning the baby (integration-of-wishes aims) with the bath water

(classical clinical attitudes). Relational analysts, of course, might well argue that the problems in Freudian theory are deeper than a "mismatch," and that an entirely new model is needed (cf. Buirski 2005).

The modern structural approach pioneered by Gray (1994) offers another interesting example of theory building in reaction to perceived mismatches within classical clinical analysis. Gray emphasized the technical implications of the shift to the structural theory, articulating (as Freud never did) a change in analytic techniques based on a fuller appreciation of the roles of the ego and superego in mental conflict. Gray (1994) explicitly endorsed integration-of-wishes aims, and explicitly rejected retrieval/discharge aims because they bypass the ego's defensive operations, preventing lasting change. In Gray's oft-quoted terms: "The therapeutic results of analytic treatment are lasting in proportion to the extent to which, during the analysis, the patient's unbypassed ego functions have become involved in a consciously and increasingly voluntary co-partnership with the analyst" (pp. 31-32).

Gray argued that such aims require a new technique: *close process attention,* which focuses on the analysis of defenses close to the analytic surface. But Gray did not seem to think that these aims necessitated a new clinical attitude, since he recommended an attitude close to that of classical neutrality (though with a strong rejection of authoritarian elements). Thus, where Kohut and relational theorists may have worked from preferred clinical attitudes to new theories of clinical aims, Gray began with theory-based clinical aims and developed a new technique for pursuing those aims, but he retained the clinical attitudes of classical theory. Controversies surrounding all these theories can be seen as reflecting, in part, questions about the consistency and coherence of their recommended clinical aims, attitudes, and techniques.

These examples also raise complex questions about the optimal and actual developmental relationships between aims, attitudes, and techniques in psychoanalysis. My point is not that aims should always precede and dictate attitudes and techniques, since the relationships among them are fluid, but rather that mismatches among

the three have been an underappreciated problem in psychoanalysis, as well as a source of creative tension behind theory building.

AN EXAMPLE FROM THE LITERATURE

Consider the following clinical vignette recounted by Buirski (2005), which deals with the relationships among psychoanalytic aims, attitudes, and techniques (although he does not use these terms). This example serves as an opportunity for us both to clarify the distinctions among aims, attitudes, and techniques, and to examine some of the consequences of a lack of clarity about them and mismatches among them.

Buirski (2005) describes an initial session with a patient during which he realizes, part way through the hour, that he has been deviating from his usual "empathic/introspective stance" and intersubjective treatment theory, and he makes a correction with seemingly beneficial results. While Buirski's main point is about the influence of the analyst's behavior on the intersubjective system, and the full vignette raises many interesting questions, I will focus only on the issues at hand. Buirski writes:

> Mr. G became more sullen and resistant when approached from an insight-oriented perspective that he seems to experience as narcissistically injurious. He became increasingly irritable and disparaging of the therapist . . . . When engaged from a stance that attuned to, mirrored, and affirmed his affective experience, Mr. G became more open to feelings and self-reflective about his experience and the meanings he made of that experience.
>
> We have traditionally been led to expect that insight results from interpreting resistance and defense against knowing. In contrast, here is an illustration of how the empathic/introspective stance, with its focus on attunement to affect states, furthers self-reflection through avoidance of interactions that provoke defensiveness . . . . Mr. G, who at first appeared to be a poor candidate for insight-oriented therapy, turns out to be quite open to knowing and revealing his inner affect states. [p. 60]

What is being said here about psychoanalytic aims, attitudes, and techniques? Buirski seems to argue that traditional Freudian attitudes and techniques ("an insight-oriented perspective") were poorly matched with the aim of promoting insight for this patient, while an "empathic/introspective stance" was better matched to this aim. He specifically challenges the traditional Freudian assumption that insight (an aim) is best achieved through the use of resistance and defense interpretation (a technique).

But the argument suffers from a number of critical-thinking flaws that the distinction among aims, attitudes, and techniques can help remediate. Most important, Buirski fails to distinguish between techniques and attitudes. He implies that a "narcissistically injurious" clinical attitude (note that important questions about the patient's possible transferential distortions are not considered here) is *necessarily* part and parcel of the technique of resistance and defense analysis; but in fact, resistance interpretation is a technique that can be used in the context of a wide range of clinical attitudes (cf. Busch 1995). Similarly, Buirski treats his "empathic/introspective stance" as a single entity, rather than teasing apart, to the extent possible, the attitudes and techniques that make up this stance. Thus, his claim that the "empathic/introspective stance" is a better match for the aim of promoting insight than the resistance-interpreting stance conflates (at least) two variables as one.

Even if we accept Buirski's reading of the clinical data, was it the interpretive technique or an accompanying injurious attitude that caused the initial problems? Was it the "affirming" attitude, the techniques of "introspection" and "mirroring," or some combination of these that helped, later, to promote insight? Finally, Buirski seems to unquestioningly assume that the aims of his "intersubjective" approach and of "traditional" psychoanalysis are singular and the same: promoting insight. At the same time, he confusingly labels traditional technique as "insight-oriented," contrasts this with his "empathic-introspective" method, and yet claims that the latter more effectively promotes insight.

NEUTRALITY REVISITED

Another heuristic benefit of distinguishing among aims, attitudes, and techniques in clinical psychoanalysis is that doing so can clarify definitions of psychoanalytic concepts. For example, let's return to the concept of neutrality. Reading Freud's *Papers on Technique* (1911-1915) makes it abundantly clear that his recommended attitudes and techniques were tightly linked to his clinical aims. Freud's rationale for suggesting that it is best for analysts to maintain a relatively quiet, nondisclosing, opaque, nongratifying stance—aspects of what have come to be referred to as classical neutrality, abstinence, and anonymity—was that these facilitated the emergence of necessary unconscious material. As noted above, Freud argued that frustrating patients' wishes was the best way to heighten the drives' accessibility in the treatment, a necessary prelude to interpretation.

While Freud understood the neutral stance as a *means to a specific end*, subsequent generations of analysts have subtly shifted toward treating the means *as* the ends. This is the case whenever neutrality is presented as a set of decontextualized *rules*, such as the rule of abstinence (e.g., "transference gratification should be avoided"), rather than a set of attitudes and techniques contingent on certain aims. Of course, one could argue that Freud was wrong about the utility of abstinence and anonymity in serving his clinical aims. My goal, however, is a different one—to highlight that Freud's recommended attitudes and techniques were developed in close conjunction with, and were contingent upon, specific clinical aims. Accordingly, any definition of a recommended analytic stance, such as neutrality, is of limited value unless it refers to the aims that this stance is intended to serve. Psychoanalytic technique, in other words, may be best viewed as a set of *tactics* in the service of analytic aims and aligned with analytic attitudes, rather than as a set of *rules*.

One advantage of defining concepts such as neutrality in terms of their associated clinical aims, rather than in terms of prescribed and proscribed behaviors, is that we can then clarify that the nature of a "neutral" stance will vary considerably from patient to patient, de-

pending on contextual factors, such as an individual patient's specific psychic structure (cf. Hansell [2002]; see also Kris [1990] on *functional neutrality*). For instance, an analyst may discover that the optimal clinical stance for a guilt- or shame-ridden patient early in treatment is one of considerable openness and support, if this creates the conditions necessary to begin productive analytic work. With another patient or at a different phase in the same analysis, the most facilitative stance may be one of rigorous abstinence, yet both could function in the service of the same aim.

The fact that psychoanalytic techniques, in and of themselves, may be ineffective unless appropriately linked to congruent aims and attitudes can be difficult to grasp. Every experienced supervisor has worked with trainees who assume that "being psychoanalytic" is characterized by the use of common analytic techniques, such as being relatively silent or interpreting dreams, rather than by the analyst's aims and attitudes. (Of course, it is easier to focus on concrete behaviors and rules than on strategic and tactical thinking when learning a new craft.) Even experienced analysts sometimes define analysis in terms of technical procedures—interpretation or the use of the couch, for example—rather than in terms of the aims and attitudes that these techniques are intended to actualize (Lipton 1983).

CONCLUDING THOUGHTS

On a larger scale, mismatched aims, attitudes, and techniques within clinical analysis may have played an ironic part in the current crisis in psychoanalysis (Garza-Guerrero 2002; Kirsner 2004)—that is, the decline in the practice of psychoanalysis in recent decades and in its intellectual cachet. According to a report of the Strategic Marketing Initiative of the American Psychoanalytic Association (Zacharias 2002), psychoanalysts are seen by both the lay public and by other mental health professionals as opaque, frustrating, and emotionally distant—attributes that are strikingly consistent with the recommended attitudes of classical neutrality. (This is another indication of the centrality of attitudes in shaping analysts' professional identities.)

How these clinical attitudes have affected the overall status of psychoanalytic practice is a complex question. On the one hand, it is natural to wonder how much allegiance to austere attitudes has contributed to the declining popularity of psychoanalysis. On the other hand, one might argue that analysis was most popular when it was most austere—during the so-called heyday of the 1950s and 1960s. Further complicating the question is the fact that the popularity of analysis during the "heyday" was partly due to the fact that there were few alternative treatments in the marketplace. Today, with many alternatives available, assessing the popularity (or unpopularity) of analysis may be more meaningful.

In any case, the evolution of clinical psychoanalysis over the century of its existence has focused, in many respects, on our increasing sophistication about analytic aims. Similarly, the conditions that make effective analytic work possible—conditions that can be described largely in terms of the analyst's attitude—are much more complex than Freud initially realized. Although his exposition of analytic aims, attitudes, and techniques in his *Papers on Technique* (1911-1915) includes some evidence of the shift from the ventilation paradigm to the integration-of-wishes model (Friedman 1991), it is worth noting that even those changes occurred before the development of numerous concepts that are now central to most analysts' thinking. Psychoanalytic theories of aggressive, narcissistic, and non-energic motives; of the role of the ego and superego in mental life; of the great variety of modes of defense in addition to repression; and of the importance of attachment and self-cohesion all developed subsequent to Freud's 1911-1915 *Papers on Technique* (cf. Gray 1994). Contemporary analysts take these ideas for granted, but we can and should use them to further clarify and harmonize our psychoanalytic aims, attitudes, and techniques in our clinical work.

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PSYCHOANALYTIC IDENTITY: PSYCHOANALYSIS AS AN INTERNAL OBJECT

BY ROBBERT S. G. WILLE

This paper presents a detailed description of the psychoanalytic identity, whose nucleus is the psychic representation of psychoanalysis in the internal world of the analyst—i.e., psychoanalysis as an internal object. Psychoanalytic training is, of course, crucial to the development of a psychoanalytic identity, but as a result of ambivalence, the psychoanalytic identity is apt to be diluted both during training and after. This process is reinforced by the worldwide trend for analysts to analyze fewer cases. The so-called crisis in psychoanalysis, usually referring to the problem of too few analytic patients and too few analytic candidates, is first and foremost a crisis in ourselves and, in particular, in our psychoanalytic identity. The author presents examples and causes of an unstable psychoanalytic identity, along with suggestions for ameliorative measures.

Just as a psychoanalysis is a process with a development, so, too, is the process whereby a person becomes an analyst. Both processes have a formal end but, in favorable circumstances, not a psychic end. These processes constitute a perpetual development that persists throughout life, if things go well. In my ongoing attempts to become and remain a psychoanalyst, the importance of the psycho-

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analytic identity has become increasingly clear to me. In my view, the psychoanalytic identity—in a word, the way in which we consciously and unconsciously feel ourselves to be analysts—is a central concept in psychoanalysis, which has a bearing on the practice of psychoanalysis, on training as an analyst, and on psychoanalysis as a movement.

The differences among analysts in terms of the manner in which they practice psychoanalysis, and the degree to which they do so, are great. For instance, it is noteworthy that, given the same clinical material, analysts may arrive at extremely divergent views on the appropriateness of an analysis. This is often due not to differing perceptions of the patient's psychic characteristics, but to differing evaluations of these characteristics in considering whether or not to recommend analysis. Whereas one analyst will recommend an analysis, another will suggest lower-frequency therapy; and whereas one analyst's practice may include a full schedule of analyses, another may have very few cases or none at all, and may attribute this situation to external causes. Similar differences are observed with regard to termination; one analyst will contemplate active termination of an analysis, whereas another will be inclined to wait and let the process take its course, in the expectation that further development is possible.

Therefore, analysts have widely differing conceptions of the best approach to adopt with the same patient. In my opinion, these differences among analysts are often due not so much to the patient's intrapsychic structure, but to variations in each individual analyst's trust in the potential of the psychoanalytic method and in himself as an analytic instrument. To some extent, these differences among analysts should be seen, I believe, as differences among their psychoanalytic identities.

A REVIEW OF THE RELEVANT LITERATURE

It is noteworthy that our literature has hitherto devoted little attention to the issue of psychoanalytic identity. The most relevant

contributions are to be found in two International Psychoanalytical Association symposia. The first was held in 1976, with contributions from Joseph, Widlöcher, and Grinberg.

Joseph (1983) describes the psychoanalytic identity as the capacity to feel and think in such a way as to facilitate observation and reflection on another person's psychic functioning. This includes awareness on the analyst's part of any feelings and prejudices of his own that might disturb the process. Joseph also mentions the feeling of belonging to the psychoanalytic community as an important component of psychoanalytic identity. In his contribution, Widlöcher (1983) also refers to the capacity to observe psychic functioning, and in so doing, to direct attention to its latent content.

Grinberg (1990) adduces a number of characteristics that together form the "psychoanalytic function of the personality" (p. 118). These are:

- a curiosity about human psychic functioning that extends beyond that of one's own person;
- a capacity for introspection and self-analysis;
- a creative capacity;
- a capacity to think in unfavorable circumstances (for instance, during an emotional storm);
- a capacity for discretion, ethical behavior, and avoidance of acting out;
- a capacity to tolerate frustration induced by isolation, by the lack of quick results, and, sometimes, by incomprehension;
- a capacity to wait and continue to listen with evenly suspended attention; and
- a capacity to tolerate uncertainty, doubt, and half-truths without having to search for explanations and facts.

According to Grinberg, all these characteristics together constitute the analytic identity; and he adds that another essential requirement

is the ability to feel that one remains the same person, or the same analyst, while change is taking place.

At a later IPA symposium, Kernberg (1987) enlarges on Grinberg's contribution, adding a further characteristic—namely, trust in the possibility of using introspection and insight to achieve new understanding and change, together with a parental attitude of holding or containment of the chaotic nature of intrapsychic conflict. Kernberg also mentions three important superego contributions to analytic identity: a degree of adulthood in the level of identification with social, political, or religious ideologies; the capacity to resist regression when the analyst is exposed to group processes; and the capacity to remain faithful to one's own system of values, as opposed to submitting to convention.

This selection of relevant literature mainly describes various capacities and characteristics that an analyst must possess in order to be a "good" analyst. I shall attempt to describe the analytic identity as specifically as possible, starting from the idea that the nucleus of analytic identity is made up of the psychic representation of analysis in the analyst's inner world. In other words, the nucleus of analytic identity is determined by the way in which we have internalized psychoanalysis and the way we consciously and unconsciously think and feel about it.

In consequence of the prolonged, intensive process of development as an analyst, whereby many aspects of psychoanalysis are internalized, there arises a complex of introjections and identifications leading to the development of an internal structure that is more than a collection of ego or superego functions. I shall attempt to describe how, through the growing trust in the psychoanalytic method and, in particular, in the unconscious process and the setting—as well as the ever deeper conception of the therapeutic and personal value of psychoanalysis—an intensive relationship with this internal structure comes into being. In this way, psychoanalysis becomes an internal companion in our lives, with which we have a relationship that, like all relationships, assumes a large number of

emotional colors and is constantly in motion. Psychoanalysis becomes an internal object whose quality, together with the relationship we have with it, forms the nucleus of analytic identity. While the internal object constituted by psychoanalysis can predominantly offer support and trust, it may also afford difficulties, as discussed in a subsequent section of this paper.

In order to emphasize that analysis is a part of our internal world and that our emotional relationship with it determines our analytic identity—so that the primary aspect is not that of a theory or technique outside ourselves—I shall consider psychoanalysis as an internal object and our link to psychoanalysis as an object relationship. We may love, hate, idealize, and devalue the internal object of psychoanalysis, but it will be central, in one way or another, to the way in which we are and feel ourselves to be analysts.

Caper (1997) very clearly describes the importance of the notion of analysis as an internal object:

> I suggest that the internal object that helps the analyst sustain his internal barrier against the patient's projections is psychoanalysis itself as a specific type of empirical investigation. It functions this way only if it is an internal object for the analyst and it becomes an internal object for the analyst only if he loves it. This love of psychoanalysis is acquired and strengthened through the analyst's own analysis, and its presence seems to be a good criterion of that elusive state called "being analyzed," or "having an identity as a psychoanalyst." [pp. 270-271]

In addition to our appreciation of this as an internal barrier against the patient's projections, the concept of psychoanalysis as an internal object allows us to see the differences among analysts as resulting partly from the inner world of each analyst, and the analyst's relationship with analysis in particular, rather than ascribing these differences exclusively to external factors. As obvious as this may seem, it is, in my opinion, actually a controversial view among analysts.

THE FORMATION OF PSYCHOANALYSIS AS AN INTERNAL OBJECT

Schafer (1979) points out that we are in fact constantly engaged in the process of becoming analysts, and that completion of training is a mere staging post on an endless journey. It is not that we *are* analysts, but that we are unremittingly involved in the process of *becoming* analysts.

Pre-Analytic Identity

The foundations of this process are laid long before psychoanalytic training. The child develops characteristics such as curiosity and eagerness to learn, interest, and emotional sensitivity, which are very important underlying elements for a subsequent analytic identity. Of course, identification with parental figures, and sometimes with older siblings, plays an important role in the formation of these early elements of the analytic identity, as in the formation of any identity.

Although I am not familiar with systematic studies on this subject, my impression is that the family background of many analysts and candidates is characterized by at least one parental figure who fosters a climate of good enough emotional warmth and openness, on the one hand, and intellectual curiosity and ambition, on the other. Sometimes a kind of psychological mindedness is clearly present. One analyst told me that in his parental home, there was a wall plate with the maxim "To understand is better than to complain," painted by his grandfather.

An additional part is no doubt played by the way a child becomes familiar with inner conflicts and emotional pain and how to tolerate these. Another finding that is not uncommon in the family backgrounds of analysts (again, according to my impression) is a serious disturbance in at least one parent. A childhood situation of chronic emotional stress and threat may bring about a strong sensitivity to unconscious emotional communication, as a form of adaptation necessary for psychic survival. Interest in or fascination with

the *not obvious*—the hidden or even the forbidden—might also play an important role, though of course most children, if not all, have these interests and fascinations. An anecdote comes to mind in which Anna Freud tells her father during an evening walk that she is fascinated by all the beautifully lit Viennese houses. Freud agrees with his daughter, but adds that what is really fascinating is what happens behind those facades.

The qualities of a future analytic identity are further developed and internalized during the individual's education and academic training. In this period of intellectual development, curiosity is booming, and critical and creative thinking are highly stimulated. Many analysts-to-be at this time meet someone—often, but not always, a teacher—who arouses an interest in inner emotional life and helps connect this with intellectual curiosity. In this way, interest in emotional processes comes into being. Sometimes this happens by way of a direct introduction to psychoanalytic reading; sometimes it is through art or literature.

For my own introduction to psychoanalytic thinking, I thank my college literature teacher, who had great skill in interpreting literature in a psychoanalytic way. I remember my pleasure and surprise at discovering something very new and exciting, which immediately gave me an enormous appetite for more. In my opinion, if such an interest in psychoanalysis is awakened during the college years, one will read psychoanalytic literature, and a search will begin for those who can offer analytic knowledge and experience. Some will attend analytic lectures or choose analytically informed teachers. Some will seek analytic help for the problems they experience at this stage of their lives.

In this way, long before the commencement of analytic training, an affinity with psychoanalysis grows, and the vision of becoming an analyst becomes part of the ego ideal. All the important figures of identification—such as parents, siblings, teachers, and possibly therapists—contribute to the ongoing formation of a pre-analytic identity. Parsons (1995, p. 83) calls a pre-identity of this kind the "life blood" of psychoanalysis, noting that it transports the candidate, at the beginning of his training, into the depths of the self, and that it must be stimulated and developed during training.

Thus, the beginning analytic candidate does not enter training naively. Often he already has a considerable amount of knowledge, and certainly also conscious and unconscious fantasies about what analytic training will offer. For some, this will mean the expectation of becoming members of a selective group of chosen super-therapists. Others might have magical expectations that analysis will provide the answers to all their personal problems. Whatever the nature of the specific fantasy, it will continuously influence the training.

Formation of the Psychoanalytic Identity During Training

In psychoanalytic training, identification is probably the most important mechanism, and in my view, the formation of a solid, permanent analytic identity is the principal aim. Arlow (1972) states that the professional attitude and ideals essential to the profession cannot be transmitted by cognitive teaching alone. Therefore, writes Arlow, "an emotional mechanism [is] required; an identification with leading figures who correspond to the collective ego ideal is the principal instrumentality employed" (p. 559). In his view, "the educational goal in training psychoanalysts is to foster that kind of identification which is stable, secure, and resistant to regressive reinvolvement in conflict" (p. 562). Although stable and secure identification is of course desirable and a goal to strive for, it is important to realize that identifications are formations made of compromises, and, therefore, they are always embedded in conflict, as Smith (2001) points out. This means that identifications can never be altogether stable or resistant to regression. They are always ambivalent—sometimes benign and facilitating, and sometimes overcritical and inhibiting.

Several authors point to the dangers connected with identification. Heimann (1954) mentions that candidates may accept analytic interpretations in order to ward off hostility and doubt, and in this way, they use identification defensively. In the same paper, Heimann calls attention to unrecognized identification with the candidate by the analyst himself, which can result in a too-intense emotional involvement of the analyst with the candidate.

Greenacre (1966a) points to the danger that the candidate may imitate the analyst instead of identifying with him, resulting in the candidate's not fully experiencing the meaning of interpretations, but instead compliantly accepting them. She writes that this risk is especially great with narcissistic candidates, but also that the most influential factor is the analyst's reactions. It is plausible that the more an analyst tends toward narcissism, the greater the risk that he will not be aware of this process and will not be able to deal with it analytically. Greenacre thinks this risk is even greater when the analyst is a person of some prestige in his analytic group, because then the candidate is more inclined to think that this renowned analyst must be right.

In this respect, the difference between the concepts of *imitation* and *identification*, described by Meissner (1973), is relevant. Imitation as a form of learning refers to the copying of overt, observable behavior without the internalization of this behavior. Identification, however, is the internalizing of abstract psychological characteristics like motives, attitudes, values, and affective states. Meissner describes identification as "an internal structural modification within the ego—a basic change in the structure of personality" (p. 800). If psychoanalytic training aims at the stimulation of free and creative thinking and at the development of an autonomous analytic identity, it is clear that identification is to be strived for and imitation is to be avoided. (Of course, imitation cannot always be avoided, and might sometimes even function as an intermediate stage toward identification.)

Training analysts, supervisors, lecturers, and prominent analysts at home and abroad, as well as other candidates, are persons, or parts of persons, with whom candidates identify and who furnish the building blocks of each candidate's analytic identity. Of all these potential objects of identification, the training analyst is probably the most influential. Several authors (Greenacre 1966a; Heimann 1954; Lampl-de Groot 1954) stress the special circumstance that, during a training analysis, the candidate has not only analytic contact, but also other types of contact with his analyst in all kinds of social situations, such as seminars, meetings, and parties. Both members of

the analytic dyad thus become members of a competitive group as well (Greenacre 1966a), which has various effects on the transference and countertransference.

Furthermore, these extra-analytic contacts influence the identification process because the candidate receives much more information about his analyst than does a patient who is not an analytic candidate. The candidate observes his analyst in various situations and roles and hears stories about him, both true and untrue. This situation can become complicated and confusing for the candidate because it may arouse competitive and narcissistic issues that can interfere with the process of identification.

Heimann (1954) thinks that "if the extra-analytic factors of a training analysis are not allowed to become sanctuaries for resistance, they prove fertile for the analytic work" (p. 164). Difficulties can thus be turned into an instrument for furthering the analysis. Greenacre (1966a) finds this point of view "optimistic and tinged with rationalization" (p. 551), however; she argues that, when new material arises in the analysis as the result of contact in reality with the analyst, it runs the risk of being encapsulated and therefore not analyzed. In her opinion, "such strangulated transference problems may be the source of a good many ambivalent attitudes toward analysis itself among analysts" (p. 551).

In another paper, Greenacre (1966b) warns of the danger of overidealization of the analyst and of analysis. Arlow (1972) states that, as a result of identification with his training analyst, the candidate frequently develops the goal of becoming a training analyst himself; consequently, becoming "only" an analyst is then not acceptable. If the goal of becoming a training analyst is not achieved, narcissistic injury and a turn away from analysis can be the outcome.

The candidate identifies not only with the person of the training analyst as an object, but also with his analytic function (Shengold 1985), and thereby internalizes parts of his training analyst's technique. Ideally, this identification with the person and function of the training analyst is followed by a phase of *disidentification,* in which the candidate develops a capacity for self-analysis and can thus become his *own* analyst, with a unique analytic identity of his own.

During the first years of training, the identifications—hopefully mostly facilitating ones, though sometimes inhibiting—will be forceful and in the foreground. In the more advanced candidate, identifications will probably become less prominent and will move to the background.

This development takes place substantially during the post-analytic process and is largely dependent on the extent to which the training analyst can maintain his abstinence and distance for a sufficiently long period after the end of the analysis. Overhasty friendships or analyst-to-analyst contacts may be excessively colored by transference and countertransference phenomena, and can disturb the process of acquiring analytic autonomy. This also holds true for analytic supervisors and teachers, although usually to a lesser degree.

The candidate identifies not only with persons, but also with entities, such as the analytic community, subgroups in this community, analytic theory, and psychoanalysis as a whole. Several authors have commented on the highly complex psychological circumstances under which the candidate is trained. Bibring (1954) speaks of "the closely knit candidates" who "represent a highly competitive group, inclined to common acting out," and also "inclined to split off their transference reactions and to displace them to other analytic instructors" (p. 169). Bibring summarizes this as the "pathogenic cross-currents of training institutes" (p. 170).

Rangell (1982) calls attention to the candidate's group experiences during the training years as one of two aspects (the other being the training analysis) that "exert a decisive influence on his future relationships to psychoanalysis with respect to both psychoanalytic theory and psychoanalytic group life" (p. 45). The "analytic family," as Rangell writes, "constitutes a dynamic social structure which corresponds in an almost one-to-one manner with the hierarchic structure of the original family" (p. 46). Arlow (1972) states that analytic training "often comes to be experienced as a prolonged initiation rite" (p. 560), which results in idealization or hostility. If these reactions are not recognized and adequately dealt with in analysis, they can be "transferred to psychoanalysis as a method or as a body of knowledge" (p. 561).

During the course of the training analysis, the psychoanalytic process, too, is internalized. In this way, the candidate forms an internal image of analysis as a necessarily prolonged, unstructured process that does not afford rapid satisfactions and that offers change, insight, and an overall view more often than actual solutions. If this is coupled with the experience that the process presents a unique opportunity for acquiring profound insight into one's own inner functioning, and that such insight also furnishes a unique opportunity for the development of autonomy and for change, a vital nucleus of analytic identity will have been formed. The experience gained while analyzing patients oneself—with the realization that the analytic process offers this unique opportunity to others, too, and can thus be an effective therapy—constitutes another decisive contribution to analytic identity.

Psychoanalytic Identity After Training

As noted earlier, the formation of the analytic identity is not completed with the termination of formal training. Owing to the many and various identification processes involved, an unwanted—but also unavoidable—side effect of analytic training is that the newly qualified analyst is still, to a considerable extent, internally controlled by his analytic identification objects. The moving to the background of the various identifications does not mean that in the end they completely disappear or remain inactive and unaltered. Smith (2001) states that "while identifications modify over time, following a predictable developmental path, they remain an active part of the analyst's inner life" (p. 786n). The analyst keeps "hearing the voices," as Smith puts it, of his internal identification objects. Because these voices do not always speak the same language and may propagate conflicting messages, Smith speaks of a "battle of voices" (p. 799) as part of the development of the analyst's autonomy.

Klauber (1986) holds that the young analyst is bound to function with an analytic false self for years to come. Many authors (Fogel and Glick 1991; Joseph 1983; Klauber 1986) emphasize that an autonomous analytic identity can come into being only long after for-

mal training is over. The development of an autonomous analytic identity takes years of nonsupervised, intensive analytic work after the completion of training. This is illustrated by Klauber's (1986) well-known remark that he needed ten years of full-time analyzing before he was able to accept a patient for analysis without guilt and anxiety.

Even when Klauber's ten years have passed and Smith's "battle of voices" simmers down, the analytic identity has not reached a definitive form. Analysts are human beings who change over time, and their analytic identities change with them. During an analyst's career, the field of psychoanalysis also changes, which means that the analyst's view of it is also modified over the years, as is the analyst's identity with it. Kris (unpublished) points out that, sometimes, "unlearning psychoanalysis" is required in order to adapt to new theories and new ideas about technique. As crucial parts of this unlearning, Kris mentions the "revision of identifications and processes of mourning" (p. 6). We must remember that formation of the analytic identity is an ongoing process.

THE INTERNAL PSYCHOANALYTIC OBJECT

Starting in early childhood and up to adulthood, the individual forms an identity that contains many elements making up the base of the later psychoanalytic identity; thus, the analytic identity is constructed on the basis of the general identity. During analytic training, as a result of all the (partial) identifications with individuals, with the analytic function, setting, and analytic process, the analytic identity is slowly but surely consolidated. The internal psychoanalytic object is the core of this analytic identity. This object includes all the cognitive and emotional aspects—both conscious and unconscious—of the individual's inner position with respect to psychoanalysis. It is not a completely new internal object because it is very much built upon and influenced by the various internal objects that have been formed since childhood. Aspects of the parental

ego ideals and values, inner attitudes and patterns of emotional functioning of significant others, are all included. Parts of it will be reflections or replacements of relationships with earlier internal objects; other parts will be more recent or new.

Looking back at my own development, for instance, I can trace my curiosity and interest in inner psychic functioning back to my parental home and subsequent education. The internalization of the values that support my analytic attitude took place especially during the second part of my analytic training and later. As indicated, the psychoanalytic identity and the general identity exist alongside each other, overlap, and exert a reciprocal influence on each other.

In my opinion, three elements make up the essence of the internal analytic object. These are not independent of each other but, while overlapping, they are nevertheless distinguishable. They are: (1) an inquiring, questioning attitude directed toward introspective and interactional knowledge as a source of inner change; (2) trust in an unstructured, unconscious communicative process; and (3) trust in the analytic setting (frequency of sessions and postural position of the patient) as most favorable to inner change. These three aspects of the internal analytic object constitute the nucleus of analytic identity (which, considered as a whole, is of course not limited to them).

In our techniques and attitudes, we analysts certainly share much with psychotherapists and other mental health professionals. In my view, though, our questioning attitude, and our trust in the unconscious process and the setting, are unique to psychoanalysis, and therefore constitute the core of the psychoanalytic identity. Parts or derivatives of these core aspects may be used by analytic therapists or other analytically informed professionals, to some extent, but not as completely or coherently as in psychoanalysis.

I have no doubt that many analysts will not subscribe to my view of the nature of the analytic internal object as I am describing it. Some will object even to the notion of an internal analytic object, and some would choose a different set of core aspects. But though there are many conceptions of psychoanalysis, I think that analysts share some basic elements in their identities.

I will elaborate below what I see as the three core elements of the psychoanalytic identity.

An Inquiring, Questioning Attitude Directed Toward Inner Knowledge

The first specific aspect is principally a basic philosophical posture, characterized by a primary orientation toward searching, questioning, and the element of surprise, in which the striving for therapeutic goals is relegated to the background. Efficacy, efficiency, relief of symptoms, and reduction of psychic pain are subordinated to the deepening of emotional experience, self-knowledge, fantasy, and contact with deeper layers of the personality. The acceptance and tolerance of not knowing (Ogden 1992), of uncertainty, of powerlessness, of one's own limitations, and of the unavoidable pain of the human condition—in a word, the unconditional recognition of reality—take priority over the desire to cover up, to repair, and to control.

Bion (1970), borrowing from Keats, applied the concept of *negative capability* to his characterization of the analyst as someone "capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason" (p. 125). Busch (2001), on the other hand, defines the nucleus of every analysis with Kant's maxim—"*dare to know*"—by which he means the experience of daring to recognize what we do not want to know about our internal world. Blum (1981) points in the same direction when he describes "adherence to unlimited inquiry" and "insisting upon truth and prohibiting lying to others and self-deception" (p. 547) as preconditions of superego functioning in the service of insight. Blum calls this "the analytic ideal of insight," which is, in his opinion, "the outcome of analytic training, experience, identifications, and the capacity to maintain an analytic attitude and identity" (p. 552).

Analysis, then, is a matter of daring to know, and, on the other hand, of tolerating not knowing what we cannot, or cannot yet, know. Poland (2002) gets very close to the inquiring, questioning attitude with his term *interpretive attitude*—a stance of analytic curiosity that is at all times directed toward insight and understanding. King (1978) illuminates another aspect of the analytic attitude with

her comment that an analyst must be capable of doing nothing at moments of maximum tension. Hence, from this point of view, doing analysis is a matter of being able to do nothing and waiting rather than actively intervening—of prioritizing experience over formulation.

An essential element of the inquiring attitude is the dialectic between the two internal positions adopted by the analyst. While connecting empathically with the other, the analyst at the same time places himself outside this direct emotional connection, which the analyst examines from a third position. From the vantage point of this third position, the analyst always looks with an unprejudiced curiosity at that which seems and feels entirely self-evident from the point of view of the other position. The analyst oscillates at high frequency between these two positions. The intense contact in an analysis is a precondition for the occurrence of this dialectic and, in particular, for the capacity to use it. As a participating observer, the analyst observes the patient, himself, and their interaction on a number of different levels.

The inquiring, questioning attitude of the analyst contrasts with that of many other mental health care professionals who have a more therapeutic or medical identity, which is oriented much more toward treatment, healing, and the resolution and relief of suffering, and in which the emphasis is more on the rational and effective (evidence-based) elimination of clearly defined symptoms and pathology.

The Unconscious Communicative Process

The second specific aspect of the internal analytic object is trust in the unconscious communicative process between analyst and patient, based on analytic experience (Jacobs 2001; Kantrowitz 2001). Trust in this process presupposes trust in one's own unconscious functioning (Parsons 1995), as well as one's ongoing self-analysis of such functioning. This self-analysis is necessary because, although the analyst can trust the unconscious process as such, he cannot blindly trust the meaning that initially presents itself to him. If the analyst notices a feeling of emptiness arising in himself, he

may construe this as a feeling of the patient's that has been put into him by projective identification—but it may also be an emptiness stemming partly from the analyst himself; we must remember that feelings always form part of the unconscious process of communication and are therefore never exclusive to one party or the other, but are always to some extent shared.

The analyst thus places trust in the unconscious communicative process, and at all times *distrusts* the meaning of this process in the form in which the analyst first becomes conscious of it. To put it differently, if the analyst trusts that what he feels at a given moment is the result of unconscious communication, then the analyst must distrust his initial perception of the meaning and source of this affect and submit it to a critical self-analysis.

Trust in the unconscious process manifests itself in analysis in a number of ways. If one attaches importance to the meaning of a spontaneous idea (*Einfall* in German) for which no rational justification can be adduced at the time, one is basing this attitude on just such trust. Another example lies in the analyst's decision not to take up certain material, based on his trust that it will come up again sooner or later because it forms part of the unconscious process.

The following clinical vignette illustrates the importance of trust in the unconscious process while emotional pressure is high.

> My patient, P, is in her fourth year of analysis. The transference is characterized by hostility, reproaches, and paranoia; I impose a burden on her and disturb her thoughts instead of helping her. She experiences me as rejecting and accusing. For some considerable time now, she has been coming to her sessions later and later, or not at all, and when she does come, she remains silent for most of the time. Everything I say is twisted, ridiculed, or simply ignored.
>
> One Thursday, she comes late, remains silent for a long time, and then angrily asserts that I am trying to force her into the role of a sick person, but says she does not want to talk about it because she is afraid of my reaction. She leaves early.

P calls to cancel her Friday session. On the next Monday, she arrives a few minutes before the end of the allotted time. She announces that she does not want to say anything, remains silent for a few minutes, says, "Okay, I'm off" —and leaves.

She skips her Tuesday session altogether, without notice. For the next few sessions, she is again either very late or fails to turn up at all. When she does turn up, she hardly says anything, does not answer questions, and ignores me.

This pattern persists for many months. Hardly anything seems to be left between us that can still be called analysis, and the temptation to end the analysis—and so to put us both out of our misery, in a manner of speaking—is great. However, the frame of the analysis remains more or less intact, so I keep P's appointment times free; I wait for her (usually to no avail); and I charge her for all her sessions, for which she pays. I find myself thinking of her frequently—feeling dismissed, discarded, powerless, and quite often furious. Sometimes she appears in my dreams. I wonder whether she thinks of the analysis and of me—whether I still exist for her. During the many hours when she is not there, I try not to distract myself with other things but rather to concentrate on her and her absence.

After a while, P begins to come more often again and to stay longer. She says that, for many months, I and the analysis have hardly existed for her. Lately, however, she has spontaneously thought more and more of the analysis, and has suddenly remembered things I have said to her. She says: "It's as if, deep down, I have continued to talk to you without realizing it myself. Although I've hardly been here at all for months, something has kept going. That's very strange—we've been separated, but linked together all the same."

During the patient's non-appearances, early departures, and many long silences, I never had the feeling that there was no contact at all between us. Although very few words were exchanged and

the contact sometimes felt very faint, it was clear to me that some kind of communication was continuing. This impression was supported by the fact that I often found myself thinking of P, that feelings toward her kept coming up, and that she appeared in my dreams. Her paying my bills—by which she kept a part of the frame of the analysis intact—of course also contributed to my impression.

Retrospectively, I think that P was unconsciously and nonverbally conveying to me that she totally despised and hated me, but that she nevertheless wanted to stay with me and continue her analysis. My unconscious message to her was that I could tolerate and survive her hate and sadism and would not send her away. I was still her analyst and intended to stay her analyst if that was what she wanted. That she, after a while, started to come more often and stayed longer felt for me like a confirmation that something really had continued.

In my opinion, the patient's comment that "It's as if, deep down, I have continued to talk to you without realizing it myself" illustrates very well the unconscious communicative process. Had I not trusted in the continuation of the unconscious communicative process between P and me, I would not have been able to endure this period of her analysis. Such trust makes it possible to refrain from active intervention and interpretation, and instead to wait. The waiting posture creates the space in which unconscious communication can occur, and in my view, this is typical of the analytic process.

The Psychoanalytic Setting: Frequency of Sessions and the Patient's Recumbent Position

The most visible and concrete, specific aspects of the analyst's internal analytic object are the established frequency of sessions and the patient's recumbent position as components of the setting. Of course, the recumbent position on the couch has become a symbol of psychoanalysis; Freud and many authors who followed him have argued in favor of the recumbent position (for a review of these, see Wille 1992). Their arguments about the positive aspects entailed in this position can be divided into three broad categories:

visual deprivation (not being able to see and not being seen); motor relaxation; and promotion of regression.

The high frequency of analytic sessions increases the intensity of the process and, together with the recumbent position, promotes regression. Daily sessions give rise to continuity, thus facilitating the unfolding of the unconscious process and making it easier to track. This continuity facilitates the way the analyst listens to the patient and to himself, and to the way the patient listens to the analyst (Faimberg 1996). The result is a deepening of contact and understanding that yields more and more varied material. If there is more than a day's break, discontinuities and interruptions occur, thus rendering the process of fine attunement more difficult to maintain. The high frequency quite simply also allows more time for analytic work to take place.

An important aspect of the analytic setting is that it offers patient and analyst alike an environment of holding and containment (Spitz 1956; Stone 1961), in which both can feel secure enough to partially surrender to a more regressive functioning that underlies unconscious interaction. Not having visual contact helps prevent the analytic relation from becoming an ordinary social interaction. Not being stared at, as Freud put it, is not just more relaxing for the analyst, but also creates more space in which to think and to regress. The extent to which such a regression is optimal varies, of course, during different phases of the analysis, and is always balanced by an observing position.

Trust in this setting as the best one for the achievement of psychic change constitutes part of the basis of a solid internal analytic object. This does not mean that an analytic setting is always the best setting for every patient, but that, seen from an analytic standpoint, it is the first choice when possible.

To summarize, the inquiring, questioning attitude and trust in the unconscious process and in the setting constitute the specific nucleus of the internal psychoanalytic object and thus of the analytic identity. A stable analytic identity presupposes that these three elements are not merely theoretically endorsed, but also thoroughly experienced on an emotional level and felt to be subjectively

true. If this is the case, the analyst possesses an inner basis on which he can have trust in himself as an analytic instrument and in psychoanalysis as the therapy of choice. Analysis can then be seen as the most suitable therapy for far more patients than is often thought to be the case. I believe that this trust in psychoanalysis, as a component of analytic identity and based on long analytic experience, makes a major contribution to the analyst's effectiveness.

It is self-evident that all kinds of things can go wrong during the prolonged and delicate process in which the analytic identity is acquired. Functioning as an analyst calls for qualities that we do not possess by nature. We laboriously develop these qualities in ourselves and must make an effort to maintain and retain them. The next part of my paper discusses some of the pitfalls that await the analyst in this process.

UNSTABLE INTERNAL PSYCHOANALYTIC OBJECTS

The foregoing consideration assumes the presence of a stable and autonomous internal analytic object. This stable object is characterized by unity, autonomy, and a relative lack of ambivalence. Much can go wrong during the many years of development of this internal psychoanalytic object, and as a result, a less stable object—or even an unstable one—may arise.

Of course, the stability or instability of the internal analytic object cannot be objectively judged or measured because, among other things, it depends on the applied conception of analysis and what constitutes its core elements. Analysts who adhere to differing conceptions of psychoanalysis may come to differing conclusions. Most French analysts, for instance, do not accept the frequency of four- to five-times-a-week sessions as a core aspect of psychoanalysis. Naturally, this does not mean that all analysts who think this way have unstable analytic identities; not every deviation from what I see as the core elements of the analytic identity automatically results in an unstable identity. Moreover, the presence of a relatively stable or unstable analytic identity is not a matter of black or white,

but has gradations. On the other hand, I am convinced that there is a point at which the bucket stops being a bucket and turns into a sieve.

Just as a sound internal analytic object is not a panacea for solving all analytic problems, an unstable internal analytic object is not, of course, the culprit behind all the ambivalence, schisms, narcissism, and other problems that trouble our profession. In all instances, there will be other factors that contribute to these problems—such as, for instance, differences in theoretical views, differences in analytic culture, and personal factors that are not part of the analytic identity. Sometimes the internal analytic object plays a major role; at other times, its influence may be less. Nevertheless, a sound internal analytic object can make an important contribution to the resolution of some of the problems we face as analysts—by bridging the schisms that split our theory and technique, for example, or by softening and containing the ambivalence and narcissism that we all too often encounter in psychoanalysis.

In this paper, I wish to concentrate on the overall very important disturbances from within—i.e., from the analyst's own inner world—that lead to various forms of (mostly unconscious) unstable internal analytic objects. I shall describe three of these below: the object imbued with intensified ambivalence; the split object; and the narcissistic object.

The Object Imbued with Intensified Ambivalence

Every analyst is ambivalent toward psychoanalysis. Psychoanalysis is not a comfortable bedfellow. Although very attractive, it imposes heavy demands. As analysts, we must endure not only our patients' emotional storms, scorn, and hostility, but also our own anxiety, jealousy, and hate.

Owing to the high frequency of analytic contact, we form an intense bond with patients who may constitute not only an emotional but also a practical burden. Analysis is a commitment for a period of many years that cannot stand too much disturbance of continuity, thereby compelling us to adopt a tight schedule. As ana-

lysts, we cannot just take a day off when we feel like it, or go away on a year's sabbatical, or move house at short notice. The emotional bond makes heavy demands on our autonomy and stability. Patients may get under our skin to such an extent that our emotional burden extends far beyond the actual sessions. The prolonged and sometimes laborious process calls for a great deal of patience.

A necessary part of analytic practice is the handling of aggression by the analyst. As we know, analytic technique is not restricted to empathy, containment, and holding, but also has a more disruptive side whose features include abstinence, confrontation, and interpretation. These latter features require the analyst to have a certain degree of hardness or tenacity at his disposal, which I have called the *capacity to inflict pain* (Wille 2006). This necessary inflicting of emotional pain arouses anxiety in the analyst and often brings about intense negative transference reactions that must be endured by the analyst. The analyst is more often a bringer of bad news than a healer who supplies solutions and relief for which he can garner praise, gratitude, and respect. For the analyst, satisfaction must be obtained primarily from the fascination of seeing psychic functioning revealed, from the intellectual challenge, and from the emotional depth of the contact. The analyst's social status is, in general, low. Government and health insurance providers have little funding available for psychoanalysis, and, indeed, psychoanalysis is regarded as an anachronism in many sectors of the mental health care world.

All the more reason, then, to have ambivalent feelings, both consciously and unconsciously. These are inherent in the job and must be dealt with thoroughly in one's own analysis, even though one cannot expect them to be totally resolved there. One's own ambivalence is a constant companion and must remain the subject of ongoing self-analysis. Provided that this ambivalence remains conscious, it need not constitute a threat to the stability of the internal analytic object.

In the case of intensified ambivalence, however, the hostile feelings toward psychoanalysis are so strong that the analytic object becomes unstable. It therefore becomes more destructive, especially

if hostility is substantially unconscious. This hostility has various sources:

1. Disappointment with psychoanalytic training, in general, and with the results of one's own analysis, in particular (Rangell 1982), is a little-discussed source of unconscious ambivalence—which, however, is certainly quite common. The conduct of candidates' training analyses is a human process in which all kinds of things can go wrong. A relevant omission in a training analysis is the analyst's failure to comprehensively address the candidate's unconscious ambivalence toward his training, his analysis, the analyst himself, and analysis as a whole (Greenacre 1966b). The less conscious the training analyst himself is of his own ambivalence, the greater this danger will be. Candidate and analyst must then increasingly validate each other in their positive, sometimes idealizing feelings in order to eliminate their critical hostility toward each other and toward analysis.

2. Dissatisfaction with the fact that structural change takes a great deal of work, patience, and time is an important source of intensified unconscious ambivalence that often develops over a prolonged period. At the beginning of training, this is still offset by enthusiasm about the analytic method and by the support of supervisors. When the novelty has worn off and the analyst-in-training has to do more on his own account and without supervision, impatience and doubt increase. The need for quicker results, more active techniques, lower frequency, and shorter treatment times becomes ever greater, accompanied by an increasing inclination toward something simpler, less onerous, and more satisfying.

3. Ultimately, insufficient tolerance of constant confrontation with one's own primitive feelings and conflicts can make it a torment to function as an analyst. The

same applies if the analyst lacks sufficient capacity to tolerate the sometimes enormous emotional pressure in the intensive relationship between patient and analyst. The analyst may not consciously realize that his emotional differentiation, flexibility, and sensitivity do not suffice to set in motion and maintain a truly deep analytic process until he has been analyzing for some years. Every analyst has limitations, but these are sometimes so extensive as to preclude his being a "good enough" analyst. If the analyst becomes aware of this fact, sometimes only years after completing his training, the discovery may be extremely painful. The process of accepting this situation is sometimes too difficult, so that denial results; a possible outcome is unconscious hostility toward psychoanalysis.

4. A fourth source of intensified unconscious ambivalence is, as stated earlier, the situation of holding fast to a professional identity that is in some respects inconsistent with the analytic identity. The physician has taken an oath to heal and to relieve suffering; he has thus identified with the caring mother who avoids aggression (McLaughlin 1961). In the context of this identification, the negative transference—the patient's hate of the analyst—may become inaccessible and hence be unconsciously intensified. The same applies, probably even more intensely, to hate in the countertransference—the analyst's hate of the patient. Physicians often cling to their role as healers and doctors, defining their relationship with patients accordingly, and psychologists also exhibit this tendency by virtue of their accustomed position as scientific researchers and problem solvers. Researchers are often on the lookout for signals that confirm or disprove. This may lead to a dichotomization of the data, thereby limiting analytic perception through evenly suspended attention. Since it can be difficult to successfully combine these opposing

identities, both physicians and psychologists must substantially relinquish their original professional identities if they wish to develop a psychoanalytic identity. This choice is so difficult that it is often avoided. The opposition is then rationalized or denied, so that unconscious ambivalence is perpetuated and deepened.

Hostility due to intensified ambivalence toward psychoanalysis, whether conscious or unconscious, may assume many guises, some of which I shall discuss below. All these manifestations may be, but are not necessarily, expressions of hostility.

1. One example is the tendency to shorten the duration of analyses, to reduce the frequency of sessions, and to apply a more active technique. This pattern is as old as psychoanalysis itself, but seems to have become more prevalent in the last few decades. This is no doubt connected with the rise in popularity of low-frequency, symptom-oriented psychotherapy. Again, psychoanalytic psychotherapy at frequencies of two or three sessions a week may be an attractive alternative to the pressure and stress imposed on the analyst by a full analysis. The distinction between psychotherapy and psychoanalysis is thereby blurred, and this may in turn lead to denial of the differences between them. Psychoanalysis may then readily be seen as obsolete—as expressed in loaded terms such as *classical analysis* or *couch analysis*. These suggest that there are also other forms of psychoanalysis, whereas, probably, other forms of analytic psychotherapy are being referred to, so that the difference between the two is obliterated.

2. Another example is the viewpoint that psychoanalysis is not a discipline and a therapy in its own right and cannot therefore stand on its own feet. Analysts who hold this view speak of psychoanalysis as if it were an endangered species in need of special care in order to survive; analysis thus becomes a museum piece that must

be cherished for its past merits and value. In this way, its present status is devalued, albeit in disguised fashion. The emphasis in this case is sometimes placed on the comparatively low incidence of psychoanalytic treatments, thus suggesting that analysis is the most suitable treatment for only a very few patients, and can therefore be virtually disregarded. The ambivalence toward analysis also emerges clearly in the idea that its future lies in its application to psychotherapy; analysis has become so old and impotent that it can no longer stand alone, but must be supported by a descendant.

3. A common and self-reinforcing negative consequence of unconscious ambivalence is for the analyst not to engage in the practice of analysis or to do so hardly at all. Throughout the world, analysis has increasingly become a part-time occupation and often seems to be gradually degenerating into a hobby, "practiced on the side because it is, after all, fun." Besides those analysts who do not analyze at all, there are many who have one or at most two cases. Doing very little analysis is not only a consequence but also a cause of ambivalence, because ample analytic experience is an important criterion for the formation and preservation of a solid internal analytic object. One of the conclusions Brauer (1993) drew from his survey of American Psychoanalytic Association members supports this idea: "Identification with psychoanalysis and satisfaction with the profession grow with the increase in the size of practice, and both identification and satisfaction are quite high if the member has four or more cases."

The Split Object

A second variant of the unstable internal analytic object is the split analytic object. Here the internal image of psychoanalysis no longer represents analysis as a whole, but is divided into two or more parts.

The most conspicuous form of splitting is between theory and practice. Analysts who dismiss the practice of psychoanalysis as obsolete and inefficient may still regard its theory as relevant and valid; psychoanalytic theory is then seen as a valuable substrate for psychotherapy and other nonclinical applications, but this split between theory and practice overlooks the inherent linkage between the two. Analytic theory—in particular, clinical theory—developed largely from practice, and could not have arisen from anything other than this practice. Without the nutriment of new insights obtained from practice, analytic theory cannot develop further and will wither. In this respect, analytic practice and theory are indivisible.

Splits within theory or within practice are more subtle. Many examples can be adduced. The history of psychoanalysis is characterized by the discipline's constant tendency to break up into mutually exclusive theories and schools. Ego psychology, object relations theory, Freudian theory, and Kleinian theory are just a few of today's psychoanalytic theories and schools, which are often distinguished as much by what they reject as by what they uphold. The analytic identity in this case is then bound up more with the relevant school than with psychoanalysis as a whole. Pine (1990) deserves credit for drawing attention to the mutual connectedness of various analytic theories, which in fact can complement and enrich each other.

Splits in the practice of psychoanalysis are also common. For instance, some groups emphasize that the essence of an analysis lies in the here and now of the transference, and that analysts must focus on this as much as possible. Others see the transference as a repetition of the past and concentrate on narrative reconstruction. The resulting antithesis gives rise to two analytic practices that seemingly exclude each other, whereas in fact all these aspects may be important in an analysis. As Roth (2001) points out, different levels of transference can be discerned, all of which form part of psychoanalysis and coexist alongside each other.

Another split has to do with the opposition between, on the one hand, psychoanalysis as a type of treatment based on a medical model that should be evidence-based, as far as possible, and, on the

other hand, psychoanalysis as an intersubjective encounter between two persons. This opposition, too, is based on a split in the internal analytic object. Psychoanalysis is both a treatment and an encounter; it includes both elements. To opt for one aspect over the other is to deny an important attribute and thereby to split the whole into parts. This seeming paradox—psychoanalysis as treatment *and* as encounter—is inherent, and analysts must accept and tolerate it if psychoanalysis is to remain a cohesive whole and not to be defensively split.

Parsons (2000) refers to the same point when he writes that:

> The originality of Freud's discovery is such that the identity of the psychoanalyst cannot be assimilated to other, more comfortably recognizable roles. The psychoanalyst at work has to do two things at once. He must carry out a technical procedure as correctly as possible and also engage with another human being. [p. 10]

After describing "this fundamental polarity" as "the repairman or the healer," Parsons states that: "Psychoanalysis is both, and the polarity between them is an essential part of its nature. This is difficult and paradoxical, and there is a temptation to escape into emphasizing one aspect at the expense of the other" (p. 10).

A final example of splitting of the internal analytic object concerns the setting. High frequency and the patient's recumbent position are two elements of the setting that are closely connected and presuppose each other. It is not these two separate elements, but their combination that permits the genesis of a regressive analytic process. Although therapies are sometimes conducted at a frequency of one or two sessions per week with the patient lying on the couch, and face-to-face therapies may be conducted in three or four sessions a week, it is noteworthy that the technique applied in such situations often remains strictly analytic, so that there is actually a twofold split: between technique and setting, and between the recumbent position and the frequency of sessions within the setting.

As argued earlier, the notion of the internal analytic object does not explain all the schisms in psychoanalysis, nor is its pres-

ence a panacea that will put an end to all diversity. On the other hand, a more coherent and less split internal analytic object might contribute to a position that leaves more room for seemingly paradoxical approaches to technique, theory, and setting.

The Narcissistic Object

The wish to become a psychoanalyst always includes an element of narcissistic motivation. In some cases, the proportion of unconscious narcissism is so great that it excessively colors the internal analytic object. In the view of Kernberg (1987), narcissistic character pathology constitutes the greatest threat to the development of a stable analytic identity in the analyst-to-be. Wallerstein (1987) writes that in the past, some candidates opted for analytic training more with a view to status and professional advancement than on the grounds of genuine inner interest; in his view, such candidates became analysts in name only, and at best ambivalent friends of analysis. In this sense, the fact that analysis has lost some of its status and prestige in the last few decades might have the beneficial effect that at least some narcissistic motives for analytic training have been reduced. Other motivations will continue to play a part in the narcissistic choice; the need to be idealized or to attain a position of power, and the possibility of filling one's own emotional and relational void (Kernberg 1987), are examples of such narcissistic motives.

Narcissistic pathology often goes unnoticed in the course of selection of psychoanalytic candidates and during their training due to candidates' apparent intellectual interest. However, what may be missing is intellectual maturation and, in particular, emotional maturation: i.e., the candidate amasses all kinds of knowledge and experience, but these fail to change him internally. The same can happen in the training analysis if the candidate forms an idealizing identification with his analyst and imitates the analyst's mode of interpreting without allowing himself to undergo a genuine process of inner change. The narcissistic identification may then be mistaken for genuine maturation and development.

The more the functioning of the training analyst himself is impaired by narcissistic pathology, the less probable it is that this pathology will be worked on in the training analysis. The narcissistic training analyst (Kernberg 1987) is impeded not only by his blind spots with respect to narcissistic pathology, but also by his limited capacity to facilitate and tolerate the negative transference. As a result, the candidate is not enabled to recognize his ambivalence and aggression toward his analyst and toward analysis. The denial of this ambivalence and aggression necessitates ever-greater idealization, sometimes accompanied by the displacement of aggression onto another analytic group or school. The internal analytic object has become an idealized object that offers little scope for learning from new experiences, and consequently undergoes little development and maturation; it is increasingly rigid and unstable.

Sooner or later, this leads to the analyst's disappointment and boredom with analytic work. The analytic fire goes out. Analysis loses its idealized splendor, the high expectations of therapeutic outcomes remain unrealized, and the principles of analytic theory prove to be not as incontestably true as the analyst had thought. Patients do not change sufficiently, and their criticism is too hurtful. The uncertainty of the analytic process gradually becomes harder and harder to bear and analysis an ever-more-difficult task. Furthermore, the now qualified analyst notices that the problems he had before he began his training are still there.

Wheelis (1956) observes that an analyst in this position may attempt to rationalize or deny the analytic crisis of identity, but there is ultimately no escaping it. Permanent total denial may lead to flight into rigid dogmatic principles, in which the analyst is compelled to cling for dear life to the old situation. The flight may also be in the opposite direction, manifesting itself in an exaggerated tendency to embrace the new, in which nothing of the old is retained. Both types of flight are characterized by irrationality and rigidity.

In some individuals, idealization degenerates into hostile devaluation of psychoanalysis. This process is sometimes conscious and overt, in which case the analyst abandons the field; on other occasions, the process is unconscious and expressed in concealed hos-

tility. Some analysts develop an analytic as-if identity and are eager to embrace analytic fashions and trends, but on a partly unconscious level, they experience their analytic work as meaningless and empty. Conversely, there are other analysts who are able to find their way back and to establish a more realistic internal analytic object—often by way of a re-analysis.

CONCLUDING REMARKS

The psychoanalytic identity is our most central possession as analysts (de Saussure 1987) and hence something we must cherish. Besides personal aptitude, it is analytic training that decisively determines the form that one's psychoanalytic identity assumes. According to Widlöcher (1983), it is not for nothing that most disputes in analytic groups center around analytic training. After all, training molds candidates' identities and hence the future shape of psychoanalysis itself. One's own analysis is probably the component that makes the greatest contribution to the formation of analytic identity.

In addition to familiarization with unconscious functioning, identification with the function of the analyst, and development of a self-analytic function, the conscious recognition of one's own hostility toward psychoanalysis is very important; discussion of this hostility is one of the principal differences between a training analysis and a therapeutic analysis. This makes heavy demands on the training analyst. A number of authors (e.g., Parsons 1995; de Saussure 1987) therefore stress the need for careful selection of training analysts, in whom a fully mature, stable analytic identity is essential.

Training is therefore crucial, and, because it is principally emotional and subjective in nature, it is also very vulnerable. A constant risk run by psychoanalysis since its earliest years is the gradual dilution of training, which could nip in the bud the development of a solid analytic identity. In the last few years, this process has been reinforced by the worldwide trend for analysts to analyze less and less. This results in the erosion of analytic identity and the hollowing out of analytic societies from within.

Although the selection of candidates and training analysts and the quality of training in general are very important, they cannot give us full protection against problems with the psychoanalytic identity as described. We know that every form of candidate selection is far from perfect, and that many mistakes have and will be made in this process. This is not a reason to abolish all selection criteria, but rather an incentive to work hard to construct a selection procedure that is good enough, without the expectation of an entirely positive score. As always, we must be modest in our presumptions.

The same goes for training. Even the best training does not guarantee that a candidate will develop a lasting, firm psychoanalytic identity. We hope that at least the probability is as high as possible. On the other hand, even not-so-good analytic training does not exclude the possibility that a candidate may develop a sound analytic identity. So again, training is important and we cannot do without it, but we should be realistic about the fact that its effect is not always what we expect.

Furthermore, it is a fallacy to think that there are analysts who have problems with their analytic identities and others who do not. In various intensities, all analysts struggle with their analytic identities sooner or later. The question of how to address these problems is thus a very relevant one.

I believe it is crucial for analysts to function actively in an analytic community where they confer with colleagues not only about their patients, but also about their own emotional functioning as analysts. Lectures and papers that openly address ambivalence and doubt as features of analytic practice, without disapproval, can help analysts acknowledge their own feelings and ideas in this respect.

Reading, lecturing, and writing are very effective activities for maintaining and reinforcing the analytic identity. Analysts who have difficulty in finding analytic patients and become more and more ambivalent and disappointed can participate in group supervisions focused on "creating" analytic patients (Rothstein 1998). Psychoanalytic societies should organize forums in which their members can discuss clinical material, especially in small, accessible groups. An

atmosphere of ongoing, even perpetual, psychoanalytic education in societies can (re)stimulate interest and joy in analyzing.

Self-reflection and self-analysis are, of course, essential in maintaining and restoring analytic identity. Sometimes re-analysis is needed, and sometimes we have to accept that not everyone who has been trained as an analyst continues to practice analysis.

The crisis of psychoanalysis, usually described as reduced numbers of patients and candidates, is not only a consequence of deteriorating social conditions, but also a crisis in ourselves and, in particular, in our psychoanalytic identity. Bernstein (1990) points out that unconscious ambivalence in the analyst can lead to a *countertransference inhibition* in the recommendation of analysis. "Do we dare be analysts?" is the very relevant question formulated by Quinodoz (2004). I am convinced that any analyst who has a robust psychoanalytic identity, and hence trusts psychoanalysis and takes pleasure in it, can himself "create" analyses and build up a more than marginal analytic practice. Psychoanalytic societies that radiate analytic self-confidence of this kind can use it to attract new candidates.

Necessary and constructive as it is for analysts to step outside, in a sense, and make contact with other clinicians and protagonists of other disciplines, it is no less important for us to maintain—or, if necessary, to rediscover—contact with ourselves as analysts. In a world less and less inclined toward introspection, and with an abundant supply of shorter therapies that promise far-reaching results, being an analyst is by no means a sinecure, so that we are compelled to choose unequivocally whether or not to become analysts. Becoming and remaining a psychoanalyst presuppose an analytic identity that, after all, cannot be put on and taken off at will. Freud (1933) expressed this as follows:

> Psychoanalytic activity is arduous and exacting; it cannot well be handled like a pair of glasses that one puts on for reading and takes off when one goes for a walk. As a rule psychoanalysis possesses a doctor either entirely or not at all. Those psychotherapists who make use of analysis among other methods, occasionally, do not to my knowledge stand on a firm analytic ground; they have not accept-

ed the whole of analysis but have watered it down—have "drawn its fangs," perhaps. [pp. 152-153]

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FOLLOW THE FOX: EDGAR A. LEVENSON'S PURSUIT OF PSYCHOANALYTIC PROCESS

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The author examines Edgar A. Levenson's argument as presented in his two seminal texts (1972, 1983), placing this argument in the context of our work today. Levenson has contributed to a profound shift in our experience of psychoanalysis. By giving priority to psychoanalytic process, he spelled out the implications entailed in the fact that patient and analyst continually influence each other in clinical work. The ongoing relevance of Levenson's work is evident first in his location of therapeutic action beyond understanding, that is, in the spontaneous interaction between patient and analyst, and second in his critique of our uses of abstraction, explanation, and theory.

Playfully adapting Oscar Wilde's famous aphorism about foxhunting as "the unspeakable in pursuit of the inedible," Edgar A. Levenson once described psychoanalytic supervision as "a marvelous example of the *infallible* in pursuit of the *ineffable*" (1982a, p. 1, italics in original). He was referring to an experience that is almost universal in the learning and teaching of psychotherapy and psychoanalysis. On the one hand, there is something infallibly clear and

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certain about the experience of supervision, while, on the other, regardless of our level of experience and sophistication, there is something ineffably complex and beyond words in the actual process of doing analysis. Throughout his long and fertile career, Levenson has followed the fox of the ineffable process of psychoanalysis, a process that eludes capture by our relatively "infallible" theories, by our attempts to pin down the process with explanation.

But Levenson is a bit of a fox himself. We can see this in the way he courts paradox. Although he is the best-known theorist of interpersonal psychoanalysis, his two decisive works are a resounding critique of the use of theory and theorizing. Although he is credited by Stern (2005a) with making a seminal, even original contribution to our understanding of psychoanalytic process, Levenson has repeatedly warned against codifying this understanding into a specific technique or method of treatment. His status as "gadfly" (Greenberg 1987, p. 689), "deconstructionist" (Hirsch 1992, p. 744), and "Puck with a purpose" (Stern 2005a, p. xiii) is more than an expression of temperament; it reflects his consistent approach toward his work with patients and toward his conception of psychoanalysis as a whole. Much like analytic process itself, Levenson eludes capture. He resists being pinned down into simplified categorization. His language for describing the ineffable process of psychoanalysis has continued to change, never quite settling into a single set of conceptions that might be elevated to a new orthodoxy.

Levenson has posed a central challenge to contemporary psychoanalytic thought and practice—a challenge arising out of what might now be considered his universally accepted contention that "you can't not interact" (Stern 2005a, p. v). Much of analytic thought since his work has contended with the question of how to formulate an analytic understanding that takes the fact of the continuous interaction of analyst and patient into account.

Although his work is well known in certain circles, it is surprising that Levenson is not more widely read, especially by relational analysts. For example, in a recent book of critiques of relational and intersubjective perspectives (Mills 2005), there is not one ref-

erence to Levenson. Bromberg (1998, 2006) has done much to rekindle an interest in Levenson's central role in contemporary psychoanalysis, even as he pursues integrations with which Levenson would disagree.

To understand Levenson's unique and pervasive contribution, it is useful to return to his two major texts, *The Fallacy of Understanding* (1972) and *The Ambiguity of Change* (1983), reprinted together as volume 3 in the "Psychoanalysis in a New Key" book series, edited by D. B. Stern (Levenson 2005). After offering a context for these works, I will describe the main thread of Levenson's argument, followed by a review of the criticisms of his perspective. My contention is that Levenson's continuing relevance is to be found first in his locating therapeutic action beyond understanding, in the spontaneous interaction between patient and analyst, and second in his particular critique of our use of abstraction, explanation, and theory. Theory is seen as an inevitable reduction of the richness of psychoanalytic process, in that understanding always entails emphasis of a point of view that obscures other ways of seeing. But further —in that our theory is used to organize what we do in the analytic encounter—our use of theory in that encounter becomes yet another form of interaction that itself requires analysis.

THE CONTEXT

In *The Fallacy of Understanding* and *The Ambiguity of Change,* originally published in 1972 and 1983, respectively, Levenson introduced or highlighted many of the ideas that came to preoccupy and reshape subsequent psychoanalytic discourse. The ideas of unconscious *mutual influence,* with its challenge to analytic neutrality; *enactment* as subsequently coined by Jacobs (1986, 1991); *perspectivism,* to be subsequently discussed by Hoffman (1998), Schafer (1989), and others; and the recursive *patterning of experience* as a rejection of drive theory—all make their early appearances here. In line with interpersonalists of earlier generations, Levenson formulates compelling arguments for a shift in focus from the intrapsychic world of

the patient to the interpersonal process between patient and analyst.

But beyond this, he spelled out the implications entailed in accepting the fact that patient and analyst continually influence each other in clinical work. Although some psychoanalytic thinkers had introduced this notion of mutual influence earlier (e.g., Racker 1953, 1957, 1968; Sandler 1976; Searles 1965, 1979; Wolstein 1959), and others addressed it later (e.g., Gill 1983, 1994; Hoffman 1983, 1991), Levenson brought it from the back roads to the main thoroughfares of psychoanalytic controversy. In doing so, he helped lay the ground-work for much innovation that followed in North American psychoanalysis, with the growing prominence of interpersonal theory and the emergence and maturation of relational theory.

Levenson wrote these texts as extended, informal essays rather than as scholarly treatises, and they read with a buoyancy and verve that carries one effortlessly along. He has a knack for summoning the bon mot in phrases that linger, take root, and sprout questions. He repeatedly turns accepted understanding on its head with wit and a spark of surprise. In many examples, it is the analysand who has insight into the analyst's character, providing succinct interpretations regarding their shared reality.

While greatly influenced by Harry Stack Sullivan (e.g., 1953, 1954), Levenson's ideas formed part of a larger paradigm shift, a groundswell in the sciences, humanities, and the arts that emphasized connectedness and contextualization over certainty and hierarchical knowing. Levenson's perspectivism, which we will explore shortly, is related to a much wider field of inquiry grounded in phenomenological philosophy, philosophical hermeneutics, critical theory, and Gestalt theory.[1] Levenson's gift was in weaving together a wide spectrum of contemporary ideas in the service of

[1] See Stern's (1991, 1997) work on Hans-Georg Gadamer; Benjamin's (1988, 1990) studies in intersubjectivity and gender; and the work on psychology as a human science (Burston and Frie 2006; Fischer 1974; Giorgi 1970, 1985) for examples of this paradigm shift. Other threads of a similar critique can be found in Binswanger (1963), Boss (1963), Wittgenstein (1953, 1969), the Frankfurt School, Habermas (1971), and the American pragmatists as represented by Peirce (1891) and Rorty (1979, 1982).

challenging the received wisdom in psychoanalysis, contributing to the formulation of a postclassical paradigm in psychoanalytic thinking.

THE ARGUMENT

As Stern (2005a) suggests, Levenson's two early texts can be read as an elaboration of a single position (p. xi), with the first text (*The Fallacy of Understanding*) providing an introduction and the second text (*The Ambiguity of Change*) providing a more mature elaboration of the author's ideas.

Argument I

The Fallacy of Understanding evolved out of a paper that Levenson gave in 1968 at the twenty-fifth anniversary symposium of New York's William Alanson White Institute, where he served as clinical director. Although the paper began with the more narrow focus of addressing issues in the treatment of clinic patients, the theme of the book is strikingly broad, as indicated by its subtitle: *An Inquiry into the Changing Structure of Psychoanalysis.* The term *structure* is key here, as it alludes to the then-contemporary theories of *structuralism,* as well as to Thomas Kuhn's influential work, *The Structure of Scientific Revolutions* (1962). Levenson poses that, rather than an ever-expanding body of knowledge, the development of psychoanalytic theory is discontinuous, context dependent, and always lagging behind the practice that it attempts to describe.

We see in this formulation the beginnings of Levenson's perspectivist model, shaped by his reading of structuralism. Drawing from the work of Levi-Strauss (1963, 1966) and Piaget (1970), and from Alfred Korzybski's General Semantics (1933), Levenson suggests that a paradigm shift offered a fundamentally different way of thinking about human experience. Rather than relying on mechanistic formulations in which meaning is derived through the interpretation of processes that lie behind what is manifest (e.g., unconscious content), meaning is evident in a description of the phenomenon *as* manifest. Specifically, meaning is found in the relationships among component parts that are understood to constitute

the whole.[2] Meaning is to be found in the enduring structure of relationships. Understanding is often fallacious (hence the book's title, *The Fallacy of Understanding*) because it attempts to explain or interpret phenomena from a position that is erroneously assumed to be independent of that which is being explained.

This simple shift has profound consequences. One consequence is to shift one's focus from the *causes* of process to *process itself*. Many of Levenson's students have described a sense of vertigo in their initial encounters with his work. Stern described the "dark nights of the soul" (2005a, p. viii) that he experienced in his first acquaintance with Levenson's work, and Hirsch noted the sense of being left hanging, "forced to fall back on my relatively novice self" (1992, p. 734) in his supervisory experience with Levenson. Such vertigo comes with the loss of familiar moorings. In Levenson's universe, analysts lose not only the drive model (which had already been dispatched by Sullivan and other earlier interpersonalists), but they also lose the entire metapsychology on which to ground their clinical work. Systems of interpretation impose an *outside* structure on the data of the patient's life, as an attribution of purpose to the patient's behavior, according to Levenson; the nature of this purpose is defined by the explanatory theory, and thus is not inherently related to the given structure of a patient's life and world (1972, p. 207).

Theory is organizing, but from Levenson's perspective, the order is in the service of the interpreter's understanding and peace of mind rather than in the service of any therapeutic function. Referring to Korzybski's (1933) often-quoted phrase "maps are not the actual territory" (p. 61), Levenson holds that our theory provides the comfort of an organization through which we define the patient. Through our explanations, we offer a framework for patients to un-

[2] Köhler (1947) addresses this in his discussion of *Ehrenfels qualities*, dynamic aspects of experience not accountable by the summation of sensations. We see this in Gestalt figures where the formation of a perceived object is found in the experienced relationship of component elements. For example, a circular shape might be formed by a ring of dots where the relationship of dots—and not the dots themselves—constitutes the circle.

derstand themselves, but in doing so, we leave the territory of patients' experience, the unique aesthetic of their own organization. By imposing an organizing frame, we overvalorize insight at the expense of grasping the particular way in which a patient structures his or her world. From this perspective, treaters do not hold a privileged vantage point regarding what is known and what is understood to be real. In turn, patients do not distort. Transference is not a projection of an internal pattern, a misapplication of internal structure onto external reality. Rather, "reality" is structured in a particular manner that might be described and explored in its uniqueness and specificity.

Throughout his work, Levenson uses clinical examples or critiques of the clinical vignettes of others in which understanding is turned on its head. A paranoid woman sees her therapist as a CIA agent not in response to interpretations about libidinal investments in the therapist as her father, but in response to the specific manner in which the therapist is, in fact, an agent in the service of the psychiatric hospital. Another patient's suicidal collapse following a vacation is not seen as a precipitous loss of ego control due to the interruption of therapy; it is seen as the patient's realistic compliance with the therapist, who made a stern prediction of such a collapse should the patient depart from therapy. The suicide attempt is one of many repeated compliances in the treatment. There is an order to be found, but rather than being found in the interpreted structure of the mind, it lies in the structuring of experience. This structuring is an active and stable process in which patterns can be discerned, described, and thus contextualized.

Another consequence of Levenson's structural shift is a reconfiguration of the field of study. "Rather than emphasis on the patient as a discrete historical process, interest shifts to the immersion of therapist-patient in their common transformational field and, most important, to their unique creation of each other" (1972, p. 221). For Levenson, the proper focus of psychoanalysis is on the immediacy of the analytic setting, on a psychoanalytic process that is inherently interactive. The patient's experience is not understood in terms of past determinants, but is described as it is constituted moment to moment in the interaction between the individuals involved.

Levenson makes it clear that this structuring interaction takes place *in spite of* the content of analysts' interpretations. It is played out in what is done in the saying, in analysts' inevitable ways of finding themselves immersed, participating with their patients, in the structuring choreography of their lives together. The implication of this is touched on by Stern (2005a):

> Without realizing it, the analyst of a masochistic patient makes sadistic interpretations of masochism; the analyst of a seductive patient who is nevertheless fearful of sexuality makes seductive interpretations of the patient's fear; the analyst of a narcissistically vulnerable patient interprets the narcissism in a way that wounds. The analyst's only recourse is to turn back on her experience of herself, the patient, and the interaction between them, and try to formulate what was going on—and then dig herself out. [p. vii]

Analyst and patient are embedded in an interaction of their own making—one that continually recapitulates a patterned structure of interaction that is reiterated throughout the patient's world.

The work of analysis, *working through*, takes place in the process of "digging out," as Stern (2005a, p. vii) so delicately put it. What this means changes over the course of Levenson's writing, but in this early iteration, he described it as the process of *resisting transformation*. From a position of immersed participation in the experience of the psychoanalytic situation, the analyst attempts to describe the pattern of experience. "The therapist, as an extension of Sullivan's participant-observer, becomes a total participant and an observer of his own *experience* of participation" (Levenson 1972, p. 215, italics in original). This "extension" of Sullivan's position is an entirely new formulation, one in which Levenson relinquishes the moorings of objectivity (Hirsch 1992). The central datum of study is no longer the patient (whether the patient's drives, defenses, or structure), but the structured interaction of patient and analyst.

Levenson spends little time on issues of technique in this exposition, which might leave the practicing analyst at a loss regarding what in particular is done in the hour if one is not interpreting. Al-

though Levenson has more to say about technique in his second text, he is nevertheless continually suspicious of technical directives, seeing them as attempts to pin down an interactive and spontaneous process in the service of the analyst's comfort and sense of certitude.

Clearly, psychoanalytic efficacy does not require rejection of the metapsychology. How does Levenson understand the success of the *praxis* of psychoanalysis, when he argues that the *theory* is often used in the service of persuasion instead of treatment? Further, what can be said about the purpose of this praxis? To what end is treatment directed? Implicit in this are questions of psychopathology, development, and change. How do we account, as Greenberg (1987) has asked, for individual differences in structure? How do these differences come about? In *The Fallacy of Understanding* (1972), Levenson leaves these questions open. His structuralist model undermines any conventional theory of motivation, since causal explanation is rejected in favor of a descriptive focus on the interrelated aspects of the immediate context.

Argument II

In *The Ambiguity of Change* (1983), Levenson addresses these issues. He presents two fundamental propositions. First, he holds that "all psychoanalysts, regardless of doctrinaire convictions, follow essentially the same process; they all go about doing therapy in the same way" (p. 8). Second, he argues that our understanding of the goals of this method have consistently led us away from addressing the concerns of individuals in their "actual" lives through giving primacy to fantasy, to psychic reality. Rather than focusing on the internal world, Levenson argues that psychoanalytic method should provide a means of "developing interpersonal competence based on semiotic skills that make it possible to distinguish the nuances of interaction" (p. 12).

Levenson's notion of the common ground of psychoanalytic praxis is hinted at in *The Fallacy of Understanding* (1972), where he finds commonality in the practices of diverse analysts in a given

age. Although psychoanalytic theory tends toward obsolescence, Levenson holds that psychoanalytic praxis remains a subversive and effective force, eluding the attempts made to explain it. He suggests that if one looks beyond the content of practice to the context, commonality is demonstrated in an algorithm of linguistic discourse:

> In a situation of great constraint—which limits and contains the anxiety of both participants and consequently their anxious claims on each other—they talk. They examine what is talked about and they examine the context in which it is talked about: that is, who they are for each other. [1983, p. 8]

The algorithm can be divided into three steps:

1. The establishment and definition of the therapeutic frame.
2. The elaboration and enrichment of implicate and explicate order in the patient's life.
3. The elucidation of this order in the therapist–patient relationship. [pp. 54-55]

Levenson uses the term *algorithm* to indicate that the steps of the process can be delineated, taught, and successfully used apart from its theoretical explication. Ancient algorithms for curing disease with herbs or for refining metals existed long before their scientific explication was developed. Indeed, as any medical school student can attest, scientific explanation shifts without necessarily changing algorithmic formulations. Psychoanalysis is effective even when the theory of its efficacy is incorrect or incomplete. The focus is on process, and this would seem to free us from the dangers and limitations of our theoretical differences.

But there is a rub. Method never exists apart from the aims and goals toward which the method is used. Our explanations have a profound impact on our choices regarding what to do and how to respond in the analytic frame. Levenson (1983) describes a clinical vignette taken from Greenson (1976): In the midst of a stream of

associations, a patient notes that his analyst grunts with what he thinks is approval when he offers certain political views from the couch, but is silent with inferred disapproval when the patient airs other views. Although this is quite a common transference scenario, just think of the possible variations in response. Does the analyst acknowledge a blind spot (the analyst does acknowledge one in Greenson's account), or is it explored as an aspect of the patient's inference? Is it explored as a characteristic response called out by the patient in others, or as an opportunity to explore a subtle dance of coercion between the two?

After validating the patient's perception, Greenson notes that "we then went on to work on why he felt the need to try to swallow my political views" (1976, p. 273). The choice of elaborating the patient's motivation—apart from an elaboration of the analyst's response—opens some doors and closes others. Levenson suggests that it is a gambit that "plays out exactly the kind of authoritarian inquiry of which the patient complains" (1983, p. 86)—an enactment that goes unexamined. However, if such an enactment were explored, one might argue that it would foreclose other avenues of inquiry.

The point is that theory does matter. Psychoanalysis is a treatment organized toward certain ends, and these ends are formulated in profoundly different ways by different treaters. Aron (2007) describes an example of this by noting the tension between the extremes of Renik's (2006) pragmatic approach and Ogden's (2005) poetic approach to treatment. For Renik, "practical" psychoanalysis is to be found in the pragmatics of symptom relief, whereas for Ogden, the power of psychoanalysis is in generating "conditions in which the analysand (with the analyst's participation) may become better able to dream his undreamt and interrupted dreams . . . thereby dreaming himself more fully into existence" (p. 2).

These are two very different conceptions of cure, one situated on the pole of action (specific outcomes of measurable changes in the "real" world) and the other on the pole of reverie (nonspecific outcomes of the capacity to be alive to the full spectrum of human experience). They come from different theoretical traditions, im-

plying different sets of values, and lead to very different decisions regarding what is attended to and what is done in specific treatments. Thus, Renik finds efficacy in a one-time meeting with a patient who is able to clarify his uncertainty about a career choice (2006, pp. 9-13), whereas Ogden works with a patient for a substantial period of time without any sense of a chief complaint, knowing little of the patient's immediate circumstances, including his age, the nature of his marriage, or whether he has children (2005, pp. 87-90). We might consider that both are practicing psychoanalysis (both work within the algorithm of praxis outlined by Levenson; both are accepted by our discipline as leading thinkers), and each facilitates a process in which we might agree that his patients change, even though the kinds of change are understood quite differently. Both writers provide a logic of explanation that informs but is different from the ineffable experience of a psychoanalytic process that transcends their attempts to capture it. And yet they pursue different directions in accepting different ends for their work.

Levenson suggests that the relationship between theory and practice is obscure at best. "Theoretical clarity does not necessarily aid in therapy; it may be harmful. Clinical practice does not appear to derive from theory in any straightforward fashion" (1983, p. 7). Although this is not a dilemma for theories of the arts, it is a continuing quandary for psychoanalysts who claim a scientific status for the field, especially for those who look to the possibility of empirical grounding beyond the more humble claims of theoretical coherence and reliability. Many analysts hold the conviction that our theory has a more determinate relationship to what we do in practice. Given that our goals shape the direction of our attention and inquiry, our theories clearly matter. However, when our convictions are grounded in a sense of certainty about the truth of theoretical tenets, Levenson suggests that we risk turning our method of change into a powerful tool of persuasion. We risk converting our patients rather than curing them, shaping them in terms of our theoretical biases. Levenson found his own solution to the dilemma of the analyst's influence in his early writing (1972), where explanation—the search for cause and validation—was relinquished in favor of the description of structure.

In his second text (1983), Levenson is less content to shun explanation. He is a psychoanalyst, after all, an inspired student of Sullivan, and thus comes to the treatment setting with a coherent system of thought about pathogenesis and the nature of change. Like Sullivan, Levenson situates motive in the interpersonal context rather than in endogenous drive, drive derivative, fantasy, or other internal process. He extends Sullivan's interpersonalism (Hirsch 1992), however, shifting from a positivist operational framework to one grounded in modern linguistic and pragmatic philosophy. Interaction is not simply valued as observable; it is part of a fundamental structure of signification, somewhat similar to Lacan's (following de Saussure's) use of *langue* as the fundamental structure of organizing experience.

From the perspective of this structure, the content of communication must be seen in relation to its context, in relation to a system of relationships. Speech does not simply communicate meaning; it is also a behavior that has an effect on the other (Austin 1962). In talking to others, we act, and they in turn act with us. This *interacting* entails a layering of our acting on others, their *re-acting* and thus acting on us, a language of behavior interdigitated with the behavior of language. As Levenson writes, "It means that every communication is a participation, which changes the communication, which changes the participation" (1983, p. 81). This becomes a new foundation that seeks to make the problem of the analyst's influence part of the solution.

A number of implications arise from this that recapitulate but go beyond Levenson's perspective as described in *The Fallacy of Understanding* (1972). First, if speech and action are part of one continuous exchange, then interaction is not something that intermittently occurs in analysis at times of distress. Rather than identified in discrete moments of *acting in*, Levenson states that interaction "goes on continually, and the relationship between patient and therapist is played out, over time, in a patterned and structured way" (1983, p. 83). Levenson calls this a "discourse of action" (p. 83), a profound reformulation of Sullivan's *participant-observation,* which situates the "playground" (cf. Freud 1914, p. 154; Levenson 1983, p.

79) of transference, the mutative impact of treatment, in the continual, spontaneous, transference-countertransference interaction of the analytic dyad.

Second, from this perspective, psychoanalysis is not focused on the interpretation of the content of communications, but on the context in which it occurs. Rather than interpret content, analysts identify patterns of interactions. As Levenson states, "The cardinal question for the patient may not be 'What does it mean?' but 'What's going on around here?'" (1983, p. ix).

Levenson describes a young woman who tells her analyst a dream of being the princess with the pea under her mattress. The analyst suggests that "she may be referring to an excessive touchiness or sensitivity to criticism. The patient feels hurt and begins to cry" (p. 82). Levenson notes the resonance between the dream's content and the interaction in which the analyst inevitably plays a part. The meaning is itself a form of shared communication that must be clarified as it emerges in the various semiotic dimensions of the analysis: a patient's telling of history, contemporary issues of the patient's and analyst's life, dreams, memories, transference, countertransference (including the analyst's embodiment of theory)—all are various kinds of interaction (1983, p. 83). Levenson sees an infinite regress of semiotic expression, an expanding iteration of *communications within metacommunications within metacommunications,* which are identified and explored in the spontaneity of the analytic setting.

Third, there is a privileged focus on "reality" rather than fantasy, on interactions in the world as opposed to internal states or processes. This can be seen in the movement of interest from the supposedly disguised content of a dream, to its telling, and on to the kinds of action and interaction that this telling might involve. Levenson claims that Freud reached a crossroads in his attempt to explain the utility of his successful method, making a fatal turn away from "real" experience with his rejection of the seduction theory and his assertion of the motivating role of endogenous fantasy. Levenson demonstrates again and again how a focus on disguised or distorted content (i.e., fantasy) leads away from a far more parsimonious description of events as they occur in situations with others.

He provides several exegeses of classical psychoanalytic treatments in which the analysts' interpretations of transference distortions glaringly overlooked enactments between analyst and patient. The patients' symptoms and expressions are repeatedly seen by Levenson as direct commentaries on their analysts' involvement. Far from distorting the nature of their involvement with their analysts, these patients engage their analysts in a kind of relating that is characteristic for them. In Levenson's description, these patients become victims of an analytic procedure that feels quite dated these decades later. It provides a cautionary tale of the extent to which theory can dictate findings rather than provide a facile lens for discovery.

If Levenson rejects a metapsychology of internal motive, how does he explain psychopathology? Does he have his own metapsychology? Given his focus on actual interaction, he argues that patients have problems in the world with others because of confusions in these interactions. He writes, "Our patients are disabled not by their drives or inadequate defenses but, rather, by an inability to read and interpret the world, to grasp nuance, and to operate with sufficient skill to affect the people around them" (1983, p. 40). He calls this confusion *mystification,* a term adapted from Laing (1961, 1965), who used it to describe the painful and maddening disorientation that a child experiences as a result of familial situations in which secrets, attributions, and misdirection are used to shift the child's attention away from events that family members find intolerable.

Neurosis thus arises not from conflict, but from confusion in the semiotic landscape. Patients have been "damaged by *real* experience which has been mystified, dissociated and depreciated" (Levenson 1982b, p. 366, italics in original). These confusions may arise out of the child's cognitive immaturity, but, more centrally, they are communicated by others who are themselves mystified. The confusions are then used by the child/patient to sustain an interaction with vital others, in order to avoid a loss of security in those interactions. Mystification becomes the means through which interactions are sustained, laying the pattern for future interactions.

Levenson suggests that the analyst "expands awareness of patterning" (1983, p. 116) through all its various manifestations in the semiotic scene. As in *The Fallacy of Understanding* (1972), Levenson never really explicates a technical procedure. To do so would pin down something that is inherently spontaneous; we would be simply looking for what our theory dictates. However, he does make clear in later texts that patterns can be identified through the process of "detailed inquiry" as first elaborated by Sullivan (1954, pp. 81-82). This is a term in the interpersonal psychoanalytic lexicon that refers to an activity playing a role similar to that of free association as the means of identifying continuities. Detailed inquiry entails "a meticulous investigation of the patient's interactions with others, past and present, in reality, fantasy, and dreaming" (Levenson 1987, p. 208), and—like free association—forms the data of psychoanalysis.

Given that the inquiry comes in the form of detailed questions from the analyst, it is an interaction in its own right, an opportunity to experience patterns in the transference and countertransference of the analytic encounter. The details discovered are not important in and of themselves. They point the way to ever-widening iterations of patterns, to increasingly complex structures that might be recognized. Pattern recognition is a form of *demystification*, a shift from semiotic confusion to greater semiotic clarity. Pattern is decentered in the process of a psychoanalytic interaction that has as its focus the recognition of patterns of interaction.

In his later work, Levenson conceptualizes this process as deconstructive rather than clarifying. Through detailed inquiry, patterned interactions are engaged in the transference and countertransference, which become increasingly complex. This complexity far outstrips the patient's (and analyst's) narrative of life and action, leading to fragmentation:

> The very breakdown of narrative order, the temporary chaos which is provoked, may, in itself, be vital to a creative process, a reorganization of experience into far more complex and flexible patterns. I am claiming that the real task in therapy is not so much making sense of the data as it

> is, but resisting the temptation to make sense of the data! [1988, p. 5]

In these moments, both analyst and patient are at a loss, in the flux of a profoundly complex and rich process that far exceeds the capacity to make sense of it. There is a destabilization of meaning and pattern making that opens interaction to something different from the old repetitive iterations. This is the "gap" elaborated with such nuance by Bromberg (2006, pp. 8-16), the "safe surprise" found in the exploration of enactment that opens the possibility of change. The subsequent "reorganization" of experience will have its own patterned limitations that call for further deconstructive inquiry, further fragmentation, and further reorganization.

There is a paradoxical tension between these two conceptualizations of process (semiotic clarification versus deconstructive fragmentation) that is characteristic of Levenson. Each conceptualization keeps to the central tenets of Levenson's vision while addressing different, related critiques of the psychoanalytic canon. Levenson focuses on pattern recognition and semiotic competence in response to his sense of the "wrong turn" of psychoanalytic metapsychology's emphasis on fantasy, drive, and internal structure. He emphasizes deconstruction (the breakdown of sense making) in response to the valorization of interpretation, understanding, and technique that he finds prevalent in diverse psychoanalytic perspectives. Hirsch (1992) notes the seeming incompatibility of the two positions, and conjectures that if Levenson were identified as aligning with one position, he would probably make a case for being aligned with the other. This is the *fox* in action, and it exemplifies a stance that Levenson takes in relation to psychoanalytic understanding—an active position in relation to theorizing that constitutes part of his continuing relevance. This point is addressed further in what follows.

THE CRITIQUE

Criticisms of Levenson's position organize into a unified set of themes. For the most part, they come from "friendly fire"—from re-

lational thinkers and other interpersonalists who comment on what they see as Levenson's retreat from his original vision as a perspectivist. Other published criticisms begin with a more fundamental disagreement regarding the nature of clinical process and therapeutic action, creating a problem in critical comparison that can be applied to Levenson as well.

Critique I

Levenson meets with receptive appreciation from relational and other interpersonal thinkers who accept his early perspectivist stance. However, they challenge Levenson concerning the consistency of his position. With his emphasis on real life (as opposed to fantasy), he seems to reject the perspectivism that he once so carefully elaborated and that came to be understood as central to a postclassical position. Further, Levenson's own metapsychology, his notion of psychopathology as mystification, and his perspective on change are open to the same critique that he levels at classical metapsychology. Is not Levenson's position yet another attempt to freeze the ineffable in psychoanalytic process, to reduce the irreducible in the service of the analyst's comfortable knowing?

Levenson's interest in "real" experience can be traced to the formative influence of Sullivan. Interactions between real others shape future interactions, and individuals cannot be understood outside the context of these interactions. In contrast to psychoanalysts of his day, Sullivan placed a more substantial emphasis on interpersonal life outside the consulting room. Hirsch notes Sullivan's interest in an inquiry into the details of patients' lives, given the "potential to lead to the clarity of self necessary for richer and more inclusive living" (1997, p. 665). Since transference was associated with fantasy and internalized relationships, Sullivan preferred an emphasis on "real" external interactions, rather than attention to what he saw as the "unreal" transference relationship (Hirsch 1997, p. 665).

It was Wolstein (1959, 1975)—and Levenson—who emphasized the importance of the transference and countertransference as a shared, real experience rather than a distorted fantasy. This consolidated a perspective that highlights the immediacy of the psycho-

analytic encounter as the distinguishing feature of an interpersonal approach. For interpersonal analysts, emphasis is on the particular, the actual, and the immediate, rather than on the universal, the virtual, and the past. Levenson's focus is solidly in this tradition with his interest in "what's going on around here" (Levenson 1983, p. ix). At many points, this focus entails a close examination of "the relevant data of [a] patient's experience in '*real life*,' out there" (1989, p. 538, italics added).

What kind of "real" is Levenson talking about here? This is the question raised initially by Greenberg (1987), Hoffman (1990), and Hirsch (1992), and subsequently discussed by Mitchell (1995), Aron (1996), and Stern (2005b). Early on, Levenson was clear in his perspectivism: "Nothing . . . can be understood out of its time and place, its nexus of relationships" (1972, p. 8). But in many later publications, beginning with *The Ambiguity of Change* (1983), Levenson writes as if the "real" refers to veridical reality, to reality existing apart from any observer's construal of it. For example, it would seem that he suggests that patients are mystified because they are misperceiving or misconstruing the true nature of things—a truth or semiotic accuracy that the analyst is in a position to discern.

If this is the case, Levenson's position is open to the same critique that he levels at classical analysts. Mystification becomes yet another term for *distortion,* and the analyst becomes the authority who interprets the truth that is distorted. As Greenberg (1987) suggests:

> If psychoanalysis "elucidates the uncomprehended" (Levenson 1983, p. 15), then the analyst must have a pretty good idea of what ought to be comprehended in the first place . . . . Solidly in the tradition of Sullivan, Levenson overvalues the possibility of objectivity in interpersonal relations. [p. 699]

In Levenson's work, as in Sullivan's, the emphasis on the "real" is juxtaposed to analysts' emphasis on fantasy. Both Greenberg (1987) and Hoffman (1990) note the contradiction between Levenson's many references to reality as a construct and the sense that his evidence

for this rests on the assumption of the classical positivist dichotomy between reality and fantasy:

> Levenson's response to the classical notion that the core of the patient's transference to the analyst is nothing but historically rooted fantasy is to say that the core, the essence, is nothing but reality, although one which happens to duplicate the reality of the past. So now the past is literally repeated in the analytic situation and now it is the analyst who is in a dream world, a cocoon of theory that protects him/her from the full impact of the patient's experience. Although the way they are allocated is reversed, fantasy and reality end up being no less the relevant terms of discourse for Levenson than they are for the classical analyst. [Hoffman 1990, pp. 296-297]

From Hoffman's perspective, Levenson treats his own inferences about what's happening as direct observation, and treats other inferences as "dubious theoretical speculations about intrapsychic processes" (Hoffman 1990, p. 295). For example, Levenson often notes that a dream means exactly what it says (1983, p. 107; 1989, p. 549)—as if there is no interpretation in his use of the dream, as if manifest content suffices without inference. Although it might be accurate to suggest that there is much to be gained in a serious examination of the manifest story, Levenson's use of manifest content entails inferences of his own.

In subsequent writing, Levenson appeals to "a measure of common sense" (Stern 2005b, p. 707) in referring to the reality of events. We might talk about events from different perspectives, but events nevertheless transcend our perspectives on them. He uses an appeal to those real events to situate the patient and analyst on a common playing field. Real events serve as bedrock. Unlike constructs, they are a final reference point that can be known, the reality of which cannot be questioned.

But contemporary critics have indeed questioned just this point. Stern (2005b) makes a useful distinction that clarifies how many postclassical thinkers differ from Levenson's stance. He suggests that Levenson's notion of "reality" refers to points of experi-

ence where we might all be inclined to readily agree. In turn, Levenson's "interpretations" or "perspectives" on reality refer to those points of experience where more prominent ambiguity leads to less agreement, to more diversity.

In referring to real events, Levenson uses the same logic as analytic philosophers (e.g., G. E. Moore 1939) in positing statements like "here is a hand" as self-evident. It would seem to be nonsensical or at least trivial to argue such a point. "We may not agree on meanings, or on interpretations, but we can all agree on the simple description of an incident" (Stern 2005b, p. 708). While this is certainly true with such simple assertions, it becomes more problematic with many other aspects of human experience, where the events always entail one point of view or another.[3] Stern, a serious student of Gadamer, reminds us that "for hermeneuticists and constructivists, experience is itself an interpretation" (p. 708). There is no raw data underlying experience, no bedrock of a "singular, rational and correct perspective" (Mitchell 1997, p. 89).

Mitchell (1997) suggests that Levenson attempts to reconcile his early perspectivism with his reliance on the bedrock of real events by contrasting the traditional psychoanalytic quest for hidden cause with his sense that analysts seek to "expand awareness of patterning" (Levenson 1983, p. 116). Such patterning of experience and interaction does not require interpretation behind experience, but rather looks for the structure apparent in experience as it is manifest. Levenson avoids "the tar pits of social constructivism and relativism" (Levenson 1996, p. 639) by referring to interaction patterns that might be identified "out there" in a way that can be mutually validated.

[3] Wittgenstein (1969) makes a compelling critique of Moore's (1939) commonsense argument for reality statements, suggesting that such propositions have no meaning apart from their context. The truth function of these statements is found in their role of establishing the rules for language and interaction. They are accepted because they participate in forming the grounds for the system in which they are used. Statements of reality and certainty are unusual in this regard, serving as boundary markers for our play in a given context. Given their acceptance by all who participate in that context, Levenson might have been able to find a nonpositivist foundation for his notion of "reality" that might have avoided the inconsistency of his position.

Like any good poststructuralist, Mitchell questions Levenson's assertions regarding patterning. In what sense are patterns "out there"? Implicit in Levenson's stance is an assumption regarding the stability, consistency, and universality of structure. What assures us that "these configurations are very powerful and consistent and run . . . through every aspect of the patient's life" (Levenson 1983, p. 19)? Are we to assume that different analysts would find the same patterning in their work with the same patient? Psychoanalytic theory has much to say about the consistency and intransigence of structure, the function of psychic structure in multiple motivational contexts. But Levenson does not provide an adequate frame of understanding to support his case for the structural continuity of interaction. His developmental model of semiotic mystification does not help us understand how structures come to be and sustain themselves over time.

Critique II

An exchange between Steiner (2006a, 2006b) and Levenson (2006) is characteristic of critical discussions with theorists of different orientations. Steiner begins a discussion of "interpretive enactments" with a different conception of enactments, indicating that they "by definition cross the boundary from thought to action and, unless they are recognized and regulated, can enter that grey area between normal technique, technical error, and unethical boundary violation" (2006a, p. 315). This conflates Levenson's use of *enactment* (which refers to the continual patterns of engagement or interaction between patient and analyst) with *acting out* (which refers to episodic violations of the protective frame of treatment on the part of patient or analyst).

Although Steiner acknowledges that there is "always some translation into action and that, moreover, this should also not be suppressed but be given expression as a free-floating responsiveness," he sees this as "always harmful," to varying degrees—a danger that has to be accepted (2006b, p. 326). Levenson contends that, from Steiner's position, the therapist is "working toward an idealized non-interference, carefully noting any violations and, at the very

least, minimizing them" (2006, p. 322). He sees such minimizing as potentially an enactment in itself. Steiner counters by reminding us of the importance of observing and recognizing enactments that "are more subtle expressions of the analyst's failure to give priority to the understanding of his patient" (2006b, p. 326).

In this exchange, Steiner and Levenson talk past each other (Smith 1997). Both would agree that psychoanalysis is a special kind of engagement that opens profound vulnerabilities; that we run the risk of harming patients through actions that unwittingly violate the trust they place in us. Steiner and Levenson differ regarding the kind of engagement that is mutative and the nature and function of understanding in a mutative process. For Steiner, countertransference feelings and reactions "are allowed to well up in the analyst, but . . . action is restrained" (2006b, p. 326). For Levenson, action is inherently part of the analyst's engagement, in that "words are also deeds" (2006, p. 322).

Although countertransference feeling is not enactment, it becomes enactment (a pattern of interaction) in the process of exchange. Steiner warns against "interpretive enactments," interpretations that subtly make our views and feelings known to the patient without our realizing it (2006a, p. 317). Levenson holds that such is our stock in trade. Steiner gives priority to understanding the patient's mind. Interpersonal aspects of analysis, found in externalization of the patient's internal world in the transference, in the relationship of the patient's projective identification and the analyst's countertransference, serve to clarify an understanding in which projections and externalizations are reclaimed as part of the mind's functioning. Levenson gives priority to understanding the interactive field. Enactment is explored as the primary source of data regarding how patients and others characteristically engage. This understanding functions in the service of opening the field to more complex and flexible interactions (toward *not* understanding), and is not seen as an end in itself.

Smith (1997, 2001, 2003, 2007) has addressed the profound confusion of tongues that is part of our shared heritage as psychoanalysts. In a series of articles, he elaborates a nuanced assessment

of the obstacles to coherent discourse among thinkers of different theoretical inclinations, highlighting the complexities entailed in our attempts to understand each other as we talk and write about our work. Calling Levenson "a true pioneer in the current understanding of enactment," Smith reports an experience with Levenson that brought home both our isolation from each other as analysts and the role of fantasy in our views of other analytic schools. In a workshop at an American Psychoanalytic Association meeting, Levenson said that the participants "must have all been taught never to say anything to an analytic patient unless the patient were lying on the couch" (Smith 2001, p. 491). Levenson appears to create a mythical stereotype of classical analysts that does not reflect what they actually do in their clinical work.

There are several kinds of obstacles to discourse that are relevant to a discussion of Levenson's work. Smith notes the sharp differences in how basic psychoanalytic terms are understood and used by different thinkers; key concepts such as *insight* and *containment* (2007, pp. 1746-1761) are defined and derived in different ways. Levenson would certainly agree with this. He noted early in his work that contemporary positions are framed in our time-honored conceptual terminology, which traces its lineage to Freud and other founders. He stated that the meanings of our central concepts change in the context of their theoretical use, such that an "archeology of language is necessary" (Levenson 1972, p. 62). In their exchange cited earlier, Steiner and Levenson both use *enactment* within their own frames of reference, without the necessary exegesis to provide a common frame for productive dialogue. Without such exegesis, concepts can tend to disguise the embeddedness of our understanding.

Beyond the specific meaning of concepts, abstraction can become another obstacle to coherent discourse. Smith (2000) and Friedman (2000) refer to the difficulties inherent in the fact that theory is presented at different levels or layers of abstraction. Smith refers to Waelder's (1962) useful delineation of the levels of psychoanalytic thinking in relation to its distance from clinical material (Smith 2000, p. 308). A clinical observation sits at one end of a sequence of abstractions, and metapsychological constructs like

the death instinct sit at the other. But one group of analysts might refer to "data" that is quite close to observation for them (*internal objects* or *unconscious fantasy,* for example)—the same data that another group might claim to be a distant abstraction.

Levenson's resolution to this problem entails rejecting the intrapsychic constructs that provide a frame of understanding for much of psychoanalytic theory. The mind is unknowable for Levenson, and, until recently, he questioned the relevance of internal process and structure altogether, privileging the immediacy of interaction. But in doing so, Levenson privileges one kind of abstraction (patterns of relatedness) over others, asserting that his abstractions are more true to the "reality" of experience—that the ends of his theoretical choices are less constrictive, less in the service of the analyst's need for clarity. This move is reductive in that it limits what can be said and known about analytic experience to what transpires between two subjects.

Although Levenson is cautious about metapsychological abstraction, he uses *philosophical* abstraction to justify his interpersonal position, referring to structuralism, hermeneutics, and other poststructural frameworks. While this may be well and good, Smith (2003) notes how many contemporary thinkers attempt an end run around experience-distant theory by grounding their work on highly abstract philosophical positions, without acknowledging that they are engaging in the same kind of metatheorizing that they criticize (but at a philosophical rather than a metapsychological level). Epistemological positions are sometimes used to ground technical considerations in a manner that attempts to integrate quite disparate levels of abstraction. At its best, this provides a foundation, a philosophical anthropology from which to examine any psychoanalytic position. At worst, when tied closely to technical considerations, such epistemological linkages can become "appeals to a higher law" (Smith 2003, p. 136) that serve a function Levenson resoundingly criticizes in the use of metapsychology—but that might in fact be implicit in his own position.

What wealth of experience is lost with Levenson's choices? Our concepts and theories are not only obstacles. They provide bridges

between the past and future, as in the subtlety and nuance of Loewald (1960), who pulled our older concepts into profoundly new uses. Theories open different vistas, different kinds of reality described at different levels of abstraction. This diversity runs from the descriptively specific, found in Schafer's (1976) action language or Renik's (2006) collaborative identification of symptoms, to the metatheoretical, such as Bion's alpha function or Lacan's equations for the relationship of the signifier to the signified. Diversity also shifts among different vantage points (Smith 2007, p. 1738), such as the action and experience of the analyst, the action and experience of the analysand, the interaction between the two, and the function of the analysis as a whole.

Smith (1997) refers to Bloom's notion of "creative misreading," where poets and thinkers misinterpret their predecessors as a means of clearing imaginative space for themselves. Bromberg (2007) sees many of Levenson's developments as just such a misreading, or "misprision" (Bloom 1973), of Sullivan's interpersonal perspective—and, indeed, Bromberg sees his own work as creatively adapting Levenson's position, integrating it with the insights of object relations theory and dissociation. Such shifts are not simply obstacles. They are creative leaps to new visions of our work, each opening a different "illusory imaginative play space" (Cooper 2007, p. 249), each responding to limitations of other perspectives, drawing from the unique readings, misreadings, integrations, and experiences of those involved.

Numerous thinkers suggest that in our clinical work, when at our best, we invoke theory only at moments of impasse. Theory is where we go after the fact, to account for what went well and what did not. We work as we do, integrating training and character, attending to the range of experiences in ways that far outstrip the frames of reference that secure our sense of certainty or conviction. In this nod to the ineffable, Levenson speaks to something with which we can all identify regarding what happens when we attempt to grasp process, when we still the movement of an encounter. Our differences are highlighted in our descriptions of the process, especially as those descriptions leave the specificity of various moments in the session.

What exactly *is* process and where is it to be found? There are many creative differences between descriptions of process, and as many differences among thinkers within one school as there are among thinkers of different schools (Cooper 1996, 2007; Smith 2003; Teicholz 2006). But in clarifying the dangers of understanding, Levenson paradoxically reduces the scope of our vision. Interaction is privileged at the expense of appreciating the vast diversity of orientations with radically different ways of seeing. What of the unconscious, the various nuances in the interpretation of conflict, the separateness and interiority of the other, the profound impact of personal history, varieties of internal organization spanning the paranoid-schizoid to the depressive, the dissociative multiplicity of states, or the selfobject function developed through transmuting internalizations? Although we may not think of theory in individual moments of our sessions, our orientations prefigure what we highlight—what we selectively see, hear, and respond to.

Cooper (2007) emphasized that an unconscious attachment to our theory and a tendency to idealize our preferred approach can lead to blind spots in our work and knowing. He notes that we are prone to rely on our formulations in a manner that inevitably precludes other ways of seeing and understanding. Much as Levenson has discussed, this happens in unavoidable unconscious enactments with a given patient, but also happens in the development and application of theory.

But, rather than narrowing the scope of our vision, Cooper suggests that we might be more accountable in working toward ends that we value if we think critically from perspectives other than our accustomed ones. He notes that if we can de-idealize our position and mourn the loss of this idealization, we might be able to step outside our preferred approach, using other theoretical perspectives as a *pluralistic third* in relation to our own. While cognizant of the fact that we never work from a single model, Cooper suggests that the creative facility of moving among different theoretical positions might provide a critical balance, a greater openness to unexpected organizations and *safe surprises* (Bromberg 2006) in the face of our fixity. This is a use of our theoretical wealth that acknowl-

edges the limitations so well highlighted by Levenson, while addressing the realities of how we actually work.

LEVENSON'S CONTINUING RELEVANCE TO PSYCHOANALYSIS

Levenson was never a systems builder and has little patience for his apologists' and critics' search for consistency in his work. He agrees that his work might be seen in terms of differing periods (like Picasso's Blue Period and Rose Period), but these periods are not the building blocks of a comprehensive view (Levenson, Hirsch, and Iannuzzi 2005, p. 622). Even so, Stern (2005b) emphasizes convincingly that throughout his work, Levenson has seen understanding as a means to an end rather than an end in itself. It is Levenson's push beyond understanding and his particular placement of our theory in relation to the ends of our work that point to his continued relevance to psychoanalysis.

This might be elaborated by drawing several points from one of his summaries of his position in *The Ambiguity of Change:*

> The thesis, then, is that psychoanalysis works not because of what it says but how it proceeds, throwing an ever-widening seine of inquiry that is of a semiotic nature. The uniqueness of psychoanalysis lies in its particular framing, which permits the participants to use themselves in an infinite regress of metacommunications about the data the patient presents about his or her life. The therapist's particular explanatory system is only a metaphor, a way of pulling things together, of parenthesizing data. It is neither intrinsically correct nor incorrect but, rather, a commentary on the interactional field. But since each commentary is a selection of position, however inadvertent an attitude about what is being told by the patient, every interpretation becomes an interaction. [1983, p. 111]

Psychoanalysis works not because of what it says but how it proceeds. With this, Levenson emphasizes psychoanalysis in its process. Yes, there is a reduction here, to the elements of our practice at its

most basic. The patient enters the analyst's office and sits in a chair or lies on a couch or sets about at play with some toys. The patient is not alone, but with another who invites the patient, in one fashion or another, into an exchange, an "inquiry." Perhaps there is silence, perhaps there are questions, perhaps a simple reiteration of the events of the day. In this situation of great constraint—which limits and contains the anxiety of both participants and consequently their anxious claims on each other—they interact and things happen. Levenson refers again and again to the *experience* of analysis, to its elusive and subversive force, always transcending our grasp.

The pendulum has swung. Far from the hegemony of a few systems of psychoanalysis, we are awash in perspectives. Given this multitude of voices, Levenson is empirical. He suggests that we look directly at the experience of our work. Rather than binding allegiances to schools, and rather than shifting about within the diversity of current pluralisms, we might move further in making sense of our work by describing what we do. This is an emphasis that Smith (2003) suggests:

> Since we do not really know what other analysts do, or for that matter what we ourselves do, in the heat of the clinical moment, if we were to take a much more clinically near view of the situation, at a lower level of abstraction and generalization, the arguments that support one theory or school of analysis over another might not look so clear . . . . If we could look, at this finer level of detail, at what we each do in the analytic moment, . . . we would begin to develop a view of practice that is based to a greater extent than heretofore on what actually goes on, rather than on what we think *should* go on. [pp. 141-142, italics in original]

The aim is not to empirically cleanse ourselves of our theories, but to give priority to the process from which our abstractions are drawn. For Levenson, abstractions can lead to concretizations of abstractions in the form of technique—practices designed to find or create what the theory dictates as the nature of the process (what *should* go on). Process transcends abstraction and technique, and as such brings us back to the source of our theory, back to an ex-

amination of what we share in common. We can find contemporary examples of this focus in the work of developmental analysts, who have been working out nuanced approaches to describing process through moment-to-moment and microprocess research developed from infant observation.[4]

Levenson suggests that process is psychoanalytic because of its *particular framing*. This is a framing in which, given the restraint of the analyst, attention is directed toward what happens, with communication being both part of this happening and an attempt to understand and elucidate it, a metacommunication in infinite regress. When interaction is not forced by heavy-handed technique or by the overbearing need to foreclose by making too much sense of it, an order can be discerned in the metacommunications that is unique to the analytic pair. The work of analysis is in the unpredictable shifts of participation that happen in attempts to elaborate this order.

For Levenson, the mutative action of psychoanalysis occurs in a spontaneous exchange. The movement of analytic process cannot be prescribed, and indeed is difficult to describe. It is something that happens as we look at and try to talk about that happening. In our attempts to describe it, we "use" ourselves through our personal participation in what happens in the analysis. Levenson suggests that this participation cannot be avoided—that with the patient's participation, it becomes the affective *potential space* that might possibly lead to something new.

In our current age, we can never completely stand outside the work that we hope to describe. A focus on the analyst's subjectivity has sparked a proliferation of voices (Teicholz 2006)—dismantling the orthodoxies of received wisdom into an array of perspectives, each elaborating something different, multiple ways of "pulling things together" that are "neither intrinsically correct nor incorrect"—a commentary on experiences of the process in the interac-

[4] See publications by the Boston Change Process Study Group (2007; also Nahum et al. 2002; Nahum and Boston Change Process Study Group 2005; Stern et al. 1998), by its individual members, and by former members Harrison and Tronick (2007) for examples of possible approaches to psychoanalytic process.

tive field. Levenson's reservations about our abstractions from process are no less relevant today than they were when he cautioned us about the traditions of his day. Our abstractions help provide a sense of orientation in the midst of complexity, but at the expense of directing process toward our own aims and goals.

One might think that Levenson's privileging of process suggests that he holds practice above the dilemmas of theory. Given that practice always surpasses our attempts to grasp it, process becomes the elusive fox that ever evades the baying hounds of our abstractions. But Levenson situates the problems of theory in psychoanalytic process itself. As we look at and talk about what happens, our descriptions inevitably become explanations. We are not only caught up in a unique dance with the patient's understanding; we also bring to it the music of our own position, an attitude about what is being told that is informed by the vagaries of theory.

As noted above, the aim is not to cleanse ourselves of theory, but now to attend to its inevitable function in process itself. Theory is part of our character, part of our own fixity in process that itself becomes part of the interaction. Indeed, Levenson is the fox, overturning our henhouse of complacency in understanding, our hope for transparency, our sense of ever being in the clear. Understanding must give way to *not* understanding, to something new that we can neither predict nor, without being part of the process of its unfolding, describe.

Perhaps the pendulum is swinging again. Levenson's description of process also suggests a description of development and change in our field. As our theories develop, we become embedded in our thinking and interacting. New theory entails discovering new complexities that upend the embedded order, opening up understanding to more chaos and complexity, until it embeds again with the search for yet greater complexity. This formulation fits well with Kuhn's (1962) classic formulation of scientific progress, and with subsequent models of the growth of knowledge that take into account the sociology of scientific change (e.g., Feyerabend 1975; Rorty 1979, 1982). Far from an embedded order of the various schools of psychoanalysis, the upheaval of subjectivity is our

new embeddedness. Once a novel insight, the fact of our irreducible subjectivity is now the established order.

We are currently saturated in our postmodern sensibility, including the dilemma of its profound skepticism regarding objective knowledge. We no longer have new, unified psychoanalytic theories of mind that attempt to provide comprehensive explanations for human behavior and experience, where controversial discussions regarding the truth and utility of competing visions dominate our professional journals and meetings (cf. Govrin 2006). The clinical case example is paramount, with more humble aims. We have "*ironic* authority," "the *endangered* self"; we have "the *analyst's* guilt," "the *analyst's* desire," and "the *patient* as interpreter"; we are full of "hope and dread." We are all sensitive, attuned, authentic, and uncertain. There are clearly retrenchments from this sensibility, but for the most part, we are chastened . . . and hungry. We are hungry perhaps not for certainty, but for substance—for contemporary perspectives that are rich, specific, and comprehensive, that pull us beyond our doubt and reserve.

Our hunger is evident in recent integrations with neurobiology (e.g., Pincus, Freeman, and Modell 2007), where we hope that the clarity of contemporary research into our most elemental substrate will provide the substance we crave. It can also be seen in contemporary reworkings of drive theory (e.g., Greenberg 1991; Schmidt-Hellerau 2002, 2008), in the empirical turn of research to quantitative methodology (e.g., Westen 1990), and in close process observation (e.g., Boston Change Process Study Group 2007). We cannot go back. The lost innocence of analytic schools is behind us, and we are forever part of the puzzle that we are challenged to solve. We are poised for new understanding, but such understanding cannot stand alone without a reciprocal questioning of our stance, of the intended and unintended consequences of our knowing.

Most likely, Levenson welcomes this state of affairs. Intimations from some of his recent remarks (Levenson, Hirsch, and Iannuzzi 2005) suggest that he is pursuing new complexities, with a fresh respect for the internal world and a curiosity regarding how the mind

organizes experience and how the analyst's presence and interaction facilitate change. He hopes to formulate this without reduction to competing metapsychologies, and without what he sees as the spurious dichotomy between drive and relational models (Levenson 2008). Levenson has always aimed to present a different way of seeing (1972, p. 57), bringing us back to the unbounded abundance of our process, ever careful of the abstractions that delimit how we can see.

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BOOK REVIEWS

THE SEDUCTION THEORY IN ITS SECOND CENTURY: TRAUMA, FANTASY, AND REALITY TODAY. Edited by Michael I. Good. Madison, CT: International Universities Press, 2006. 318 pp.

Why, you may wonder, should the seduction theory—abandoned by Freud back in the nineteenth century—be dragged into the twenty-first? The first hundred pages or so of *The Seduction Theory in Its Second Century: Trauma, Fantasy, and Reality Today,* which constitute Part I, are devoted to this very question. The issue is further elaborated in the concluding papers presented in Part IV. Part II is about "Analysts at Work with Patients Whose Lives Are Characterized by the Traumas of Everyday Life," and Part III deals with "Analysts at Work with Severely Traumatized Patients."

This book is a compendium of presentations and discussions at the 1998 New York symposium of the same name, chaired by Arnold Rothstein, along with an introduction and a postscript by editor Michael I. Good. The symposium brought together analysts from Freudian, relational, interpersonal, and self psychological perspectives. The fact that the list of presenters, discussants, and moderators reads like a "Who's Who in American Psychoanalysis" is the first indication of the high quality of the material.

So why are we still talking today about the seduction hypothesis? The general answer is because it bears on the core of psychoanalysis: its history, development, and major theoretical and clinical questions. Good traces the roots of the seduction theory, while George Makari, in a piece of erudite historical research, places Freud and his ideas in the context of nineteenth-century medicine. He outlines Freud's struggle with the notion of specific causes (of hysteria) and trauma theory. He delineates the shift in Freud's thinking that gradually gave rise to the importance of fantasy and the pri-

macy of the unconscious. But of course ambiguity remains and the debate continues, spurred on over twenty years ago by the controversial work of Jeffrey Masson.[1] Is history itself seductive?

Jay Greenberg develops the theme of the ambiguity of seduction, hoping to show that the seduction theory was Freud's first attempt at creating a theory that was uniquely psychoanalytic. It "required some way to anchor the entire history of hysterical illness in psychic experience" (p. 67). But seduction remains "marvelously elusive . . . delicately poised between the literal and the metaphoric" (p. 67). Greenberg elaborates by looking at Freud's views on trauma and why he used the word *seduction* rather than *abuse* or *molestation*. Seduction implies participation, willing or unwilling. Greenberg notes that its essence, for Jean Laplanche, is "the confrontation of the child with the otherness of his or her objects" (p. 73). For Greenberg, it evokes "the forces that bring about the creation and the destruction of human desire and human relatedness" (p. 75).

The book benefits from the inclusion of comments by the symposium's discussants. Helen Meyers speaks to the seductiveness of seduction, calling it "the act of enticing, or tempting or leading astray into the wrong" (p. 77). She traces the slow, vacillating process Freud went through in the shift in his thinking. She gives more reasons why we are revisiting the seduction hypothesis: to address issues of external trauma versus instinctual trauma, external events versus inner fantasy, objective reality versus psychic reality, and the question of historical truth.

Henry F. Smith highlights the difficulties inherent in retrospective research, citing struggles in distinguishing types of truth: reconstructed versus historical versus narrative. In disagreement with Greenberg, Smith does not see Freud's search for a specific cause as a struggle over metaphor. Instead, he describes Freud's painstaking attempt to understand what is real and what is not, what is internal and what is external, and whether something is

[1] See Masson, J. M. (1984). *The Assault on Truth: Freud's Suppression of the Seduction Theory*. Gordonsville, VA: Farrar, Straus & Giroux.

done to the patient or in him (every analyst's dilemma). Freud eventually shifted his focus of attention "not to fantasy instead of reality, but to that mix of the two we call psychic reality" (p. 93). Smith concludes, "It is *not* that seductions do not occur but the way we study them that was revolutionary" (p. 95, italics in original).

Chaired at the symposium by Owen Renik, the discussion that follows enables participants to clarify their views and areas of agreement and disagreement (for instance, about what is meant by fantasy and by psychic reality). It is noted that everyone's views are based on "present beliefs and wishes" (p. 65).

This first section is a preamble to the central topic of the book: trauma, introduced here by Arnold Cooper. We are then served with a plethora of richly detailed clinical examples and theoretical views on trauma, pathogenesis, and clinical technique. At the center is the concept of psychic reality. With two clinical vignettes, Jacob Arlow illustrates the notion that "one person's mouse may be another person's dragon" (p. 121).

Scott Dowling takes up the question of whether trauma must be rooted in an external event or may be rooted in a fantasied event. With clinical examples, he illustrates his facilitation of the process of discovery (as opposed to the confirmation of "truth") when faced with the following dilemma: "If we equate psychological trauma with unconscious fantasies, we sidestep the patient's experience of impingement; if we equate it with external event, we sidestep the influence of meaning and unconscious fantasy" (p. 131).

Marylou Lionells brings an interpersonal perspective in her paper entitled "What Happened Matters, and What Really Happened Really Matters." In describing a difficult case, she illustrates the unfolding of transference and countertransference struggles with a focus on the relational matrix. "Nothing I did was affirmed" (p. 147), she notes. This experience leads her to understand the patient's need to have the analyst describe her sense of him—her reactions to him, as well as her hypotheses about his inner state. This and her ability to recall details of his history were "as important as any interpretation" (p. 152). This discussion serves as a point of departure for another line of debate taken up in the book: the issue of valida-

tion. If we cannot be sure of the historical facts, how do we understand the need for validation in a particular patient, and what, if anything, do we validate?

Anna Ornstein offers a self psychological perspective on the concept of trauma and its neurogenesis and their relation to reconstruction. Her emphasis is not on the recovery of actual pathogenic events, but on the recovery of intrapsychic experiences of childhood. She stresses the importance of understanding the child's developmental stage at the time of the trauma.

Robert Michels's incisive discussion raises thorny questions: How do we know what we know? And are we "dealing with factors in the etiology and pathogenesis of neurosis, or rather with symbolic elaborations that provide clues for our understanding of dynamic constellations but offer no explanation of causation" (p. 175)?

The pièce de résistance (perhaps the pun is intended) comes in Part III: "Analysts at Work with Severely Traumatized Patients," a section chaired by Leon Hoffman at the symposium. Peter Fonagy takes us inside the soul of a female murderer who was a victim of incest and of sexual abuse by a teacher. Of the many conjectures about what was going on between analyst and patient in this analysis, Fonagy held on to his understanding of the "intolerable sickness that the closeness of two human minds created [in her] . . . . Analysis was obscene seduction because thinking about mental states was an *incestuous act*, experienced as the intrusion of an object into a space too small to contain it" (p. 203, italics in original). Fonagy expands on his conceptualization of traumatized patients with a "self representation distorted by containing within it a representation of the other" (p. 204). His aim is the recovery of reflective function rather than the achievement of insight.

Leonard Shengold describes his work with disturbed patients in the throes of primitive feelings and inadequate and excessive defenses against them. He stresses their murderous aggression and the analyst's need to tolerate being the object of their rage. He is clear about the difficulty of being certain about traumatic pathogenesis, but also about the importance of the question, "Does it matter if it really happened?" His answer: yes and no! So we are

back to ambiguity, although Shengold goes on to explain what he means; in the end, though, "the conviction that something has happened, right or wrong, optimally should originate with the patient, not with the therapist" (p. 216).

One of the aims of treatment, for Shengold, is to get the patient to care about the analyst as a separate person and to tolerate that feeling, a point with which Glen Gabbard disagrees in his discussion. Instead, Gabbard sees this as the end result of the treatment rather than the cure itself. Shengold has the opportunity to clarify ways in which he has been misunderstood. The discussion also bears on ownership: owning what one feels and thinks, or, as Gabbard puts it, "owning the representations of the past that continue to be active in the present" (p. 228).

The concluding papers offer more discussion and further insights. Steven Ellman takes up seduction in the psychoanalytic process, the role of trust, the question of how we know what we know as it relates to the transference, and the paradox of love versus solitude. Stephen Mitchell expands on the meaning and the usefulness of taking a both-and, rather than an either-or, approach. He outlines key issues embedded in the seduction hypothesis: "The problem of the analyst's position vis-à-vis the patient's self-understanding of the relationship between her current pain and the life circumstances she was dealt" (p. 273), and the displacement "for our struggle to come to terms with the ambiguities of seduction in the analytic relationship" (p. 277). Michael Good highlights recurring themes and conflicts regarding the seduction theory and proposes a research approach for specimen clinical case studies.

In its intent and delivery, this book illustrates basic aspects of the psychoanalytic enterprise: our reliance on history and our struggle with its uncertainty, the need to revisit and reinterpret history as our ideas evolve, the need to tolerate ambiguity in the melding of the internal with the external, and the need to appreciate the impact of actuality and the contribution of what each individual brings. We become reacquainted with Freud the psychologist versus Freud the medical doctor, with the ambiguity of the literal versus the metaphorical, and we delve further into the debate about

causation versus narrative understanding. At the core is the concept of trauma. We are invited to become sensitized to trauma's subtlest manifestations, but also to immerse ourselves in its most alarming and dreaded impact.

The high-level dialogue in this book brings hope, as expressed by Marylou Lionells, "for a paradigm that fully incorporates the interpenetration of these dimensions" (p. 142) (that is, the intrapsychic and the interpersonal). It has not often been said of a psychoanalytic book that it was hard to put down, but this is such a book.

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MORAL STEALTH: HOW "CORRECT BEHAVIOR" INSINUATES ITSELF INTO PSYCHOTHERAPEUTIC PRACTICE. By Arnold Goldberg. Chicago, IL: University of Chicago Press, 2007. 150 pp.

In an era of increasing anxiety about negative publicity, psychoanalysts have become increasingly concerned about boundary crossings and other moral indiscretions. Our professional organizations have mandated codes of ethics, prescriptions for moral behavior, and the establishment of ethics committees to address breaches of moral conduct that occur among our colleagues.

Within this context, Goldberg's *Moral Stealth: How "Correct Behavior" Insinuates Itself into Psychotherapeutic Practice* attempts to examine the impact of such moral prescriptions on the practicing analyst and pleads for a new approach to our thinking about ethics and morals. This slim volume of thirteen essays espouses a psychoanalytic mode of thinking about such issues that tolerates ambiguity, contradiction, and doubt, with the ultimate goal of a more consciously considered resolution. Goldberg's prescription rests upon his observation that unconscious moral judgments "stealthily" infiltrate our attitudes toward our patients and ourselves in relationship to our patients. Dangers arise when we apply moral judgments to issues that are not in themselves matters of morality, as well as when we fail to examine our seemingly non-negotiable or unconditional positions. Goldberg's approach is at once scholarly and personal as

he weaves together the philosophical and the anecdotal. He provides illuminating clinical vignettes and offers pithy references to the literature on ethics and morals.

Overall, this is a thought-provoking and engaging contribution by a distinguished psychoanalyst. However, the volume suffers from unnecessary repetition and some discontinuity in the flow of the material (perhaps partly due to the inclusion of essays previously published in journals). Goldberg's opening vignette, a jarring reflection on his complete lack of interest in an elderly former patient whom he meets years later at a dinner party, is disconcerting. The patient is eager to reconnect, tells Goldberg of the benefits of his treatment, and suggests that they have lunch together. Goldberg introduces two points to the reader, that he is uncomfortable with any blurring of patient and therapist roles, and that the personal qualities expected of a good therapist differ from those of a good friend. While Goldberg's points have merit, it is hard to imagine that a total disconnect is possible between the capacity for empathy as an analyst and the capacity for an empathic response as a human being. Reading this did not encourage me to continue reading the remainder of the book.

Goldberg orients the reader to the distinction between *ethics* and *morals*. He describes the former as a broader and more conceptual domain that is the focus primarily of religious and philosophical thinking. He describes the latter as concerned with duties, obligations, prohibitions, and imperatives. Although it might seem more useful to think about psychoanalytic and psychotherapeutic issues from the standpoint of the moral realm based on our concern about conforming to the rules and regulations that govern our behavior, Goldberg identifies dilemmas raised by such thinking. He points out that certain behavior, such as non-intimate physical contact, might be acceptable to the psychotherapist under certain conditions, but probably would not be acceptable to the psychoanalyst.

Furthermore, the evolution of psychoanalytic theory has shifted notions of what is required of the good therapist, exposing a conceptual tension between discussion of technique and discussion of

morality. Goldberg believes that prescriptions for moral behavior are doomed from the outset because a multitude of factors inevitably shifts the discussion toward one judgment or another. While such a view might have pushed Goldberg toward a stance of moral relativism, he is careful to reassure the reader that he has no such allegiance.

Before elaborating his own stance of "moral pragmatism," Goldberg describes three positions outlined by others regarding the relationship of psychoanalysis to moral and ethical issues: "It has been variously condemned as an activity intent on undermining morality, as having nothing whatsoever to do with morality, or as itself offering a cogent ethical theory" (p. 11). Goldberg rejects all three of these views and arrives at his own unique position, in which he views moral judgments and concerns as woven into the fabric of the analytic relationship, whether consciously recognized or unconsciously influential. His view reflects the contemporary focus on countertransference and intersubjectivity that directs us to consider our judgments and personal stake in our treatments. Such a focus has also shifted our discussions to considerations about the personal qualities and behaviors of analysts and how such qualities impact our patients and the efficacy of our treatments. Goldberg believes that, inevitably, such qualities are judged not only by their efficacy, but also by what is "proper"—in other words, judgments are made not only about what is therapeutic, but also about what is ethical. While some behaviors clearly fall into one or the other area, other behaviors remain somewhat murky. Goldberg concludes that we must recognize that our attempts to establish moral ground put us in an impossible position—but he adds that, paradoxically, our recognition of the impossibility of this position gives us greater freedom to make moral judgments.

Goldberg's solution to this dilemma draws upon the American philosophical tradition of pragmatism that dates to the early 1900s, when it was espoused by such philosophers as William James, Charles Peirce, and John Dewey. Goldberg distinguishes their pragmatism from his view of relativism, in which any idea is as good as another. He describes pragmatism as a philosophy that rejects absolute truths

in favor of an attitude of open inquiry that considers the specificity of time, place, and person, and that accepts a "medley of workable opinions" (p. 43). Goldberg champions "moral ambiguity" and decries "moral laxity." He embraces the pragmatist position that knowledge does not correspond to facts, but to a "shared interpretive horizon" (p. 42) among members of a community. While Goldberg recognizes the dangers of decision-making based on community consensus, he argues that open inquiry permits the rendering of absolute positions as well as of more conditional ones. One might question how the rendering of an absolute position can ever be consistent with Goldberg's pragmatic stance, but this is a minor quibble. I have a more substantive concern.

Goldberg begins with an effort to uncover moral stealth, but, I believe, he ends by committing an act of *theoretical* stealth. He argues that pragmatism can help us address the dilemmas of contemporary psychoanalysis, which, he states, continues to be burdened by a destructive attitude of certainty and authoritarianism that is the unfortunate legacy of Freud's followers (which seems to me a gratuitous dig). Although Goldberg lays the groundwork for considering the interplay of moral issues within the larger context of theory and technique, he slips into another realm entirely when he proffers a solution to the problem of theoretical pluralism—a solution utilizing therapeutic efficacy.

Goldberg returns to somewhat firmer ground in part two, where he examines the inherent tension between specific concepts of correct behavior and actual psychotherapeutic and psychoanalytic practice. He examines a diversity of issues, including confidentiality and the linked issue of psychoanalytic publishing, a perspective on the nature of thoughtlessness, and the relationship of disavowal to superego function. Chapters 5, 8, and 9 develop a discussion of confidentiality in relation to the concept of ownership and would be more effective if they were organized sequentially. Goldberg uses confidentiality to illustrate the philosophical notion of *background,* in which certain assumptions become absolute and thereby lose their place as matters that warrant exploration.

While most of us would automatically subscribe to the principle of confidentiality as an unarguable moral position, most of us also participate in a variety of departures from the strictest confidentiality by virtue of our participation in supervision, clinical conferences, professional writing and publication, and communication with insurance companies. While some of these departures may be justified as being for the good of the patient, others may be relatively distant from the patient's care. Goldberg argues that both the breaching of confidentiality and adherence to it may represent the analyst's enactment, and that it is only through analytic exploration of its countertransferential meaning to the analyst—and its transferential meaning to the patient—that genuine analytic understanding can emerge. Only then can the discussion of morals be a rational one.

Psychoanalytic publishing that includes writing about patients necessarily engages issues of confidentiality and patients' privacy. Goldberg references several analysts who have grappled with the ethics of case writing, including Glen Gabbard and Robert Galatzer-Levy, both of whom have concluded that a thoughtful consideration of the issues yields no clear-cut answers. Goldberg conceptualizes these dilemmas in terms of ownership. He posits an imaginary line, at one end of which is the view that the treatment is for the patient's benefit alone and is therefore the patient's property, and at the other end is the view that the treatment belongs to the therapist. Somewhere in the middle is Goldberg's co-constructed zone of dual creation and dual ownership. While this leads to a willingness to consider the complexity of such issues, Goldberg is clear that it leads to no easy conclusions.

Again invoking the philosophy of pragmatism, Goldberg cautions us to discard rules meant to apply to all circumstances and asks us to recognize that each situation must be examined independently: "We need to recognize that some patients should indeed be consulted beforehand, some disguised minimally, some disguised thickly, and perhaps some disguised not at all" (p. 99). Goldberg concludes that there is no writing without some risk, but that the

progress of psychoanalysis as a scientific endeavor requires that we weigh the risks against the benefits to both patient and analyst. It does seem to me as though Goldberg has gone the long way around to reach a fairly obvious conclusion.

Goldberg further develops his concept of ownership as an alternative metaphor for addressing the issue of what is intrapsychic. He rejects both the spatial, inside/outside concepts of conflict and object relations theory, and the superficial trends of conscious, interpersonal paradigms. While this may help in thinking about the question of who owns the transference and the countertransference, it goes no further in addressing the complexity of the issues that Goldberg raises. Goldberg again tries to address complex theoretical issues, but he does so with insufficient elaboration and depth, and at the same time loses the focus of his central argument.

Two other chapters in this section address more specific clinical matters. One of these, providing a discussion of thoughtfulness and thoughtlessness, describes how moral judgments can infiltrate our thinking in areas that are not about moral issues at all, and also how our "background" thinking encourages us to avoid fuller psychoanalytic explorations. While Goldberg's discussion of the relationship of narcissistic pathology to these two qualities seems cogent, I think it is doubtful that most analysts would actually fail to subject these qualities to psychoanalytic examination.

The other of these two chapters describes the expression of moral conflict in some patients with narcissistic behavior disorders; this occurs through disavowal and an associated vertical split in the ego. The patient is able to maintain both a view of reality and an acceptance of transgression, which, when expressed in the transference, evokes a corresponding split in the analyst. In fact, the analyst must also experience both sides of the conflict in order for genuine psychoanalytic exploration to take place and, ultimately, for the split to be integrated. Goldberg warns that underlying depression may often accompany such splits and must be anticipated. He contrasts this view with a model in which interpretive work focuses on repressed, forbidden impulses and superego

transferences. This is an interesting topic that Goldberg has written about elsewhere in depth, but one that is difficult to fully explicate in this brief chapter.

Goldberg reiterates his position in the third and final section of the book, first exploring the impossibility of analytic neutrality, in a discussion that lacks conceptual clarity. Goldberg reviews the Anna Freudian standard of therapeutic neutrality and contrasts it with Gabbard's view that the underlying principle of a nonjudgmental stance is virtually impossible for the analyst to achieve. He focuses here on the countertransference evoked by the patient's moral conflicts, distinguishing those situations that clearly evoke the analyst's moral judgment from those that may not. Goldberg dispenses with the latter as situations of indifference for the analyst; however, such instances seem to invalidate Goldberg's rule that therapeutic neutrality is never attainable. There would seem to be examples of just such a situation in which analysts are able to explore patients' intrapsychic conflicts, moral or otherwise, without making them their own.

However, it is certainly the former in which Goldberg is most interested, and for which he rejects a neutral position as desirable. He emphasizes that genuine analytic work is impossible unless the analyst is able to empathize with the patient and experience the "momentary embrace of an essentially immoral posture" (p. 108). He asks us to experience both sides of the patient's conflict and to join in his own analytic experience, one that is never an "objective or indifferent vision" (p. 109). He invokes Jurgen Habermas's "discourse theory of morality" (p. 111) for guidance in the resolution of moral conflict. In reaching such resolution, Habermas, like the American pragmatists, relies on both the particularization of experience and the process of shared argument and interpretation, rather than on laws or fixed standards. While Goldberg is clear that patient and analyst must struggle together with the complex and uncertain analytic exploration of the patient's moral conflict, it remains unclear exactly what role Goldberg assigns to the analyst in resolving such conflict.

In a chapter entitled "Deontology and the Superego," Goldberg defines deontology as "one's obligations and personal imperatives, the language used to inform these, and their origin and development" (p. 113). He offers a perspective on superego development that focuses on the contribution of preoedipal precursors, in which predominant affective experiences of shame become intertwined with later oedipal and postoedipal moral conflicts involving guilt. His point is that adult moral conflicts continue to evoke the complex affective intermingling of guilt and shame associated with early fantasies of propriety and retribution, and their resolution is far from a purely cognitive process. Emphasizing that self-reflection can go only so far, and that the process of open dialogue may be what is most beneficial, Goldberg here somewhat clarifies the analyst's role, noting that the analyst helps not only by interpreting unconscious obstacles, but also by providing the patient with the benefit that comes from conversation. Such conversation allows the patient to explore his or her own position, as well as to hear that of another. Goldberg understands that this dynamic process offers no sure or testable outcome. Exactly what the content of such conversations would be is not revealed in the book, leaving the analyst's role in the resolution of moral conflict still somewhat obscure.

In his final chapters, Goldberg returns to his primary thesis that the stealth-like intrusion of moral judgment into our thinking about therapeutic issues can be addressed only if we are ready to examine all of our assumptions. He maintains that much of our technique is based on historical tradition and then is rationalized as moral necessity, leaving us unable to properly evaluate its efficacy. Goldberg cautions us not to abandon moral standards but to suspend our certainty, in order to ultimately approach a position of greater certainty. While his method relies on the power of discourse to resolve moral ambiguity, Goldberg is willing to conclude that there may be some unbridgeable differences of perspective. For him, examples of such unbridgeable differences are any attempts to shift the boundaries that privilege patient status; thus, he demonstrates that even pragmatists have their limits.

ESLEE SAMBERG (NEW YORK)

PSYCHOANALYSIS AS BIOLOGICAL SCIENCE: A COMPREHENSIVE THEORY. By John Gedo. Baltimore, MD/London: Johns Hopkins University Press, 2007. 189 pp.

In *Psychoanalysis as Biological Science: A Comprehensive Theory,* John Gedo continues to elaborate his idiosyncratic, interesting, and opinionated view of psychoanalysis from a singularly prolific retirement, adding another enjoyable contribution to his huge opus of twenty books and over one hundred papers. In this slim, readable volume, he addresses his attention to the neurobiological basis of psychoanalysis and supports his ideas, some of which will be familiar to readers of his previous work, with references to recent advances in the neurosciences and related disciplines. This book is a decisive, dogmatic, and doctrinaire description of his comprehensive approach to psychoanalysis, based on his integration of things old and new, including cognitive neuroscience, neuropsychiatry, self psychology, and what looks to this reader like a version of ego psychology.

At its core, Gedo's theory rests on what for some might seem an old-fashioned conceptualization of development that is linear, genetically preprogrammed, hierarchical, and directly correlated with cerebral anatomy. This is juxtaposed with a similarly hierarchical developmental sequence of self-organizations. Every developing individual moves through the stages of mental and associated brain development as follows: tension regulation (Mode 1, lower centers); self-organization (Mode II, right hemisphere); reality testing (Mode III, left hemisphere); conflict resolution (Mode IV, integrated cortex); and expectable adult functioning (Mode V, prefrontal cortex). Gedo derives his theory of psychopathology from this foundational idea:

> Psychopathology is best understood in terms of developmental considerations, for each developmental phase (defined as a mode of organization of the central nervous system) corresponds to a distinct cluster of apraxic and dyspraxic possibilities, whenever its challenges are poorly met. [p. 59]

Since content is personally meaningful to the patient, "sound psychoanalytic hermeneutics are essential, although they are not in themselves curative" (p. 45). It is the patient's ego deformations that are the focus of psychoanalytic therapeutics. Gedo asserts emphatically that: "Psychoanalytic theories divorced from the neurophysiological (especially neurocognitive) considerations encourage the disastrous technical prescription to deal with all patients as if they possessed the 'intact' ego Eissler long ago showed to be a theoretical fiction" (p. 35).

Gedo builds his argument from these premises. Patients come to us for disturbances in information processing, disruptions in "intrapsychic communication" (p. 31; this is equivalent to or sustained by defensive operations). Because of the "motivational imperative" (p. 71) to maintain self-organization, individuals are compelled to repeat these apraxic and dyspraxic modes of experiencing the world. Insight into mental content and meaning is not enough, in part because many of these disturbances precede prefrontal cognition, and so are not available to adult cognitive experience, and in part because insight does not alter "the functional arrangements of the brain" (p. 25).

Psychoanalysis, through the transference mobilization of affective intensity, is a particular kind of emotional learning process that facilitates the following curative changes:

1. mastery of the propensity to become disorganized (i.e., traumatized) when confronted with intense stimulation;

2. expansion of "referential activity" (Bucci 1993) (i.e., the correlation of primary and secondary thinking processes);

3. increasing tolerance for the intensity of affects; and

4. the acquisition of hitherto missing skills in interpersonal and intrapsychic communication. Teaching analysands to interpret the significance of their associations is the clearest possible example of the expansion of referential activity—and enhanced intrapsychic communication. [p. 31]

In this formulation, for example, primary and secondary process are manifestations of right- and left-brain activity, and dreams are a correlative activity that places current experience in the form of affectomotor schemata, so as to bring it into contact with the core (preverbal) aspect of the self. Dreams furnish an opportunity with which to teach patients referential activity (p. 104); they provide confirmation for the analyst that the patient is gaining insight and beginning to correlate the past and transferential present.

Similarly, transference configurations are deemed essential for mobilization of archaic modes of self-organization, but their specific content is devalued. In fact, Gedo has remarkably little interest in countertransference (despite evidence that he has experienced his share) and scoffs at the idea of a two-person psychology. He acknowledges that different theoretical orientations will tilt the nature of the transferences observed, but asserts that these are epiphenomena; the crucial discovery in the course of analysis is the clarification of the patient's repertory of organization modes and his or her preferred mode for adaptation to current circumstances. These modes, directly derived from Gedo's developmental sequence, must be tackled sequentially from the most primitive on up (although he does not go so far as to suggest that they appear sequentially), and resolved through integration of these self-nuclei and "unification" (p. 160) of the personality (not so different from the relational focus on self-states and dissociations). All successful analytic treatments ultimately cure by lifting patients' blocks to learning and recognition of their cognitive distortions rooted in childhood cognition. Analyses that too readily reverse the regressive states necessary to elicit archaic modes leave the patient handicapped, since life stressors will inevitably lead to their reemergence.

Gedo's case vignettes, scattered throughout to illustrate his view of psychoanalytic therapeutics, range from familiar scenarios to didactic scoldings. The clarity of his thinking seems unshaken by the complexity of clinical presentations. He states decisively: "Both Freud's theories and the object relations theory developed to replace them are grossly reductionistic" (p. 127). One cannot help

wondering if he is unaware of his own reductionism: "As I have repeatedly stated, a theory centered on a concept of self-organization should be able to encompass all of the data previously dealt with by those competing reductionistic theories" (p. 127).

Nonetheless, despite the author's sweeping claim to the definitive neurobiologic/sequential self-organization foundational theory of psychoanalysis and his adherence to a rather old-fashioned linear model, this book is a readable and informative distillation of Gedo's remarkable reflections on the field. Moreover, to this reviewer, a modern ego psychologist, much of what Gedo says seems to arise from the welcome recognition that psychoanalysis must grapple with the biological substrate of the mind. However, when he declares that a technical implication of his view is that we need to recast our conceptualization of mutative interventions as "analogous to the activities of physiotherapists" (p. 169), I fear he has gone too far.

KAREN GILMORE (NEW YORK)

SUFFERING INSANITY: PSYCHOANALYTIC ESSAYS ON PSYCHOSIS. By R. D. Hinshelwood. Hove, U.K./New York: Brunner-Routledge, 2004. 187 pp.

Here is a badly needed book on psychoanalytic approaches to psychosis. The author is R. D. Hinshelwood, a British psychoanalyst who has worked in mental hospitals for many years and has broad experience with psychotic patients. He is also an excellent writer and an outstanding scholar whose publications include a dictionary of Kleinian thought.[1]

The key to excellent scholarship is clear thinking, thoroughness, and accessibility of writing style. This book, a series of related essays, has all these features. The first essay is "Helping to Help: The Impact of Madness on Those Who Care"; the second is "What's It Like? Psychoanalytic Theories of Schizophrenia"; and the third is

[1] Hinshelwood, R. D. (1991). *Dictionary of Kleinian Thought.* London: Free Association Books.

"Suffer the Mad: Countertransference in the Institutional Culture." There is an epilogue: "Being Psychotic, Being a Person." These titles help the reader immediately understand that this book relates what we know psychoanalytically to the experience of being psychotic, to people who are psychotic, and to those who try to help them.

Chapter 1 describes the stresses of caring for psychotic patients experienced by the staff of inpatient psychiatric services. In his introduction to the chapter, Hinshelwood notes that, significantly, "meaninglessness and identity distortions are occupational hazards" (p. 4) afflicting us as helpers. He believes that a supportive group is a requirement for resilience in health care workers in these settings. He points to an aspect of medical care that is central to our calling: the burden of responsibility felt by those who give care. He points out that human caregiving includes a link to the person being cared for, as well as to the work itself, and that this "sets caring apart" (p. 8). Added to that, in psychiatry, is the "difficulty of the work" (p. 8). For me, also a psychoanalyst and psychiatrist who has worked for many years with psychotic patients in and out of the hospital, this chapter is of crucial importance.

The author further describes the effect of the psychotic patient group on the collective emotional experience of the caregiving staff group. He discusses defensive maneuvers by staff members, which are unconsciously designed to lessen stress by maintaining emotional integrity; he includes a description of interactional boundaries, organization, and identity. Defenses ebb and flow as the task requires, as the illness mix evokes, and as the helping group consolidates and matures or fragments and regresses. One might call this collective interaction the institutional culture, and Hinshelwood believes that patients can end up "suffering more from the institution than from the illness" (p. 13).

This leads him to compare inpatient psychiatric units to the one famously depicted by Kesey,[2] and he approvingly quotes Goffman, Foucault, and Laing. He also discusses the well-known psychoanalytic work of Tom Main. These writings are of the view that the hos-

[2] Kesey, K. (1962). *One Flew Over the Cuckoo's Nest.* New York: Viking Press.

pital treatment is the real illness. While considering the limitations of inpatient units, he acknowledges that the institutional culture and the professional identity boundaries that are usually maintained in such settings have "in part to do with the particular kind of care the psychotic patient requires" (p. 14). And he also understands that, particularly with schizophrenic illness, the staff tries to make "meaning out of something meaningless" (p. 15).

Thus is revealed the tension in this chapter—and indeed in the book—between what is biological, what is psychological, what is institutional-cultural, and which is cause versus which is effect. This is a tangled web indeed, and it pays for all of us to take another look at our own thinking about these factors and their interactions. But I think that, ultimately, this is a situation of *also and*, rather than *either or,* with numerous bidirectional and multidirectional arrows between the biological and the psychological, depending on illnesses and individual cases.

There is also a tension between schizophrenia as a fragmenting illness that cannot be understood, and the schizophrenic person whom we hope to understand. But in chronic schizophrenia, almost all areas of the personality may be fragmented, and this sad state can require the accessory ego function provided by reliably routinized and organized daily living in the hospital setting. Clear role definitions and reliable behaviors may also be helpful. This is the ego theory of hospital treatment of psychiatric patients, first articulated in Cumming and Cumming,[3] a theory that can help us understand why organized psychiatric units evolved and how to use them to maximize patient and staff resilience. Unfortunately, in this country, psychiatric hospitalization has been seriously impaired by unfairly imposed financial demands, leading to hospitalizations that are too brief and too busy for the kind of organized, reflective help that both we and our patients need.

Hinshelwood's second chapter reviews psychoanalytic theories of schizophrenia. This essay is a gem that examines the most salient psychoanalytic theories and applies them to schizophrenia.

[3] Cumming, J. & Cumming, E. (1962). *Ego and Milieu: Theory and Practice of Environmental Therapy.* New York: Atherton Press.

The last such overview—both historical and comprehensive—was published more than twenty years ago.[4] Hinshelwood's history covers Freud, early and middle; Klein; Bion; Segal; the ego psychologists, especially Federn, Eissler, and Rosen; the existentialists—Laing, Bateson, and the Americans Reichmann, Sullivan, and Searles; and even the hermeneuticists Ricoeur and Habermas. All this in ninety pages! This chapter refamiliarizes the reader with these different approaches not only to psychosis, but also to the mental organization of the symbolic function in both the normal and the schizophrenic. To me, this is the crucial issue for the psychoanalyst. Included are descriptions of various major theoreticians' views of this issue.

Of particular interest to me are Hinshelwood's comments on Freud and the ego psychology approach to primary process and thing presentations. Interestingly enough, the authors notes that "ego psychologists pay less attention to Freud's theory of thing and word presentations than might be expected" (p. 70). This caught my eye because I, too, believe this and have used a thing-presentation approach to symbolic representation as the basis of a modern ego psychology way to treat psychotic conditions.[5]

The last chapter, "Suffer the Mad: Countertransference in the Institutional Culture," is a follow-up to the first chapter. It is directed to caregivers within institutions, helpfully describing the unconscious defenses and relationships that mediate and may impinge on the task. Most interesting is Hinshelwood's description of two different cultures: the biological psychiatric and the psychoanalytic. He succinctly points out the categorical reifications that an overly scientific approach can bring, though he somewhat underplays the biological denial that can accompany an overly psychological approach.

I think we need to deal with illnesses by incorporating both these substrates, since all illness involves both of them to a greater or lesser extent. The challenge is to accept both sets of factors and

[4] Frosch, J. (1983). *The Psychotic Process.* New York: Int. Univ. Press.

[5] Marcus, E. R. (2003). *Psychosis and Near Psychosis: Ego Function, Symbol Structure, Treatment.* Madison, CT: Int. Univ. Press.

accurately describe their relationship. This will help greatly in integrating our interventions and in healing splits in the therapeutic community and in our caregiving experiences.

In summary, this wonderful gem of a book should be in the libraries of all psychoanalytic institutes, inpatient psychiatric units, and psychiatric residency training programs. It will inform, evoke, provoke; we will agree at times and disagree at others, but the information is all there. From this can emerge something quite beautiful: a renewed resolve and commitment in those of us who have a calling to work with the severely psychiatrically ill. My congratulations to Hinshelwood—and my thanks.

ERIC R. MARCUS (NEW YORK)

WOUNDED BY REALITY: UNDERSTANDING AND TREATING ADULT-ONSET TRAUMA. By Ghislaine Boulanger. London/Mahwah, NJ: The Analytic Press, 2007. 202 pages.

As a psychoanalyst and psychotherapist for some forty years, I approached this book eagerly seeking explanations for numerous experiences I have had with patients trapped in catastrophic, unthinkable traumas, ranging from those involved in the Nazi Holocaust—who would lose consciousness in my presence rather than recall the tortures and humiliations they had suffered—to, more recently, those who experienced trauma through the tragedies of 9/11 and the aftermath of devastating hurricanes. Newspapers suggest that every day severe traumas are present, occurring increasingly more frequently. Less than 50% of homicides are solved, and many seem to involve torture and mutilation, as well as often unspeakable cruelty to young children. One whole page of a newspaper I recently read was devoted to a list of multiple killings, tortures, and mutilations that had been visited on ordinary citizens.

Boulanger's book is not about rare occurrences, then; it describes everyday reality. It is sobering to consider that perhaps violence has increased due to the widening economic disparity between the rich and the poor, and the desperation of those used to

a better standard of living who have been humiliated by their inability to afford even the basic necessities of everyday life.

The author writes in the very last paragraph of *Wounded by Reality:* "I am a stranger in this world, and if I am lucky I shall remain a stranger" (p. 183). In this last paragraph, she also quotes Bernstein[1] in suggesting a role for psychoanalytic treatment: to help in "making the past a living present held within a bearable yet unpredictable future" (p. 182).

Boulanger clearly identifies herself as a relational thinker (and at times irritatingly asserts this position); she takes traditional analysis to task for its failure to capture the immediacy, intensity, and vividness of the effects of unbearable trauma on adults. She sees analogies with infantile and other past experiences as reductionistic and off-putting to patients, who may assume that analysts are apt to intellectualize trauma because they are otherwise unable to manage its intensity and unthinkability.

My own approach to the treatment of trauma does not arise from any particular school of psychoanalysis, but is characterized by adopted elements from various schools, depending on what seems to benefit a specific patient and on what is ethical and safe under the circumstances. I do not see the particular method of treatment as being as important as the commitment of the therapist to a technique that s/he can make work. This philosophy evolves from long-standing studies indicating that general factors in psychotherapy are more influential in determining outcomes than is a specific technique—leading me to read this book from a perspective that minimizes theoretical differences. Therefore, Boulanger's arguments about *relational* theory versus *traditional* versus *object relations*—versus whatever other ways in which analysts think—did not make a huge impact on me. I was looking instead for what she had to say about unspeakable trauma that may *not* be best handled by discussing analogies to the past, or by various efforts—whether based on ego psychology, object relations, or self psychol-

[1] Bernstein, J. W. (2000). Making a memorial place: the photography of Shimon Attie. *Psychoanal. Dialogues,* 10(3):347.

ogy—that position trauma as manageable by the patient using established theory and practice. Generally, by virtue of brief clinical examples and an exhaustive and sensitive literature review, the author makes her point: that these methods do not seem to work very well.

One of the patients Boulanger discusses is Jason, a courageous police officer and Vietnam veteran who spent many years protecting others after having carried out similar duties while serving in Vietnam, but who finally found that this work did not make him happy. This case was the most telling clinical example in *Wounded by Reality* (although the book did not contain many such examples). Jason told the author that the treatment options she outlined for him were not acceptable since they would compromise his need to protect others.

My sense was that Jason and the other patients described in this book were not particularly responsive to what the author said or did, in spite of her obviously sensitive and authentic attempts to empathize with them (that is, to *mentalize* them). Boulanger references Fonagy frequently in the later chapters (and, I think, usefully so), citing his idea that patients who have been severely traumatized enter an early, regressed psychic-equivalence mode in which the world must be the way they want it to be because trauma has made them unable to tolerate its differences from that ideal. Although she does not support this discussion with sufficient clinical material, her comments reflect what I have seen in a variety of patients who have suffered catastrophic trauma: that is, the narcissistic investment in the unspeakability and incomprehensibility of the trauma makes these patients unapproachable in therapy unless they begin to see it as a regression to a pretend mode via psychic collapse.

Although I understand that this formulation of the situation could be seen as reductionistic, I believe that, if treatment is carried out with absolute conviction and interpersonal sensitivity by the therapist, it really does not matter what school of technique s/he works within; more important is that the patient feels under-

stood—which is a central feature of mentalization-based psychotherapy—and can thus develop a way to think about the unthinkable.

In this approach to treatment, therapist and patient co-construct criteria for their interactions, and although the patient's mind is considered opaque to the therapist, the therapist is nonetheless curious about it, while acknowledging the patient as the expert. The therapist might suggest a number of models that the patient can usefully apply to him- or herself—without forcing an external model onto the patient, which can cause a repetition of the trauma.

The author characterizes massive trauma as involving a collapse of psychic space, leading to a problem in distinguishing inside from outside; she notes that "intersubjective space is often rendered uninhabitable by catastrophic trauma" (p. 15). Catastrophic trauma compromises symbolization, and Boulanger suggests that the most helpful formulations might be those independent of dynamic conflict, motivation, structured defect, and developmental arrest (p. 22). The author more than once references Winnicott's statement that reality is something about which we must have illusions if we are to live without crippling anxiety; those who have experienced catastrophic trauma seem to have lost the ability to have these illusions.

Reading *Wounded by Reality* reminds me of Allen Wheelis's first novel,[2] in which a man loses his small dog and subsequently realizes that the dog was a very important individual in his life, and in fact the dog made his life worth living. The man had lived in a dialectic between, on the one hand, *the way things are* (a world without meaning or direction; in this case, the subject felt that he was gradually dying) and, on the other hand, the *scheme of things* (what we do with reality to make it bearable). Freud, in his final essay, *Moses and Monotheism* (1939), suggested that these schemes enable us to manage the way things are; as he indicated, we look

[2] Wheelis, A. (1980). *The Scheme of Things*. New York: Harcourt Brace Jovanovich.

at a catastrophically meaningless reality through the smoked glass of our repressions.

Boulanger gives numerous examples of what is destroyed in catastrophic trauma—basically all coming down to the *soul,* the *self.* She briefly considers the way in which past experiences are revived by present ones (*après-coup*) and notes that adult-onset trauma can be passed down through generations. Dissociative states protect self states from terror, yet leave the survivor in a state of confusion and anomie, the author states. She suggests that death anxiety is among the most significant anxieties, along with those of castration, separation, and the superego.

Citing the psychoanalytic literature, Boulanger notes that the fluid matrix of the core self is destroyed in cases of catastrophic trauma, resulting in a sense of emptiness. She graphically illustrates that what is central in catastrophic trauma is "not the incomprehensibility of near death, but the incomprehensibility of one's own survival, [leading to] . . . post-traumatic repetitions" (p. 83).

There is a brief description of the neurobiology of trauma, suggesting that the amygdala is deactivated by catastrophic trauma and that memories are stored as physical sensations rather than as verbal traces. The release of cortisol then makes it more difficult for verbal memories to be restored; in fact, paradoxically, both cortisol and adrenaline enhance explicit memory but later destroy it if the trauma is not processed.

Much of the neurobiology of catastrophic trauma as described by Boulanger reminds me of some of the early work on LSD psychotherapy.[3] It has been postulated that LSD amplifies the early perinatal experiences of birth trauma that are recorded in the psyche as physical sensations and movements. That is, every baby, from this perspective, undergoes an experience of catastrophic trauma in the act of being born. Although the author does not reference this work, I think it would be interesting were she to consider these references, as well as *The Trauma of Birth.*[4]

[3] See, for example, Grof, S. (1980). *LSD Psychotherapy.* Sarasota, FL: Multidisciplinary Assn. for Psychedelic Studies.

[4] Rank, O. (1957). *The Trauma of Birth.* New York: Robert Brunner.

The author goes on to observe that patients with such catastrophic trauma seem to lack benign mitigating internal objects, making it difficult to engage in alpha transformations, in Bion's terms. (The author does not give much information about how to manage such patients.) In the last chapter, entitled "The Psychological Politics of Catastrophe: Local, Personal, and Professional," she explains in graphic and sensitive language the center of the problem: "the need to reconstruct the narrative that interrupted the patients joining back to the land of the living" (p. 162).

Boulanger deals with information about some relatively important countertransferences that would be helpful for therapists addressing overwhelming trauma, and she suggests one or two techniques for managing acute trauma, including CISD (not particularly effective) and EMDR (which may be effective in healthy people in the context of psychodynamic psychotherapy or relational psychoanalysis). The author's description of the Israeli model of treatment seems much more conducive to the reality of managing catastrophic trauma, in my view; people need to have multiple ways of verbally and nonverbally conceptualizing their trauma through imagery, writing, and discussion.

The author's description of the uncanniness of patients who unexpectedly find themselves in situations that are horrifyingly life-threatening suggests a careful rereading of Freud's "The 'Uncanny'" (1919). Freud uses the analogy of a man who falls in love with a mannequin in a window across from his apartment, thinking it is really a beautiful young lady. When he finds that it is a mannequin, he is struck with a moment of uncanniness that makes him feel nonhuman. Although Freud connects this experience with castration anxiety, it reminds me of Boulanger's implication that unexpectedness can be as horrifying—if not more so—as the experience itself.

Personally, I have faced death a number of times in ways that were self-selected because I had an interest in exploring parts of the world where danger was a fact of life. I was able to develop the skill of calculating the risk of death and trained myself to downsize

an adrenergic response, instead keeping myself calm and able to manage the situation. In overcoming the traditional frozen-victim mode, I was able to keep my mind expanded and to manage catastrophic trauma without denying that it could lead to my actual death.

Without wishing to appear simplistic, I might note that, clearly, death is part of everything we do; time passes, seasons pass, and life passes. As Buddha said in articulating the principle of impermanence, everything dies. And in order for us to deal with catastrophic trauma, Boulanger suggests, we may need to change the way in which we bring up our children, incorporating the view that the possibility of eminent death is an ongoing part of life itself. I wholeheartedly agree with her.

I will conclude with the description of a vivid memory that came to me as I was reading this book. Many years ago, while working as a locum tenens in Australia, I saw a patient who had been described to me by numerous others as a "decorated war veteran." I have quite a traumatic recollection of our meeting; I have never seen such a look of horror on a human face. I immediately broke out in a cold sweat. The patient smoked continuously; his eyes were like those of Hannibal Lector in *The Silence of the Lambs*—simmering while ruminating on an internal experience that seemed to have destroyed his mind. His friend who accompanied him told me what the patient was thinking and what he needed, that I simply had to give him certain medications. I touched the patient's hand briefly—a cold and clammy hand—and I thought of the horrors of World War II, of which this man had truly become a perpetual victim.

Boulanger's book is a beginning. I think she explains catastrophic trauma very well and brings it to the attention of the psychoanalytic public in a graphic yet sensitive and human way (although a description of specific clinical techniques is mostly lacking). I recommend that every psychoanalyst and psychotherapist read *Wounded by Reality*.

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THE MIND ACCORDING TO SHAKESPEARE: PSYCHOANALYSIS IN THE BARD'S WRITING. By Marvin Bennett Krims. Westport, CT: Praeger, 2006. 218 pp.

Marvin Bennett Krims, an experienced psychoanalyst, has read Shakespeare closely and lovingly, and reflects in depth on his works from a psychoanalytic perspective in this interesting volume. Krims does an excellent job of teaching the reader about a psychoanalytic view of the mind, using ten plays and one sonnet to illustrate several core psychoanalytic concepts. At the same time, he enriches our understanding of Shakespeare's works. Scholars have long noted that Shakespeare has a genius for telling us what to think *about,* but not what to think; he forces us to think about profound questions that have no simple answers. I do not find Krims reductionistic in offering a psychoanalytic perspective. He raises further important questions about Shakespeare's works, but he avoids the trap of implying he has all the answers. He makes impressive use of the scholarly literature on Shakespeare without getting bogged down in it. He is respectful of past critical contributions but is confident in asserting his own ideas.

Krims cogently argues that Shakespeare and other great writers have an "intuitive ability to represent unconscious processes along with conscious motivations" (p. xvii). He further observes that:

> Authors' ability to create the illusion of real people must also include unintentional but intuitive representation of unconscious motivations as a necessary requirement for verisimilitude of character portrayal . . . . I believe it is very much our business to probe below the surface of texts . . . even if we might at times prefer otherwise. [p. xix]

Krims's fascinating comments lead me to reflect that Shakespeare's extraordinary appeal may lie partly in his astonishing capacity to force us to confront slightly more than we are comfortable in confronting. That is, Shakespeare simultaneously undermines *and* supports our defenses against unbearable feelings. And then he seems to speak directly to our unconscious minds and reveal those truths that we cannot face consciously—like the multiple

appeal of the analyst's interpretation. He may thus collude with our wish to keep crucial matters out of our awareness.

I would suggest that readers begin with the final chapter of *The Mind According to Shakespeare,* Krims's deeply personal epilogue. Reading it first will deepen appreciation of the entire book. Krims courageously reveals several aspects of his personal development that have shaped his response to Shakespeare. He gives a moving account of the life-changing impact of discovering the joys of reading from a devoted teacher of his childhood. He has the self-assurance to admit that the first article he wrote was on Harry Hotspur because he identified with this Shakespearean character and historical figure (immortalized as Henry IV in the play of the same name) as "one of Shakespeare's warriors who was unable to sit quietly to enjoy poetry and song" (p. 183).

Krims's autobiographical disclosures give us remarkably personal material that supports his celebration of "the power of texts to heal" (p. 188). In his case, it was Shakespeare who helped him recover from the shattering loss of his first wife in his late fifties. He maintains that reading literature can be "similar to psychoanalysis" (p. 190) in its beneficial effects. He encourages us to use literature in this way ourselves.

One of the most unusual chapters (and the longest by far) is Krims's imaginary, epistolary analysis of Beatrice, a character in *Much Ado About Nothing.* (True to the informality of letters, this chapter contains half the typographical errors that I found in the entire book!) Reading this chapter was a special pleasure, reminiscent of the fictional analyses in the splendid novel *Dream Interpreters.*[1] It blends psychoanalytic wisdom with Krims's fascinating and playful enactment of what I assume is a richly overdetermined fantasy. Novelist Gail Godwin said she wrote *Evensong* because she was curious to find out what happened to a character in her earlier novel *Father Melancholy's Daughter,*[2, 3] and, similarly, Krims was clearly

[1] Shevrin, H. (2003). *Dream Interpreters: A Psychoanalytic Novel in Verse.* New York: Int. Univ. Press.

[2] Godwin, G. (1999). *Evensong.* Westminster, MD: Ballantine Books.

[3] Godwin, G. (1992). *Father Melancholy's Daughter.* New York: Avon Books.

curious to learn more about Beatrice. Putting words in Beatrice's mouth means emulating Beatrice's creator—having the audacity to play at being Shakespeare.

Krims reveals in his epilogue that Beatrice and Benedick reminded him of his parents. *Much Ado About Nothing* was the first play he read after he "discovered" Shakespeare following his first wife's death. I wonder if there might also be some actual patient whom Krims treated behind his Beatrice. In addition, I sense that Krims has a deep wish to interact firsthand with Shakespeare, or at least with one of his characters. (What can we learn about Shakespeare's character from the characters he created?)

For example, Krims writes that Beatrice's associations are more important than the words attributed to her in Shakespeare's play. I was stopped in my tracks by this startling assertion. I pondered the fact that all we have are her words—Shakespeare's words—and *our* associations to them. I wonder, then, if Krims's comment about his Beatrice might reflect a displacement of his underlying wish to know the *author* of the play—the only real person who could have provided us with the associations Krims seeks. (One Shakespeare scholar, offered the hypothetical choice of spending a week with the real Shakespeare or discovering a new play by him, chose the latter.)

Krims's book is chock full of speculations about unconscious and unrepresented aspects of the characters he discusses. But, ironically, he is reticent when it comes to the actual person of the playwright: "I must share with the reader my reservations about the value of speculation about Shakespeare's psyche . . . . The exact details of Shakespeare's childhood development are so very meager . . . and we know so little about Shakespeare as a real person" (p. 94).

I suspect our conception of Shakespeare is so hazy because of what Keats called his extraordinary *negative capability*—his ability to put his own identity into the background as he, like Pygmalion, brought his artistic creations to life. Because we know so little about the historical figure of the author, we have become accustomed to the tradition of treating him as mythical. We probably have some-

thing of a blind spot for the extent to which we treat Shakespeare's characters as more real than Shakespeare himself, as though they are surrogates for the missing author. In addition, I suspect that Shakespeare is a transference object for many of us, and we may prefer not to have our transferences disturbed by learning the truth about him.

I say this because I share with Freud the controversial belief that "Shakespeare" was Edward de Vere, who wrote under this pseudonym.[4] A pseudonymous author's self-concealment is consistent with Shakespeare's extraordinary proclivity toward keeping his own personality and identity in the background in his works.[5] Krims, along with most analysts, has chosen not to engage with this aspect of our psychoanalytic legacy. But open-minded analysts will surely hunger to know Shakespeare's life story because this knowledge leads to quantum leaps in our appreciation of his plays and poems.

For example, what of Krims's central reconstruction that Beatrice suffered from childhood abandonment by her parents before being adopted by her uncles? If he is correct, might there be childhood experiences in the life of Beatrice's creator that contributed to this characterization of her? In fact, de Vere experienced several crucial childhood losses: first, when he was a young boy, he was sent to live with his tutor, Sir Thomas Smith. Apparently due to the boy's precocity as observed by Smith, de Vere was then sent to Cambridge at only eight years of age. At twelve, he suffered the unexpected death of his father who was in his mid-forties—an overwhelming loss that seems to be echoed in Hamlet's feelings about his father's death. De Vere's mother seems to have had almost nothing to do with him after his father died, and he was then raised by William Cecil. He presumably first used the pseudonym "Shake-

[4] For a summary of this topic, see Waugaman, R. M. (2007). [Review of] *Shakespeare by Another Name*, by Mark Anderson. *Psychoanal. Q.*, 76:1397-1403.

[5] Waugaman, R. M. (2008). Samuel Clemens and Mark Twain: pseudonym as act of reparation. Paper presented at American Psychoanalytic Association Meeting, June.

speare" when he was in *his* mid-forties, in 1593; perhaps one of the overdetermined meanings of this decision was to create a fictive authorial self who could outlive his father's life span.

Krims gives a fascinating account of the universal human propensity for cruelty as one subtext of *The Taming of the Shrew*. He then places the misogyny of the play in that more general context, noting that feminist critics sometimes downplay Kate's aggression as they castigate Petruchio and what he reflects about his gender. It is characteristic of Krims's deep knowledge of Shakespeare that he reminds us that the familiar aspects of this play are themselves a play within a much less well-known play. That rarely performed outer plot structure concerns a practical joke played by a lord, who tricks the beggar Sly into thinking he has awoken from the "dream" of his real life to discover he is the lord himself, while the servants play along. Krims compares the outer play's opening "induction" scene with Sly and the lord to a dream in which the dreamer reassures herself it is "only a dream."

I would surmise that this play within a play is analogous to Freud's observation that the defensive layering of a dream within a dream alludes to some piece of reality that is being warded off. Recall Robert Greene's notorious 1592 reference to Shakespeare—in a pamphlet called "Greene's Groats-worth of Wit"—as the "upstart Crow, beautified with our feathers, that . . . is in his owne conceit the onely Shake-scene in a countrey."[6] I would suggest that this passage shares important roots with *The Taming of the Shrew's* plot structure; I believe that both reflect allusions to the role of Shakespeare of Stratford, who some contemporaries would have known was receiving public credit for the work of de Vere, Earl of Oxford. I imagine that being de Vere's front man sometimes went to the head of the man from Stratford, and that de Vere here lampooned him as the drunken Sly who starts to believe he is truly a

[6] See, e.g., Melnikoff, K. & Gieskes, E. (2008). *Writing Robert Greene: Essays on England's First Notorious Professional Writer.* Hunts, England/Burlington, VT: Ashgate Publishing. (See also http://darkwing.uoregon.edu/%7Erbear/greene1.html.)

lord. (Farina argues that Dogberry in *Much Ado About Nothing* also spoofs the pretensions of the man from Stratford.[7])

Krims quotes Freud's remark that in *Hamlet,* "a real event stimulated the poet to his representation, in that his unconscious understood the unconscious of his hero" (Krims, p. x). Krims's psychoanalytic approach is classical, so he resurrects some formulations that are so "well known" that we often forget them. He argues, for example, that our neglect of the negative Oedipus complex has led us to overlook this aspect of Hamlet's conflicts. Perhaps so. But I am less convinced by Krims's argument that the play reveals Hamlet's negative oedipal feelings toward Claudius; instead, I would expect to find more of those feelings toward King Hamlet—that is, toward Hamlet's father rather than his stepfather.

This chapter is one of the few places in the book where I sensed that Krims was overly invested in his theory, leading him to perhaps misread the text. His thesis depends on his assumption that Hamlet wept during the First Player's audition. But that assumption is contradicted by the wording of the first quarto of *Hamlet* in this scene, which makes it clear that it was the *player's* face, not Hamlet's, that changed color and teared up.

Famously, Freud followed up his 1897 comments on the "real event" that stimulated *Hamlet* with his later admission that he was now "almost convinced" (p. 63n) that de Vere wrote Shakespeare's works, and that *Hamlet* had many crucial connections with de Vere's own life.[8] For example, Freud believed that de Vere, like Hamlet, never forgave his mother for remarrying so quickly after his father's death. Many nineteenth-century Shakespeare scholars identified Polonius as William Cecil, de Vere's guardian and father-in-law. Freud would have been intrigued to learn that Polonius's name in the first quarto was *Corambis*—"two-hearted"—a jab at Cecil's family motto, which contained the words "cor unum" or *one heart.*

[7] Farina, W. (2006). *De Vere as Shakespeare: An Oxfordian Reading of the Canon.* Jefferson, NC: McFardland.

[8] Freud, S. (1935). *An Autobiographical Study. S. E.,* 20.

Helen Vendler notes that Shakespeare's poetry has been neglected in comparison with his plays.[9] So we can be grateful to Krims for including a chapter on "Sonnet 129," the "Lust Sonnet" ("Th'expense of spirit in a waste of shame"). Krims reads this sonnet as exploring the paradox of how much pleasure *and* pain lust can bring, as it "simultaneously endorses and subverts the idealization of sex" (p. 119). Krims argues that the overdetermined meanings of this sonnet include allusions to unconscious fears that sex will be primarily aggressive, not loving: "Lovers do not love; they hurt, and in the extreme, they destroy each other" (p. 125). Krims is ever alert to the multiple meanings of each of Shakespeare's words, and he uses these highly condensed verbal allusions to expand our awareness of Shakespeare's power to move us.[10]

The short index to *The Mind According to Shakespeare* includes an entry for Falstaff, but omits all the other characters discussed in the book. It includes an entry on "Mother and Mothering," which cites forty-eight pages, and one on "Aggression," which cites a whopping fifty-four pages. Then there are entries for "Anger," "Cruelty," and "Hate." Each of these entries directs us to "See Aggression." I have heard that many publishers no longer create indexes, and I am sympathetic with authors who might feel anger and aggression—even cruelty and hate—about this chore being left to them.

[9] Vendler, H. (1997). *The Art of Shakespeare's Sonnets*. Cambridge, MA: Belknap Press.

[10] Sonnet 129 echoes a passage from Baldassare Castiglione's *The Book of the Courtier,* originally published in 1528, a work that heavily influenced Shakespeare. This passage speaks of "all those lovers who satisfy their unchaste desires with the women whom they love . . . [and] as soon as they have attained the end desired, they . . . not only feel satiety and tedium, but hate the beloved object as if appetite repented its error and perceived the deceit practised upon it by the false judgment of sense, which made it believe evil to be good" (pp. 295-296 of Castiglione, B. [1528], *The Book of the Courtier,* trans. L. E. Opdycke, New York: Barnes & Noble, 2005). Furthermore, Bergmann and Bergmann link Sonnet 129 with the Bible's similar sequence of lust fulfilled, followed by disgust when Amnon rapes Tamar: "Then, Amnon hated her exceedingly" (p. 49 of Bergmann, M. S. & Bergmann, M. [2008], *What Silent Love Hath Wrought: A Psychoanalytic Exploration of Shakespeare's Sonnets,* New York: Gotschna Ventures).

Krims's book is a real treat to read, and I recommend it enthusiastically. It should appeal to lovers of Shakespeare who want to learn more about psychoanalysis, as well as to analysts who want to learn more about Shakespeare. And I hope many readers will be inspired to learn more about Freud's beliefs about who Shakespeare was.

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EDWARD BIBRING PHOTOGRAPHS THE PSYCHOANALYSTS OF HIS TIME, 1932-1938. Edited by Sanford Gifford, Daniel Jacobs, and Vivien Goldman. Hillsdale, NJ: The Analytic Press/ Psychozial-Verlag, 2005. 206 pp.

Harold Bloom, the psychoanalytically informed English professor, critic, writer and editor of numerous anthologies of creative works, has described the way in which his graduate students tend to study the works of the great writers in history with awe and reverence—so that they might then demolish them and themselves replace them in the panoply of literary greats.

Psychoanalysts, as my training analyst observed to me one day when I was lamenting the foibles and personal deficiencies of some of my teachers, "are just people—who went to school." As such, they are no less likely to succumb to their still-active oedipal strivings and inclinations than are Bloom's students. It has always saddened me when I have watched some of my psychoanalytic colleagues deriding, bashing, and lapidating the courageous, hard-working, productive pioneers who established and built the foundations of our still-young and evolving field of endeavor, instead of gratefully celebrating them and thanking them for their generous contributions to our profession. What does it mean that, far more often than not, such attacks are directed against psychoanalytic investigators who are no longer with us and are therefore unable to defend themselves against assault?

We owe a debt of gratitude, do we not, to those who ventured out into dangerous waters and were willing then to share their ob-

servations and ideas in an open, forthright manner in the hope of providing improved tools with which their colleagues, as well as future generations of analytic practitioners, might better offer help to suffering humanity. In a letter to Robert Hooke, dated February 5, 1675 (or 1676), Sir Isaac Newton wrote, "If I have seen further (than you and Descartes) it is by standing on the shoulders of giants."[1] All scientific disciplines are imperfect and in a state of continual development. Even the most dazzling apparent breakthroughs emanate, in reality, from all that has come before.

It is refreshing, therefore, to find that one group among our number, the Boston Psychoanalytic Society and Institute, has begun to comb its archives for material that would lend itself to the possibility of creating a series of publications that will add in a lively way to the historical record of the field of psychoanalysis as a living, growing, evolving body of scientific vitality. As noted in *Edward Bibring Photographs the Psychoanalysts of His Time:*

> The BPSI Library and Archives . . . [which] have been in existence since 1933 . . . include 8,000 books and journals that circulate, a sizable rare book collection, the personal letters and papers of many prominent analysts, and an archive of 1,000 photographs of psychoanalytic colleagues. [p. 7]

It is from the last of these that this volume derives.

Edward Bibring photographed many of the attendees at meetings of International Psychoanalytical Association Congresses between 1932 to 1938, as well as at the Vierlandertagung in Budapest in 1937. The editors of this book have put together approximately 150 of these photographs. Included in them are Ernest Jones, Max Eitingen, Abraham Brill, Sándor Ferenczi, Sándor Rado, Helene and Felix Deutsch, Heinz and Dora Hartmann, Jeanne Lampl-de Groot, Hans Lampl, Ernst and Marianne Kris, Grete Bibring, Anna Freud, Melanie Klein, Alice and Michael Balint, Ludwig Jekels, Wilhelm Reich, Franz Alexander, Jenny and Robert Waelder, Ru-

[1] Bartlett, J. (1992). *Bartlett's Familiar Quotations,* ed. J. Kaplan. Boston, MA: Little, Brown & Co., p. 281.

dolph Loewenstein, Istvan Hollos, Dorian Feigenbaum, Hermann Nunberg, Edward Glover, Annie Reich, Thomas French, Rene Spitz, Jan van Emden, Kurt Eissler, O. Spurgeon English, Melitta Schmideberg, Henry Lowenfeld, Willi Hoffer, Berta Bornstein, Otto Fenichel, Paul Federn, Dorothy Burlingham, Margaret Mahler, Anna Maenchen, Elisabeth Geleerd, Helen Tartakoff, Marie Bonaparte, Raymond de Saussure, Mary O'Neill Hawkins, Anny and Maurits Katan, and others.

These are people whose names were of course familiar to me from the halcyon days of the emerging new discipline that I entered, with pleasure and excitement—whose works I had read, a few of whom I had met, and with whom, in one instance, I had once had the pleasure of discussing a case over the telephone. It was a delight to see photographs of them in which they appeared as bright-eyed, relaxed, friendly, smiling individuals greeting one another, embracing, chatting over lunch, strolling along the waterfront, and otherwise coming to life to me as ordinary human beings within the pages of this charming little volume.

I am grateful to the Boston Psychoanalytic Society and Institute and to the editors of this collection of Bibring's photographs for sharing them with us. It was a pleasure to have been afforded the opportunity to make the visual acquaintance of so many people whom I have long admired and long appreciated. I look forward to the next entity that emerges from the BPSI Archives.

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ABSTRACTS

ZEITSCHRIFT FÜR PSYCHOANALYTISCHE THEORIE UND PRAXIS

Abstracted by Rita Teusch

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Deconstruction of Sexual Normality in "Three Essays on the Theory of Sexuality." Martin Dannecker, pp. 11-28.

The author discusses Freud's *Three Essays on the Theory of Sexuality* (1905), focusing especially on Part I, "The Sexual Aberrations." He asks why Freud did not start his treatise with the chapter on infantile sexuality, which would have been more plausible from a psychoanalytic point of view. Dannecker maintains that, by starting with sexual aberrations, Freud wanted both to show the superior explanatory power of psychoanalytic theory over the scientific discourse on sexuality of his time, and to question the popular hegemony of heterosexuality.

Dannecker outlines how Freud deconstructs the idea of sexual normality in the following ways: (1) by showing the pervasiveness and variety of homosexual manifestations in everyday life (behaviorally manifested in those who are absolute and occasional homosexuals or bisexuals, and in those with an emotional homosexual inclination not manifested in homosexual behavior); (2) locating the roots of the term *perversion* in normal infantile sexuality, and claiming that healthy persons make so-called perverse additions to the normal sexual aim; and (3) emphasizing the mental forces of shame, disgust, and morality (which are socially constructed) as factors inhibiting a less repressed sexuality.

There follows a discussion of Freud's suggestion that "normal" sexual activity does not take shape by itself, but through the rearrangement of perverse inclinations, and of Freud's idea that neuroses are the negative of perversions. The author is critical of Freud's concept of latent homosexuality in neurotics, and cites as a case history the autobiography of the Spanish writer Juan Goytisolo, who suffered in the light of his latent homosexuality.

Dannecker concludes that today's homosexuals have become more comfortable with both male and female attributes, which has allowed more latent homosexuals to become "positive" homosexuals. He ends with a critical discussion of the fact that Freud nevertheless returns in his *Three Essays* to a conception of sexual normality, however difficult to attain—i.e., Freud's belief that as a result of optimal organic and psychological developmental maturation, a genital, heterosexual, and reproductive sexuality becomes possible and is held up as a model of psychological maturation and health. Dannecker believes that Freud's motivation for this conclusion was to avoid a perversion of his own theory.

The Repressed in the Image: On The Relations Between Imaginative-Sensory Thought and the Unconscious. Philipp Soldt, pp. 29-47.

Soldt aims in this paper to present a comprehensive discussion and clarification of Freud's notion that "thinking in images" (or "image thought" or "imaginative-sensory thought") is especially close to the unconscious. He collects passages from thirteen of Freud's works in which he discusses or alludes to the nature, function, structure, and meanings of thinking in images as it occurs in dreams, daydreams, fantasies, screen memories, and even in visions.

Using psychoanalytic research informed by semiotics, and arguing against psychoanalytic interpretations that thinking in images is primarily defensive, Soldt develops the following theses:

1. Thinking in images is not necessarily more primitive than thinking in words. It is rather a different form of

thinking, and the two forms of thinking are complementary.

2. Thinking in images presents an iconic sign—i.e., the content that is presented is at the same time presented as an image.

3. When neurotics think in images, the images tend to be fixed and recurring, pointing to an unconscious fixed meaning. Thus, a more normal, imaginative-sensory thought is restricted by neurosis.

4. Just as a dream image is a sign of latent dream thoughts and needs to be retranslated into the verbal thought it originated from, image thought—especially if the images are fixed and recurring—is also a sign of the repressed and is characterized by a degree of distortion. The associations given to the image or images will reveal the fixed, repressed, unconscious thought(s). Freud's suggestion that image thought is like a rebus applies primarily to neurotic images.

5. The resymbolization of images in neurotics resolves these fixed, recurring images and allows normal imaginary-sensory thought to once again function as healthy trial-thought.

Transference-Focused Psychotherapy for Borderline Patients: Its Possibilities and Limitations from a Psychoanalytic Perspective. Gerhard Dammann, pp. 71-116.

The author describes the rationale for the development of psychotherapy manuals for treating patients with severe pathology. Specifically, he discusses the manual for borderline patients developed by Kernberg and his study group.[1] The aim of this group's manual-guided *transference-focused psychotherapy* is to transform the

[1] Clarkin, J. F., Yeomans, F. E. & Kernberg, O. F. (1999). *Psychotherapy for Borderline Personality*. New York: John Wiley & Sons.

borderline's primitive and rigid object relations into more flexible and mature ones. Since externalization and projection of intolerable and unwanted aspects of the self and internal objects onto the therapist occurs regularly and forcefully in this patient population, working in the transference of the here and now allows the therapist to interpret the transferred and distorted aspects of the patient's experience, and thus to gradually modify them.

Dammann describes the risks of such a manual-guided approach—for example, overfocusing on the negative transference to the exclusion of other difficulties (such as dealing with loss or self-object needs), not allowing patients enough room to be active and creative in their treatments, or losing the possibility to intervene psychoanalytically altogether because of too many parameters. He suggests that there is a spectrum of borderline pathology, and that for certain treatment-resistant patients, a more active and confronting approach, as is required by the manual, is likely to be indicated. Dammann notes that therapists seem to have already generally accepted the necessity for parameters in the treatment of this patient population (e.g., greater structure, verbal treatment contracts, and a more active engagement on the part of the therapist).

A manual-guided psychotherapy approach is not designed as a substitute for psychoanalysis, but can serve as a preliminary helpful instrument to get the patient ready to do analytic work in the narrower sense. A psychodynamic manual could, moreover, attract more patients to analytically oriented therapeutic work, allow for increased empirical validation of analytic work, and make analytic principles teachable. Furthermore, a psychoanalytically focused treatment manual will also make analytic concepts such as transference, countertransference, projection, splitting, and acting out more popular, which allows analysis to remain competitive with other forms of psychotherapy in the treatment of borderline conditions, such as dialectical behavior therapy.[2]

[2] See Linehan, M. M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder.* New York: Guilford.

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Curative Factors and Termination of Analysis: A Model of the Mind. Antonino Ferro, pp. 159-175.

The author begins by presenting Bion's model of the mind in a simplified form to allow the reader to understand how Bion's model can explain various levels of psychopathology and offer guidelines for treatment by highlighting the curative factors for each level of psychopathology. Ferro presents helpful case material to illustrate his points, and also draws attention to the analyst's countertransference reactions in the termination phase of long analyses.

In summarizing Bion, Ferro describes the following aspects of the mind:

1. Beta elements—the mind's receptivity to perceptual and sensory impressions. It encompasses everything that has had an impact on our minds in the past and present, but has not yet been "digested."

2. Alpha elements and alpha functions—referring to a person's ability to "digest" or transform sensory perceptions and impressions (such as pain, for example) into an image, and thus represent them. In other words, alpha elements are the results of stimuli reaching the mind that have become manageable by the patient after having been represented in the form of an image.

3. The tools of thinking (the container/contained, the paranoid schizoid position, and satiated versus unsatiated states of thought). This refers to the phenomenon that in order to be further processed, the sequence of alpha elements needs to be woven into a coherent narrative. This happens through oscillations between (a) container and contained (the ability to hold thoughts and emotions and keep them inside); (b) the paranoid schizoid and depressive positions (that is, between a

more fragmented form of thinking and feeling, and a more coherent form); and (c) a more vague versus a more definitive form of thinking and feeling.

The author suggests that each sector (alpha elements, beta elements, and tools of thinking) has curative factors associated with it. If the patient's pathology primarily consists of a mass of "not digested" experiences—i.e., in which micro- and macrotraumatic events cannot be transformed into emotions and thoughts—the therapeutic intervention needs to be primarily interpretation. In cases where the pathology involves missing alpha functions (which is the case in more severe pathology, such as borderline cases), the curative factor in the analysis is the analyst's capacity for *reverie*—i.e., the analyst needs to be able to activate his or her own alpha function and transform the beta elements of the patient into alpha elements. Over time, the patient will identify with the analyst's transformative "activity."

Finally, if the pathology is located in the patient's tools of thinking, the analyst primarily needs to be able to tune in to the patient in order to develop the container/contained function. Furthermore, the analyst must access his or her capacity for creativity and mourning to allow the patient both to oscillate between the depressive and paranoid schizoid positions, and to develop greater definition of his or her own feelings and thoughts.

According to Ferro, most patients exhibit a mixture of these three modes of functioning, even though one mode may be the predominant one. He suggests that it is important for the analyst to be sensitive to the changing modes of functioning in patients, sometimes even within a session.

The author elaborates how the process of transforming beta elements into alpha elements can be reflected in the analyst's countertransference dreams and in his gradually developing insight into the patient's state of mind. He suggests that the analyst's dreams reveal the process of alphabetization in that they can draw our attention to what cannot yet be represented in the patient's and analyst's waking consciousness. In the dream, the beta elements contin-

ue to display their typical sensory character, but they are already little alpha sequences, which Ferro calls *Balpha/Alpha*.

Several clinical examples illustrate the author's model. Ferro's first example is four-year-old Diego, who at the beginning of analysis exhibited untamed, aimless, and stereotypical behaviors that he evacuated into his environment. But only a month into the four-days-a-week analysis, he began to show signs that he was responding to the structuring comments of the analyst and the regularity of the analytic situation, although his violent eruptions continued. The analyst's reverie led to play in which the hero was a cowboy who had to work on a farm and develop the land. Every so often, a band of bad guys invaded the farm and brought destruction and terror. It became apparent that the function of a sheriff was needed to keep the world together and set limits.

A section from the analysis with Diego nine years later includes a session in which Diego for the first time experienced the world as three-dimensional rather than two-dimensional, reflecting the change he had experienced in his inner life, which had gradually become deeper and fuller. Two years later, Diego proposed reducing the frequency of his sessions to three and two per week. A series of dreams reported by the patient revealed his pain and anxiety, as well as his regressions, in the face of the impending loss of the analyst and the analysis.

Ferro states that during the process of this long analysis, he had to restrict his interventions to a minimum so as not to overwhelm Diego's capacity to "alphabetize." Ferro assumed the position of the "chorus in a Greek tragedy," mostly commenting on what he saw happening in the analysis. The author stresses the importance of the emotional tone of the analyst's voice, arguing that the tone is perceived by the patient before s/he perceives the actual content. Ferro also draws attention to what he calls the *negative ability* of the analyst—i.e., his or her tolerance of doubt and uncertainty.

A second extensive clinical example describes the final stages of the analysis of Gianluca, a patient who used to be subject to "terrible hallucinatory evacuations." In the phase described here, the patient has made considerable progress but is not cured. When the

patient shows initiative and a wish to end the analysis and live more independently, the analyst describes his own struggle to accept the patient's decision and to begin to see the patient as someone capable of living a life away from analysis. As the analyst helps Gianluca deal with intense anxiety about terminating, old symptoms recur, and the patient shows himself to be unable to work through the planned termination phase. Gianluca calls the analyst a year later "to finish the last session." He reveals a profound mourning process during the previous year, which allowed him to be more reality-based and to say good-bye (*auf Wiedersehen*—literally, "I will see you again"), feeling for the first time that he would be able to rely on the analyst in the future.

Ferro further describes a little girl who speaks about her pet dog being sensitive; she says that it is important not to upset him because he gets angry easily and then will not be able to sleep. Ferro states that while the girl may be talking about reality aspects of her dog, she may also be talking about her own inner states and fears, or the fantasies about an aspect of herself that has not been transformed into an alpha function. Taking an even wider perspective of the whole analytic field, the little girl might also be talking about her perception or her fantasy of the analyst and the patient–analyst couple.

Ferro reminds the reader that in his model, in addition to the skill of interpretation, the analyst's ability to be receptive, to transform, and to tolerate uncertainty and doubt are major therapeutic tools. When certain mental functions are missing or underdeveloped, these functions must first be developed before the patient can accept interpretations, as is the case in borderline and narcissistic pathologies. In autistic and schizophrenic individuals, the alpha function, i.e., the ability to "digest" images, is impaired, and the patient lacks the "container" to receive interpretations. Ferro suggests that once the missing psychic functions have been developed, a more classical analysis can occur, incorporating working through and achieving a cure through interpretations.

Ferro concludes his article by commenting on what he views as the goal of analysis. Optimally, analysis enables the patient to

make contact with his/her true inner being through contact with the authentic mind (*Seelenleben*) of the analyst. From the beginning, the questions that the analyst needs to ask relate to the functions and dysfunctions of the patient's mind. The author views analytic process as proceeding from the help initially offered to the patient to develop the ability to create pictograms (visual images of his or her experiences and emotions); these pictograms can then be developed into a coherent narrative. Once such abilities are present, a regular analysis focused on content can be conducted. For Ferro, the analyst's theoretical orientation is secondary to how his/her personality allows him/her to interact with the patient and how it is responsive to the patient's level of functioning as described in his model.

The Silence of the Mother, or: Twenty Years Later. Pearl Lombard, pp. 197-223.

Lombard addresses the issue of silence in the analytic hour, discussing dual functions of silence: defense and enactment (of an unconscious experience that the patient has not been able to put into words). The author's reflections are based on her work with twenty patients, twelve women and eight men, whom she saw over a period of twenty years. The shortest of these analyses lasted eighteen months. In all of them, the patients' silences were a major issue. They were all patients who were functioning reasonably well, but suffered from a feeling of not being able to move forward because they felt themselves limited by profoundly depressive feelings. Some had attempted suicide; others had fantasized about suicide as a way out of a hopeless psychological situation. The author remarked that some patients expressed their wish for help openly in the beginning sessions, but more often they did not use words, communicating instead with an intensely painful gaze that deeply touched the analyst. The majority of these patients usually avoided direct eye contact because of their inner painful experiences.

Lombard's first case example is a 27-year-old married, intelligent, attractive man who looked more like a 20-year-old, and who

was unable to stay with a career or job. He had the expectation that everything he might try or begin would end in failure. In fact, this had been so up until the start of the analysis, and he had even failed to appear for his final exam in film studies. His childhood had been characterized by loneliness and a vague sadness. He had attended a boarding school starting at age five.

Lombard states that with this patient, there was a period of about eighteen months of the analysis during which the patient was mostly silent, and the analyst found herself engaged in fantasies and images of what his inner life had been like during his childhood, using the fragments and facts he had related to her at the beginning of the analysis. Lombard states that he emerged from his silence one day with the statement that he had fallen in love with an actress named Carol. The analyst responded from a place of her own romantic memory, thinking that he was thinking of the actress Carole *Lombard* (her own last name). The author explains how this meeting of minds between analyst and patient opened up a path to meaningful communication between them.

This patient eventually discovered that he had had a stillborn older brother, of whose existence he had been kept uninformed because the brother was the product of his mother's shameful love of a German soldier. Lombard comments that the eighteen months of long silence encompassed the time of two pregnancies—the patient's mother's pregnancy with his brother, and then her pregnancy with the patient himself—and that the patient was identified with the shameful silence of his mother. His continual failures reenacted his mother's adultery and her punishment. The patient eventually went on and founded a successful business.

A second extensive case example is of a 26-year-old, highly intelligent woman, G, married and a scientist, who felt unable to advance in her career and her personal life—i.e., she wanted to have a child, but was too afraid. She also complained of feeling depressed, anxious, and paralyzed in her writing ability.

G was the older of two girls. Her sister, ten years younger, was seen as the preferred daughter of their mother, who was described as silent, distant, unemotional, and cold. G's father was described

as warmer, but also as demanding and authoritarian. While the patient talked to the analyst, the analyst did not feel that the patient was really involved in what she was talking about. At some point, the patient fell asleep on the couch, and this pattern—of the patient essentially sleeping during the sessions and waking up by herself at the end of a session—continued for about nine months.

The author described her internal struggle with G's presence and absence at the same time—her own fears, anxieties, rage, boredom, her questioning of her own competence, and her theories about what the patient was doing. Initially, she wondered if the patient was simply feeling safe enough to sleep, or whether she actually wanted to take revenge on the analyst. What was G resisting? Did she want to protect herself from the analyst?

It turned out that the patient had become pregnant, which the analyst intuited in reflecting on how she had felt during her own pregnancy. G told the analyst about her pregnancy after a month, when she herself found out. The analytic couple attempted to talk about what was happening, but the patient kept falling asleep, which the analyst finally understood as the patient's unconscious need to create a space for herself where no demands were put on her, given her history of constant expectations of herself and by her demanding parents.

The silence was finally broken by the analyst when she reflected on her own experiences with her son—specifically, on a moment when she realized that her own wishes and those of her young son (then five months of age) coincided when he "showed" her that he wanted to be more independent and to sit up on his own. These associations enabled the analyst to envision a situation with her patient that could be gratifying to both of them, and the analyst felt able to interrupt the silence with a question about whether G thought the analyst preferred her to have a son, just as G's mother had wanted G to be a boy. From then on, the silence was broken, and the patient began discussing her deep jealousy and envy of her sister for having had the tender attention of their mother. She talked of the painful neglect that she herself had felt.

In summarizing the analysis of this patient, the author identifies three phases: (1) G's initial identification with the cold, distant, and unemotional mother, which led her to reject the analyst and made the analyst "obey" her. (2) The silence in the analysis eventually became a place to play and to develop autonomy. (3) Later, G understood that the analyst respected her autonomy without forcing her to talk about or show things to her, which allowed the patient to develop the capacity to be alone.

Lombard reveals her lifelong experience and fascination with silence in her article and suggests that there is a difference between silence and mutism. She states that silence is a prelude to a potential unveiling. Silence, on the one hand, can be a resistance to accepting the unveiling of inner life and talking about it, or, on the other hand, it may express a punishment for having become confused amidst gestures and passions. The author defines silence as "an opening" and as progress, whereas mutism represents a regression, a cutting off of possibilities.

Lombard quotes Freud as follows: "Concerning the factors of silence, solitude and darkness, we can only say that they are actually elements in the production of the infantile anxiety from which the majority of human beings have never become quite free."[3] Lombard suggests that important change in the patient will happen if the analyst is able to accept the patient's need for silence and does not intervene by making premature interpretations. She describes her own countertransference struggle with her patients' silences, and especially her intense aggression as a result of being shut out. If the analyst is able to use the analytic space created by the silence to work through her own disturbing and destructive feelings activated by the silence, and subsequently allows herself to engage in reverie, she will arrive—as a result of associations from her own life and the patient's material—at a deep and fuller mental picture of the patient's experiences that have not been symbolized.

In the second part of her essay, the author replies to papers written by colleagues, including André Green, in response to dif-

[3] Freud, S. (1919). The "uncanny." *S. E.*, 17, p. 252.

ferent aspects of her paper. Topics that are touched on include the analyst's personal imagery, femininity and silence, the timing of interventions, acting in the transference, motherliness, mentioning the fundamental rule, and processes of excessive splitting.

The Analyst's Pregnancy—An Examination of the Developing Triadic Relationship. Grazia Monzardo Linderholm, pp. 275-290.

Linderholm aims to show that analyzing patients' reactions to the analyst's pregnancy allows activation of defenses—i.e., disavowal, denial, reversal, oedipal illusions—that were developed to manage the Oedipus complex. The central challenge for the patient is the confrontation with a triadic relationship, which upsets the more comfortable dyadic relation to the analyst and requires the patient to face his/her separateness from the mother, to accept sexual and generational differences, and to become more reality based.

This analytic work may result in frightening regressions in more vulnerable patients, accompanied by persecutory feelings and fantasies and by intense fears of loss of the maternal object, while more stable patients will be enabled to work through the so-called oedipal illusion. Linderholm presents two case histories, of a man and a woman, to illustrate these analytic gains.

John, a 25-year-old man in three-times-a-week analysis, believed that his parents were neither sexually nor emotionally involved with each other; in fact, he believed that his father had been damaging to his mother and to himself, and he had always had the wish that his parents would divorce and that the "true" couple—John and his mother—would be united. After his mother died when John was sixteen, John began to fantasize that his mother was waiting for him to be united with her in eternity.

John had only had brief sexual encounters, never a lasting relationship. When the author-analyst became pregnant five years into the intensive therapy, John initially denied the changes in the analyst's body. When, seven months into the pregnancy, he could not maintain the denial any longer, he revealed the fantasy that the analyst

would go into labor during her session with him, and he would drive her to the hospital and assist her during delivery as if he were the husband.

John appeared to have two parallel relationships with his analyst: the first a seemingly strict analytic one, while the second was dominated by the fantasy that their relationship would eventually be transformed into a love relationship. He resisted any interpretation of this dynamic, and the author stressed that John was unable in the beginning phases to recognize his fantasies as fantasies. He was compelled to rewrite history, eliminating generational barriers.

In understanding this case, Linderholm draws on Britton (1989),[4] who states that in more healthy patients, there is a recognition of the parental couple, but an *oedipal illusion* is created as a defense. According to Linderholm, John's fantasies had the character of delusions rather than illusions. Only after repeated interpretations and confrontation with reality over a long period of time did John report a dream that indicated his acceptance of generational difference and a recognition of the primal scene. Only then did he begin to show awareness of triangular space—what Britton referred to as an awareness that allows us to see ourselves in interaction with others and to recognize a different point of view while still holding onto our own point of view and reflecting on ourselves as being ourselves. John, even though a very intelligent man, had not possessed this ability to reflect on himself. And it was only after significant analytic work on his fantasy of his parents (a sadistic father and a masochistic mother who were united in a destructive primal scene) was done—and after the analyst's second pregnancy—that John was able to realize that his parents had had a loving relationship in reality, and that he had engaged in wishful thinking about his mother.

V, a 30-year-old single, woman who had difficulties forming a lasting relationship, denied her analyst's pregnancy for six months.

[4] Britton, R. (1989). The missing link: parental sexuality in the Oedipus complex. In *The Oedipus Complex Today: Clinical Implications,* ed. R. Britton, M. Feldman & E. O'Shaughnessy. London: Karnac.

However, from her associations, it was apparent that, unconsciously, she experienced the pregnancy as an abandonment from its beginning, and she was enraged by it. When the analyst finally drew the patient's attention to her pregnancy, the patient (who at this point had fallen in love with a man) said, "I wonder if my falling in love has prevented me from seeing certain things about you." V then expressed great surprise and shame that she had failed to notice this seemingly obvious fact. She was gradually able to discuss her intense anxieties about losing the analyst, which emerged in many dreams that were filled with anxiety, loss of control, hopelessness, rage, and destruction.

V experienced primitive aggression and murderous wishes toward the unborn baby and the analyst, as well as a regression to the oral stage, dreaming of a baby being born dead through the mouth. Linderholm explains—again quoting Britton, and also Klein[5]—that the impending separation and the intrusion of a triangular relationship into V's fantasy of oedipal symbiosis with her analyst brought on persecutory anxieties about the death of the mother–child relationship. After working through these difficult feelings, V became able to reflect on her relationship with the analyst and to understand that she had seen the analyst as a substitute mother. She was able to express her feeling that she could survive the analyst's pregnancy.

This was followed by a phase in the analysis in which V could better appreciate her relationship with her father and the way he loved her—i.e., a love that gave her freedom even as it demanded that she be grown up. Her relationship with her boyfriend was strengthened because V had become able to trust that he was there for her and loved her, even if they did not see each other all the time. Later in the analysis, V showed oedipal guilt about hostile feelings toward her mother.

In her concluding remarks, Linderholm emphasizes that the pregnancy of the analyst activates a developmental stage in the patient in which child and mother begin to separate. This is followed

[5] Klein, M. (1926). Infant analysis. *Int. J. Psychoanal.*, 7:31-63.

by a painful recognition of the father's existence and his relationship to the mother. It is important to analyze these difficult feelings and fantasies in order to help the patient work through the depressive position and avoid a malignant regression. Linderholm suggests that pregnant analysts must be aware of countertransference guilt, which might make them avoidant of addressing these oedipal issues directly with their patients.