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AN EMPTY MIRROR: REFLECTIONS ON NONREPRESENTATION

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André Green has proposed that when a failure occurs in the process of differentiating from, mourning, and symbolizing the primary object, that is, of representing it, a void is left in the place of a representation. The author considers how such a failure might manifest itself in clinical material and whether an understanding of this theoretical thinking might help us conduct our clinical work. Green's thinking on this subject is summarized, and two detailed case examples are presented to illustrate the clinical application of his ideas.

INTRODUCTION

My niece, age five, came to the country with me a day in advance of her parents, who stayed behind to work. She had recently decided not to marry her father when she grew up, but instead to marry a little boy in her class. Her father would "be very old" by the time she was ready to be married, she explained. Lately, she had presided over the wedding of her favorite stuffed animal, a male, to a female from her vast menagerie. She brought that favorite animal with her on our trip. Before going to sleep, she said that this animal's new wife could not come because she was "at work."

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The next day, my niece told me that, while in the car the day before, she had imagined her mother sitting next to her, laughing and playing with her. She then brought up the subject of growing old and dying and mentioned my own mother, who had died before she was born. She thought for a moment and asked, "When she died, were you really, really sad?" "Yes," I answered. "Even though you were angry at her for going to work?" she asked.

My niece seemed to be asking whether her sense of the presence of her mother could survive within her in the face of the hostility that the child felt toward her. If it could, she would not only be able to imagine her mother in the latter's absence, but to think about and miss her. Her ability to conjure up her mother as a companion in play and as a potential object of mourning—indeed, to ask her question—appeared to testify to the crucial developmental achievement I shall refer to here as the *representation of a primary object.* I am not in this way referring to all thoughts about and images of important objects, but to a representation that ultimately involves differentiation and the capacity to mourn, and is part of a process of symbolization (Segal 1957, 1978).

Although I have started with an everyday illustration of this crucial achievement, the subject of my paper is less familiar: the possibility of a *failure* of representation of a primary object, a stark and contrasting concept advanced by André Green and other French thinkers influenced by him (e.g., Anzieu 1986; Botella and Botella 2005; Roussillon 1999). I am asking how we might understand such a failure to present itself in the psychoanalytic process, and whether our understanding of this theoretical thinking might help us to conduct our clinical work. In considering these questions, I shall not venture into the comparative analysis of different theories. My aim is more modest: to clarify how Green's ideas might manifest themselves in the clinical situation.

THEORETICAL BACKGROUND

The failure of the representation of a primary object is not something most analysts think about directly. To be sure, we think about

closely related subjects—from an ego psychological perspective, the process of separation-individuation, for example, or the achievement of object constancy, or the existence of contradictory or unstable self- and object representations. From a Kleinian perspective, we might consider the achievement of the depressive position and/or the danger posed to this achievement by murderous aggression that destroys all internal objects.

Although there may be significant overlap, each of these formulations has its own distinct network of related theoretical concepts, different from the network in which the starkness of the failure of representation is embedded. For example, the alternatives I have just mentioned are couched in terms of *presence* rather than *absence*—islands of meaning rather than the empty spaces between them (Green 1998).

My attention to the empty spaces has arisen out of my interest in Green's work. His focus on the negative has led him to conceptualize voids in symbolic representation existing in nonneurotic but potentially analyzable patients, and to see these gaps as significant (Green 1983, 1986, 1993, 1997, 1998, 1999c, 2002; Reed and Baudry 2005). In doing so, he has mined a rich vein in French psychoanalytic theorizing that explores beyond, in McDougall's (1989) words, "Freud's restriction of the psychoanalytic field to the . . . [psyche's] representational system as anchored through language" (p. 14).

Green's theoretical network, as it concerns representation and its failures, is far-reaching. It includes not only a very thorough grounding in Freud, but also Winnicott's (1951, 1971) work on the transitional object and transitional space and the role of the object in sustaining and enlarging that realm. My niece's recently married stuffed animal was originally her transitional object, and we can trace its differentiating and expanding development from that first "not-me" possession into a space of illusion that fosters representational play in the physical absence of the object.

But, as Green (1997) has pointed out, Winnicott was aware of something more: interruptions in the maternal presence can lead to a failure of progressive development toward symbolization in the transitional sphere. Winnicott wrote (and Green [1997] cites him):

> If the mother is away over a period of time which is beyond a certain limit measured in minutes, hours, or days, then the memory of the internal representation fades. As this takes effect, the transitional phenomena become gradually meaningless and the infant is unable to experience them. We may watch the object becoming decathected. [Winnicott 1971, p. 15, quoted by Green 1997, p. 1074]

This observation leads us to Freud's formulations of drive activity as it interacts with the development of ideation (Green 2004). The emphasis, however, is on the role of the object as mediating the development of meaning, and therefore also on the too-long absence of the object as presaging the failure of meaning.

As Winnicott's observation about decathexis implies, the gradual building up of self- and object representations requires a relative consistency of the object's need-satisfying behavior. Repeated memory traces of the satiation of hunger, for example, combine as memory traces of tension followed by satisfaction. They then become associated with the attuned and satisfying object, as well as with pleasurable changes in bodily state and with pleasurable affective interchanges. The achievement of object representation, from this point of view, signals the uniting of drive impulse with meaning.

In situations of failure, the object representation is not joined to memories of pleasurable satisfaction. Instead, the fading away that Winnicott notes comes when an intolerably long rupture occurs in the repetition of satisfying experience, either through the object's inconsistency, through a prolonged change in mental or affective state, or through absence. In such circumstances, neither the association to the object of satisfaction nor the memory of satisfaction itself can be maintained. This fading away of the maternal representation is different from conceptualizations of its internal destruction, despite the importance of rage and vengeance in many of these patients, since an internal object representation has to exist before it can be destroyed.

By contrast, Green reformulates Freud's last drive theory in terms of an opposition between drive investment and a withdrawal of investment. Green posits a conflict between the connecting, investing,

or objectalizing creative power of Eros that links the infant with life, pleasure, the world of objects—in short, with meaning—on the one hand; and a reimagined death drive, on the other. This death drive, manifested by a disobjectalizing function, withdraws investment, dissolves connections, and disconnects meaning from the seeking of satisfaction. Whether or not the representation of a primary object occurs depends on whether the life drive can bind its opposite so that love, in its objectalizing function, prevails over the withdrawal of investment.

Both objectalization and disobjectalization are in play, for Green, each time that internal tension forces the individual to face the unpleasant external reality of a lack of satisfaction. The defense of disavowal is called on to make the unpalatable reality of unsatisfied internal tension disappear. The result is a blanking out. Where an internal representation of a primary object is present, this blankness becomes a background for fantasying; my niece's imagining her mother's playing with her in the latter's absence is an example of this.

But where internal representations are not sufficiently present, the blankness is a void—what Green calls a *negative hallucination,* the equivalent of a loss of meaning. Such a void is not a defense against sexual and aggressive drive derivatives, as conscious feelings of emptiness usually are (Levy 1984); drive derivatives, by definition, already unite meaning and impulse. Rather, it "seems to be a radical and extreme defense" that wipes out what we might call the creative inner workings of the unconscious. These generally take place through such mechanisms as displacement, substitution, repression, and affective reversal (Green 1999c, p. 195).[1]

Green's network of ideas extends from this formulation to envision defenses against the meaninglessness of negative hallucination. The defenses utilized, however, are not those typically seen in neurotic illness. They include eruptions of impulses disconnected

[1] "From the point of view of the unconscious ego, negative hallucination is indeed the representation of the absence of representation" (Green 1999c, p. 196).

from ideation and manifested by action, depressive withdrawal, masochistic behavior, addictions, and somatic illnesses. Affects may also fill the void (Green 1977, 1999a, 1999b). Green and Winnicott both describe a patient for whom frustrated longing substitutes for an unsatisfying object. The unbreakable attachment maintained through perpetual frustration functions to ward off a terrifying gap (Green 1997; Winnicott 1971).

Green (1975) also describes contradictory anxieties in these patients: on the one hand, they are terrified of abandonment and so are emotionally voracious and needy; on the other, they are terrified of intrusion and so reject and withdraw. Object relationships must not only defend against both anxieties simultaneously, but must also patch over the void. The needed, longed-for, but nonrepresented object—unlike my niece's image of her mother, whom she imagines playing with her—may be turned into a quasi delusional, eternally present, internal persecutor: a bad object, constantly attacking, yet clung to with persistence.[2] Split off from this object is an idealized object seen as perfect, all-knowing, and omnipotent. This idealized object remains a distant and unattainable figure, a critical judge, easily disappointing. Corresponding split-off self-representations often complement these object representations.

Green refers to these defensive patterns of object relations as the choice of delusion over death, since the result of a pure culture of disobjectalization is Spitz's (1965) foundlings succumbing to death from hospitalism. In regard to patients potentially capable of analytic work, however, we must imagine something less easy to grasp, a continuum in which life forces bind only tenuously the forces of withdrawal. In other words, the capacity to represent exists, but in a very weak and vulnerable form.

The network of ideas associated to representation and its failure also includes work on symbolizing (Lacan 1954; Segal 1957, 1978), as I have already discussed; on linking and thinking (Bion 1962); on free association and its limits; and on countertransference as a

[2] I refer to these defensive representations as quasi delusional to distinguish them from internal representations that can be mourned.

necessary alternative source of data about the unconscious of the patient.[3]

As repeated experiences of drive satisfaction lead to the establishment of meaning—that is, to the representation of the object—drive impulses are bound by the representation of that satisfaction in words. This process, which Green calls *a transference onto words,* allows the inner world to become an intact fabric of displacements. In the case of neurotic patients, this displacement onto language is assumed by our technique and permits the analyst to use the patient's free association to infer repressed unconscious content.

The clinical picture we perceive changes, however, if we posit that the fabric of verbal displacements is rent by a failure of object representation. Then voids may appear—breaks in continuity signaling something that cannot be expressed in language and cannot therefore be thought. Instead of transference onto words, what Green calls *a transference onto the object* predominates. Words are taken over by the need for drive expression and become meaningless, disconnected pieces; what is expressed is a need for the transference object qua real object, contradictory attitudes, split-off and shifting versions of self and object, senseless impulsive actions, and psychosomatic symptoms.

This pressured expression may appear to be the opposite of the void, and the clinician may not realize that this action is an attempt to fill it unless free association is significantly impeded (Milrod 2007) and a depressive, devitalized state emerges. To emphasize my understanding of the clinical ramifications of these ideas: given the appropriate context, the sign of the lack of stable representations of primary objects is discontinuity.[4]

[3] For an explanation of the difference between Lacan's concept of lack and Green's pathological negative, see Reed (2006). For an account of similarities and differences in the thinking of Bion and Green, see Green (1998).

[4] In an important work on nonrepresentation, Botella and Botella (2005) use the term *discontinuity* to refer to the developmentally normal awareness of difference, e.g., between self and other, male and female, etc. In contrast, I use it to designate various irregular interruptions of meaninglessness in the expectable process of thinking and feeling, such as shifts between contradictory self-representations, abrupt changes of mental states, or sudden regressions frequently linked to trauma, all indicative of an absence of inner continuity.

Because the analyst cannot depend entirely on free association to lead him or her to curative inferences about repressed, unconscious fantasies, the patient must be helped to connect to the analyst in such a way as to be able to detour through the analyst to arrive at the unconscious, unverbalized part of him- or herself. Thus, the analyst must consider carefully whether emotional reactions in the sessions might involve communications from the patient about his or her unrepresented inner state, and sometimes, when the analyst judges that this is the case, to put these states into words for the patient (Green 1975).[5]

The analyst must become for these patients not only the stimulus for aggressive and erotic impulses, but also, Winnicott-like, what Green (2000) calls a "similar other": sufficiently close to and in tune with the unconscious that the patient cannot articulate, yet different enough to be able to think about and verbalize it. The analyst in the transference thus has a double function: to utilize the setting to foster a transference onto words, and to analyze the traditional transference thereby called forth.

I should like to illustrate how we might understand clinical material as presenting a failure of representation, and how recognizing not only the phenomenon, but also its relation to the network of ideas in which I have shown it to be embedded, might be helpful in thinking about a patient. I shall do so, as much as possible, through the words of two analytic patients, Ms. F and Ms. N.

FIRST CLINICAL CASE

Ms. F: Background and Clinical Excerpts

Ms. F, a woman in her mid-forties, fits rather obviously Green's description of the sort of individual in whom early, preverbal conflict leads to voids instead of to object representation. Impulse ridden, substance abusing, paranoid, and unable to work consistently

[5] Green comes close to Klein's concept of projective identification here. He differs from her quite decidedly, however, in matters of technique—by offering possibilities to nonneurotic patients, rather than "imprisoning" them in deep interpretations pronounced with certainty.

with contradictory good and bad self- and object images, with a mother experienced as rejecting and who herself had been rejected very early by her own mother, and with a highly intrusive father, she was, after ten years in treatment, sober, more reflective, working creatively, and struggling with her first serious relationship. Although there was much that remained to be accomplished, it was still a surprise when, in this Monday session, it was as if the bottom we had constructed had suddenly dropped out:

> This past couple of days has [sic] been really rough for me. I felt like I was spinning out of control, faster and faster; I couldn't stop. No matter what I tried, I couldn't get grounded. When this happens, I have nothing to hold onto. Nothing. No way to stop. I feel desperate. Before, I used to think, "this is life"—that's all I ever felt: desperate, out of control, no way to stop it, nothing to hold on to. Now, part of me knows it will pass. I believe that, but it doesn't change what I am feeling. If I didn't know that, I would've done something self-destructive. I wanted to. [She describes what substances she thought of abusing.] I talked myself out of that. I thought it through. I thought, "I'll just feel twice as bad."
>
> I just beat myself up all weekend. On top of everything else, I felt bad that I was having all the feelings I was having.

Despite her sense of herself as more continuous, and her ability to talk to herself about her impulses to hurt herself and not to give in to them, Ms. F's turmoil was as contagious and distressing in its acuteness as it was unexpected. Time was awry and I felt knocked off center.

> I was in the middle of working when I left for the gym. I felt the need to be working because stopping made me feel I wasn't doing what I should be doing. But I couldn't stand how I was feeling. Robert [her companion] came back; I don't remember when. I just remember going to sleep Friday night and thinking, "This isn't what I want." Part of it was he told me he was going to see his children the next day. Here's another day he has off that I don't get to spend with him. I only get to spend it with him by default. It was

> the domino effect, on top of the shaky way I was already feeling. I was already feeling bad about the whole cooking thing. Friday you said I was losing respect for myself; that made me have less respect for myself. I was saying, "I'm just the biggest piece of shit."

As I listened, I felt her confusion, desperation, and sense of worthlessness. Although I had not used a critical tone nor said what she accused me of saying, her familiar, attacking tone made me *feel* guilty, a feeling amplified by my distress at the way she imprisoned herself in the loop of feeling bad and attacks on herself for bad feelings. She continued with bitterness:

> You coulda said, "This is all new for you. Anybody in your situation would be struggling." Instead, you said that I was having difficulty holding onto my respect for myself.

I pulled myself together and thought about the previous Friday's session. I had said that she was so frightened about being abandoned by her companion that it made it difficult for her to take her own part when they had a difference of opinion, and that she then became upset with herself for not standing up for herself. I realized now that I had spoken as the session was drawing to a close, at a moment when she was probably feeling vulnerable about the coming weekend separation. Now I said:

> Could it be that your disappointment with me for being out of the office over the weekend colors how you are thinking about me and how you remember what I said to you? Not only that you are angry at me, but that you made me your tormentor to keep me with you?

Ms. F burst out again, but this time with more coherence and less anger:

> He went to see his children and didn't invite me to come along. That's when I just felt so terrified—there was nobody. I had nothing to hold onto. I couldn't sit still. Couldn't stay at home, couldn't work. I called everyone. I got so angry! Last time his children were playing with him, and I was all

> by myself. I got angrier and angrier; I was afraid he would never come back. I was waiting and waiting for him to call and I couldn't stand it.

Ms. F had experienced a double abandonment, by her analyst and her companion, each of us a substitute for a mother who chronically forgot to pick her up after school, and whom Ms. F experienced as favoring a sibling barely a year younger. This gap in experienced affection and presence had yawned over the weekend, its sign the breaking up of her sense of diachrony, continuity, and security, compromising her ability to think and leading to an engulfing desperation.

I remarked that she seemed now to feel less desperate. "Yes," Ms. F said, "since you came back." I took her to mean that I'd come back at this point in the session.

Ms. F: Discussion

The discontinuity created by Ms. F's encounter with the void within her over the weekend and in the Monday session—that is, the space between the before and after mental states—can be seen, if one is tempted to go in the direction Green proposes, as the equivalent of the missing maternal representation. What I am calling an *encounter with the void* is what we might think of as a regression—although, for Green, the void, when it is there, is *always* there, even if concealed. I do not want to suggest that every violent discontinuity such as this one should be understood as the equivalent of a failure of the representation of a primary object; rather, given the unstable object tie as a context, I believe it is useful to understand Ms. F's reaction in this way.

From this point of view, Ms. F was on a difficult journey, in transit between the experience of the internal void she had filled with both drugs and promiscuity and a more potentially reflective, stable state. The vehicle for the journey was the analysis. It was a relatively reliable vehicle in its consistency and acceptance, so long as too much time did not elapse between sessions, or too many time-collapsing events did not occur to make her need too great for her

to tolerate my not being her wished-for mother. However, when I was not available, Ms. F sometimes looked for a substitute, and when her designated substitute also appeared to have left her, she defended against her acute, unfulfilled need by turning me into a persecutor who tormented her, but who was also ceaselessly present in her mind.

This sequence illustrates an important technical point. Although Green's emphasis on the representation of the primary object does not minimize the roles of destructiveness and rage, it also does not see them as the primary dynamic focus. It is the void that is preeminent. Thus, my intervention did not emphasize Ms. F's anger at me; instead, it interpreted her paranoia as a way of warding off her feeling of abandonment. This understanding, in turn, led to Ms. F's more focused recognition of the feeling of being abandoned, to reversal of the subjective discontinuity, and to the reestablishment of a sense of subjective continuity.

This reaction made me consider that, although we had worked for years on Ms. F's need for my presence and adverse reactions to separations, I had never consistently thought about her difficulties in terms of a failure of representation of a primary object at the base of her psychic structure. We had worked usefully, from the point of view of her aggression, on Ms. F's narcissistic denials of her need for my presence, on her fear of retaliation for hostile wishes that she saw as omnipotent, on her hostility and rage toward me for not satisfying her needs that existed beneath her denials of her need for me, on her defensively turning those same emotions against herself to protect me, on her projecting her rage onto me, and on the reasons for her need to keep the two versions of me and herself separate.

I do not want to imply that I never thought about Ms. F's difficulty holding onto a benign image of me under the pressure of a separation, or that I never interpreted some aspect of that problem, because that would be quite inaccurate. But I had not previously considered the whole picture in the terms I am describing here.

Ms. F: Additional Clinical Material

As our work began to focus more on the problem of a failure of representation and its voids, on Ms. F's consequent terror of aban-

donment, and on her difficulty holding a positive image of me in her mind, she was able to reflect on her internal experience and to connect it with her behavior and thinking. The following excerpts, in which she reflects on her ability to represent, are drawn mostly from one session two months later. She had ended the previous session with the following comments:

> The other day I was thinking, "Who do I love?" You and Carrie [a friend]. How do I feel about you right now? I wasn't feeling anything. I was thinking of your saying you're the enemy, but sometimes I feel you're there. With you, I know you are there for me, a good person. With Robert, I don't know it.

She began the next day:

> This whole relationship with Robert feels so life-and-death because I have so little sense of myself; I abandon myself. No one's there for me, including me. I turn into this scared child who feels so alone in the world. I lose my perspective on things . . . .
>
> My whole childhood, I was looking for a mother. I was always thinking, "Are you my mother? Are you my mother?" I told you about this stranger who picked me up in a rainstorm . . . . I even told her I didn't remember where I lived. I was thinking, "Why can't she be my mother?"
>
> When you said yesterday that I sometimes forget I'm an adult woman and feel, instead, that I'm a little girl without a mother, I'm thinking, "I'm this damaged person with part of them missing." There's shame in it. I can't look the world in the face. When you feel this rejection from your mother, it's like "How can you be a worthwhile person when your own mother rejects you?" It feels like I have egg on my face. Worthless, worthless . . .

In response to my pointing out that she had described her mother in similar terms, Ms. F said:

> It's hard to separate myself from her. The way I tried was to be masculine and tough. That was not me either. I don't want to be a tough, callous person, and I certainly don't want

> to be this kid with egg on her face, tripping over her feet, looking down at the ground and being ashamed . . .
>
> As soon as I could, I combed my own hair and had a collection of rocks, sang in the church choir, played the piano, and rode horseback. I thought I wouldn't even need her if I got good at all these things. I wouldn't need her. I didn't have a choice; no one was there for me anyhow.
>
> Everything was empty. I started to look for meaning in all this stuff. Everything was meaningless. When I started drugs, I threw everything out because I'd been looking for an answer and it wasn't there.

Ms. F is here neither discharging affects nor complaining about her plight. Rather, she is observing herself from the point of view of an adult, reflecting on and trying to understand her experience. Since she does not here abandon her adult self, there is no void apparent. In the context of the previously observable discontinuity of thinking, however, her words may be taken to describe what she could only previously experience. That absence of meaning represents the phenomenon with which we are engaging.

SECOND CLINICAL CASE

Ms. N: Background and Clinical Excerpts

From rural beginnings in the far North, Ms. N was the only one of her five siblings to have left the immediate area where she was born and embarked on a professional career. She described her father as domineering, hard, and self-involved, and her mother as anxious and controlling. She sought treatment following the breakup of a relationship.

When she lay on the couch for the first analytic session, this poised, attractive woman of thirty-nine suddenly became a frightened, abandoned child. It was as if I had left the room.

> It feels like I am talking to myself. I feel alone . . . . I don't want to be alone . . . . I feel the way I did when I was a little girl. This has something to do with my mother . . . . She wouldn't stay with me, not even when I was desperate. I'd

> want her to be with me, but she would just leave me, on purpose. I would cry, feel anxious or desperate, and she would just leave me anyway. I felt angry, too. She still does it! Home felt bad, always sad . . . . I was always looking for somebody.

This sad feeling reminded Ms. N of when, at fifteen, she had become anorexic: "I realized that . . . my parents were not there for me . . . would never be, that I had no connection to anybody."

The here and now and the past were, throughout this first week of analysis, complexly condensed. "If I can't see you, I think you aren't listening to me," she said. During the Friday session, angry at a friend, she interrupted herself:

> I just now realized that before I stopped eating, I saw myself as horrible. I would look in the mirror and think, "Oh, my God, that's horrible!" I was fat. I didn't want to see that.

Reacting to the apparent domination in Ms. N of the present situation by past distress, I tentatively suggested that she might be afraid of discovering with me what was inside her. She sat up abruptly and announced that she was leaving. I encouraged her to try to talk about the feelings she was having, and she gradually lay down again and continued:

> I don't know what my feelings are. I'm startled when I see myself so angry and depressed. Nobody could like me when I look so angry. I see a certain physical image.

I asked what she saw when she looked in the mirror. There was a pause, and in a chilling tone different from what preceded or followed, she said: "It is not there." There was another pause. Only then did she describe her reflection: "I see somebody unattractive, very disembodied, where things are not harmonized."

Ms. N's mixed use of tenses emphasized the uncanny feeling present in the room. Although her words were ambiguous, it seemed as if she might have briefly entered a different mental state, so that when she thought about looking at herself, she could not initially find her reflection, but saw only emptiness.

After this first week, work went along more quietly. Ms. N began gradually to experience her anger at her former companion. She was also able, little by little, to discern aspects of the past in many of her current attitudes and reactions, particularly her rage toward both parents and her disappointed expectations of them. Omnipotent destructive wishes toward her mother, as well as fear of retaliation, emerged. Her self-attacks for her anger toward them and toward colleagues lessened. So, too, did her depression.

In the second year, Ms. N began, occasionally, to have acute reactions over the weekends, but was dubious about my attempts to connect these to my unavailablity. She wondered instead whether she had *ever* had strong positive feelings toward others. Maybe she was not suited to analysis. Most of the time, she could not free associate either, she observed; indeed, she tended to recount external events. Still, she recognized that she would arrive for the Monday session reporting a weekend of loneliness, despair, insomnia, and various physical symptoms with no discernible symbolic content. At these times, she would give vent to intense frustration at her inability to do something immediately to change her life, to disappointment with the selfishness of family and friends, and to anger about her lot.

I felt helpless at, and sometimes attacked by, this onslaught, although I recognized the importance to Ms. N of my not leaving the room while it was occurring. I had to struggle, often unsuccessfully, not to offer "helpful" suggestions.

In the third year, a drawn-out family crisis deeply disturbed her. In the process of exploring her reactions, she was stunned to recognize that her mother's thinking had always been paranoid, and that her mother had tried to prevent her from having friends; during Ms. N's adolescence, her mother had tried to keep her in the house almost all the time. In addition, her mother had insisted, from Ms. N's early childhood on, that her paternal grandmother (who lived with them) was evil. Ms. N saw no grounds for this accusation and realized that her mother had deprived her of much available comfort and love. In tears at the lost opportunity to feel this love, she said that her "mother's thinking could drive you mad." She had had to re-

nounce the evidence before her eyes and believe her mother's version of the facts, even when she knew herself to be right.

Ms. N also recognized that her mother had eyes only for her older brother, and must have seen Ms. N, the next child, as an unwanted intruder. Her mother never protected her from this brother's aggression, and she had lived, she realized, in absolute terror of him. Even now, a thousand miles away, "He stops me from speaking up. He is involved in all my anxiety . . . . I do finish projects, but the terror connected to him comes up again the moment I have another project. Every day he used to scream that he wished I would die."

Her brother, Ms. N realized, also contributed to her acute childhood separation anxiety. The activity and noise of her kindergarten classmates was linked for her with her fear of her brother's violence.

> I never realized how physically scared I was all the time. That fear I have that something horrible is going to happen —it's that I'm afraid I'll be attacked and killed. Aggression always reminded me of my brother. It was like being like him.

More and more sessions began to resemble the Monday sessions. Ms. N's emotional pain became physical and seemed unbearable. Her physical symptoms and sleeplessness increased. The analysis was too much; she could not stand it. She felt she was going insane.

None of my interpretations seemed to help—not those about Ms. N's anger toward and fear of retaliation from various members of her family, about her anger toward me for leaving her on weekends, about her fear of my becoming exasperated with her and walking out, about her disappointment with and anger toward me for exposing her to these painful discoveries of being unwanted, nor about her anger toward me for failing either to fix her parents or to somehow compensate for her past deprivation.

Ms. N was considering ending the treatment. In sessions, when not vocalizing her discomfort, she was silent. In one Friday session, she was so frustrated, upset, and in pain that, after very careful consideration, I later called her to see how she was. In the next session, she contrasted my calling to her mother's walking away, and reluc-

tantly recognized that she had been worried that I would not want to see her any more. I told her that she had been confusing her experiences with her mother with what she might expect from me.

Now, very occasionally, Ms. N mentioned her work. When she did, I was surprised to discover that her work life was improving significantly. It finally dawned on me that this difficult period in the analysis had followed *successful* analytic work.

When Ms. N mentioned that she seemed able to do only the work that she detested when she would like to have fun, I pointed out that something in her was preventing her from having fun. She was relieved at my understanding and interested in this response. Her interest allowed me to embark on the following interpretive line over many sessions: She seemed to believe that she was not allowed to be separate from her family, fearing abandonment if she became independent of them. As a result, the moment she felt free in thought and successful in her life, part of her turned against herself and attempted to destroy herself. Part of her was doing to herself what she believed her parents would do to her, and she was keeping her family with her by becoming them and hurting herself.

Stopping the analysis was one way of hurting herself, and Ms. N's wish to do so was a reaction to her feeling frightened about what would happen to her as her life began to improve. She was trying very hard to convince me of how damaging the analysis was to her as well. It was as if she were showing me that she was suffering and not getting better because she did not believe she deserved to be freer, and she felt she would destroy her family through neglect if she were independent of them, alive and happy.[6]

Ms. N wondered what made her stop herself, and eventually began to discuss with intense affect her painful conflicts around separating from her family. In this context, she returned to the subject of her anorexia for the first time since the first week of the analysis:

> I cannot get angry at my father . . . . If you don't let him have control, he'll destroy you. That's exactly what he did when

[6] Here I interpreted *within the transference* rather than interpreting the transference more fully because her psychic reality was, for the moment, so entirely engaged with her family.

> I weighed ninety pounds. I couldn't sit. And he said to my mother, "If she wants to die, let her die." He didn't ask if I had a problem, even though I was disappearing in front of his eyes.

Soon after I began this line of interpretation, but well before the work just quoted, Ms. N began to notice a change in herself. She could again experience herself in interactions with others from the complexity of different viewpoints. She could distinguish the past from the present in her reactions. Sessions became meaningful once again.

In a session approximately two months later, Ms. N spoke about her feelings toward her mother in terms similar to Ms. F's comments about *her* mother:

> I had the thought: "I never had a mother." This sense was so strong—"I never had a mother." It was so sad. It makes me angry at the same time. It's as if I can touch it . . . . Something definitely happens every Sunday . . . . Something comes up. How difficult it is—how difficult. Even when you think you know not to expect anything from your mother, you still do. It's not over.

The next day, Ms. N turned to the transference: "Yesterday when I was walking in the street, I thought, 'I am very glad that I am here [in analysis]. This is probably the best thing I have done for myself in my life.'"

She also returned to the second image of herself in the mirror, the one that followed the missing reflection. "No one will talk with me. They will be disgusted." We had already connected this self-image to her rage and vengeful wishes toward her mother. Now, Ms. N also linked the element of disgust to her mother, who had lost her upper teeth by the age of forty: "I was afraid of becoming like her." She associated, too, to her perpetual terror of the dentist and to her helplessness at extractions forced on her as a child by bad dental care and parental indifference.

Ms. N continued, "I hated my mother's way of feeling 'there is nothing you can do about it—that's the way it is.' No, that's *not* the

way it is." It might be said that in the struggle envisioned by Green between life (here in defiant form) and death (in the form of a masochistic wish to disappear from the face of the earth), life was winning.

Ms. N: Discussion

My central interventions to Ms. N addressed a negative therapeutic reaction that was clinically observable. Although the terms I used left room for a possible interpretation involving unconscious guilt (and thus for possible interpretations aimed at an oedipal level of conflict at some later time), my interventions were directed toward an earlier developmental level on which object representation either would be, or would fail to be, consolidated. I addressed this preoedipal level because the available clinical material led me in that direction. My interventions were directed toward the establishment of Ms. N's identity in the face of her feeling unwanted, the destructiveness she believed to be inherent in her differentiating herself from her parents and becoming successful, her fear of retaliatory abandonment, and her tendency to become in action her indifferent, critical father, her controlling mother, and her attacking brother, in order to punish herself and keep her family with her. That is, I addressed narcissistic and preoedipal issues involving separation, identity, destructiveness, and fear of abandonment.

Since many of the clinical issues in this case—especially the obvious conflicts around aggression—are addressed in theories as disparate as those of Kernberg, Klein, and psychoanalytic ego psychology, one might legitimately question why I have included this material as an illustration of Green's concept of nonrepresentation. In my view, Green's ideas create a frame that changes the value of customary elements in other, more familiar theoretical schemas, so that we look at the functioning of each element as part of a new and larger whole.

For instance, Green does not minimize aggression. On the contrary, it is very much present in both his theoretical thinking and clinical understanding. But Green understands Freud's change from the topographical to the structural theory differently from the way

this development is viewed in, say, North American ego psychology. He identifies the major change as the division of the system *Ucs.* into pure *urges* in the id and unconscious *content* in the unconscious ego. Some of this unconscious content is, to be sure, transferred onto language, but there is other unconscious content, as well, that is not (Green 2000, 2002; Levine 2009). Green understands this change as enabling us to better understand and treat nonneurotic patients.

Thus, the central question for Green in respect to aggression is whether the aggression is connected to a represented object—that is, whether or not a particular patient is struggling with aggression in the form of a drive derivative. If ideation and urge have united through the mediation of an object, that object has been represented and is part of the patient's inner, vital world. If, on the contrary, a patient is struggling with an explosion of unconscious urges not yet transferred onto language and therefore not joined with ideation, we are in the presence of nonrepresentation, of inner voids, devitalization, paralysis, and even fragmentation.

The driven quality of Ms. N's need to "do something," her attempts to defend against onslaughts of aggression through her body, her paralysis and inability to find words to understand and work through her tortured state, the thinness or deadness of her experience of herself and of the world during the period in the analysis I have described—all can be said to point to a state of affect flooding and "transference onto the object," occasioned by the void that was revealed by her reactions both to the weekend break in the daily analytic sessions, and to the concurrent and too-familiar behavior of her family during its crisis. My interpretations put into words the patient's desperate clinging to the bad objects, which was a defense against awareness of this void, while the act of translation separated me, for the time being, from these objects, offering an alternative to the void.

SUMMARY AND CONCLUSIONS

The void, when it exists, exists concretely, in its discontinuity and defensive radicality, as a negative hallucination: "the nonperception

of a psychic object or phenomenon that is perceptible" (Green 2002, p. 289, my translation). It is possible (although not necessary) to understand the empty mirror in which Ms. N missed her reflection during the first week of the analysis as such a "representation of the absence of representation" (Green 1999c, p. 196; 2002, p. 289)—the type of void Green describes as an unconscious identification with the "dead" mother (Green 1983). This unconscious identification is not, however, transferred onto language, but exists in the unconscious ego, unrepresented.

I emphasize the radicality and concreteness of this concept because this material—being unconscious, not transferred onto language, and unrepresented—does not share the layered texture of typical neurotic compromise formations. Rather, it takes the form of a rupture. The momentary, nonappearance of the patient's reflection could be understood as such a rupture.

Ms. N's distorted and disembodied reflection that followed this nonappearance, and Ms. F's similar "I'm this damaged person with part of them missing . . . worthless, worthless," were self-images condensed with images of devalued mothers who were experienced by both Ms. F and Ms. N as insufficiently available—if not, at times, as actively hostile. These devalued images were seen from the perspective of idealized, omnipotent, judgmental fathers whose criticism the subjects also shared. These self-images are *highly condensed fantasies*, but they are also versions of what Green calls a *patch covering the void,* where the bad object is clung to and submitted to, split off from another that is made perfect, distant, omnipotent, critical—and disappointing. That is, multilayered meanings exist in these patients, but often as primitive defenses concealing the void.

Significantly, both patients repudiated these devalued self-images at a time when they felt sufficiently anchored in a positive transference to an analyst who listened to them and tolerated their rage. Thus, they could recognize and reflect upon (instead of reacting to) their deprivation, and could embrace their identities as adult women.

In their seminal paper on the misuse of the interpretation of penis envy in two patients whose conflicts involved narcissistic sen-

sitivity, aggression, and identity diffusion, Grossman and Stewart (1976) warned us not to lose sight of the "emotions and experiences that lie behind" (p. 199) any stereotypical way of expressing conflicts by applying too mechanically the concepts that they call *developmental metaphors*. It seems useful to repeat their general warning about mechanically applying a developmental metaphor. Because failure of representation can become such a metaphor, it is important to note that not every patient who complains about his or her inattentive, unsupportive mother, or about being mistreated, or about feeling empty is dealing with such a failure. Context is crucial, and that context must include the mental state of the patient at the time he or she encounters something that we might be tempted to identify as the experience of a void. Although, in reflection, patients can reexperience and speak of longings for care and love that were not present in their childhoods and can describe how that absence caused them anger, emptiness, and pain, they are not "empty" while so reflecting. They are empty when they cannot reflect, cannot put words to inchoate internal experience.

The void Green is pointing to is identifiable not as a subjective feeling that occurs during reflection, but as various forms of unreflected-upon-but-experienced discontinuity—formal elements indicative of conflict solutions that have not joined the drive-induced tension requiring satisfaction with the memory of satisfaction, that is, with meaning. These might include actions divorced from meaning so that it is impossible to reflect upon them, the absence of the capacity to think, or the abandonment of oneself as an adult (as occurs in certain regressions).

Finally, is there any clinical benefit to thinking about the voids left by a failure of object representation, as opposed to paying attention to what *is* there—that is, to more familiar ways of thinking? I believe so. There is value in trying to grasp not only a new idea in isolation, but a new idea as part of a complex theoretical network that amounts to another psychoanalytic language. Such networks connect concepts that might not otherwise be linked, and in this way often enrich our thinking.

Moreover, Green's inclusion of the negative as an element of clinical data adds a level of complexity to the psychoanalytic field.

For example, his concept called my attention to the analyst's affective experience of the discontinuity in the patient and in the session. Awareness of this experience—if we are not too busy trying to fit the pieces together to allow the empty spaces to reverberate within us—may alert us to a deep, central problem that the patient is avoiding, and to the particular way in which the patient is avoiding it.

If we are so alerted, it will call our attention to the patient's capacity for thinking, reflecting, and transferring. Since, in my understanding of Green's thinking, these voids are the remnants of past conflict solutions—and, therefore, the equilibrium of which they are a part is subject to disturbance—there is a chance that the pleasure and satisfaction derived from aspects of the analytic setting, the analyst's listening, attention, presence, and verbalizing, may come to change the balance of forces in the patient in the direction of investment in a new, potentially less disappointing transference object (Loewald 1960).

To foster this process, we need to monitor our technique. I am not suggesting any major divergence from the ordinary analytic frame—far from it. The minimum is always preferable, but we ought to attend carefully to the patient's possible need for contact during separations, to titrate the degree of frustration within sessions, to help verbalize experiences that patients may communicate to us only nonverbally, and to establish a collaboration around understanding. To bring about the essential transference onto words, the analyst must become a new object for the patient, and in this way replace the void with hope.

This task, as analysts will no doubt anticipate, is the most difficult of all. It involves the patient's giving up a bad object, as well as giving up the self-blame attendant on that object's failures. Such an object functions to ward off the experience of the void, and, although the experience of a bad object is painful and destabilizing, the illusion of omnipotence implied by self-blame remains a powerful lure.

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BION'S EGO PSYCHOLOGY: IMPLICATIONS FOR AN INTERSUBJECTIVE VIEW OF PSYCHIC STRUCTURE

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Of all Freud's writings, Bion was most deeply influenced by "Formulations on the Two Principles of Mental Functioning" (1911), and the author asserts that much of Bion's major theoretical thinking may be seen as an elaboration of this paper. Bion's introduction of the concept of alpha function, *which "may be regarded as a structure" (Bion 1962, p. 26), constitutes what the author calls "Bion's ego psychology." A clinical implication of Bion's ego psychology is a focus upon the unconscious interaction between the analyst's and the patient's communicating alpha functions. Clinical material from the analysis of an adolescent is offered to illustrate the author's points.*

> And we have to judge how to tell the patient the truth about himself without frightening him.
>
> —Bion 1994, p. 173

> Thus, if a resistance is in operation, it indicates that the patient is experiencing his or her thoughts or feelings as a danger.
>
> —Busch 1995, p. 40

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INTRODUCTION

Freud's writings are frequently mentioned in Bion's work, yet when they are referenced, the corresponding citations are invariably to Freud's texts up to 1920. This is curious, especially given Bion's much-deserved reputation for erudition, and one must assume that he was very familiar with the entirety of Freud's work. It is as though he lost interest in Freud after the introduction of the structural theory (Freud 1923a). Bion, however, often spoke of the ego, found the idea of a superego useful, and furthered our understanding of the relationship between these two entities by promoting the notion of an *ego destructive superego* (Bion 1959, 1962). Nevertheless, Bion (1994) found the conception of the tripartite model of the mind to be incomplete and overly simple, "a crude but shrewd subdivision of the mind into various parts" (p. 286).

In my view, although Bion largely eschewed Freud's structural model, much of his major theoretical thinking may be considered the development of his own view of an aspect of the ego that is engaged in giving meaning to emotional experience. Bion produced a view of the functioning ego, without naming it as such, that dealt with many of the same theoretical and clinical matters that Freud and the ego psychological school addressed from their perspective (see, for example, the two quotations from Bion and Busch on *resistance* at the beginning of this article).

My main point is that what I will refer to as "Bion's ego psychology" leads to an appreciation of the intersubjective nature of psychic life, and also to a different view of structure. Furthermore, with regard to the clinical encounter, I contend that the so-called classical/relational split in psychoanalysis, which has been promulgated by both sides of this supposed divide, is a false dichotomy, and I assert that a consideration of Bion's two-person "ego psychology" is a conceptual tool with which to bridge that split.

Additionally, I offer the view that the traditional ego psychological emphasis on the analyst working on the psychic "surface" should be broadened to include the mental functioning of the analyst. I pre-

sent a clinical example in which the analysis of an adolescent is discussed from an enlarged view of the ego that combines ego psychological and Bionian viewpoints.

THE BIONIAN VIEW OF THE EGO

Bion was profoundly influenced by Freud's (1911) seminal paper, "Formulations on the Two Principles of Mental Functioning." Indeed, this paper is by far the most widely quoted work of Freud's in Bion's writings and, in my view, it is probably not excessive to state that *much of Bion's theoretical contribution may be seen as an elaboration of this paper.* Freud stated in "Two Principles" that the pleasure principle had to be supplemented by the reality principle because the "psychical apparatus had to decide to form a conception of the real circumstances in the external world" (p. 219), in order for it to survive. The establishment of the reality principle was a "momentous step" (p. 219) that placed new demands on the psychic apparatus for adaptation.

Freud also delineated the important role of *action,* which, under the aegis of the pleasure principle, "served as a means of unburdening the mental apparatus of accretions of stimuli" (p. 221). However, with the appearance of the reality principle, action was now to be more directed toward a goal in order to accomplish an "alteration of reality" (p. 221). *Thinking* developed as a means of restraining motor action by allowing the mental apparatus "to tolerate an increased tension of stimulus while the process of discharge was postponed . . . [and was] an experimental kind of acting" (p. 221).

Freud did not identify the force requiring that "the psychic apparatus had to decide to form" a relationship with reality that demanded these new maturations, but did give us a hint of this in a long footnote. He said that adaptive changes are necessary for survival, and then dropped a bit of a teaser when he noted that the supremacy of the pleasure principle is ended "when a child has achieved complete psychical detachment from its parents" (p. 220). This statement suggests an intimate connection between what happens in a baby's object relations and the growth of ego functions.

THE COMMENSAL RELATIONSHIP AND THE DYADIC EXPANSION OF CONSCIOUSNESS[1]

The association between the infant's early relationships and the growth of the ego is a vast area that has been explored extensively, and its scope is too broad to be reviewed here. However, *Bion's unique contribution to this territory is that the infant, in collaboration with its mother, comes to know reality, gives emotional meaning to its experiences, and learns from those experiences.* According to Bion, a specific function of the personality is responsible for comprehending emotional reality and giving affective meaning to perceptions, a function that develops in a unique choreography with an analogous function in the mother. He calls this *alpha function,* which "may be regarded as a structure" (1962, p. 26), and which deploys consciousness like a searchlight to "probe the environment" (Bion 1963, p. 19) and ascribe affective meaning to the objects detected in that probe.

In my opinion, Bion, without saying so, is in essence offering alpha function as a superordinate ego function responsible for ascribing emotional meaning to experience. Alpha function, therefore, is the mechanism underlying the reality principle, and also makes thinking possible. Bion (1962) described two kinds of basic thoughts, the first of which are *beta elements:* raw sense impressions and emotions that are "not so much memories as undigested facts" (1962, p. 7). Beta elements are concrete things-in-themselves that are "thought" about in a muscular way,[2] meaning that the mind expels these elements through projective identification.[3]

The second kind of thought described by Bion is necessary for the capacity for narrative and metaphor, with latent meaning that

[1] Bion described the mother–infant relationship as *commensal,* meaning that each depends on the other.

[2] This is similar to Freud's (1911) description of the role of action in primary process as "unburdening the mental apparatus" (p. 221).

[3] Projective identification is a mechanism akin to one Freud (1915) implied but never described in detail: his concept of the *purified pleasure ego,* which evacuates unpleasure to the environment.

may be accessed by reading between the lines, and that depends upon the existence of alpha function. The constituents of this kind of thinking are *alpha (α) elements*, which are beta (β) elements that have been transformed (mentalized) by α function. Though Bion does not make the direct connection, it seems to me that β elements are equivalent to the "accretions of stimuli" of which Freud stated the primitive psyche sought to unburden itself. It is important to emphasize here that both the primary process and secondary processes as described by Freud depend upon α function, since both operations require the presence of a symbolic capacity.

Freud (1911) saw the emergence of the reality principle as something forced on the mental apparatus by the demands of reality, and Bion agreed with this as a partial explanation for the development of thinking. However, *Bion's great innovation was to accord the mother and her α function a central role in the evolution of the infant's capacity to think, and therefore to learn from experience.* How does this happen? In "On Arrogance" (1958), Bion reported the case of a patient who found the analyst "stupid" because he could not understand that the patient's attacks were a form of communication. Then Bion realized that this patient needed to "put bad feelings in me and leave them there long enough for them *to be modified by their sojourn in my psyche*" (p. 92, italics added).

This finding represented a significant extension of Klein's (1946) view of projective identification as primarily an evacuative phenomenon, emphasizing instead its role as a communication designed to elicit a response (from the object) that "modifies" the projected emotions. In addition, Bion's use of the word *sojourn* implies that what is projected into the analyst remains there for a limited period before returning to its source. Thus, the analyst's mind (and the mind of the transferential mother) is elevated to a position of heretofore unappreciated importance in the development of the capacity for thinking.

Bion is here describing a communicative interplay between the minds of the infant and its mother that transforms unmanageable and concrete (β-element) experience by virtue of its "sojourn" in the

mind of the mother (Bion 1965). The receiving mother takes in the projection and subjects it to her *reverie,* which is defined as

> . . . that state of mind which is open to the reception of any "objects" from the loved object and is therefore capable of reception of the infant's projective identifications, whether they are felt by the infant to be good or bad. In short, reverie is a factor of the mother's alpha function. [Bion 1962, p. 36]

Interestingly, Bion calls what is projected into the mother the *contained*, denoted by the symbol ♂, while the receptive function of the mother is the *container*, which is represented by the symbol ♀ (Bion 1962). The container takes in the contained (β element), processes it through its reverie—which is a constituent of the mother's alpha function—and through that processing transforms the β element into an α element. Bion (1962) views the mother and infant who interact in this manner as a *thinking couple,* and the activity of this ♂♀ pair is introjected as the *apparatus for thinking* that is "part of the apparatus of alpha function" (1962, p. 91).

Bion considers this container/contained (♂♀) relationship *commensal* (1962, p. 91) in nature—i.e., the infant and its mother are dependent on one another—and also that both grow through the process by which meaning is made of experiences that were previously merely raw, sensory, and concrete things-in-themselves (Brown 1985). Thus, Bion's view of this inchoate thinking couple who are beginning to co-construct meaning is similar to what Tronick (2005) and Tronick et al. (1998) observe in the interaction of the states of consciousness (SOC) of the infant and mother,

> . . . in which the successful regulation of meaning leads to the emergence of a mutually induced dyadic state of meaning . . . [by which] new meanings are created, and these meanings are incorporated into the SOCs of both individuals. As a consequence, *the coherence and complexity of each individual's sense of the world increases,* a process I refer to as the dyadic expansion of consciousness model. [Tronick 2005, p. 294, italics added]

THOUGHTS WITHOUT A THINKER: MUTUALITY AND GROWTH IN THE CONTAINER/CONTAINED

Bion offers two models, one explicit and the other more implicit, for the development of the relationship between the container and the contained. The more explicit model, emphasized in his earlier writings (1958, 1962), is an *alimentary* one: that the infant evacuates an internal emotional experience into the mother, who "digests" through her α function what has been projected and gives it back to the baby in a more palatable state after its sojourn in her —not unlike a mother bird premasticating food for her newly hatched offspring. In my view, this is not a commensal model that leads to an increase in "the coherence and complexity of each individual's sense of the world," but instead emphasizes what the mother does for the infant.

In contrast to this alimentary model, Bion (1962, 1997, 2005) offers, largely in his later writings, a *sexual/pro-* or *co-creative* paradigm that is more implicit and is directly suggestive of an interaction between mother and baby, between container and contained, that results in the growth of both partners and the creation of new meaning. For example, in discussing the appearance of unbidden "wild thoughts," Bion (1997) argues that it is not important to be "aware of the genealogy of that particular thought" (p. 27), a statement that implies a lineage of thought from the interaction between analyst and patient. More to the point, Bion (2005) compares the germination of a child with the development of an idea in analysis: "It certainly is a collaboration between the two, and there is something fascinating about the analytic intercourse; between the two of them, they do seem to give birth to an idea" (p. 22).

I have long been interested in Bion's choice of the symbols of ♀ and ♂ to represent *container* and *contained,* since these are imbued with highly "saturated" meanings of femininity and masculin-

ity.[4] I suggest that he employed ♀ and ♂ because he intended (consciously or unconsciously) for the reader to consider the procreative dimension of the container/contained relationship, the "something fascinating about the analytic intercourse" that creates new ideas and meaning. Thus, the new structure of the ego he proposed, the apparatus for thinking (♀♂), was modeled upon a pro-/co-creative "analytic intercourse" that germinates, gestates, and gives birth to new ideas. Though he did not reference Klein's (1928, 1945) concepts of the "feeding" and "creative," internalized (oedipal) couple (Brown 2002), Bion's idea of the ♀♂ as the apparatus for thinking appears to be an elaboration of her description of the creative couple.

Mutuality, from the perspective of the creative mating of minds in analysis, involves the interplay between the internalized creative couple (the ♀♂, or apparatus for thinking) in both analysand and analyst. This interplay, therefore,

> . . . rests upon a capacity in both the patient and the analyst to affect, penetrate and influence the other alongside of the receptivity to being affected, penetrated, and influenced . . . made possible by the existence within the patient and analyst of a fantasy of an internalized couple engaged in a creative act of mutual cross fertilization. [Brown 2004, p. 49]

This act of shared creativity involves the patient inseminating the analyst's mind with an unprocessed emotional experience that the analyst transforms into a thought through reverie. One way of regarding this process is to consider the exchange as a "thought looking for a thinker" (Bion 1997)—that is, that the patient projects an unmentalized experience into the analyst with the expectation

[4] Bion used the term *saturated* to refer to psychoanalytic ideas that are imbued with such well-established meaning that the experiences to which these terms originally referred may be lost. Thus, he introduced symbols to denote some of his concepts in order to take a fresh look at phenomena unencumbered by a "penumbra of associations" (Bion 1962). The reader should take note that Ferro (2002, 2005) uses *saturated* to refer to interpretations that convey the analyst's pronouncements of meaning, as contrasted with open-ended or "unsaturated" statements that await the discovery of meaning.

that the analyst will "think" (transform) the thought for the patient and then return this newly minted and transformed thought back through observations, interpretations, etc. The analyst's comments, now planted in the patient's mind, stimulate the growth of new associations of the analyst's ideas, which subsequently evoke further elaborations in the analyst. Thus, analytic collaboration is also a cross-fertilization in which new meaning is mutually created by the interaction between the internalized container/contained (♀♂) of the analysand and the analyst.

SOME CLINICAL IMPLICATIONS

Bion (1970) called analysis a probe that expands the very area it is investigating, and Ferro (2005) contrasts this emphasis with the traditional analytic perspective on technique:

> Thus, the analyst presents him- or herself as a person capable of listening, understanding, grasping, and describing the emotions of the field and as a catalyst of further transformations—on the basis that there is not *an unconscious to be revealed*, but a capacity for thinking to be developed, and that the development of the capacity for thinking allows closer and closer contact with previously non-negotiable areas. [Ferro 2005, p. 102, italics in original]

While I agree with Ferro in principle, he appears to draw too great a contrast between "an unconscious to be revealed" and the development of "a capacity for thinking" that permits "closer and closer contact with previously non-negotiable areas." What are these "non-negotiable areas" if not the unconscious contents of the patient's mind?

I believe that Ferro (2002, 2005) is attempting to broaden our appreciation of the centrality of the analyst's mind (α function/reverie/♀♂/apparatus for thinking) as it works interactively with the patient's mind to give meaning to what has been "non-negotiable" or unconscious for the patient. He stresses the mutuality of this undertaking, as distinct from the classical analytic view in which the analyst sifts through the analysand's associations to

gather latent meaning from the patient's material, and then offers his view of how the patient's unconscious has been revealed.

It may be instructive at this point to consider how, in the classical tradition, the analyst comes to know what is in the patient's unconscious. Freud (1923b) advised us to listen to the patient's associations, drew our attention to the importance of repetitive actions (Freud 1914) and dreams (Freud 1900), and underscored the vital role of analyzing resistance (Freud 1926) as technical methods by which unconscious material may be detected. Freud (1912) also introduced what we might call today an *intersubjective strategy* when he stated that the analyst should use his unconscious as an instrument in the analysis, but he did not guide us as to how this is to be done (Brown 2004). He did say that "the *doctor's unconscious* is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that [the patient's] unconscious, which has determined the patient's free associations" (Freud 1912, p. 116, italics added).

Interestingly, Freud here is underscoring the *unconscious work* that is done by the analyst when he says that "the doctor's unconscious" is responsible for "reconstructing" the unconscious of the patient from the analysand's free associations. Freud (1923b) later appeared to emphasize the *conscious work* the analyst does when he stated that "the patient's associations emerged like allusions . . . [and that] it was only necessary for the physician . . . to guess the material which was concealed from the patient himself and to be able to communicate it to him" (p. 239).

Isakower (1957, 1963) further developed Freud's notion of the analyst using his unconscious by adumbrating the idea that the patient's free associations and the analyst's free-floating attention are two sides of the "analyzing instrument" coin. He wrote that there was a "near identity" (Isakower 1963, p. 207) between the ego states of the analysand and analyst while the analyzing instrument was in operation, a point that some of his followers have extended by describing the process of *mutual free association* (Lothane 1994; Spencer, Balter, and Lothane 1992).

I suggest that what is inherent in Freud's concept of the analyst using his unconscious as an instrument of the analysis, in Isa-

kower's notion of the analyzing instrument, and in Ferro's outlining "the development of the capacity for thinking" is the concept of an unconscious aspect of the ego capable of receiving unconscious (emotional) communication, processing that communication, giving meaning to it, and ultimately of communicating that meaning back to the sending unconscious. This is a mutual unconscious process that goes nearly unnoticed when good analytic work is "purring" along, and constitutes an unconscious streaming that flows back and forth between the linked ego structures of α function in analysand and analyst. By the time the analyst has become aware of an interpretation to give the patient, much unconscious work has already transpired.

This is the territory that has been so richly explored by Bion, who recommends that the analyst have faith in his unconscious (Bion 1967) to eventually bring spontaneous and unbidden thoughts to him that offer clues to the unconscious work occurring within him; thus, we should begin each session without memory and desire, and give ourselves over to what Freud (1912) called our "unconscious memory" (p. 112).

AN ILLUSTRATIVE CLINICAL VIGNETTE

Sally is an 18-year-old girl who has been in analysis for about one and a half years. Although exceptionally intelligent and without any noteworthy learning difficulties (as assessed in neuropsychological testing), she has significant problems in school because of intense anxiety experienced with peers. At the beginning of analysis, she frequently adopted a haughty attitude toward other adolescents, complaining about their stupidity and general intellectual inferiority. However, our analytic work helped her understand the defensive underpinnings of this posture, and we were able to link this stance to a chronic sense of inadequacy that she had felt in growing up with very high-achieving parents, who were exceedingly sparse in any form of encouragement. She once remarked that "the closest I ever came to a compliment was the absence of criticism."

This work was initially promising and led to the realization that Sally felt she had nothing to say to the friends whom she was now beginning to make. There was an empty quality to her interactions with them: she generally tried to tack herself onto conversations, adding little of her own thoughts and avoiding any confrontation. She wanted to fit in and simultaneously to remain anonymous. There was a paranoid quality to these interactions in that Sally often felt she was under the watchful scrutiny of others, and this theme soon emerged in the transference. She often apologized to me for being a few minutes late, or if she felt she was wriggling excessively in her chair, or did not have much to say.

Although she appeared visibly uncomfortable, Sally would say she did not feel much of anything when I commented on her appearing anxious. Her Mona Lisa smile conveyed a vague sense of being discomfited, and though she said she was quite at ease with me because I knew her, she was rather removed from her affects. We regularly spent long periods in silence during which she said she had no thoughts in her mind, yet she often complained of vague physical symptoms of muscle aches, and of difficulty sleeping. It was as though she were present through her emotional absence, an experience that engendered a "reverie deprivation" (Ogden 2004b), characterized in me by an odd sense of enfolded inner silence and a lack of associations to anything she said.

At the outset of analysis, the patient lived in a world in which her relationships tended to be experienced in gradients of tolerable sensory encounters. Her mother told me that Sally had been a thin-skinned infant and young child, easily overwhelmed by sensory stimuli and difficult to soothe. She could feel comfortable only in loose-fitting, soft, cotton clothing. She had few friends in childhood and always needed to be in control of activities during play dates. She was also exceptionally concerned with orderliness and appeared to erect a wall around herself, a barrier built from stony expressions of banal formalities and cemented by her prodigious intellect.

Sally's mother had initially contacted me when Sally was asked to leave school because of her failing grades, and I was among sev-

eral clinicians whom Sally "interviewed." The initial meeting was noteworthy for my sense of disconnection, though we managed to have a conversation about science fiction. Later, Sally said that she had wanted to work with me because she found me "bright," though it was not clear whether she meant I was intelligent or was perhaps referring to some sensory experience of light.

We began meeting on a twice-weekly basis, although I had suggested we get together "as often as possible." Sally typically did not have much to say of emotional significance, and I frequently felt as though I were speaking to someone who represented her—an acquaintance of hers perhaps, but someone who was remote from the actual Sally. I had difficulty tolerating the emotional flatness of being with her, of not being able to get through, until I realized that she needed me to be like the loosely fitting, cotton garments she had preferred as a child: soft to the touch, close, but not form fitting. I was reminded of some of Tustin's (1991) patients who were encased in "autistic shells," often highly intelligent individuals whose impressive IQs were used like moats surrounding thick castle redoubts.

But one day, Sally arrived in my office sobbing and hatefully criticizing herself for being stupid because she had just gotten a flat tire on her new car, which was now parked outside my office. She was helpless, fearful, and terrified in a rampaging affective storm about what to do. I suggested we go to her car together and see if we could find material in the owner's manual that could help. I located a roadside assistance card and called the number for her, telling Sally that next time she would know what to do. She was still very distraught, though somewhat calmed, and I offered her an appointment for the next day, which she gladly accepted. At that appointment, I again suggested we meet the following day, and in this way we started meeting four times a week.

Although I was aware of having been Sally's "roadside assistance" in this interaction, she was barely able to recall the exchange when I brought it up in subsequent sessions. Any suggestion, however gingerly given, that she might be keeping herself from uncomfortable feelings about relying on me was met with a blank re-

sponse, as though I were speaking a foreign language. And indeed I was conveying my thoughts in an unfamiliar tongue, since Sally was more preoccupied by sensory concerns, such as her difficulty sleeping. At night she was genuinely confused about whether she was sleeping or awake, and reported being up for forty-eight hours and then sleeping for thirty hours. She also said that she did not dream. I was reminded of Bion's (1962) comments about those patients with disturbed α function "who cannot dream, cannot go to sleep, and cannot wake up" (p. 7).

Some months later, during the winter, Sally spent several sessions berating the glare of the sun that poured into her apartment so intensely that she felt she needed to wear sunglasses indoors. She conveyed a sense of helplessness, as though the sun pursued her from room to room, relentlessly bombarding her with its blaze as it pierced through her window shades. I had difficulty grasping the meaning of this complaint since the days had been very cold—until the word *azimuth* suddenly came to mind, a word that was foreign to me but strangely familiar. As I thought about it, I recalled learning in a college science class that it denotes the arc the sun cuts across the sky, a path low on the horizon in winter. This permitted me to gain contact with the emotional meaning that the sun's unceasing glare held for Sally, and I was able to speak with her about the resultant sensory overload that she could scarcely filter out. My interpretation eased her anxiety, and she began to talk about her mother, who was "in my face and all over me." The meaning of her battle with the sun became more apparent, and I drew a connection with her experience of her mother invading her, but Sally could not comprehend what I was saying.

Needless to say, I felt encouraged on two accounts: first, that my capacity for reverie was coming alive, albeit with the lone word *azimuth* springing to mind; and, second, that Sally was able to make a link, however unconscious, between the persecutory sun and her experience of her mother. This was an important step away from a sensory world and toward the object world.

Our sessions in subsequent months showed further gains as Sally and I slowly evolved into a thinking couple with mutually en-

riching associations, though these periods of contact remained infrequent. One noteworthy hour began when Sally asked before sitting down if it was okay to put a little trash that she had in her hand into my wastebasket. I was surprised that she needed to ask since she had previously done so, and said that of course it was okay. She sat down and took the last sip of the iced coffee she had brought with her, reached into her bag, searched around, and pulled out a fresh bottle of water. Looking embarrassed, she said, "Sorry," smiled awkwardly, and said, "Hi" to indicate she had settled in and the session could begin.

I said she seemed particularly self-conscious today (a comment that felt off target as I said it). She said she was "fine." She stretched out one leg and then the other, something she generally did at the beginning of sessions, smiled again, and then lifted her hands as if to say, "So—I don't know what to talk about." She had just come from a visit to her dermatologist, who had applied a peel to her face (for her acne), and she described the process when I asked about it. I said her face looked smooth, and I became aware of how "comfortable" she seemed with this topic about which many adolescents feel very embarrassed. She then put on her light jacket, smiled, and said, "Sorry." I said that talking about this seemed to make her self-conscious, that perhaps she had to apologize for her skin as though it was something that needed to be covered up. (I felt my comment was "correct," but obvious, and it did not lead to any further thoughtful comments from her.)

Sally apologized again for something, and I said I often had the sense that she felt herself under constant inspection and needed to check out whether others were checking *her* out, perhaps to criticize her. (I chose to make a general comment that was not "saturated" [Ferro 2005] with transference references.) She said that she often felt inspected, though she was not sure for what, and not so much here with me as with her friends and her parents.

At this point, I remembered a trip to Russia a few years earlier in which I had visited an outdoor museum in Moscow that was like a graveyard for the discarded statues of the former Soviet Union. The visual image was of overgrown grass, an untended place next to a new, well-maintained indoor museum. The words *Big Brother* came

to mind, and I thought of saying something like "It feels like Big Brother is always watching you." However, I felt that comment would be hackneyed, like much of what I had been saying that felt "correct" but did not make real contact with the patient. I debated whether I should share my memory with her and decided to do so.

I said that, as she was talking, I remembered a trip to Russia I had taken, and that I thought my remembering it at this moment must have something to do with what she was telling me (her feeling of being inspected by friends and parents). As I related the memory to Sally, there was an immediately palpable sense of her relaxing, as though her mind and body had suddenly been loosened from some hold. She quickly said that my memory reminded her of a recent movie she had seen, *Good-Bye Lenin,* about a woman who had been in a coma while East Germany transformed into a non-Communist state. (I had also just seen this movie.) Sally explained that, due to a recent heart attack, the woman could not physically tolerate knowledge of the loss of her beloved Communist government, and so her family created a ruse to hide the shocking changes of a now-democratic but more disorderly society.

I commented that many people who had lived under the Soviet regime missed the strange kind of safety they felt when they knew everything they were doing was inspected and watched. Sally said she had read about that, that it kept people in line, and some could not handle the freedom of a democratic state. I felt at this point that we were "clicking," that real contact had been made.

The session was nearing its end, and I wondered aloud whether Sally's near-constant feeling of being inspected might be similar to what we had been discussing in regard to the Russian people: that although she was uncomfortable feeling inspected, some measure of safety might also be offered by being watched, and that was hard to give up. This comment interested her, and she said she would have to give it some thought.

DISCUSSION

Despite Sally's overall significant ego strengths, her capacity to process unrefined emotional experience was severely limited. Conse-

quently, she found it exceedingly difficult to understand the subtleties of interactions with peers, and resorted to tagging along in a nearly invisible style, as well as to the adoption of a haughty attitude to keep this limitation hidden. Making emotional contact caused great distress: Sally easily felt overwhelmed and her constant apologizing expressed her fear that this difficulty would be unmasked, thereby exposing her to intense criticism. Her α function—that aspect of her ego functioning that was capable of receiving normal, communicative projective identifications of emotional input, processing these affects into thoughts, and conveying the thoughts back to her peers—was quite limited.

When the patient's α function is limited, the analyst must lend his own to assist the patient in transforming emotional stimuli (converting β elements to α elements), as Ferro (2002, 2005) states. Thus, I emphasize a technique that assumes the ego is dyadically helped into existence, rather than presupposing it exists, is intact, and may be actively followed as well as pointed out to the patient (Busch 1999; Gray 1994). When the patient lacks substantial α function, or if this function is disturbed in the analyst, the analytic couple ceases to operate as a creative pair engaged in the construction of meaning.

The difficulties that followed from Sally's disturbed α function led to a situation in the transference in which there was a significant restriction in the capacity for our respective "states of consciousness" to engage in a "dyadic expansion of consciousness" (Tronick 2005; Tronick et al. 1998). Put in the language of Ogden (1994, 1997, 2004a), there was little development of an intersubjective analytic third, and I experienced a sort of reverie deprivation in its place. This deprivation was directly connected to my difficulty in understanding that the patient and I were at certain times speaking different languages: Sally, a sensory-oriented language, and I, a verbal one. In this regard, I was guilty of the same "stupidity" of which Bion (1958) was accused by his patient, not grasping that we were operating on different communicative levels.

However, when I was able to tune into the sensory channel through which Sally was contacting me in her account of the unrelenting winter sun, my α function picked up her signals and converted these to one condensed word: *azimuth*. This product of my

α function was simply a word—a dry and emotionally distant scientific term, at that—but it signaled a small shift in me that, when shared with Sally, triggered a commensal and analogous change in her. This exchange was surely a "dyadic expansion of consciousness," but clearly did not reach the level of the rich associative dialogue that we achieved in the session in which we discussed my reverie about Russia.

I began that session with the assumption that Sally was capable of interacting on a level of mutuality that was beyond her capacity. Thus, when I said that she seemed particularly self-conscious, she was truthful in saying she was "fine" because she was not registering any emotional distress, which is why I felt that my comment did not make contact with her. She told me about her visit to the dermatologist, then put on her jacket, which I—again mistakenly—interpreted as expressing shame against which I thought she was defending. My interpretation presupposed that she possessed in that moment a proficient α function. It is more likely that I missed the real meaning of her communication, which had more to do with the sensory experience of a doctor who helped soothe her irritated skin. Sally probably needed the loose-fitting, soft, cotton me, rather than the interpretative me who offered a transference comment too direct for her to manage. Thus, I instead expressed an unsaturated, general observation about feeling inspected that appeared to trigger the start of an unconscious process of our thinking together, which resulted in the feeling that we were "clicking."

As mentioned, while Sally continued to elaborate on her feeling of being inspected, I had a reverie about a graveyard for the icons of the former Soviet Union. The words *Big Brother* came to my mind, but expressing them felt too formulaic, and I was concerned about cutting short what appeared to be a rare moment of mutual engagement. I debated about sharing my reverie, then decided to do so, and put it in the context of my mind's reaction to what she was saying.[5] Telling the patient my reverie had the very positive effect

[5] This is a technique that I frequently use with adolescents in whom there is a fear of knowing about and expressing what is inside. It is aimed at increasing receptivity to thoughts that are otherwise troubling. In addition, particularly with those whose α function is disturbed, I find sharing my reveries as contextualized in

of furthering our engagement as a thinking couple whose respective associations mutually enriched each other.

In addition, this reverie-based response constituted an analyst-centered interpretation (Steiner 1993) that helped diminish the patient's paranoid anxieties and lessen her sense of being watched by me. Sally quickly experienced a physical and psychological easing; she immediately thought of the movie *Good-Bye Lenin* and told me about the woman who had been in a coma and who, once awake, could not bear too much reality. I thought this association was a commentary on Sally's own often comatose state in which she was present through her absence, and that she was frightened of leaving the old emotionally blunted state too quickly. Staying with her elaboration of my reverie, but now informed by her unconscious about the nature of her fear, I added that some people missed the sense of security that the erstwhile Soviet empire afforded through watchfulness over its citizenry. We were now in a commensal frame of mind in which we could elaborate on each other's associations, achieving a dyadic expansion of consciousness (Tronick 2005; Tronick et al. 1998) that was creating meaning *in statu nascendi.*

Sally's association about the woman in a coma who could not tolerate the reality of major political changes alerted me, in a stark manner, to the very real limitations she experienced in her ability to manage powerful affects. Put in the language of one branch of ego psychology (Busch 1995, 1999; Gray 1994; Paniagua 1991), her defenses were fragile and required her analyst not to put undue strain on them. Paniagua (1991) recommends staying on the "workable surface," which Busch (1999) describes as "that combination of the patient's thoughts, feelings, and actions, and the analyst's reaction to these, *that is usable by the patient's ego*" (p. 62, italics added).

While I agree with this perspective, in general, it leaves out the ways in which the psyches of the analyst and the patient interact in a collaborative way to generate meanings *on an unconscious basis*—

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their communications offers an approach to thinking with which they may identify. After all, the α function is the apparatus for thinking (♀♂) that is the introjection of the thinking couple.

meanings that the analyst slowly becomes aware of and that allow him to make interventions that are "usable by the patient's ego." By primarily paying attention to the conscious ego, the ego psychological approach eschews discussion of the unconscious activity of the ego, except for its initiation of defenses in response to signal anxiety (Freud 1926).[6] In this regard, "Bion's ego psychology," which addresses the unconscious ego activity of the linked (ego) α functions of analysand and analyst, seems an important counterbalance to the point of view that largely emphasizes the conscious ego in staying with the workable surface.

In the session that dealt with Sally's sense of being pursued by the sun, there was only surface—one of sensory overload, and no depth with which or from which to work. I suggest that the appearance of a workable surface depends on the existence of an unconscious stream of communication between analyst and patient. Without such a connection, the two are not an analytic couple, but are rather like a duo of meandering states of consciousness, incapable of together creating a meaning that would register on the surface as something to be worked with. Stated another way, *there can be no workable surface if there is not some commensurate unconscious work being done.* Something shifted, almost imperceptibly, when my α function picked up a signal from Sally and transformed it into the word *azimuth.* Depth had suddenly emerged, and with it a surface on which to work—like a lily pad that appears to float on water, its roots extending unseen to the floor of the pond.

In the subsequent session that addressed my Moscow reverie, by contrast, there was greater emotional substance both on the workable surface and in the breadth of the unconscious interplay

[6] Busch (2006) discussed what he terms *defense enactments,* in which the analysand engenders a reaction in the analyst that is "an unconscious response to the patient's feeling of danger . . . [and a] role-responsiveness to the patient's defensive position" (p. 68), which leads the analyst to collude with the analysand's avoidance of painful affects. While this is a welcome expansion of Gray's rejection of the usefulness of countertransference (Phillips 2006), I am focusing on the uniquely collaborative way in which the unconscious of the analyst and the unconscious of the patient create emotional meaning together, a way that is different from the analyst's unconscious resonance with a role evoked by the patient in the service of resistance.

between Sally's and my α functions. There was a definite movement from talk filled with seeming non sequiturs to a meaningful development of emotional exchange, to which we both contributed consciously as well as unconsciously.

It could be said from a traditional ego psychological point of view that this change was effected by my shifting to deal with Sally in displacement, thereby allowing her to feel more at ease in collaborating with me. I do not disagree, in principle; however, there is more to this picture than displacement. I had to override my feeling of impatience with Sally's tendency to speak about quotidian details and wait until either she or I were able to bring something of emotional significance from the depths to the workable surface. Discussion about putting her trash in my wastebasket, acknowledgment of her iced coffee and comments about replacing it with water, her stretching out her legs, etc.—while possibly being displacements—were, on another level, a kind of gathering together of day residues to be woven into a dream. Ogden (2007) described a certain kind of talk between patient and analyst that

> . . . may at first seem "unanalytic" because the patient and analyst are talking about such things as books, poems, films, rules of grammar, etymology, the speed of light, the taste of chocolate, and so on. Despite appearances, it has been my experience that such "unanalytic" talk often allows a patient and analyst who have been unable to dream together [i.e., their α functions have not been "clicking"] to begin to be able to do so. [p. 575]

It was from this "unanalytic" work that Sally and I were able to begin to dream together, a dreaming of the kind that promotes the enrichment of both conscious and unconscious life, as well as the interchange between them.[7] From the perspective of the conscious ego, my intervention about Sally's covering herself up led to her

[7] Bion (1962) believed that dreaming—that is, transformations of raw emotion by α function—performs an essential task in differentiating the conscious from the unconscious. A boundary is created between these two domains called the *contact barrier,* a permeable membrane that permits a constant dialogue between the conscious and unconscious. This differs from Freud's emphasis on a strict separation of the two.

apologizing, which registered consciously with me that I had put her on the defensive by making her feel inspected. I realized that I had been assuming she was operating on a less than symbolic level, and therefore I shifted my focus to a general, unsaturated observation about her feeling under inspection by others. This statement stayed on the workable surface of what Sally's ego could tolerate and permitted her some increased flexibility to speak more openly about how she often felt inspected by others (perhaps also gratifying the wish to be watched over; see above).

On the other hand, from the standpoint of the unconscious ego, there was significant "unconscious work" (Ogden 2004b) occurring within the patient, within me, and between our communicating α functions that collaboratively generated a deeper understanding of the meaning of Sally's adherence to feeling inspected. My reverie about the outdoor museum in Moscow appeared unbidden (Bion 1997) and was the product of my unconscious ego (α function) at work, elaborating pictorially the idea of being watched. On reflection—though I was not aware of it at the time—I think this particular memory also expressed my unconscious wish for Sally to overthrow the symbols of oppression under whose watchful gaze she lived. My sharing this reverie led to her immediate relaxing, and her unconscious ego went to work to offer mine a response and a rebuttal. In effect, her association to the woman in a coma said, "Wait a minute, not so fast; I'm not sure I want to be iconoclastic because it frightens me."

The patient's reply permitted me to become consciously aware of the nature of her anxiety, which I could then interpret to her in a manner that was now usable by her conscious ego. Thus, the unconscious work Sally and I were able to do together gave me sufficient conscious knowledge of her specific anxiety to enable me to address her conscious ego.

What I am calling "Bion's ego psychology" allows for the coexistence of both an intrapsychic and interpersonal point of view, without necessity to opt for one approach over the other.[8] There

[8] Grotstein (1997, 2000), writing from a Bionian perspective, raises the legitimate concern that the increased emphasis on a two-person model may neglect

is a tendency in the ego psychological literature (as put forth by Busch, Gray, Paniagua, and others) to favor the intrapsychic over the interactional, and an analogous bias in the American relational school that deemphasizes the role of the intrapsychic (Spillius 2004). Pray (2002) identified what he calls the "classical/relational split," and states that in the ego psychological school, "the emphasis is on camouflaged, unconscious intrapsychic conflict, not on current interpersonal realities" (p. 252). Busch (1999) praised the important ways in which the relational schools have raised our awareness of the actual interactions between patient and analyst, but decried a leaning in this perspective "toward a treatment structure focused on the analysand's needing to grapple with the analyst's personality and associations" (p. 95).

I see this as a false distinction that denies the connection between the intrapsychic and the interpersonal. Indeed, there has long been a trend, evidenced in other American analysts who have called themselves ego psychologists, writing in the 1940s and '50s, who did not advocate a "classical/relational split," and instead viewed the psyches of patient and analyst as interacting together. These analysts (Fliess 1942; Isakower 1957, 1963; Reik 1948—to name a few) extended Freud's concept of the analyzing instrument in important and creative ways; however, my impression is that their writings were often dismissed as throwbacks to Freud's topographical model, lagging developmentally (Gray 1994) by not paying sufficient attention to structural issues or to Freud's (1926) second theory of anxiety. In addition, their work was criticized as excessively based in countertransference (Spencer, Balter, and Lothane 1992); this is an interesting critique that still gains traction, as evidenced by Busch's (1999) comments about the American relational school.

Chodorow (2004) identified another trend that falls under the umbrella of ego psychology, which she termed *intersubjective ego psychology*. This movement combines aspects of traditional ego

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the significance of a one-person point of view, partly because the former model "suggests that psychic reality owes its origin to actual events in the individual's life . . . [that could] eclipse the concept of unconscious psychic determinism" (2000, p. 42).

psychology with the contributions of Erikson and Loewald. Chodorow quoted a relevant passage from Loewald:

> The analyst in his interpretations reorganizes, reintegrates unconscious material for himself as well as for the patient, since he has to be attuned to the patient's unconscious, using, as we say, his own unconscious as a tool, in order to arrive at the organizing interpretation. [Loewald 1960, p. 241]

These intersubjective ego psychologists have offered creative extensions of some traditional concepts. For example, Poland (1992) —as though in counterpoint to the diligent attention to the psychic surface of Gray and others—argues that excessive focus on the psychic surface is itself a holdover from the topographical theory in its dismissal of the analytic space generated by the effects of the minds of analyst and analysand upon each other. Smith (1999) also argues against those analysts (e.g., Renik 1993) who advocate a radical revision of certain basic technical approaches, such as neutrality and abstinence, and encourages us to consider technique as "shaped to a large extent by the personal character of the analyst and by the practical exigencies of the analytic situation, including . . . the intersubjective field" (p. 467).

My purpose here is not to evaluate the traditional and "intersubjective" ego psychological schools, but to compare them with what I refer to as Bion's ego psychology. The Kleinian perspective (Feldman 1997; Money-Kyrle 1956), in which Bion is rooted by virtue of Klein's (1946) discovery of projective identification, has long considered that the patient's intrapsychic universe is played out in the transference-countertransference dynamic (Brown 1996), and, in this regard, it has considerable overlap with the intersubjective ego psychology adumbrated by Chodorow (and others of this "school").

Bion's contributions, especially in *Learning from Experience* (1962) and *Transformations* (1965), extend both the traditional and intersubjective ego psychologies by emphasizing not just the impact of the patient upon the analyst's mind, but how that impact upon the analyst's mind represents the search for another mind to

transform/dream what the patient cannot manage. It is a *procreative* endeavor that creates new meaning—like a child born to two parents, an offspring that owes its lineage to both, yet is simultaneously its own agency (Ogden's [1994] intersubjective analytic third is relevant here). Furthermore, what I miss in the writing of the so-called intersubjective ego psychologists is a discussion of the ego per se as a functioning structure, given that these authors tend to focus on character rather than structure. Bion's ego psychology, by contrast, minutely delineates the working of α function in the context of an intersubjective matrix.

From a Bionian point of view, the analyst "rents himself out" (Grotstein 2004a) to the patient as a kind of processing agent to help the analysand manage emotional truth (Grotstein 2004b)[9]; however, "in practice, it is much more difficult because one does not know whether the patient is strong enough to hear the truth" (Bion 1994, p. 179). Where Bion's ego psychology differs from both the traditional and intersubjective ego psychologies is in its emphasis on the analyst's role—through the unconscious operation of his α function with that of the analysand—as a partner in pursuing emotional truth, requiring "a capacity to tolerate the stresses associated with the introjection of another person's projective identifications" (Bion 1958, p. 88).

In this regard, the patient must always "grapple with the analyst's personality and associations," but the object is not to burden the analysand with the analyst's private reactions. The patient needs an analyst who can introject the analysand's projective identifications, tolerate the transference (Mitrani 2001), and transform what has been projected (Bion 1965)—all of which is accomplished through the unconscious work of the analyst's reverie and α function independent of, and in conjunction with, that of the analysand. Thus, the intrapsychic and the interpersonal are inextricably knitted together, which results in evolution and transformation in both partners: there is a constant elaboration of the analytic partnership, com-

[9] Green (2000) takes a similar view in stating that "the essence of the situation at the heart of the analytic exchange is to *accomplish the return to oneself by means of a detour via the other*" (p. 13, italics in original).

mensal growth in the container and contained, and a dyadic expansion of consciousness. It has been said that every analysis is a reanalysis.

CONCLUSION

This paper has explored how Bion's major theoretical writings may be seen to represent the development of his view of a central aspect of the ego's functioning. Though he did not generally subscribe to the tripartite model of the mind, in my opinion, his elaboration of the ego's relationship to reality represented an expansion of ideas inchoate in Freud's "Formulations on the Two Principles of Mental Functioning" (1911), from which Freud was later to craft the structural theory.

In postulating α function, Bion introduced an intersubjective dimension to our understanding of how the ego makes meaning of emotional events, because α function represents the internalization of the mother–infant couple's creation of meaning together through a process best described by Tronick (2005) and Tronick et al. (1998) as the *dyadic expansion of consciousness.* This leads to a deeper understanding of the unconscious exchange between analyst and patient in what Freud (1912) described as the analyst's use of his unconscious as an instrument of the analysis. Thus, there is a constant, unconscious, interactional process between the linked α functions of the analysand and the analyst, by which meaning is constantly being created and expanded. When treatment is going well, this results in the mutual growth of the container/contained (♀♂).

"Bion's ego psychology" has been compared to various other branches of ego psychology, and it is important to take into account all perspectives in psychoanalytic work. The analyst's attention to what is on the workable surface of the clinical hour is greatly enhanced by his gaining access, through attention to his reveries, to the parallel undercurrent of unconscious work in which the analytic couple are simultaneously engaged. Thus, there is considerable clinical utility to expanding the notion of the workable surface to include the mental functioning of the analyst.

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A NEW VIEW FROM THE ACROPOLIS: DISSOCIATIVE IDENTITY DISORDER

BY IRA BRENNER

The author reviews psychoanalytic viewpoints on dissociation and dissociative identity disorder (DID), the controversial condition previously known as multiple personality. He expands his own contributions to the literature over the last fifteen years, incorporating the burgeoning data from research on disturbances of attachment as precursors to dissociation. Utilizing clinical material, he then contrasts DID with trauma and dissociation in adulthood as well as with schizophrenia. He contends that the complexity and myriad manifestations of this condition warrant deeper psychoanalytic exploration to help elucidate not only its true nature, but also to further our understanding of all psychopathology.

> Depersonalization leads us on to the extraordinary condition of "double conscience" which is more correctly described as "split personality." But all of this is so obscure and been so little mastered scientifically that I must refrain from talking about it any more to you.
>
> —Freud 1936, p. 245

> If the shocks increase in number during the development of the child, the number and the vari-

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> ous kinds of splits in the personality increase too, and soon it becomes extremely difficult to maintain contact without confusion with all the fragments, each of which behaves as a separate personality yet does not know of even the existence of the others . . . . I hope even here to be able to find threads that can link up the various parts.
>
> —Ferenczi 1933, p. 165

INTRODUCTION

Freud's last words on the subject of "split personality," written while reflecting upon his visit to the Acropolis, left much doubt about it and its place in psychoanalysis (Freud 1936). Part of Freud's uncertainty related, perhaps, to his alienation from Ferenczi (Rachman 1997) and his devaluation of his later work with the dissociated mind (Ferenczi 1933), which contemporary thinkers now find remarkably prescient (Blum 1994; I. Brenner 2004a).

Even though Freud was originally very interested in dreamlike, hypnoid states and in hysteria and sexual trauma before his break with Breuer, he never realized his goal of uniting dream psychology with psychopathology (Freud 1900, 1917). After developing his ideas about repression, the structural theory, and then ego psychology, he was unable to unify all the earlier concepts. Freud's unfinished work, coupled with the fact that diagnosis in American psychiatry is essentially based on symptoms and not dynamics, has left psychoanalysts with a gap in the deeper understanding of those entities characterized by dreamlike, altered states, such as the realm of what are now referred to as *dissociative disorders.* Dissociative identity disorder, or DID, is probably the most controversial and misunderstood condition in the history of psychology, prompting some researchers to conclude over sixty years ago that there were two types of believers: the naive and those with actual experience with such patients (Taylor and Martin 1944).

The DSM-IV-TR describes the diagnostic criteria for DID as follows:

(a) The presence of two or more distinct entities or personality states (each with its own relatively enduring pattern

of perceiving, relating to, and thinking about the environment itself);

(b) At least two of these entities or personality states recurrently taking control of the person's behavior;

(c) Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness; and

(d) The disturbance is not due to direct physiological effects of a substance . . . or general medical condition. [American Psychiatric Association 2000, pp. 240-241]

In contrast to DSM-IV-TR, which categorizes this entity as an "Axis I" major psychiatric illness, the more recently published *Psychodynamic Diagnostic Manual* (Psychodynamic Diagnostic Manual Task Force 2006) considers it a *dissociative personality,* and thereby promotes the idea of a spectrum of severity of character pathology. This viewpoint is congruent with, but slightly different from, my own clinical understanding of DID, which is equated with the *lower-level dissociative character* (I. Brenner 1994) and will be discussed later in this paper.

Although there is growing recognition of the value of such a characterological formulation from a psychoanalytic perspective, this does not represent the prevailing psychiatric attitude, and is perhaps the latest source of many confusions to enshrouding this condition since it was first recognized. Reflecting this historical confusion, the disorder has been known by an extensive list of names, such as *split personality, Gmelin's syndrome, exchanged personality, multiplex personality, double existences, double conscience, dual consciousness, dual personality, double personality, plural personality, dissociated personality, alternating personality, multiple personality, multiple personality disorder,* and now *dissociative identity disorder* (Ellenberger 1970; Greaves 1993). The current nomenclature conveys the idea that the underlying problem is not that there are too many personalities or identities, but not enough of one. It also emphasizes the importance of dissociation, a concept that itself has long had a troubled history among psychoanalysts.

Adding further to this identity crisis was Bleuler's coining of the term *schizophrenia,* or split mind, which he applied to the condition originally described by Kraeplin as dementia praecox. Indeed, after the introduction of the term *schizophrenia,* the number of published case reports of multiple personality significantly declined, leading Rosenbaum (1980) to conclude that much diagnostic confusion must have ensued. He has even suggested that some of the highly proclaimed psychotherapeutic "cures of schizophrenia" may have actually occurred with misdiagnosed cases of severe dissociative psychopathology.

There is no doubt that in DID, the presence of depersonalization, derealization, emotional withdrawal, bizarre conversion symptoms, auditory hallucinations, and other Schneiderian first-rank symptoms of schizophrenia (Kluft 1987) further muddies the waters. It has been reported that it often takes up to eight years of mental health treatment before DID can be definitively recognized (Coons, Bowman, and Milstein 1988). Furthermore, it has been noted that there is a great potential for secondary gain in disowning one's behavior and attributing it to a separate personality, especially when criminal behavior and legal charges are involved (Orne, Dinges, and Orne 1984).

It must also be noted that it has long been suspected that iatrogenic influences through hypnosis or other interventions are the cause of such fragmentation in the creation of multiple personality (James 1890; McDougall 1926). Indeed, suggestibility and compliance with authority may affect the nature and presentation of such symptoms, as described by critics of Charcot's dramatic demonstrations (Ellenberger 1970). However, there has not been one documented case of manufactured DID, *de novo,* reported in the literature, although it has been claimed that it could be fabricated for the purpose of carrying out top-secret military operations (Estabrooks 1945).

It is no wonder that many clinicians today still question the existence, validity, and pathogenesis of DID. Therefore, the question is raised of whether it is a hoax, or a missing link between dream psychology and psychopathology, or a clinical Rosetta Stone

that may "reveal an alphabet and a language, and, when they are deciphered and translated, yield undreamed-of information . . . *saxa loquuntur* (stones talk!)" (Freud 1896, p. 192). Thus, the ghost of Anna O.—Breuer's legendary case of hysteria, clearly described in the original work (Breuer and Freud 1893-1895) and later confirmed in Freud's biography by Jones (1953) as a case of multiple personality—has continued to lurk in the shadows of psychoanalysis ever since.

EARLY PSYCHOANALYTIC VIEWS

Attempts to understand the pathogenesis of this entity have led writers to consider a range of possibilities. Since its incidence is correlated very highly with severe, early, sustained trauma, i.e., potentially life-threatening circumstances including physical and sexual abuse (Kluft 1984; Putnam 1989; C. Ross 1989; D. R. Ross and Loewenstein 1992), the role of psychic trauma in dissociative identity disorder is generally accepted by those who are open to the validity of the diagnosis. Janet's (1889) theory of *disaggregation,* or dissociation, posited a split in the psyche of traumatized people with a constitutional susceptibility, a passive disintegration of the mind resulting in the development of autonomous components that could be disowned and treated by hypnosis. This spatial model is very appealing and has not only persisted, but has also greatly increased in popularity in recent decades, owing to the resurgence of interest in dissociative psychopathology. Jung (1902) also subscribed to a split-psyche model in which so-called personified autonomous complexes exist.

Freud himself continuously grappled with a split in the psyche model from his early work with Breuer (Breuer and Freud 1893-1895) and the "splitting of consciousness" and hysteria, to dissociation and perversion (Freud 1923), as well as neurosis (Freud 1940a) and psychosis (Freud 1940b) in his last writings. Although he accurately recognized an active, defensive, unconscious process that was operative in the service of warding off anxiety—in contradistinction to Janet's passive, organic model—Freud's theory of re-

pression could not explain all the data. For example, his method of free association, which was intended to replace hypnosis and extend to all the various areas of the mind, did not fully take into consideration the phenomenon of spontaneous self-hypnosis that he himself recognized could occur in very suggestible people (Freud 1891). This defensive style, in fact, is quite resistant to classical analytic intervention as such. Writers such as Fleiss (1953) subsequently described hypnotic "evasion," while Dickes (1965) redefined the hypnoid state as "protecting the ego against unacceptable instinctual demands" (pp. 400-401), and Shengold (1989) considered both "hypnotic facilitation" and "hypnotic vigilance" in the autohypnotic defense (p. 143). Even Anna Freud (1954) recognized that a patient could ward off sexual anxiety through a trancelike sleep. However, as Glover (1943) pointed out, the term *dissociation* has a "chequered history" (p. 12) in psychoanalysis, and so, while such phenomena have been described in the literature, few writers have dared to reintroduce this term until recently.

As noted above, the original theory of a split in the psyche has been so appealing and versatile that it has evolved and been invoked to formulate many types of psychopathology, including multiple personality or dissociative identity disorder (I. Brenner 1994, 1996b, 2009). However, there are limitations to its explanatory value. Freud's (1923) theory that different identifications could take over consciousness at any given time was very important but insufficient. This theory relied upon repression, but did not take into consideration autohypnosis or trauma. Indeed, Jones's (1953) affirmation of Anna O. as a case of double personality suggested there was much more to be understood about her psychopathology than Freud could have explained at the time. And although Ferenczi's (1933) ideas about early sexual trauma were linked to the child's automaton-like states and her enslavement to the parent, he did not apply his formulation to this famous case.

LATER PSYCHOANALYTIC VIEWS

Fairbairn (1952) viewed the structure of multiple personality as simply another model of the mind, analogous to Freud's tripartite

model, noting the importance of layering and fusion of internal objects, which varied in complexity in each individual. Glover (1943) described early, unintegrated ego nuclei as precursors to dissociation, while Federn (1952) hypothesized the reactivation of various repressed ego states. In their pioneering efforts to integrate clinical experience with theory, Watkins and Watkins (1979-1980, 1997) elaborated upon Federn's ego states, conceptualizing a continuum of mental dividedness, from an adaptive, normative differentiation to a maladaptive, pathological end characterized by dissociation and, ultimately, dissociative identity disorder.

Having done extensive research on hysteria, Abse (1974, 1983) maintained that both splitting of the ego and altered states of consciousness were necessary to explain the dissociation essential to DID. He recognized that this defensive constellation sacrificed repression and a clear, continuous consciousness, which, because of the amnestic, dissociated "personalities," reflected identity diffusion as well (Akhtar 1992).

In his review of the subject, Berman (1981), too, emphasized the importance of splitting, citing seriously disturbed mother–daughter relationships, followed by the loss of a compensatory, overly intense, eroticized, oedipal relationship with the father. Consequently, the separate "personalities" became the crystallization of "part object representations which evolve into split self representations" (p. 298). A developmental arrest (Laskey 1978), as well as psychotic features, may also be seen in such a fragmented self, as in Kernberg's (1973) continuum of dissociative psychopathology. Here psychosis with poor differentiation of self and object lies at one end of the spectrum, while hysterical dissociation, mutual amnesia of two personalities, and repression are located at the other end. Such a continuum of psychosis is an important idea (I. Brenner 2004b) to which I will return later in this paper.

Dissociative identity disorder has also been considered a subtype of borderline personality (Buck 1983; Clarey, Burstin, and Carpenter 1984) or a variant of a narcissistic character (Greaves 1980; Gruenwald 1977), the latter of which invoked Kohut's (1971) updated version of Erickson and Kubie's (1939) vertical split, while Marmer

(1980) considered DID a type of transitional object. Kluft (1984) viewed it as a post-traumatic disorder of childhood secondary to overwhelming experience, especially sexual abuse, contingent upon proneness to dissociation and the child's propensity for mental dividedness, depending upon the level of development at the time of trauma.

Arlow (1992) elaborated upon Freud's idea and explained DID on the basis of "alternating conscious representations of highly organized fantasy systems, each of which coalesces into a particular idiosyncratic entity . . . . [They] are not compatible with each other and . . . can dramatize internal conflicts" (p. 75). Especially significant here is Arlow's recognition that "altered ego states . . . may be incorporated, in part, into the *character structure* of the individual" (p. 75, italics added).

I hypothesize that a pathodevelopmental line may exist from the earliest sleep/wakefulness cycle, to altered states in disturbances of attachment, to aberrations in the repression barrier, to the reliance on dissociation as the central defense in DID. Such a consideration allows for the incorporation of more recent findings from child psychoanalysis into my clinical experience with adults (I. Brenner 1994, 2001, 2004a). I find this hypothesis useful since, despite the comprehensiveness of the other theories discussed above, they do not fully integrate the nature of dissociation and its developmental significance.

DISTURBED ATTACHMENT AND DISSOCIATION

It is now recognized that the earliest infant–mother relationship has implications for the development of dissociative symptoms and defenses. Following the discovery of disorganized attachment patterns (Main and Solomon 1990) and their correlation with behavioral problems in latency-aged children (Main 1993), Bowlby's (1969) controversial notion of a preadapted behavior system that maintains a feeling of security has been rehabilitated and incorporated by developmental researchers. Signs of disorganized, disoriented

infant attachment behavior include simultaneous or sequential contradictory actions, such as efforts at contact and avoidance, freezing or confused activity, stumbling, wandering, postural evidence of fear of the parent, and rapid fluctuations of affect.

Mistreatment of infants is highly correlated with disorganized patterns that are associated with fear and stress responses involving the hypothalamic-pituitary-adrenal (HPA) axis, which can create lifelong patterns of neurobiological activity. Primate research (Coplan et al. 1996; Kraemer 1992) suggests that this system is subject to early influences that may result in "stress inoculation" or exaggerated arousal responses. Attempts to replicate this data in humans are underway, though much more work needs to be done (DeBellis 2001; Spangler and Grossman 1993). Clinical research has clearly delineated, however, the development of the dynamics of fear in infants during the first year of life (Main 1993) by observing alterations in attention and affect in response to attachment cues.

As a two-person model of conflict, symptom, and defense, such early attachment patterns underlie the "unthought known" (Bollas 1987), i.e., implicit enactive behavior preceding symbolization and explicit memory (Lyons-Ruth 1999; D. Stern et al. 1998). One could therefore conceptualize steps along a pathodevelopmental line, to include disorganized attachment leading to the internalized dialogue as a defense, to dissociation.[1] Taking into consideration Pine's (1992) caveat about not drawing too direct a correlation between infant observation and adult psychic structure, we nevertheless find considerable research linking dissociation to early experience. Main and Hesse (1990) hypothesize that unresolved fear in the parent is transmitted through behavior that conveys that fear, or through other behavior frightening to the infant; this can have long-term implications (Jacobovitz, Hazen, and Riggs 1997; Lyons-Ruth, Bronfman, and Parsons 1999; Schwengel, Bakermans-Kronenberg, and Van Ijzendoorn 1999).

[1] It is important to note here that Winnicott (1960a, 1960b) considered the earliest changes in mental state to be from sleep to wakefulness. He also viewed the all-important twilight state in between, which can be so variable in infants (Weil 1970), as the origin of dissociation.

Lyons-Ruth (2003) compiled an array of disturbed parental communication, to include (1) physical or verbal withdrawal; (2) negative-intrusive behavior, such as teasing or pulling on the infant; (3) confused role behavior, such as seeking reassurance from the infant instead of vice versa and using sexualized, inappropriate tones of speech; (4) disoriented responses, such as becoming dazed, confused, or disorganized by the infant; and (5) affective miscues, such as giving contradictory messages or failing to respond to an infant in distress. Infant disorganization was highly correlated with maternal behavior characterized as frightening, hostile, and withdrawing. Infants of such mothers had elevated cortisol levels in response to mild stressors, increased hostile tendencies in early school years, excessive controlling attachment behaviors by six years of age, and chaotic or inhibited use of fantasy and play during preschool (Lyons-Ruth and Jacobovitz 1999). Not only was a history of maternal trauma associated with disturbed parenting behaviors as seen during interviews using the Adult Attachment Interview; these mothers also often demonstrated evidence of unintegrated mental processes of their own (Lyons-Ruth and Jacobovitz 1999; Main 1993).

Stimulated by Liotti's (1992) observation of similarities between dissociated mental contents and the way in which disorganized infants behave, other researchers have paid attention to attachment disturbance. For example, a longitudinal study of subjects from infancy to nineteen years of age (Ogawa et al. 1997) correlated disorganized attachment with the development of dissociative symptoms —a correlation enhanced by intercurrent trauma. Interestingly, communication errors, role confusion, and sexualized communication by the mother seemed to be more highly correlated than was frankly hostile or disoriented behavior. Genetic or constitutional factors, such as the proclivity to be hypnotizable (Frischholz et al. 1992), was acknowledged but not considered in this research.

These findings suggest that early interactional or dyadic processes underlie the pathogenesis of dissociative phenomena, leading one to conclude that clinical treatment fostering collaboration and healthy dialogue facilitates an integrated experience for the patient. For example, Bach (2001) described the importance of the

maternal caretaker in providing the infant with an ongoing, relational, intimate experience that enables a continuous sense of self to be experienced. "Knowing and not knowing" (Laub and Auerhahn 1993) probably begins with a disturbed dissociogenic mother's need not to know about herself—which hinders her ability to know her infant, who then cannot fully know who she is. Whitmer's (2001) ideas about dissociation are consistent with these views, as he maintains that one cannot find meaning in one's experience until it is recognized by the other.

Clinicians familiar with severe dissociative pathology regularly observe that adult patients of this type often have excessive and extensive amnesia not only for their early childhood years, but also for events in latency and adolescence, often leaving them with disturbing gaps in memory of continuous self experience. These "holes" in the memory may be embarrassing, and may be minimized or covered over by confabulation or reports of alcohol or drug abuse, which only exacerbate the problem. Once in treatment, it may be revealed that an unusually dense "repression barrier" is present, which, paradoxically, may be easily breached through hypnosis (I. Brenner 2001, 2004a).

From a relational perspective, Bromberg (1994, 1998) sees dissociation as a ubiquitous, interpersonal defense such that what is not known is unthinkable because it was not properly recognized by the primary caretaker. Whitmer (2001), however, takes a further step, recognizing dissociation as, ultimately, an intrapsychic defense, since in this condition, finding meaning in experience is blocked by an active decoupling of a natural developmental process. In this vein, Fonagy (1991) explains that a child reacts to the intolerability of knowing her mother's hatred toward her by actively inhibiting the capacity to mentalize. Since children cannot develop the capacity to integrate mental content unless the maternal object can sustain a "good enough" affective, symbolic, and interactive dialogue, dissociation is described as beginning as a two-person, interpersonal experience.

As a result, in families where a climate of denial accompanies abuse, the absence of acknowledgment in the dyad facilitates a dis-

sociative state of mind. That is, "conflicted approach-avoidance attempts at dialogue of the disorganized child [are seen], as well as the inability of the abusive mother to help the child integrate the contradictory aspects of her experiences through collaborative dialogue" (Lyons-Ruth 2003, p. 901). Significantly, however, such dissociative tendencies are thought to originate from within a continuum of relational disturbances much less severe than frank abuse or the mother's overt dissociative disorder. Essentially, the mother's need not to know that her infant is in distress seems to be a central dynamic factor, leading to the mother's facial expressions and behavior being severely uncoordinated with the dialogue; this results in "disrupted forms of mother–infant communication [that] are important contributions to the developmental pathways that eventuate in dissociative symptoms" (Lyons-Ruth 2003, p. 905).

In my own experience with patients with DID, a very disturbed early mother–child relationship is ubiquitous. It seems to set the stage for continued impairment, requiring extraordinary measures on the child's part to psychically survive. However, we need to be open to additional considerations besides disorganized disoriented attachment, as other pathways to this disorder may be possible; for example, avoidant attachment disturbances may be implicated, which I believe is the case in a particular patient whose situation will be described later. "Mary" seemed totally oblivious, unreactive and unaffected by my comings and goings for the first several years of treatment. She utilized whatever ego strength she had to create a dissociative defense of not caring and not knowing if I were present or absent. Over time, as her defense was analyzed, we could see that making herself impervious to the object had become her only option.

OFF THE ROAD TO SELF-CONSTANCY

Dissociation has been described, then, as simultaneously knowing and not knowing due to a persistence of an infantile state of mind in which the maternal object failed to ascribe meaning to a sensory experience or mental state (Whitmer 2001). As a result, one who

dissociates presumably cannot know the self except through another's eyes and interpretation. Self-knowledge through introspection is not possible due to a major disturbance in representing one's own experience. There can be no self-constancy because the self-image is always fluctuating as the result of an impaired capacity to represent the self, leaving the individual utterly dependent upon interaction with others for definition. From a Mahlerian point of view, self-constancy is the reciprocal accompaniment of object constancy, the central acquisition of the separation-individuation process (Mahler, Bergman, and Pine 1968).

More recent developmental research, however, has called some of these findings into question (Pine 1992), as there is growing evidence of a differentiated self in infancy that predates object constancy (D. Stern 1985). According to Stern's model, the disturbances seen in DID imply a history of major problems in the very early development of the core self, especially in the areas of self-cohesion, self-continuity, and self-agency. Sensory input may be accurately perceived and conscious, but its meaning is initially relegated to the object because the experience is unsymbolized (Ogden 1986), unformulated (D. B. Stern 1997), and, therefore, unrepresented (Fonagy and Target 1996). As a result, the individual persists in overriding his or her own senses in order to conform to another's reality, leaving him or her unaware and therefore protected from knowing very painful somatic and psychological states.

This "repression by proxy" (Whitmer 2001, p. 816) is initially conceptualized as an interpersonal rather than an intrapsychic defense that, through another route, keeps the subject from knowing something—not because it is unconscious, but because it is unacceptable to others. According to this view, dissociation is seen as the quintessential example of evidence that the interpersonal nature of the self must be defined in relation to the object. This plight has been defiantly proclaimed in the genre of hip-hop music by the controversial superstar Eminem, who in his 2000 song "The Way I Am" put it this way: "And I am whatever you say I am. If I wasn't then, why would I say I am?"

In the psychoanalytic literature, Fonagy and Target (1996) have observed that the self-image originates in the earliest interactions, since

> . . . the infant comes to know his own mind by finding an image of himself in his mother's mind. The child sees his fantasy or idea represented in the adult's mind, re-introjects this and uses it as a representation of his own thinking. [p. 229]

Such dependency on the mother's reality, if it persists into adulthood, results in major impairment of the capacity to mentalize (Fonagy and Target 1996). It also creates a paradox, in that this very inability to think independently may leave the individual impervious to the influence of others. Perhaps this contradiction is an adult manifestation of the gaze aversion seen in the overstimulated infant who withdraws in order to reregulate him- or herself (Beebe and Lachman 2002). In doing this, one has to look away from the object in order to compose oneself and, as a result, loses contact. The extreme suggestibility and stubborn negativity in highly hypnotizable people, observed by Janet (1907) a century ago, might also be related to this paradox.

This "illusion of an autonomous psyche" (Whitmer 2001, p. 817), I would contend, is further enhanced, reconfigured, and carried to the extreme in cases of DID, where there are seemingly separate selves or personifications who may deny or not know of the existence of others, or who may be engaged in lethal (i.e., suicidal) battles over exclusive control of the body (I. Brenner 2001, 2004a). Not only are there disturbances in the core self, but also in the intersubjective self, and, quite dramatically, in the narrative self (D. Stern 1985), where the various alter personalities may claim very different autobiographies.

In order to better integrate these ideas into my view of DID as a "lower-level dissociative character," it seems important to emphasize that the disorder may also be thought of as one of the self that is characterized by an overall lack of self-constancy, which is defended against by a cadre of seemingly separate selves with their own co-

hesion. The vulnerability to submission and sadomasochistic exploitation is often seen in the scared child selves who cannot say "no," but who also reflect an exceedingly complex intrapsychic structure that functions as a compromise formation (C. Brenner 1982). The patient's intrapsychic conflict over her wishes might be quite evident in these submissive child selves, as fear, guilt, and self-destructive urges may be deeply felt. However, the patient may employ a unique defense, described as *pseudoexternalized displacement,* in which her instinctual strivings might be disowned, banished from consciousness, and attributed to someone else—and in the case of DID, that someone else is not an outside person, but rather an "inside" self (I. Brenner 2001). Working with this defense and recognizing it for what it is as it emerges in the transference is a crucial part of the treatment, since it involves working with elusive altered states, amnesia, traumatic memories, and the pathognomic development of dissociated selves.[2]

Another illusion, that of cohesion of the self, is created by these personifications, who may have their own biographies, sexual proclivities, relationships, dreams, avocations, and continuous memories. These selves have achieved a degree of secondary autonomy, and so may appear through the patient's effort to take flight from an overwhelming situation, or may be accessible through hypnotic interventions. They also may emerge spontaneously as a result of anxiety in the here and now. This property of "switching" from one self to another in response to anxiety may then occur in the transference, thus providing an opportunity for the analyst to begin to work interpretively with this seemingly bizarre symptom/defense constellation.

However, the patient's overall lack of self-constancy and object constancy may not be generally recognized because the underlying

[2] It should also be pointed out that, in those individuals for whom identification with a violent, brutal aggressor vastly predominates over identification with the victim, rescuer, or bystander, the prognosis for treatment may be questionable, as sadism, impulsivity, and severe superego pathology may preclude the development of a therapeutic alliance with such "dissociopaths." A subpopulation of so-called "serial hoaxers" may also be part of this category.

susceptibility to organismic panic (Mahler, Bergman, and Pine 1968) and separation anxiety is warded off by the various selves, who appear to have a narcissistic investment in separateness (Kluft 1986a, 1986b). Maintaining this separateness (as in splitting) may reduce anxiety through an illusion of protecting the "good" self or "good" object at the expense of a continuity of identity. In addition, the well-known difficulty in symbolic thinking associated with trauma —i.e., the quality of concreteness (Bass 1997; Bollas 1989; Grubrich-Simitis 1987; Levine 1990; Ogden 1986)—may be encapsulated by some of the selves, allowing others to develop extraordinary creativity and high-level abstract thought.

A recent memoir by an internationally renowned expert in Asian affairs illustrates such high-level capabilities (Oxnam 2005). These personifications can be defensively shielded from one another's traumatic affects and memories, apparently protected by a psychic barrier reinforced by autohypnotic amnesia and analgesia. It seems as though this type of encapsulating organization may allow more normative development to occur in some regions of the psyche (Wholley 1925) and may even protect from frank psychosis (Kramer 1993). This protective barrier appears to function as a powerful repression barrier, but is much more extensive and less amenable to the usual interventions because of alterations in consciousness and the patient's loss of observing ego during these dissociative shifts in identity. It is therefore essential to develop a therapeutic alliance with the patient in all states of mind and to be able to empathize with his psychic reality.

Data from analytic work with adult patients traumatized in childhood reveals the presence of a unique psychic structure, the "It's not me!" Self (I. Brenner 2001). Therefore, in DID, in addition to "knowing and not knowing," the patient may experience "being here and not here," as well as "being me and not me." This structure is thought to be the creative force behind the genesis of these selves, incorporating a number of organizing influences, such as the divisive effect of aggression, perverse sexuality, the dream ego, near-death experiences in childhood, and intergenerational transmission of trauma, which I will elaborate upon. This last influence has been correlated with disorganized attachment to traumatized mothers.

DISSOCIATION, HYPNOSIS, AND NEUROBIOLOGY

If disorganized attachment is correlated with dissociation, and if hypnosis is a form of dissociation (Hilgard 1986), then it would follow that there would be a much higher degree of hypnotizability in persons with disorganized attachment patterns. While I am not aware of any current research in this area, it is expected that such studies will be done in the future. Not surprisingly, the hypnotic induction techniques commonly employed (Watkins 1992) rely on an interactive paradigm that anticipates and coordinates the subject's inner state with the hypnotist's agenda—not unlike the very subtle interactive processes observed in mother–infant research studies (Beebe 2005).

While it has long been thought that the hypnotic interchange harkens back to early dyadic relatedness (Fromm and Nash 1997), the precursors to the autohypnotic state are probably in the fuzzy borderland of the neonate's wakefulness and sleep, which observation has revealed may vary widely from infant to infant (Weil 1970). Therefore, what likely occurs in a "dissociation-prone" patient is the activation of presymbolic representations of the disturbed dyad (Beebe and Lachman 2002), in which the overstimulated infant may employ observable defenses, such as gaze aversion and freezing (Fraiberg 1982). We might assume that in more normative development, this activation diminishes over time and evolves into a defensive system in which motivated forgetting—i.e., repression—occurs without disruptions in levels of consciousness or disturbances in continuity of self.

From a neurobiological standpoint, this infantile reaction of freezing resembles the "defeat reaction" seen in animals (Blanchard et al. 1993; Henry et al. 1993; Miczeck, Thompson, and Tornatzky 1990). Here, in addition to an increase in circulating stress hormones, such as steroids and epinephrine, which accompany the brainstem-mediated activation of the central nervous system, there is also an increase in vagal tone. As a result, heart rate and blood pressure decrease, sometimes to the point of fainting (Perry 2001).

In the animal model, which parallels that seen in humans, both the dopaminergic and the opioid systems are activated in the defeat reaction. Significantly, these "reward system" pathways are also activated by cocaine and narcotics, which induce euphoria, reduce sensitivity to pain, and cause distortions of reality. Such alterations in mood, sensory input, and orientation are seen, furthermore, in dissociative reactions to trauma.

DISSOCIATIVE IDENTITY DISORDER: THE CASE OF ROBERT OXNAM

A compelling memoir by an internationally renowned expert in the field of Asian studies, who is a credible, high-profile individual, reveals the author's tortured inner life. Robert Oxnam, Ph.D., described in great detail the ways in which he became depressed—after having reached the pinnacle of his career—and developed a serious eating disorder; he also started drinking very heavily to self-medicate in reaction to his tortured memories. His nighttime formula was "two packs of cigarettes, Polish sausage, a gallon of ice cream, a two-pound bag of peanuts, a bottle of scotch, and a pornographic movie on the VCR" (Oxnam 2005, p. 30). Weeks after he became sober and started to open up during a therapy session, he blanked out, and one of his young alter personalities emerged to introduce himself to the treating therapist. The patient then displayed amnesia for this period of time, and was utterly bewildered to learn not only that the therapy session was over, but also that an unknown part of himself had been talking while he was in an amnestic state.

Oxnam painstakingly described his complex system of eleven different selves with different ages, different traits, different intellectual capabilities, different genders, and different responsibilities regarding the overall functioning of the human being known to his friends as Bob. His inner people resided in a psychological castle that housed a library in which a book of his childhood existed—the "Baby Book." In this highly symbolized, dreamlike way, memories of the severe early trauma inflicted upon him by his grandpar-

ents, including anal rape and near death by suffocation, were kept separate and inaccessible until therapy unlocked them. As Oxnam described it: "The 'Baby Book' was totally etched in my mind, waiting for me to open it. And as soon as I thought of its possible contents, my smile faded with a shudder" (p. 38).

Amazingly, Oxnam's selves were so geared toward mastery of knowledge and success that, unlike less gifted individuals with this type of mental organization, "they" achieved great prominence. In one extraordinary passage of the memoir, he described his horror at being mercilessly plagued by his voices while hosting a multimillion-dollar fundraiser at which former President George H. Bush was the keynote speaker.

> Suddenly, just as President Bush arrived, I felt inner vibrations, like a ringing cell phone. I knew there was an incoming Bobby message [that is, a message from one of his alters]. "The president's not happy. He's sad." Of course he's happy. He's smiling. Please not now! "Just look at his face. He's not happy. He's making a hurt smile. Who hurt him?" OK, I see. But we can't talk now. I mean it. We'll talk later. Goodbye! [Oxnam 2005, p. 117]

In a cautionary note about the potentially lethal nature of this misunderstood condition (I. Brenner 2006), Oxnam reports that after the death of his mother, he very nearly killed himself via overdose. Despite this massive regression, he benefited greatly from his treatment, which appeared to consist of a combination of insight-oriented, supportive, and hypnotherapeutic approaches. There was no evidence of analysis of the transference or of a methodical analysis of defenses, however; in order to address these goals, the therapist would need to view DID through a characterological lens.

THE DISSOCIATIVE CHARACTER: RECONCEPTUALIZING DISSOCIATIVE IDENTITY DISORDER

In my experience as an administrator on a dissociative disorders unit and as a private practitioner, I have had the opportunity for

clinical contact with hundreds of such patients in various contexts, including admission interviews; consultation; supervision; group therapy; short-term inpatient treatment; long-term inpatient treatment; and five-times-a-week, psychoanalytically oriented, outpatient therapy lasting well over a decade. The conceptual model that I have found most useful is that of a continuum of dissociative character pathology in which dissociation, rather than splitting or repression, is the central defensive operation (I. Brenner 1994). In this model, dissociation may be considered a primary defensive process, and perhaps a precursor to repression.

McWilliams (1994) also views dissociation as a primary defensive process, and her theory emphasizes characterological factors in DID as well, but it differs from my view in that what she terms *dissociative personality* posits neurotic-level conflicts as core issues in higher-functioning DID patients, and views borderline or psychotic conflicts as the central conflicts in poorly functioning DID patients. I believe that data from psychoanalytic work does not support this contention because, in my experience, even such high-functioning patients with greater capacities for sublimation show evidence of severe preoedipal problems, including a disturbance in object constancy (I. Brenner 2004a). Therefore, it may be more accurate to describe the dissociative character model by incorporating the concept of a continuum, where the severe-end or lower-level dissociative character, replete with seemingly separate selves, corresponds to DID; and the intermediate-level dissociative character, with less cohesive and less organized "selves," is comparable to the so-called attenuated cases of multiple personality (Ellenberger 1970). These latter cases are currently classified as dissociative disorder not otherwise specified, or DD-NOS (American Psychiatric Association 2000). An upper-level dissociative character, which has more overall self-constancy but relies on defensively motivated, altered states resembling "absent-mindedness," can be placed along this same continuum.

Different personifications or alter personalities—the hallmark of DID—may be viewed as multiply determined compromise formations that encapsulate one's disowned traumatic memories, affects, anxiety, drives, and fantasies. The pathogenesis of these selves is

the responsibility of the so-called Dissociative Self (or the "It's not me!" Self), who, like the "man behind the curtain," wants to be ignored while he creates the illusion of an omnipotent, frightening "Wizard of Oz."[3]

As mentioned earlier, the illusion of oneness, or self-constancy, is maintained when each self is kept ignorant of the presence of others. However, through analytic work that incorporates an appreciation of the vicissitudes of dissociation, the reconstruction of a massively traumatic childhood may be possible through the development of a therapeutic alliance with the patient in her various states of mind, enabling an analysis of the ensuing "mosaic transference." The previously mentioned organizing influences are recruited by the "It's not me!" Self in the service of creating these seemingly separate identities, which are kept separate by the amnestic, autohypnotic barrier. For example, Oxnam (2005) was not aware of his other selves prior to his decompensation in adulthood; when a child self emerged during his therapy, Oxnam experienced amnesia for this period of time and had to utilize his therapist as an auxiliary memory until he could acquire "co-consciousness" and expand his observing ego to incorporate these states.

The first organizing influence is perverse sexuality—aggressively infused sexuality with part objects and body parts—in which the individual seems to traverse multiple sexual developmental pathways in different states of consciousness (I. Brenner 1996a). A frequently seen triad of personifications is a transsexual self, a homosexual self, and a sadomasochistic heterosexual self. In a case with which I am familiar, that of a married man, it was eventually discovered that the patient would become utterly overwhelmed by urges to drink other men's urine while in an amnestic, altered state of consciousness. He would lure young men to a private apartment and carefully give them calculated amounts of beer to dilute their urine just enough so that he could swallow it while performing fellatio and while he ejaculated.

[3] Relevant here is Freud's (1936) formulation regarding his depersonalization while in Rome, in that he created an intrapsychic illusion that it was not he who was there, lest he surpass his father and risk retribution from his superego.

Of equal importance is the nature of ego functioning in the dream state, especially regarding the *functional phenomenon* (Silberer 1909). Here the ego may symbolize its own alterations in consciousness not only in dreams, but also in hypnogogic and traumatic states. This appears to be the underlying discovery described by Kohut (1971) in his discussion of the *self-state dream.* Utilizing this mechanism, the patient might anthropomorphize a traumatically induced dissociated state and symbolize it in the form of a young child or an angry teenager, who could then be expressed both in recurrent dreams and in subsequent traumatically induced altered states. For example, Oxnam's hermetically sealed castle in his mind might have been a transformation of the refrigerator that he had been locked into while a child, which had nearly suffocated him. The terror and fluctuating state of consciousness he experienced at that time may have been represented and crystallized into the castle imagery.

A third influence is the role of intergenerational transmission, in which the perpetrator's own traumatic history may become bizarrely incorporated into the "biography" of a given personification, usually one based on identification with the aggressor. Originally described in children of Holocaust survivors (Bergmann and Jucovy 1982)—and, as mentioned earlier, currently recognized in disturbances of attachment with traumatized mothers—this phenomenon may be overshadowed by other factors in DID. For example, a woman patient with a destructive male personification who wanted to "take over the body" had attempted a crude mastectomy, leading to severe bleeding; she manifested not only a dissociated transsexual conflict, but also the occult transmission of her father's own trauma. Her male alter insisted that he was a military man who had been sodomized as a young boy (I. Brenner 2001).

The divisive effects of aggression originally described by Freud (1920), and the unusual manifestations of near-death experiences (Gabbard and Twemlow 1984), such as autoscopic and even *psi* phenomena, may also figure in the creation of alter selves (I. Brenner 2001, 2004a). In one such case, it appeared that a patient who had sustained a near-death experience in childhood by almost

drowning later encapsulated that experience in the form of a "dead child" self who had uncanny powers of perception, perhaps including extrasensory perception (I. Brenner 2001).

While dissociation itself is a compromise formation, its defensive aspects are emphasized in the approach I am describing, enabling the psychoanalytic clinician to conceptualize a way to work with it interpretively. Psychodynamically, I have defined it as

> . . . a defensive, altered state of consciousness due to autohypnosis augmenting repression or splitting. It develops as a primitive, adaptive response of the ego to the overstimulation and pain of external trauma which, depending upon its degree of integration, may result in a broad range of disturbances of alertness, awareness, memory and identity. Dissociation apparently may change in its function and may be employed later on as a defense against the perceived internal dangers of the intolerable affects and instinctual strivings. Thus, it may be a transient, neurotic defense or become characterological and may even be the predominant defense. [I. Brenner 2001, p. 36]

In the former case, in which dissociation serves as a transient, neurotic defense, the analyst may observe the quality of what is commonly referred to as "spaciness" in higher-functioning patients whose conflicts are more oedipally based. However, dissociation, in my view, typically encompasses qualities of both repression and splitting, thus perpetuating confusion over its categorization as a distinct means of dynamically keeping mental contents separate. In her comparison of repression and dissociation, Howell (2005) points out that, while both are motivated and defensive, the latter may occur spontaneously during acute trauma or hypnosis. In addition, the former typically refers to actively forgotten, declarative memories that were once known, whereas the latter often refers to unformulated experiences (D. B. Stern 1997), which are simultaneously known and not known (Laub and Auerhahn 1993).

Although parapraxes are typically attributed to repression and fugues are attributed to dissociation, it may be that some of the psychopathology of everyday life (Freud 1901) is more akin to disso-

ciation (I. Brenner 2007). For example, a self-destructive patient who repeatedly and intentionally cut herself in dissociated amnestic states became accident prone and had a propensity for unconscious "bungled actions" (Freud 1901), as a merging of selves, co-consciousness, and neutralization of aggression began to occur during treatment (I. Brenner 2001).

In Kernberg's (1975) view of splitting, the intrapsychic world is divided into aggressive and libidinal self and object representations, i.e., "bad" and "good" ones. In dissociation, however, such a division is not as clear-cut, and amnesia is typically present. Furthermore, as Howell (2005) noted in her attempt to link the two from a relational perspective, "what we call 'splitting' involves a reenactment of post-traumatic dominant-submissive relational patterns . . . a particular organization of alternating dissociated helpless/victim and abusive/rageful self states . . . [which] may have developmental underpinnings in attachment style and biological states" (p. 163).

Despite clinical blurring at times, in extreme situations such as with the changes seen in DID, the underlying mechanism of dissociation seems distinct. Analyzing not only the timing of such a dissociative defensive switch, but also the content of what is being said in that state of mind, is of importance. Such clinical findings, along with the reconstruction of childhood trauma during work with adults, closely correlates with the data derived from child observation and developmental research. Therefore, it appears that very early developmental disturbance potentiated by sustained, severe trauma in childhood is necessary for the pathogenesis of DID. Although dissociative symptoms may occur in cases of later-onset trauma, these are less disorganizing than in frank DID.

MASSIVE TRAUMA IN ADULTHOOD VERSUS DISSOCIATIVE IDENTITY DISORDER: A CASE REPORT

The traumatically induced fracture of the already developed adult psyche is poignantly described in the autobiographical writing of

an Auschwitz survivor who was plagued by incessant nightmares of remembered and unremembered horrors. Yehiel De-Nur, the acclaimed Israeli author, is better known by his nom de plume, *Ka-Tzetnik 135633,* the designation tattooed on his forearm. Lamenting his psychological paralysis during the Eichmann trial in 1961 when a judge asked him whether he had "hidden behind another name" in his books, he writes:

> A routine question, ostensibly, but the moment it flashed into my brain all hell broke loose. Not only did they want me to melt the two identities into one, but they wanted a public confession, an open declaration that this was so. Escaping to no man's land was my only solution—becoming a vegetable in a hospital ward. [Ka-Tzetnik 1989, p. 70]

In this remarkable account, written more than forty years after the author's liberation and a decade after his LSD therapy, Ka-Tzetnik further elaborates on the dissociation of his personality in Auschwitz and his subsequent attempts at integration. He marvels at finally being able to write in the first person instead of the third person:

> All that I have written is in essence a personal journal, testimonial on paper of . . . I, I, I, till halfway through a piece, I suddenly had to transform I into he. I felt the split, the ordeal, the alienation of it . . . . I knew unless I hid behind the third person, I wouldn't have been able to write at all. And lo and behold, here I am in the thick of the manuscript and totally unaware of how naturally I am allowing —from the first line onward—the connection with I. How did I miss this until now? . . . Without a shadow of a doubt I can at last acknowledge my identities, co-existing in my body. [1989, p. 71]

During his hallucinogenic treatment, Ka-Tzetnik revived an intolerable memory of peering through a window of the SS barracks where Jewish women were being raped. He describes the experience as follows.

> I behold "feld hure" (field whore) branded between my sister's breasts. And I see myself instantly splitting in two. I see how I leave my body, separating into two selves: I stand and stare at my body, in a dead faint on the ground . . . . I couldn't hear the camp commander's order then. I was unconscious. Now that I have left my body, I am also able to see the way Siegfried is dragging me by the feet back to the block; I am my own cortege; I am behind my own bumping head. I see Siegfried [a guard] spitting in my face . . . .
>
> I stare at myself, dragged by the feet back to the block and see the key to my nightmare. It's hidden beneath the brand between my sister's breasts. This time I don't fall into a faint, because I've split myself in two. Just as then and now are actually a single unit of time multiplied by two. The I of then and the I of now are a single identity divided by two. I look at my unconscious self, and I look at the self staring at my self. [Ka-Tzetnik 1989, p. 100]

DISCUSSION

The lifting of the amnestic dissociative curtain in Ka-Tzetnik's mind, evidently aided by the psychodynamic effects of his hallucinatory experience in treatment and by ten more years of soul searching, enabled him to decode the nightmare of his life in Auschwitz. While at times in his writing, it is difficult for the reader to distinguish his original horror from his drug psychosis, or even from his rich literary style, what does come across are his "knowing and not knowing," his "being here and not here," and his experience of the self as "me and not me." Although dissociative in nature, his assigning a name to his "traumatized self" (Volkan 1995) appears deliberate and conscious, as opposed to its being a structured personification that is relatively autonomous, unknown, separated by an amnestic barrier, and capable of taking over the subject's behavior—as is the case in the frank DID described by Oxnam. In Oxnam's (2005) words:

> I have come to think that a lot of people, possibly all people, have multiple personae [but] . . . the biggest difference

> between "normal multiplicity" and MPD is that most people recall what happens to them as they move through their array of personae. By contrast, MPD is characterized by rigid memory walls that prevent such recall until therapy begins to break down barriers. [p. 5]

Furthermore, we have no evidence of impaired object constancy or of defensive efforts to camouflage a lack of self-constancy or a need to create the illusion of self-cohesion. Instead, the author whose real name was De-Nur intentionally clings to his Ka-Tzetnik persona, uses him as a shield, and is connected in a manner more consistent with depersonalization. If one were to try to categorize his symptoms, one might find that they are most consistent with the diagnostic criteria for DD-NOS (American Psychiatric Association 2000).

In my experience, even the massive and sustained trauma from genocidal persecution in adulthood does not result in DID. This is because the latter, in my view, is a lower-level dissociative character requiring determinants from childhood. However, DID may be confused with schizophrenia, also thought to have its origin in childhood and to be associated with a preponderance of annihilation anxiety.

ANNIHILATION ANXIETY

In his comprehensive view of annihilation anxiety, Hurvich (2003) traces the importance of these "survival-related apprehensions" (p. 579) throughout the analytic literature, and he enumerates the various terms that have been coined for this condition. They include traumatic anxiety (Freud 1926), aphanisis (Jones 1929), psychotic anxiety (Klein 1935), instinctual anxiety (A. Freud 1936), schizoid anxiety (Fairbairn 1940), primary anxiety (Fenichel 1945; Schur 1953; Zetzel 1949), and biotrauma (M. M. Stern 1951), in writings extending through the 1950s. In the latter half of the twentieth century, writers have described unthinkable anxiety (Winnicott 1960a, 1960b), annihilation anxiety (Little 1960), a background of safety (Sandler 1960), mega-anxiety (Waelder 1960), nameless dread

(Bion 1962), basic fault (Balint 1968), primary unrelatedness (Guntrip 1969), basic anxiety (Frosch 1983), organismic distress-panic (Mahler and Furer 1968; Pao 1979), adhesive identification (Bick 1968; Meltzer 1975), fears of being negated in one's existence (Lichtenstein 1964), disintegration anxiety (Kohut 1977), cataclysmic catastrophe (Tustin 1981), prey–predator anxiety (Grotstein 1984), doomsday expectation (Krystal 1988), infinity (Matte Blanco 1988), "too muchness" (Shengold 1989), and dissolution of boundedness (Ogden 1989).

Defined as "mental content reflecting concerns over survival, preservation of the self, and the capacity to function" (Hurvich 2003, p. 581), annihilation anxiety—forming the psychophysiological bedrock of the human condition—may be intensified as a result of inherent ego weakness, threats to cohesion of the self, trauma (Hurvich 1989), and disturbances of attachment, most notably the disorganized and insecure type (Main and Solomon 1990). This fundamental anxiety may underlie all the classic potential dangers of object loss, loss of love, "castration," and retribution of the superego (Freud 1926); or, if on its own, annihilation anxiety may arise from the here-and-now danger of a traumatic moment.

A deeper appreciation of the various ways in which annihilation anxiety may be incorporated and mobilized could serve as a bridge to understanding the vicissitudes of psychic trauma and psychopathology in general. Specifically, with regard to psychosis and the realm of dissociative disorders, a comparison of defenses mounted against the manifestations of annihilation anxiety may be a crucial area of inquiry and differentiation.

SCHIZOPHRENIA VERSUS DISSOCIATIVE IDENTITY DISORDER

There are times when seemingly autistic preoccupation and hallucinatory experiences quite reminiscent of schizophrenia—associated with the Schneiderian first-rank symptoms of schizophrenia, in particular—may be present in dissociative identity disorder (Kluft 1987). In such cases, differentiating the two conditions is of consid-

erable clinical importance, as the most efficacious therapeutic approach may be quite different. For example, how one understands the presenting phenomena (such as auditory hallucinations) has technical implications, given that "talking" to the voices in DID can be shown to further the treatment, whereas in schizophrenia, such talking may risk the therapist's collusion with a psychotic process and her joining with the patient in a delusional world (I. Brenner 2001, 2004a). Many analysts feel very uncomfortable with this approach, which may, in fact, become a turning point in the treatment of DID, given that an empathic appreciation of the dissociated mind's subjective experience facilitates an opening up of the patient's inner life—i.e., a "free dissociation," rather than free association.

These severe regressive states have been a source of both interest and confusion to clinicians, and they warrant a revisiting of the idea of a continuum between the psychoses and the spectrum of dissociative disorders (I. Brenner 2004b). As mentioned earlier, Kramer (1993) speculated that DID might protect the individual from frank psychosis, and Kernberg (1973) conceptualized a continuum extending from poor differentiation of self and object representations at the psychotic end, to hysterical dissociation with mutual amnesia of personalities and underlying repression at the other. Abse (1974) drew a parallel with molecular disintegration at the psychotic end and molar disintegration at the opposite end.

Differentiation between schizophrenia and DID is sometimes difficult, as the number of cases of multiple personality reported in the literature was greatly reduced after Bleuler's term *schizophrenia* was introduced. It has been postulated that some very highly publicized treatment successes of schizophrenia may actually have been misdiagnosed cases of DID (Rosenbaum 1980). The diagnostic confusion between schizophrenia and DID has added to doubt about the validity of the latter, but the resurgence of interest in trauma, advances in the neurosciences, and child studies of attachment styles may enable us to make better distinctions.

Volkan's (1995) theory of psychosis offers some suggestions for differentiating dissociative psychopathology from the most severe

realm of psychopathology. In psychotic decompensation, the susceptibility to organismic panic or annihilation anxiety, he felt, could not be explained on the basis of a decathexis of objects (Freud 1924a, 1924b) or regression alone. He postulated the presence of an *infantile psychotic self* (Volkan 1995) or *seed of madness* (Volkan and Akhtar 1997) in those adults susceptible to schizophrenia. Observations of the high concordance rate of schizophrenia in monozygotic twins (Gottesman and Shields 1972), as well as the results of adoption studies (Kendler, Gruenberg, and Strauss 1982) and neuroimaging studies conducted over the past twenty-five years (Andreasen et al. 1982; Lim 2007; Salisbury et al. 2007), have been very convincing with respect to the role of biology, genetic vulnerability, and constitutional factors, but the interaction of environmental factors appears to be an essential component also (Pollin and Stabenau 1968). Clearly, the earliest mother–infant environment provides the "channel" through which "disposition and experience" (Freud 1914, p. 18) evolve into early psychic structures, of which analytic writers have long been aware (Mahler 1952; Sullivan 1953, 1962). Therefore, very early, extreme trauma, such as severe loss, neglect, or abuse involving sexualized or aggressive misuse of the developing child, may be a determining factor. In addition, the actualization of the child's unconscious fantasies as a result of trauma interferes with the development of reality testing (Caper 1999; Kestenberg, and Brenner 1996; Volkan and Ast 2001, p. 569).

By definition, the *infantile psychotic self* is imbued with aggression and its accompanying affects, has impaired reality testing, and is strained by the tug of war between the forces of maturation and the failure to differentiate self- and object representations. In addition, there is a perpetual state of projection and reintrojection of self-object representations, leaving the individual in a chronic state of insatiable hunger for good objects. This disturbance of desire, while not unique to the psychoses, has been the subject of renewed psychoanalytic interest, and was thought by Lacan to be the central issue in the human condition (Kirshner 2005). Here, however, the only hope for meaningful human contact and reasonable ego functioning would be the later development of an *infantile*

non*psychotic self,* thought to be libidinally saturated and capable of self-object differentiation and cohesion.

While an infantile psychotic self may be formed through regression due to later trauma, e.g., oedipal or latency-age, once a child has reached adolescence, maturation of the ego has arrived at a point that, according to Volkan, the child is protected from developing frank schizophrenia. Once formed, this infantile psychotic self may theoretically shrink or "calcify" due to successful treatment, or mushroom into full-blown childhood schizophrenia, or become encapsulated (D. Rosenfeld 1992; H. A. Rosenfeld 1965; Tustin 1986; Volkan 1976, 1995) by the nonpsychotic self and its more mature functions that attempt to contain this "sick" aspect of the psyche. If this encapsulation is incomplete, one may see a psychotic personality organization characterized by bizarre, idiosyncratic, and repetitive activities or fantasies, even though a modicum of reality testing may be present. Perhaps corresponding to the schizotypal personality disorder as described in the DSM-IV-TR (American Psychiatric Association 2000), there may be a relatively unremarkable social facade that belies such autistic preoccupations, which will be recognized by the alert clinician. Another potential development is the onset of an acute regression, should the protective capsule suddenly crack due to external factors that replicate the original psychotogenic influence of early childhood.

The last possibility described by Volkan is the onset of frank adult schizophrenia due to overwhelming organismic distress, in which the protective, encapsulating structure essentially dissolves and is rapidly replaced by a new outer layer, the *adult psychotic self,* which quells massive pain at the expense of reality testing. This dynamic formulation would explain the sudden onset of a crystallization of "delusional insight" in acute schizophrenia. In contrast to a psychotic personality organization in which the outer layer becomes the "spokesperson" for the infantile psychotic self, here the adult psychotic self almost completely absorbs the infantile psychotic self and becomes its voice. As a result, this primitive, new self, so unable to handle the vicissitudes of reality, loses the capacity for self-observation and resorts to magical, omnipotent control and hallucinations as well as other oddities of mental functioning.

In Volkan's schema, key elements are early traumatic influence, a very damaged young self, a preponderance of aggression, extreme susceptibility to annihilation anxiety, encapsulation by the creation of an outer self, an endless cycle of projection and reintrojection of poorly differentiated self and object representations, and an outer facade that becomes partially or completely nonfunctional under stress. Thus, the infantile psychotic self is located at the psychotic end of the continuum, whereas the "It's not me!" Self of the dissociative character is at the opposite end, with the fate of the latter contingent upon later growthful or destructive influences.

The following case summary illustrates the overlap of symptomatology in a patient who might be said to fall in the middle of such a continuum.

CASE VIGNETTE

A very masculine woman, Mary, who dressed in unisex clothing and was typically taken to be a man, was in treatment for approximately two decades. She was seen up to five times a week, both as an outpatient and through numerous psychiatric hospitalizations. She initially presented for treatment with acute suicidality and severe alcoholism. She was in the throes of a homosexual panic as the result of an affair with a woman, and saw killing herself as the only escape from her massive guilt. Severe character pathology, with borderline, masochistic, and avoidant features, was a diagnostic consideration until she eventually became totally abstinent from alcohol, at which time her true diagnosis emerged. Her social withdrawal and blunted affect led one psychiatrist who covered for me during my vacation to think she was schizophrenic.

After several years of a rather chaotic clinical course that often involved more psychiatric management than psychoanalytic therapy, Mary suffered a particularly self-destructive period of time, and I recommended rehospitalization. She had severely cut herself and planned to cut deeper; while I was sitting with her at the admissions office, she suddenly began to look at me strangely and to speak with a different cadence and usage of words. I experienced

a sense of surprise (Smith 1995) that altered my whole view of the patient. Though she seemed a bit disoriented, she calmly told me in the third person that Mary had a blade hidden in her possessions and had full intention of using it if left unattended for any period of time. I commented on the unusual way in which she was speaking to me. The patient then told me that Mary was very dangerous to the body and that she, Priscilla, wanted to tell me about some things that Mary would not. She said that she could tell someone else about the cutting, but could not stop it on her own.

Over the ensuing period, a history of maternal incest persisting into adulthood and even into the early years of treatment was ascertained. This stunning revelation was a turning point in treatment, as it signaled a deepening of the patient's trust and readiness to let go of her sexual relationship with her mother. Through her complex system of seemingly separate selves, Mary revealed dissociated sexuality in the form of transsexualism, bestophilia, homosexuality, and sadomasochistic heterosexuality. A literal life-and-death struggle over possession of the body, including an attempt to cut off the breasts and perform a sex change operation, ensued over the years; as a result, near-fatal overdoses and blood loss due to cutting required extensive hospitalizations.

A typical therapy hour with Mary would consist of her staring into space, sitting quietly for several minutes, and then describing her suicidal impulses and her constant auditory hallucinations, especially inner voices from a tormented young boy, Thomas, who would scream, "God is trying to kill me!" We eventually learned that Mary's mother had told her that if she ever revealed the sexual abuse, God would kill her. Thomas apparently represented her dissociated guilt over betraying her secret bond with her mother by telling me. Most significant in Mary's "system" was a series of male selves, most prominently and violently represented by Ralph, whose hatred and envy of me and my maleness represented a critical transsexual conflict in the patient's psyche.

In the transference, Mary was prone to intermittent paranoid psychotic regressions that had a schizophrenia-like quality to them. For example, Mary's mother once told her that she had seen me

interviewed on television. Mary was unable to tell me about this incident for several weeks, at which time she finally revealed that she was convinced that my office had a secret recording device that transmitted our conversations directly to her mother, with whom I had had ongoing contact. Mary could not be convinced to the contrary. She also took note of the slightest changes in the placement of my office chairs, convinced that there were secret meanings in these deviations and that she was being tested by me to see if she would notice. Adept at keeping her secrets inside all her life, she did not tell me about this referential thinking for almost five years. This delusional thinking eventually resolved, and her clinical presentation became much more consistent with DID.

In the mosaic transference, Ralph and his minions expressed sadism and envy characterized by an erotic fantasy of smashing a window with his fist, removing his bloody hand, taking a shard of glass from the window, and cutting my throat, as well as mutilating my genitals while he "masturbated." The "children," mostly frightened young girls, sought comfort and protection from me due to Ralph's threats to hurt them, i.e., via self-mutilation. "They" eventually began to cry during weekends and breaks, signaling a softening of Mary's initially stony and avoidant relatedness.

Mary, as herself, felt either dead or frightened, and she was doubtful that anyone could help her, yet remained completely devoted to the therapeutic process. She desperately sought to be rescued (Davies and Frawley 1991) but could not ask for anything. She revealed that she had become mute during first grade after being molested by a female teacher, quite sure that she would be struck dead if she told anyone. Interestingly, she had periods of silence in the sessions and experienced this conflict over speaking as a menacing, older, female presence—Millie—holding her throat and preventing her from revealing secrets of the incest.

Analysis of the patient's resistance to speak took the form of my interpreting that she was reliving in the transference fears of retribution from her childhood, and that Millie appeared to be an internal representation of her mother. I averred that the injunction against speaking did not apply to treatment, as I had no in-

tention of getting her mother into trouble, and Mary eventually began to talk more. Her subjective experience was of Millie releasing the grip on her throat and backing off.

Once Mary began to speak, she then feared that she would start to cry "like the children," and would never stop. She also sensed that a bloodcurdling scream was stuck in her throat, which if released would also never end. Her deadness and inhibition belied her profound inner need to finally be heard. Mary often told a symbolic story about herself and her mother: a puppy was stuck in a hedge, and every time it poked its head out, it would get hit with a baseball bat. After a while, the puppy simply stayed hidden in the hedge.

Reconstruction of the patient's childhood was extremely painful, fragmented, and without temporal sequence. For example, Mary intermittently reported symptoms of blurred vision and burning in her nose and throat. Despite the disturbing nature of these complaints, they were described with *la belle indifference,* usually during times of anxiety associated with suicidal thoughts. These conversion-like symptoms resolved after an abreactive experience in which the patient recalled in various altered states having been held underwater in the bathtub until she choked; she had subsequently become more cooperative in submitting to her mother's sexual demands.

Shortness of breath and fears of suffocating were then associated with terrifying memories of her large mother sitting on her face for extended periods of time and forcing her to perform cunnilingus, until the mother collapsed with orgiastic exhaustion. Haunted by her mother's contorted facial expression at a time in her young life when she did not understand orgasm, Mary could not read her mother's face (or, subsequently, other people's faces), and became even more terrified of what was going on, especially when she was left with a mouthful of mother's menstrual blood. This extraordinarily painful reconstruction occurred over a period of several years, with gradual melting of amnestic states of "the children." It was punctuated by numerous suicidal crises. Mary's mournful lament was summarized by her cry: "*Why* did she fuck me?"

The turning of passive sexual victim into active participant had apparently occurred during late adolescence and early adulthood, when Mary readily identified herself as having been "soul-murdered," and she became more masculinized. After having been penetrated with everything from fingers, harsh washcloths with soap, knitting needles, and broomsticks throughout her young life, the patient began drinking heavily and using marijuana to further alleviate her awareness of her enslavement to her mother. Ralph became stronger and more defiant, hoping to get revenge one day. What little dating the patient did usually ended in drunken, forced sex, and Mary retreated further.

Consoled by her writing and her growing talent as an artist, she felt safest when alone in her self-created world. Therefore, her opening up in treatment was both desperately longed for and a source of ongoing terror. She had profoundly impaired object constancy, self-constancy, and social skills, and an inconsistent capacity for sublimation. In order to learn how to talk with people and to pay for her therapy, she took a counter job in a store and worked overtime six days a week. The owner of the store and his wife became benign, surrogate parents. By creating her own structured day program, as it were, Mary began to regulate herself in a safe, holding environment and to build the semblance of a more normal life.

A crucial junction was reached during an earnest but unsuccessful attempt at a medical sex change, complete with plans for bilateral mastectomy and testosterone administration in preparation for attachment of a surgically crafted penis. Overtly stemming from a lack of funds for the breast removal, but primarily owing to profound inner chaos and the realization that such a step would destroy her 10-year relationship with her lesbian partner, a severe depression engulfed Mary. As the patient nearly starved to death, ultimately requiring a short course of ECT (which restored her mood, but did nothing to quell her incessant voices and internal warring factions), Ralph became more powerful, but also eventually more amenable to talking with me. I explained to "him" that, despite his nearly successful attempts to highjack the body and succeed in his plan for a sex change operation, there was so much internal conflict that he could not have survived such a major up-

heaval; he would need to compromise and find a way to accept living in the female body.

Originally convinced to the point of delusional thinking that if he killed off everyone else inside, he would be victorious and become exclusive owner of the body, Ralph demonstrated a dissociated form of suicidal thinking that eventually and begrudgingly gave way to a truce and a deeply emotional acknowledgment that maybe I was not his enemy after all.

Signaling a long-awaited alliance with this most deeply disturbed stratum of Mary's psyche, two significant psychological developments occurred. First, the dissociated amnestic barrier between Mary and her sadistic, masculine self, Ralph, became quite porous, and "co-consciousness" occurred on a more regular basis. Now in a mental state approaching depersonalization, Mary could be present and observe her mental functioning when Ralph was out, and vice versa. Second, her paranoia and use of projective defenses (an uncommon feature in less disturbed dissociative patients, but more evident in schizophrenic states) substantially diminished.

As the patient became more able to tolerate and own her psyche, she explained that, in order to become an active participant in the incest, she had needed to become a man. Ralph then reported that he had begun to forcefully "fist-fuck" the mother as he grew older, hoping to hurt her and drive her away, only to succeed in providing more pleasure for what sounded like an insatiable monster. At a moment when the patient seemed unusually receptive to my own "penetration"—a transference interpretation—I said that I now understood that Ralph's wish to smash my window with his fist and stab me in a bloody orgy reflected his desire for deadly, sexualized revenge against the mother. Quietly taking in my words, Ralph—for the first time—began to cry, and as tears streamed down his face, he decried all the wrongdoings to which they had been subjected, and lamented that they had not deserved any such mistreatment. After the hour, Ralph left me a tender message saying that he actually felt better, had more control, and had never felt so calm.

The work continued in a similar vein as the patient became more integrated over time.

CONCLUSION

The pathological effects on development of severe early trauma may be considered along a continuum ranging from schizophrenia to dissociative psychopathology, which is epitomized by dissociative identity disorder. Depending on constitutional vulnerability and the timing of massive interference in the development of the self, such disturbances may result in the formation of an *infantile psychotic self* (in schizophrenia) or an "It's not me!" Self (in DID). The "It's not me!" Self may protect against psychotic disintegration through its ability to manufacture personifications that are compromise formations, and may incorporate the dream ego, perverse sexuality, intergenerational transmission of trauma, near-death experiences, and the divisive effect of aggression. Therefore, differentiation of these conditions is aided by paying particular attention to the nature of the disturbances in the formation of the self, the role of encapsulation, the reliance upon dissociation, amnestic defenses, and the fate of annihilation anxiety.

DID—formerly known as multiple personality disorder and by a host of other names, as previously noted—is a disorder of the self characterized by an overall lack of self-constancy and the illusion of cohesion. This illusion is created within various personifications or dissociated selves that appear to have developed in order to encapsulate traumatic memories, as well as annihilation and separation anxiety.

DID is probably the most controversial and misunderstood mental condition known at this time. Clinical experience with adults has led to three basic assumptions:

1. DID lies at the extreme end of its own continuum of dissociative character pathology—i.e., it represents a lower-level dissociative character.

2. The central defensive operation is dissociation, rather than repression or splitting. Dissociation, rooted in disturbed communication in the mother–infant dialogue, is, to paraphrase Freud, the intrapsychic "precipitate" of these earliest object relations. It may be defined as

> . . . [a] defensive altered state of consciousness due to autohypnosis augmenting repression or splitting.[4] It develops as a primitive, adaptive response of the ego to the overstimulation and pain of external trauma which, depending on its degree of integration, may result in a broad range of disturbances of alertness, awareness, memory, and identity. Dissociation apparently may change in its function and may be employed later as a defense against the perceived internal dangers of intolerable affects and instinctual striving. Thus, it may be a transient, neurotic defense or . . . the predominant defense. [I. Brenner 2001, p. 36]

3. There is an underlying Dissociative Self, or an "It's not me!" Self, which disowns mental contents and creates the illusion of separate selves. In contrast to what is seen in schizophrenia, some of these selves appear to function with rather high levels of ego strength, as revealed by their subliminatory capacities, creativity, empathy, and reality testing.

Developmental research and reconstruction from psychoanalytic work with adults suggests that this condition requires precursors in childhood, even though nonspecific psychotic and dissociative regressions may result from adult trauma alone. A deeper understanding of annihilation anxiety, as well as the nature of this putative continuum of psychopathology, may provide better insights into patients' relative resilience and vulnerability, and contribute toward the refinement of psychoanalytic approaches to treatment.

In summary, it is my opinion that dissociative identity disorder is not only a clinical missing link, but also a clinical Rosetta Stone. The enormous complexity of this entity and its pathogenesis in re-

[4] The autohypnotic defense, as described by Shengold (1989), incorporates Freud's early ideas about the hypnoid state and its various functions, including motivated forgetting, enhanced remembering, and increased vigilance.

sponse to massive and, at times, life-threatening, sustained trauma in childhood illustrates the human mind's potential to construct and locate virtually every type of psychopathological symptom in a single individual.

Understanding all these mechanisms requires an integrated, multidisciplinary effort, which in turn will help us better understand other psychic conditions and further refine the practice of psychoanalytic therapy. Those who benefit from our current treatments present us with an invaluable opportunity to rethink our cherished theories and move toward a more encompassing, unifying theory of adaptation and psychopathology.

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SEEING THE LIGHT

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Seeing the light *is an expression that usually connotes a conceptual grasp of meaning in all its complexity, while the perception of light is not the issue. In this paper, the authors present a patient with an exquisite light sensitivity that disturbs her sleep; she is "seeing the light" in a symptomatic, concrete way. Light itself has become a compliant and collusive element onto which an aspect of conflict is displaced in the service of self-deception. Ironically, the analysis and deconstruction of the symptom eventually led to the kind of insight that the expression* seeing the light *conveys.*

Seeing the light is an expression that attempts to capture insight *in statu nascendi.* What was unclear suddenly becomes clear, but the suddenness can almost totally occlude a more incremental process that must have been anything but sudden in its gestation. Metaphor invokes the speed of light to capture the "eureka" quality of insight, but the slow pace of the gestational process can get overlooked in this metaphoric compression.

In this paper, we focus on such a clinical event in an analysis and try to fathom its multiple components. The analysand at a particular moment in the transference neurosis allowed a light to

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penetrate a symptomatic darkness, and the new insight had a startling effect: a symptom disappeared practically overnight. The energy that informed it was rerouted into a more comprehensive flow of free-associative process.

CLINICAL VIGNETTE

In the patient we will present, Ms. L, the symptom of extreme light sensitivity had been present for many years without being noticed because it was only on summer vacations, when she could sleep late, that the analysand became aware she was very sensitive to light. The least amount of morning light would awaken her, and she could not get back to sleep again, try as she might. Ms. L would try to ensure that the windows were "dawn-proof," so to speak, by closing the shutters and sealing the curtains carefully and tightly when she retired for the night, a ritual that took on a somewhat comical meaning to her and her bemused husband. That the symptom was a revenant of some forgotten issue from the past was an insight that must have lain dormant for years. In fact, most of the time, when not on vacation, Ms. L awakened early, and the "symptom" was not even worth considering as she prepared herself for her busy professional life as a financial analyst. As insignificant as the symptom seemed when it first came up for analytic scrutiny, it would turn out to be full of meaning as the analysand came to reflect on it.

When this symptom first appeared in the analysis with one of us (D. B.), Ms. L was sixty years old. It was the fifth year of the analysis. Ms. L, whose childhood in France had been severely compromised by the shadow of World War II, had learned to appreciate that the analytic process itself was a new theater of love and war that could reprise the past and render its dangers somewhat more manageable—but not always. At times, the transference of the past into the present seemed to disrupt the process rather than enhance its unfolding. It was this clash between the past as reality and the past as transference that seemed to ignite the moment of insight we will examine.

Ms. L's turning sixty had a profound effect on the analytic process. If life had seemed to symbolize light for the first six decades of her life, suddenly, she found herself beginning to reflect on the darkness of death. She was a joyous person; war had disrupted her childhood, but not her spirit. Her reflections at age sixty about death did not take the form of depressive ruminations, but were rather a realistic confrontation of reality.

In the countertransference, the analyst noticed that she herself was moved to reflect on her own mortality. The analyst was startled when Ms. L asked: "When there is no light at the end of the tunnel, then what?" The question was rhetorical, but it seemed to clamor for an answer nonetheless. It led to the telling of a dream that in turn led to the dismantling of the symptom we are highlighting here.

"In the dream, there is a Venetian blind flapping a little in the wind," the analysand related. "One broken slat is piercing the otherwise darkened room with a single beam of dawn light." Her immediate association seemed to break no new psychological ground, given that it had been referred to many times in the past: it was a memory of German soldiers who had beamed their flashlights into the faces of the residents of her village as they slept or tried to sleep in 1943. Ms. L, then aged seven, hid with her family and others in a farmhouse not far from where she had grown up in privileged circumstances until war broke out; suddenly, the lives of Jews of all socioeconomic classes had become precarious. A child who did not completely understand the necessity of concealing her identity was a threat to the safety of the group, and this fact lived on in the analysand in the form of an abiding conflict about self-expression that survived years after the guns of war were silenced. This conflict had been the subject of analysis for many years, and much had been accomplished as wartime memories were revived and revised somewhat in the reflective laboratory of psychoanalysis.

A subsequent association to the dream did yield something new, however, as it opened up a prewar trove of memories that not only deepened Ms. L's understanding of her genetic complexity, but also entirely eradicated the symptom of light sensitivity. (Even-

tually, she could sleep no matter how much light entered her room as morning peeped through chinks in the curtains.) A significant association was made between the beam of light from the defective Venetian blind and the light on the forehead of the surgeon who had removed her adenoids when she was three years old—without anesthesia. The child had been brought unsuspectingly to the surgeon's office. When she asked her grandmother, "Where are you taking me?" she was told, "You'll see!"

The adenoidectomy was performed quickly. Ms. L remembered the beam of light on the surgeon's forehead, and she remembered her fury at the deception that seemed like an even greater trauma than the surgical procedure itself. For years afterward, all doctors were kicked in the shins by this traumatized child until, eventually, she could tolerate "civilized" medical visits again. For the rest of her life, however, she insisted on absolute honesty from her physicians—the passivity of the "good" patient being an "ideal" she detested. This insistence on straight talk and full disclosure of all information from her caregivers stood her well in her analysis.

The beam of light from the Venetian blind illuminated not only the past; it shone a direct light onto the transference as well. The analysand seemed to be saying in dream language, "My Venetian analyst is blind." While it had not been established that the analyst (D. B.) was in fact Italian, her European identity would have been difficult for the patient to ignore. This projection of the analysand's *blindness* (denial, disavowal, repression) onto the analyst was experienced in clinical reality as an accusation: how could the analyst have allowed the analysand to be blind to her genetic history for so long? Where was the analyst when Ms. L was being neglected in the past? Wasn't analytic neutrality merely a euphemism for cruel indifference? These reactions were significant: like all transferential accusations, they illuminated a developmental dialogue, the words of which were mostly located in the *potential* realm until they found an *actual* voice in the transference years after the fact. (This will be discussed in greater detail later in this paper.)

Although the transference focused on the immediacy of the here and now, it also hungered for an examination of the past. The dream

opened up free-associative pathways that led to exploration of affects about the parental and grandparental deception and the surgeon's collusion. Thus, the light from the window that was interrupting Ms. L's sleep was truly kaleidoscopic—a Janus-like window into both the past and the present. Associating to it, she realized that her whole idyllic childhood had been interrupted by the madness of wartime and the incomprehensible prejudice that created anti-Semitism.

But there was also a prewar memory to be dealt with. Well-meaning parents and grandparents, following the conventional wisdom of the time, believed that deceiving the child was preferable to preparing her with the truth about impending surgery. The trauma of this deception, the trauma of the surgery, the traumatic climate of wartime, the denial of the patient's identity during the family's period in hiding, and the furtive movements from village to village and from farmyard to farmyard formed a complemental series of events that had taken their toll.

The associations that led to the memory of the traumatic adenoidectomy reached even further back in time to a weaning experience when Ms. L was one year of age. Her grandfather, a revered pediatrician, advised her parents to wean the child in a manner that seems sadistic in retrospect: the parents were to leave the child with substitute caretakers, and on their return the weaning would be a *fait accompli!* (Incidentally, this was the same grandfather pediatrician who had advised the adenoidectomy.) The story was further complicated by the fact that the grandfather then died when the analysand was two years old. The subsequent adenoidectomy may have been arranged as part of a grief reaction, a wish to posthumously honor the advice of the wise pediatrician. All of this had to be reconstructed in the analysis as these associations led further and further back in psychological time.

Ms. L's seemingly irrelevant symptom of exquisite sensitivity to light had unearthed significant developmental issues from the preoedipal period that had been screened, perhaps, by the trauma of war. One trauma can screen another, as Glover (1929) suggested many years ago. The weaning experience at age one was not re-

membered firsthand, but was reconstructed from later information provided by the parents. There were direct memories, however, of a consequence of the abrupt weaning: a subsequent sleep disturbance ensued whenever the parents attempted to leave the child with a babysitter for an evening. In adulthood, when the analysand expressed criticism of her mother in regard to the abrupt weaning experience, her father would hear nothing of it, insisting that her mother had been ideal in every way. In such a climate, it was obviously not easy for a child—or an adult—to cultivate her own voice and self-expression.

Thus, recognition and deconstruction of the symptom of light sensitivity were brought to the fore and became a central focus of the analysis. Light sensitivity was clearly a screen for far deeper sensitivities, with the focus on light understood as a massive displacement onto an inert substance of all that the analysand could not address on a much more personal level with mother, father, grandfather, grandmother, or analyst.

Ms. L's capacity to "see through" the symptom's deception was a product of many months of analytic process that had dealt with her reluctance to use the transference as a window into her emotional life. Ironically, although analyst and analysand were both *analysts*—to be sure, of very different commodities (the one a psychoanalyst, and the other a Wall Street analyst of financial risk management)—it was as if no conflict could be allowed to arise between the two, so deferential was the analysand to the authority of her psychoanalyst. This was respect carried to an extreme, a displacement onto the analyst of the idealized state that Ms. L's mother and father had claimed during her childhood and seemed unwilling to relinquish even when she reached adulthood.

Ms. L began to realize that it was her own unwillingness to wean herself from such idealized illusions that prevented her from *seeing the light*. She became aware that the expression *seeing the light* is metaphoric: it does not really mean the *perception* of light itself, but rather the complex appreciation of all the components of reality, no one element of the totality upstaging others in the service of self-deception or distortion. Ms. L began to recognize her own

skill at shifting the emotional emphasis onto an inert element (light), as well as her lack of skill at displacing emotional issues onto her analyst—the better to understand the complexity of her genetic origins.[1]

The analysand came to realize that her seemingly sudden insight into her symptom of extreme light sensitivity had been prefigured in the transference throughout a much longer period of analytic process. It is significant in this context that the analyst was of European origin, and that Ms. L, French by birth, unconsciously identified with certain aspects of the analyst—some real and some imagined. The identification was defensive in that it did not allow the analysand to speak her mind at times. For instance, she felt that the analyst's office was more European than American, with the obvious love of ancient artifacts and antiques being a clear giveaway, but she did not at first comment on this.

The lighting in the analyst's office was also decidedly European, in Ms. L's estimation, since track lights—which would have illuminated efficiently from above and given a modern feel to the office—were conspicuously absent. A small antique chandelier and a desk and table lamp gave adequate illumination, but just barely so! The analysand had often thought of remarking on this quaint and muted illumination, even criticizing it, but had thought better of it. "It's a good thing you're not doing surgery in here," she once felt like saying—but she suppressed such subversive humor.

All this unspoken *politesse oblige,* which compromised Ms. L's voice, was eventually fully aired in the analysis. The analyst's interpretations of such obligatory politeness sometimes seemed like repetitive nagging to the patient; at one point, she snapped and said, "That may seem obvious to you, but we can't all be Einsteins!" Suddenly, a deep trove of repressed affect became accessible.

A dream that the analysand had had many months prior to the Venetian blind dream was perhaps pivotal in this context. She

[1] This analysand brings to mind another patient, the son of an analyst, who, believing that he had been parented too "analytically" in an excessively Freudian atmosphere, refused to "play the game of transference" with his analyst. The irony, of course, was that this seeming resistance to the transference was also a powerful expression of it!

dreamed that "a one-eyed man was pointing in dismay at his forehead, and a crowd was laughing at him." Her first association pursued the days' residue: she had gone to Wimbledon with her husband. The electronic referees, called "Cyclops," had made a significant error at a crucial moment. Her husband joked, "Only the English would trust a machine over the umpire's human eyes!" Ms. L did not think the joke was very funny, but kept her criticism to herself at the time. She had wanted to challenge his prejudice by saying: "It's not just the English—Cyclops is everywhere now."

The words "even in my dreams" was another of the analysand's immediate associations to the dream. Deeper analysis of the dream led to some disturbing insights. Was she a Cyclops whose own beloved grandmother had deceived her? Was she the *nobody* whom parents and grandparents took her for as a child when they ignored her in the weaning experience, deceived her about the adenoidectomy, and doubted her capacity not to divulge her Jewish identity to the Nazis?

In classical mythology, Ulysses made a fool out of the Cyclops by disguising his identity with the word *Nemo* ("nobody"), and Ms. L began to sense that she herself embodied both Ulysses and the Cyclops, and that her transference etiquette reflected this. She began to realize that the self cannot be deceived unless it colludes in its own self-deception. She began to question the analyst's taste in furniture and lighting, even teasing her about her allegiance to the past, as though the analyst had not fully embraced today's world of reality! Wasn't the analyst's fascination with the past a Cyclopean blind spot that tended to ignore the present and the future, a genetic fixation that blinded her to current reality?

The joke that Ms. L had suppressed earlier ("It's a good thing you're not doing surgery in here") was now voiced, allowing both parties to relish its humor. When the Venetian blind dream was analyzed yet again, the analysand realized that the retrieval of the Cyclopean surgeon of her childhood—"with one glaring eye on his forehead"—had indeed been prefigured by this earlier work in the transference. She was gratified by her analyst's obvious enjoyment of the newfound irreverence that allowed her to poke fun at and de-

idealize the "stodgy" analyst—an analyst whom she had "created" along the lines of the father who had forbidden her to tamper with his idealized version of parenthood.

Reflecting on the total disappearance of the symptom that analysis of these insights had effected, Ms. L was impressed not only by her sudden, newfound ability to sleep in any room day or night regardless of the amount of ambient light; she could also see a comical thread in the way she had lived with the symptom in the past and its eventual deconstruction. For example, during vacations, her husband used to go to heroic lengths to make sure no beam of light disturbed her sleep, so intent was he on protecting her from the slightest intrusion. There was great love in this, not to mention much shared zany humor. By stitching together additional attachments to windows and curtains and Venetian blinds, her husband ensured—like an obsessed scientist in a darkroom—that no intrusive light whatsoever would penetrate the sleep-enhancing darkness. With the symptom dismantled and set aside, Ms. L developed a curious respect for it, in the sense that it was a portal—a bizarre one, to be sure—into a past that she might not have had the courage to explore and reclaim without the enlightenment of analysis and the constancy of marital love.

DISCUSSION

Insight and defense in general (displacement, in this particular clinical instance) must coexist in a complex, dynamic compromise of unconscious, preconscious, and conscious psychic forces and elements. Brenner (1982) pointed out that our concepts of supposed structural stabilities have to be reconceptualized, with constant dynamic fluidity and compromise being the rule of the psyche rather than any reified certainties or structural absolutes. The clinical case presented here illustrates the complexity of an insightful, intelligent, and resourceful mind that coexisted nonetheless for many years with a seemingly innocuous symptom, which, when fully explored, revealed hidden meanings of marked significance.

Light and relativity have been inextricably bound since Einstein expanded the Newtonian vision of the universe. Modern man takes

pride in his sophisticated grasp of such relativities, but fear of the dark antedates such sophistication—born, no doubt, of the twin genetic seeds of childhood immaturity and imagination. Fear or intolerance of light is more unusual, perhaps, but its presence shows that the mind is free to attach distorted meanings to any feature of the phenomenal world in the service of defense.

In the case of Ms. L, a beam of light from the forehead of a surgeon had been repressed, but was later *re-pressed* (Mahon 2005) into a new service that helped the conscious mind maintain its disguise for many years. This phenomenon brings to mind another case in which a child patient, in his play in the analysis, constructed a whip out of string and paper and would beat the lamps in the office —some of the lashes finding an "accidental" target on the analyst's body as well, as the transference invited an alternative expression of the assault. In the analytic process with this young boy, it became clear that the analyst's lamps had become fused with the overhead lights in the operating room where the child had undergone thoracic surgery many years earlier. It was more acceptable to him, given his defensive developmental point of view, to displace his emotional reactions onto inert sources of light than it was to rail against parents or surgeons or his analyst in the new theater of transference.

If transference relies on displacement to set it in motion, it is a displacement that requires some *practice,* it would seem, as analytic process reaches beyond resistance and toward the free-associative expansions that allow it to achieve momentum. Here the word *practice* is shorthand, obviously, for the complex, incremental, and dynamic starts and stops through which the analytic process proceeds as insight and resistance engage each other.

In the clinical case under discussion, the analysand could not reconstruct the precise journey of the light that began in childhood and ended up in a dream many years later, having been detained on a lengthy detour through a symptom that seemed so innocuous at first that little attention was paid to it. The psychopathology of everyday life is peopled with these minor psychic events that never reach the organizational complexity of a symptom, perhaps—and might always have escaped notice had Freud not brought our attention to them a little more than a hundred years ago.

It was the analysis of two dreams that made Ms. L's symptom of light sensitivity disappear entirely, its sudden absence illuminating its meaning more than its presence had. Ironically, the resistance to the transference itself was the vehicle that allowed hidden affects to become exposed, the analysand becoming irritated at the analyst as she implied that the analysand was avoiding her, so to speak. Analysis of resistance to the displacement of transferential meanings from the past onto the current relationship with the analyst eventually brought attention to the displacement concealed in the sensitivity to light. Interpretations of Ms. L's characterological avoidance of personal affects involving the analyst felt like instances of nagging to the analysand, and she eventually "called" the analyst on these. Her comment that "It may seem obvious to you, but we can't all be Einsteins!" was her first acknowledgment of fury toward pompous intellectuals, and she could eventually see that it was leveled at father, mother, grandfather, grandmother, and analyst all at once. "I'm beginning to see the light" became her favorite expression of a newfound capacity to appreciate how the past and the present were not as far apart as she had perhaps wanted them to be.

It was this clinical and metaphorical grasp of the dynamics of transference that allowed Ms. L to be less afraid of its emotional spontaneity and its very personal immediacy and intimacy. It was this almost philosophical—but not at all intellectualized—grasp of her own clinical process *in statu nascendi* that fostered the climate out of which the Venetian blind dream emerged. It was quite an achievement for this reserved woman when she was able to complain that her foreign (Venetian) analyst had been "blind" to much of the analysand's past suffering. Ironically, it was only after Ms. L began to *see the light* metaphorically in the analytic process that she could tackle the more concrete way in which she had been *seeing light* symptomatically for many years without realizing it.

When the analysis of her dreams made the meaning of this symptom so clear that it could not be (nor did it need to be) maintained any longer, Ms. L's curiosity turned to the particular element—light—that she had focused so much unwitting attention upon for years. Although her interest in light had begun tragically as it assaulted

her from the forehead of a surgeon—not to mention the more ironic and subtle reference to it in her grandmother's words, "you'll see!" —there had been, she could see in retrospect, an attempt to understand light and to integrate it into her understanding of reality, not merely into the peculiar fabric of a symptom. In a very early prewar but postadenoidectomy memory, Ms. L remembered having talked to a chandelier in her room as if to get answers or to break out of her loneliness in its company. This personification of an inanimate source of light is a poignant depiction of a child's search for insight in the midst of self-deception as conflict is being engaged by the immature mind. This memory, which was probably a screen memory and had an intense luminosity in her mind's eye, eventually lost its "haloed" status, no doubt as analysis stole much of its thunder (and lightning!) in the free-associative plunder of analytic process (Mahon and Battin 1983). (This chandelier memory brings to mind again the aforementioned child patient who enacted repressed memories of his surgery in the flagellation of his analyst's lamps.)

Ms. L had an aesthetic appreciation of light as it peered through chinks in the forest and projected images of branches and leaves, a landscape of shadow and light spread out all around it like an artist's canvas. She connected her abiding interest in art and art history to these aesthetic attempts to master and coopt an element that had sometimes turned against her. In adolescence, she had written an essay on the artist Tintoretto, which was recognized by her teachers as an astute piece of art criticism. The essence of her essay had to do with Tintoretto's astonishing manipulation of light in his dramatic artworks.

Ms. L's interest in embroidery was another aesthetic pursuit that she could trace back to the war years, her beloved grandmother having taught her the technique of fastidious tracery as the elaborate stitch-craft was held up to the light—even as bombs could be heard exploding in the distance. In retrospect, she could appreciate the genius of her grandmother—who knew a thing or two herself about displacement—in finding the ways and means to distract an impressionable child from the sights and sounds of war.

The great theater of displacement in psychic life is, of course, childhood—play being the activity, par excellence, that thrives on it as fantasy is harnessed to the concreteness of playthings (Freud 1908). Dramatic play seems essential to a child in the first five years of life, its displacements making the conflicts of preoedipal and oedipal life manageable in a little theater of defense and adaptation where disguise can harness the instinctual to the sublimatory and bring relative happiness and stability to the active and imaginative world of childhood. *Relative* is the crucial word in the foregoing sentence, as the almost ubiquitous nightmares of these early years confirm. The immobility of sleep removes activity and play from the child's defensive repertoire, making well-constructed dreams essential if sleep is not to be disrupted by the kind of dreams that fail to sufficiently modify instinctual life and hence turn into nightmares.

During latency, when postoedipal life is relatively subdued by the developmental advances provided by identification, repression, and greater cognitive maturity, play is no longer the dramatic, almost transparent defensive structure of earlier years. But it remains an important world of activity and structuralized displacements, as games of latency and their centuries-old heritages attest (Opie and Opie 1959).

If adolescence brings an end to these ritualized games of latency, it is because this later developmental phase claims a new kind of theater of action, one in which satisfaction of these repressed instincts of childhood can be expressed, as non-incestuous outlets are pursued beyond the family of origin. The displacements of childhood are not cast off by the adolescent without the major upheavals, turmoil, and tumult for which this period is well known. The adolescent must come to terms with such emotional upheaval, which brings about a restructuralization of the internal world—an essential one if the adolescent is to be capable of eventually embracing maturity and manhood or womanhood. Such are the vicissitudes of displacement from childhood to adolescence, which prefigures the role of displacement in adulthood and its very unique role in the adult analytic process.

In the clinical case under review, the patient's displacement of major psychic issues onto the element of light became clear as a

defensive maneuver only in the course of her analysis. As Ms. L's initial difficulties in using the displacement offered by transference (her resistance to the development of transference) were gradually overcome, the whole issue of displacement and insight in general could be explored. As a child, she had been denied a chemistry set when she expressed an interest in understanding how the various elements of the phenomenal world interacted with each other. It is not clear whether war or gender prejudice lay behind this academic withholding, but her curiosity about how psychic elements interacted with each other was not to be denied as the analytic process promoted or resuscitated some of her dormant ego functions.

Focusing with great intensity on her symptom of light sensitivity, Ms. L was not satisfied that the disappearance of the symptom meant that it had been completely understood. Analytic process made it clear that the sensitivity to light emerged from a crucial, complemental series of genetic issues, the free-associative flow of ideas now touching on one source, then another. Ms. L's wartime experiences seemed pivotal at one moment, but so did the adenoidectomy and the Cyclopean surgeon at another. Her unvoiced anger at grandmother, mother, father, and surgeon (and analyst, eventually) was the root of all conflict for her, she came to believe. She depicted her recognition of her anger as the retrieval of her own voice—a reclaiming of it, a celebration of it.

Despite all her analytic progress, the analysand was aware that at night, occasionally, as she was about to fall asleep, she experienced a sense of anxiety. This could not be described as a fear of the dark, and, with her symptom of light sensitivity now a thing of the past, it could not be attributed to that either. Ms. L began to realize that the weaning experience she had undergone at the age of one year may have been pivotal in the genesis of this nighttime anxiety, even though the experience could only be reconstructed rather than revisited emotionally or in recovered memory. But she sensed that her one-year-old self, suddenly bereft of her parents, must have been bewildered, sleepless, angry, inconsolable.

Years later, Ms. L was aware that her nighttime wariness that her parents might leave her was an issue of unmetabolized anger and

the damage it had done to an internal psychological sense of trust. Subsequently, much of this internal turmoil was metabolized and processed. Despite an adenoidectomy and war experiences that had shattered her sense of stability, her childhood was overseen by basically loving, decent parents whose values promoted development in all its complexity. But the transient, nagging anxieties she experienced before falling asleep suggested to Ms. L, as she reconstructed her earliest experiences, that the night was the final repository of these preverbal terrors—intense affects that might never be completely integrated (or neutralized, to use Hartmann's [1955] concept).

Seeing the light through even the most complex psychoanalytic lens does not change the human condition into a fairy tale, Ms. L came to realize. But it can reclaim the privileges of a human voice that can speak its mind even when reality is at its most menacing. When the eye of the mind flinches at such moments and transforms the truth into a mirage for a period of time, psychoanalysis, which recognizes such defensive displacements, can also in time reclaim the hidden truth in them.

CONCLUSION

This paper has focused on one clinical dimension of a topic at the very core of psychoanalysis. It is ironic, perhaps, that a concept as synthetic in form and as global in content would seem to suggest by its very name—*insight*—a *perceptual* preference, as if *visual* aspects were its main component. On reflection, after this perceptual prejudice is set aside, insight can be viewed as a much more complex integration of all attributes of mind in the service of self-knowledge.

The idea that an exclusive focus on light could obscure the form beneath the light brings to mind the differing perspectives of the artistic movements of impressionism and postimpressionism—the latter insisting that Cezanne's focus on form was as important as, if not more important than, Monet's obsession with light. This paper examines two analogous points of view in the analytic situation, suggesting that reality is a complex mixture of perceptual and conceptual qualities of mind, and that insight ignores none of these as it attempts

to take the measure of *what is real. Seeing the light* is a beautiful, metaphorical way of capturing such complexity, and—as long as one does not confuse metaphor and reality—insight, in all its multifaceted glory, is not compromised.

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BODY, AFFECT, THOUGHT: REFLECTIONS ON THE WORK OF MATTE BLANCO AND FERRARI

BY RICCARDO LOMBARDI

The author takes the body to be the point of departure—and the central foundation of symbolization—in psychoanalytic theory and practice. This perspective recognizes the body as a precondition for the formation of affects and for their registration in conscious awareness. Ignacio Matte Blanco (1975, 1984, 1988) considers that sensation-feeling *is the link that connects emotion with thinking, the unrepressed unconscious with consciousness, and the body with the mind. Armando Ferrari (1986, 2004) conceptualizes the body as the* concrete original object (COO), *from whose inchoate promptings the sensory function and perceptual activity upon which mental functioning is founded are derived. The author suggests that these hypotheses offer a structure that facilitates psychoanalytic process in the treatment of difficult patients.*

INTRODUCTION

A preoccupation with the bodily matrix of subjectivity is intrinsic to Bion's (1962b, 1963, 1965) epistemological formulation. He centered his research on phenomena inherent in the genesis of emo-

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tions and thought, which he tried to emancipate from their implicit Cartesian body–mind dualism.

This integrated conception of body and mind finds its natural application in the investigation of serious psychopathology, including eating disorders such as anorexia and bulimia, panic disorder, and the psychoses. These are extremely challenging to treat and require fresh conceptual and technical approaches. Furthermore, the recent inauguration of a dialogue between psychoanalysis and the neurosciences is orienting analysts back toward the corporeal in a way that Freud himself anticipated (Solms and Nersessian 1999). In both philosophy of the mind and in modern neurophysiology, the physical body, rather than being seen as the passive container of a thinking function concentrated exclusively upon the brain, is instead conceived as the indispensable frame of reference for all the processes that we are in the habit of identifying with the mind (Damasio 1994; Hofstadter and Dennet 1981; Nagel 1974).

Out of this set of elements, there has been a new flowering and rediscovery of the model of one-person psychology functioning (Grotstein 1997), as well as an interest in placing the body at the center of theoretical and clinical psychoanalysis (Bucci 2000). As McDougall (1978) noted, the exploration of somatic manifestations at any depth inevitably leads us to see the body as the psyche's object.

This psychoanalytic observational vertex of *the body as the psyche's object* is the one I will pursue in this paper, with particular reference to some of the original theoretical and technical ideas that both Matte Blanco and Ferrari elaborated on the basis of certain of Freud's central formulations. Matte Blanco's (1975, 1988) work develops the characteristics of the system *Ucs.*, as these were inferred by Freud (1900, chapter 6); Matte Blanco correlates these with important insights into the function of emotion, in which thought assumes the logico-mathematical connotations of infinite sets. Ferrari's (2004) research into the relationship of body–mind, on the other hand, is built on the metapsychological oscillating system of word-presentation/thing-presentation drawn from Freud's topographical model (Freud 1915b).

These two perspectives in part converge and are in part complementary in that both refer to Freud's system, attaching mental function to its links with its bodily aspects and to a more specifically cognitive one, respectively. Bria (2000) spoke of the meeting between Matte Blanco and Ferrari as one that had failed to take place, or that at least had not been developed, given that each system touches the very heart of psychoanalysis and seems similar to the other system, notwithstanding the extreme difference of their languages.

I shall select those aspects of Matte Blanco's and Ferrari's contributions that seem most in keeping with what I have seen and learned in my personal clinical experience, and which have led me to attribute particular value to *the interaction between sensation and abstraction* as a possible *nodal point that can account for the formation of thought disorder* (Bion 1962a, 1962b), even when such a disorder takes the external form of a deterioration in the most evolved mental functions and of object relations. Our analysands, in fact, with an ever-increasing frequency, reveal a lack of integration of sensory experience with symbolic elaboration. This puts us in need of *theoretical and operational tools with which to help them feel and discriminate within their own sensations,* as an indispensable precondition to personal growth and to the capacity to form relationships.[1]

Even though a theoretical model comprises a coherent ensemble that cannot be directly replicated outside its conceptual framework, I maintain that a study of the epistemological strands that meet in Matte Blanco and Ferrari is an important contribution to the debate about current developments in psychoanalysis. In this paper, I will concentrate on certain theoretical issues and illustrate them with very short clinical vignettes, having previously published

[1] Bolognini (2000) refers to a patient's surprise at one of his interpretations in which he asked him about his "not feeling." He talks about "*an intervention that doesn't make much sense in terms of technical theory,* but which none the less works, just as when we touch ripe fruit on a tree and feel it deposit itself gently and effortlessly in our palm." The unusualness of an intervention about "feeling"—or about the workings of body–mind, with respect to what is habitually shared of psychoanalytic technique, seems to me to underline the novelty of the perspective that I am putting forward.

their more detailed clinical descriptions (Lombardi 2002, 2003a, 2003b, 2004, 2005, 2008).

A NOTE ON THE PRESENCE OF THE BODY IN PSYCHOANALYTIC THOUGHT

In the historic beginnings of psychoanalysis as a means to understand hysteria (Freud and Breuer 1895), the psychoanalytic process characteristically took as its starting point the body and its stimuli as they lead to emotion and thought, because of the specific manifestations of this condition that directly involve the body. The point at which the "pains in her legs" (p. 135) regularly start "to join in the conversation" of Elizabeth von R's analysis is an emblematic moment (p. 148). Freud's references to the physical reality of the body in the construction of his theories became gradually fewer following this first phase; but an overall glance at psychoanalytic evolution reveals that the body has always been considered central to the function and development of the mind, above all because of the pressure of instincts that surge from its interior and permit, among other things, the discrimination between inner and outer (Freud 1916-1917).

The bodily implications of Freud's essays on sexuality (1905) and narcissism (1914) are evident, as are those contained in his essay on the two principles of mental functioning (1911)—in particular the theory of thought as an instrument for the containment of muscular discharge, and the theory of the birth of the mind by means of directing the sense organs toward the external world. It should be remembered that these theories lent themselves to enormous expansion at a later date with Bion's theory of learning from experience (Bion 1962b).

A few years later, faced with the daunting task of constructing a metapsychology for psychoanalysis, Freud (1915a) decided to place the biological component—linked to the needs of the body and their consequent psychic expression—at the foundational level of his construction, expounding his theory of instincts (*trieb*) as the expression of the "demand for work" (*Arbeitsanforderung*) that is imposed on the

psyche by virtue of its connection to the physical. In his essay on *The Unconscious* (Freud 1915b), he puts forward the need for a connection between thing-presentation (*Dingvorstellung*) and word-presentation (W*ortvorstellung*) as a basic element in the process of thought, thus firmly reestablishing the body and sensory experience as links in mental processes.

With the advent of his tripartite model of the psychic apparatus, Freud remained preoccupied with connections between the concrete and the abstract, locating the roots of the id in the workings of the body, while at the same time recognizing the fundamental contribution of the body to the ego and to the establishment of a sense of identity (Freud 1923). He returned to these issues in the last work he wrote before he died (Freud 1940), when he recognized that "the supposedly somatic concomitant phenomena" are assimilated with "what is truly psychical, and thus in the first instance disregards the quality of consciousness" (p. 158). Here Freud seemed to reformulate the conscious–unconscious relationship in terms of the body–mind relationship, at the point where exploration of the unconscious (which by its nature is inexhaustible) coincides with a progressive approach to the individual's physical basis.

While the role of the body tends to stay somewhat in the shadows in Klein's theoretical elaborations, Isaacs (1948) clearly recognizes the structuring contribution of the body–mind link in the formation and interpretation of innate unconscious fantasy. She sees unconscious fantasy as the direct derivation of what Freud observed in the bodies of his hysterical patients, who dramatized in their so-called conversion symptoms the emergence of the sensory matrix:

> Each detail of the symptoms turns out to have a specific meaning, i.e., to express a specific phantasy; and the various shifts of form and intensity and bodily part affected reflect changes in phantasy, occurring in response to outer events or to inner pressures. [Isaacs 1948, p. 85]

In this way, the body comes to be considered the place where the first stirrings of the mind emerge, before they can assume mental connotations: "The earliest phantasies, then, spring from bodily im-

pulses and are interwoven with bodily sensations and affects" (Isaacs, p. 86). This statement is consonant with Freudian drive theory as the link between psyche and soma, as Segal (1964, p. 31) was to emphasize at a later date. Isaacs continued: "Since the infant has so few resources at his command for expressing either love or hate, he has to use all his bodily products and activities as means of expressing his profound and overwhelming wishes and emotions" (1948, p. 87).

Isaacs's perspective makes it possible to value the importance of the body in cases (more common than ever today) in which a deficit in the capacity for symbolization impedes the transfer of sensory exigency into the mind. In these forms, *the body expresses something that has not yet found the strength to develop into emotion and thought* —or *something concrete* that awaits the means for symbolic unfolding.

In the wake of Freud, numerous authors have underlined the importance of the body in primitive mental states (e.g., Gaddini 1980; Lieberman 2000; Mahler and McDevitt 1982; Marty 1976, 1980; Peto 1959; Resnik 2001; Scott 1948; Winnicott 1949). Their interest, furthermore, centers on the exploration of specific areas of disturbance or pathology, such as so-called psychosomatic states, or the atrophy of certain mental functions that compromise emotional registration (as is the case in alexithymia; see Nemiah and Sifneos 1970), or Marty's (1976) *pensée operatoire.*

Apart from physical sensation, the workings of the body and the body image (Schilder 1956) contribute importantly to a sense of identity. In relation to this, studies that recognize the interrelation between bodily sensation and the sense of reality (Frosch 1966; Lichtenberg 1978), and the constitution of the self (Meissner 1997, 1998a, 1998b, 1998c), assume particular importance. It is noteworthy that Meissner critically underlines the presence of "a dualism familiar enough in analytic discourse" (1997, p. 422), and (in line with Gill) he observes that psychoanalysis generally considers the body in terms of its meanings, rather than the body per se. This tendency is potentially dangerous because it can confine psychoanalysis to a hermeneutic methodology. Nor should we fail to acknowledge the importance of the sense of unity that derives from "material internal reality" as the expression of a "reality constancy" (Frosch

1966, p. 353) furnished by the body. This is an area of theoretical and clinical relevance that needs to be deepened by further study.

PURE SENSATION, SENSATION-FEELING, AND THOUGHT IN THE WORK OF MATTE BLANCO

An exhaustive treatment of Matte Blanco's work is obviously beyond the scope of the present paper; the reader can find this elsewhere (Rayner 1995; Rayner and Tuckett 1988). Here I will concentrate on his thought as it pertains to the relation between bodily phenomena and mental manifestations.

Freud (1900, 1915a, 1915b) enunciated the characteristics of the unconscious system: the absence of a logical framework, the coexistence of thought with nonthought, the absence of temporal ordering, the absence of contradiction, condensation, displacement, the substitution of psychic reality for external reality, and so on; and in this way, he enunciated the laws that characterize the unconscious system as *a structure that violates the laws of common logic.* A common trait of unconscious mechanisms is *to dissolve and to unite,* as opposed to the tendency to employ discrimination that is typically seen in human reasoning. This perspective on the unconscious system led Matte Blanco to reformulate Freud's discoveries, shifting his observational focus from the repressed unconscious to the *structural or unrepressed unconscious,* and to reorganize the characteristics of the unconscious into two fundamental principles, which are active not only in dreams and in other manifestations of the unconscious, but in every manifestation of thought.

For Matte Blanco, there are two fundamental principles related to the unconscious: the *principle of generalization* and the *principle of symmetry.* The first recognizes that the unconscious treats any element, whether person, object, or concept, as an element of a class or set. The second principle refers to the fact that the unconscious treats asymmetrical relations (whose very asymmetry indicates that they are founded on distinctions) as if they were symmetrical, and all distinction disappears.

While the principle of generalization—conforming to the laws of normal logic—leads to the formation of ever-wider categories, contributing significantly to the phenomenology of the unconscious, the principle of symmetry, nullifying all distinction and logic, leads to "real havoc in the temporo-spatial structure of our thinking"; in this way, "the differentiated and divisible aspect of our thinking/world is substituted for a tendency to homogeneity and the indivisible" (Bria 1981).

The interrelationship between *bivalent logic* (the common logic of thinking as described by Aristotle) and *symmetrical logic* (that is, the aberrant logic of the unconscious discovered by Freud, which latter parasitizes and tears apart the order of thought) is called by Matte Blanco a *bi-logical structure*. In phobia, for example, the phobic object represents the condensation (symmetrization) of several emotional situations that become so numerous and indistinguishable, one from the other, as to paralyze thought; *the emotion of fear becomes infinite as a result of symmetrization*. Psychoanalysis eases the passage from symmetry to asymmetry by encouraging the capacity for discrimination; that is, *asymmetrical distinctions* make it possible to get the anxiety into proportion, to confront the distinct situation in its specificity, and to think about it in its own particularity.

An example is George, an adolescent patient who has attacks of panic and phobia. He becomes paralyzed because he attributes to every new situation all the failures he experienced during a period of acute illness. This happens principally because *he symmetrizes past experience with future experience*, attributing failures of the past to situations in the future. Furthermore, he attributes to every event an absolute value, whereby *he fears failure because he interprets each failure as the epitome of every failure* (symmetrization), rather than recognizing each experience as separate and evaluating it according to its own merits (asymmetrization).

The same process of symmetrization is operating when George *lives every experience as if it were "a struggle against the forces of Evil"* (that is, *Evil* as an infinite affect that is distinct from the singularity of an *evil* with a small *e*). Thus, every experience becomes a sort of *Star Wars* episode in which the world is in danger, and George has

this reaction to every occasion, rather than considering it *a circumscribed experience* in which he might learn something useful, even when things go badly. But the introduction of asymmetry over the course of psychoanalytic psychotherapy made experiences that George previously found impossible both more acceptable and more thinkable.

"What psychoanalysts sometimes overlook," writes Renik (2006), "is that every clinical analysis can be understood as a desensitization process in which the patient learns to tolerate experiences that were previously intolerable" (p. 128). If we consider that thought plays a central role in this desensitization process, we might say that the therapeutic action of psychoanalysis is accomplished principally by means of a restructuring of the tendency toward symmetry, and by activating the capacity for asymmetrical discrimination, so that experiences that had been intolerable now become tolerable.

The following clinical fragment presented by Rayner (1981) helps us more easily grasp the concept of symmetrization at a relational level:

> A patient dreamt she was going down a ski slope with her instructor. Part of the way down, he stopped, but she continued the rest of the way easily by herself. The session then showed how she experienced parting from "givers of instructions" at different periods of her life. The ski instructor could be recognized as a condensed, timeless image of her mother, her father, her brother, her husband, her analyst, and also a part of herself. [p. 407]

Rayner shows how the *principle of generalization* gives rise to a dream figure that encompasses a very wide context ("her mother, her father, her brother, her husband, her analyst, and also a part of herself"), causing the meaning of the dream to broaden considerably. Thus, an understanding of the way in which the principle of generalization operates helps the analyst make significant connections that enlarge his understanding of the meaning of the analytic relationship. The *principle of symmetry* means that the ski instructor of the dream becomes indistinguishable from the other objects—real objects—with which he has been assimilated via the principle

of generalization, and the same mechanism allows the analyst to be concretely experienced as the patient's mother (or other objects) at an emotional level.

What these facts demonstrate is that for the deep unconscious, the analytic relationship, as a real relationship, implies continuous affective symbolization that is mediated by the principle of generalization at a level we now understand to be that of implicit memory (Clyman 1991). This unconscious symbolic activity becomes a direct agent for change to the deep structures of the unconscious, and can discharge a therapeutic function that does not necessarily need to involve historical reconstructions. This characteristic of unconscious structural function explains, at a metapsychological level, why it may be that an intersubjective approach results in profound change through an essential reliance on the mutative impact of the analytic relationship. That is, the analytic relationship is incorporated into the system of categories that contains all the subject's emotionally meaningful past relationships, and the analytic relationship also helps promote modifications toward more realistic configurations within that system.

From this epistemological basis, Matte Blanco approaches the awareness of emotion, privileging the logical aspect, whereas the Freudian tradition studied it from an energetic point of view. To emotion that arises out of the bodily matrix is added *propositional activity,* which introduces into sensory data the establishment of relations. This is, properly speaking, the activity of thought. In this way, *emotion* is conceived as being *made up of sensation-feeling* and *thought*, where the latter assumes its own logical organization, one that is different from the order of conversationally logical thought. "Emotion, insofar as it is emotion," writes Matte Blanco (1975), "does not know individuals but only classes or propositional functions, and, therefore, when confronted with an individual, tends to identify this individual with the class to which it belongs" (p. 244).

When we look at an individual from the point of view of emotion, we no longer see that particular individual, but the category that denotes him, together with all the implications of its constituent features. And this is the case even though, from the point of view of

adult logic, we might simultaneously recognize that we are looking at one particular individual. This emotional logic is the same logic that Freud discovered at work in the unconscious. From this perspective, it is unequivocal that the unconscious manifests and expresses itself in every emotion that we live.

In emotion, then, there is a loss of boundaries between individuals. This is exactly what happens in psychosis, in that the psychotic individual treats people as *identical*, even when they are only *equivalent*, or have in common a single relating feature. Freud's study of Schreber provides an example: Flechsig was identified with God merely by virtue of their both belonging to the category of fathers (Matte Blanco 1975, p. 139).

In addition to its being a component of thinking, emotion has within it "the expression of some corporeal state" (p. 220), according to Matte Blanco—expressions manifested as such or serving as the spurs to action. Matte Blanco defines *sensation-feeling* as the psychological registration of bodily events. Upon this initial mental manifestation of the physical state of emotion, thoughts can develop, and we may consider them to be a constituent part of the emotion itself.

Inasmuch, then, as Matte Blanco sees in the establishment of relationships an essential part of sensation, he is at pains to distinguish a borderline condition in which sensation appears in consciousness in a state of absolute nakedness—*pure sensation*. This is registered as simple and indivisible, at the point of being felt, outside time and other distinctions that otherwise generally signify thought. Where distinctions do appear, we have simply covered the sensorial event with thinking (Matte Blanco 1975, p. 234).

The distinction between *pure sensation*, *sensation-feeling*, and *thoughts* connected to sensory activity seems to me a crucial one, especially in the light of different paths that depart from each of these individual components, creating the conditions for the dominance of either symmetrical or asymmetrical components present in any given life experience. Making use of such a discrimination would allow one to hypothesize, for example, that pure sensation could become enclosed in itself and static to the point of being infinite and indivisible, an exclusive area *radically dissociated* from the realm of thought. When such

sensory states are concretely experienced, *the presence of sensation in the mind tends to be saturated to such a degree that its participation in any thought is blocked.* This sort of state is marked phenomenologically by confusion and sensory chaos, and logically by the absence of asymmetry, so that symmetry dominates.

I will illustrate this state with some material about Anna, who is forty and who comes to analysis three times a week. As an infant, she suffered sexual abuse at the hands of her adoptive father. She and I have had to endure a period of intense suspiciousness and hatred in the course of the first two years of her analysis, and overcoming these difficulties has greatly strengthened the analytic relationship; the analysis now seems to progress in a positive way.

In the course of a session during the third year, in which the dialogue between us seemed very productive, at a certain point, Anna started to show signs of evident agitation and of chaotic thinking and to enter into a real panic. She made it clear that she wanted to leave the session. I wondered if I was witnessing a paradoxical case of negative therapeutic reaction (Freud 1923; Rosenfeld 1975). I felt physically agitated and breathless—without, however, being able to pinpoint either my analysand's agitation or my own.

All at once, she burst into tears and said that, while I had been speaking earlier in the session, she had suddenly been insistently aware of her vulva in its place between her legs, and it was at this point that she had been seized by panic. I suggested that she had experienced the dialogue in our session as indicative of our becoming emotionally closer, and hence as expressive of some intimacy; she had consequently linked *emotional intimacy* between us with *sexual intimacy* (via generalization), to the point that she had experienced them *as if they were absolutely one and the same thing* (symmetrization). Her desire to escape was thus a way of running away from what she perceived as sexual contact, when it was actually only her emotional participation in our relationship. This mutually constructive relationship had been equated with the sort of intimate exchange that appropriately occurs in the context of a sexual exchange. My intervention to this effect immediately calmed the analysand, and she visibly relaxed on the couch.

We can surmise that Anna's genital sensations involved a flood of somatic input, to the point that her capacity for thought was overwhelmed. My registering this in the analytic reverie (Bion 1962a, 1962b) allowed me to share her panic, which immediately made it more tolerable. Following this, my intervention offered the patient a clearer *distinction between,* on the one hand, *a sensation that was a concrete, bodily fact of a sexual nature,* and, on the other hand, *her bodily, emotional participation, which was of a symbolic nature.*

This interpretation helped Anna reconfigure the symmetrical nature of what she had experienced. Her lived emotional experience in the here and now reintegrated her bodily participation with her experience of our relationship, which indirectly permitted her to work through some of the symmetrical components that had been linked to her history of infantile emotional trauma. In such cases, psychoanalysis can work "in vivo" to reconfigure an all-engulfing emotion so as to facilitate thinking in the presence of emotion (Bion 1962a, 1962b). This is in contrast with the psychoanalytic use of rational and historical reconstruction, which risks becoming too abstract and too removed from the pragmatic work of emotional function; such reconstructions often introduce an *as-if* situation—as evidenced, for instance, by a conventional transference interpretation such as "you are having an experience of me *as if* I were your incestuous father." This reading of the analytic exchange as an *as if* can, in my view, invalidate the impact of the emotional experience and the benefit of the experience as it is lived authentically in the relationship.

I believe that, when sensation becomes absolute in this way, it represents a boundary that is very important to the understanding of certain clinical phenomena. It coincides with various psychotic states and states induced by some intoxicants, as well as with the sort of primitive states described in Winnicott's later writings (1974) and by Tustin (1981). Such absolute states also seem to correlate with those described by poets, being far from integrated mental function—such as the pure sensory state of Mallarmé's *notion pure* (Agosti 1982), or those that evoke sensory and bodily states in which the activation and function of consciousness is constantly being pre-

sented again in *statu nascendi* ("Je rayonne—mon corps rayonne, dans le noir, vers une conscience, la sienne" [Valery 1973, p. 917]).

If, then, for Matte Blanco, "sensation-feeling is orientated towards the grasping of corporeal events" (Matte Blanco, 1975, p. 306), it becomes *the expression of a functional relationship between body and mind via the unfolding of biological phenomena.* This offers a vantage from which to view the oscillation between the function of pure sensation and that of sensation-emotion, and between the dominance of symmetry and that of asymmetry. And this in turn helps us understand the phenomena occurring in this specific area, which provides both a watershed and a staging post between the physical and the psychic phenomena. For Matte Blanco (1975), emotion and the unconscious are subject to the same laws; this leads him to assert that "when Freud discovered the laws governing the unconscious, he actually discovered the intimate nature of emotion, even though he did not express it in this way" (p. 307).

But if the function of emotion as infinite sets is above all the mental expression of the registration of bodily events, we have to conclude that Freud's discovery of the unconscious and of the structural laws that govern its function coincide quintessentially with *the discovery of the way in which body and mind are related*, as well as the logical and psychological implications that derive from the existence of these two functional axes and their sovereign importance for overall mental functioning.

Apart from the intersection between sensation and thinking that sensation-feeling and emotion as infinite sets offer to the state of coming-into-being, an example of the use of the body that seems significant to me is provided by Matte Blanco in the form of the concept of the *epistemological seesaw*, for which he takes inspiration from a section of Bion's *A Memoir of the Future* (1993). For the sake of brevity, I will confine myself to quoting only a fragment of this section here: "'E fell on 'is arse. And 'is arse wuz angry and said, Get off my arse!" Matte Blanco (1988) comments that in this fragment, "the arse is promoted from the status of part of the body to that of an honourable person. 'He' then proceeds to speak, i.e., behave like a person" (p. 49).

The author recognizes in this proposition a symmetrization between part and whole, or rather between one part of the body and the person as a whole. At the same time, he recognizes the epistemological seesaw whereby "whenever one of the modes is expressed, the other one comes forth and claims its rights, and so on" (Matte Blanco 1988, p. 51). If we consider the previously described clinical vignette of Anna, we can hypothesize that this patient who became aware of her vulva during the session was realizing a symmetrization between herself as a subject and a part of her body deeply connected with her sexual identity. She was in effect "being" her vulva via the experience of pure sensation and panic, identifying her *self* with her sexual organ, as she experienced emotional containment and respect in the analytic relationship; eventually, this experience of the relationship allowed her to significantly modify her previous traumatic experiences.

It seems to me, then, that the confrontation with one's own body, in the oscillation between referring to one of its parts and assuming this to be a reference to one's totality, to one's self, contains the important potential whereby both modes of being are, by their very nature, drawn into play. In light of what I am proposing in this paper, the epistemological seesaw should not be considered only as a different bi-logical structure, but rather as a crucial stage in mental functioning, because of its ability to ensure a relationship and continuity between the levels of a concrete, bodily nature and the symbolic levels of the mind (Freud 1915b). The epistemological seesaw is a central stage for the unfolding of thinking as a function in the service of sensory processing.

FERRARI AND THE ECLIPSE OF THE BODY

Ferrari (2004) calls the body the "Concrete Original Object" (COO) in order to underline its generative potential and the strangeness of the experiences it generates. The *onefold* nature of the individual's body is translated by successive mental development into its mental expression, according to Ferrari. *The body* comes to be taken as

the *object of choice for the mind,* and as *its first reality.* This means that the mind—or, more precisely, the *twofold*—derives directly from the body, the *onefold,* and that its primary function is to contain and organize the sensory thrust that originates in it. Were sensation to find no coordination within mental function, it would be so disorganized as to be incompatible with the subject's very survival.

The *eclipse* of the body is a metaphor that describes the progressive reduction of space primitively occupied by sensory phenomena with the appearance of the first perceptual phenomena and with mental registration, which constitute the "shadow" that comes to cover the COO—or, more precisely, that primitive body that is all sensation. The diminution of sensory tension that is ushered in by the eclipse of the body is achieved thanks to the interposition of a maternal filter. As Bion (1962b) notes, the mother discharges the vital role of reverie in desaturating the infant's sensory input.

But Ferrari makes the particular point that the operation of containment and transformation takes place essentially within the interior of the infant. In this sense, the eclipse of the body belongs to an area that is distinct from and at a stage occurring before those phenomena of projection and introjection described by Klein (1952). Kleinian projection and introjection presuppose a level of mental functioning and integration that is already more sophisticated than what can be applied to the primitive conditions surrounding the activation of mental phenomena that depart from sensory data.

Ferrari locates the body–mind relation at the organizational center of analytic development, and he confronts the resultant, inevitable metapsychological implications for mental function as a whole. On this basis, Ferrari posits a *double primary relationship* that proceeds in a parallel fashion throughout the course of development. This consists of the ego–body relationship, which Ferrari refers to as the *vertical relation,* and the ego-external object relationship, which Ferrari refers to as the *horizontal relation.* The vertical and horizontal relations are themselves in a mutual and dynamic relationship, and are constitutionally indissociable. The vertical on its own does not have the means to represent itself without access to the relational possibilities offered by the horizontal, just as the

day residues of dreams permit conscious representation that would otherwise be impossible (Freud 1900).

The horizontal axis—that is, the ego-external object relationship—does not represent a departure from what is already well known and studied in terms of manifestations in the transference and the analytic relationship. *The vertical axis,* on the other hand, *that of the body--mind relationship,* represents *a far more original technical advance for psychoanalysis.* The distinction between these two axes raises the important technical possibility of using only one of them in the construction of what Ferrari (1986) calls *analytic propositions* that can be offered to the patient in the course of an analysis.

The vertical axis is particularly useful for bringing conflicts between body and mind into focus (the so-called *disharmony of the body –mind relationship*), as well as the corresponding conflicts between *animality* and *humanity* that can arise when the reality of the body and its manifestations are not completely recognized and mentally elaborated. Such conflicts can involve the subject in, for example, *bodily shame* dynamics, from neurotic levels to those more clearly psychotic and paranoid (Lombardi 2007). These conflictual manifestations commonly come to be attributed to more fully developed areas, in the manner of an ego ideal failure triggered by oedipal objects (Morrison 1989), which may cause us to lose sight of the more primitive implications of the subject's conflict with the real, animal nature of his body.

For example, Elise (2008) described a case of sexual shame, closely correlating it with the patient's sense of oedipal defeat with her father. This patient felt that she was "reduced to being an animal" while making love in certain sexual positions, despite the fact that this afforded her intense enjoyment. "Like a monkey—she thought—what kind of position is this for any self-respecting adult!" (p. 82). According to Ferrari's perspective, in this case, the bodily shame and inhibition of sexuality could be explored for implications more directly connected to body–mind conflict and to devaluation of "animal" tendencies, in addition to possible relational implications.

The experience of working with patients with a thought disorder, in particular, often demonstrates the difficulties inherent in fol-

lowing the many vicissitudes of the transference relationship. So-called narcissists, for instance, tend to easily deny the implicit relationship observed with the analyst, or to grossly distort its meaning. In such contexts, interpretation on the vertical axis—on the relationship that the analysand has with himself, and, more particularly, with his body, body parts, or body functions—can be an invaluable aid in moving the analysis forward.[2]

This becomes particularly evident in cases where the analysand is overwhelmed by psychosis and delusions that cannot be reached through more sophisticated channels, and that are beyond the mental resources of the patient (Lombardi 2000). Using the vertical helps organize a certain level of work on the patient's internal world by seeking to represent it in the patient's primary relationship with himself while in the presence of another (Winnicott 1958), whereas an emphasis on the transference runs the risk of reinforcing primitive fusional/confusional mechanisms, on the one hand, or of fostering imitation, on the other, to the point of obstructing real participation in the analytic experience.

In order to illustrate the clinical application of the concept of the vertical axis, I will relate a clinical vignette from the analysis of Maria, a 26-year-old patient in four-sessions-a-week analysis. She had severe difficulties with relationships and life in general, and was inhibited to the point of never having had a sexual relationship. A recurring image in her dreams was of herself with neither arms nor legs. This seemed to correspond to her tendency to obliterate her body and to paralyze her capacity for learning from experience at its very root. The analytic approach was to validate the sensory experience aroused in her body during the sessions in order to facilitate her body–mind relation.

In one dream, Maria experienced herself for the first time as having a complete, unmutilated body. In the dream, she was taking

[2] The way in which the vertical transference unfolds with respect to the horizontal should be read in light of the relationship between physicality and the psychic within the analysand, rather than in terms of dynamic conflict with another. This modality favors the possibility of repairing conflict in the body–mind relationship, which is otherwise irreparable because it is located in a very concrete area, hard to access or elaborate mentally.

a class in popular dancing and learning to move her legs in time to the music. Her teacher put his hands under her dress so as to direct the movements of her legs through contact with his hands, and in describing this aspect of the dream, Maria commented that the feeling of contact on her legs was unpleasant.

The analyst, a woman, suggested that Maria was starting to get to know her body and its sensations; she was allowing some space within herself for the music of her sensations, rather than considering herself absent and paralyzed. In this way, the analyst added, Maria seemed to be tolerating her hatred of her bodily sensations, a hatred that on other occasions had led her to feel that she was handicapped or without a body.

Maria replied that in the dream, the dance movements were executed with her legs spread wide and while she was crouching down, so that it seemed to her that they were a sort of preparative exercise for childbirth. The analyst wondered out loud whether Maria was not preparing to give birth to herself as a real person, who, by *allowing herself to have her own real body, could give birth to her own thought*, rather than staying imprisoned in an intrauterine, unborn state. Maria's response was to say that she felt relaxed on the couch, and that this state of relaxation felt pleasurable, whereas this would have been impossible previously.

In this session, the analyst used the vertical relation to communicate with the analysand. This emphasized the relation with herself that Maria was putting in motion by operating a *sensorial perception,* that of being "touched" on her legs, through which she initiated *vital movements,* in marked contrast to her former state of paralysis. In this clinical context, sensory perception was considered unpleasant, and was indeed hated and feared by the patient as a source of catastrophic change (Bion 1974), which might threaten her omnipotent defensive system of control.

The teacher's contact with the analysand's legs in the dream also referred to the *horizontal* relation—specifically, to the role played by the analytic reverie (Bion 1962a, 1962b) in facilitating the patient's approach to her own physical sensations; but the technical choice of a *vertical* approach emphasized *the patient's orientation toward*

herself, and allowed her to play an *active role* in accepting or refusing to acknowledge her body–mind relationship. In addition, working with the clinical material on the vertical avoids possible misunderstandings that can arise when the connection between the sensory world and the relationship with the other is emphasized. In patients with severe pathology, this can induce an erotization of the relationship, together with dangerous acting out (see, e.g., Gabbard 2003).

For Ferrari, the body is not only the point of departure for the birth of mental activity, but also the center from which psychic activity, in its constant state of becoming, is initiated and is confronted. Sensations, emotions, and feelings are continually in play in mental processes. The framework of the *eclipse of the body* affords some interesting extensions of Ferrari's hypotheses (among which is an original view of adolescence [see Ferrari 2004], which space does not allow me to dwell on here). Ferrari was also able to reformulate Bion's (1957) concept of psychotic and nonpsychotic areas, locating them in a context that highlights their functional rather than their pathological aspects. He distinguishes an *entropic area* from a *negentropic area* (Ferrari 2004). The first of these is the expression of what emanates from the body as primary emotion and sensation. The negentropic area, on the other hand, is a function of the relationship with the outside world, with the mother in particular or with the analyst in the analytic relationship, both being vital in furnishing conditions of containment and representability to the entropic area.

Ferrari's translation of the psychotic area into an entropic one is not merely a matter of nomenclature. It is an attempt to transcend the pathological and defensive aspects that derive from a theory that conceives beta elements as hostile to thinking, and to emphasize those elements that, arising out of sensory turmoil, contain the germ of new registers of language and thought. In this light, Bion's distinction between beta and alpha becomes less significant for Ferrari, because it is only the failure of the body–mind relation that impedes the structuring of elements that can be used for thinking. If elements for thinking are not constructed, it is because, for what-

ever reason, the internal vertical relationship has been obstructed and interrupted. The analyst's job is to find out what sort of internal disposition the analysand is using, so as to come to some understanding of the different harmonic and/or disharmonic components he employs to relate body to mind and vice versa.

While Ferrari clearly differentiates the sensory element from the abstract level of thought, he nonetheless conceives of sensation as already containing within it an indispensable thrust toward communication and thought. The concept of a *language register* (Ferrari 2004) connects disparate manifestations that emerge from featureless sensory turmoil when they are still laden with the confusion that is the property of raw ethological elements. What others describe phenomenologically as symptomatic of disturbance (anxiety, phobia, hypochondriasis, delusions, dream states, and so on) Ferrari understands to have linguistic possibilities, to be awaiting refinement into something that can occupy the more objective realm of shared language.

While Bion's (1962a) theory of thinking emphasizes the role of the absence of the satisfying mother's breast as a requirement for setting in motion the function of thinking, Ferrari moves the observational vertex, and is more disposed to consider the role of sensation when the infant is confronted by loss of the breast. It is the experience of pain that moves the infant toward an awareness of his body, which imposes itself on his awareness, because he is flooded by an urgent sense of loss (Ferrari and Lombardi 1998).

To illustrate these points, I will briefly describe Anthony, an adolescent of sixteen who is seen once a week. He dreamed that his parents were moving away and finally disappeared all together; when he found himself alone, he saw himself attacked by a tigress that mauled his belly. He associates this with the bellyaches he sometimes suffers from, and after a long pause he adds with real anguish, "I'm really afraid of growing up." He is in this way able *to link his somatic pains to the painful feelings connected with the idea of separation* (a horizontal relationship), but above all are *connected with his anxieties about the responsibilities of growing up* (a vertical relationship).

The *contact net* (Ferrari 2004) is a concept that describes the encounter between the pressure of sensation toward more articulate

expression, on the one hand, and the availability of thought to construe "meaningful connections" between representative data and sensory data, on the other. It is a theory of thinking that seeks to describe the coordination between body and mind, between *one-fold* and *twofold,* in a dynamic cooperation that has the capacity to generate psychic activity. It is therefore from the sensory level—which can in no way be evaded due to the dramatic power that characterizes it—that one's vertical relationship with one's self is constructed. Thus, the infant's state of suffering markedly distinguishes the object's absence from its presence, uncoupling the vertical—the relation between the infant and himself—from the horizontal, which is the relation between infant and mother.

Let me briefly describe Rose, a 30-year-old patient who comes to analysis (now at four times a week) because of panic attacks, bulimia, and anorgasmia. She tells me of a dream in which her friend was showing nude photographs of herself to others, and, in the dream, Rose reacted in a scandalized way because she felt that this was unacceptable and exhibitionistic behavior. In a second dream, she saw herself on a bed, waking up with a photo of the naked girl beside her, though it was now torn up. At this point, the same friend came to sit beside her; the friend's cheek was swollen with toothache. The patient drew closer to her friend and kissed her swollen cheek.

Rose's association is that she has never been able to bear seeing herself naked. The day before, she had tried to look at herself, completely naked in front of the mirror, but it had seemed to her an unsupportable sight. She felt nudity to be an intolerable taboo for her.

I suggest that she is telling me about her hatred of her body, and that this hatred is so intense that she does not even want to see her body in its crude reality, or any body in its reality. So she disavows her body, behaving as though it does not exist, just as she tore up the photo of her naked friend in the dream. When, on the other hand, she is able to put aside her hatred, she can then be affectionate toward her body, just as she was able in the dream to be affectionate to her friend with a toothache, even though this rapprochement exposed her to the pain and conflict she had at first felt on seeing her friend's nude photos.

Here, too, the interpretive orientation is toward the vertical relation, focusing on the conflict that the patient experiences in relation to her body. This interpretation does not read the dream as an expression of relational envy, competitive conflict, or seduction of the analyst. The patient's attempt at depressive integration in the dream (kissing her friend's painful cheek) is viewed as a reference to the relation that the patient has with herself (healthy narcissism), rather than with the object. A vertex that centered upon the object, on the other hand, would have hypothesized the presence of exhibitionistic perversion, or of a homosexual orientation (pathological narcissism), by which the analysand would have been understood as defending against the conflict engendered by the transference.

Ferrari proposes a new vertex, then, that allows us to examine the phenomena involved in the birth of thought. It is a vertex that, centered as it is on the relationality of the subject with the nucleus of his sensoriality and emotionality, offers a new technical modality —apart from the transference—within which to frame the interventions that we offer our analysands. In contrast to Matte Blanco and other psychoanalysts concerned with the body–mind relationship, Ferrari makes this vertex paramount, putting it at the very center of his clinical observations, as the organizing node with which to reorder all other relevant psychoanalytic knowledge. The oscillation between onefold and twofold is, furthermore, something he considers crucial to every form of thinking activity, and so, for him, the body and references to it are a constant theme of psychoanalytic experience; and *psychoanalysis represents the choice to confront and engage in a dialogue with the promptings of internal sensation.*

INFINITY AND SENSORY EXPERIENCE IN PRIMITIVE MENTAL STATES

Matte Blanco's theoretical edifice gives infinity a central place in the concept of the unconscious, rather than its being merely an adjunct to the unconscious as it was discovered and conceptualized by Freud (1900). In addition, infinity has a certain connection, of course,

to the history of logical, mathematical, and philosophical thought (Zellini 1980). For his part, Ferrari attributes the formation of a thinking defect (Bion 1962b) to the relationship of the mind with the *indefinite* fluctuation of physical sensation; that is, the continual, progressive passage from the concrete body to the abstraction of thought confronts the mind with the multidimensional proliferation of the first discernible traces of thinking, and with the inexhaustibility and ineffability of this task.

For both Matte Blanco and Ferrari, then, notwithstanding the differences between their respective models, *the infinite and the indefinite are understood as the most extreme and central challenge involved in the problem of what can be rendered in thought*, so that these are taken as nodal points in the two authors' observational frameworks. For both, the differentiating function of thought permits an *unfolding* (Matte Blanco 1975) from a generative matrix. This matrix is *the sensory world that emanates from the body* as an ineluctable expression of "reality" (Freud 1911; Frosch 1966), a foundational principle outside of which subject and mind have no existence. *The sensory world furnishes the* prima materia *to which the organizing function of the mind is applied.*

The Freudian unconscious is thus led back to its constitutional physical-sensory matrix. In Ferrari, the body is a primary given: mental functions emerge as a result of the reawakening of primitive turmoil and the activation of specialized sense organs. In Matte Blanco, the infinite aspect of pure sensation and of primitive emotion links the presence of the body to a knowledge of the unconscious and the mind. For both authors (however different they may be at the level of theoretical explanation), *the body–mind relation is central* to the extent that this represents the area in which the transformation of the unrepressed unconscious (or the structural unconscious) into conscious manifestation takes place. This is the context that permits passage from the concreteness of the body to the linear and abstract dimensions of thought—allowing the proverbial camel of infinity to pass through the finite eye of the needle.

These authors' interpretations of this great creative effort of abstraction enable Ferrari and Matte Blanco to frame new hypothe-

ses about the function of thought, drawing also on discoveries of insights into object relations and the analytic relationship made by authors like Klein, Balint, Winnicott, Mahler, Bion, and others over the previous fifty years. Matte Blanco's and Ferrari's interest in the abstract implications of the function of thinking shifts the focus from object relations as such to the internal function in more primitive relational states, so that the area they choose to explore moves from the analytic relationship or the original mother–infant relationship to the functioning of the internal world. In this realm, from the point of view of the external observer, subject and object, internal and external cannot be differentiated.

De Jonghe, Rijnierse, and Janssen (1991) systematically reorder the different components of the analytic relationship, helpfully clarifying the various planes that make it up. For these authors, the plane of the transference, that of the realistic relationship, and that of the alliance can be clearly differentiated from the plane of the so-called *primary relationship*, in which any form of differentiation between subject and object disappears, so that it becomes possible to say that, *at the deepest levels, there are no object relations*—without there being, however, any question of falling back on a by-now-outmoded one-person psychology.

De Jonghe, Rijnierse, and Janssen underline the terminological ambiguity that exists in psychoanalysis today as a result of different vocabularies that have been put forth both by individual authors and in broader psychological trends. For example, when authors such as Bibring, Stone, and Kohut used the term *transference,* they were referring to primitive levels of the "primary relationship" (a case in point would be Kohut's narcissistic transference), while others, such as Zetzel, Luborsky, and Greenacre, referred to the same level by using the term *alliance*. "Both 'transference' and 'alliance' suggest the existence of two or more separate individuals and are thus unsuited to indicate a bond between not-yet-individuals" (De Jonghe, Rijnierse, and Janssen 1991, p. 699).

Serious questions arise, therefore, as to which approach is being assumed in relation to interventions aimed at the so-called primary relationship. Interventions based on the body–mind relation

imply the central importance of a relationship between the subject and himself, with his own body, its particular sensations and emotions. These are aimed at putting in motion the beginnings of self-observation and self-awareness. A central assumption is the need for the analysand to recognize himself as an individual, with his own workings and internal dialogue, before confronting another as an external object within a relationship, in contrast to what is assumed in the classical approach to the transference.

Though interpreting the transference at these levels might not seem to forward the development of the analytic process, the transference is nonetheless of utmost importance in terms of the functions it fosters via projective identification (Klein 1946) and reverie (Bion 1962b). It is the means whereby those elements that cannot be directly processed by the analysand can be gathered in and transformed. When the analyst privileges interpretations centered on the relationship that the analysand has with himself, the analyst aims to facilitate the working of the internal body–mind relationship, and with it, the interchange between sensation and thought, a prerequisite to any approach that takes into account the level of the intersubjective relationship.

A common interest in the most primitive levels of mental functioning leads both Ferrari and Matte Blanco away from an emphasis on the transference or the countertransference, which have been so much the familiar ground of psychoanalysis. They choose instead to approach primitive dynamics, where the most pressing problem is the fragmentation of the internal perceptive organization. Such fragmentation puts the capacity to recognize perceptual and emotional phenomena into a state of constant crisis, so that the capacity for self-observation and self-awareness is extremely precarious, if not entirely absent.

Matte Blanco's and Ferrari's renunciation of the level of the transference as containing the most relevant data, and their choice to instead highlight the formal and dispositional aspects of the mind, might expose these two theoreticians to the charge of neglecting the relational. It must be kept in mind, however, that their approach represents, above all, an attempt to respect the limitations of cer-

tain analysands and to use a level of communication that is more accessible to them, in order to establish a dialogue and the exchange of experience. In cases where what is being explored is narcissism and those depths of the psyche that it involves, we need an instrument capable of lowering itself *into* such a system, so as to understand its workings from the inside, and so as to foster positive development of the most primitive and disturbed areas of the analysand. Such a vertex can also contribute to and expand our general understanding of the depths of the human psyche.

As a result of the shift in vertex that they propose, Ferrari and Matte Blanco deliberately move away from an emphasis on the pathology of narcissistic states, adopting instead a theoretical and clinical focus based on the assumption of the patient's structural difficulty in instantiating thought in the presence of the overwhelming force of disorganizing sensation and emotion. In addition, both of them distill the concept of this overwhelming force into two fundamental principles (entropic/negentropic, symmetrical/asymmetrical), which can be reduced to the structural opposition of disorder/order, thereby boldly drawing psychoanalysis into a territory that is central to contemporary science (Keene 1998; Prigogine 1988; Quinodoz 1997).

THE RECOGNITION OF THE BODY AS A PIVOTAL ELEMENT AND THE ESTABLISHMENT OF ASYMMETRY

Matte Blanco shows how the application of the logic of the unconscious (or of the id) leads, via the principle of symmetry, to the abolition of time, a concept that implies the asymmetrical differentiation of each instant that forms a part of it. Fink (1993), in particular, has demonstrated the way in which working with a central nucleus of asymmetry such as time can be crucial for the development of the analytic process. The same logic that abolishes time also abolishes space, as well as the difference between subject and object, and the very notion of *object* itself (Matte Blanco 1975). In contrast to this primordial functioning of the id, the discriminating function of

asymmetry makes possible the recognition of parameters such as space and time, which are then available for the mind and for thought. Matte Blanco (1988) writes:

> There is an intimate relation between thinking and space-time; this latter underlies every thinking activity and, in consequence, every psychical *activity* . . . . The fact that human beings have a body determines in a basic way all their psychic life, *which appears as built from bodily and material experience as a starting point.* [pp. 126-127, italics in original]

Matte Blanco cites Heimann:

> An inner world comes into being. The infant feels that there are objects, parts of people and people, inside his body, that are alive and active, affect him and are affected by him . . . . The infant has only his body with which to express his mental processes. [Heimann 1952, pp. 155-160]

Matte Blanco (1988) comments, "It is from this experience of the body and of the internal world that our psychoanalytical study starts" (p. 127).

The correlation between the body and space-time is very close. Working with the body psychoanalytically involves elements that insist on the presence of time and space and the putting in motion of asymmetrical differentiation. The body moves unavoidably within the confines of day and night and is subject to the cycling of weeks, months, and so on. Tiredness from lack of sleep is marked by signs such as circles under the eyes, pallor, general lassitude, and the slowing down of thought. In the same way, the passage of time is marked on the body with the appearance of wrinkles and all the other characteristic bodily changes of aging. The attempt to make the body disappear is part of an omnipotent strategy that is widespread in our patient population, though it is somewhat underestimated, while the recovery of the body during analysis forces us to confront our realistic physical limitations, which inevitably impact mental functioning.

This type of working in analysis helps resolve an important split between appearance and existence, between life as imagined and life

as reality, of the sort that is brilliantly portrayed in Wilde's *The Portrait of Dorian Gray* (1891), in which corporeal life is confined to a picture. The working through involved is equivalent to actively suggesting an encounter with a real—that is, physical—part of the individual's self that confronts him with a concrete limitation, and is then consequently treated to drastic negation. Although the mind can generate desires and fantasies that take no notice whatsoever of the real limitations of the body, the body refuses to go along with this omnipotent manipulation. The dynamic confrontation with the limitations of the body, then, is an important store of experience from which an asymmetrical unfolding arises.

The development of consciousness of reality and of the self that derives from taking limitations into account seems relevant to the growth of the ego. It is often the case, and especially in psychosis, that the analysand shows no awareness whatsoever of his own limitations, and demands more of his body than it can possibly provide. Physical exhaustion can contribute a great deal to the deterioration of the mental state. And this can form the basis of a dangerous vicious circle leading to repeated episodes of collapse. In such conditions, it is useful to place the real body and its appropriate limitations at the center of the analytic endeavor, so that a knowledge of the body and its breaking point can form the nucleus of a respect for limits and of an awareness of self and reality (see Lombardi 2003b, 2005, for clinical examples). In short, the body plays a pivotal role in its insistence on asymmetry, and constitutes an essential element in the development and elaboration of thought.

THE BODY AS THE ORIGIN OF SYMMETRICAL FORMS

Matte Blanco emphasizes that the symmetrical mode can only be known when it is clothed in bi-logic. He compares the situation with the one in which Wells's invisible man can only be perceived when he is wearing clothes (Matte Blanco 1984). We can say the same for the body: even though it partakes of external reality, *the body enters the realm of individual experience only when it becomes the object of men-*

tal elaboration. This is a type of elaboration that can be realized only by means of bi-logic, or by means of that mixed product of both the modes of being that is symmetrical logic.

The sensations and emotions that arise from the body are unpredictable and difficult for the mind to contain. *These sensations and emotions arising from the body contain the multidimensional meanings of thought as it comes into being, and are highly destabilizing on account of their preponderance of symmetry.* An emphasis on the body–mind relationship in analysis therefore implies attention to the various manifestations of sensations, emotions, and feelings that require a continuous asymmetrical unfolding, so that the component symmetries and infinitizations nested there do not engender confusion and block thinking.

In other words, we are confronted by a paradox with which the body, in and of itself, is endowed: it is a three-dimensional structure that generates multidimensional configurations by virtue of its function, in the moment when it creates "meaningful connections" (Ferrari 2004) with the mind. And in the moment that the body generates a mental phenomenon, it can no longer be reduced to the three dimensionality of its appearance, but appears with the features of nascent thought, which coincide with the logic of emotion or, as previously stated, with the laws that govern the functioning of the unconscious.

Matte Blanco was fascinated by the mysteries of the body–mind problem (1988, p. 136). He took pains at various points in his work to emphasize that emotion, feeling, and mathematical reasoning are by their nature different from crude bodily givens—such as, for instance, the contraction of a muscle. He went on to make the suggestion that "the body, a three-dimensional structure, might, for instance, be a substructure of something which has more dimensions than three" (1988, p. 136). In this he seems to be suggesting the importance of a line of research into the multidimensionality of thought and its connection with the three dimensionality of the body.

Apart from this level—which we might call the generative level of thought arising from a physical matrix—we must consider that the relationality maintained by the mind with the body has all the complexity of an object relationship, which explains the strength of feel-

ings felt toward the body, be they of admiration, deification, hatred, contempt, or murderousness.[3] All this can and needs to be brought within the purview of inquiry into the thinking function and its various ramifications. Matte Blanco (1988, p. 187) supplies a pertinent example when he cites a clinical case in which a young man deals with his anxiety about his body odor by denying it and projecting it into someone else's body. If we integrate Ferrari's contributions with those of Matte Blanco, we might consider another sort of relationality, the subject's relation to his own body, alongside that of projective identification/symmetrization, which operates in relation to the relational other.

THE DISSOLUTION OF THE DISTINCTION BETWEEN SUBJECT AND OBJECT: BEYOND TRANSFERENCE ANALYSIS

Ferrari's thesis that there is an area inherent in the body–mind relationship that exists prior to the emergence of the phenomena of projection and introjection described by Klein (1952) posits the idea of a psychic activity that exists outside the distinction between external and internal. At the beginning of an analysis, when the analysand's mental functioning may amount to little more than a capacity tied to the specialized sense organs and the endowment of the body, the transference arises as a situation in which the analyst becomes an expression of the patient's mental space. This conception of the work of analysis and of the transference might be considered an extension of Bion's (1970) proposals, which concentrate on pro-

[3] Fairbairn (1944) notes the possibility that part of the structure of the ego might treat another as if it were an object, underlining that the relation between the individual and his drives—and obviously, therefore, between the individual and his own body—must be an object relations problem. Fairbairn was concerned that interpretations in terms of drives might lend themselves to defensive use, in the sense that the central ego would have a tendency to withhold itself from what was being described. Hence the necessity for thinking about the relationship between the ego and its body in terms of an object relationship as well, for according to Fairbairn, what an individual must do with his impulses is clearly a problem of object relating.

cesses in the here and now so that they are free from memory and desire, thus eliminating or reducing the risk of relegating experience to the past or the future. From Bion's perspective, this is a sort of discipline to be actively cultivated and sustained in the analyst; its purpose is to combat a tendency to allow references to the past to impede the development of an experience that can take place only insofar as it is tightly related to what is emerging on the sensory level at that moment.

The confrontation with the present is the confrontation with the self, with the vertigo of sensory stimulation that assails it with perception and awareness—or, as Matte Blanco might have put it, with the problem of translating sensation-feeling into thought. Here any distinction between external and internal, or between past and present, loses the relevance it may have at more organized levels of function. In these levels of the psyche, the processes of symmetry are at their most intense. As Matte Blanco (1988) puts it:

> As we go "deeper," we begin to enter the strata where time and space relations are dissolving, where asymmetrical relations begin to decrease, and we find ourselves confronted with increasing proportions of symmetrical relations. We are then approaching the region of what I have called *symmetrical frenzy* . . . . Space–time coordinates become increasingly hazy, so that persons and things begin to fuse with one another until we reach the region described by Freud where time—and, we must add, space—does not exist. [p. 228, italics in original]

In considering all this, it is important to avoid the misconception that this situation must necessarily represent a total fragmentation of consciousness, as is evident in acute confusional states, simply because it offers an explanation of the typical behavior seen in these levels of functioning. Time and space should always be considered continuously present in analysis because they are constitutionally connected to the strata of sensation-feeling; and awareness of them can be facilitated in a crucial way through an analytic tech-

nique selectively aimed at the vertical (Ferrari 2004), which is where the organizational interface between sensation and thought is located.

Systematic interpretation of the transference loses meaning in the perspective of the vertical because, as we have seen, the events lived by the analysand in the analytic relationship emanate from the interaction and interchange between the physical and the psychic as transformative moments that can lead to a structuring of the sense of identity. We should remember that the term *transference* was first defined by Freud (1900) as an intrapsychic mechanism whereby dreams use day residues to gain expression through the transfer of an unconscious trace onto a preconscious idea. This conception permits us to understand the link between the patient's corporeality and the intrasubjective/intersubjective transference present in his verbal communications to the analyst—a perspective more crucial for approaching difficult patients than the generally accepted concept of transference as an exclusively relational mechanism (for details, see Lombardi 2002, p. 372). Bollas (2006) affirmed that contemporary psychoanalysis needs to rediscover the wisdom of this early Freudian perspective, because the excessive focus on transference interpretation risks becoming an illness inside psychoanalysis, a form of paranoia that transforms a selected fact into an absolute truth, which is then used to avoid deep contact with the analysand's unconscious.

The vertical axis, then, permits exploration of areas in which the impact of the concreteness of the body emerges from what is undifferentiated, creating the conditions for a birth of experience on the border with the unconscious. As Matte Blanco (1988) states:

> I think the time is overdue for psychoanalysis to consider systematically the perpetual co-presence and intermingling of timeness-spaceness and timelessness-spacelessness or, more generally expressed, of heterogeneity and indivision, which constitutes the very essence of human nature: an insight which, though not explicitly formulated by Freud, springs directly from his conception of the unconscious. [p. 228]

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[4] *Author's Note:* Ferrari's first book was published in Italian as *L'Eclisse del Corpo* in 1992. In 2004, it was translated into English in a considerably revised format (much editorial material by other authors was omitted), entitled *From the Dawn of Thought to the Eclipse of the Body,* of which it forms Part I. The 2004 book also contains translations of the bulk of two of Ferrari's subsequent books: *L'Alba del Pensiero* (1998), coauthored with Stella, which appears as Part II, "The Dawn of Thought"; and *Adolescenza: La Seconda Sfida* (1994), which appears as Part III, "Adolescence, the Second Challenge."

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THREE VARIETIES OF AUTHORITY

BY JASON A. WHEELER VEGA

Doubts about what can be known may hide what can be said. A focus on knowledge claims and norms that order them —first-, second-, *and* third-person authority—*can replace epistemological projects of all stripes. Further, skeptical worries can be alleviated by attention to the way in which competent language users are secured from radical error by the intersubjective origin and refinement of our thought. Clinical examples, brief outlines of applications, and closer examination of two topics—the assertion of interpretive authority and therapeutic self-disclosure—illustrate some practical uses of these ideas.*

What can and cannot be known about the thoughts, feelings, and motivations of patients in psychotherapy and psychoanalysis, and with what authority may interpretations of these phenomena be given? Mitchell (1998) asserts: "There is no issue on the contemporary psychoanalytic scene, either in our literature or in our clinical conferences, more important than recent, wide-ranging efforts to understand and redefine the nature of the analyst's knowledge and authority" (p. 1). Mitchell writes that he and the whole field of psychoanalysis are struggling to produce "contemporary revisions of psychoanalytic epistemology" (p. 10). Interest in epistemology among clinical theorists has seemed a necessary intellectual and moral activity.

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In contrast, in this paper, I will make the case that analysts' interest in epistemology is optional and may be motivated by insecurity. I shall aim to show how concepts drawn primarily from the work of Donald Davidson (1980, 1984, 1991, 2004), contextualized and outlined in the early pages of this article, can be applied to the understanding of everyday clinical interactions—indeed, to all interactions. I will briefly attempt to show how these concepts may be applied to an analysis of several topics, with scope for further discussion in such areas as, for example, the relationship between authority and authoritarianism, the early history of experiments with interpretive authority, and the question of therapeutic supervision.

Toward the end of this article, I will concentrate on two controversial and complex issues: the authority of the analyst versus that of patients and the role and value of self-disclosure, through examinations of some of the work of Schwaber (e.g., 1997, 1998), Renik (e.g., 1995), and Aron (e.g., 1991).

I believe that the ideas presented here—about how to understand the place of epistemology in relation to psychoanalysis, and the use of three concepts of authority to clarify questions of theory and technique—are of great practical value, as I hope to show in their applications. I also hope that these concepts may find a place within the thinking of clinicians who may not otherwise be interested in philosophical debates.

Knowledge and authority were paired in a group of papers published in *The Psychoanalytic Quarterly* over a decade ago. Many contributors took it as their duty to engage in some manner with "epistemology" as it applies to psychoanalysis (e.g., Elliott and Spezzano 1996; Hanly 1996; Hoffman 1996; Mayer 1996; Schafer 1996). Despite the seriousness of the many contributions, there remained unsatisfying obscurities. Epistemology, the study of empirical knowledge, has been and still is a central philosophical project in the Western world. Major questions about empirical knowledge (or major problems, depending on your point of view) have been posed, such as: how can a mind know itself, another mind, and the contents and qualities of the world of things?

The goal of epistemology in the Western philosophical tradition has been to develop a theory or theories of knowledge that would function to make empirical knowledge *certain*, rather than perennially open to question and beset by skeptical worries. Such theories have often turned to extrinsic justifications for knowledge claims, such as the so-called *given* to experience—a class of foundational experiences to which we may impartially appeal to adjudicate questions of the truth or falsity of our beliefs (Rorty 1979; Sellars 1963). Theories of knowledge also imply ontological commitments—about the kinds of things there are to be known, and whether they are there to be discovered or are fashioned of whole cloth by people making knowledge claims. Thus, such portentous matters as the very nature of reality seem to depend on our epistemological commitments (Oliner 1996).

Psychological motivations for epistemological projects are powerful. As Dewey (1929) puts it: "Man who lives in a world of hazards is compelled to seek for security" (p. 3). A more recent pragmatist, Rorty, asks and answers:

> What was epistemology? A bad answer to a bad question—a question as bad as "What is the good?" Knowledge, like goodness, is a good thing. So it was thought, in both cases, that by having a theory of this good thing, we might be able to acquire more of it. Neither project panned out. [Rorty quoted in Brandom 2000, p. 240]

Not just unfortunate failures, but ill-conceived, these projects may attempt to satisfy psychological needs for security that would be better analyzed than institutionalized (a moral from the later Wittgenstein [1953]). To seek an epistemology for psychoanalysis, or for any other knowledge-producing discipline, is to seek something that will ensure us against error, provide us with algorithms for the congregation of truths.

What would a psychoanalytic epistemology look like? Take a theorem from Freud (1911-1915, p. 113): *The doctor is always right.* This implies a decision procedure initially based on who makes the claim—doctor or patient—and then on whether the patient's claim

would be contradicted by the doctor. One might call this an *epistemology of certainty*. Consider another theorem (Hoffman 1991, p. 77): *The doctor is not always right,* because the doctor is human, too, and so just as fallible as patients.

Despite the limitations of my caricature of a Freudian epistemology, at least it entails a decision procedure for knowledge claims. On the other hand, Hoffman's influential epistemological alternative, what one might call an *epistemology of error,* does not generate decisions. Indeed, recent writing on psychoanalytic epistemology has not attempted to produce anything like a decision procedure for what can be known about patients. This is despite suggestions that formal theories might be formulated for this kind of epistemology (Hoffman 1991, p. 101). Moreover, epistemologies of error are motivated by the same insecurity as are epistemologies of certainty. There may be some security, even moral satisfaction, in the tradition of Socrates—in knowing, at least, that one does not know.

The traditionally accepted way of assessing the correctness of an interpretation is to observe what the patient does after the interpretation is offered. Early in Freud's writing, it was clear that the patient's assent or dissent was not to be accepted as confirmation or disconfirmation of the accuracy of interpretations. For example, Freud did not privilege the statements of Fräulein Elisabeth von R.: "I no longer accepted her declaration that nothing had occurred to her, but assured her that something *must* have occurred to her . . . . I derived from this analysis a literally unqualified reliance on my technique" (Breuer and Freud 1893-1895, p. 154, italics in original). More directly, in regard to his treatment of Dora, Freud (1905) asserted that the analyst should not "rest content with the first 'No' that crosses his path" (p. 24). On the contrary, "No" may signal resistance to an accurate interpretation and offer a metric of its strength. Freud takes relevant associations as confirmations of his hypotheses, adding, "No other kind of 'Yes' can be extracted from the unconscious; there is no such thing at all as an unconscious 'No'" (1905, p. 58). Rather, after delivering an interpretation, Freud asks (to himself): "And now, what have your recollections to say to this?" (p. 72).

However, what counts as a relevant association remains an open question. The patient may reject an interpretation, yet through changes in symptoms, the recollection of a new memory or dream, or some other verbal or nonverbal behavior, the patient may be understood by the analyst to have confirmed or disconfirmed the interpretation. However, this method obviously—perhaps notoriously—lacks formalization. There is no algorithm that one may follow to determine whether a dream or memory, for instance, related after an interpretation, confirms or disconfirms it. Similarly, while it may seem natural to infer that the lessening of a symptom after an interpretation confirms that interpretation, a worsening of the symptom may also coherently be understood as a confirmation of its correctness. (A more recent example of this dilemma, drawing on the work of Arlow [1995] and Schwaber [1998], is discussed later in this article.)

Another idea has been that we might finish our work once we have interpreted to some particular level of psychic functioning—for instance, when we can interpret to patients some of the derivatives of their drives. Ricoeur (1970) writes:

> It is too easily said [though Ricoeur himself argues it is true] that symbols carry within themselves, in their overdetermined semantic structure, the possibility of various interpretations, an interpretation that reduces them to their instinctual basis and an interpretation that develops the complete intentionality of their symbolic meaning. [p. 341]

Here Ricoeur indicates that the drives ("their instinctual basis") may provide a foundation for interpretation. On the other hand, an interpretation might be considered partial if it stops at tracing symbols back to drives and does not go on to fill in more meanings. Though it is tempting—because it provides some security for the interpreter—to take the drives as bedrock for interpretation, Ricoeur rejects the idea that there can be any final (scientific) justification for an interpretation. Instead, he argues that psychoanalytic interpretation is an independent practice (akin to historical hermeneutics) and one whose objects are not circumscribed. It is a

fact, however, that the process of refining a psychoanalytic interpretation does end; it ends when the analysis terminates (Ricoeur 1970, pp. 433, 439). Maybe this is the same truth that we find in the old saw about when a book or poem or painting is finished—that is, when one stops working on it. Perhaps this is not a comforting thought.

But what if there were a way to feel secure without having an epistemology? And if not through epistemology, then how? As Wittgenstein (1953, p. 128) wrote of interpretation in its broadest sense: "nothing is hidden." In fact, all we need to understand the knowledge and authority of therapists and patients is out in the open.

My first aim in this article is to show that three varieties of authority operate within therapeutic and supervisory relationships, and will be referred to here as *first-person authority, second-person authority*, and *third-person authority*. This approach is presented as an alternative to the resort to epistemology for help with particular cases of uncertainty. The three varieties of authority, with which interlocutors and observers of dialogues may make knowledge claims about their own or another's beliefs and desires, do not depend on a theory that purports to sort truth from falsity or certainty from doubt; they consist of norms of everyday communication that have been delineated with special care and given names, so that their operation may be perspicuous. These authorities depend on the mutual authorization of participants to make such claims.

Second, in addition to this normative alternative to epistemology, I will outline an account of *intersubjectivity* that illustrates the unreal nature of skeptical worries about psychoanalytic knowledge in the general case.

Third and finally, I will outline several of the many possible clarifying uses of the concepts presented here, and, by way of illustration, I will apply them in more detail to debates about the assertion of the analyst's authority in treatment, and to the process and value of self-disclosure by analysts and therapists.

FIRST-PERSON AUTHORITY

Everyday communication takes it for granted that Jack knows what he thinks and wants better than Jill knows what he thinks and wants. A

philosophical name for this norm is *first-person authority* (Davidson 1984).[1] More specifically, it is a name for the idea that we should treat Jack's claims about what he thinks and wants differently than we should Jill's claims about what Jack thinks or wants: we should usually take Jack at his word. Jill's claims about Jack, on the other hand, are inferences, second hand, and usually open to question.

In clinical writing, Schafer (1996) describes one of many possible formulations of this principle: "analysands often claim that they are the final authorities on their own subjectivities" (p. 236). This is the normal state of things. Ceding one's first-person authority as an adult is an unusual and unsettling experience. Readers will no doubt easily think of patients, often quite paranoid, who are particularly jealous of their first-person authority and insecure in their knowledge of their own minds, for whom the interpretations of the therapist are at least unwelcome, or even terrifying intrusions, and for whom angry rejection of the therapist's implicit claim to know their thoughts and feelings is the typical reaction to almost any interpretive remark.

The norm of first-person authority rests on an asymmetry between our knowledge of ourselves and our knowledge of others: between first persons, on the one hand, and second or third persons, on the other. Wittgenstein (1953, p. 191) argued that when we ascribe a belief to another, we do so on the basis of observation of that person; but when we say "I believe that *p*," we make a non-inferential assertion and do not have any justification for such a statement. Nevertheless, my saying "I believe *p*" tells my listeners something about my mental state. Given a general theory of action, in which beliefs

[1] Though preceded by others, Davidson's (1980, 1984, 1991, 2004) analysis of first-person authority is seminal and is a central concept of this article. Psychoanalysts have been introduced to Davidson's ideas by Cavell (1993, 2006). In her most recent book, Cavell (2006) also writes about subjects that feature in this article: specifically, first-person authority, triangulation, and epistemology. However, her approaches to these topics are quite different. She aims to contrast first-person authority with alternative accounts of self-knowledge, and discusses triangulation and epistemology in arguing against antirealism. I hope to take up elsewhere other ideas of Davidson, such as the implications of his work on "prior" and "passing" theories of interpretation for the clinical understanding of nonverbal behavior.

and desires motivate and make reasonable our behaviors (that is, make them *actions* rather than mere movements of our bodies), when I make claims about my beliefs and desires, predictions about my actions can be reasonably based on such claims (Wittgenstein 1953, p. 190).

To refine this conclusion, Rorty (1970) observes that there are no practices for challenging first-person reports of some mental states, while there are, in fact, practices for challenging some other reports about other mental states. He distinguishes the *mental*, including such ephemeral phenomena as sensations of color, taste, and so on, from the *psychological*, which centrally includes propositional attitudes (such as "I believe that *p*"). A large part of interacting effectively with others is being able to explain and predict their reactions, and mostly we do this through the attribution of attitudes to others—what philosophers of mind have called *folk psychology, intentional psychology,* or *belief-desire psychology* (Dennett 1978; Stich 1996), and what psychoanalytic writers have more recently called *mentalizing* (Fonagy et al. 2002).

Note that some of these psychological states may initially seem nonpropositional. But if, for example, one says of someone that he is *sad* (as I will show in an upcoming example), one might also try to determine what he is sad *about:* "He is sad that *his sister will not speak to him.*" Mental events, Rorty claims, are marked by *incorrigibility:* there are no procedures for challenging first-person reports of sensations like "I see red" (imagine the unlikelihood of such a statement being followed by "No, you don't," "Yes, I do!," "No, you don't," and so on).

The psychological, on the other hand, *is* corrigible:

> [Psychological reports] are such that our subsequent behavior may provide sufficient evidence for overriding contemporaneous reports of them . . . . Statements about beliefs, desires, emotions, and intentions are implicit predictions of future behavior, predictions which may be falsified. Such falsification provides an accepted procedure for overriding reports. In this they are distinct from reports of thoughts and sensations, which are compatible with any range of future behavior. [Rorty 1970, pp. 419-420]

In everyday life and dialogue, nevertheless, the genuinely incorrigible nature of mental events—the absence of a decision procedure for establishing error in their case—extends its halo over the psychological realm. Also, the general efficiency of taking people at their word as a means of predicting their behavior means that challenging first-person authority is reserved for special circumstances. Thus, we may not often notice that norms for challenging the first-person authority of speakers exist in ordinary life. In addition to the most vivid case of this—of inconsistencies between behavior and the range of beliefs and desires that most would attribute to make those behaviors *actions*, that is, the consequences of beliefs, desires, and intentions—we may notice that there are other general grounds for challenging an individual's first-person authority. Such grounds include: (1) inconsistency with other propositional attitudes; (2) inconsistency with theoretical predictions (either from formal clinical theory or from informal folk-psychological theory) about expectable wishes, hopes, fears, and such, in response to some event or in some situation; and (3) inconsistency between content and form, words and affect. There are doubtless other grounds.

More relevantly to clinicians, Davidson (1984) touches on a link between the concept of first-person authority and psychoanalytic theory:

> Freud's views, by extending the concepts of intention, belief, desire and the rest to include the unconscious, do mean that with respect to some propositional attitudes a person loses direct authority. Indeed, a loss of authority is the main distinguishing feature of unconscious mental states. [p. 7]

Specifically, Freud noticed that we may offer inferences about the psychological states of others that not only aim to correct their first-person reports, but also assume that their first-person authority is radically compromised: the dynamic unconscious includes the subset of a speaker's beliefs and desires that cannot be reliably self-reported.

If we accept that the existence of the unconscious indicates a limit for first-person authority, in Davidson's sense, we might seek to extend it, as indeed Freud's early psychoanalytic method aimed to do. Why extend one's first-person authority? There are many therapeutic reasons for doing so with which readers will be familiar: chiefly, the belief that greater self-knowledge enables greater freedom and lesser suffering. And there are also broader reasons. For instance, in a minor media spectacle, the actor Mel Gibson was arrested for drunk driving and is reported to have harangued the arresting officer with anti-Semitic epithets. Subsequently, in a public statement, Gibson said: "I am in the process of understanding where those vicious words came from during that drunken display" (Weiner 2006). Gibson thus sought to raise doubts in the mind of the public about the origin of his stated attitudes, and he professed a commitment to discovering their roots, implicitly as a preliminary to claiming responsibility for them.

Some argue that one can be held responsible only for one's actions, not for one's attitudes; one can be responsible only for things one has created, and one does not create one's attitudes (Shapiro 2005). In Kant's (1785) ethical theory, responsibility for one's actions is inherent in being a rational being, one who can conceive and follow universally applicable reasons for acting in particular ways. The now-traditional sense of *action*—behavior performed with an intention—carries the implication that actors, as opposed to mere "behavers," know the reasons for the things they do (Davidson 1980). Responsibility for one's actions (rather than for things one's body simply does) entails responsibility for one's intentions and other attitudes that motivate action. Therefore, an ethical sense of responsibility is connected with restrictions of first-person authority.

As Davidson (2004) observes in several essays on problems of irrationality—including those created by the psychoanalytic concept of the dynamic unconscious—there is less clarity about where to locate responsibility for attitudes and the actions they make reasonable when the actor disavows them. So one can and should be responsible for one's attitudes. This is not meant in the Orwellian sense of being convictable for one's thoughts, but in the sense that, where

one's claims about one's attitudes and behavior diverge to a significant degree, one's status as a moral agent—as someone who can and should be held responsible for actions *at all*—becomes tenuous. Gibson can raise doubts about his responsibility for his words, but to do so, he must accept that his status as an actor decreases in proportion to the narrowing scope of his first-person authority.

Positively, taking responsibility for our attitudes as well as for our actions may enrich us as agents, and so as humans. Cavell (1993) looks to the moral of *Oedipus the King:*

> There is a point to Oedipus' taking responsibility even for what he didn't do intentionally, since it is by coming to see the tendencies of our behavior [irascibility, for instance], to anticipate unwanted consequences of our actions, to discover what causes were at work in us or the world that made things come out in the surprising ways they did, that we become better able to match consequence to intention. [p. 92]

As we try to take responsibility for our actions, widening the scope of first-person authority over our attitudes makes us more reasonable, in a literal sense, and, more broadly, our own authors.

SECOND-PERSON AUTHORITY

Infants learning a language must learn what they mean—how to use words with sense and reference—from competent language users. Among adults, the psychoanalytic concepts of the dynamic unconscious, the repressed, and the interpretation of symptoms create a context for an adult dialogue in which first-person authority is limited for some of our attitudes. Interpreting another person is not a special occurrence, but rather a necessary and everyday one, in the basic sense that we must constantly infer another's attitudes and ascribe meanings to another's utterances. Not only in speech and listening, but also in reading and writing, we are faced with a choice between accepting the speaker's or writer's assertions, on the one hand, or rejecting them, on the other. This has been noted by Bloom (1973) and Barthes (1977), to give two examples. What we do with another's reports of her attitudes or meanings becomes an

open question once we recognize that we might challenge that individual's assertion of first-person authority.

A complementary name for the right to correct another person about his first-person psychological reports is *second-person authority*. Psychoanalysis and related therapies are communicative situations in which the limits of first-person authority are foregrounded for the purpose of allowing another person to help expand them. Cavell (1998) makes this point:

> If I am a patient in analysis, the only truths about me that will do me any good are truths I myself possess. But sometimes a first step in my knowing, for example, that I am sad, and being able to link up a feeling with the thoughts that make it comprehensible to me, may be somebody else's pointing out to me that I seem to be sad. [p. 456]

The increased frequency of this type of practice makes it particularly vivid in therapy, but the practice itself, and the second-person authority it asserts, is also a part of the resources we utilize in everyday life.

Here is a familiar clinical example of the assertion of second-person authority. A manic and psychotic inpatient of mine, often demanding, sometimes violent and unmanageable even on a locked unit, comes to knock on my office door. He asks to make a phone call, and is told he can make one as agreed earlier. He tries to call his sister, but gets his young niece. He becomes much more organized and speaks very sweetly to her: he promises her a new pair of sneakers for Christmas; he asks about her grades. The girl calls to her mother twice, but she does not come to the phone. The following exchange occurs between us:

PATIENT: [He speaks to his niece on the phone.] Tell her I love her. [He hangs up.] I need to call my grandmother.

THERAPIST: I said you could make one call.

PATIENT: But I really want to hear her and talk to her right now!

THERAPIST: One thing at a time. What happened with your sister?

PATIENT: She wouldn't talk to me.

THERAPIST: How come?

PATIENT: I don't know. She don't wanna talk to me.

THERAPIST: What does that feel like?

PATIENT: It feels bad. Come on, let me call my grandmother. [He picks up the phone and starts to dial.]

THERAPIST: No, hold on a minute. [Patient puts the phone down.] If *my* sister didn't want to talk to me, I'd feel sad.

PATIENT: I really need to talk to my grandmother! I need to feel something good right now.

THERAPIST: I can see that. It's hard to stay with feeling bad, even for a second. It's hard for you to feel sad. [The patient stops and stares at me for a very long ten seconds. He springs up from the chair. On his way out the door, he picks up a snow globe paperweight of a Christmas scene and shakes it.]

Here I asserted two species of authority: the first, deriving from my role as a member of the professional staff, included restricting the number of phone calls the patient could make; the second, deriving from my ability to see more clearly the patient's defenses and conflicts than he himself could, involved asserting second-person authority about his feelings. Drawing on a mixture of clinical theory, experience, and folk psychology, I inferred that the patient was sad *that his sister did not want to speak with him,* and I offered an inference about his mental state that went beyond his ability to report it. The patient responded by suspending his mania for a fleeting depressive moment. Then, the defense restoring itself, he fled, demonstrating to me that he had been shaken up by this experience.

THIRD-PERSON AUTHORITY

Along with norms that allow the non-inferential assertion of propositional attitude reports by speakers (first-person authority), and the assertion of interpretive authority by second persons to speakers (second-person authority), third persons may also assert interpretive authority about the assertions of pairs of speakers. Individuals participating in a dyad cannot observe their own interaction in the way that someone outside the pair can. A name for the inferential authority that third persons may assert about first and second persons in interaction is *third-person authority*.

Cavell (1998) mentions this: "One needs to see not only oneself as a whole, but also the relationship between oneself and the other. In having such a third-person perspective, the analyst can help her patient begin to discover one like it" (p. 460). Cavell is talking here about the view that an analyst might have of a patient's interaction with an absent person, but a third-person view is equally valuable to a pair of speakers/interpreters (for each is both).

Second persons are typically granted more authority to interpret speakers than third persons not directly communicating with the speaker. This may reflect the fact that people who merely overhear a conversation, rather than directly participating in the dialogue, are generally in a less advantageous position to understand what the speaker means (Schober and Clark 1989). But therapists—particularly, therapists in training—frequently discuss their dyadic therapeutic interactions with third persons (such as in supervision). Though they may see their patients' unconscious attitudes more clearly than their patients do, therapists are not all-seeing; also, they may not see their *own* attitudes (including transferences and countertransferences to the patient) as clearly as someone else, and they may not fully trust the patient to be able to present an undistorted second-person view.

We might think of clinical supervision as involving this variety of interpretive authority, the authority ceded to a supervisor by a therapist to infer the attitudes of one or both members of the ther-

apeutic dyad. The supervisor stands relatively outside the therapeutic dyad, forming a triangle—opposite the hypotenuse, as it were—and it is this external perspective that allows her to see more clearly than the therapist, at times, what is going on in the therapeutic relationship. Being able to do this does not necessitate standing outside the world, being a god, having no subjectivity of one's own, or being oneself conflict-free—all potentially "epistemological" concerns about psychoanalytic knowledge; for there is still another way of understanding knowledge that quite undermines the value of worrying about epistemology.

Davidson (1991) describes the traditional division of three kinds of empirical knowledge: knowledge of one's own mind, of other minds, and of things in the world. The three varieties of knowledge are interdependent, though none reducible to the others. The relationship between them may be thought of by analogy with the surveying or navigational practice of *triangulation.* Davidson writes:

> It takes two points of view to give a location to the cause of a thought, and thus to define its content. We may think of it as a form of triangulation: each of two people is reacting differentially to sensory stimuli streaming in from a certain direction. Projecting the incoming lines outward, the common cause is at their intersection. If the two people now note each other's reactions (in the case of language, verbal reactions), each can correlate these observed reactions with his or her stimuli from the world. A common cause has been determined. The triangle which gives content to thought and speech is complete. [pp. 212-213]

The knowledge that develops through such a process is social, intersubjective. To call the result a collection of beliefs that are *intersubjectively objective*, as I would prefer, need neither weaken the idea of objective perception nor promise freedom from error. For, as Davidson argues, a coherent concept of objectivity can be based only upon communication between people; it cannot be based on something outside our ways of establishing basic distinctions like agreement and dissent. He explains as follows.

> There is no going outside this standard [of triangulation] to check whether we have things right, any more than we can check whether the platinum-iridium standard kept at the International Bureau of Weights and Standards . . . weighs a kilogram . . . . We can, of course, turn to a third party and a fourth to broaden and secure the interpersonal standard of the real, but this leads not to something intrinsically different, just to more of the same. [Davidson 1991, pp. 217-218]

It is, in fact, only through replicating this process of triangulation that the objectivity of perceptions is agreed upon. Without this interaction, no differences between things, and hence no things to be the objects of propositional attitudes, and so no propositional attitudes themselves—beliefs, desires, wishes, fears, hopes—would be determinable.

Subtle and even gross differences of beliefs about the world are trivial in this basic notion of sharing an intersubjective world: even my patient who tells me that he is God and will save the world from his throne in Jerusalem goes to the public assistance office with his case manager. Self-knowledge can only come about through an internalization of the kinds of communication we develop in triangulating about things in the world. Further, knowledge of other minds is not possible without the assumption that people know their own beliefs, since interpretation—inferring the meanings of others' utterances—operates by a process of matching and contrasting others' thoughts with our own (Davidson 1991, p. 213). The three varieties of knowledge—of the world, of our minds, and of others' minds—are interdependent and hang together intersubjectively: "The three sorts of knowledge form a tripod: if any leg were lost, no part would stand" (p. 220).

This is the basic sense in which we are all intersubjectivists (apart from other meanings attached to this term in clinical theory). Note that this is not an epistemology: it does not aim to provide a method for securing us from error; it simply illustrates the incoherence of skepticism on a general scale. It is not a method for accumulating truths (an epistemology of certainty) or a cautionary, skeptical theory

(an epistemology of error). It is an account of the way our knowledge originates and solidifies.

To return from the general situation to the particular clinical, communicative one: being able to assert third-person authority is a matter, first, of participating in the kind of intersubjectively objective process of communication that generates, by its nature, mostly true beliefs about ourselves, others, and our shared world, and, second, of being permitted to interpret the therapist–patient dyad. Third-person authority depends upon a supervisee who is prepared to relax his second-person interpretive authority about the patient, and perhaps his first-person authority about his own attitudes as well. Exactly as in therapy, neither how well an interpretation hangs together nor the conviction of the supervisor can force the therapist to relax his interpretive authority: these are sturdy norms. While the fact of our intersubjective objectivity undercuts general skeptical worries, a focus on norms of communication provides an alternative to seeking either certainty or certain uncertainty in any particular case. How to decide what someone wants or feels or believes in any instance cannot be answered by appealing to a theory of knowledge; such decisions are made in the process of asserting and relaxing these varieties of authority.

Here is an example from a clinical supervisory group. A therapist presents notes of a case. The patient, in early remission from substance abuse, is contemplating leaving her boyfriend. The therapist observes that her plan has a "cold-turkey, plunge-forward, don't-think-about-it" sound to it, much in the manner that she recently quit drugs. The therapist asks the patient what would happen if the patient sat with her feelings a little more, to which she nervously explains: "I've just been suppressing all my feelings all my life and not thinking about them. If I let them all out now, I don't know what would happen—I'd wind up high in Bellevue! So I can't do that. I just have to keep going and not think about it."

The therapist points out the polarization in this patient's thinking, and wonders if there might be some middle way for her. After the presentation and a long discussion, the therapist asks for advice from the supervisory group about how to proceed with the therapy, and the following dialogue takes place.

THERAPIST: I really want to ask her to think more about her using [drugs], about what she enjoyed about it, about how it helps her, but I think she couldn't tolerate it if I did.

SUPERVISOR 1: What would you want to say to her?

THERAPIST: Something about that: "Tell me about how fun you are when you're high."

SUPERVISOR 2: What would happen if you said that to her?

THERAPIST: Oh! She'd end up high in Bellevue!

SUPERVISOR 3: Really?

THERAPIST: Probably not. I don't know what would happen.

SUPERVISOR 3: I think maybe you're identifying with the patient a bit. How about that middle ground you pointed out to her?

Here Supervisor 3 offers an interpretation about partial identifications of the therapist with the patient's attitudes. Standing outside the dyad, the supervisors quoted in this vignette are not limited only to these identifications (though, of course, supervisors can and do identify with patients, therapists, their good and bad objects, and so on).

Here is another example that speaks to this point. In a case conference with several peers and a supervisory consultant, I, as the presenting therapist, described the history and formulation of a recently treated patient, Mr. T. He is depressed, lonely, and isolated, struggling to cope with serious medical problems and recent unemployment. Among the elements of his psychology are oppressive superego identifications: a father who worked until the day he died in his late eighties of a heart attack, and a moralizing and physically abusive mother. The patient has rebelled against his moralistic upbringing and taken to drink, cigarettes, food, and casual sex, including sex with prostitutes.

I had noticed many libidinal needs but not much overt aggression in Mr. T, whom I had seen for only two months. Other members of the group, however, saw more aggression in the patient: they saw his attempts to dictate his appointment times and frequency as controlling. Mr. T had come literally knocking on doors to find me on two occasions, half an hour before his scheduled appointment time. In one session, he had complained repeatedly about his medical problems and consequent inability to get a job, which I felt I had responded to empathically, but we had ended up going round and round in the same pattern: "I'm sick," "That must be hard," "I'm sick," "That must be hard," "I'm sick," "That must be hard." I had struggled to stay awake during that session.

One member of the group thought of my somnolence as a defense against Mr. T's masochistic complaining. Another group member, a male, asked *why* the patient could no longer work, and wondered if I were colluding with his view of himself as "sick" and needing support; maybe he could, in fact, support himself. A female supervisory consultant said she found herself feeling antipathetic to Mr. T in regard to his relationships with women, and found his sexual behavior degrading, phallocentric, and a displaced retaliation against his abusive mother. A female peer agreed, and reported a fantasy of the patient cruising prostitutes, hanging leeringly out of the window and trying to talk them into his car.

I was struck by a theme that seemed to connect these last three observations, and I commented that it sounded as though the speakers were having reactions to Mr. T that were rather like the moralizing attitudes of his father and mother. In response to this remark, the male peer agreed that he felt as though he were getting angry with an idle son; the female peer disagreed, however, saying that she did not think of her remarks as moralizing or identifying with the patient's mother; and the female consultant remained silent.

The fluidity of the assertion of third-person authority in clinical supervisory settings is well illustrated, I think, by this example. Third-person authority, like the other two varieties, is independent of titles and formal roles. The supervisory group initially identifies

aspects of the patient's behavior—in this case, notably, passive-aggressive ones—and responses of the therapist—sleepiness—that I, the therapist, had missed, and that allowed me to broaden my view of the patient. Members of the supervisory group, relating in fantasy as second persons to Mr. T, had, from the therapist's point of view, taken up passing, part-identifications with Mr. T's parents. Unusually, the therapist had asserted some third-person authority by interpreting what he understood to be the supervisors' unconscious attitudes.

The reactions of the supervisors to this were evenly distributed: one accepting, one rejecting, and one abstaining from responding to the interpretation; they were relaxing, asserting, and tacitly retaining their first-person authority, in turn. The position of third-person authority can be taken up by any third party to a dyad or larger group, and is not restricted to those in designated supervisory roles. Supervisors may identify as easily with people or objects as with therapists. The question of whether or not assertions of interpretive authority will be accepted in particular instances—for example, whether the addressee will relax first-person authority—is a matter of how the interlocutors negotiate the assertion and relaxation of these norms.

APPLICATIONS

In the preceding sections, I have outlined an approach to understanding the knowledge and authority of participants in therapeutic interactions that is based in everyday norms for making and challenging claims about our own and others' attitudes. There are many places to apply the concepts of first-, second-, and third-person authority and the particular conception of intersubjectivity presented here. I will outline several—authoritarianism, the early history of interpretive authority, and therapeutic supervision—and then concentrate on two, as an illustration of what I believe to be the metatheoretical leverage of these ideas. (Those points of application that I will only briefly sketch here deserve greater exposition than is possible in this paper.)

Writers with good intentions have been misled by philosophical bugbears and the contingent closeness of *authority* to *authori-*

tarianism (Kernberg 1996) and of *objectivity* to *objectification*. Some clinical theorists (Orange 1995, pp. 150-151; Stern 1992, pp. 333-334; Stolorow, Atwood, and Orange 2002, p. 42) seem without a concept of authority that does not entail authoritarian abuses, the "dark side of authority" (Safran 2005). So, too, some automatically equate any claim to objectivity with an inevitable slide to objectification (Benjamin 1998; Stern 1992, p. 341). I want to emphasize the point that while these pairs may in fact be contingently related, they are not necessarily so, and an important call for clinical sensitivity should not be mistaken for a philosophical discovery.

The concepts of authority described above may be applied to historical developments in clinical psychoanalytic technique. Freud's magisterial use of second-person authority and principled discounting of his patients' first-person authorities were observed in cases mentioned earlier in this paper: Elisabeth von R. and Dora.[2] Besides the authority of suggestion and that of the physician, the transferential authority of the father/Father, the moral authority of the analyst who aims at unalloyed honesty, and Freud's authorial rhetoric, we can observe that his developing but consistent view of the limitations of first-person authority in normal and neurotic people amounts to a kind of systematic doubt about other minds—almost as counterpoint to the radical skepticism of Descartes, who doubted everything else. The starting point for this perspective was Freud's attempt at self-analysis and the discovery that this method could not provide a truly second-person view (Masson 1985, p. 281). The notion of third-person authority does not arise in Freud, for he was the one analyst who would not be analyzed or supervised by another, not even his friend and colleague Ferenczi, who offered to do so (Freud and Ferenczi 2000, p. 250).

In contrast (but also in continuity with Freud, in some respects) were Ferenczi's early and unparalleled experiments in technique. Flexibility in first- and second-person authorities begins in earnest with his "principle of relaxation" (Ferenczi 1955). The most radical, eventually infamous experiments in technique that Ferenczi attempt-

[2] For a few more of many possible exemplars, see Freud 1905, pp. 55-59; 1909, p. 223; 1911, p. 35; 1918, pp. 80, 95; 1926, p. 219.

ed he referred to as "mutual analysis" (see Ferenczi 1988). With a few self-selected patients, he explored relaxing his own first-person authority by allowing himself to be analyzed by his patients, as a way of increasing their trust (decreasing their paranoia) that his impulses or conflicts would not be harmful to them.

In the terms utilized in the present article, we note that Ferenczi offered a few patients the authority of the therapist to assert second-person authority with regard to his unconscious attitudes, in alternating sequences of analysis and counteranalysis. But in continuity with Freud—despite explicitly characterizing his interpretive work as fallible—Ferenczi remained committed to his own second-person authority; and he argued that reasonable confidence in one's knowledge of others is essential to an effective analysis (Ferenczi 1988, p. 131). At no time did Ferenczi experience a crisis about his ability to know his analysands sufficiently well to help them through the assertion of second-person authority (although he was beset by other demons).

The concepts of authority presented here may also clarify complex technical recommendations. For example, writers who are otherwise far from classically oriented, such as Safran and Muran (2000), may nevertheless have points within their clinical theory that promote the assertion of interpretive, second-person authority. In particular, Safran and Muran's concept of "metacommunication" includes the belief that the therapist can observe aspects of the pair's communication that the patient cannot immediately observe. This is counter to their explicit doubts about the possibility of accurately knowing a patient's attitudes (p. 90). Doubts about what can be known may hide what can be said and done.

Supervision has received less attention in the clinical literature than therapy. The concept of third-person authority both emphasizes the value of supervision and can elucidate a wide range of technical recommendations. Taxonomies of supervisory styles include varieties that assert or forgo the assertion of interpretive authority (e.g., Frawley-O'Dea and Sarnat 2001; Levenson 1982). Assertions of third-person authority by supervisors are potentially challenging to therapists, as they may threaten the assertion of both the therapist's sec-

ond-person authority regarding the patient and her first-person authority about her transferences and countertransferences. However, it is also possible that some interpretations to the therapist may be more effective in supervision than in therapy, where the focus on the dyad may mitigate the challenge to the therapist's first-person authority (Issacharoff 1982).

Certain variations in supervisory technique have been prompted by skepticism about supervisory knowledge and authority. In the same way that therapists have doubted their authority and objectivity, writers on clinical supervision have doubted the objectivity and authority of supervisors (Slavin 1998, p. 231). The account of intersubjectivity presented here is intended to show that these doubts cannot be grave, in general. A focus on the supervisory relationship, as suggested by writers like Teitelbaum (1990) and Frawley O'Dea and Sarnat (2001), emphasizes that supervisors are prone to the same reactions and blind spots as patients and therapists; in other words, everyone's first-person authority is limited. Such a view need not attribute unrealistic or transcendental abilities to supervisors, but simply the kind of benefits that come from calibrating our perceptions against others.' As with writing on therapy, some writing on clinical supervision, such as that by Sarnat (1992), seems concerned with unwarranted, skeptical fears.

Practical issues of authority in supervision may be vividly seen in the therapeutic supervision question: how much second- and third-person authority should a supervisor regularly assert over a therapist about his unconscious attitudes, countertransferential or otherwise? Some favor "supervisory analysis" (Blitzsten and Fleming 1953), which includes considerable interpretive authority of supervisor in relation to supervisee. Others (Langs 1978) aim to protect therapists from supervisory countertransferences by deferring the assertion of interpretive authority to training analysts. Some propose cautious flexibility (Issacharoff 1982; Frawley-O'Dea and Sarnat 2001; Marshall 1993).

An unusually elastic exercise was conducted by Harris and Ragen (1993). Their approach to "mutual countertransference analysis," echoing Ferenczi, shifted authority back and forth between

supervisor and supervisee, and they reported finding the experience very gratifying. A surprising moral of such exercises might be that *more* authority, not less, is desirable in such relationships; specifically, more flexibility in the relaxation and assertion of authorities, rather than a uniform rejection of authority per se or any particular interpretive role, may be optimal. While flexibility in technique is desirable, the radical for its own sake is not: one can be dogmatically radical as easily as rigidly conservative. Little (1957) observes that "what is most valuable can also be dangerous and useless . . . . The great need is for flexibility, reliability, and strength (as opposed to rigidity), and a willingness to use whatever resources are available" (p. 252).

Having outlined several areas with scope for further discussion, I will proceed to a closer examination of two topics, which will hopefully make the relevance of the ideas presented here more fully evident.

THE ANALYST'S AUTHORITY

Early in the history of psychoanalysis, the authority of the analyst was considered benign and pedagogic, whereas a "patient's right to influence with her view of things" (McLaughlin 1996, p. 207) was seen as resistance to be analyzed (as indicated by Freud's remarks in regard to the cases cited earlier). The patient's view of things, particularly of his own mental life, has been generally viewed as one of the patient's problems. This assumption may be reframed as patients (people) having a limited first-person authority. Psychoanalytic interpretation involves the challenge of a patient's first-person authority with the therapist's second-person authority.

Some therapists, particularly those influenced by self psychology —but also those from interpersonal (e.g., Stern 1992) and intersubjectivist (e.g., Orange 1995) traditions—have been explicit in their wish to respect the patient's view. Reactions against the classical use of the therapist's second-person authority may reflect an explicit desire to counter authoritarian attitudes in analysis, developed and modeled by Freud and associated with sexism (Benjamin 1998).

There may also be other, less explicit motivations; therapists may be wary of employing second-person authority for fear of being "placed in the role of aggressor, the role attributed to the one who interprets" (Oliner 1996, p. 269).

I will focus in this section on the writing of Schwaber, who has developed and refined a strong position in relation to the authority of the analyst versus that of the patient (though her position has not so far been put in quite these terms). Influenced early on by Kohut's writing on empathy (see Schwaber 1981), she has more recently described herself as a "traditional analyst" (2002, p. 59), which signals the complex trajectory of her approach. She has been criticized for different aspects of her position (e.g., Allison 1985; Arlow 1995; Gabbard 1997; Hamilton 1993; Renik 1993). Here, I wish to put forth a specific analysis of Schwaber's approach, which I find particularly rich in opportunities to illustrate the use of the ideas presented here.

A great strength of Schwaber's attitude, and her central point, I believe, is her emphasis on attending seriously and consistently to the ways in which the patient sees things, and on our maintaining circumspection and humility as clinicians. Schwaber's position includes particular conceptions of transference and countertransference. For example, she proposes setting aside the usual psychoanalytic goal of seeking to identify and correct the patient's transferences and projections; instead, she suggests that the patient's view, including the patient's view of the analyst, should be "not seen as a distortion, for this would imply that there is a reality more 'correct' than the patient's psychic view of us, which we as 'outside' observer could ascertain" (1983, p. 522; see also 1986). The patient's first-person authority is not seen as seriously compromised. Assertions of second-person authority by analysts, if made at all, should be put forth with great modesty. Unusually, also, the patient's second-person authority, generally interdicted, might be permitted—or even invited.

Schwaber also has a particular view of countertransference: she sees it as sticking with one's own point of view over that of the patient (1992a). In the more specific terms introduced here, this

translates into a tendency to privilege the analyst's second-person authority over the patient's first-person authority. Schwaber (1995a) gives a memorable example that illustrates her attitude toward the analyst's presumption of second-person authority:

> One time I told a patient that I anticipated I might be away for three days; later I learned I needed to be away only one day; I said this to him. "Who are you," he rejoined, "to say what is *only*?" [p. 558, italics in original]

It is the patient's view of what is "only" that matters, in other words. The analyst may have another view, but should not presume that it must carry when and if those views differ.

Alongside these distinct reconceptualizations of transference and countertransference, there are many other places where Schwaber discourages seeing the patient's first-person authority as deficient or the analyst's second-person authority as automatically warranted. For example, she repeatedly cautions against making "leaps of inference" beyond the patient's point of view (e.g., 1981, 1983, 1986, 1987, 1992a, 1992b, 1996). She strongly objects to the idea that analysts may be "capable . . . of apprehending meaning that is still unconscious to the patient" (1996, p. 236). Also (and more equivocally), throughout her writing, she uses terms like "point of view" (e.g., 1990, 1998) and "vantage point" (e.g., 1992a) that imply a focus on what patients can say—within their first-person authority—rather than on what they cannot.

It is significant that some of the clinical work Schwaber has presented (e.g., 1983, 1995b), in contrast to the trend of her statements on theory and technique, does not eschew the analyst's authority. Schwaber observes and interprets to patients things they do not see about themselves, suggests what they may be thinking and feeling, and draws connections between earlier relationships and the here and now. For example:

- "I said that she was perhaps thinking about surpassing me, and that might stir up what we had seen to be a familiar conflict." [1983, p. 524]

- "You sound different talking about this today than you did yesterday, when you seemed more upbeat about it." [1995b, p. 717]
- "I see . . . it is when you feel or fear blame, the finger pointed at you, that your tone takes on this more anxious cast." [1995b, p. 718]
- "When I wondered if this wish bore on her feelings about her grandfather . . ." [1983, p. 526]

These few examples of her comments to patients—representative ones, I think—all fit easily within the repertoire of a traditional analyst, illustrating second-person authority that seeks to expand the patient's first-person authority. What I believe this signifies is that second-person authority is an integral part of every variety of psychoanalytic technique, even of those who question it.

Schwaber does not say that she gives up her point of view to the patient's (2002, pp. 61, 63). The question that becomes more pertinent, then, is not whether a separate view is *held,* but whether it is *used*—whether it is asserted to another person. Schwaber acknowledges the value for analyst and analysand of using what I have been calling second-person authority—although, unusually, she emphasizes the value of the analysand's use of this authority (2002, pp. 58, 62-63). She suggests that accepting the patient's view of the analyst—relaxing the analyst's first-person authority—may "jar our view of ourselves" (1996, p. 242) and stir up countertransference resistances (1992a), but also that we might learn about ourselves from allowing this assertion of second-person authority by our patients.

Schwaber suggests that patients, too, may benefit from being granted this authority at times. She discusses a case of Spillius's, stating that "she demonstrates the therapeutic power in recognizing at least the possibility that the patient . . . perceived something in the analyst's participation bearing directly on her experience" (1996, p. 249). The precise way in which this is therapeutic is not clear, however, and using this technique raises questions, for me at least, about how to distinguish a resistive turning-the-tables, to be appro-

priately analyzed, from something that is perhaps beneficial, like supporting the patient's accurate empathy. It might be that these questions simply do not arise within Schwaber's approach, since they assume concepts of resistance and accuracy that she might see as representative of the analyst's failure to respect the patient's vantage point.

Schwaber (1992a) also writes revealingly about the value of supervision. Describing a peer-supervision exercise on predicting session material, she was surprised to be shown a particular, unrecognized emphasis in her predictions: "I realized that one always needs another person for such a corrective; lacking a live patient, I had to seek it from someone else. That is what our patients will offer us, if we but heed them" (p. 359). It is striking how open Schwaber is here to the value of another point of view (see also Schwaber 1995a)—specifically, to the third-person point of view of a consultant and to the second-person view of a patient; and yet she is reluctant, at least in doctrine, to assert second-person authority as a therapist. It would be interesting were Schwaber to open up this implication of her position more and further explore the therapeutic pros and cons of relaxing her first-person authority with the patient and granting the patient second-person authority with her.

Schwaber frequently states that she is taking up important epistemological issues in her writing (e.g., 1992b, 1995a, 1997, 1998, 2002). But I think that turning to epistemology to settle disagreements of theory and technique is unhelpful.[3] Consider Schwaber's (1998) reply to Arlow's (1995) critique of her article on countertransference (1992a). Schwaber (1998) argues that an initial remark to her patient was unempathic—shifting from the here and now to the there and then—and that it triggered a serious regression. However, a later remark acknowledging the patient's point of view was therapeutic, ended the regression, and set the stage for a successful completion of the treatment, Schwaber maintains. Arlow's view, on the other hand, was that her initial remark had prompted the

[3] See also Smith (1999, 2001) on the topic of levels of analysis and the value of turning to epistemology, and on the relationships among data, clinical theory, metatheory, and philosophy.

regression because it was correct, not because it was an empathic failure, and that the destabilization that followed revealed the patient's intense, unrealistic guilt about his sexual desires.

Here we have two coherent interpretations of the same phenomena. Schwaber (1998) asks of her patient (and implicitly of Arlow, too): whose point of view should prevail here? With her patient, she decides that maybe she missed something, and that she should accept his point of view (that is, relax her interpretive authority). With Arlow, on the other hand, she maintains her own view in preference to Arlow's. Framing this question as one of epistemology (as she does) is unrewarding because there is no way to choose, in those terms, between Schwaber's and Arlow's interpretations: neither one provides a method for settling on the truth. It is a matter of when to assert or relax some varieties of authority with an interlocutor.

As I have argued thus far, a normative account of shifts in authority, coupled with an understanding of the intersubjective objectivity of our beliefs, avoids more unfruitful responses to problems and offers more local benefits than does the turn to epistemology.

AUTHORITY AND SELF-DISCLOSURE

Self-disclosure is one of the most controversial topics in clinical technique: should the therapist reveal personal things to the patient? And if so, what and when? Self-disclosure may be imagined to be a way of reducing the therapist's authority and making therapeutic relationships more equal. This upends the usual basis of therapy and raises questions about self-exposure by the therapist, who may be seen as colluding with the patient's defensive interrogation, not really doing analysis, and narcissistically imposing her own needs onto the treatment (Aron 1992). Renik (1995, p. 466) sees many recent questions about the analyst's knowledge and authority and the epistemology of psychoanalysis as crystallizing within the problem of self-disclosure. If we apply the concepts of authority defined previously, and if we hold in mind the general concept of intersubjectivity also defined earlier, these issues may be further clarified.

Renik argues that it is impossible for the therapist to be anonymous, as the therapist cannot "transcend his or her subjectivity" (1995, p. 476). Anonymity is a myth—the other side of what Hoffman (1983) called the myth of the naive patient who has no interest in interpreting his therapist. Renik aims to debunk this "myth of the analyst's anonymity" (1995, p. 481) as an extension of his earlier (1993) assertions about the "irreducible subjectivity" of the analyst.

Renik (1995) observes that the analyst may in fact earn authority through exemplary behavior facilitated by the structure of the analytic situation, which minimizes the analyst's own interests more than in most other relationships in life. But one aspect of the analytic situation, the anonymity of classical technique, may, Renik says, have a harmful effect on the treatment by encouraging idealization of the analyst "as an omniscient sphinx whose ways cannot be known and whose authority, therefore, cannot be questioned" (p. 483). Since therapists cannot help but disclose things about themselves, in his view, he advocates being self-consciously self-disclosing. Thus, among the many kinds of self-disclosure we might imagine, Renik encourages a particular kind: "For me, the what and how of self-disclosure consists of the analyst's trying to communicate what is in the philosophical tradition termed *pensées pensées,* that is to say, the analyst's thoughts as they have been thought" (1995, p. 484). His goal is to make his own clinical reasoning relatively transparent to the patient. So, rather than simply making an interpretation, he might outline how he went about putting it together and what effects he thinks it might have.

In offering patients his reasoning as well as his interpretations, Renik sees himself as respecting the "epistemological symmetry" (p. 486) between therapist and patient. As discussed earlier, there is a significant *asymmetry* between the ways in which we can claim knowledge about our own and another's mental states (though both therapist and patient are subjects with an unconscious, and so alike in the sense of having a circumscribed first-person authority). Closer to Renik's intent, I believe, is the sense that his work aims to be collaborative rather than authoritarian. It seems clear to Renik that the analyst may be able to say things about the patient that the pa-

tient cannot say, and vice versa. I think he might do well to attend more, however, to an insight he attributes to Mitchell (as I will argue below): "I think Mitchell (1994 [in an untitled manuscript]) describes the analyst's position in relation to self-disclosure cogently when he says, 'I am not necessarily in a privileged position to know, much less to reveal, everything that I think and feel' (p. 9)" (Renik 1995, p. 488).

Renik gives a clinical example in which his patient complains that Renik sounds irritated; Renik reveals his private reactions to the patient, which he says helped to clear up some negative transference (pp. 488-489). He says of his self-disclosure:

> I took responsibility for my view of how I had both attacked and been attacked, which had the beneficial effect of requiring and helping my patient to do the same. It permitted my patient to reflect on his experience of me as an authority, rather than to continue to live it out within the treatment relationship. [1995, p. 490]

It is possible to see his self-disclosure in a contrasting way. It may have given the patient, amongst other things, an experience of Renik as an authority on his own attitudes; the patient could then agree with him or not. But in the face of an assertion of the analyst's first-person authority—"Here is what I felt and why I felt it"—it may be especially difficult for the patient to assert his second-person authority. This kind of self-disclosure of the therapist's private reactions may encourage a kind of idealization of the therapist as someone who is all-self-knowing. Renik thinks the opposite: remaining nondisclosing leaves the analyst appearing superior, objective, and authoritative, he contends (p. 492). But consider that when Renik makes his thoughts and feelings explicit, his assertions may be understood as carrying—in addition to the usual first-person authority we all carry—the sense that he is, one might say, a subject who is *really* supposed to know, for his professional livelihood, what people think and feel. The fact that the analyst will, in fact, know herself better than most is here beside the point.

If a goal of analysis is to improve the patient's reality testing (Renik 1998a), or, better, "realisticness" (Friedman 1999), then it

may be that, rather than asserting one's own first-person authority as a therapist through self-disclosure of clinical reasoning, a more effective method would be to invite the patient to assert second-person authority in regard to the therapist's attitudes. In that scenario, whether the therapist wants to accept or reject the patient's interpretations, and whether the assertion of first-person authority present in doing either would be clinically helpful or unhelpful, are more particular questions that might be addressed at the level of the individual case. In fact, Renik (1995) cites Hoffman (1983) and Aron (1991), who have written on the issue of inviting the patient to assert what I have been calling second-person authority with the analyst. However, he sees their views as partial:

> Disclosure of the *patient's* perception of the analyst's subjectivity is invited, but explicit communication of the *analyst's* perception of his or her own subjectivity is not equally recommended. A stance of anonymity is not entirely relinquished, even as the myth of the analyst's anonymity is analyzed. [Renik 1995, p. 481, italics in original]

This assessment underplays the authority implicit in asserting one's view of one's own attitudes, that is, one's first-person authority. In a later paper, Renik (1998b) reports a case in which he agrees with his patient's suggestion that his mind was wandering during the session, though Renik had not realized this until the patient pointed it out:

> Ethan gets teary-eyed and is clearly enormously touched and pleased. This is great, he says. No big deal about your mind wandering—that's got to happen from time to time. What's a big deal to me, Ethan goes on, is that we can talk like this. You can admit when you've made a mistake, when I show you something you didn't know. [p. 489]

The relaxation and assertion of first-person authority shift momentarily: in accepting the patient's second-person authority, Renik relaxes his first-person authority; then, in the same breath, *in agreeing with the patient,* he reasserts his first-person authority: he claims authority over some aspect of his mental life that he could

not before. This is exactly the value of a speaker's assertion of second-person authority: if the addressee can relax her first-person authority, she may expand the boundaries of her self-knowledge and responsibility for her attitudes.

Like protorelational writers such as Racker (1968, p. 172), the contemporary relationalist Aron (1996) is circumspect about self-disclosure. As just discussed, self-disclosure may actually communicate to the patient a professional level of self-knowledge that may be especially hard to challenge. Aron notes: "If the analyst reveals something about himself with a tone of certainty and authority, then he may close off further inquiry rather than opening it up" (p. 113; see also pp. 97, 236; and Greenberg 1991). Indeed, this may often be the point of such a conversational move in everyday life: asserting one's first-person authority is frequently seen as the last word, since any challenge must operate with a different set of norms—those for inferential attributions of attitudes.

But surely closing off dialogue is not a goal of therapy. There are many things unsaid in any conversation; asserting one's view, even as honestly as one can, will always leave out certain things. Even though "saying to a patient, 'Yes, you are right. I was annoyed when I said that!' or 'No, I'm not aware of feeling impatient with you'" (Aron 1996, p. 97) may look as though all potentials of the dialogue have been encompassed, such definitive assertions tend to obscure the fact that the therapist, too, has an unconscious—that the scope of his first-person authority is limited.

Aron argues, however, that on occasion it may be beneficial to reveal some of one's subjectivity to a patient. He gives a clinical example in which he and a patient are discussing some of the patient's critical feelings toward his wife (Aron 1996, p. 226). The patient asks Aron whether there are important things that he does not like about *his* wife. Aron replies that indeed there are, and further that there are things she does not like about him, and in fact things that he dislikes about himself. Aron's self-disclosure offers the analyst himself as a model of normal ambivalence and compromise. Aron argues that the patient's conflicts around having ambivalent feelings toward intimates later loosened up because of this self-disclosure,

in part because it was "more about myself than about him" (p. 226). One might explain the efficacy of this type of intervention as due to the lesser challenge it poses to the patient's first-person authority, which consequently excites less resistance in the patient.

The approach to self-disclosure that Aron prefers, following Epstein, invites the patient to discover the analyst's subjectivity for himself. Where Renik's technique involves asserting the analyst's first-person authority, Aron's is based upon inviting the assertion of the patient's second-person authority. He imagines some different ways in which a therapist can talk about her subjectivity:

> Rather than saying to the patient, "I'm not aware of feeling overly concerned about your fragility and therefore you must have other reasons for thinking that I am so concerned," I suggest saying, "I'm not aware of feeling overly concerned about your fragility, but you seem to think that I am. What am I doing that is giving you that impression? Perhaps you are picking up on something that I haven't noticed." [Aron 1996, p. 237]

Whereas Renik's approach asserts the therapist's first-person authority and then asserts second-person authority about the patient's attitudes, Aron's method (again, following Epstein's) relaxes the analyst's first-person authority, inviting the patient's second-person authority instead of asserting the therapist's. Rather than asserting one's self-knowledge in the role of expert self-and-other-knower, Aron proposes that an element of expertise in therapists is "some fair capacity and willingness to expose aspects of themselves that make them anxious and to contain this anxiety sufficiently to work with this material in the long-term interest of their patients and themselves" (1996, p. 248).

Elasticity, in the sense of a long-term investment in being able to relax one's first-person authority, Aron seems to argue, may pay out to everyone in terms of increased knowledge and authority.

CONCLUSIONS

Epistemologists of psychoanalysis have been worried, though not entirely self-consciously, about how to justify analysts' knowledge

claims. Aron (1996) wonders, assuming the "postmodern collapse of the analyst's authority," "what is left to authorize the analyst to make these distinctions [between reality and transference, progress and regression, authenticity and defense] and thus guide the process as we would expect any expert to guide a professional undertaking?" (p. 259). No longer applicable are the things that were earlier assumed to authorize the analyst to make such distinctions: educational and professional status, class, or gender—nor, less sociologically, a theory of how psychoanalytic knowledge is justified and preserved from error.

One alternative to certainty-seeking epistemologies or epistemologies of error is to conceive the therapeutic situation in terms of norms and conversational practices, rather than in terms of justification and quelling or embracing doubt. At the risk of adding to a glut of concepts of mutuality (Aron [1996] lists a dozen of these [p. xi]), I will venture the concept of *mutual authorization.* My answer to Aron's question—"What is left to authorize the analyst?"—has been to point to first-person authority and its related norms: that is, *patients authorize the analyst.* More generally, any knowledge claims about attitudes, conscious or unconscious, are authorized by the participants in a dialogue, not by any extrinsic sources (though extrinsic factors, like education and training, and other species of authority—some of them no doubt "dark"—may influence a person's acceptance of an assertion of second-person authority).

In conclusion, and to return to the question with which I began this article, what can and cannot be known about the particular thoughts and feelings, conscious and unconscious, of particular patients in therapy and analysis—of people in any context, in fact—may be reframed as a matter of what is authorized by interlocutors and what is not. This should not be taken as an impoverishment. As Davidson (1991) remarks:

> Understanding is a matter of degree: others may know things we do not, or even perhaps cannot. What is certain is that the clarity and effectiveness of our concepts grow with the growth of our understanding of others. There are no definite limits to how far dialogue can or will take us. [p. 219]

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THE UPWARD SLOPE: A STUDY OF PSYCHOANALYTIC TRANSFORMATIONS

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In an examination of twelve audiotaped psychoanalytic sessions, the authors, using both quantitative and qualitative methods, observed a stepwise progression in mental organization, which they term the upward slope. *Its constituents include a phase of regression (desymbolization and the agony of equivalence), a phase of transition (disruptive enactment leading to transitional space), and a phase of reorganization (triangulation leading to symbolic synthesis). The hypothesis of a phase-specific progression is advanced, wherein different forms of mental functioning evoke distinct dynamic processes of psychic repair. The authors present detailed clinical summaries of the sessions they examined, as well as their own observational comments, to illustrate these ideas.*

What is time? A secret—insubstantial and omnipotent. A prerequisite of the external world, a motion intermingled

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> and fused with bodies existing and moving in space. But would there be no time, if there were no motion? No motion, if there were no time? What a question! Is time a function of space? Or vice versa? Or are the two identical? An even bigger question! Time is active, by nature it is much like a verb, it both "ripens" and "brings forth." And what does it bring forth? Change!
>
> —Thomas Mann [1924, p. 338]

INTRODUCTION

Time and Transformations

Time implies change and change implies time. Time is a pivotal issue in psychoanalytic transformations. "Macro"-transformations span many years and lead to shifts in psychic structure. Fonagy (Fonagy et al. 1993) and Pine (1989) refer to these as *developmental transformations.* They are alterations of the most stubborn kind, *governed by a slow rate of change.*

In contrast, there are "mini"-transformations. Freud (cf. Blum 2000) illustrated these in his discovery of dream work, wherein he noted the rapid-fire shifts from wish to image to word and back to image. The immediacy of these "mini"-transformations is the hallmark of primary process thought.

The area in between is the transformation cycle. This is time-space stretching over a few weeks or months of psychoanalytic work, intervals defined by cyclic phases in mental functioning, its peaks and troughs. All the events that matter in analytic process can be observed here—regression and progression, transference-countertransference constellations, and the impact of interventions and their consequences. The temporal frame of the *transformation cycle,* a discovery of our previous research (Freedman, Lasky, and Hurvich 2003), is our laboratory for this study of change in the psychoanalytic process.

THE UPWARD SLOPE

As we have found, the *transformation cycle* involves the motion of psychoanalytic work, within the patient and within the analytic dyad, from

a state of integration to a state of non-integration and back to a state of reintegration. Inherent in the movement from integration to non-integration are processes of regression, the *downward slope*. The movement back to reintegration, the scene of psychic repair that we are calling the *upward slope,* is our focus in the present paper.

What might one encounter, clinically, in an upward slope? We will give detailed process material involving twelve sessions from the recorded analysis of Ms. Y, but first, here is a snapshot of the process: In a state of regression, Ms. Y despairingly speaks of the "storm" in which she finds herself and of how lifeless, depressed, and helpless she feels. A few sessions later, she is aware of her "mean" and "brutal" images involving the analyst and a wish that she felt only compassion instead. But soon she begins to reflect upon her inner conflicts, torn between her erotic desire for the analyst and her guilt toward her husband.

We believe this sequence portrays a movement from regression to reintegration, and that the sequence can be divided into three distinct phases: *non-integration, transition,* and *reintegration*. We will document whether, when, and how such a move toward integration can occur; that is, whether a clinically significant move toward integration can be shown, when it emerges, and how it can be accounted for in terms of psychoanalytic theories of change. We will conclude with a formulation that emphasizes the phase-specific nature of mental transformations: namely, that different theories of change have relevance for different phases in the course of the upward slope.

FOUR PROPOSITIONS DERIVED FROM THEORIES OF CHANGE

Let us begin by advancing certain views on psychoanalytic change, rooted in mainstream thought and stated in the language of clinical propositions. We will limit ourselves to Waelder's (1962) frame of *clinical observations* and *clinical generalizations, levels 1 and 2*. The proposition approach will aid us in spelling out the relevance of particular theories of change and their pertinence to different phases in the movement toward integration, observed both within the patient and within the analytic dyad.

Proposition 1

Change is marked by a shift from less differentiated to more differentiated compromise formations. This is a view of transformation guided by the vision of the *mind in conflict* (Abend 2005; Brenner 1982). In the course of analysis, distinct conflictual strivings are evoked and reshaped, leading to a more complex awareness of self and other. We expect this to be observed at various points in time during the upward slope.

Proposition 2

Change is marked by shifts in interactional synchrony, arising in the communicative interchange between analyst and patient. In this theory of change, transformation resides not primarily within the mind of the patient, but is inherently a matter of mutual regulation (Aron and Bushra 1998). The phenomenon of interactional synchrony has several theoretical roots. In self psychology, interactional synchrony is seen as a sign of optimal mirroring and its disruption, a sign of empathic failure (Kohut and Wolf 1978). From the viewpoint of the Boston Change Process Study Group, synchrony is a sign of implicit relational knowing (Nahum 2002).

In the present study, discontinuities of synchrony, in the form of disruptive enactments, will be found in the phase of transition just prior to reintegration.

Proposition 3

Change is marked by a shift in the ego from a state of desymbolization (and psychic equivalence), toward symbolization (and symbolic synthesis). This proposition has its roots in a psychoanalytic culture dating back some fifty years, to the seminal work of Rycroft (1956). He viewed symbolization as an action of the ego, a bridge capable of embracing both primary and secondary processes. To be sure, symbolization (or its reverse, desymbolization) can be regarded as just another compromise formation (as Brenner would say), but we consider it a unique one, having far-reaching consequences

for therapeutic action. For inherent in the notion of symbolization or desymbolization is that it embraces those intervening and mediating bridge processes necessary for the reversal of mental functioning. We expect to find this in the phase of reintegration.

As mentioned earlier, our propositions have been stated in the language of clinical observations and generalizations, yet one may question whether they really capture the essence of the theories of change purported to be evaluated. For example, we have just suggested crucial intervening processes inherent in the notion of symbolization, yet the question remains: how are these intervening processes to be spelled out? We recognize, for example, that the term *symbolization* in the Kleinian model reflects a replay of the depressive position from the earliest moments of infancy, whereas Fonagy and Target (2000) view it as a later attainment culminating in mentalization and reflective functioning. However, Smith (2005), in his comprehensive and integrative review of these issues, stresses the need to distinguish, in the choice of inference making, between description and etiology. While it is true that all clinical propositions are ultimately rooted in certain etiological and developmental beliefs, he suggests that, nonetheless, at the level of our daily work, we use and choose clinical formulations without their being tied to their presumed theoretical origins. We will pursue this issue further in our discussion section.

Having now selected these three propositions, and having articulated our expectations for the upward slope, we cannot deny that the very choice of these three perspectives has been guided by a matter of informed clinical belief. From our perspective, the process of transformation from non-integration to integration inevitably entails first a more differentiated form of compromise formation; it depends on an intersubjective experience taking place within a facilitating field of mutual regulation; and it then evokes a symbolizing process within the patient, where illusion, allusion, and the imaginary can flourish.

Moving from generality to particularity, let us briefly return to our consideration of transformation within a frame of time. This consideration of the temporal dimension leads us to a fourth proposition, to be described in what follows. As we have stated, the transfor-

mation cycle reflects shifts in mental functioning over a period of weeks. But what is the motivational force that makes these shifts a psychic necessity? To understand this, we redirect our attention from phases within a cycle to crucial moments within a single session.

In his infancy and toddler studies, Pine (1981) observed singular, brief moments standing in relief, in opposition to the surrounding field, that herald and anticipate (in a preparatory fashion) the next phase of development. To be sure, the psychoanalytic situation in the treatment of adults offers an incomplete analogue for infancy development; nonetheless, these developmental findings alert us to the usefulness of distinguishing specific, critical moments from more continuous, phase-specific processes when studying analytic change.

Here we will identify critical moments within sessions, standing in relief to the rest of the surround, portraying paradoxical positions in relation to before and after, and heralding an upcoming shift in the process. These moments, which we call *nodal points of change*, are brief but likely to be memorable for both the researcher/observer and the analyst. They tend to evoke vivid allusions and images in both participants of the analytic dyad.

Proposition 4

Our fourth and final clinical proposition holds that, embedded within each phase of an upward slope, are *nodal points of change*, and that contained within those moments are the "seeds" that point the way toward the phase to come.

RESEARCH METHODOLOGY

The Clinical Database[1]

The material we are presenting is drawn from the four-times-a-week, audiotaped analysis of Ms. Y, a married woman in her thirties and

[1] This enterprise would not have been possible were it not for the resources of the Program of Research at the Institute for Psychoanalytic Training and Research in New York (IPTAR), which includes a database of recorded psychoanalyses.

the mother of a young boy and girl.[2] The analyst is an experienced clinician, a graduate of an analytic institute who works within a contemporary Freudian frame. The data was drawn from fifty-four consecutive sessions occurring in the third year of the analysis. Each taped session is followed by what we call a *clinical scan:* a brief (approximately five-minute) recording made by the analyst at the end of the session, reflective of her immediate impressions.

Discovering the Transformation Cycle: From Integration to Non-Integration and Back

The initial delineation of a transformation cycle in this material was based on an analysis of the clinical scans. Two of the authors of this paper (N. F. and R. L.) listened to the scans from the fifty-four sessions and judged them as reflective of either *integrative* (A) or *non-integrative* (Z) sessions. The abstract symbols of A and Z were chosen in order to avoid the judgment of a session as either good or bad.[3]

Sixteen criterion sessions, nine A and seven Z, were then chosen on the basis of further statistical analysis so as to arrive at unambiguous A and Z sessions. The range of A and Z scores of the sixteen sessions suggested a cyclic distribution: session 232 represented a peak of A activity, sessions 245 to 249 showed a prevalence of Z activity, and sessions 252 through 257 reflected a return to A activity. This cyclic distribution suggested both a downward slope and an upward slope.

The Transformation Cycle Confirmed

The process just described was based on evaluations of clinical scans. Next, the typed transcripts of each entire session were submitted to a computer-assisted program, the Discourse Attribute Analytic Program (DAAP; see Bucci and Maskit 2005), in order to evaluate the patient's and the analyst's spoken language for a description of the referential process. This procedure yielded a profile of

[2] Written consent for use of the recorded material was obtained.

[3] The agreement between judges yielded statistically satisfactory reliability: standardized Item Alpha for A ratings was 0.78 and for Z ratings was 0.84.

both symbolizing and subsymbolic processes. Using the measures of this referential process, it was possible to obtain highly statistically significant discrimination between the A and Z sessions. Those designated as A sessions proved to be high in symbolizing activity, in the integration of reflectivity with referential activity, and in positive affect. By contrast, Z sessions were not only low in these functions, but also revealed higher speech disfluencies (pausing or fragmentation) and the prevalence of negative affect. Thus, integration and non-integration, identified first through the immediacy of the analyst's clinical experience (the scans), was corroborated by methods quite independent of clinical judgment.[4]

Focusing on the Upward Slope

As already stated, the phase from sessions 245 to 249 was one of non-integration, and session 257 marked an unambiguous peak of reintegration. However, sessions 252 through 255 represented an intermediary zone, a phase of transition. We are therefore not drawing a simple dichotomy between non-integrated and integrated sessions. The intermediary zone was a toss in the direction of new discovery, and, as will be noted, it paid rich dividends.

Qualitative Analysis

The final and crucial step in our research method involved careful listening to the audiotape of each session. This was carried out by two of the authors of this paper (N. F. and R. W.). We listened much like supervisors who share a theoretical frame and were attuned to the nuances and subtleties of the unfolding dynamic fluctuations.

As we scrutinized each session, we first sought to distill the salient clinical events, considering both explicit speech (evocative verbatim quotes) and sounds of nonverbal behaviors (shuffling of papers, sighs, restlessness). From this we obtained descriptive clinical summaries of each session. We then arrived at preliminary interpretive readings of these descriptions. Finally, we were in a position to de-

[4] For a detailed description of these findings, see Bucci and Maskit, in press.

velop a formulation about psychic change, responsive to the four propositions stated in the foregoing sections.

The yield of this qualitative analysis is presented below, in the following fashion: (1) Highlights of the descriptive clinical summaries appear in indented text, with direct quotations from the patient's dialogue where indicated; (2) The relevant interpretive readings—our observations as listeners—appear as non-indented text in the following sections; and (3) Our formulations are described under the commentary sections.

AN UPWARD SLOPE IN THE ANALYSIS OF MS. Y: CLINICAL OBSERVATIONS AND CLINICAL PROPOSITIONS

Phase 1: A Phase of Non-Integration and Desymbolization (Sessions 245-249)

The session we will describe, 245, is the first of a series of five consecutive, unambiguously non-integrative sessions, and is a representative session of this phase.

> The patient begins the session in conflict about sharing her erotic, envious, and critical thoughts about the analyst.
>
> Ms. Y: When I, uh, pulled up in the parking space just outside the garage, I just caught, uh, just caught a glimpse of you walking, to, uh, over here . . . and I saw that you were wearing a dress I liked, and then it . . . [sighs] y-you . . . . Like my criticism was that it's the same old thing, sort of like, "You look heavier on top . . . . You're not, like, five-foot-ten, and . . . and . . . and ultra-thin and svelte or, or something" and, and then I thought, "You're short and dumpy," and then I got horrified by that. You're not short and dumpy . . . and then I thought, "well wha-what do you like about her?" And then I thought, "Oh, I love your legs. I love your legs! . . . I wish I had your legs." I hate my legs. I just have heavy calves and thick ankles. My thighs are not too hot either . . . . Well, actually, each half from

> the thigh to the knee and from the knee to the ankle, both are equally pretty poor.

The intense focus on the analyst's body and clothing suggests a sticky overinvolvement—a hypercathexis. A state of desymbolization and concreteness is reflected in the focus on body parts (part-object representations). Both overinvolvement with the analyst and part-object representations throttle the space of interactional synchrony.

> The patient then begins to speak about a decision she must make regarding buying a new house or renovating the one in which she and her family currently live. Her affect is flat and her voice is a monotone. She spends about thirty minutes describing the various rooms of a new house for sale that she has seen, explaining how the rooms could be utilized and detailing the numerous steps involved in an alternative plan to renovate her present house. She obsesses about the decision, wishes the whole thing would "go away," and declares that she has to deal with it but is just not dealing with it. She says of the thought of living in the house for sale:
>
> Ms.Y: [It] just, just immediately makes me feel, uh, lifeless, kind of lifeless and depressed and upset . . . . I don't even know if it makes sense why I don't think it's a good thing. It's that I'm, I'm happy where I am, but you can't hold, I mean you can't hold onto things forever.
>
> She describes the house for sale as "staring me in the face," and regarding what she feels are her only two choices, she says, "it's very black and white, how I'm looking at it."

The patient's detailed description of the two houses reflects an intensification of concreteness. While there is tension and conflict regarding a decision about the two houses, it is not represented in object relational terms. Instead, it is a frozen conflict or a prerepresentational mode of thought. There is an absence of fantasy. The endless repetition suggests a symbolic equivalence.

The patient's ruminations about the houses eventually lead to increased disintegration:

> Ms. Y: I don't know, I'm really kind of stuck here. [There is a 53-second pause, and she sighs loudly.] I, I start spinning in circles even as soon as I start thinking a thought. I, I can't even articulate it because it, it gets all, uh . . . . [There is a 37-second pause.]

Here we see that symbolic equivalence leads to regression.

Then, about fifteen minutes before the end of the session, a dramatic shift takes place. The patient directly expresses her feelings toward the analyst. She remarks that she and her husband, in their discussions about the houses, have been reminded of past fantasies of moving out of state:

> Ms. Y: But . . . I wouldn't want to leave you . . . . I thought, "I can't." Um, I'm tied here to you. I can't, I can't move before I, I mean, I have to finish this process, it just feels like a priority to me and I, I, I wouldn't tell Jack [her husband] that, but, um [20-second pause] . . . that's a pretty strong tie.

The patient's mounting anxiety is momentarily reduced through an expressed desire for object relatedness—a tilt in the direction of self-reflection. She also hints at potential triangular conflict involving her husband, who represents a possible intrusion into the dyad.

At this point, the analyst remains silent. In fact, the analyst's activities throughout the session were minimal—limited to a few exploratory questions and supportive comments. No interpretations were offered.

We note that, in spite of the analyst's silence, the patient is moved to reaffirm her tie to the analyst.

The patient ends the session by expressing feelings of confusion: "My mind is a blank." She declares that she is "whacked out," that she cannot stop eating, is totally depressed, does not know what to do, and that she is driving her family crazy. She feels that she is going to buy a house she hates. It all

reminds her of her despised childhood. She dreads voracious consumption, being technologically menaced, and out of control.

The patient's affirmation of relatedness offered only scant repair. The moment of desired union was not consummated.

Commentary: The Propositions Evaluated. As we have observed, there appears to be a paralysis of *interactional synchrony* between patient and analyst. There was pervasive inactivity on the part of the analyst, and when supportive interventions might have been indicated, the expected rhythmic "uh-huh's"—signals of implicit emotional support for a distressed patient—did not occur. Was the analyst colluding with the transference? Nonetheless, the disruption in the relational balance, as an indicator of non-integration, cannot be discounted here.

We also noted the paralysis of thought. Much of the session is devoted to concretized, circular thinking about a house to be chosen or not. As equivalence mounts, confusion ensues, peaking in desymbolization: "My mind is a blank."

As the concreteness surfaces, so does the primitivization of inner conflict. This is already seen in the opening of the session. Ms. Y emerges from her car and arrives in the consulting room, expressing idealized desire for the analyst, juxtaposed with feelings of envy and shame. The conflict is resolved through a sticky attachment to the analyst and through fragmentation of the body self. Although this conflict can be recognized by the analytic observer, it is not accessible to Ms. Y. At this point in the treatment, the conflict cannot be represented in spoken language.

We conclude that our first three propositions outlined earlier appear to be confirmed and relevant here. Nonetheless, the event sequence pervading the entire hour suggests that the paralysis of the synthetic function of the ego was the most relevant psychic event. This is seen in the fragmentation of the body self, in the juxtaposition of disconnection and hyperconnection of object relations, and in the paralysis of the symbolic. This fragmentation, present at the very onset of the hour, functioned as a signal to the analyst, inviting her to collude with a countertransference reaction of mutual helplessness.

In sum, we consider *desymbolization* to be the leitmotif of this phase of non-integration.

Of great interest is a nodal point of change (proposition 4), arising about fifteen minutes before the end of the hour. We can only surmise that at this juncture, the patient experienced the cumulative impact of her own withdrawal (i.e., her retreat into repetitive meaninglessness), so that the dread of object loss became intolerable. The result was a reversal, a stab toward refinding the lost object: "That's a pretty strong tie." It is worth noting, as reported in another study (Freedman, Lasky, and Webster 2008), that such paradoxical reversals can be found in every session of this non-integrative phase, perhaps in preparation for or in anticipation of the upward slope.

Phase 2: The Enactive Phase—A Phase of Transition (Sessions 252-255)

Almost immediately following the conclusion of the non-integrative phase, a new pattern of mental functioning emerged. There was a series of nonverbal acts, both patient- and analyst-initiated, having a disruptive impact on the mutual regulation between patient and analyst. Thus, we have termed this the phase of the *enactive transference*. We will summarize and comment upon all four sessions of this phase.

> **Session 252.** Ms. Y begins with a childhood memory in which she is a frightened little girl. She is tearful as she speaks of her current desperate sadness, feeling weighed down and so disconnected from herself and others. She wonders if the intense sadness is about the fact that "how I want to be and how I really am are so discrepant."
>
> She reports a dream that stresses a sense of being fused: "My mom tries on my wedding gown; she looks great in my dress. Why my mother in my dress? . . . Am I identifying with her, or is it more like an intrusion?" Her associations lead to how mean and spiteful she feels when changing her daughter's diaper and her guilt about such feelings.
>
> Then a patient-initiated enactment ensues. Ms. Y remembers that, just an hour before the session, she accepted an invitation to a social event that conflicts with the next ana-

lytic hour. She asks to reschedule. The analyst is drawn into the action, expressing apparent discomfort through the shuffling of papers, interrupting the patient, becoming excessively accommodating, and reassuring the patient that she is not rigid. The patient retorts, "I am at the mercy of your response." An interchange involving misunderstanding and confusion follows.

In spite of this enactment, the patient continues with a series of associations about her efforts to stay internally connected to others and to the analyst. Having taken on her analyst's comments from a previous session as an "assignment," she announces that she has been trying to attend to the lustful side of herself—dancing to the music she loves in order to get her juices flowing, having sex, and masturbating.

Viewing this entire scene from the vantage point of the patient-initiated enactment, Ms. Y entered the session with the intent to break the frame, that is, to reschedule. The resultant themes—the confusion of identity (mother wearing her wedding gown), her meanness in the role of mother herself, and her escape into lustful fantasies—all speak to an evolving transference conflict through the medium of enactment.

Session 253. The reverberations between analyst and patient continue in more explicit fashion. Due to an accident on the highway, the analyst is forced to start the session thirty minutes later than usual. She has called the patient, who lives nearby, to alert her about this change. In session, Ms. Y has several critical and challenging thoughts evoked by the delay, but is reluctant to mention them, asking only, "How many roads can I open up here—how many roadblocks are there to overcome?" Then, quoting her husband about the delay, she adds, "He said I should charge you because you didn't give me twenty-four hours' notice."

Significantly, the analyst, in what can be viewed as a concretized denial of hostile intent, retorts, "Of course he was only teasing." The patient remarks that her husband's joke evokes difficult feelings, inasmuch as this points to a conflict of loyalty involving herself, her husband, and her analyst. This crucial conflict, alluded to as well in session 245, remains unexamined until session 257.

Later in this session, Ms. Y notes how controlled she feels with the analyst.

Ms. Y: It's an annoying thought to think that you see other patients for forty-five minutes and they may take full advantage of all the space, and I come in here and I feel like I'm lying in a casket on the couch and can only take this much space.

Citing earlier material, the analyst interprets, "It must feel too dangerous. If you're not in a casket, you'll be tossed around by a team of men, having them fondle your breasts." The patient then reveals a subsequent fantasy of being in a whorehouse, bouncing around on the penis of a man she does not know, while women are sucking her nipples.

Then the patient once more addresses the analyst's lateness and the road accident. She comments, "Things are not resolved between me and you in here. There is no such thing as an innocent question because I'm not innocent in here. I'm always somehow sneakily looking for a way in."

Toward the end of the hour, the patient returns to her default position. "Things are not clear—we are in the muck and the mud . . . . I feel discouraged. I have felt like I've wanted to ask you to, like, guide me, show me where to go . . . . I hear my stomach growling; I hear your stomach growling."

What matters in this session is not the analyst's inadvertent lateness, but rather the fact that Ms. Y used the occasion to activate her hostile fantasies. The climate of inadvertent action and analyst countertransference enactments also serves to crystallize Ms. Y's core triangular conflicts. But here they remain dormant until the reintegrative phase.

Session 254. The patient opens this session with "I look at the title of a book on your desk and that is a way of shutting you out." She has noticed the analyst's tight-knit top and breasts upon entering the office. A great deal of self-preoccupied rambling ensues, with minimal interaction between the two participants. Then the patient resumes her attack on the analyst, stating in a complaining voice that she is still in the same place, with the world spinning around her. She adds, "You are my best friend, though something in me feels you are an enemy."

About two-thirds of the way into the session, the analyst interrupts and excuses herself, saying she has to go to the

bathroom. Sounds of the door closing, vomiting, and the toilet flushing can be heard. She returns a few minutes later and resumes the session. Ms. Y inquires if she is all right. The analyst answers that she is feeling better, explaining that she had an upset stomach. In spite of her illness, the analyst makes an effort to continue the hour, but there is a depressed quality in her voice.

This is a session of mutual avoidance: the patient looks at a book in order to avoid looking at the analyst's breasts, and the analyst leaves the room to vomit. While the vomiting was mentioned only minimally in this session, it assumed center stage in the material to come.

Session 255. The opening of this session is so remarkable that we shall quote it verbatim.

Ms. Y: I had two reactions to it, but I was thinking, uh, all day yesterday and last night, uh—well, I don't have, like, a compassionate reaction, but I felt for you . . . and remembered nausea during my pregnancy. I found myself going over it and over it and over it in my mind like with a still camera, wondering how many seconds or minutes you were sitting there feeling uncomfortable before you realized you were going to throw up, because it's a—that's the worst part. I would think I just . . . a-and wondering if you felt, uh, uncomfortable or embarrassed that you, that that happened at all, or if it was no big deal inside of you. Um, it made you seem human, you know, and I, and I just felt for you. And the other, uh, fantasy thing that was coming out last night was that I started having these fantasies of, um, I don't even know if I'd call them fantasies or just like thoughts that—that, uh, came to mind, you know. Instead of pushing them away or just sort of discounting them, I would try to feed them to sort of see where they would go. It was real, uh, mean, um, uh, brutal type of, uh, imagery—where you're over the [she laughs]—kneeling down over the toilet bowl, and I have, and I'm there too, and I have your hair, like I'm pulling, you know, like I could flip your head back if I pull your hair, or else push your head in the toilet or, um, like, uh, almost like I would say,

> you know, "throw up," and if you didn't throw up, I'd kick you in the back or something or on the behind or something like that. Like, real mean! And then I also thought of more embarrassing scenarios where, how you'd be, uh, throwing up and then you would fart too because you had no control over anything, you know, any—the mouth or the other part of your body. And you know what's interesting? Before I walked in here, when I was walking to the cabin, I was actually, it came to mind the time that you went into the bathroom during our session. That happened like a year or two ago; um, where you just excused yourself for a minute. And I think that when I thought that, I just thought "yes, I remember when that happened and kind of"—wasn't that something? But I thought, I remembered that yesterday before our session, so that when you went to the bathroom, it was as if something was familiar about it, because I had remembered the other time. I feel uncomfortable right now. I think the reason I feel uncomfortable is because I wish I could just, um, have that compassionate reaction.

The opening of this session marks the peak of the enactive transference. Note how the analyst-initiated enactment in the previous session is transformed and reverberates in the patient's representations. The sequelae include empathic concern, sadistic enjoyment in contemplating (in vivid visual form) the analyst's suffering, and then a return to reflective remorse. Here is a second nodal point of change. The sadism is contained through a measure of reflective functioning: "I think the reason I feel uncomfortable is because I wish I could just, um, have that compassionate reaction."

> As might be expected, following this attainment of reflective awareness, there is a slide downward during the session. The analyst, probably shocked by the patient's assault, is extremely passive. For about twenty-five minutes, the patient rambles, touching on various seemingly significant topics: a mystic hired to help her with her daughter, a quasi-suicidal fantasy of driving her car into a tree, and a dream about anger. The analyst fails to intervene and a new panic arises. There is

joint confusion and a return to desymbolization. A shock wave follows the dramatic outburst at the beginning of the hour.

But in the final moments of the session, even though panic is present, a reversal takes place. Ms. Y has a moment of regained reflection: "I am thinking about yesterday, when you went into the bathroom, and for some reason that whole incident made me feel closer to you, made me feel more connected to you."

We are left wondering: *had* the patient regained her compassion?

Commentary: The Propositions Evaluated. The fabric of these sessions suggests that the repeated experience of discrete, nonverbal, often disruptive actions—be they patient- or analyst-initiated—have a profound impact on the continuous process of mutual regulation between analyst and patient. This relational climate leaves a traceable impact on the patient's ego functioning. In these sessions, the patient moves closer to her psychic reality, shows an enhanced capacity for the symbolic, and reveals an awareness of who she is and who she would like to be—i.e., she is gaining a sense of agency.

In each session, enactment precedes an alteration in mental functioning. For example, the breaking of the frame leads to the whorehouse fantasy and the image of the analysis being conducted in a casket. But the most persuasive transformation of action into a verbalized image involves the vomiting—the precursor to the revenge fantasies, where in the next session the patient imagines, with sadistic pleasure, the analyst in a state of total helplessness. These two sessions form an echo chamber, setting off reverberations in the patient's state of consciousness, ranging from empathy to violence and then to remorse.

If, as a consequence of such disruptive experiences, space is created and new ego functions are stirred up, then nodal points of change can appear and lend new direction to analytic process. In Ms. Y's session 245, the nodal point contained the yearning to overcome the dread of object loss ("That's a pretty strong tie"); and now, ten sessions later, the patient longs to feel only compassion. She gives

expression to her effort at containing and protecting herself against the terrible sadistic wishes she has just lived through. A new treatment context is created, one that lends new direction to the analytic work.

In sum, while there is support in this phase for the relevance of all of our propositions, the enactments and subsequent alterations in the relational matrix carry the day here. Indeed, the enactive phase is one of transition in two senses of the word: For Ms. Y, it is a transition between the non-integrative and the reintegrative phases of the upward slope; it is also a phase in which transitional space is created —not through enactment itself, but through a process of mutual regulation.

Phase 3: A Phase of Reintegration and Symbolization (Sessions 256-257)

We began with the barren and concretized inner landscape of the desymbolized transference (session 245); we described a phase of transition with interactive patterns, the enactive transference (sessions 252-255); and now we will describe the cumulative impact of these precursors as they culminated in a new form of integration. This we call the *symbolized transference*. Session 257 is a representative session of this phase.

> Early in the session, Ms. Y tells of a dream that felt to her like a nightmare. She explains that the day residue involved her husband discovering a menacing animal in their back yard as he attempted to bring their children from the car into the house. "I dreamt that I was in this cabin and there was a threat of an [animal] outside. Both the kids were in infant seats and I had to get them before this [animal] got them."
>
> The tone of the session then shifts to a playful image as she tells of a game she played with her 5-year-old son. He was sitting on his Lego bucket, pretending to poop in the potty and then spread it everywhere. Her pleasure in the game is palpable as she quotes her son: "I made mommy laugh." This messy game, however, evoked the ire of her husband.

The transition from the nightmare to the scene of play with her son reflects the emergence of a pretend mode of thought. Also, Ms. Y was aware of provoking her husband as she participated in the play. This set the condition for a triangular conflict.

> Ms. Y then tells the analyst of the guilt and sadness she felt when her husband later questioned her priorities in relation to their marriage. This leads her to stress her alliance with her analyst. What ensues is the clear recognition of a triangular conflict:
>
> Ms. Y: I feel like I've done something with you and with this process that's beyond just me coming here for help. I feel like I've intentionally made this a priority, as if I were having an affair . . . . It's odd. I started to have this fantasy of us making love, and our groin areas were pressed against each other . . . . Jack's kind of the safety, secure person, but you're the exciting, uh, you know, you're the one I want to be even closer to.
>
> The analyst remains silent and seemingly receives the patient's desires, but then appears to switch identification. The analyst agrees with the patient that she is trying to play out an affair, and reminds Ms. Y of an earlier notion of wanting to "wear down" the analyst. But then the analyst adds a guilt-inducing intervention, "Jack certainly sounds like he's very interested in being connected with you."

The explicitly erotic transference appeared to be intolerable to the analyst. She failed to acknowledge the patient's direct yearning for her and deflected the expression of desire by identifying with the husband. This is an analyst-initiated enactment and a prelude to a regressive experience for the patient.

> Then the analyst shuffles papers and moves restlessly. The patient begins to cry.
>
> Ms. Y: I'm getting a headache. [There are shuffling sounds, crying, and pauses.] I kind of have glimpses, but I don't get it. [Pause.] I'm not thinking very well right now . . . . I wish I could think of something else to say, and I wish this session were over.

> After a long silence, remorse sets in once more. Referring to her husband, Ms. Y notes, "We hugged each other this morning and told each other that we love each other. We just both felt sad. Jack said he felt sad, and I feel bad, too. But I feel more complicated than just sad."

The regression is relatively brief and seems to be resolved with a gesture of "making up"—probably a compliance with the analyst's wishes.

> Now associations widen. Ms. Y tells of another imaginary scene, this time making love to her chiropractor. (Her speculation was that the analyst's husband was a chiropractor.) She adds that while she was making a phone call to her chiropractor about her next appointment, she regretted not having left a friendly message for his wife as well, since she knows both of them socially. "I wasn't giving what was inside of me, that I wanted to give just naturally, because my fantasies get so full-blown." She has become self-reflective once more.

The strong desire to leave a friendly message for the chiropractor's wife was most likely a way of diffusing the guilt of her erotic (probably oedipal) fantasies. It is after these last associations—the remorse over her erotic fantasies about the chiropractor, the wish to undo her transgression by appealing to the wife—that we find a third nodal point of change: "My fantasies get so full-blown."

Commentary: The Propositions Evaluated. Symbolization seems to be a dominant mode of mental functioning during this hour. We find symbolization first in the form of a dream, giving visual expression to dread and helplessness. Then, as the patient's affect shifts, symbolization occurs in a scene of play, the poop game with her five-year-old son. This pretend mode of thought is the precursor to reflective functioning (Fonagy and Target 2000). What follows is an explicit, articulated expression of a triangulation scene, as Ms. Y spells out her conflict of loyalty toward both her husband and her analyst. She survives the transitory regressive episode, reverts to an erotic fantasy, but seeks to contain it through self-reflection. This might well be a transitory attainment, but it marks a *symbolic synthesis,* the activation of the synthetic function of the ego.

Surely, this development took place in a reciprocal interchange between patient and analyst. The patient was able to make use of the empathic other. There were rhythmic "uh-huh's" emanating from the analyst, a sign of interactional synchrony. The core conflict surfaced at the center of the intimate interplay: Ms. Y's statement that "You are the exciting one." This frankly erotic confrontation led to a countertransference enactment and a momentary regression, which the patient survived. A rebound ensued. Both the felt presence of the analyst as object and the experiencing of a difficult triangular conflict were undoubtedly factors allowing for a psychic consolidation; this supports our earlier-described propositions 1 and 2. But the manner in which Ms. Y took recourse in reflective thought after the regression can be traced to an inner integrative force, *symbolic synthesis*.

The trajectory of session 257 replicates the structure of an entire transformation cycle. The session begins with an integrative, well-articulated sequence of object representations, expressed in symbolic form. At a critical juncture, a transitory regression occurs, and then recovery ensues. Furthermore, soon after this regressive dip, a nodal point of change is expressed in a peak of reflective thought: "My fantasies get so full-blown." This is a paradoxical reaction to a state of helplessness, as she affirms her connection to her analyst. This reflective thought can be given two readings: it is a move toward further symbolization, for Ms. Y shows greater reflectiveness, but we also hear a tone of ambivalence and awareness of her own limitation, so that it may yet be a move toward desymbolization.

DISCUSSION

We have described the psychic events that moved Ms. Y toward reintegration within the time-space of an *upward slope*. Of the four propositions advanced, each played a decisive role in the three phases of the upward slope. Furthermore, additional scrutiny of the clinical material reveals that during each phase, different dynamic forces became salient, offering distinct clinical challenges. This selective relevance suggests a *phase-specific hypothesis* of reintegration.

Hence, during the phase of non-integration, desymbolization and psychic equivalence were the central issues. The challenge became one of overcoming equivalence. In the phase of transition, patterns of enactment surfaced, both analyst- and patient-initiated. In this concretely communicative climate, the challenge was one of enabling the patient to use the analyst as object. During the phase of reintegration, synthetic ego functions were activated, and the challenge became one of *symbolic synthesis*. Thus, we consider the phenomenon of the upward slope to entail a shift from symbolic equivalence to symbolic synthesis, with the intervening challenge of an enactive transference.

In this line of inquiry, we are making use of three concepts that have a long tradition in the history of analytic thought: desymbolization, enactment, and symbolization. These concepts, like others of their species, are tied not just to clinical observations, but to developmental and/or metatheoretical notions as well. As previously noted, while concepts are assumed to be tied to their theoretical origins, this is often not the case; indeed, as Sandler (1983) notes, concepts are elastic and shift over time, and, as Smith (2005) observes, concepts are not so tightly bound to abstract theoretical notions. The same clinical observation can serve many concepts, and vice versa.

The Concept of Desymbolization and the Task of Containing Equivalence

To our knowledge, the term *desymbolization* was first used by Rycroft (1956) when he spoke of a reversal or displacement in the centripetal direction, often "called 'regression,' though it could as appropriately, and perhaps less confusingly, be called 'desymbolization'" (p. 143). More recently, the paralysis of symbolic functions has been equated with concreteness—almost as a diagnostic term (Steiner, in preparation); as a defense against hallucinatory wish-fulfillment fantasies (Bass 1997, 2002); and as the outcome of uncontained destructiveness, as in attacks on linking (Bion 1959). In contrast, Rycroft gives the concept an object relational tilt when he notes that words lose their connection to the object and a series of endless equivalence ensues.

Here Rycroft comes close to Segal's (1957) idea of *symbolic equation* or equivalence.[5] Segal sees this as a state that reflects intolerable ambivalence, which is a source of panic. For Segal, a Kleinian, the motivational force that underlies such equation is destructiveness. While it may be true that the engine for symbolic equation is destructiveness, the main point is that the patient is overwhelmed by unending ambivalence about object choice. We saw this as part of Ms. Y's terror as she agonizingly ruminated over a choice between two houses, feeling far removed from the objects in her life while her thoughts spun in reverse.

The clinical challenge becomes one of hearing the patient's endless repetitions and concreteness not as elements of a diagnostic fact, but as a process borne in the agony inherent in equivalence. Ms. Y's panic was temporarily contained when she voiced what we have termed a *nodal point of change,* spontaneously affirming, "That's a pretty strong tie." The clinical task, one of enabling the patient to refind the analyst as object, was actualized as Ms. Y entered the next phase —a phase of transition, the enactive transference.

The Concept of the Enactive Transference and the Transition Toward Object Choice

In our earlier comments on this phase, we noted that Ms. Y, through a process of mutual regulation, found a new connection to her analyst as object. We attributed this to the *enactive transference,* but our use of this term calls for elaboration.

Boesky's (1982) historical critique of the concept of acting out served as an impetus for a substantial literature on enactment. Many issues have been raised in regard to the term *enactment.* For example, the notion of the enactive dimension (Katz 1998) implies a continuous interchange between analyst and patient, predominately on a nonverbal level, which actualizes transference and countertransference

[5] The term *symbolic equation* was first used by Jones (1916), who gave the concept a divergent meaning. Jones emphasized the common phylogenetic roots, while Segal (1957) stressed object relational origins. To avoid confusion, we use the term *symbolic equivalence.*

wishes. Enactments are continuous events, calling for a special form of conflictual listening (Smith 1995).

But enactments are not only a continuous aspect of the analytic process; they are also noncontinuous, discrete events. Here Steingart's (1983) notion of the enacted symbol comes closer to our usage. In distinguishing the *enactive transference,* we are emphasizing discrete, often disruptive, nonverbal actions, either analyst- or patient-initiated, which impact the other member of the dyad. While we appreciate—and indeed, emphasize—the importance of mutual regulation, the clinical material in this enactive phase forces us to distinguish the continuous process from the discrete event structure. These discrete events can be thought of as flags, embedded within the enactive dimension.

In Ms. Y's analysis, such events—the breaking of the frame, the analyst's lateness, and the vomiting episode—all appear to have left their shadow on the patient's ego. This intersubjective process had a definable impact on the intrapsychic sphere. A shift in the transference-countertransference balance occurred: new affects were articulated (the desire to torture), previously difficult affects were reframed in a more modulated form (yearning for contrition), and new memories were brought to life. Further, as a sequela of this pattern of enactments, a greater interpenetration between analyst and patient took place, with a loosening and permeability of boundaries. There was an opening up of psychic space. Here the clinical task was accomplished in that the patient enjoyed the use of the object in the Winnicottian sense of play, and it is not surprising that this quality of "acting" appeared during a phase of transition.

The distinction between discrete and continuous enactments deserves commentary. The issue is one of time perspective. For Smith (1993), enactment or the enactive process is always continuous, and the apparent discreteness of any process, including enactment, is an artifact of observation. To be sure, viewed retrospectively, any given, "discrete" event is a compromise formation. Smith (1995) paraphrases Brenner on transference, noting that "what is unique about enactment in analysis is not its presence, but that it is analysed" (p. 72). Thus, when viewed retrospectively, even discrete events are

merely moments within the flow of time. From the vantage point of the retrospective experience of the analysis, nothing is intrinsically special about enactments. Smith (2008) notes:

> It is not that the event itself is discrete; the salient change is the shift in the analyst's attention. We notice what is going on and in so doing give an apparent discreteness to what is fluid; we make it "an enactment."

On the other hand, analysis is also concerned with the moments before and the moments after. This is the prospective view. For us, enactments have an onset, a termination point, and are of consequence to subsequent events. This is the position advanced here.

The Concept of Symbolic Synthesis and the Task of Confronting Inner Conflict

Following the enactive phase, a process of symbolic synthesis was observed. This early Freudian notion was reevoked by Solms (1995). He speaks of it in relation to dream formation, where he describes a process of selecting words to represent objects—those that are wanted and those that are dreaded. Symbolic synthesis bears an intrinsic relationship to Nunberg's (1931) early notion of the "synthetic function of the ego." In his classic paper, Nunberg refers to a process of assimilation that yields the first and plainest manifestation of the ego as it "mediates between opposing elements and even reconciles opposites and sets productivity in train" (p. 125). This is what takes place in the symbolizing transference. When the symbol is used predominately in the service of the secondary process, the symbolic is deeply connected to the object of presence, reflecting a widening of the patient's libidinal and object-related interests and investment.

In Ms. Y's session 257, she was able to sort out her opposing and contradictory feelings, articulate her triangular conflict, survive a crisis of identity during a brief regressive episode, and reaffirm her commitment to the analysis in a reflective, symbolizing fashion. She seemed ready to confront her inner conflicts, and, as many authors have noted, the tolerance for conflict and ambivalence is an achieve-

ment. In this case, what matters is not that Ms. Y had attained a level of triangular organization—for it is doubtful whether she truly had —but the fact that her ego could countenance this dilemma of opposites and still retain the sense of self was an important therapeutic achievement.

It is evident from the line of thought developed here that integration is not a unitary event, arising within the limited time-space of an upward slope. Rather, it entails the sequential unfolding of multiple events. It involves the challenge of overcoming equivalence, the finding and the use of the object, and the activation of the ego's capacity for symbolic synthesis. Nodal points of change anticipate the next challenge. They stand in a paradoxical relationship to the current context and presage the psychic events to come. Hence, the last symbolizing session in this cycle, dominated by symbolic synthesis, also contains signs of frailty and ambivalence—perhaps a return to desymbolization.

This vision of distinct phases toward reintegration offers divergent technical choices for the analyst. The desymbolized transference is either not interpretable or cannot be interpreted since the patient cannot be reached; the enactive transference need not yet be interpreted, since the impact of the interaction carries its own implicit meaning and force; while the symbolizing transference offers an avenue for joint interpretation. Perhaps it is this last version of the transference that represents the ideal of analytic work.

LIMITATIONS AND POSSIBILITIES

At this point in our paper, the time for qualifications has arrived. We have focused on three brief phases of one particular upward slope, taken from the long psychoanalysis of one patient. There are a host of methodological issues.

First, there is the challenging issue of individual differences among patients. It may be contended that Ms. Y was a very labile patient given to cycloid moods, and that this transformation cycle reflects a basic diagnostic profile. Elsewhere, it has been shown that peaks and troughs, the constituents of a transformation cycle, can be

observed in a wide range of clinical syndromes (Freedman 2002). The length of the cycle may vary, as well as the steepness of the slope (e.g., in obsessive-compulsive versus hysterical organization), but the fact of cycles applies to all clinical entities.

Next, there is the issue of generalizing from a single cycle in an analysis. Was this cycle a unique oscillation of mental functioning for Ms. Y? Were these three months a particular crisis in her analysis, or does the cycle represent a repetition of previous phases as well as of later recurrences? We have at our disposal follow-up clinical material, so that we are in a position to trace the recurrence of a cycle three years after the present one. Preliminary observations suggest upward and downward slopes, and, rather surprisingly, these often stretch over about as many sessions as does the cycle described in this paper.

Now to the particular time-space event sequence we have termed the *upward slope*. What mattered here were the ingredients: the phases and moments and their sequential deployment over time, as the patient moved toward integration. But it is quite likely that the ordering of events observed belonged to the uniqueness of Ms. Y. The constituents, in whatever order they might come about, are nevertheless essential aspects of all psychic repair. When they recur in succession over time as future cycles, they are part of *working through*. They contribute to macrochanges and move the patient toward a more consistent and stable symbolizing transference.

The vision of a transformation cycle as pure repetition of ups and downs must be supplemented by the vision of the spiral, the incremental gain over time. Laplanche (1999) noted that one of the most important aspects of transference has been virtually ignored: namely, its cyclical quality. To be sure, the process often appears repetitive, the same furrows being traversed again and again. But, he notes, there also appears to be "some [specific] gap, some change of level," an enriching of language. Thus, the question is: "Will one more turn be a turn for nothing, pure repetition, or is a certain potential for elaboration still present in the analysis?" (p. 232). Our methodology incorporates the vision brought about by this question and

will allow us to address in future research the movement from cycles to spirals.

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"YOU'VE HURT ME!": CLINICAL REFLECTIONS ON MORAL SADISM

BY CORDELIA SCHMIDT-HELLERAU

I was boarding a shuttle from New York to Boston. Three rows in front of me, a mother seemed to be in some sort of struggle with her four- or five-year-old son. "You've hurt me!" the boy exclaimed. The mother responded with a comment. "You've hurt me!" the boy insisted. More talking followed. "You've hurt me," the boy kept complaining. Eventually, the mother grew silent. "You've hurt me" the boy reiterated throughout the flight in what seemed to become an increasingly demanding tone—pausing at times, but continuing to repeat the words until we arrived in Boston an hour later. "You've hurt me!"

* * * * * * * * *

This interaction reminded me of patients who do just what the little boy did: they blame us and cannot stop blaming us for having hurt them. In order to outline the general dynamics I am referring to, let me sketch a typical situation with my patient Peter, who in his mid-thirties is married, has five-year-old twins, and is a hardworking lawyer in a successful practice. Peter came to treatment depressed and angry because, despite all his efforts and care for everybody, he continuously feels treated unfairly and unappreciatively by his wife, his clients, and even his two little sons. The very fact that he was recommended for analysis made him feel hurt.

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Soon the two of us have a similar situation between us. I make some small intervention, even something that seems of minor importance, and Peter feels hurt. "You've hurt me," he says, seemingly disgusted (more than wounded) by my misdeed. I acknowledge that he feels hurt. "That's what I said!" he rebukes. "And . . . ?"

" 'And . . . ?' " I echo. Peter stares at me. I wonder aloud to him what it was that felt so hurtful. "Isn't that obvious?" he says. "You've hurt me! I wonder how you could say that." All efforts to explore and clarify fail. Peter insists that I have hurt him, throughout this and the following sessions.

In the meantime, the event itself has become blurred. I am under the barrage of my patient's attacks. His eyes pierce me, and he clearly enjoys my struggle with this complication. I feel I am supposed to apologize, to confess that I *did* hurt him, to explain how I could do this—and I do not want to do so. As much as I understand the importance of this enactment (more than I do the complexity of the enactment itself), I feel unjustly accused. His claim to having been brutalized by me is brutalizing me. Whatever I say, he continues trying to corner me, hoping to force me to my knees in front of him while he tells me that I am using bad technique and he is paying all this money for nothing. "You've hurt me!" As I try to awaken his sense of what is going on, interpreting aspects of the particular interaction we are engaged in, he counters with something like: "Am I supposed to feel sorry for you? You didn't answer my question! How could you do this!?"

After some time, Peter seems to be finished, and the blame fades from his attention—readily available, though, to be picked up again whenever it fits the purpose. Real insight has not been achieved, I feel. And a little while later, after another intervention of mine, sure enough, we will get into another cycle of this kind in which his feeling hurt by me justifies his persecuting me with his accusations.

* * * * * * * * *

We have all seen patients who, for quite a while, engage in this kind of repetitions with us before they open up to the idea that such enactments have meaning. Of course, we can understand and con-

ceptualize their occurrence from various angles. Narcissistic issues are always involved, as are primitive sadomasochistic fantasies played out in the transference with the analyst. Triumphantly observing how the object is humiliated serves as a manic defense against feeling small, helpless, and not in control of what is going on.

These functions have been widely discussed in the literature. Here I want to limit myself to a particular aspect while leaving aside all the other secondary gains that form a part of these clashes. Drawing on my countertransference feelings whenever I am in this kind of struggle with a patient, I am most impressed by what I would call the patient's *moral sadism*. For example, it is with strong sadistic satisfaction that Peter crashes on my psychoanalytic conscience and makes me feel bad—how could I possibly be so insensitive, thoughtless, and technically clumsy as to say something that hurt him so much, that he was not ready to hear and not able to bear?[1]

My patient is not simply trying to humiliate me. Rather, it feels as if he wants to force a sense of guilt into my analytic conscience. If the moral masochist says, "I did it all wrong, I shouldn't have done it, I'm a bad person," the moral sadist says: "*you* did it all wrong, *you* shouldn't have done this, *you* are a bad person!"

In thinking about these clinical moments, I became intrigued with the fact that Freud conceptualized *moral masochism* but not *moral sadism*, even though he certainly saw masochism and sadism as an inseparable couple. Until 1915, he understood sadism as primary, and masochism as a result of turning sadism around "upon the subject's own self" (1915, p. 127). In 1919, sadism was still viewed as primary, and—in light of repression—the unconscious masochistic masturbation fantasy of "my father is beating me" was taken to be a compromise between morality and lust, combining a "sense of guilt and sexual love" (1919, p. 189). As Freud explains: "*It is not only the punishment for the forbidden genital relation, but also the regressive substitute for that relation*" (p. 189, italics in original).

[1] Of course, when a patient feels hurt, we always have to wonder in what way our intervention might have been hurtful; e.g., it might have stirred an unconscious sadistic or retaliatory impulse in the analyst. Here, however, I am referring to interventions that seem to have been arbitrarily picked out and designated as hurtful.

In revising his whole drive theory (1920, 1924), Freud finally stated his formulation of a primary masochism, in which the death drive fused with libido is directed toward the self; sadism occurs when a part of this mixture is directed toward the external object. As much as the erotogenic masochism seeks sexual pleasure via physical pain, moral masochism seeks the satisfaction of a sadistic superego (or its more primitive precursors) because of an unconscious sense of guilt. As always with his predilection for sexuality, Freud understands moral masochism as a dissolution of oedipal achievements, a resexualization of morality.

This latter idea certainly can hold for moral sadism as well. Moral sadism then represents the sadistic side of resexualizing morality. Here the refusal to feel oedipal guilt leads to the externalization of a bad conscience (its projection onto the analyst), which allows the patient to feel morally superior, even flawless, while enacting the unconscious erotic fantasy of intercourse as a sadistic subjugation and penetration of the object. As in Freud's concept of moral masochism, this aspect of moral sadism can be viewed as an expression of sexuality and aggression.

Leonoff (1997) follows a different path. He is interested in the use of sadism with regard to annihilation anxieties, when the fear of losing an object deemed essential for the subject's survival becomes overwhelming:

> Faced with unarticulated primitive dread . . . the sadist triumphs over death by becoming its agent. Clinically, such dread can be expressed through a malignant fear of passivity, helplessness, or ego collapse, as well as in the wordless panic of nonexistence. These may be defended against through moments of sadistic triumph, which, through omnipotent control of the object, symbolically guarantee the survival of the sadist. Sadism, therefore, garners grandiosity and through aggression sidesteps psychic death by becoming the harbinger of it. [p. 100]

In his presentation of a clinical hour and its minute analysis, Smith (2008) shows how and why this works. The patient's sadistic attack of the analyst, her punishment of him, goes hand in hand with

and is implicit in her self-punishment; envious attacks, guilt, and reparation turn round and round in vicious circles, with the final aim of holding the analyst tightly in place. Analyst and patient are "glued to each other in this sadomasochistic, self- and object-punishing unit," thereby avoiding "any sense of separateness at all" (p. 216). As Smith puts it, "moral masochism is always also moral sadism" (p. 209).

It is worth noting that Freud's and these latter approaches represent two different—if not opposite—perspectives on sadism, both of which are clinically valid. The first is focused on sexual perversion guided by the sexual drives; the second on the threat to survival and thus, as I see it (Schmidt-Hellerau 2001, 2005a, 2005b, 2006, 2008), is guided by the preservative drives. This is the perspective I want to develop here: *moral sadism in the service of self-preservation.*

It is my countertransference feeling when entangled with a patient in one of these "you've-hurt-me" episodes that has led me to think of moral sadism in this particular function. When I am blamed for having harmed or wronged someone, I can react in one of two ways: (1) I can acknowledge the correctness of the blame, consequently wanting to apologize and repair the damage (showing an urge to be object-preservative), or (2) I can dispute or deny my wrongdoing (thus being essentially self-preservative). And both feelings are usually stirred up in my countertransference and present the two sides of a monolithic conflict (Schmidt-Hellerau 2005a, 2005b). I feel urged to, and sometimes tempted to, apologize and repair—yet I also feel that I did not mean to do it, and that in fact I did not do anything wrong.

First, I want to address my patient Peter's feelings: he is hurt. Consequently, in his view, my duty is to apologize and remedy the injury. If this is what my patient wants to coerce me into doing, then I contend that his *moral sadism* is his effort to provoke an object-preservative response in me—an increase of care in the form of soothing his pain, healing his wound, reassuring him of his intactness, and helping him with something that seems unmanageable. "You've hurt me—now repair the damage!" would be his claim to be taken care of.

To be sure, understanding my countertransference in this way is not the means simply to enact the required reparation, but to work toward analyzing the patient's need to bring me into this corner. "It is true," the moral sadist says, "*you are a bad person*"; however, this accusation does not mean "*Go away*"—it rather expresses the idea that the object owes something to the subject. The expectation is that the object will then make up for it, will do the restoration. This view strips this particular form of moral sadism from its erotic core, seeing it not as primarily about gaining anal-sadistic pleasure, but instead about a heightened need to be cared for.

I think we should make a clear distinction between the *pleasure* of our sexual strivings and the *satisfaction* of our preservative needs. Pleasure and satisfaction do feel quite differently. And it is satisfaction, not pleasure, that I sense when Peter seems to notice that he has brought me close to an admission of my guilt and an apology for my supposedly hurtful intervention. He is then briefly satisfied, while also feeling the previous extension of his narcissistic boundaries reestablished. Now he can let go for a little while.

But the issue is not resolved and reemerges—even jumps up without warning, it seems, soon after. Again, Peter claims that I have done something hurtful to him and pursues my assumption of guilt with all the cruelty and sadism of which he is capable. I notice it is not that he merely wishes I would take good or better care of him—as do those patients who emphasize their neediness, thus evoking in us a countertransferential urge to be helpful. His issues are more pressing, more intense; his transference message to me is: "Not only did you not take good enough care of me—you even hurt me by doing something bad!"

My patient wants to force guilt into me (using projective identification), and I feel like refusing to accept it. He does not stick something into me like a symbolic knife (penis) that would cut or hurt me; the unmanageable something that he wants to force into me is *guilt*—and that is what makes this form of sadism a *moral sadism.* It is a guilt that he wants to get off his chest, that he himself refuses to accept, and that he wants me to take over. I have to apologize for it—which, if I do, gives him relief for a short time, until the whole

cycle starts again, because as long as we have not understood what this unconscious guilt is all about, he will continue to feel guilty.

Guilt that is so unbearable to a child's mind that it potentially leads to moral sadism usually goes beyond normal oedipal fantasies. It can be the consequence of a traumatic event in the family (e.g., the death of a sibling or parent or mother's miscarriage, possibly during the oedipal phase) for which the child takes omnipotent responsibility. It may also be evident in patients whose parental objects have used them as containers for their own excessive projective identification with guilt (Williams et al. 2004). In these latter cases, the patient's use of a moral sadistic attack on the analyst represents an attempt to get rid of the indigestible parental guilt while simultaneously reenacting the moment of guilt intrusion (a turning of passive into active). Having once been the victim of such a guilt intrusion, the patient feels quite justified in blaming the transferential object—the analyst—of hurting or wronging him or her.

The idea of justice is central to moral sadism: it not only defends the patient against the perception of his or her own sadism; it also expresses a deep-seated sense of the right to be oneself, authentic and separate, the need to purge oneself from one's bad objects in order to restore, preserve, and develop one's own pure self. When the guilt is less particular and more pervasive, when there is confusion about what the object and what the subject might have contributed to the crime, the patient often insists on "misunderstanding."

In severe cases, the claim of "misunderstanding" does not aim at clarification, but rather at bolstering the "reality" of the patient's having been hurt by the analyst, if only by accident. Nevertheless, despite the difficulties in working with these aspects of "malignant misunderstandings" (Britton 2003), it may be helpful to keep in mind that these patients' attachment to moral sadism includes a reparative offer extended to subject and object alike: it is as though the patient is suggesting, "Neither of us is truly bad; we just misunderstood each other." However, this offering to the analyst can be a trap if both parties agree that this is what took place. In fact, moral sadism is never based on misunderstanding, but on an intrusion of guilt that requires analysis.

* * * * * * * * *

With these few strokes, my goal has been to elaborate on a clinical concept that, to my knowledge, has not previously been made explicit as such in the literature. "You've hurt me" seems to be the central formula that promotes the secret strivings of the moral sadist to force guilt into the object, with the expectation of repair and compensation. The apology of the object never helps because whatever was originally the object's guilt has since become the *patient's* guilt. Analyzing and helping the patient to own his or her guilt by differentiating between which aspects belong to the object and which to the subject will provide the relief the patient yearns for. Owning one's guilt means to transform some of the moral sadism into healthy moral masochism (Rosenberg 1991)—including the acknowledgment of one's sadism and one's need to repair.

We can leave open Freud's question of whether masochism or sadism is primary. Rather, I would say that the primal need to be taken care of becomes sadistic, as in moral sadism, when a part of the self that was in need of being cared for by the object feels unbearable, even dangerous to the subject—the child, the patient—since the maternal/parental object has closed off that part and refused to take it over, leaving the child with the feeling of being bad.

Moral sadism is then an intensification of the subject's claim for help, piercing the object's wall of refusal and loading it with all the indigestible badness that was once stirred up within the child. Thus, in an inescapable vicious cycle, the object becomes the bad object, avoided by the subject as a source of direct help, but used for further evacuation of all that feels bad inside. Signs of "moral masochism"—or rather of true feelings of guilt and sorrow—eventually indicate to the analyst that the patient has become capable of containing some of his or her guilt and working it through.

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REPRESENTATIONS AND THEIR VICISSITUDES: THE LEGACY OF ANDRÉ GREEN

BY HOWARD B. LEVINE

André Green is a leading voice in French psychoanalysis whose contributions sit at a crossroads, where the challenges posed and the opportunities presented by the work of Lacan, Klein, Winnicott, and Bion meet the still-generative insights of Freud, many of which Green reminds us have yet to be fully appreciated or developed. In offering a summary of Green's work, two of his recent books, *Key Ideas for a Contemporary Psychoanalysis: Misrecognition and Recognition of the Unconscious*[1] and *Psychoanalysis: A Paradigm for Clinical Thinking,*[2] give readers a chance to join him in his struggles to understand and treat patients whose difficulties lie beyond the spectrum of neurotic disturbances for which psychoanalytic treatment was originally intended. Additionally, they allow readers to listen in depth to the reflections of a sensitive clinician who is also an intellectual and a theoretician in the best sense of these words, as he looks back over some of the major issues that have shaped his professional lifetime and ahead to what is still to be settled in our field.

Readers of these excellent translations will discover that Green's work is accessible, thought-provoking, original, and deeply rooted

[1] Translated by A. Weller and published in 2005 by Routledge (London and New York).

[2] Translated by A. Weller and published in 2005 by Free Association Press (London).

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in the complex challenges of day-to-day clinical practice. While engaging with and responding to many of the major influences and controversies in contemporary psychoanalysis, his work relates in particular to two nodal points in analytic discourse. The first and most important, of course, is Freud. But—and this may be most relevant to those American analysts who, like myself, were introduced to and trained in an ego psychological Freud that tended toward the mechanistic—Green's reading of Freud maintains the centrality of the drives while restoring a vital human dimension to analytic theory that is breathtaking and liberating.

The second voice, which is often implicit and whose importance for Green is perhaps more personal than conceptual, is that of Lacan. Like many of the other leading French analysts of his generation, Green was at one time close to Lacan and powerfully affected by him. In some ways, Green may still be reacting to that influence as he carefully clarifies and draws distinctions between his own thinking —along with that of more centrist (i.e., Freudian) French analysts— and the ideas espoused by Lacan.

In particular, Green's work is deeply engaged with the roles of drive, perception, representation, language, and words in the structure and functioning of the psyche. Unlike Lacan, however, Green's theories are closely allied to those of Freud. Where Lacan turned away from the drives and asserted that the unconscious is structured like a language, Green views the drives as a foundational concept, believing, as did Freud, that the id consists of unbound and unrepresented impulsion and action that cannot be captured by or associated with words and their "presentations." "What Freud is trying to tell us . . . is that the unconscious can only be constituted *by a psyche which eludes the structuring of language,* it is constituted essentially of thing-presentations [i.e., impulses and affects]" (*Key Ideas for a Contemporary Psychoanalysis,* p. 99, italics in original). Thus, for Green, "the separation between preconscious and unconscious is not open to discussion. There exists a real break, a change of regime separating the two agencies" (p. 98).

This position is reflected in Green's clinical theory, in which the transference is the locus of a primordial struggle between discourse

and action: that which can be bound by and put into words versus "the elements of the psyche that cannot justifiably be connected with language" (*Key Ideas,* p. 50).

Despite Lacan's famous rallying cry of "Back to Freud!", Green argues that Lacan abandoned his place as a Freudian when he turned away from the concept of drives and advanced a theory that in effect introduced word presentations into the id. Green, who is quite approving of the French psychosomaticists such as Marty and de M'Uzan, further contends that in so doing, Lacan also slighted the somatic and the role of the body and failed to take account of the insights and implications implicit in Freud's introduction of the structural theory.

In contrast to Lacan's, Green's *oeuvre* offers a compelling development of the implications of representation (which Freud believed was intimately connected to the role of words in the psyche) and nonrepresentation for psychoanalytic theory, relating these to a creative and enlivened use of Freud's drive theory. Green's discussions of time and timelessness, affect and idea, perception and negative hallucination, Eros and the work of the negative constitute major clinical and theoretical contributions, all of which are consistent with and evolve from fundamental tenets in the work of Freud.

Given Lacan's reputation for controversy and contentiousness, it may not be too far-fetched to speculate that Green's exposure to Lacan was in some sense problematic. Perhaps in Green's writing, we continue to witness the fallout, abreaction, and recovery from that exposure as Green distinguishes his ideas from those of his former teacher. To the extent that this speculation is correct, painful as it may have been for Green, we are truly the beneficiaries of these struggles.

At the heart of Green's work is the distinction between neurotic and non-neurotic (borderline) structures. In this sense, Green works out the implications of "the epistemological break"—"the turning point of 1920" (*Key Ideas,* p. 97)—that marked Freud's (1920, 1923) shift from the topographic to the structural theory. In Green's view, the challenge that psychoanalysis faces is how to take account of the "growing number of non-neurotic structures in analytic practice" and

"recognize the commonly acknowledged insufficiency of the [topographic] Freudian theory to account for the non-neurotic structures" (*Key Ideas,* p. 16).

As Green convincingly describes it, the major development in Freud's theory was the change from

> . . . one model, at the centre of which one finds a form of thinking (desire, hope, wish), to another model based on the act (impulse as internal action, automatism, acting) . . . . The analyst now not only has to deal with unconscious desire but with the drive itself, whose force (constant pressure) is undoubtedly its principal characteristic, capable of subverting both desire and thinking. [*Key Ideas,* p. 47]

Green further argues that the clinical realities—unconscious guilt, masochism, various forms of the negative therapeutic reaction—that necessitated this change in models have had a wide-ranging theoretical impact on our field:

> The dispersion, or even fragmentation, of psychoanalytic thought into many opposing theories (ego psychology, Kleinism, Lacanism, Bionian, Winnicottian and Kohutian, etc.) could all be interpreted as attempts to propose a solution to the limitations of the results of classical treatment. [p. 47]

This reading of Freud's theoretical shift is significantly different from that of ego psychologists. While Green concurs with the latter that the ego "registers, observes, judges, decides, while remaining under the triple influence of the id, the superego, and reality" (p. 103), he believes that the recognition that portions of the ego remain unconscious, coupled with the discovery of various forms of unconscious guilt and self-destructive tendencies, splitting of the ego and disavowal (Freud 1927), led Freud to lose confidence in the ego as a reliable ally in the treatment. In Green's words:

> It seems undeniable that, from 1923 on, both with regard to masochism and to splitting, it was the ego's responsibility to which Freud wanted to draw attention, as if he wanted

> to warn analysts that they not only had to deal with a terrible adversary that was unknown to them, the death drive, but, in addition to that, the agency which they thought was on their side in the cure was nothing but a double agent. [*Key Ideas,* p. 111]

For Green, the significance of portions of the ego remaining unconscious goes far beyond the phenomena of unconscious defensive activity:

> It implies taking into consideration the awakening of instinctual life, the acceptance of it, the recognition of its manifestations, the conservation and introduction of what is attached to it, the sorting out according to their qualities, among the erotic and destructive aspects, of those which respect the major prohibitions and conserve the ego's vitality, without the risk of disorganization and without the contrary danger of sterilization. [p. 104]

The primary task of the ego, then, is not predominantly that of defense, but how best to maintain aliveness while navigating "*between chaos and sclerosis*" (p. 104, italics in original).

In close agreement with Freud, Green remains keenly aware that, while the topographic theory is extremely successful when applied to patients with a neurotic organization, it is insufficient as a theory of therapy when facing the clinical problems that are increasingly encountered in contemporary analytic practice. The crucial distinction is between that which can be represented and that which cannot yet be connected to language. The latter, which can only manifest itself as drive pressure, impulse, and action (*Agieren*), will first require transformation—often through the intervention of intersubjective, dialogic work, and linkage to language (word presentations)—in order to be contained by and made accessible to psychological processes.

Thus, in describing clinical work, Green places the dialogical couple at the heart of the active matrix of the treatment, and emphasizes that the transformational processes of the session are intersubjective as well as intrapsychic. For the patient, these processes will reflect two aspects of the transference: *transference onto speech* and

transference onto the object. The former is "the result of the conversion of all the psychic elements into discourse" (*Key Ideas,* p. 50). The capacity to effect a transference onto speech is the consequence of good enough attunement, availability, and responsiveness on the part of the object. This capacity will develop as a result of the binding of drive impulses by words in the process of representation of satisfaction that follows from repeated experiences of drive satisfaction provided by a sufficiently invested libidinal object.

Transference onto the object implies that there are dimensions of the analytic relationship (e.g., impulse, action, enactment, raw feelings, somatic reactions) that cannot be contained or mediated by discourse alone. These reflect unbound areas of drive pressure, which can be made more peremptory and disorganizing by repeated and/or traumatic experiences of failed drive satisfaction. When disorganization leads to failure of representation, object attachment and associative links may be weakened or severed and the fabric of the psyche may be torn, so that self-continuity, object constancy, and meaning itself may be severely disrupted. In the context of a progressive analytic experience, however, the two components of the transference, taken together, imply that for the patient, transference will include not only *repetition* of the past, but also the dialogical, intersubjective *creation* of what has not yet been fully experienced—i.e., that which has not yet been (or only weakly been) represented or symbolized.

For the analyst, it is crucial to remain receptive and emotionally available to his or her own associations and responses as well as to those of the patient. This requires both tolerance and understanding, with a special concern for maintaining a sense of aliveness in both members of the dyad:

> Sometimes, paradoxically, it will be less damaging to the process to allow a lively countertransference reaction to be expressed, even if negative, in order to gain access to the internal movements animating the analyst. These are all evidence of . . . spontaneity . . . having more value for the patient than a conventional pseudo-tolerant discourse, which will be experienced by the patient as artificial and governed by technical manuals. [*Key Ideas,* p. 35]

Here Green makes note of Ferenczi's contributions and is in agreement with Winnicott, who, according to Green, believed that:

> It is better to have a patient who has retained certain symptoms at the same time as preserving or increasing his creative vitality and his spontaneity, than a patient completely free of his symptoms and psychically neutralized, that is to say, psychically dead. [p. 104]

For Green, as for Winnicott, vitality and aliveness are essential considerations for the analyst to bear in mind. And, like Freud, Green believes that the affects that sustain these qualities are closely related to the movement and expression of libidinal drive energy. Thus, in his formulations, sexuality and desire play a central and organizing role in the psyche, especially the organized, represented, and symbolically invested psyche of the neurotic.

But what of non-neurotic patients, whose problems lie "beyond the pleasure principle"? These patients, perhaps the most numerous in contemporary analysts' caseloads, are the subjects of some of Green's most powerful and persuasive contributions. As already noted, however, "the necessity of taking into account states that are situated beyond neurosis does not do away with the cardinal role of sexuality" (*Key Ideas,* p. 63).

This implies that psychoanalysis must retain an interest in and recognition of "the importance of the body as an erotogenic body" (p. 61) and in the centrality of sexuality-pleasure-gratification, frustration and desire, in the structuring and functioning of the psyche. What animates the latter is the "search for an object capable of procuring the satisfaction of the [drive] pleasure that is not immediately accessible" (p. 62). Thus, Green emphasizes that one cannot choose between theories that valorize the intrapsychic, the relational, the ego/self, or the object; instead, for Green, drive and object each imply the existence of the other and form an indissoluble pair that must be central to any comprehensive psychoanalytic theory. The "fundamental cell of the theory" is "the drive-object couple" (*Key Ideas,* p. 113), seen to be "two currents, at once independent of each other and richly interconnected, in which subjective formations and object formations are linked together" (p. 113).

The object, then, elicits and excites the drive, just as the drive searches out and helps internally constitute the object. Green states: "*The construction of the object leads retroactively to the construction of the drive, which constructs the object*" (*Psychoanalysis: A Paradigm for Clinical Thinking,* p. 48, italics in original). And a key element in this process is the stimulus of unsatisfied drive tensions produced by the absence or failure of the object: "If the object was not lacking, we would not know that the drive existed, for it is precisely then that it manifests itself with urgency" (p. 41). It is in part the recognition of this crucial stimulus for psychological development that stands behind the French preference for an analytic treatment frequency of three sessions per week, believed to build the necessary and sufficient degree of object absence into the clinical process with neurotic patients.

Green's theory is very much cognizant of the fact that the way in which the object responds to the demands of the instinct "contributes to the primitive, organizing structuration" (*Paradigm,* p. 43) of the mind. The experience, perception, and hence the internalization and representation of drive, self, and object are all dependent upon the quality of the interaction—frustration, satisfaction—between the self and its objects. As a stark illustration, Green reminds us of the Schreber case (Freud 1911) and the essential question raised by Winnicott: "What is the effect of having a mother who is psychotic or mad, or a father who is mad?" (*Paradigm,* p. 43).

Thus, Green believes that drive and object are inextricably and dialectically linked, together contributing to the matrix of the self. Any theory that fails to recognize the role of the drives in this process does so at its own peril, because "a subject with its instinctual dimension amputated is an inanimate, mechanical, operative, and, if you wish, cognitive entity" (*Key Ideas,* p. 114). The latter caution is central to one of Green's main criticisms of ego psychology, which he feels became too mechanistic in its overdependence on the concept of a conflict-free, drive-independent, autonomous sphere.

The work of the drive "drives" the psyche to invest in objects and seek satisfaction in order to reduce somatic tensions at the bodily source of the drive. This work not only includes searching for realization in the external world, but also internal movements toward psy-

chic representation and the creation of meaning—symbolization, signification, and the creation of links (*Paradigm,* p. 45).

From this perspective, the reality most crucial to the structuring and development of the mind is the internal reality of the demands of the drives, the internal constraints "pushing the mind to search for solutions in order to obtain the satisfaction that it is lacking" (*Key Ideas,* p. 114). But since satisfaction usually requires an object, and the veridical nature of the object and its response are often (if not always) decisive to the quality and degree of satisfaction, then the object as well as the drive must be taken into account in any comprehensive theory of psychic functioning. In some formulations, this has led to a valorization of the object at the expense of the drive and/or the self. Herein, Green tells us, lies the source of the confusion and debate about whether humans are to be seen as fundamentally pleasure seeking or object seeking.

A major contention of Green's work is that it is in the treatment of non-neurotic patients that the interconnection and potential theoretical confusions between pleasure seeking and object seeking become most painfully clear. Often, these patients present a narcissistic form of relating in which loss of the object carries with it a disturbance or loss in the sense of self. Associated with this disturbance, one often finds a disorganization, weakening, and/or failure of representation, and therefore a diminution of the capacities to experience, perceive, and be enlivened by drive derivatives.

In contrast, for the neurotic patient,

> . . . the essence of psychoanalytic experience, insofar as the classical treatment is concerned, depends on the very fact of the analyst's presence-absence (that is, his invisibility), on psychic activity inducing representation and exciting the patient's earlier memory traces which are here put to the test in the transference. [*Key Ideas,* p. 128]

The non-neurotic patient, however, whose emotional balance is apt to swing wildly between devitalization on the one hand and affective flooding and fragmentation on the other, often cannot respond to the absence or loss of the analyst with fantasy and wish, even a re-

pressed or disguised fantasy or wish. Instead, separation or absence provokes disorganization, devitalization, affective flooding, impulsive action, or somatic illness. In these circumstances, the tactical aim of the analytic encounter must be altered from uncovering or discerning what is disguised or hidden to strengthening the processes involved in the formation, associative linkage, and symbol signification of enlivened—and enlivening—psychic representations. Green comments, "Whereas a neurotic will have no great difficulty in conjuring up a psychic reality in which he replaces the analyst by imagining him as he wishes, the non-neurotic subject finds he is paralysed in such an activity" (p. 150).

What is lacking for the non-neurotic, what underlies the paralysis that Green refers to, is the capacity of the mind to link primary and secondary processes, a function that Green calls the *tertiary processes* (*Key Ideas,* p. 82). It is useful to think about the latter not only as "the work of the preconscious" in linking word presentations to thing presentations (creating secondary-process phenomena), but also as imbuing words and images with libidinal investment and symbolic significance, and linking them to other symbol-laden elements to form true associative chains. Without this work of the tertiary processes, interpretation of hidden meanings cannot effectively take place because the patient's speech, upon which these interpretations must be based, is apt to be flat, empty, and devoid of depth and greater meaning. "The representative network, including the world of things and of words, is severed at the level of thought—the thought circulating between things and words. These patients complain that their thought is empty; thus, there is nothing to say" (*Paradigm,* p. 49), Green observes.

At times, this emptiness of discourse may become extreme:

> In certain analyses, and I am thinking particularly of borderline cases, patients say that they are unable to speak. This does not mean censorship is at work, as with neurotics who hold back what they are thinking because it is bad to say it or to think it. No, it is not so much prohibition that is involved here as impossibility. [*Paradigm,* p. 49]

The tertiary processes "have no material existence as such, but are limited to the bindings that can be established between the first and the second [i.e., primary and secondary processes] in order to give unconscious desire a greater degree of legibility" (p. 83). It is this "legibility" that allows us to discern the unconscious and interpret latent dream thoughts, the wish behind a parapraxis, the meaning of hysterical symptoms, and so forth.

It is when legibility is absent that we most require a theory and technique that extend beyond the formidable insights of Freud's initial formulations. At first, Freud (1905) contrasted neurosis with perversion, and elucidated defensive organizations in which forbidden or unacceptable desires that achieved and maintained psychic representation were dealt with by forgetting (repression) or disguise. After 1920 and 1923, however, clinical considerations redirected his interest to the contrast between neurosis and psychosis; he began to examine defensive organizations, such as splitting, disavowal, and denial of internal and external reality. These defenses centered upon *negative hallucination*—i.e., not seeing or knowing what was there to be seen or known—and were marked by the failure, weakening, or erasure of psychic representations.

Green's careful reading reminds us that Freud's focus upon these issues, which involve the relationship between perception and representation and problems of reality and reality testing, marked a return to the point where psychoanalysis had originated:

> In the early days of psychoanalysis, [the study of] perception lost ground from the moment Freud invented the psychoanalytic setting aimed at facilitating and stimulating the sphere of representations. But it made its return, many years later, when psychoanalysts began to take more interest in psychotic structures and psychoses. [*Paradigm,* p. 37]

The crucial questions remain, in Green's words: "How does the external world help the internal world construct itself? What are the organizing parameters? How does the internal world shape our vision, our conception of the external world and, again, what are the organizing parameters involved?" (p. 37).

Put another way, Green is saying that early attention to fantasy, representation, and the intrapsychic dimension—how the drives, especially libido, influence the psyche and are represented within it—drew Freud's focus away from crucial problems concerning the ego's judgment of, relation to, and handling of reality. It was only with Freud's (1924, 1925, 1927, 1937, 1940) investigation of negation, splitting, fetishism, and the problems surrounding the avoidance, denial, and destruction of perceptions of reality, both internal and external, that the issue of reality testing and the nature of the object again assumed a central role in psychoanalytic investigation and theory.

In those parts of the psyche—or those patients—in whom non-neurotic structures predominate, where representation and symbolization do not play a dominant role, prominence is assumed by raw, peremptory affect and action. But it is important to note that these are not ordinary feelings or actions expressed in the external world. Rather, they are more unmodulated feelings and primitive acts that have been internalized and then discharged, often internally into the body (*Key Ideas,* p. 101).

While it is common to refer to such discharges as the consequences of desire, Green cautions us that it may be misleading to do so. We often "speak of desire . . . [when] it is legitimate to ask . . . if this category is really present . . . . [The] raw, and barely nuanced forms [of action], expressions of imperious instinctual demands, throw a doubt over the relevance of this qualification" (*Key Ideas,* p. 102). To put it succinctly, desire is the provenance of neurotic patients, differing in both quality and quantity from the blind, instinctual, action-oriented discharge and demands of the non-neurotic.

Green's understanding of borderline conditions and non-neurotic states is closely allied to his reformulation of Freud's final drive theory (Eros versus the death instinct). What he emphasizes, perhaps even more than the vicissitudes of conflicts over aggression turned inward or outward, is the opposition between investment and withdrawal of objects, ego (self-) representations, and psychic processes and functions. Following Freud, he describes Eros as generating linking, investing processes and movements that connect the ego and psychic representations with life, pleasure, objects, words, sym-

bols, and meaning. In contrast, the death instinct moves toward stasis, withdrawal of investment, disconnection from internal and external objects and representations, disconnection from psychic processes and functions, and abandonment of the search for satisfaction.

Conceptually, Green links the clinical effects of the death instinct to a set of defenses—repression, negation, disavowal, foreclosure, and splitting—that tend toward and support a general disengagement or subjective emotional withdrawal. He places them in context, each with the other, and designates their relation to and effect upon the perception of reality as *the work of the negative.* This "work" is often

> . . . sustained by a more or less omnipotent phantasy of self-sufficiency on the part of the ego . . . [that aims toward] escaping the object's control, asserting the ego's freedom through its quasi-all powerful capacity to undo its ties with the object and, if necessary, with itself. [*Key Ideas,* p. 217]

At the heart of these processes and this disengagement is a *negative hallucination of thought:* "*the non-perception of an object or of a perceptible psychical phenomenon* . . . the erasure of what should be perceived" (*Key Ideas,* p. 218, italics in original). Clinically, this erasure may present as a mind gone blank or a profound and even structural disregard of the analyst's interpretations, each of which Green is careful to distinguish from the forgetting of an idea (repression). He elaborates:

> It is as though there is a real dissociation between the sonority of words and their conscious meaning, on the one hand, and their unconscious meaning as it has been presented by the interpretation, on the other. It is this meaning that is neither perceptible nor recognized. [p. 220]

In regard to these issues, Green finds Freud's paper "On Negation" (1925) of great interest, noting that in contrast to Klein and her followers, Freud's concept of splitting involved *both* a recognition and misrecognition of reality, with a simultaneous preservation of both sides of the split (*Key Ideas,* p. 217). This formulation differs from the more usual view that emphasizes an *alternation* of oppo-

site states or affective qualities and helps explain the stasis that Green associates with the death instinct.

These views call to mind Bion's (1967, 1970) description of attacks on linking and minus-K phenomena. At its most extreme, the withdrawal described by Green may produce a "destruction through disinvestment" (p. 222), which in turn may reflect a last-ditch defense against annihilation anxiety, fear of breakdown, and the unleashing of instinctual chaos. All of these may reflect the early trauma of physical separation from the mother or her severe emotional unavailability, which Green (1999) examined at length in his work on the *dead mother syndrome.* The mother who is affectively unavailable, absent, or misattuned

> . . . progressively becomes for the child an object of an ambivalent, perpetually demanding fixation, infiltrated by *hainamoration*—[i.e., "lovehate," a neologism invented by Lacan that plays upon the combination of the French words for love (*amour*) and hate (*hain*) and the word for being enamored, *enamoration*]—without the feeling of passionate love, which lies behind the recriminations, being given any recognition. [*Key Ideas,* p. 223]

The result of this constellation may be frustration intolerance and an

> . . . internal reorganization . . . in which the subject who has experienced distress, negligence and an absence of interest (this, at least, is what he complains of consciously) considers his mother as a child whom he has to take care of. The mother's presence-absence is such that, if the subject tries to think about the maternal object itself, he feels he is faced with a void or a hole. [p. 223]

It is in these instances that the patient's speech may seem empty and the analyst's speech futile, neither able to make contact with the other or with the relevant conflicts. At such moments, sexuality "frequently assumes traumatic or perverse forms, discharging itself frenetically, giving the impression that it consists less of pleasure than of furious aggression" (*Key Ideas,* p. 224). Green describes these

movements in terms of a *disobjectalizing function*, which in essence divests not only objects and their substitutes of meaning, but also divests psychic processes of meaning—and in extreme cases, divests the ego of a connection to itself.

In a key section of *A Paradigm for Clinical Thinking* entitled "Return to Neurosis," Green further explores the differences between neurotic and non-neurotic states as he examines in detail various formations—hysteria, "primary anality," and phobia of thought, "the central phobic position"—whose surface morphology resembles that of the transference neuroses, but whose underlying structure is that of non-neurotic, borderline conditions. In the hysterias, for example, Green notes that one can see all kinds of intermediate forms—what in the past were sometimes called *hysteroid states* or *oral hysteria*. "True hysteria," however, remains a neurosis by virtue of its neurotic organization—that is, its intact representations and robust tertiary processes.

In contrast, borderline cases

> . . . can present all or part of the characteristic features of hysteria . . . [but] the neurotic organization is absent. Here, one is dealing with forms of conflicts which, despite involving the problems of love (and not always that of sexuality), remain secondary compared with others, among which the most important are destructiveness, masochism, and narcissism. [*Paradigm,* p. 77]

The conflicts encountered in neurotic hysterias are predominantly those concerning genital love and sexuality (e.g., castration anxiety), while the conflicts found in borderline cases deal predominantly with manifestations that reflect the fragility of ego boundaries (e.g., separation and penetration anxiety). In hysteria, the principal defense is repression (of desire), while in borderline states, repression is joined by splitting and other forms of denial—"negative hallucinations of thought in relation to desire" (p. 82). As a result, in the latter conditions, "it is not only phenomena of desire that are subject to erasure, but also the work of thinking itself" (p. 82).

This "erasure" (disobjectalization, the work of the negative) can affect verbalization, fantasy, instinctual movement, and so on, and

can produce long periods of stasis that require great patience on the part of the analyst. Intermediate structures, which would ordinarily be produced by the work of the tertiary processes, are weak or absent. One finds irresolution and splitting instead of neurotic compromise formations, making conflict resolution difficult if not impossible.

It is the weakened or absent capacity for representation that makes separation so difficult in borderline states. If the patient cannot represent the analyst, then he or she cannot hold onto the presence of the analyst in his or her absence. This is a different state than that of repression, in which unconscious representations persist in the absence of conscious awareness. (In order to forget, one must remember what one wishes to forget!)

Green's description of *primary anality* is of a constellation in which early trauma to self-esteem and the sense of self is responded to with chronic negativism and opposition (*anal narcissism*). The latter can provide an "invisible prosthesis" that helps patients define their identity through continual unconscious eroticization of struggle (combat). "What passes as willpower or tenacity is, in fact, based on a deficiency—and is designed to protect against the temptation of masochistic surrender [to objects linked to parents who devalued instead of offering support]" (*Paradigm,* p. 130).

To protect against impingement—a condition made more complicated by unconscious wishes for fusion—these patients fall back upon thought "as a last refuge, an inviolable shelter against enemy intrusions" (p. 120). There is an almost

> . . . permanent feeling of being impinged upon by others [with] . . . solitude, frequently experienced as an object-desert, . . . [yet] sought after, to the extent that it can signify the suppression of invaders . . . [and a place in which] one no longer has to fear the abuses of power by others who are disrespectful of the liberty of others. [p. 131]

These feelings often appear in the transference, where the patient may cling to the analyst despite a stagnant and empty, "parasitic" quality to the sessions. *"Obstinacy in communication exists alongside*

. . . *a fusional relationship* in which the subject is in secret and internal communication—assisted by an uninterrupted internal discourse—with a wholly good object" (*Paradigm,* p. 122, italics in original). Thus, the world seems split into

> . . . the domain of reality from which nothing is expected so that there is no risk of disappointment, and . . . the realm of phantasy in which everything is possible because nothing can really happen, and so consequently it cannot inflict any disappointments. [p. 124]

Green's concept of the *central phobic position* distinguishes between repression and avoidance of unacceptable desires and a more pervasive kind of denial aimed at thought and reality. This is an aspect of negative hallucination—i.e., failed or weakened representation, a not seeing of what is there, resorted to in order to avoid overwhelming and catastrophic anxiety situations. Clinically, this so-called phobia can take the form of certain things never coming to mind, either in their own or in derivative forms, or of associations that are flat, uninteresting, without depth, and devoid of insight. As in other non-neurotic conditions in which unconscious representations are absent or weakened, there are absent or weakened *intermediary forms* and *tertiary processes,* and therefore absent or weakened pressure for displacement and symbolization—hence, a reduced legibility of the unconscious. Unlike the latent thoughts behind the neurotic's dream, there are few or no connections to other associative chains needed to form disguised and collateral expressions. That is, unconscious conflict is weak or absent, and so there is little or no repressed material to return in a disguised form via displacement and symbolization.

Repression is a form of preservation in that it maintains unconscious representations. Negation, denial, or foreclosure, on the other hand, imply negative judgments of the existence of a thought or object, and are therefore mechanisms of erasure or uprooting from the inner world. As Green observes, "The non-existence of the representation, its suppression, is a guarantee of the non-reality of that

which has been foreclosed, as if the object's non-representation sufficed to free oneself of the threat it represents" (*Paradigm,* p. 164).

These descriptions of non-neurotic states of mind have tremendous implications for psychoanalytic technique and the meaning of the transference. According to this view, rather than focusing on the disguised repetition of repressed conflicted complexes, we enter the realm of the not yet represented or the only weakly represented, of inchoate sensations and of not yet actualized feelings that gradually achieve psychological form, perhaps for the first time. What is required is intersubjective work akin to Bion's (1970) description of the alpha function and containment. It also calls to mind what Botella and Botella (2005) call *figurability* (i.e., the co-construction of the unrepresented and not yet psychologically usable that is accessible to adaptive psychological operations; see Levine 2008)—rather than the intrapsychic work of the patient's remembering something from the forgotten past.

The phobia that Green describes is not the classical one, which is circumscribed, reflects a set of unacceptable, unconscious meanings, involves symbolization and displacement concerning action, and is the price one pays to protect areas of more normal psychic functioning. Rather, Green's phobia (really a denial or foreclosure, a delinkage or attack on linking [Bion 1967]) is of thought and recognition of reality *experienced in the session.* It is more widespread and general than the avoidances one finds in the neurotic state; in fact, it is an inhibition marked by massive avoidance, impoverished associative connections between mental elements, and an increasing isolation from external relations and alienation from one's internal world. It is a drastic set of measures necessitated by

> . . . a situation of inseparability between subject and object in which the feared transference towards the analyst reveals the projection on to him of a power to penetrate the patient's thoughts, so that the only remaining solution is the radical erosion of intelligibility which could come from communicating. [*Paradigm,* p. 135]

This projection, however, "disguises the patient's need to flee from himself as if he were facing a danger far greater than that consciously feared by the lifting of repression" (p. 135). This danger is inchoate, catastrophic, and ego destructive, and may be approximately envisioned as the fear of "mutually reinforcing relations between diverse events which, as a whole, create a virtual disintegration arising from the combination of different traumatic situations echoing with one another" (p. 136).

In summary, these two books, based upon almost fifty years of psychoanalytic practice and thought, deserve careful study, debate, and integration into our ongoing psychoanalytic discourse. They contain a wealth of ideas derived from the author's unique synthesis of clinical work and his close and compelling study of Freud. They are, for this reader, a powerful summation of Green's particular distillation and vision of psychoanalysis, reminding us of what psychoanalysis has been able to achieve, the point at which it has arrived, and what remains to be addressed. Taken together, *Key Ideas for a Contemporary Psychoanalysis: Misrecognition and Recognition of the Unconscious* and *Psychoanalysis: A Paradigm for Clinical Thinking* constitute the legacy and achievement of a consummate thinker.

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BOOK REVIEWS

PSYCHOANALYTIC DISAGREEMENTS IN CONTEXT. By Dale Boesky. Lanham, MD: Jason Aronson, 2008. 230 pp.

Most analysts would agree that we confront the critical task of finding a methodology that can, over time, help us select those theories and techniques that are most efficacious in allowing us to understand our patients' mental functioning, with the goal of helping them toward more gratifying and effective lives. Psychoanalytic pluralism, a necessary and welcome stage in the developing history of psychoanalysis has, not unexpectedly, evolved into a multiplicity of opposing theoretical and technical dogmatisms. What we lack are the means to arrive at decisions concerning the superiority of one or another of these views. This dilemma dates back to the earliest days of psychoanalysis, but today we lack the authority of a Sigmund Freud to settle our disputes. Dale Boesky, author of *Psychoanalytic Disagreements in Context,* is appalled—as am I—by the continued "absence of a consensually accepted methodology for the justification of our interpretations" (p. 202).

In this volume, Boesky describes his attempt to bring good sense to many of our disputes by use of the concept of *contextualization.* Because his argument is complex, I will quote him extensively in this review. The ambitious intent of this volume is to provide

> . . . a method of contextualization that could reliably demonstrate the inferential processes by which the analyst arrives at conjectures about the disguised meanings of the patient's associations . . . . This is the location of many of our incoherent disagreements . . . . [Further,] all meaning is relative to some context and no universal meanings exist outside of context . . . . Our methodology of contextualization remains obscure and controversial. The neglect of this problem is all the more remarkable because it has always been, and remains, the Achilles heel of psychoanalysis. [pp. xi-xii]

Boesky intends to establish the scientific status of psychoanalysis by demonstrating "the contextualizing strategies that underlie the far more abstract and visible differences between the competing models" (p. xv). He asserts: "Although I am, of course, influenced by my own bias, this is not a book that knowingly trumpets the superiority of one theoretic model over another" (p. xv). Some readers might disagree. As he says, "Given that anything that the patient says can be interpreted to mean anything, there is no boundary to the limits of overdetermination other than the ingenuity and imagination of the analyst in any disagreement" (p. 202). He elaborates:

> The novelty of my book resides in my emphasis on locating this incoherence in our failure so far to clarify our methods for inferring latent from manifest meanings. I suggest preliminary steps to reduce this ambiguity about our inferential processes by refining our understanding of our methodology for contextualizing the associations of the patient when we infer latent meanings from manifest associations. [p. xix]

Thus, it is Boesky's view that if we can understand the contextual background of an analyst's thinking and interventions, we can begin to decide which ideas are more credible, which interventions more efficacious, and which are not psychoanalytic, and thus resolve many of our disagreements. He attempts to carry out a philosophically informed contextual analysis of a variety of analytic contributions with the aim of demonstrating that such an analysis will lead logically to relatively clear, consensually agreed-upon conclusions. Unfortunately, despite a most valiant effort, the contextual guidelines he provides are, in my opinion, still inadequate to the task of deciding what precisely are the appropriate criteria for judging the interaction of a given patient and analyst. The task may be beyond our capacities at this time. It seems apparent that Boesky, like the rest of us, is a captive of a priori convictions concerning what is or is not proper psychoanalysis.

Boesky correctly emphasizes that "the literature about our primitive methodology for comparing our diverse theoretic models remains relatively small" (p. xi). He stresses the importance of clarity and our lack of it concerning the contextual criteria that analysts have em-

ployed in the past. However, as he demonstrates in a discussion of his disagreement with Brenner concerning a clinical intervention (p. 116), even analysts sharing the same theoretical basis may come to different conclusions concerning the relevant context for their interventions. In fact, it becomes clear in the course of this volume that the notion of contextualizing the interactions of patients and analysts may promise more than it can deliver. As Boesky says, "the complexity of what transpires in the mind of the analyst at work is certainly daunting" (p. 117).

The author's intention is to focus on "the question about the inference of latent from manifest meaning as a neglected aspect of our efforts to compare the work of various psychoanalysts" (p. xiv). He argues strongly that psychoanalysis is a scientific endeavor, and opposes "evidential nihilism" (p. xvii). A considerable portion of the book is devoted to discussing the philosophical underpinnings that support this science.

While agreeing that verbal associations are only a part of the data requiring contextualization, his emphasis is on the relative absence of attention given to the patient's associations. He accepts that "theoretic eclecticism is necessary and logically inescapable" (p. xviii), but argues that interpretive disagreements should be anchored in clear linkages to original clinical material. I believe that few analysts would disagree.

The volume is largely a compilation of previously published papers and talks that share a concern for understanding the unities or discontinuities among contemporary psychoanalytic modes of thought. Each chapter is independent and sometimes quite disconnected from previous or following chapters. Since the chapters lack continuity, the reader misses the build-up of a coherent argument. Rather than a unified discourse, the volume presents a series of discussions of varying clarity and relevance around the problems of the current pluralism of psychoanalytic ideas, as well as the attempt to demonstrate that attention to context can help resolve many of our dilemmas.

The author's scope is wide-ranging, including arguments about one-person versus two-person psychology, science versus hermeneutics, coherence versus correspondence theories of truth, the alleged

decline of interest in free associations, and repeated attempts to help the reader understand issues of contextualization in psychoanalysis. The volume shifts frequently between modest claims and positivist assertions, as the following quotations illustrate:

> It is my intent to stimulate discussion among ourselves about how we can find more rational and productive ways to agree or disagree about the comparative merits of our views about our disagreements. [p. xiv]

> I discuss a methodology of inference that is anchored in assumptions about the basic importance of the associations of the patient and how these associations are contextualized by the analyst. [p. 9]

> If a theoretic model is based on assumptions that do not call for any kind of interpretation, my suggestion is that we openly acknowledge that we are dealing with a category error when we try to compare the views of that model with the views of a model that gives epistemic weight to interpretations of latent meaning. [p. 9]

Boesky devises the term *contextual horizon* to describe what it is that we do or should be doing: "By the term *contextual horizon,* I mean a group of associations that are dynamically linked by the contextualizing criteria utilized by the analyst to capture the major dynamic urgency in a given session" (pp. xix, 28). I would suggest that these criteria are so vague that analysts could agree with these concepts without giving up any prior belief systems and without being able to come to any agreement concerning an appropriate intervention. Boesky concedes this and places himself above the current battles:

> Enough time has passed now for us to consider some of the problems that face us in our efforts to sort out what we have gained, but also what we are in danger of losing as a consequence of our continuing science wars, in which constructivist epistemology and critical-realism-science have been proclaimed as antinomian opposites . . . . Moreover, my emphasis on the role of context and the associations of the patient presupposes the acceptance of the principle of psychic deter-

> minism, and this formerly bedrock assumption has, of course, been challenged long ago—for example, by Schafer (1980). [pp. xii-xiii]

This challenge, a subtopic throughout the volume, is never adequately addressed. Rather, Boesky attempts to bolster his views with several chapters concerning problems in the philosophy of science, most of them familiar, as well as with a glossary and a reading list, but these would seem to provide little assistance in solving the core problem that Boesky identifies—that is, even analysts who think they think alike and who listen to the same clinical material may come to vastly different conclusions about the appropriate context for deriving meanings and interventions.

Boesky argues powerfully for the provision of more complete data in clinical vignettes. In chapter 2, he provides a brilliant overview of the many discussions of Casement's famous case of the patient who wanted him to hold her hand. Boesky shows us how much relevant data was lacking and would be required in order for the analyst to make a meaningful assessment of the wisdom of acceding to the patient's request. He uses this as an example of case reporting in general, in which we are typically given far less information than we need in order to contextualize and assess the analyst's interventions and conclusions.

However, his own clinical presentation (see chapter 4) illustrates the difficulty of trying to present adequate clinical data that would enable the reader—or even the author—to present a convincing context. Despite Boesky's desire to provide clinical information of the sort that Casement did not, the reader is left with questions at least as significant as those about Casement's case. Boesky begins by telling us that "I relied on observing my countertransference reaction to contextualize an affectively charged transference-countertransference enactment" (p. 82); however, there is no reason why we should rely on his observations of his own countertransference—always a problem in analytic reports of clinical material.

Following are some examples of missing information in this account. Speaking of the patient, Boesky refers to "the possibly ominous recurrence of his chronic psychophysiological symptoms" (p. 83). We

do not know what that refers to: does the patient have a life-threatening disease—imminent, long-term? Certainly, knowing the answer to a question like that would influence how we respond to this patient at various points in the clinical account.

Boesky refers to his having been either asleep or sleepy in sessions; there is a big difference, and we often do not know which he means, nor is it clear what the patient observed about his analyst's state of alertness or lack of it (p. 83).

Boesky refers to the patient's having had sex with a "Jewish prostitute" and then becoming ill. We do not know if the illness was venereal (HIV, gonorrhea, syphilis, warts, herpes, etc.) or something else, nor do we know why we are being told that the prostitute was Jewish.

We are told that the Friday session of the week had been canceled by the analyst, but we do not know how many days in advance the patient had been informed of this, nor how the patient reacted to the cancellation (p. 93).

The patient reports childhood enuresis for the first time in the analysis, and Boesky refers to this as a recovered memory. However, as reported, it is not at all clear whether it is in fact a recovered memory or simply the first moment that an old shameful childhood memory was reported in analysis.

Boesky mentions that "an old adage about dream interpretation states that the last association before the dream is the first association to the dream. That is also an example of a contextualizing criterion" (p. 87). He uses this as a justification for one of his interventions, but this is precisely the problem: "an old adage" can hardly be a scientifically or heuristically acceptable basis for establishing the legitimacy of the context for an intervention. Other homilies that he mentions include the special interpretive significance of the first and last associations during a session, or the first associations following a dream. These ideas may all be correct, but there is no evidence to support them.

I believe it likely that clinical reporting, no matter how complete, will never provide an adequate basis for the contextualization that Boesky feels may be the key to settling our theoretical and methodo-

logical disputes. Every clinical report, no matter how carefully done, leaves the reader with multiple ambiguities that cloud the possibility of secure context.

Some of the arguments in this book seem dated and reflect biases of the author, such as those about one-person versus two-person psychology (p. 104). Boesky seems to believe that these two approaches can clearly be distinguished (and he claims to be in favor of both). In attempting to distinguish the one from the other, he draws what seems to me a false dichotomy between whether the analyst is acting in a "subjective interacting and participating perspective" or in an "objective observing perspective" (p. 92). Regardless of which analytic model one prefers, I doubt that anyone would think there are analyses or moments in an analysis when the analyst is not part of what transpires.

Boesky is passionate and insistent, even repetitive, in his assertion that psychoanalytic theory and procedures can be made coherent and consistent across schools, if only we would agree to give sufficient attention to contextual issues. However, he also seems to be saying that inferences drawn from any model other than the conflict model are basically not psychoanalytic, and therefore are irrelevant to a discussion of analytic theory and technique. He asserts:

> The analyst first assumes that nothing that the patient says can be taken safely at face value. And secondly assumes that the arrangement of the associations of the patient has been extensively altered by the unconscious conflicts of the patient. But not every analyst shares these assumptions. Theories about the courses and nature of these defensive alterations vary between models, but those models that share this epistemological view can be coherently compared and those that do not will be incommensurate. [p. 140]

Boesky accepts as bedrock that

> . . . the sequential patterning of the associations of the patient is defensively determined . . . . Those models that do not derive inference of meaning from the associations of the patient are in a different frame of reference. Attempts to compare phenomena derived in two different frames of reference that

> are incommensurate, without recognizing the incongruence of this difference, are properly called *category errors*. [p. xviii, italics in original]

Boesky seems to privilege inferences drawn from the schema of free association and defense as being truly psychoanalytic, while other methods of inference of unconscious intent and meaning—those that draw on nonverbal behaviors and interactions, for example—are considered nonpsychoanalytic, or at least less significant.

Not only does Boesky rule out the findings of the Boston Psychoanalytic Change Study Group, but also, apparently, the implications of attachment theory and implicit procedural memory. This is to ignore the recent work of Gabbard, to name one example, who has written clearly and convincingly about what accommodations of analytic technique are available and necessary for the inclusion of vitally important implicit and procedural, nonverbal, unconscious but not necessarily conflictual mental contents and activities as part of the patient's analysis.[1] Other works by such notable theorists as Fonagy and Target are similarly ignored in this book.

The author states:

> To summarize, it is my suggestion that when we make the contextual organization explicit, it becomes possible to see what we are disagreeing about at a level closer to the original data. That is no small achievement. We can then agree or disagree more coherently. [p. 41]

Boesky aims to carry out a philosophically informed contextual analysis of a variety of analytic contributions, and while he attempts to demonstrate that his discussion and conclusions represent the logical outcome of appropriately contextualized thinking, it seems apparent that he, like the rest of us, is held in the grip of a priori convictions concerning what is or is not appropriately psychoanalytic. I will not attempt to recapitulate here Boesky's elaborate descriptions of his philosophical underpinnings, his reliance on the concept of contextual horizons, and his notion of category errors.

[1] Gabbard, G. O. (2007). Unconscious enactments in psychotherapy. *Psychiatric Annals,* 37(4):269-275.

At the end of his book, the author observes:

> The future refinement of our justification of interpretations, in my view, lies in our adherence to some form of correspondence theory of truth about what we claim to know that is transcontextual, even though our methods for interpreting our data are context bound . . . . We psychoanalysts seem to think that we will find the solution to validating our ideas from some domains other than our own hard-won clinical knowledge. But that will not come from philosophy or from neuroscience or from literature . . . . I think it would be best if our authors in both camps [pro-science and anti-science] would provide us with persuasive detailed clinical examples supporting their views. Explicit statements describing how the details were contextualized should accompany these reports. Debate is too often waged at the level of lofty theoretic abstractions that foster labeling and misrepresentation and misreading . . . . The claim that an example really illustrates a theoretic view is often a sham . . . . It is time for editors to require far more rigorous vetting of such claims prior to publication in our journals. [pp. 203-204]

Few do not share Boesky's ardent desire for more evidence and better arguments:

> One can still hope that an enterprise dedicated to the enhancement of the rationality of humanity will find better ways to disagree in the future. If we stop disagreeing, psychoanalysis will die. If we do not get better at disagreeing, we will slow our growth. [p. 204]

Boesky greatly desires to end, or at least reduce, the ongoing—even growing—disagreements among groups of psychoanalysts, and the lack of any scientific evidentiary base for these varying beliefs. He puts his faith in the notion of context. It is here that the problems arise. Whether or not one accepts his views, this volume does not yet succeed in demonstrating how one would go about coming to a consensus either about the contextual background or the appropriate response.

This passionately written volume demonstrates the enormous difficulties in the path of psychoanalytic advance. We can easily agree on

the need for more and better clinical data, both across schools and within schools, even if we cannot agree on the methodology of contextualization or validation. Boesky clearly describes the task before us and attempts to provide some of the clinical and philosophical context that should guide us. I look forward to his next contribution.

ARNOLD M. COOPER (NEW YORK)

THE MANY VOICES OF PSYCHOANALYSIS. By Roger Kennedy. London/New York: Routledge, 2007. 297 pp.

Roger Kennedy, the author of this diverse collection of papers and chapters, has worn several hats over the more than thirty years of clinical and institutional experience covered in his updated compilation. He has analyzed adults and adolescents in private practice, and has brought a psychoanalytic perspective to the treatment of inpatients, mainly at the Cassell facility in London, where he has worked since 1982. The inpatient population he works with has included both individuals and groups. Additionally, the author has worked in an experimental program to treat entire families as inpatients. He has also testified in court and applied his insights to theatrical productions. The scope of Kennedy's intellect allows him to incorporate the ideas of multiple philosophers, as well as of psychoanalytic thinkers from Europe, South America, and the United States.

The wide scope of this collection of papers and chapters makes it complex to review, and the philosophical bent provided a challenge for this reviewer. The "many voices" of the title refer to the three sections of the book: theoretical voices, clinical ones, and other voices.

Kennedy himself is part of the British Independent tradition of psychoanalysis, which he tells us is difficult to define. It emphasizes the central role of object relations theory, is rooted in classical Freudian theory and technique, and remains open to contributions from multiple theoretical perspectives. The significance of affect states, of transference and countertransference, and of oedipal and preoedipal dynamics are all recognized. The facilitation of self-analytic skills is seen as crucial.

The thinkers who have particularly influenced the author's work include, among others, Winnicott, the Balints, Milner, Klauber, and Bollas. One quibble I have is that, since Kennedy considers development to continue throughout life, references to Erikson and/or Loewald would be pertinent but are nowhere to be found.

The inclusion of a philosophical viewpoint is particularly apparent in part 1, entitled "Theoretical Voices," containing five chapters with the following subtitles: (1) "Freedom to Relate," (2) "Human Aspects of the Psychoanalytic Relationship," (3) "Aspects of Consciousness—One Voice or Many?" (4) "On Subjective Organizations: Towards a Theory of Subject Relations," and (5) "Restoring History to Psychoanalysis."

The first chapter states that relevant interpretations, in the context of a non-authoritarian analytic relationship, may improve a patient's ability to relate to his objects in a nonpathological manner. It includes a rather sketchy overview of the meaning of freedom and of freedom versus determinism, as pondered by such philosophers as G. W. F. Hegel and Isaac Berlin. Modern analytically and philosophically oriented thinkers, such as Julia Kristeva and Marcia Cavell, are also cited, as are great literary figures such as Dante and Mills. Freud, Winnicott, Fromm, and other analysts are included, too. The sweeping nature of this chapter unfortunately lessens its usefulness for any direct clinical application, and the two clinical examples—the first of a man with dependency longings, and the second, a man bogged down in sadomasochistic relationships—are difficult to link with the opening philosophical presentation.

In chapter 2, several viewpoints concerning the analyst's subjectivity are discussed. The author opines that while it is important to examine the impact of our individual personalities and reactions to our patients, for the most part, we should refrain from disclosing aspects of our personal lives. He concludes that the analyst needs to rely on interpretation for a variety of reasons: to help the patient make sense of things, to make contact, and also for his own defense against the impact of the patient.

The author returns to the topic of subjectivity in two other chapters. In chapter 4, he approaches the nature of human subjectivity from

a combination of philosophical and psychoanalytic viewpoints. The works of Ogden and Lacan, as well as of Stolorow, Mitchell, and Bollas, are cited. Chapter 9, in part 2, deals with the voice of the subject. Following a philosophical inquiry on the issue, Kennedy discusses "becoming a subject" (p. 189) from a clinical perspective.

Chapter 3 begins by summarizing Freud's ideas about the phenomenon of human consciousness and continues by referring to a variety of philosophical, natural, and social science and historical ideas about conscious mentation. The insightful observations in chapter 5 succinctly point out the relevance of historical awareness to the clinical psychoanalytic endeavor. The importance of the aliveness of the past in the transference, as well as the repetition compulsion and the need for interpretation of enactments, are some of the concepts discussed.

Part 2, "Clinical Voices," comprises chapters 6–9. Chapter 6, "Handling the Dual Aspect of the Transference," an updated version of a previously published paper,[1] explores the oscillating nature of transference, as a patient alternates between viewing the analyst as identical to archaic imagoes and as "something else, different" (p. 127). This is an interesting paper with an in-depth clinical presentation. However, a point of concern for the reader of 2009 is that this case presentation (and others in the book) has a dated quality because it leaves out any monitoring of the state of the analytic dyad. Whether we think in terms of transference/countertransference, enactments, or intersubjectivity, our current sensitivity to locating the state of the analyst, as well as that of the patient, has altered the way most analysts write about clinical material today.

The analytic treatment of a psychotic, self-mutilating adolescent is described in chapter 7. The author emphasizes the need for the analyst to be able to tolerate painful, dissonant affect over extended periods of time. Chapter 8, in its description of analytic work with adults who have been abused in childhood, continues the theme of a need to bear the unbearable. Part 3, "Other Voices," comprises chapters 10–14.

[1] Kennedy, R. (1984). A dual aspect of the transference. *Int. J. Psychoanal.,* 65:471-483.

The diversity of the contents of the various chapters—the theater, group therapy of psychotic inpatients, psychotic families, the work carried out at Cassell Hospital, and court testimonies—point up an inherent problem with compilations such as this. The title *The Many Voices of Psychoanalysis* is clever but, reasonably, one cannot quite succeed in spreading the umbrella over such a variety of topics. Hence, individual chapters might be relevant to a given professional's interests, while others might not be.

Having said this, I would add that, overall, Kennedy's work is interesting and enlightening. All the chapters are well written and researched in a thoughtful, scholarly manner. I enjoyed the author's insights into the theater and found his description of the experiment with treating psychotic families as inpatients fascinating. I gained a better understanding of how a British analyst of the Independent School thinks about theory and works with patients. Hence, with the caveat that the numerous "voices" in this book detract from thinking of it as a cohesive volume, I found this a work to enjoy and learn from.

SYBIL A. GINSBURG (ATLANTA, GA)

COASTING IN THE COUNTERTRANSFERENCE: CONFLICTS OF SELF-INTEREST BETWEEN ANALYST AND PATIENT. By Irwin Hirsch. New York/London: The Analytic Press, 2008. 215 pp.

Irwin Hirsch is a dedicated and prolific advocate for what has come to be called the *relational turn* in contemporary psychoanalysis. He is also a fluent and engaging writer, so that his most recent book on "coasting in the countertransference" is both a lucid statement of that point of view and a forthright challenge to the theory and practice of psychoanalysts of all persuasions. He is here concerned primarily with the infinite variety of ways in which analysts, consciously or more often unconsciously, permit their own selfish interests to intrude upon the conduct of their practice, at times to the neglect and even the detriment of the analytic process and of the patients whom they are supposed to be serving.

Hirsch buttresses his argument with many clinical vignettes from his own practice and those of supervisees, in which he demonstrates ways in which, to secure personal comfort or advantage, he and they have subtly shaped the analytic situation. These include such stratagems as failing to address the patient's manifestations of erotic or negative transference, overidentifying with attractive or charming analysands, offering preferred hours to particularly engaging or "celebrity" patients, and, needless to say, manipulation of fees to accommodate "special" patients at one end or the other of the economic scale. Each of these witting or unwitting maneuvers (and there are others), he suggests, allows the analyst to "coast" in a comfortable, unchallenging, often interminable analysis that is marked by mutual dependency, and that fails to promote the patient's development toward self-understanding and autonomy. Alternatively, such tactics may lead to premature termination by a patient who senses that he is not being attentively listened to or is, in one way or another, being exploited.

What Hirsch is describing here, of course, are what analysts of the relational or intersubjective schools speak of as *mutual enactments* that are, they believe, in one form or another inevitable. The problem, Hirsch maintains, is that all too often these behaviors escape analytic scrutiny because the analyst's self-interest is served by their being ignored and lived out rather than examined. The author's many citations of the publications of colleagues (primarily from the relational school) make it clear that such matters have come to the attention of others as well.

But on one issue, Hirsch can legitimately lay claim to originality, even uniqueness. He devotes an intriguing chapter to the attribute of baldness—his own as well as that of some of his male patients. He confesses—the only suitable word—to his failure to deal with the meaning of this condition to his patients because of his own feelings of shame and impaired self-esteem, not to mention rivalry with those more "fortunate" (and more "masculine") hirsute types. This is certainly a common situation, and one to which both he and I believe that few analysts so afflicted have given much, if any, consideration.

A (previously published) chapter on theory is a thoughtful reflection on its benefits and drawbacks.[1] The author acknowledges that some grounding in theory is necessary to any psychoanalytic endeavor and that it provides a secure base for the perception and formulation of analytic data. And he is correct in pointing to the possibility of stereotypy and formulaic thinking when theory—any theory—is applied too rigidly and defensively. But although he grants the possibility that in the proper hands the one-person ego-psychology model can serve as the theoretical base for successful analytic work, he is—rather repetitively—outspoken in promoting the two-person relational turn as a more "humanistic" basis for exploring "internalized personal relationships" as they emerge in the "analytic playground" (p. 130). Intrapsychic conflict does not appear to be a player in this game.

For this reader, several problems come to mind. First is that of repetitiveness. "As I have said" is a phrase that recurs repeatedly in the text, perhaps inevitably in a compilation of which some chapters are republished from other sources, but more often than necessary even in the newer sections. More significant, however, is Hirsch's use of the concept of countertransference. He stretches it to cover virtually every aspect of the analyst's relation to the patient; thus, he goes far beyond the classical notion of the doctor's response to the patient's transferential projections, as well as the Kleinian view of the analyst's reception of projective identification as the critical clue to the patient's unconscious fantasies. This broadened perspective is not unique to him, but it seems to me to weaken the explanatory value of the concept. And one does wonder about his suggestion (pace Gill) that meaningful analysis can be done on a once-weekly basis.

More troubling to me is Hirsch's generous use of self-exposure in his clinical illustrations. I am aware that in the intersubjective psychoanalytic world, a measure of self-exposure is thought to be helpful in promoting the two-person, "democratic" character of the analytic relationship. I cannot but wonder, however, about the relentlessly confessional quality of Hirsch's self-description and his ready acknowl-

[1] Hirsch, I. (2003). Psychoanalytic theory as a form of countertransference. *J. Amer. Psychoanal. Assn.*, 51:182-201.

edgment of his failures, character flaws, and all-too-frequent lapses from analytic attentiveness in response to one or another aspect of his patients' appearance or behavior. Were I looking for an analyst for myself, I would be a bit leery, I think. Isn't it possible for patients to know too much?

Finally, I have some questions about Hirsch's use of clinical material. Though he professes appropriate disguise of his patients' identities, his descriptions of them are generously detailed, such that they might well recognize themselves even if others do not recognize them. The reader wonders whether the descriptions are synthetic or whether, if real, they have been authorized by the patients themselves. Indeed, this brings to mind recurrent questions recently emphasized by Kantrowitz and others about complex ethical issues surrounding the use of such clinical descriptions in analytic writing (though these questions are not discussed here).[2]

Hirsch has certainly done the profession a service by specifying in rich detail many of the ways in which his colleagues may, and often do, "coast in the countertransference." This book should encourage both experienced analysts and candidates—and, indeed, other professionals—toward more systematic and continuous reflection about ways in which they may be serving their own comfort and self-interest in preference to the emotional needs of their patients and clients.

AARON ESMAN (NEW YORK)

[2] See, for example, the following: (1) Kantrowitz, J. L. (2004). Writing about patients, I. Ways of protecting confidentiality and analysts' conflicts about choice of method. *J. Amer. Psychoanal. Assn.,* 52:69-99; and (2) Kantrowitz, J. L. (2005). Writing about patients, II. Patients reading about themselves. *J. Amer. Psychoanal. Assn.,* 53:105-129.

LISTENING TO HANNA SEGAL. By Jean-Michel Quinodoz. London: Routledge, 2008. 171 pp.

Our appreciation of any given writer increases with the possibility we have to express not only our agreements but also our disagreements with what he or she proposes. What Segal says may not coincide with our criteria, but what is in-

> disputable is that her ideas have dialectical value. [Maldonado quoted by Quinodoz, p. 89]

This is a biography in the presence of its subject. Many people have contributed to this portrait, not least Hanna Segal herself, when Jean-Michel Quinodoz listened to her with a tape recorder in his hand during 2004-2006. His fascination with Segal as his muse started when he was in supervision with her during the years 1979-1989. Segal had been appointed as Melanie Klein's representative in Geneva, when, in a letter quoted more than once in this book, Klein wrote, "I really think she [Dr. Segal] is by far the best person to explain my work succinctly and also not to be provocative."[1] For Segal, Geneva was more than a Kleinian missionary post; it had been her home as a child after her family left Poznan in Poland when she was twelve years old. Segal has never let Klein down, always sticking to the mission of explaining without seeking to provoke.

Nevertheless, Segal has been at the center of professional controversy throughout her career. Her gift has always been to present Klein's work in as unproblematic a way as she can, and there are surely few of us who did not begin our acquaintance with Klein through Segal's transparent gaze. This book could therefore be a lucid beginning for studying Klein. However, Quinodoz's intention has been to present the essence of Segal herself, and this is what we get. It is a solid treatment of Segal's enduring professional interests, portrayed in ten acts. The ten chapters explore specific themes: the first one, biographical in nature, is followed by nine others into which Quinodoz has shuffled Segal's published contributions. These themes start with aesthetics, her initial work and love; then the schizophrenia work with colleagues; symbolic functioning; clinical aspects of the life and death instincts; Segal's explicit presentations of Klein's work; the functioning of dreams; analyzing the elderly; Segal's teaching work; and a final chapter on how psychoanalysis might comment on urgent contemporary political issues. These topics are always grounded in Klein, and despite Segal's commitment and interest in

[1] This quotation is from a letter of May 8, 1956, to Marcelle Spira, who had invited Klein to come and teach.

writing about her topics creatively, they are still vehicles for her exposition of Klein.

Quinodoz was favorably impressed by Segal's supervision and teaching in Geneva; as he states, "the clarity and concision with which she communicates her thinking" (p. ix) is what attracts. I can attest to the accuracy of Quinodoz's impression, as this is the first thing that strikes and attracts the listener when Segal holds a class or when she speaks in discussion. Her words and ideas come across with a fluid clarity, as if preformed without struggle.

In writing this book, Quinodoz set himself the task of finding out "how could that invaluable teaching be conveyed to the reader in a sufficiently lively manner?" (p. ix). The answer he came up with is this animated mélange of exposition and interviews that together produce a colorful mosaic of multiple perspectives. When it comes to dealing with Segal's own ideas, Quinodoz does so with that same transparency and evocative clarity with which she has presented Klein to us over the years. This is what is on offer here, and the reader should not expect a critiqued, unpacked account of either Klein or Segal.

This unusually vivid editorial idea has been accomplished remarkably successfully. Each chapter is crafted from multiple sources and gathered around a specific theme; each is a cut-and-paste collage that starts with Quinodoz's careful exposition of Segal's texts on the theme, after which he adds the relevant recollections, reminiscences, and other teaching material that he gained from his taped interviews with many of her colleagues. Not content to stop here, he also interviewed others in Europe and in North and South America about the topic of each chapter. Despite this bricolage, the final result is in fact a beautifully woven together and crafted tapestry. The final result is very much Quinodoz's book.

What did I expect when I picked up this book? I wanted a sense of familiarity with someone I know and have had a connection with ever since my own analysis with one of Segal's analysands. It is a connection with a pedigree that goes back to Klein and the time of significant controversies. This work is a tribute to this pedigree, as well as to the trust that Klein put in Segal, who herself played a part in the aftermath of controversy as the great and dedicated expositor

following Klein's death in 1960. Segal stood up for views and theories unpopular at that time in Britain and internationally. This is the biography of a survivor of one of the great controversies in the history of psychoanalysis, and I wanted to admire it and capture it all from Segal's point of view.

In Quinodoz's interview with him, Jorge Luis Maldonado notes that Segal has always worked in the context of controversy and a dialectic in the psychoanalytic world (see the quotation with which I began this review). However, Klein was right: Segal was not a provocative apostle, indeed the reverse. Moreover, things have changed in Britain and internationally since Klein's death. Her ideas are more seriously discussed and used than ever before. Klein herself is no longer provocative, and the book now casts a spell of calm thoughtfulness over its subject.

Quinodoz's transparent style eschews any comment, criticism, or debate about Klein's thinking, and his quietism belies the passion that the act of producing this complex and editorially difficult book must have required. The sense of controversy is not here. Segal takes pains to deny the view that Klein had a row with Paula Heimann that precipitated Heimann's leaving their collegial circle. As she says, "When people say that [Klein] quarreled with Heimann because Heimann wrote a paper on countertransference, that can't be true. She never attacked Heimann" (p. 50).

Segal also scotches the rumor about a rift between herself and Betty Joseph over Segal's views about interpretations that construct the past, in contrast to exclusively here-and-now interpreting: "people tend to use certain differences between Betty and me to make a split, particularly in America" (p. 95), Segal observes. It is true that people do insert opposition where there is merely difference; this creates an invigorating energy that Kleinians know about and have termed the paranoid-schizoid position. On the other hand, the denial of controversy can be a common survival strategy.

Perhaps the ember of contention still smolders around the concept of the death instinct, and chapter 5 on this topic comprises Quinodoz's summaries of the views of Jean Laplanche and André Green, with Jorge Luis Maldonado's admiring interview appended.

Perhaps any life needs to work toward harmony and peace, and Segal's seems to have given her what she deserves.

One thing I looked for in the book was a personal account of that historical moment at the end of the 1940s when—with Klein and Herbert Rosenfeld, and later Wilfred Bion—there was a sudden collective sense of pushing the boundaries, a great leap forward that still echoes through the corridors of our history. But in that respect, I was disappointed. The excitement, the hopes, the rivalries, the blood on the floor, the sleepless nights spent wringing new thoughts and understanding from old problems, and perhaps the eventual disappointment in the schizophrenia project—none of that is to be found in this book. It is as if the taped interviews say, "Let us put the debates, conflicts, and casualties that have lain in the wake of Klein's work behind us and move on"—perhaps a wise strategy from veteran warriors.

Aside from my voyeuristic fascination with those times that my psychoanalytic forebears struggled through, the really important aspect of this book is Segal's persistent prodding of certain topics. These are not so much the themes that the book identifies and brings forward, but rather two important dimensions that percolate all the way through each theme, pervading the text. They are more general conceptual perspectives than are the book's individual themes, which come, of course, directly from Klein; but today these concepts are of increasing importance to psychoanalysts of all stripes.

The first of these pervasive concepts is the set of observations about how a mind can intrude into and penetrate another; and the second is the relative importance of process in relation to content in our material. Let me make a few comments about each of these, because I believe the notions of intrusions into the individual and of the supremacy of relational process are more generally emergent in psychoanalytic thinking and practice today. They are perhaps easily glossed as *projective identification* and *enactment,* but Segal does not rely on jargon; she simply talks about people, the people who have been her patients. As mentioned, these two perspectives, although not highlighted as themes, permeate the text and particularly the interview material. If nothing else, the book is worth paying attention

to just to gain a sense of how these approaches range so helpfully across a spectrum of human interests and functions.

With regard to intrusion, Segal's first schizophrenic patient, Edward (discussed in chapter 3) was a great exponent of making equations of minds or mental contents. Segal's observations of him and of other psychotic patients point to the insertion of one's "self" *into* another mind or into a symbol—or, in the case of psychosis, into a physical object. Such equation is brought about in fantasy, but what Segal and now many Kleinian researchers have shown is that this fantasy, when dominated by more aggressive impulses, leads to a committed belief that intrusion has actually occurred. Moreover, when confronted by such a tenacious belief and such omnipotence of fantasy, the object of the intrusion can be drawn along with the fantasy of having been invaded. As is well known, this process has destructive effects on identity, symbol formation, and ego functioning.

We are also familiar by now with the contrasting, less aggressive forms of intrusion at the benign end of this spectrum, dominated more by libido. Segal's work traces the swinging variation between benign and sinister intrusiveness, and we witness her profound exploration of Klein's idea. Segal shows us the extraordinary relevance of the concept across a range of human affairs. A benign form of intrusion underpins the constant, empathic, psychoanalytic activity of entering another subject's mind.

Such an activity is also illustrated in this biography: it is exactly what Segal has been doing—getting inside Klein and her ideas in order to benignly express and explain them. Quinodoz, too, in his masterly exposition of Freud,[2] and now in his interviews and his account of Segal, invites us to insert ourselves empathically into his subjects. But at the very moment of reading this book, we, too, are simultaneously drawn into the act of entering the life and mind of Segal. This book is therefore not just an informative one from which the reader learns about psychoanalysis and a great psychoanalyst; rather, to read it is to experience an activity close to the kinds of intrusions that human beings effect into each other.

[2] Quinodoz, J.-M. (2004). *Reading Freud,* trans. D. Alcorn. Hove, England/New York: Routledge, 2005.

This curious polarity represented by the book—between reading about and immersing oneself in someone else's personal subjectivity—is exactly what psychoanalysis is all about. And this leads me to the second overarching perspective of this book, which is most pointedly apparent in chapter 7, on dreams. Segal emphasizes that a dream is not just to be analyzed for its content. She extends Freud's work by observing that the act of bringing the dream needs analyzing as well: when a patient brings a dream, why he or she does so and how it is brought are open to analysis. In fact, she goes so far as to say, "You don't analyse the dream, you analyse the dreamer" (p. 94).

Of course, this is not a Kleinian discovery about dreams, since Freud confronted the same conundrum in 1899. Just as his dream book was coming out,[3] Dora left her treatment with him—seemingly, we can say with hindsight, on the grounds that Freud was exploiting her dreams for his purposes, just as Herr K had desired her body.[4] Freud never quite came to grips with this, although it set him on the road to developing the theory of transference and a psychoanalytic technique based on it. Like most analysts, he had been circumspect about the balance between content and process.

By contrast, Kleinians have increasingly tended to emphasize the process of *acting in*. After all, a child's play is action, and the process of acting in gave Klein a precise way of observing the enactment of the child in the play room. It is not just the way dreams are brought, but the way everything is brought. This attention to the intersubjective process as a constituent of subjectivity itself pervades all of Segal's thinking.

The very process of publishing this book is also a message in its own right, quite in addition to its content. It enacts a story of Hanna Segal as the marker of a moment in psychoanalytic history, an icon of the struggle for Kleinian ideas to take their proper place in the development of our field. Segal deserves the greatest of honors for her achievements in that respect, and this book is a monument to which she is certainly entitled. Its readers not only learn about the body of

[3] Freud, S. (1900). *The Interpretation of Dreams. S. E.,* 4/5.

[4] Freud, S. (1905). Fragment of an analysis of a case of hysteria (Dora). *S. E.,* 7.

her ideas; they also engage in an act of marking the progress of psychoanalysis itself.

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ESCAPE FROM SELFHOOD: BREAKING BOUNDARIES AND CRAVING FOR ONENESS. By Ilany Kogan. London: International Psychoanalytical Association, 2007. 106 pp.

"Please help our son," the couple said to me. "He's acting more and more strangely." Fifteen-year-old Jacob's mother focused on me with a frightened look in her eyes. "My husband thinks it's just adolescence," she said, "but I'm worried that something is seriously wrong with him. He refuses to do anything his teachers tell him to do, and he's insulting and defiant with them. He treats his classmates so badly that no one wants to be his friend any more. He beat up one of his friends for little or no reason, and the school insists we get him evaluated. If it weren't that we're big donors to the school [a Jewish parochial school] and that all four of his grandparents are concentration camp survivors, they would have thrown him out."

Jacob's parents told me that he was withdrawing more and more from the world and locking himself up alone in his bedroom for hours and hours. He had painted the walls of his bedroom black, except for a strange, jagged white line all around the room, high up, near the ceiling. He had also insisted that heavy black curtains be installed that he could draw over his windows.

When I met with Jacob, I found no sign of serious emotional disturbance. He appeared to be an ordinary teenager, except for an air of bristling anger and defiance and a significantly more-than-average anger toward and suspicion of authority figures. He offered glib explanations for the various forms of behavior that had been troubling his teachers and worrying his mother.

The situation began to clarify itself when his mother brought me a copy of a Holocaust Remembrance pamphlet that she had helped produce for distribution at Jacob's school. Jacob, who possessed a fair degree of artistic talent, had drawn the cover for it. It consisted of

circular strands of sharp, barbed wire, such as his grandparents had encountered daily during their incarceration in concentration camps. The pattern on the cover was almost identical to what he had drawn on his bedroom walls!

For many years, I have treated Holocaust survivors, their children, and their grandchildren. Jacob is but one of a number of youngsters with whom I have worked who dramatically identify with their survivor grandparents as well as with the Nazi persecutors who tormented them and threatened to take their lives.

Early in her book, Ilany Kogan indicates that

> . . . there exists a cluster of damaged boundaries between Holocaust parents and their children . . . [that] includes the permeability and blurring of temporal boundaries between past and present, between self and object, and between fantasy and reality . . . . [This] leads to "primitive identification" . . . of the child with his or her damaged parent . . . . Primitive identification impedes separation-individuation and facilitates the transmission of aggressive and destructive aspects of the parents' own traumatization, as well as feelings of mourning, pain, and guilt. [p. 10]

This is precisely what I have seen in my own patients.

Kogan provides an account of her analysis of a man who was "born after World War II to parents who had been physically and emotionally damaged by the Holocaust" (p. 18). Most of his parents' family members perished. As a Jew, his mother was given hormone injections to prevent her from conceiving a child. After the war, she underwent new hormone treatment to restore her fertility, despite the doctors' serious doubts that it would work. She did become pregnant, however, and she regarded the birth of her son as a miracle. She became very ill after he was born and later developed cancers, possibly as a result of the hormone treatments. She steadily deteriorated physically thereafter. When she was fifty-four, after undergoing surgery to remove a malignant tumor, she committed suicide. Significantly, Kogan's patient came to her for treatment when he turned fifty-four. He came because of "exhaustion, depression, difficulty functioning at work, and thoughts of suicide" (p. 17).

The patient had been the central focus of his mother's life. They slept together in one bed until he turned seventeen. As an adult, he attempted twice to leave his mother by escaping from Communist Hungary, only to return each time she asked him to do so. Between those two attempts, he married a non-Jewish woman who bore him two sons. After his mother's death, he totally abandoned his wife and children and immigrated to Israel, where he married a Jewish woman, with whom he had another son. This son, who was extremely troubled all his life, shot himself to death while serving in the Israeli army; this occurred a year after the beginning of the analysis. Both the patient's wives strongly resembled his mother physically.

Kogan gives a gripping and at times startling account of the early years of the analysis, an account that is troubling to read but impossible to put down. The central themes on which she focuses revolve around (1) the patient's insistent need to violate the boundaries of the analytic frame so that he might get close to, unite with, and become one with his analyst, and (2) her periodic terror that the intense pain, misery, guilt, and murderousness within her patient could volcanically erupt so that he would either kill her or kill himself.

The author's description of her sensitive reading of the transference-countertransference storms—at times of seismic proportions—and of her deftly courageous interpretive interventions is must reading for every psychoanalyst. At times clumsily and at times skillfully (how could it have been otherwise?), she assisted the wild man in her office in staying in treatment, wrestling with his searing pain and wracking guilt, and navigating through his supersonically manic flights away from his powerful homicidal and suicidal urges and away from his intolerable feelings of emptiness and the yearning to be dead.

The patient finally became able to go through the mourning and the reparative processes that would ultimately allow him to become a whole, intact, autonomous human being with the ability to recognize that his aggressiveness did not have to kill anyone. When I read these pages, I could not help thinking of the Flying Dutchman, Rigoletto, and Captain Ahab. Kogan's patient was all three of these dramatic literary figures and more, but she helped him arrive at a very different ending than they experienced.

Part 2 of the book deals with "theoretical issues connected to the case illustration" (p. 49). The first of these is "the struggle against mourning" (p. 51). Kogan tersely and clearly defines mourning "from two perspectives: as a process that occurs in reaction to the loss of an object, and as a process that accompanies growth and change from one stage of life to another . . . a process linked to growth and development" (pp. 51-52). The Holocaust and its aftermath grossly distorted Kogan's patient's experience of these developmental dimensions:

> Mourning due to growth and change was one of the patient's major problems, as he was unable to go through the normal process of mourning accompanying the dissolution of symbiosis from the maternal object; thus he was trapped in a state of pathological mourning throughout his life . . . . What was required for recovery in this case was not retribution and triumph, not just the relief of rage, not even simply forgiveness, but an emotional awareness of the loss, genuinely experienced, however painful it was. [p. 52]

Kogan's patient employed massive manic defenses to deny his psychic pain, to denigrate his objects so that losing them would seem unimportant, and to create the illusion of omnipotently transforming terrible into wonderful (p. 57). Kogan tersely summarizes Klein's and Winnicott's ideas about manic defenses as they seem to apply to her patient and to his transferential use of her as an idealized object who was nevertheless in constant danger of becoming a de-idealized, dangerous, persecutory object whom he might have to destroy. She speculates as to the ways in which the traumatization of his parents by Nazi persecutors appeared to contribute to the creation of an extremely disturbed mother–child relationship that interfered with separation-individuation and led to a twisted, sadomasochistic, homicidal-and-suicidal Oedipus complex organized around the fantasy of returning to the womb by joining mother in death.

Kogan scours the literature (to which she herself has previously contributed) on the effect of the Holocaust on subsequent generations, that is, "the way in which [shared] massive trauma . . . [leads to] transgenerational submission of its images . . . [which] become intertwined with the core identity . . . and self-representation . . . of

subsequent generations in the groups for which the trauma is a historical legacy" (p. 74). She notes that William Faulkner, too, observed in another context, "The past is never dead; it lives in the mind, never to perish" (p. 74). The most salient and convincing observations Kogan makes involve the ways in which her patient was invaded by the emotional effects of his mother's Holocaust experiences, which transmogrified the naturally occurring developmental conflicts evolving within him as he grew up, and which led him to unavoidably recapitulate his mother's experiences in his fantasies and in his interpersonal relationships throughout his adult life.

Kogan made deft use of her countertransference reactions to her patient to guide her in understanding what was spilling out of his phantasmagoric inner world so that it traumatized and retraumatized him over and over. Her conclusions, which are eminently sensible, are completely consistent with what I have observed in my patients who have been members of Holocaust survivor families.

I have just one minor cavil. Kogan has an unparalleled depth of experience with this patient population, as well as a degree of expertise in working with it that is unequaled or at least unsurpassed. In this book, she exerts considerable effort to dress her clinical formulations in abstruse theoretical garb, designed by avant-garde psychoanalytic couturiers, some of whom tend to utilize exotic fabrics and precious ornamentations even for simple, everyday clothing. Her understanding of her patient's problems is cogent and convincing; it does not need abstract and abstruse legitimization. A doctor who truly cures illness and saves lives does not need to speak Latin and Greek to his patients. I wish Kogan had presented more clinical information and less theoretical speculation in this little gem of a book. If only there were more about the role of her patient's experience with his father and with extrafamilial individuals in giving shape to his emotional makeup, for example, and more about the way in which he processed the Holocaust-derived emotional impingement that came from his mother in the course of his development.

I have worked with patients whose parents or grandparents went through experiences that could have fit easily into the imaginative excesses of Dante Alighieri or Lina Wertmüller. One of my patients,

for example, who was born in a DP camp after the war, recounted her father's truly amazing series of hair-raising tightrope walks among sadistic masters of torture and murder, as he went through a series of concentration camps and Russian death camps from which he survived as the result of quick-wittedness, the mobilization of multiple talents, and random luck. For years, she maintained to me that her mother had spent the war years safely hidden in a root cellar.

One day, I mentioned to this patient that I had spent the previous evening at a local university watching newly released Soviet concentration camp liberation film footage, and had listened to shocking personal accounts provided by concentration camp survivors. My patient looked at me and *matter-of-factly* said, "Oh, I never told you about the time, *before* she got to the root cellar, that my mother was caught, taken with a lot of other Jews to the side of a ditch, and made to strip naked and stand there while a machine gun opened fire on them? What saved her life was that she fainted before the bullets struck, so that she fell down and they didn't hit her. She woke up covered with twitching dead bodies, blood, and feces. She clawed her way out and walked down the road, covered with blood and gore. She went up to a man who helped her escape, but a friend of hers wasn't as lucky as she was; the friend also climbed out of the ditch alive, but the man she ran up to turned her over to the Germans and she was killed. Do you wonder why my mother was so crazy?"

Among other bizarre behaviors, my patient's mother, in a state of confusion and wild terror, had periodically dragged her out of bed in the middle of the night during childhood, and made her hide under the mother's bed because she was convinced that the Nazis were coming. It is not surprising that one of my patient's presenting symptoms was an inability to sleep at night.

The parents of Kogan's patient were never incarcerated in a concentration camp. They rode out the latter part of the war in a Wallenberg house; nevertheless, the atrocities going on around them continued to affect them mightily. One important implication of what is contained in *Escape from Selfhood* is that it is not necessary for people to directly experience the worst of genocidal horrors for them to be profoundly affected by those horrors. My own experience is in keep-

ing with this. I was born and raised in the Untied States. My parents had been brought here as little children by their parents, who were fleeing from pogroms in what is now the Ukraine. I grew up during the Second World War, and repeatedly heard about the pogroms and the Nazi atrocities that followed them. I was warned regularly about anti-Semitism and I experienced it directly while growing up. I could see very clearly that my grandparents were extremely troubled, haunted human beings. I was exquisitely aware that family members had committed suicide, and I knew that many of my relatives perished during the Holocaust. From time to time, I met extended family members who had escaped from Nazi Europe. I am still haunted by the hollow, lifeless, empty look in the eyes of a visiting distant cousin who spent the war years, as a child, hidden in the walls of a convent in France, after which he found that all the rest of his family had disappeared without a trace. He had been wandering fretfully from one country to another and was about to immigrate to Israel. I know only too well how all this helped shape the sadomasochistic, homicidal-suicidal form and contents of the preoedipal and especially oedipal configurations that crystallized within my own psyche.

Kogan touches, though only tangentially, on the roles played by resonance between her patient's Holocaust background and her own Holocaust background, and by the analysis having been carried out in the state of Israel. Kogan and her patient have a common, powerful, personal history of the Holocaust, and they live and work in a country that is ringed by enemies who want to destroy it. This inevitably pulled them so closely together—even before the analysis began—that they were united with one another and bonded in oneness against a common, superordinate enemy. It seems to me that, to a significant extent, they were conjoined emotionally, the way that so-called Siamese twins are conjoined physically.

Could it be that this was so terrifying to Kogan that she could not let herself know that she knew it? I should have liked to hear more about this. Perhaps Kogan will provide that information in a future communication. In the meantime, I express my deepest gratitude to her for having favored us with this wonderful little book. I cannot recommend it highly enough.

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PSYCHOANALYSIS AS A JOURNEY. By Franco Borgogno. London: Open Gate Press, 2007. 239 pp.

In this collection of essays and lectures spanning his professional career, Italian analyst Franco Borgogno invites the reader to accompany him on what he views as his journey as a psychoanalyst, through his readings of the journeys of other psychoanalysts whose ideas have been most important to him. Further, he aims to use this journey to argue for the idea of an approach—both to the analytic engagement and to life as an analyst—that emphasizes movement, change, and growth, rather than the mastery of a set of ideas and techniques.

Both the content and the form of this difficult but rewarding book are worthy of note. The content is deceptively straightforward in appearance. Borgogno's essays are mostly structured around close readings of selected works of several psychoanalytic pioneers. Aspects of the work of Freud, Heimann, Bion, and Ferenczi (progenitor of the relational school, in his view, and as such an unequaled hero for our field) are revealed to contain unarticulated insights, unnoticed themes, and fleeting glimpses of ideas that were not to be developed in the field until decades later. Borgogno reveals himself to be a master of a kind of archaeology of psychoanalytic theory, dusting off the minor early writings of the likes of Ferenczi to bring their astonishingly prescient features to light, and plowing steadfastly through the most difficult and off-putting of Bion's works, his irritated and befuddled reader's transference leading him to new understandings of the development of the theory and the theorist.

Over and over in this volume, Borgogno demonstrates and celebrates the perspicacity and power of the preconscious. In parallel with his own developing sense of the psychoanalytic process—that is, as a process that works by way of bringing affective experiences into a shared arena where they can be transformed and made understandable—so he sees the development of each theorist's work individually and the development of theory across generations of analysts. Through his readings, he reveals the gradual dawning and conceptualizing of theoretical elements that have been present but unrecognized, experienced only as shadows of the main idea or as fragments.

In particular, in two beautiful instances, he reinterprets early papers of Freud and Ferenczi as "calling cards," each intimating valuable intuitions that were out of conscious awareness for the writer, but that remained in the unconscious of the body of psychoanalytic theory—intuitions that would eventually be metabolized and incorporated into this body.

The first three chapters are reexaminations of early writings of Freud's. In each case, Borgogno mines the material for something missed by previous readers. First, he examines Freud's famous obituary of Charcot, making the surprising case that in revealing his own ideals, Freud preconsciously anticipated the need for a relational psychoanalytic theory. Borgogno observes that Freud's portrait of Charcot differs in significant ways from those painted by others, concluding that in its projective aspects, it reflects idiosyncratic aspects of an unconscious ideal of Freud's. Freud's emphasis on the value of close observation, close contact and personal involvement with patients, and the feelings that arise in the encounter (trust and mistrust, doubt, anxiety, enthusiasm, and disappointment) signifies, in Borgogno's view, a preconscious grasp that the relationship with the patient is at the center of the process of understanding the patient.

Next, Borgogno quite ingeniously examines a little-read 1892 paper of Freud's, "A Case of Treatment by Hypnotism," suggesting that in this apparently simple essay, Freud apprehended much more than he realized. Failing to understand why his own treatment worked, Freud nonetheless laid out thematically and conceptually the basis for an approach to treatment that drew on not-yet-conceptualized apprehensions about dyadic interchanges. Although Freud evidently believed he was writing about a treatment in which hypnosis with suggestion was the main technique, this paper—about a young mother who could not breast-feed her child—in fact conveys a completely different mechanism of cure.

Borgogno argues convincingly that Freud eventually succeeded with this patient because he implicitly understood her symptom as a symbolic communication of undigested affective facts—her rage against her own withholding environment—and in understanding, he effectively allowed his mind to be used as a container, in a process that

would not be theorized for decades to come. Borgogno goes further in situating this case in the context of Freud's evolving imagining of the therapeutic encounter. In the vignette of a mother who cannot nurse, Freud's metaphors suggest an implicit analogy between the situation of the nursing mother and baby, and that of the doctor and patient. His initial approach to technique, in the context of hypnosis, was to devise what Borgogno calls a "maternal setting" (p. 28), consisting of regularity, constancy, and minimal stimuli. Borgogno laments that this early maternal sensitivity in Freud was overtaken by the "investigator/conquistador" (p. 26) figure of Freud's later case reports.

In a third essay on Freud, Borgogno turns to a paper that is far from neglected, the case of Little Hans, and breathes fresh life into it—not by turning to the newly available historical data, as many have done recently,[1] but by making a fresh observation about what Freud was doing. He reads the case as a technical paper, showing that here Freud was taking steps toward a technique based on careful attention to the patient's communications within the analytic exchange.

In this chapter, Borgogno shows his affiliation with the work of his compatriot Antonino Ferro, while claiming for Freud the role of true originator of the idea of the "field," which Ferro has explored at length.[2] In Borgogno's interpretation of the case, being the supervisor allowed Freud to develop a "second look," as he identified in turn with both Hans and his father. He was thus able to hear (as he was not with Dora, for example) the patient's "suggestions" to the "analyst." This, in Borgogno's opinion, was less a kind of supervision than the beginning of the idea of the analyst's "divided consciousness": the analyst engages with the patient while observing the engagement at the same time. From this point of view, Borgogno interprets Freud's grasping of Hans's child's-eye-view communications as "flashes of future progress" (p. 47)—in contrast to the reactions

[1] See, for example: (1) Stuart, J. (2007). Little Hans and Freud's self-analysis: a biographical view of clinical theory in the making. *J. Amer. Psychoanal. Assn.,* 55:799-819; and (2) Wakefield, J. C. (2007). Max Graf's "Reminiscences of Professor Sigmund Freud Revisited": new evidence from the Freud archives. *Psychoanal. Q.,* 76:149-192.

[2] See, for example: Ferro, A. (2002). *In the Analyst's Consulting Room.* Hove, U.K.: Brunner-Routledge.

of Hans's strangely literal-minded and rigid father who cannot empathize and is constrained by theory.

Differing from his treatment of Dora, Borgogno notes, in this treatment Freud was able to give vastly more dignity to the contribution and resources of the patient, seeing the work as the product of the encounter of two minds. For example, Freud was able to understand some of Hans's "cryptic" responses as covert reactions to the father/analyst's mistakes.

Having reminded the reader of Freud's limitless capacity to surprise and delight, Borgogno turns his attention to Paula Heimann, in two chapters that are more tribute and partial biography than textual interpretation. In keeping with his task of constructing a personal psychoanalytic ancestry through these readings, he highlights the elements of Heimann's thought that contributed to the development of a more intersubjective approach to treatment, and explores and interprets some of her experience as Melanie Klein's misused analysand. In particular, he lauds Heimann's appreciation of both the child's and the patient's real needs for the parent/analyst to serve a function in sustaining and eliciting mental growth. He also admires in Heimann her recognition of the role played by actual parental pathology and the need to validate the patient's experience.

In this section, Borgogno offers the reader some of his own clinical material in order to illustrate Heimann's ideas about children's identifications with antilibidinal or deadly objects projected into them by disturbed parents. While Borgogno is clearly passionate about his view of Heimann's later work as central to the development of a better psychoanalysis, this section of the book is less successful than those that focus on texts, in my view. There is a moralizing tone to the frequent, often italicized reiteration of precepts about the need for respect, authenticity, and so forth, both those attributed to Heimann and those claimed by Borgogno himself. And the vignettes are evocative in conveying Borgogno's own sensitivity to self and affect states as conveyed in dreams and bodily experiences, but are frustratingly vague about the actual clinical dialogue or exchange, detracting from their usefulness as illustrations.

Borgogno's journey takes him next to a highly personal account of his struggle to read and appreciate Bion, a story filled with fascinating insights. Borgogno and a group of like-minded colleagues, motivated by "irritation at the *fashion* for Bion" (p. 130), set out to find their *own* Bion. Borgogno grapples with *A Memoir of the Future*[3] by essentially paraphrasing it, in what I take to be a text-based version of the process of containment. Borgogno takes in the text by reading it, seems to accept into himself the author's point of view and experience, and, having digested it in this way, presents it to the reader. The result is a fascinating intellectual experiment—although I imagine that many readers will feel irritated by the confusion that results about where Bion's ideas end and Borgogno's begin.

In Bion's diary-like *Cogitations*,[4] Borgogno confesses, he had hoped to find something like Ferenczi's "clinical diary"[5]: a self-revealing account of the struggle to develop a therapy. Instead he found the opposite, a deeply disappointing exposure of what he calls Bion's "deafness" to his patients, his "mental laziness and insensibility" (p. 137). Yet, unlike many of us, Borgogno does not let his reaction go at that. Determined to "get" Bion, he tries treating Bionian texts as if they were a patient, noting that they "evoked rejection, irritation—sarcasm" (p. 136), and he becomes the analyst whose work it is to understand by using these reactions. In Borgogno's words:

> We felt that the difficulty being attuned with Bion and his language could not simply be *our problem* . . . . It had to be something that Bion himself was responsible for, a kind of coldness and distance that frustrated all . . . possibility of an encounter. [p. 135, italics in original]

Borgogno observes: "By approaching Bion the analyst this way, we begin to feel more sympathy, even to his harshest and most hostile qualities" (p. 143). He concludes that the text is actually a "trage-

[3] Bion, W. R. (1993). *A Memoir of the Future.* London: Karnac.

[4] Bion, W. R. (1991). *Cogitations.* London: Karnac.

[5] Dupont, J., ed. (1988). *The Clinical Diary of Sándor Ferenczi,* trans. M. Balint & N. Z. Jackson. Cambridge, MA: Harvard Univ. Press.

dy" about Bion's relationship with the Kleinians, revealing how elements of the clinical encounter that he intuited theoretically were not available to him emotionally. Here Borgogno comes around again to the idea of the genius of the preconscious, the unarticulated intuitions and nascent insights that can be fully appreciated and turned to use only retrospectively.

Borgogno's final chapters address what is evidently a most heartfelt subject: the career and thought of Ferenczi. As he did in the essay on Freud's early hypnosis paper, Borgogno takes one of Ferenczi's early papers, "The Effect on Women of Premature Ejaculation in Men,"[6] and mines it as a "calling card" for what it reveals about Ferenczi's most basic intuitions about the therapeutic process and relationship. While the paper is about sexual relations between men and women, and demonstrates Ferenczi's unusual and forward-thinking appreciation for the woman's point of view in sexual relations, Borgogno also sees it as a metaphorical reference to themes that later became important in Ferenczi's understanding of the analytic couple. In particular, these themes include: the idea of "mental coition"; the malign consequences of the refusal to recognize the partner's needs (a problem he later identified in traditional psychoanalytic technique —specifically, in Freud's treatment of him); the need for appropriate timing and rhythm in the analytic encounter; and the need for the stronger partner (i.e., the analyst) to put himself at the service of the other, rather than treating the other as an object of masturbatory or exhibitionistic impulses.

This interpretation of Ferenczi's paper, naturally continuous with Borgogno's own tendency to describe the analytic encounter using metaphors of both sexual union and childbirth, rings true and adds depth to the portrait of Ferenczi the thinker. The other chapters on Ferenczi, each anchored in a study of one of that author's texts, have the same adulation-heavy quality as those on Heimann, however; in particular, Borgogno highlights Ferenczi's role as the new profession's

[6] Ferenczi, S. (1908). The effect on women of premature ejaculation in men. In *Final Contributions to the Problems and Methods of Psycho-Analysis,* ed. M. Balint. London: Maresfield, 1955, pp. 291-294.

constant internal critic of tendencies toward narcissism, authoritarianism, and exploitiveness in psychoanalytic practice. Borgogno views Ferenczi as having forged a path that placed "the person and mind of the analyst at the forefront" (p. 232) and as having focused on the affective relationship between the two analytic partners—as did Heimann and Bion, each in his own way, in following and extending that path.

While it is exciting and refreshing to be privy to the sometimes startling and moving vicissitudes of Borgogno's own journey as he grapples with his chosen texts, the reader is likely to experience some irritation of her own in getting through this book that contains, as Borgogno acknowledges in the preface, an entire "new book in the footnotes" (p. xiii). Many pages are indeed more footnote than text, while others contain strings of loosely related statements that convey the tone of an informal lecture. This makes it difficult to follow a line of argument; yet the format conveys, as I assume it is meant to, a vivid picture of a mind in conversation with itself. The writer struggling to liberate himself from the linear demands of conventional text certainly brings to life the free-associative, hypertext quality of thought, but the demands this places on the reader are considerable. Another difficult stylistic element is Borgogno's very frequent use of an exclamatory and moralizing style (characterized by long passages in italics) that left this reader feeling somewhat harangued, especially in the chapters on Heimann.

Perhaps these difficulties in communication are related to the fact that, at times in Borgogno's appreciation of the preconscious insights of his admired psychoanalytic forebears, he seems too smoothly to imbue them with the qualities of his own, twenty-first-century psychoanalytic ego ideal. In a paper about "publication anxiety," Britton (1998) describes a conundrum facing writers in any scholarly discipline:

> The writer would like his or her version of this object [of inquiry] to be unique because this would give the writer possession of it; he or she alone would know the truth of the object. *On the other hand, the writer desires the approval of his or her*

> *ancestors and wishes to be at one with his or her scientific affiliates, his or her scientific family, who have their own view of the object.*[7] [p. 202, italics added]

As Britton goes on to argue, this type of conflict can produce, even in the most eminent of scholars, distortions and distractions in the communication, "arising from the wish to further or preserve affiliation with the significant peer group or parental figure" (p. 207).

Ultimately, in Borgogno's highly original reinterpretations of the works of these distinguished ancestors, he offers the reader the privilege of witnessing both the struggle itself and a most interesting compromise between the wish for affiliation with parental figures and an oedipal triumph of insight into the minds of these same figures—a triumph that they themselves, in their own time, could not have achieved.

WENDY W. KATZ (NEW YORK)

[7] Britton, R. (1998). *Belief and Imagination.* New York: Routledge.

AESTHETIC EXPERIENCE: BEAUTY, CREATIVITY, AND THE SEARCH FOR THE IDEAL. By George Hagman. Amsterdam, Holland/New York: Rodopi, 2005. 168 pp.

In his study of Leonardo da Vinci, Freud famously discovered the psychological roots of the *Mona Lisa* and *The Virgin and St. Anne* in the artist's unusual childhood circumstances and in his fixation on his mother's smile. But Freud did not explore the ways in which Leonardo's bond with his mother affected either the formal qualities of his art or his need to create. Such investigations would have to await the writings of Melanie Klein, D. W. Winnicott, and the theorists who arose in their wake.

George Hagman in his *Aesthetic Experience* not only extends and deepens this object-relations approach to art, but adds a new perspective as a practicing self psychologist. His book is original in other ways as well. Unlike many psychoanalytic interpreters, he is concerned neither with the artist's conflicts nor the unconscious mean-

ings of the content of the artist's work. As Hagman's title indicates, he focuses instead on how artists and audiences experience art and how they come to value certain man-made and natural objects as beautiful or sublime.

For Hagman, aesthetic experience and especially the sense of beauty are grounded in the infant's interactions with the mother. Her voice, touch, temperature, bodily movements, and above all her smiling face, with its bilateral symmetry, serve as templates for the later appreciation of form in art and music. These infantile experiences, however, are much more than simply cognitive. They are all strongly charged with affect, and this is what will allow the adult to find even the formal dimension of art so moving.

These early perceptions are also accompanied by both fusion with the mother and differentiation from her. The infant, moreover, is constantly reconciling projection and fantasy with his mother's actual attributes. All of this forms the basis for later relationships with art works. Just as the infant playfully combines merger and separation, so we as adults can feel at one with a symphony, yet remain critically aware. Likewise, just as the baby transforms the breast in fantasy while also confronting its sometimes obdurate reality, so we can feel that we both shape and are shaped by a sculpture or a poem.

These ideas, as Hagman acknowledges in his thorough and sensitive review of the literature, have already been articulated by Winnicott in his discussion of the transitional object, and by other psychoanalytic writers such as Christopher Bollas and Gilbert Rose. The new element that Hagman brings to the discussion is the importance of idealization. Hagman believes that the mother and infant are hardwired to idealize each other. And, in a vivid passage, he provides a specific description of this mutual valuation:

> There is a gleam in the mother's eye, the smile on her face, the excitement in her tone of voice, all of which say "I love you. You are special to me. You are the best little baby in the whole wide world." And then there is the child's simultaneous communication that "You are the best, most beautiful mother in the world." [p. 49]

According to Hagman, this interaction is accompanied by a sense of complete attunement and resonance between mother and child. Such infantile states form the basis for our later experience with the beautiful object as something that not only enthralls us by its perfection, but also exalts and revivifies our sense of our selves.

Hagman concentrates on the ways in which our appreciation of form replicates these archaic experiences of mutual idealization. But his insights can easily be applied to other, non-aesthetic aspects of the relationship between the spectator and the object. As we gaze at a Rembrandt or Picasso, we admire the artist's extraordinary talent and remain in awe of his towering fame in comparison to our own insignificance. At the same time, we feel that our understanding of the artist's work (to the extent that we do understand it) grants us a small portion of his monumental importance. We, too, are special as we stand within touching (or striking) distance from the canvas.

Hagman's remarks also shed light on the intensity of the fan's preoccupation with a star. The fan's devotion would not be so powerful were he not returning to a state in which he was adored as well as adoring. Although Hagman does not pursue this line of argument, his ideas break down some of the distinction between the experiences of high and low culture; the worship of art and the worship of celebrity are not so different if we recognize that they both involve primitive idealization. Andy Warhol, with his looming Marilyns, Elvises, and Maos, seems to have constructed an entire career out of this realization.

Hagman's emphasis on the perfect rapport between mother and infant as the foundation for aesthetic experience invites the inevitable criticism that his model is too good to be true. What about artists who are driven by conflict, pathology, and compulsion? What about viewers whose enjoyment derives from sexual and aggressive content? Hagman anticipates this charge and deals with it by essentially bracketing off the nonpathological from the pathological. He acknowledges that "conflicts, deficits, and distortion" may play a role in aesthetic experience, but declares at the outset that they will not be his concern (p. 11). He also distinguishes between "aesthetic" and "non-

aesthetic" emotions. The former respond to the "formal design of the beautiful object" with its "symmetry, harmony, and completeness" (p. 97). The latter engage the content of the work, which may be sadistic, lascivious, or terrifying. The sense of beauty, with its nonpathological grounding in the mother–infant dyad, can coexist with darker, unconscious impulses. Indeed, the aesthetic emotions redeem the non-aesthetic. As Hagman writes, "Some of the most brutal or violent fantasies, when given perfect form, are felt to be beautiful and evoke both joy and terror in a single sensation" (p. 97).

The question, of course, is whether these aspects of art can be so easily separated. After all, a century of modernism has taught us that form is content and perversity is harmony. Hagman maintains the dichotomy in his discussion of creativity. The artist, in his view, is not primarily motivated by libidinal and aggressive drives or by defensive needs; instead, he needs to "idealize, to seek, and to perfect a formal organization of experience" (p. 39). This recaptures archaic states of merger with the parent and restores the artist's sense of self. And, in the case of the artist who has suffered severe maternal deprivation, creative pursuits allow him to establish with an art work the kind of mutually enhancing relationship that was largely absent in his childhood.

One is curious about what Hagman would make of Michelangelo's treatment of the infant's ties with the mother in his depictions of the Madonna and Child. In nearly every example of this subject in his sculpture and drawings, the artist chose an iconographical type called the "sibylline Madonna." This is a virgin who experiences a mystical pre-vision of the Passion and gazes off into the distance with a somber expression. Not only do Michelangelo's aloof Madonnas avert their gaze from the Christ Child, they rarely even touch him. The infant Jesus, moreover, is often straining with herculean effort (and musculature) to nurse at the breast of his distant mother. It would be hard to imagine works that more powerfully convey a complete *lack* of attunement between parent and child.

Psychoanalytic interpreters have pointed to the repeated disappointments in Michelangelo's infancy as an explanation for his strange-

ly nonresponsive Marys. Michelangelo was taken from his wet nurse when he was two, was displaced by the birth of three brothers in five years, and lost his mother to a premature death when he was six. His mournful and preoccupied sibylline Madonnas appear to have served as a way for Michelangelo to re-create his own mother; she was both figuratively and literally "dead" to him.

How would Hagman account for these works? He might argue that Michelangelo was working on two tracks. On the one hand, he was recalling his frequently absent mother. On the other, he was repairing these very maternal failures in his engagement with his unsurpassed designs and by his virtuoso carving of marble blocks. In his interactions with his sculpture, Michelangelo could create an admired and beloved object that mirrored his sense of his own perfection. What is missing from this reconstruction, however, is the artist's need to master in his art the traumas that he suffered passively as a child. In works such as his *Bruges* and *Medici* Madonnas, he not only compensated for deficits in his infancy, but also used his sovereign powers as an artist to undo the helplessness he had experienced while enduring maternal losses and frustrations.

As important for Hagman as the artist's need to re-create ideal selfobject relationships (to use the Kohutian terminology) is his desire to externalize and objectify his subjective experience. In Hagman's words, "The artist's relationship to the art object is in actuality a relationship with his or her own subjectivity" (p. 77). This is a very a-historical view of art-making, and really applies only to the romantic and modernist periods in the Western world. Neither an Egyptian sculptor carving an image of a pharaoh, nor a Renaissance artist painting an altarpiece, nor a Baroque master executing a portrait commission was concerned with, or would have thought it appropriate, to express his inner world. Their art served goals that transcended the self. Yet Hagman's emphasis on archaic idealization still applies. Both the artist who depicted a pharaoh, God, or a king and the viewer looking at that work would have been under the spell of an image that recalled ideal figures from infancy. As the parent is to the child, so divinity and royalty are to the adult.

Regarding beauty's opposite, ugliness, Hagman characterizes it not so much in terms of a lack of aesthetically pleasing traits, but as a disruption. Influenced by Loewald's conception of sublimation, Hagman assumes that all of us constantly maintain an aesthetic relationship with the world. This allows us to derive pleasure in living and to establish satisfying connections between inner and outer reality. When we encounter an "ugly" thing or person, we are responding not primarily to any inherent qualities of the object, but to a disruption of our aesthetic organization. Sublimation has broken down and the object has evoked in us troubling sexual or aggressive fantasies. The experience of ugliness combines both the eruption of disturbing unconscious content and the upsetting of our normal expectations about the seamless "flow of being" (p. 111). The relationship between inner and outer is also thrown off balance. The ugly object becomes flooded with our subjective responses, yet at the same time, it seems to capture and objectify our emotions—hence the dual reactions of repulsion and fascination.

Although Hagman widens the psychoanalytic understanding of ugliness, he does not ignore the issues that have traditionally preoccupied psychoanalytic theory. He is, in fact, particularly impressive in his application of his ideas to the primal scene:

> It is not just the observation of the primal scene or the female genitals that evokes a sense of ugliness; rather, it is the expectation of one thing (loving affection between the parents and the presence of a penis, respectively) and the shock of encountering a form of violation of that expectation that results in anxiety, revulsion, and the sense of ugliness. In object relations terms, it is the expectation of unity and wholeness that is violated by the encounter with chaos and disintegration. [p. 109]

Nor does Hagman neglect the important role of ugliness in modern art. He recognizes that the artist can transfigure the ugly—turn shit into gold—and that the viewer can reabsorb it into a pleasing "interplay of fantasy, projection, and identification" (p. 121). But one would like a more detailed description of the ways in which, say, a

Duchamp urinal or a Cindy Sherman photo of a hideous crone can become rewoven into the fabric of our normal aesthetic sensibilities.

Hagman's most innovative claims grow out of his treatment of the sublime. It is an aesthetic dimension largely ignored by psychoanalysis, and among Hagman's novel contributions is his assignment of a crucial role for the father. This is a welcome departure from the typically mother-dominated object-relations theories of art. Hagman identifies six aspects of the sublime—immensity, incomprehensibility, power, obscurity, formlessness, and complexity—and finds a parallel for each in the child's interactions with his father. Just as the tourist is astonished by the immensity of an Everest, so the infant is awed by the father's seemingly gigantic size. Just as the spectator is thrilled by the power of a waterfall, so the infant is excited by the father's seemingly omnipotent strength. Just as a sunset or star-filled nighttime sky seems obscure, formless, and infinitely complex, so the father's world of adult work and action appears endlessly mysterious to the child and beyond the limits of his imagination.

But what makes the experience of the sublime unique is not simply the observer's sense of smallness and vulnerability in the face of the sublime object. The sublime combines terror with safety. If the spectator were actually in the middle of a raging storm or falling down a steep cliff, he would feel nothing but extreme fear. Safely removed, however, he can contemplate the sublime spectacle in such a way that it becomes, in Edmund Burke's words, a "delightful horror" (quoted by Hagman, p. 125).

Likewise, the infant's awe at the prospect of dangerous new vistas is tempered by the father's secure embrace. Hagman finds examples of these contradictory emotions of shock and pleasure in such ordinary acts as a father raising his child above his head:

> As the father lifts the child high into the air, that immensity spreads out endlessly, as from the peak of a high mountain . . . . The child is in the arms of the idealized father, and even while feeling held safely, is excited by the expansion of space and the experience of the world beyond. [p. 136]

The quality of the father's play also anticipates aspects of adult susceptibility to the sublime. The father participates in roughhousing, makes noisy exclamations, and pretends to menace the child.

For Hagman, this *paternal aesthetic* of the sublime is not merely different from the *maternal aesthetic* of beauty, but is actually its opposite. The mother provides a predictable and calming environment that is fitted both physically and emotionally to the child's needs. She creates an enclosed and controllable space where the infant's capacities are gently matched and not overpowered. The father's realm, by contrast, is marked by the new, the unwieldy, the vast, and the powerful. The mother is the safe harbor while the father is the open sea. The father's greater reserve, moreover, will contribute to the impersonal and inhuman qualities of the sublime that make it so terrifying.

Hagman tries to preempt feminist criticism of these polarized images of the mother and father by declaring that his use of the terms *maternal* and *paternal* does not refer to "persons of a particular gender or social/familiar role, but rather as orientations toward self and self-in-the world" (p. 130). He appears to be saying that mothers as well as fathers can lift a child up in the air and play-act as a scary monster. But this hardly solves his problem. On the one hand, he remains open to the charge that there is a *maternal sublime* as well as a *paternal sublime:* mothers, too, can seem vast, awesome, and frightening. On the other, he appears to undermine the value of his own arguments for the *paternal aesthetic:* what makes his remarks so compelling is that they are grounded in very detailed and gender-specific descriptions of exchanges between fathers and children, not in observations of generalized parental roles.

These are not the only difficulties that Hagman leaves unresolved. Freud had to explain how the manure of sexual and aggressive drives could produce the delicate flower of the creative arts. Hagman's burden is to account for the ways in which the most primitive infantile experiences can significantly influence adult artistic pursuits that are infinitely sophisticated and complex. In many respects, he succeeds in this. But not enough attention is paid to the mechanics of continuity between early and late stages of a normal life span. How

are maternal and paternal aesthetics refined over the intervening years in which the artist or spectator has undergone decades of training in a discipline? There is also a circular quality to some of Hagman's arguments; for example, infantile activity is defined as *aesthetic,* and adult artistic behavior is characterized as *infantile.*

These reservations should not, however, obscure the great strengths of Hagman's book. He brings to his task a remarkably extensive knowledge not only of psychoanalytic theory, but also of contemporary aesthetic and critical writing, from Arthur Danto to Dave Hickey. Equally important is his ability to draw on his own years as a painter and poet. The latter vocation must have contributed to a prose style that is graceful and often very evocative.

Hagman's volume is timely as it appears at a moment when many scholars and critics have rejected the old structuralist and Marxist notions that beauty is always false, always a mystification, and always in the service of some ideological program. Beauty is now something that even the most informed cultural observers must take seriously, as is attested to by Umberto Eco's recent anthologies on beauty[1] and ugliness.[2] One could not find a better psychoanalytic companion to these volumes than Hagman's *Aesthetic Experience.*

BRADLEY COLLINS (NEW YORK)

[1] Eco, U. (2004). *History of Beauty,* trans. A. McEwen. New York: Rizzoli Publications.

[2] Eco, U. (2007). *On Ugliness,* trans. A. McEwen. New York: Rizzoli Publications.

THE NEUROBEHAVIORAL AND SOCIAL-EMOTIONAL DEVELOPMENT OF INFANTS AND CHILDREN. Edited by Ed Tronick. New York: W. W. Norton & Co., 2007. 571 pp.

This book opens with a presentation of Tronick's important research on the infant–parent relationship. Two of his studies, the Neonatal Behavioral Assessment Scale and the Still-Face Paradigm, serve as the book's lynchpins. Both pinpoint bidirectionality: the biological with the psychological and the infant with the parent.

Bidirectionality is further underlined in crosscultural studies. Different cultural mores lead to different developmental tendencies. Multiple caretakers raise Efe children; consequently, they are less tightly bound to a single caretaker and more socially mobile. Gusii mothers who limit eye contact and tamp down affect display have children who are avoidant of eye contact and less affectively expressive. Tronick notes the infant's impressive variety of coping maneuvers, as well as the bidirectionality between mother and child and the influence of cultural input.

The infant's predisposition for social engagement and his or her active role in the interchange are two underlying tenets. Communication is established with the caregiver. Strategies develop to modify caregiver behavior in order to help the child establish internal regulation and acquire needed resources. This leads to an increase in the child's ability to self-regulate, freeing the child to engage in other developmental tasks. The caregiver's regulation pattern is reflected in the child's personality, social expectations, and sense of self. The child actively influences the caregiver, but must also conform to the caregiver's strategies—strategies that are determined both culturally and uniquely individually.

With this as background, we move on to a series of theoretical formulations, the most central of which are the Mutual Regulation Model and the Dynamic Expansion of Consciousness. These are based on dynamic systems theory, which states that we need to gain energy and meaningful information in order to make sense of our place in the world, our state of consciousness at the moment. A psychobiological sense expands as the infant gathers energy and information from the world, bringing about increased coherence and complexity. Without growth there is dissipation. Growth occurs when two individuals take meaning from each other, creating a dyadic state of consciousness. (This is not exactly familiar psychoanalytic jargon, though it is not completely foreign to psychoanalytic thought.)

The Dyadic Expansion of Consciousness model states that each individual is a self-organizing system that creates its own states of consciousness (of brain organization), which can be expanded into

more coherent and complex states in collaboration with another self-organizing system. The Mutual Regulation Model is the process of communication that generates these dyadic states of consciousness. It is also what produces change in therapy, the "something more" than interpretation.[1, 2]

The Mutual Regulation Model is a model of infant–adult interaction that focuses on the interactive nature of development. Mutual regulation shapes behavior, the body, and the brain. The infant is motivated to communicate with people, to establish interactive states, since meaning can only be created in collaboration with others. Out of this collaboration arises a dyadic state of consciousness from which both partners experience an expansion of their own states of consciousness.

Affect is the medium through which infant and adult communicate, thereby mutually regulating each other and engaging in the world. The infant communicates his or her internal state and external goals, and the caregiver must have the capacity to understand and respond. The interactions are "messy," with frequent mismatches. Between mother and infant, mismatch occurs 70% of the time. What is important, however, is the reparation process, achieving a matching state, as it is this that leads to emotional regulation, the desire for further engagement with people and the environment, new coping maneuvers, the development of a sense of effectiveness, trust in the other, and a burgeoning sense of self. The extent of the success or failure of repair will determine the child's affective core as the interactive pattern is internalized. Once in place, this will bias the infant's evaluation of each new situation and regulate his or her interactive behavior.

Affective displays are the basic units of the infant's experience. They are organized into coherent configurations of face, voice, ges-

[1] Stern, D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Bruschweiler-Stern, N. & Tronick, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: the "something more" than interpretation. *Int. J. Psychoanal.,* 79:903-921.

[2] Nahum, J. P. (2005). The "something more" than interpretation revisited: sloppiness and co-creativity in the psychoanalytic encounter. *J. Amer. Psychoanal. Assn.,* 53:693-729.

ture, and regulatory behaviors, which serve different communicative functions related to environmental events. These are what the infant uses to regulate the mother's responses and to express his or her own state of affairs, and are what the mother responds to. The interactional goal in our culture is the achievement of a shared positive emotional state, i.e., mutual delight; when attained, this yields a high sense of effectiveness in both mother and child.

Mother–infant relationships develop stable characteristics. For a change to occur, the mother's perceptions of her infant and of herself as a parent—as well as her interactive behavior with the infant—must change. The infant's interactive representations and behavior must also change, given the reciprocal nature of interactions and the infant's active role in shaping relationships. These postulations give rise to the importance of infant–parent psychotherapy. It is hard not to consider the therapeutic implications of this work, both with depression in the context of the Still-Face Paradigm and in terms of influencing the infant's interactive representations and affective core.

Other chapters touch upon and express research efforts on topics as diverse as gender differences, the impact of the depressed mother, interpersonal stress, coping devices, the interrelationship of social engagement and environmental exploration, and the impact of mother–infant interaction on the infant's future relatedness, moods, and resilience.

And so one comes to the final section of the book, which left me with the impression that herein lies the real purpose of this effort: the application of the concepts garnered from the infant–parent interaction studies (namely, the Mutual Regulation Model and the Dyadic Expansion of Consciousness) to the therapeutic relationship. It is proposed that in therapy, as in development, the locus of change is in the arena of implicit relational knowing. In the messiness of match and mismatch, reparation yields a sense of trust and effectiveness, as well as new implicit ways of being together. The dyadic state of consciousness is the transactional event that rearranges the patient's implicit relational knowing. It is a heightened affective moment that creates the potential for new forms of shared experience.

The Boston Process of Change Study Group (BPCSG) applies these concepts to the patient–therapist relationship. However, that group uses alternative terms. This reader, having worked diligently to familiarize herself with Tronick's lexicon of infant–parent interaction, now found herself faced with learning a whole new vocabulary. This seems to be an unnecessary complication that would probably have been avoided if this were not a compilation of articles previously published, along with articles by authors who have been immersed in psychoanalytic therapy rather than in infant research.

The Dyadic Expansion of States of Consciousness is now replaced with the concept *Moment of Meeting*. This is considered the point of change, the moment at which the goals of behavioral fittedness and mutual recognition are reached. I find it fascinating that this is quite close to Virginia Woolf's *moments of being:* rare moments in which we briefly glimpse some real thing behind appearances that offers us a fleeting appreciation of the foundations of life.[3] Woolf's idea was that in much of our conscious life, we are separated from reality by a protective coating (defenses?) of cotton wool. These protected states are states of non-being, and she contrasts them with rare moments of being—moments of violent shock or discovery.

Other terms utilized by the BPCSG are *moving along* and *a string of present moments*. A present moment may become affectively hot, and if the moment is seized—i.e., responded to with an authentic, specific, personal response from the partner—it becomes a *Moment of Meeting*.

In summary, the writers (Tronick and members of the BPCSG) recommend that our focus be on changing the patient and therapist's way of being together, and note that no one process is sufficient to induce change. There must be an interplay of explicit, insight-oriented work, as well as work on implicit relational knowing. Change emerges from co-creative processes. Although not everything is dyadic, we need to abandon the idea that things are preformed and formed only inside the individual. Dyadic states of consciousness (*Moments of Meeting,*

[3] Woolf, V. (1976). *Moments of Being: Unpublished Autobiographical Writings,* ed. J. Schulkind. New York: Harcourt Brace Jovanovich.

if you will) are the fundamental terrain of therapeutic and developmental change, and portray the uniqueness of relationships.

Tronick and the other contributors leave us with the thought that interpretation has traditionally been viewed as *the* nodal event, acting upon the transference with resulting intrapsychic modification. Moments of Meeting are being offered as the new nodal event, acting within and upon the shared implicit relationship and changing it by altering implicit knowledge that is both intrapsychic and interpersonal. In case there is concern that interpretation is being discarded in favor of the "something more," we are reassured that these are complementary processes and that both are mutative. However, different change mechanisms are employed in different domains of experience.

Although its language gets complicated, the book is well organized, being divided into five sections: neurobehavior, culture, infant social-emotional interaction, perturbations—natural and experimental, and dyadic expansion of consciousness and meaning making. Each section is subdivided into chapters in which ideas are explored and expanded upon. The reader has an opportunity to follow the creative process as Tronick establishes ideas, develops themes and variations, and then notes the emergence of something new.

As a compilation, the book gives us a broad swathe of Tronick's work, though a negative aspect of this is that there are redundancies, since basic ideas (and not so basic ones) are repeated in different articles. And there are language difficulties; Tronick's lexicon is not one with which the average psychoanalytic reader is familiar. Furthermore, in the chapters integrating the work of the Boston Process of Change Study Group, new language is introduced that deals with the same concepts. No doubt this is necessary because this is the language used by the BPCSG, but it makes for hard going for the uninitiated reader.

All in all, this book provides an opportunity to immerse oneself in Tronick's research and appreciation of the infant–parent interchange. It allows us to wonder about the "something more" that occurs in the analyst–patient clinical interchange. To be steeped in this work is to taste it, smell it, and feel it; it is to experience the essence,

and this is an exciting and stimulating endeavor. In my consulting room, I found myself automatically applying these ideas, both with patients and with supervisees.

Tronick notes that this is a work in progress, and as we read the book, he engages us in that process.

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ABSTRACTS

PSYCHOANALYSIS IN ITALY: "FREUD AFTER ALL"

2007

Abstracted by Jack Giuliani

The Italian Psychoanalytic Annual, 2007: Freud After All is a collection of essays representing the views and interests of many of today's leading Italian psychoanalysts. Edited by Patrizio Campanile and published in 2007 by Borla Edizioni in Rome, it contains articles selected from those published in the *Rivista di Psicoanalisi* (the best-known Italian psychoanalytic journal and the official journal of the Società Psicoanalitica Italiana), Volume 52, 2006. Unlike the standard fare for the *Rivista di Psicoanalisi,* whose topics generally reflect the diverse spectrum of interest in contemporary psychoanalysis, this annual's content is unusual since it is mainly devoted to reflections on Freud's work, in celebration of the sesquicentennial of his birth. The articles have been translated into English and are published here as the inaugural volume of the Italian Psychoanalytic Annual, with subsequent volumes planned for publication each year.

Prior to World War II, there was limited knowledge of Freud or of psychoanalysis in Italy. This is surprising since Italy and Austria are neighbors, and also because Freud traveled to Italy many times. In part this lack of awareness was the result of the opposition that psychoanalysis encountered from Italian Fascism and from the Roman Catholic Church.

A notable exception to this state of affairs was the early enthusiasm for psychoanalysis demonstrated by the psychiatrist Marco Levi Bianchini of Naples. And the most prominent Italian analyst of this period was Edoardo Weiss of Trieste, who was analyzed by Federn and became a member of the Vienna Psychoanalytic Society in 1913.

The Italian Psychoanalytic Society was founded in 1925, and the *Rivista Italiana di Psicoanalisi* in 1932. However, with the enactment of racial laws in Italy in 1938, the Italian Psychoanalytic Society was dissolved, and many psychoanalysts—among them Loewald, Arieti, Weiss, Limentani, Servadio, Hirsch, and Kovacs—were forced into exile. Marco Levi Bianchini was marginalized but remained active as a psychiatrist; while others, like Nicola Perrotti and Cesare Musatti, lived underground for the remainder of World War II.

After 1946, when the *Rivista di Psicoanalisi* resumed publication and psychoanalysis in Italy was revived, many new theoretical influences from within the international psychoanalytic movement contributed to the subsequent development of the field in Italy. The result is an original and diverse blend of several historical and theoretical traditions that can be traced to the professional contact that Italian analysts have had with analytic writers, consultants, and teachers from England and the United States, as well as from France and South America. The result is a unique synthesis and cross-cultural dialogue of theories whose presence characterizes Italian psychoanalysis, meriting our study and greater understanding.

A significant historical milestone that may perhaps illustrate the uniqueness of Italian psychoanalysis concerns the fact that the entire Freudian corpus was not translated and published as one collection until as recently as 1980, by Cesare Musatti. Prior to that time, the divergent translations of Freud, while perhaps contradictory and confusing, may have also cultivated an acceptance of diversity and controversy in Italian psychoanalysis, which markedly differed from a monolithic theoretical tendency elsewhere.

The selection of articles in this annual reflects an interest in several overarching themes. One theme is Freud's discovery of unconscious life and of the laws governing unconscious psychic functioning, such as the discovery of transference, the meaning of transference, transference as a metaphor, and transference as the central illustration of a dynamic and dialectical paradox. A second important focus in these articles is a close examination of Freud's cases, especially as they reflect the development of his method of treatment and

of his working through an understanding of transference and countertransference. A third prominent theme is an interest in Freud's style of writing as it provides an illustration of the very psychoanalytic method that he invented. A fourth interest of many of the writers is the role of group processes in the history of the psychoanalytic movement, in the development of psychoanalytic theories, and in the continuing presence of unconscious group functioning in contemporary psychoanalytic professional groups.

These essays offer a rich and textured introduction to the unique treasury of Italian psychoanalysis. Although all twelve authors have been widely read in Italian and French Psychoanalytic journals, none has been widely published in English. I was also rather surprised to find that none of these authors made references in their bibliographies to any of the Italian analysts who are better known to English readers. The editor has, therefore, done English-speaking readers a valuable service by publishing these writers, since they provide an important, fresh perspective on the Italian and European psychoanalytic scene, with its own unique mix of theoretical, philosophical, and technical questions, unlike those discussed elsewhere.

One finds evidence in these articles of a greater appreciation for, and contact with, academic perspectives, especially from philosophy, philology, and classical literature. An important factor influencing the development of Italian psychoanalysis, as noted above, is that a complete edition of Freud's collected works, comparable to Strachey et al.'s translation in the *Standard Edition*, was not available in the Italian language until 1980.[1] As mentioned, prior to that time, differing translations available to Italian readers very likely contributed to an interest in the text itself, textual interpretations, and divergent theoretical perspectives, which are all reflected in this collection of articles. Consequently, a close reading of each of these papers will repay the reader well for the effort invested.

The introduction to this annual describes Italian psychoanalysis as "polyphonic," with a "variety of tones" (p. 5), emerging from ten

[1] Freud, S. (1980). *Opere* [in twelve volumes], ed. C. Musatti. Torino, Italy: Boringhieri.

psychoanalytic centers in Italy, each with its own history and culture, and having contact with diverse psychoanalytic traditions from outside the country. Regrettably, however, only five of the ten centers are represented among the contributions to this annual. The introduction also promises an emphasis on a discussion of Freud's cases, yet this, too, was reflected in only four of the papers.

However, I was most aware of how many articles, perhaps owing to the selected group of authors, seem to be virtually carrying on a conversation with one another, without making specific reference to that fact. For example, the topics of transference, paradox, ambiguity, dialectical literary, and dialectical psychoanalytic style, and group processes, are all discussed by several writers in this volume, as I will elaborate below. There was also a significant interest in a discussion of the history of the psychoanalytic movement, especially as it has unfolded at the international psychoanalytic congresses, and with particular interest in the theoretical and political positions taken by American Psychoanalysis at these congresses (cf. especially Rossi, chapter 5, and Campanile, chapter 6, described below).

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In the volume's lead article, "Transference: Notes on the History of a Paradox," Francesco Napolitano begins by marking out the territory to be explored as he quotes Freud's emblematic and paradoxical remarks about transference (in "The Dynamics of Transference," 1912), as follows: "Actually, I have to admit that transference is not an excuse at all; it is a basic demand which is honestly opposed to our effort, and because it is honest, we must encourage it" (Napolitano, p. 7). Napolitano is eager to illustrate how Freud laboriously came to realize, over many years of clinical and theoretical work, the important dual and paradoxical nature of transference as embodying both a psychic truth and a lie, i.e., a distortion of external reality, and, further, that transference revealed both intrapsychic and interpsychic phenomena.

Napolitano first traces the protohistory of transference as it was understood by classical and continental philosophers. He then care-

fully demonstrates how the concept of transference was further developed by early neurologists who anticipated the birth of psychoanalysis and who most influenced Freud, viz. Charcot and Bernheim. Napolitano demonstrates that, throughout Freud's first 10-year period of research into transference—described in *Studies on Hysteria* (1895), "Project for a Scientific Psychology" (1895), *The Interpretation of Dreams* (1900), and "Fragment of an Analysis of a Case of Hysteria" (1905)—his theory of transference as both internal and as a false link remained unchanged.

Napolitano declares that:

> Transference . . . becomes the prototype of psychodynamics in general, in the form of the displacement of cathexis from the unconscious to the preconscious. It is this displacement that first triggers the desire/censor dialectic and then promotes the deformation of representation. [p. 13]

Placing Napolitano's essay first in this collection serves to underscore what will follow, which is a reassessment of Freud's contributions from a predominantly, though by no means exclusively, contemporary relational lens. Like many contemporary analysts, Napolitano approaches the transference empathically, i.e., from the perspective of its subjective truth, as experienced within the psychic reality of the patient.

Transference is also the central topic of the second article in this annual, entitled "Transference and Unconscious Communication: Countertransference, Theories, and Analysts' Narcissism," by Antonio Alberto Semi. This author begins by discussing the problems that Freud encountered in developing transference, since he was simultaneously burdened by the discovery of the phenomenon, its clinical comprehension, and its further theorization. Like Napolitano, Semi recognizes that:

> The process of psychical transferability is a fundamental process for Freud . . . . This idea of mobility and transferability gradually becomes more and more specific and detailed, so in turn it can explain the origins of hysterical symptoms, the

> creation of a phobia, or the appearance of an anxiety attack . . . and the ideal of possible mobility is obviously at the basis of the free association method. [pp. 31-32]

In referring to the Dora case, Semi quotes Freud's comment on transference as

> . . . by far the hardest part of the task . . . the one thing the presence of which has to be detected almost without assistance and with only the slightest of clues to go upon, while at the same time the risk of making arbitrary inferences has to be avoided . . . if one manages *to guess* it each time [Freud (1905) quoted by Semi, p. 33]

It is this experience, in which the analyst is "possessed" by the patient, becomes "the patient's prey" (p. 33), and has to "guess" about the circumstances, that seems most intriguing to Semi. He wonders how Dora's transference to Freud worked "*inside* Freud. The very same Freud who then wrote an essay on the case study of Dora . . . one could say *the person inspiring this writing* is Dora" (p. 35, italics in original).

To underscore the presence of the patient's unconscious in the unconscious of the analyst, Semi refers to a statement in "Recommendations to Physicians Practicing Psycho-Analysis" (1912), where Freud writes that the analyst

> . . . must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone . . . so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct *that unconscious*, which has determined the patient's free association. [Freud 1912, pp. 115-116, italics added]

Semi suggests that this would seem to result, however improbably, in the peculiar circumstance of the analyst "hosting someone who is making him think, and at the same time, realizing he 'is being thought of' and of having to observe his own unconscious as expressing someone else's thought" (p. 36). Semi continues following Freud, who further admonishes his readers that if the analyst is unable to dis-

entangle the patient's unconscious from his own, then he is likely to project unresolved unconscious conflicts into theories having universal validity (Freud 1912, p. 117).

Thus, theorizing, Semi suggests, may be the analyst's narcissistic attempt at self-reintegration, following the experience of having been colonized by the patient's mind. At this point, the reader feels led to the inevitable question, which subsequently Semi explicitly poses: "How much transference and countertransference are there in theories?"

In the third chapter, entitled "'All Dreams Are Wish Fulfillments': Is This Still a Tenable Thesis Today?," Francesco Conrotto explores the role of dreams, and of dream interpretation in psychoanalytic theory and practice, following the advent of Freud's structural theory. Conrotto highlights Freud's (1932, p. 59) discovery of the earlier splits present in the ego as illustrated in the "'crystallographic metaphor' in Lecture 31 of the *New Introductory Lectures on Psycho-Analysis*" (p. 50).

Conrotto wonders how contemporary psychoanalysis has responded to the role of dream analysis in the treatment of borderline and psychotic states, which he calls "group-type personalities" (p. 50). In Conrotto's view, these patients' lack of an integrated subjective experience, as the result of a chronic split or of fragmented states, means that the most useful psychoanalytic model is one that pays closer attention to this "group" functioning of the individual personality, as opposed to the dream model of Freud's first topography, which was based on conflict arising between repressed wish and censorship.

Conrotto considers that the psychoanalytic setting and the analyst's countertransference are two factors that assume far greater importance in the treatment of such cases. Although traditionally regarded solely as a technical device, the setting, according to Conrotto, becomes the locus of primitive psychic functioning in the treatment of primitive borderline and psychotic states. However, it is the analyst's countertransference, utilized as a means of gathering up and analyzing the patient's unrepresentable affects and states, that plays an even more important role for Conrotto:

> Because the patient is sometimes, owing to the absence of the dimension of subjecthood, incapable of "thinking,"

> "dreaming," or associating—that is, of expressing a wishful subjectivity . . . to perform his function, the analyst must then rely on his countertransference. [p. 53]

Conrotto means that the analyst must come to identify and differentiate, through careful self-analytic work, his own feelings during the analytic session as "the intersection between the patient's (unconscious) transference and his own—equally unconscious—countertransference response" (p. 53), together with the analyst's own personal transference to the patient. Since all these dynamic interactions are occurring unconsciously, a great deal of difficult and complex psychological work is required of the analyst—a task unimaginable without the help of consultation.

However, Conrotto sees this as a creative and fruitful process, especially when the analyst's conscious derivatives can eventually lead to the formation of a "representation," a "double," or a "screen" (upon which can be projected and depicted these "inter-transference processes," p. 53). Conrotto concedes that his description of this process is reminiscent of Bion's conception of *maternal reverie,* and that the analyst's aim is to help the patient develop the capacity for thinking, playing, and dreaming through introjection of the analyst's capacity to perform these functions in the patient's stead.

We notice a consistent interest and an abiding perspective among the essays reviewed thus far. Each of these three authors has given considerable attention to a reexamination and a reinterpretation of drive theory, especially within the context of Freud's structural theory, the so-called second topography, and of object relations, especially through the prism of transference and countertransference.

By contrast, Fernando Riolo, in the fifth chapter on "Freud and Lichtenberg's Knife," while pursuing some of these same points, adds somewhat of a corrective to the tendency to valorize the psychoanalytic relationship. Riolo begins his essay by revitalizing some of Freud's pioneering discoveries, starting with Freud's assertion that psychic reality does not coincide with consciousness, but rather that psychic processes are essentially unconscious, bodily based processes, with consciousness being an incomplete sense organ of their perception

(p. 60). Riolo adds that Freud did not claim to have discovered the unconscious, since it had already been known to poets and philosophers; instead, Freud's original discovery lay in the exploration and in the organization of the laws underlying its functioning.

Riolo tells us that, by clarifying and systematizing dream thought —the rules by which dreams transform unconscious content into something capable of being represented to consciousness—Freud believed that he had discovered a "primary" mode of psychic functioning. In fact, it is this discovery that Riolo believes constitutes Freud's paramount achievement, the very method of dream interpretation:

> The fundamental rules of analytic technique—breaking down into component parts, free association and evenly suspended attention—are indeed isomorphic with the rules of the dream work . . . the equivalence of the part with the whole; the violation of the principle of non-contradiction; and logical and temporal bidirectionality . . . . The rules of the method consist in the mutual exercise of the type of thought intrinsic to dreams . . . . The dream work assumes the character of a paradigm. [p. 61]

Riolo identifies two paradigms in contemporary psychoanalysis that are competing for dominance: a vertical one comprised of drive theory, psychosexuality, transference analysis, and interpretation; and a horizontal one, which places primary importance on the mutual construction of meaning within the object relationship as located in the continuously evolving intersubjective field. Riolo ends his essay by making a passionate appeal for the scientific paradigm, arguing that psychoanalysis cannot be reduced to hermeneutics alone, since it must account for the body, history, drive, and affect, for which neither representation, narration, nor signification are sufficient. His plea for an embodied drive theory serves to retain a preeminent role for sexuality as "indispensable" to a psychoanalytic view of psychic life (p. 68).

Although by no means limited to this area of analytic treatment alone, nowhere is Riolo's appeal more compellingly illustrated than in the analysis of children and adolescents. The sheer physicality and

driven qualities that an overstimulated child or troubled adolescent can add to the analytic mix forcefully assert the role of body and drive, history and development that Riolo seeks to affirm.

In the sixth chapter, entitled "Travels Around the Wolf Man: A Diary," Pier Luigi Rossi comments on Freud's use of the case history as a literary genre. Rossi argues that Freud seems to use this less as a means to illustrate a particular point of clinical theory (as he does with case vignettes in other works) and more as a device aimed at demonstrating his clinical technique by replicating a psychoanalytic experience in writing. Freud thereby illustrates psychoanalytic theory "in the process of its constitution" (according to Rossi, p. 71), with the reader virtually participating as a co-creator. In fact, Rossi asserts, the persuasive effect on the reader can be described as similar to the persuasive effect that Freud's interpretations might have had on his patients. What we witness is the psychoanalytic experience both from the side of the analyst, as he is thinking out loud, creating his theory and forming his interpretations, and from the side of the patient who is the object of those interpretations.

Rossi explains that, though following in the footsteps of his teacher Charcot, Freud could be even more compellingly persuasive in his five case histories with his *tableaux cliniques*. In the Wolf Man's case history, Rossi states, Freud sets himself the task of showing the case's complexity, as well as of demonstrating the clinical relevance of infantile sexuality in the analysis of adults (p. 73). Furthermore, Freud wants to illustrate ways in which memories from a period of early childhood (eighteen months of age)—a time for which memories are typically unavailable or unclear—can "subsequently" be "understood and interpreted" (p. 73). Rossi also shows us that Freud—paralleling his patient's subsequent and revised understanding (Rossi declares this case and the wolf dream "the paradigm of 'deferred revision,'" p. 78)—is himself in a continuous process of revising. This process results in the progressive augmentation of Freud's clinical understanding and of his own theories, as well as of his patient, subsequent to various unforeseen crises in the analysis.

This process of working in a state of theoretical ambiguity, and with continuous development and dialectical revision, is another im-

portant feature of the psychoanalytic method underscored by Rossi. He believes that this process is well demonstrated in the genre of the psychoanalytic case history as it was developed by Freud: "Anything that was truly his [Freud's] is never simply dropped, but put away for possible reuse. As already noted, this approach is similar to how analysis proceeds in the form of a spiral" (p. 74).

The author carefully takes us through a detailed summary of Freud's analysis of this patient, making every effort to link the case with the theory explicated in 1905's *Three Essays on the Theory of Sexuality* (which, Rossi reminds us, Freud had recently revised). Rossi's critique of Freud's treatment is limited to two areas of countertransference: first, in Freud's reconstruction of the Wolf Man's history in accordance with Freud's own theoretical prejudices, and second, Freud's "injunction to terminate the analysis by a fixed date" (p. 79). More importantly, Rossi believes that the effectiveness of this "technical error" (p. 79) by Freud lay in the fact that it constituted an enactment, a second traumatic scene within the treatment, "to which such a revision will then be applied" (p. 79).

In this way, Rossi declares, the anamnestic model of psychoanalysis, along the lines of "Remembering, Repeating, and Working-Through" (1914), is reaffirmed by the rediscovery in the Wolf Man case of "how remembering actually takes place, partly by way of evocation of 'a piece of real life' in repetition" (p. 81). Here Rossi uses a contemporary understanding of the centrality of enactments in the treatment. Many other contemporary analysts—and not only Italian ones (e.g., Renik 1993[2]; Smith 1997[3])—come to mind as representing a contemporary perspective on the apparently inevitable necessity of enactments, and of the need to examine them through the lens of transference and countertransference. One of the unique merits of Rossi's chapter, however, is his skill in finding and elucidating what appears to be a contemporary perspective in Freud's early work in the case of the Wolf Man.

[2] Renik, O. (1993). Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanal. Q.,* 62:553-571.

[3] Smith, H. F. (1997). Resistance, enactment, and interpretation: a self-analytic study. *Psychoanal. Inquiry,* 17:13-30.

In the chapter that follows, "The Witch of ha-ish Mosheh: Some Considerations (and Conjectures) on "'Analysis Terminable and Interminable,'" Patrizio Campanile, this annual's editor, discusses this paper of Freud's as forming one part of a triptych that includes *An Outline of Psycho-Analysis* (1940) and *Moses and Monotheism* (1939). Campanile pays particular attention to the fact that this paper took shape from within the vicissitudes of the psychoanalytic movement at that time. Campanile reads Freud in this essay as more remote, skeptical, and wise, and juxtaposes this particular sensibility with the political, scientific, and personal developments occurring around him.

Freud's pessimism in "Analysis Terminable and Interminable" (1937), according to Campanile, must be considered in light of the following staggering sequence of events: at eighty years of age, Freud had already had thirty-three mouth surgeries over the previous fourteen years; he had lost several significant psychoanalytic colleagues (Abraham in 1925, Ferenczi in 1933) and family members (most recently, his mother in 1930). With the Nazis in power after 1933, there followed the burning of Freud's books, the appointment of Jung to preside over the state-controlled psychotherapy association, the appointment of Goring's cousin as director of the Berlin and Vienna Psychological Association in 1936 and 1937, and the closing of the Verlag publishing house. Campanile describes how uncertain Freud must have felt about the future of the psychoanalytic movement, noting that he was particularly "tormented" by the situation of psychoanalysis in America (p. 91).

Campanile understands Freud's "torment" as related to the recent attempts (especially by Otto Rank) to shorten the duration of analyses—a movement seen by Freud as a "child of its time, conceived under the stress of the contrast between the post-war misery of Europe and the 'prosperity' of America, and designed to adapt the tempo of analytic therapy to the haste of American life" ("Analysis Terminable and Interminable," 1937, p. 216). Campanile's illumination of the background events in Freud's life may make the case for viewing "Analysis Terminable and Interminable" as an extended elegy to Ferenczi, and as a continued effort to mourn the loss of his friend-

ship, especially given its unresolved state at the time of his death. This idea may also be supported by the fact that other authors in this annual seem interested in Ferenczi (cf. Mangini in chapter 8), someone who is regarded as a psychoanalytic maverick, and therefore integral to the questions that Campanile suggests were a concern to Freud at this time.

Campanile points out that at the 1934 International Psychoanalytical Association Congress in Marienbad, which Freud did not attend, a day-long symposium was dedicated to the therapeutic results of psychoanalysis. Various contributors to the congress, such as Edmund Bergler, Edward Bibring, Herman Nunberg, James Strachey, Otto Fenichel, and Edward Glover expressed varying opinions. Freud's pessimistic attitude toward this topic, according to Campanile, "ran counter to the trend at the Marienbad symposium" (p. 93). Campanile expands his discussion of Freud's conservative view of the therapeutic effects of psychoanalysis, by citing contemporary writers as well, notably Arlow and Cooper.

Campanile ends his contribution by returning to "Analysis Terminable and Interminable," and by stressing his belief that the resistances within each analyst, and within psychoanalytic institutions, are what Freud most wanted to address in that essay: "These are the mechanisms involved between generations and between analysts as well, and they are not extraneous to the development of theories and positions we hold in the psychoanalytic movement" (p. 104). Here we can perhaps hear allusion to the current controversies over training and standards of psychoanalysis that seem to be, Campanile might say, unavoidably repeating themselves and continuing earlier conflicts in the history and literature of our field.

Fausto Petrella, in chapter 7, "Freud's Style: Terminology, Metaphor and Textual Strategies," resumes discussion of a topic of great interest to many of the writers of this annual, and especially to Napolitano in chapter 1 and to Rossi in chapter 5—i.e., Freud's style of writing and the objectives that he sought to achieve in developing that style. Petrella emphasizes the richness in metaphor and simile of Freud's writing—a richness drawn from many fields, but particularly employ-

ing similes of "space and energy" (p. 111). The need for such similes and metaphors reflects the fact that no vocabulary or language had previously existed for the phenomena and concepts that Freud discovered, and so he was required to struggle with the creation of an original lexicon. This development reflected two different fields of discourse, requiring two different genres of writing. The first field of discourse sought to describe a clinical experience, an individual history, and a course of analytic treatment, while the second discourse attempted to provide an explanatory model of psychic processes, i.e., a metapsychology.

Petrella is concerned about the split that can develop between these two realms of discourse when analytic writers and their readers lose sight of the personal—sometimes irrational but always experiential—foundation of those metapsycholgical concepts, and of the struggle Freud and his early collaborators underwent in developing them. In addition, Petrella is concerned with the banalization and meaningless, "textbook" feeling of certain metapsychological concepts when they become detached from the lived experiences of analytic practice.

Petrella argues for a continuous appreciation of the Freudian dialectical method, which maintains a tension between both poles, between a not too "hasty reaching for meaning" and a "turning one's back on meaning . . . precisely because the analyst has got hold of it but has rejected it as intolerable" (p. 120). Petrella compares this Freudian balance to Bion's idea of negative capability, wherein a space for psychoanalytic ideas is always maintained as provisional, open to correction and to greater refinement and precision drawn from additional observational evidence and experience. This dialectical tension, Petrella asserts, is the foundation for a unique Freudian style, both in his writing and in his clinical practice, tantamount to a "third topography":

> It means taking style as a generative principle which makes movement between the various points of view possible; which allows shifts between the clinical and the theoretical, thus permitting the adventure of conferring meaning to unfold within the play of analysis. [p. 121]

Petrella remains convinced that Freud was born with a gift to create metaphors. Petrella's agenda is not solely to praise Freud's literary style, however; he also means to emphasize the benefit to psychoanalytic progress afforded by Freud's capacity to depict and represent, since this enabled him to create a mental space for thinking about the theory, giving form and shape to the objects that it contained. This third Freudian topography, Petrella maintains, serves to "mediate" and to act as the flexible and provisional "connective tissue" between clinical practice and theory, thereby facilitating future growth and development by other analytic contributors.

The following chapter, by Enrico Mangini on "The Schreber Case: The Discreet Charm of the Paranoid Solution," is the first of three chapters devoted to Freud's other case studies. Mangini places Freud's conception of and composition of the Schreber case squarely within the context of Freud's relationship with Ferenczi, and specifically as it unfolded during their tense two-week holiday in Sicily during the summer of 1910. A study of the Schreber case within the context of this conflicted relationship enables Mangini to convincingly flesh out the homosexual dynamics that underlie Freud's theory of paranoia in his analysis of Schreber's memoirs.

Regrettably, Mangini passes over an opportunity in the paper to offer a critique and to suggest a reassessment of the linkage that Freud established between mourning, conflicted homosexual desire, and paranoia along more contemporary psychoanalytic lines. It has been proposed by other analytic writers (e.g., Frosch 1981[4]) that the unconscious homosexual features within paranoid dynamics are "secondary" and "pseudophenomena" (p. 587). Still other writers (Butler 1997[5]; Corbett 2001[6]) view paranoia and homosexuality in radically different and deconstructed terms, when compared to Freud's in the Schreber case. Contemporary views of gender theory and gender

[4] Frosch, J. (1981). The role of unconscious homosexuality in the paranoid constellation. *Psychoanal. Q.,* 50:587-613.

[5] Butler, J. (1997) Response to Lynne Layton's "The Doer Behind the Deed." *Gender & Psychoanal.,* 2:515-520.

[6] Corbett, K. (2001). Faggot = loser. *Studies in Gender & Sexuality,* 2:3-28.

development (Harris 2005;[7] Stryker and Whittle 2006[8]) might also have offered an enriched perspective to Mangini's discussion.

Mangini instead calls attention to Freud's development of a theory of narcissism—to complement his theory of psychosexuality, trauma, and repression—as thereby opening up the possibility of the psychoanalytic treatment of the psychoses. Mangini adds an additional important group dimension to this theoretical development in psychoanalysis, noting that consideration of the Schreber case came precisely at a time when Freud was expanding his psychoanalytic movement outside Vienna, to include Jung, Abraham, and Ferenczi, and was laying the groundwork for the establishment of a psychoanalytic institution with an organized form and structure. "It is known how group and institutional functioning is always at risk of paranoid rigidities, composed around phantasies concerning survival and transmission" (p. 135), notes Mangini. The author goes on to explain how these dynamics operate within our own contemporary psychoanalytic groups, as well as in groups undergoing crises or transitions. In discussing the projective functioning in Schreber's paranoia, Mangini notes that Freud described the phenomenon by observing that what was abolished internally returns from without.

Might this pathological development have been altered, Mangini wonders, had Schreber had access to an object's capacity for maternal reverie? The object's availability would then have provided a container into which the projections could have been directed—as may also be the case in hypochondria, when the body attempts to contain primary anxiety, a process often called "'paranoia of the body'" (p. 137).

Mangini concludes by noting Freud's concern about descendants, transmission, and safeguarding psychoanalysis. Like Campanile, Mangini refers to disputes over lay analysis and analytic training.

In the following chapter, Diomira Petrelli's essay on "A Case of Female Homosexuality: Notes and Comments on a Case with No

[7] Harris, A. (2005). *Gender as Soft Assembly*. London: Analytic Press.

[8] Stryker, S. & Whittle, S. (2006). *The Transgender Studies Reader*. New York: Taylor & Francis.

Name," begins by drawing interesting comparisons between this case and Freud's other and better-known 18-year-old, Dora. Petrelli notices traces—conspicuous, she thinks, by an absence of explicit acknowledgment—of Dora in much of the background of this case. Petrelli finds Dora in Freud's "unease," "like a traumatic 'residue'" (p. 152). Freud describes both girls as intelligent, good-looking, from proper families, and rebellious.

This particular girl's rebellion takes the form of an openly homosexual love affair, whereas in Dora it was disguised in hysterical symptoms. Both girls would not have sought treatment without parental insistence. This girl seemed more compliant, but frankly admitted no need to be rid of her homosexuality. Although both girls came to analysis at the insistence of their fathers, with this case, Petrelli writes, Freud was nearly twenty years older and therefore wiser—"more attentive . . . skeptical . . . disillusioned . . . ironic, and self-mocking" (p. 154).

Petrelli praises Freud for his modernity in his initial evaluation of this case. Unlike with Dora, Freud met the patient's mother in person, and found her to be subtly pleased by her daughter's choice of lovers, since in this way, Freud thought, she would be neutralized as a rival. In fact, Freud suspected both parents to be unconsciously colluding with their daughter's arrangement, despite their conscious objections, since it mollified the mother's hostility. Petrelli is also struck by Freud's contemporary view of adolescence, which he regarded as a developmental phase marked by new and critical psychic rearrangements, and which could become traumatically disrupted by life events such as occurred in this case with the birth of a brother. In addition, Petrelli praises Freud for not regarding her object choice as pathological, and for declining to view her as a case of "'physical hermaphrodism'" (p. 157).

Nevertheless, Petrelli notices that something is awry in the treatment. She states that throughout the analysis, Freud seems distracted by the recent traumatic birth of the patient's brother, as well as by the continual conflict with the father—to the exclusion of giving serious consideration to the abundant evidence for mutually hostile

feelings between mother and daughter, likely beginning in early childhood. As with Dora, the positive oedipal conflict gains prominence in Freud's clinical evaluations, overshadowing conflicts with and envy toward the mother.

The fateful unconscious comparison that Freud makes between this case and the Dora case is responsible, Petrelli believes, for his misgivings and eventual discontinuation of treatment. Unlike with Dora, who took the initiative and broke off the analysis, in this case, it is Freud who catches a glimpse "of that 'cruel' desire for revenge which had brought about the end of analysis in Dora's case" (p. 157). Petrelli believes that it was Freud's "traumatic residue" from Dora that "'demolished' all his hopes of taking therapy through to a good end" (p. 157).

Petrelli then makes the point—emphasized earlier by Rossi—that Freud's literary style sought to draw the reader into this case study as a co-creator and co-discoverer, akin to the style of his teacher Charcot. Petrelli writes that Freud achieves this by juxtaposing two events from different time periods, combining and interweaving the two different narratives, one of the patient's history and the other of the history of the analysis. Petrelli says that Freud thereby "aims to re construct in writing the course [that] analysis takes and to bring about in the reader the effect of actively participating in the process" (p. 159).

Petrelli also wants to show that Freud includes in his understanding of this case—and in his interpretations to his patient—ideas about masochism and perversion that he had been developing after completing "Mourning and Melancholia" (1917) and *Beyond the Pleasure Principle* (1920), as well as during the contemporaneous writing of "A Child is Being Beaten." One such central notion that Freud develops is the idea that "the ego can identify itself with an intensely hated object" (p. 160).

In the remainder of this essay, it is Freud's unconscious countertransference enactment that most occupies Petrelli's attention. While recognizing that Freud's narcissism was wounded by his patient's indifference to his interpretations, Petrelli believes that a "deep pessimism" (p. 164) also influenced Freud to dismiss her from analysis, because he had "a deep unconscious understanding . . . of the patient's

central problems. There was something that enabled him to feel, and probably come into contact with, the destructive range of the patient's unconscious behavior" (p. 163).

A shortcoming of this essay, I believe, is Petrelli's relatively shallow interest in, and appreciation for, a developmental perspective when considering this case. The fact that both this patient and Dora are adolescents is treated more as a peripheral issue than as a central factor around which discussion could be organized. Absent is any serious consideration of the nonsequential, developmental sea change, often experienced traumatically, to the adolescent body, self and object concepts, identifications, fantasy life, and behavior that occur at that time of life. Many contemporary adolescent researchers have focused upon these major issues in discussing both their own adolescent cases and the Dora case in particular.

The following chapter, by Giovanna Regazzoni Goretti, entitled "A Girl of Intelligent and Engaging Looks," is a riveting and illuminating discussion of the Dora case, the so-called companion case to the homosexual girl from the previous chapter. Goretti approaches this case full of a sense of mystery and puzzlement. She begins by pointing out the many inconsistencies and questions raised both by Freud's behavior in treating this case and by his writing. She notes that he worked on it immediately after the treatment was interrupted, finishing it in less than a month, perhaps as a salve to a painful interruption of the analysis. At first entitled "Dreams and Hysteria," it was immediately accepted for publication, but Freud held it back, initially for several rounds of editorial changes and then by requesting return of the manuscript. Four years later, with the new title of "Fragment of an Analysis of a Case of Hysteria" (1905), he resubmitted it for publication.

Goretti notes that Freud's reactions to the piece were thoroughly mixed. He wrote to Fliess that he thought it the most "subtle" thing he had written, yet he feared that it might "horrify" his readers. Goretti suggests that the case felt incomplete to Freud, as reflected in the title ("Fragment"). His word choice also reflects his conviction that every analysis must terminate with both patient and analyst facing

the inevitable limitation of what they can accomplish. Goretti reviews Freud's doubt over which "'unknown quantity'" he might have missed, and wondering whether the case would be persuasive (p. 170). Goretti points out how Freud's anxiety, many inconsistencies, and his fragmented and nonlinear writing style make the case seem more like a modern novel, and that it also appears to approximate "hysterical speech" (p. 171).

Having established Freud's disclaimers over the painful incompleteness of this case, Goretti then finds considerable evidence that, to the contrary, he is striving to achieve a complete understanding of this patient, her dreams, her symptoms, and her transference to him. Goretti seems to regard this as some sort of split working within Freud, noting that the strangeness of the case report is "perhaps because of the strange way in which the ego works, which is subsequently described by Freud, that is, one part of it knows while the other part behaves as if it did not know" (p. 172). Goretti wants to emphasize that since Freud's conscious goal was to explore "Dreams and Hysteria" (the first title of this paper), interpreting the transference was assigned a much lower priority, and in fact split off as well. Yet, Goretti recalls to our attention that, as early as *Studies on Hysteria* (1895, p. 300), Freud had been aware that one of the analyst's tasks is to intervene in order to put into words what had never before been said or thought. Goretti imagines it likely that one of the unthought knowns of this adolescent girl, anxious about being trapped with Freud, with whom one might lose control somatopsychically, was flight, in order to safeguard a fragile adolescent self.

Goretti explores, from a feminist and Lacanian perspective, what some of the theoretical clutter may have been that prevented Freud from being more open to his patient, and from finding a way to identify with her dilemma. Goretti suggests that this would have required Freud to think creatively while "under fire" (p. 179), especially in the final session before the unexpected breaking off of treatment, and to challenge her decision to terminate, rather than indifferently saying to her, "'You are free to stop treatment at any time,'" which defended the analyst against a painful insult (p. 180).

The significant coda to the Dora case that Goretti highlights is that she returned to see Freud after one year. Goretti seizes upon Freud's pessimism, and is very interested in trying to grasp his unwillingness to again accept Dora into analysis. Goretti proposes that "the blind spot in that clinical case, both during treatment and during successive additions and reflections, is femininity—Dora's, but also Freud's" (p. 182). But it is not only Freud's difficulty with femininity that concerns Goretti; it is also his difficulty with talking about maternal longings and longing for mothers, and Dora's deeply buried homosexual love for Frau K. "This tendency to uncover and then lose Dora's homosexuality as well as the difficulty of integrating it into the text, seems to exist alongside a forgetfulness which covers a broad range of theory concerning transference" (p. 183). Integrating both aspects into the treatment of Dora would have required Freud to see himself as the object of Dora's female homosexual love in the transference, which, Goretti thinks, Freud seemed incapable of doing.

"Isomorphism: A Transitional Area in Psychoanalysis," by Alessandra Ginzburg, is a chapter unlike any of the others in this annual since it deals with a topic that is not very well known by many psychoanalysts, at least in North America: Ignacio Matte Blanco's rather challenging idea that "an isomorphic function highlights the intrinsically classificatory component in the working of the mind" (p. 191).[9] Ginzburg helps the reader considerably by clarifying what she wants to discuss very gradually, at first via a brief case vignette and then by using concepts already familiar to analysts, such as *correspondences, parallels, transference, similitudes, displacement, projection,* and *condensation,* as well as by clarifying how all these processes, found in dreams, films, and fiction, can illustrate how the mind intrinsically makes links represented in each of these "isomorphic" processes.

Ginzburg then makes explicit what is to be "the theme of this paper: the inappropriate extension of identity to all isomorphic structures as a characteristic trait of the Unconscious and of emotions" (p. 191). Ginzburg continues her explication of the importance for

[9] *Editor's Note:* For more about Matte Blanco's thinking, the reader may wish to refer to Riccardo Lombardi's article in this issue, pp. 123-160.

Matte Blanco of the two modes of being and the two forms of logic: one is *asymmetrical,* seeing reality as divisible and heterogeneous, and the other is *symmetrical,* viewing reality as *one* and *indivisible* (p. 192). Matte Blanco considered the first to be typical of thought, and the second typical of emotion and of the unconscious. Ginzburg adds that Matte Blanco argued that people usually function in a *bi-logical,* mixed fashion. When we function exclusively in symmetrical logic, then, "the part becomes identical to the whole; space and time disappear; there is no contradiction and everything becomes compatible" (p. 192).

Ginzburg gives four extended case examples to further describe what she has in mind. One case illustrates how all objects belonging to a particular class, i.e., men, were regarded by her female patient as identical. Gradually, Ginzburg shows us, the men in her patient's life become more differentiated and less interchangeable as the patient became more capable of articulating increasingly specific qualities of the object. Ginzburg believes that "in traumatic situations, the mind remains trapped in the abstract dimension of the class—or . . . it withdraws to that dimension, losing all capacity for an individualized relation" (p. 194).

I found the placement of this otherwise interesting article in this particular collection of essays puzzling. It is difficult to see how this article and its topic fit with the others in this annual. With the possible exception of similar questions raised in regard to the analysis of psychosis, contained in the chapter on Schreber, I did not find much common ground with the overall topic of this collection of essays, that is, Freud's 150th anniversary, or with any of the other writers or their topics. Perhaps this seemingly misplaced article simply serves to highlight how remarkably interrelated are the remaining articles, making it appear to the reader as though the authors are seamlessly carrying on a clinical and theoretical dialogue with each other.

The final chapter, by Valeria Egidi Morpurgo, entitled "Why Does *Moses and Monotheism* Still Make Us Uneasy?," seems appropriately placed at the end of this collection of essays, since it is a commentary on Freud's own final contribution. Morpurgo begins her discus-

sion by characterizing Freud's ideas in *Moses and Monotheism* (1939) as a demonstration of "the originality and validity of *psychoanalytic thinking*, by showing us 'a revival of the ancient fight for interiority, to bring exteriority into interiority'" (p. 203, italics in original). Morpurgo shows how Freud brings this about by a careful review of his writings that discuss large and small group development and dynamics. She clarifies the interactive role that these group and individual dynamics have with one another by discussing oedipal dynamics in the formation of limits, religion, and group ethics.

According to Morpurgo, Freud remained concerned, throughout his writings on individuals and groups, with the conflict that exists between the fulfillment of individual desire and the limits to that fulfillment. Morpurgo traces this theme through Freud's earlier writings, such as *Totem and Taboo* (1912-1913), *Beyond the Pleasure Principle* (1920), *Group Psychology and the Analysis of the Ego* (1921), and *Civilization and Its Discontents* (1930), all of which lead up to the conjunction of oedipal dynamics and group dynamics in his comprehensive explanation for the persistence of anti-Semitism in *Moses and Monotheism*.

Morpurgo summarizes Freud's formulation for anti-Semitism as follows: "Those who carry the higher intellectual and spiritual values are repeatedly attacked, so that their much coveted and envied characteristics can be incorporated" (p. 205). Morpurgo does excellent work in summarizing all the main points in Freud's thesis about Moses as the Primal Father, murdered by his children, who continue to endure centuries of fratricidal and rivalrous struggles over who is favored by the dreaded father. Morpurgo, however, wishes to underscore that for Freud—and also for its relevance to a contemporary psychoanalytic perspective—"faithfulness to Mosaic legacy . . . implies the capacity to accept the limits of individual needs and the acceptance of oedipal norms and prohibitions" (p. 209). To Freud, "what seems so grandiose about ethics . . . owes these characteristics to its connection with religion, its origin from the will of the father" (p. 209).

Morpurgo takes up similarities between Jewish identity and flexibility, and the paradoxical capacity to maintain a bridge between one-

self and the other, that is, between individual and group identities (p. 214). She believes, referring to Janckelevitch (1964), that:

> The capacity to keep different truths or positions open within oneself, and to mediate without necessarily meaning a meeting point has to be found . . . this capacity "to be in the middle" arouses both admiration and envy and involves a strenuous oscillation, difficult to bear, but fruitful. [p. 215]

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This volume of essays has been a pleasure to read and rewarding to study. It constitutes a virtual minicourse in a psychoanalytic tradition from another culture and with another lexicon, a tradition that seems more sensitive to its own history, language, and text than is typically seen in psychoanalytic writing in the United States. As a group, these writers reflect often and deeply on the parts that they play as clinicians in the individual analyses that they conduct, and as teachers and colleagues in the analytic groups to which they belong. They take seriously the Freudian and Bionian ideas concerning primitive group processes that are ubiquitous in all group functioning. They seem to realize that analysts themselves can place psychoanalytic thinking and psychoanalytic practice in jeopardy as frequently as non-analysts can.

Furthermore, I was repeatedly struck by the intimacy of the dialogue in this annual. It seemed as though nearly every writer had read nearly every other writer's article and was responding with these others in mind. While this may reflect a certain parochialism, and perhaps even an exclusion of writers from diverse perspectives outside the roster of those who contribute to the *Rivista di Psicoanalisi*, it nevertheless reflects a literary and theoretical integration that is impressive and compelling.

Finally and most importantly, I was moved by the novel insights that these authors bring to many of Freud's writings—perspectives that are fresh and innovative. I look forward to next year's volume with the expectation that, no doubt, new and equally vital contributors will add their voices to the 2008 *Annual of Italian Psychoanalysis.*